United States General Accounting Office

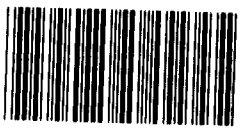
GAO

Report to Congressional Committees

March 1991

MEDICARE

Need for Consistent National Payment Policy for Special Anesthesia Services



GAO/HRD-91-23

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-242715

March 13, 1991

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

The Omnibus Budget Reconciliation Act of 1987 (OBRA) (P.L. 100-203) adjusted Medicare payments for anesthesia services and directed us to perform several studies of Medicare's anesthesia payment system. In addition, the conference report to that legislation directed GAO to perform an additional study, to which this report responds. We were to review the extent to which "modifier units" were used to allow extra anesthesia payments for such factors as a patient's age, physical status, or unusual risk circumstances, and the appropriateness of such payments.

In doing so, we examined a recent Health Care Financing Administration (HCFA) policy change concerning these payments and reviewed Medicare payments to anesthesiologists for special monitoring services. Our methodology, which included visits to 9 Medicare carriers and 11 hospitals across the country, is discussed in appendix I.

Background

Medicare bases payments for physician anesthesia services on what anesthesiologists in a given area normally charge for such services. Under this "reasonable charge" method, the carrier calculates the number of anesthesia payment units Medicare allows for a particular service and multiplies them by a "dollar conversion factor" for the geographic area in which the service was provided.[1] Before March 1, 1989,[2] anesthesia payment units had three components:

[1]The average dollar conversion factor among the carriers we visited was about $18.

[2]Effective March 1, 1989, HCFA limited the computation of anesthesia units to two components: base and time units.

1. Base units reflect the relative complexity of various anesthesia procedures.

2. Time units reflect the actual time the anesthesiologist spent providing the service or medically directing a nurse anesthetist. One unit was allowed for each 15-minute time interval for services personally provided by an anesthesiologist and for each 30-minute interval when an anesthesiologist was medically directing nurse anesthetists.[3]

3. Modifier units provided additional payments for factors that supposedly complicate the anesthesia procedures but not necessarily the related surgical procedures.

Historically, HCFA permitted Medicare payments for modifier units at the discretion of the insurance companies with which it contracts to process and pay claims (carriers). Effective March 1, 1989, HCFA revised its policy on separate payments for modifier units. It required carriers that previously had permitted these payments to discontinue them and to raise dollar conversion factors to compensate for the value of modifier units.

Carriers also decide whether to allow additional payments for special patient monitoring procedures,[4] such as placing catheters in a patient's body to monitor cardiac and vascular pressure. At the time HCFA revised its modifier policy, the agency required carriers to maintain their current payment policies for special monitoring procedures.

Results in Brief

Before 1989, because payments for anesthesia modifiers and special monitoring procedures differed considerably among carriers, Medicare paid some anesthesiologists more than others for identical services delivered under similar circumstances. In fiscal year 1988, of the 52 Medicare carriers, 33 paid an estimated $43-72 million for anesthesia modifiers. The other carriers did not reimburse for these factors.

HCFA recently discontinued separate modifier payments but required carriers to adjust payment conversion factors to compensate providers

[3]Before January 1, 1989, time units for anesthesiologists who were medically directing nurse anesthetists they employed were calculated in 15-minute intervals.

[4]Most carriers pay for these procedures as medical/surgical services, based on Medicare's "reasonable charge" methodology. However, some carriers allow payment units, essentially treating the procedures as modifier units.

for the value of the discontinued modifiers. Our analysis of Medicare payments made by nine carriers for eight common procedures indicated that this action did not eliminate the payment inconsistencies and inequities caused by the modifier payments. Rather, HCFA's action had the effect of perpetuating them. Also, HCFA allowed problems with special monitoring procedure payments to continue by requiring carriers to maintain prior practices.

To remedy this, HCFA should assess the appropriateness of additional Medicare payments for anesthesia services and establish a consistent national payment policy for such services.

Modifiers Resulted in Payment Inequities

Medicare payment practices concerning modifier units differed considerably among carriers; some allowed four or more modifiers, others a few, and some none. These inconsistencies, which HCFA could not justify, resulted in substantially different payments for identical anesthesia services delivered under similar circumstances.

Carrier Payment Practices Varied

Of 52 carriers responding to a HCFA July 1988 survey, 33 allowed anesthesiologists one or more payment modifiers (see table 1). Frequently allowed were payments for patient age, patient physical status, and emergency situations. However, both the type of modifier allowed and payment units for a given modifier differed considerably among these 33 carriers. For example, of the nine carriers we reviewed four allowed modifiers. One of these provided no additional payment for a patient over age 70, another allowed two payment units, and the remaining two allowed one unit. For total body hypothermia, one carrier allowed no additional payment while a second allowed 10 payment units.

Table 1: Medicare Carriers Using Payment Modifiers (1988)

No. of carriers	Payment modifiers allowed
19	0
7	1–3
26	4 or more

To illustrate the effect of the different carrier policies, table 2 compares an actual payment made by a carrier that allowed modifiers to the payment that would have been made for identical circumstances by a carrier that did not allow them. A Pennsylvania anesthesiologist was paid $319 for anesthesia services during emergency gallbladder surgery to a

74-year-old patient with severe systemic disease. Had he provided the services in Massachusetts, payment would have been $266, or $53 less. Because the carriers in the two states allowed the same number of base and time units and paid about the same conversion factors, this difference is due to the Pennsylvania carrier recognizing modifier units and the Massachusetts carrier not recognizing them.

Table 2: Example of Effect of Different Modifier Policies on Medicare Payments to Anesthesiologists

	Payment if made by	
	Pennsylvania	**Massachusetts**
Base units (removal of gallbladder)	7	7
Time units[a] (anesthesia services lasted 1 hour and 50 minutes)	8	8
Modifier units:		
Age 74	1	0
Severe systemic disease	1	0
Emergency	1	0
Total units	**18**	**15**
Conversion factor	$17.70	$17.75
Payment (total units x conversion factor)	$318.60	$266.25

[a]Time in excess of a whole unit was rounded up. Effective April 1, 1990, time units are based on actual time rather than rounded up to the next whole unit.

We tested whether modifier payments had the effect of equalizing payments with those in areas where modifier units were not allowed. For each of eight common procedures in our study, we compared the average anesthesia payment for base and modifier units, including conversion factors, made by the four carriers paying modifiers with those made by the five carriers that did not. We made 160 payment comparisons (4 carriers x 5 carriers x 8 procedures) and found that payments made by carriers paying modifiers exceeded payments made by the other carriers in 121 (76 percent) of the cases. For example, one anesthesiologist in rural Pennsylvania was paid, on average, about $106 for the base and modifier components of anesthesia services at cataract surgery; another providing the same services in Boston, on average, received $71. Similarly, an anesthesiologist in Jefferson City, Missouri, received $107 for these service components at prostate surgery while an anesthesiologist in Greenwich, Connecticut (a suburb of New York City), was paid $84. This indicates that modifier payments were not used to adjust for differences in dollar conversion factors and did not have the effect of balancing payments among carriers.

Modifier Units Costly to Medicare

In 673 physician anesthesia claims reviewed at the four carriers that allowed modifier units, payments for such units averaged almost 10 percent of total anesthesia payments (see table 3). The claims involved eight procedures provided during a 6-month period in 1987. HCFA also estimated that modifier units account for roughly 10 percent of anesthesia payments made by carriers allowing modifiers.

Table 3: Average Modifier Payments at Four Carriers

Carrier	Number of claims reviewed	Average modifer units allowed per claim	Modifier payments as a percent of total anesthia payments
AETNA Life and Casualty Co.	30	8	20
Blue Shield of California	186	2	11
General American Insurance Co.	68	1	3
Pennsylvania Blue Shield	389	2	9
Total	673		
Weighted average		**2.1**	**9.8**

Modifiers accounted for about $8,400 (5.8 percent) of the approximately $145,400 allowed for seven procedures. For the eighth, heart bypass, the carriers allowed $126,000, of which about $18,300 (14.5 percent) was for modifier units. Average modifier units allowed for heart bypass procedures were high because three of the four carriers paid for special monitoring services provided in heart surgery as part of their modifier units. For example, one carrier allowed up to 10 additional units for one such service—insertion of a Swan-Ganz catheter.[6]

HCFA could provide no estimate of Medicare payments for anesthesia modifier units. A rough extrapolation of available data[7] indicates that these payments totaled $43-72 million during fiscal year 1988.

[6]A procedure in which a flow-directed catheter is placed in a patient to monitor cardiac and vascular pressure.

[7]We applied the percentage of carriers allowing modifier units (33 out of 52, or 63 percent) to fiscal year 1988 anesthesia payments ($1.2 billion) and multiplied the result by the percent of total anesthesia payments that modifiers represent. We used two percentages for this last step, one (5.8) that represents the weighted average for seven procedures (excludes heart bypass), and a second (9.8) that includes modifier units allowed for heart bypass procedures. We could not separate out the number of modifier units allowed for special monitoring of heart bypass procedures.

Payment Policies for Special Monitoring Procedures Inconsistent and Inequitable

Carriers' policies on additional payments for special patient monitoring procedures are inconsistent, as are the amounts allowed for a given procedure. As with modifiers, carriers decide whether to allow additional payments for these special procedures. Most carriers pay for at least one type of special monitoring procedure but differ substantially in amounts allowed for identical procedures.

Of the 52 carriers responding to HCFA's July 1988 questionnaire, 44 allowed additional payments for special monitoring procedures. Although the number of procedures and amounts allowed varied, each of these 44 recognized the Swan-Ganz procedure. Ten carriers allowed only one special monitoring procedure (the Swan-Ganz), while 34 allowed additional procedures (see table 4).

Table 4: Medicare Carriers Allowing Special Monitoring Procedures
(1988 HCFA Survey)

No. of carriers	Special monitoring procedures allowed
8	0
10	1
6	2
28	3 or more

In addition, payments for the same special monitoring procedure differed dramatically from one carrier to another. For the most commonly allowed procedure, Swan-Ganz, payments ranged from an average of $63 in Louisiana to $561 in areas of New York. This difference is even greater when the eight carriers that did not allow additional payment for this procedure are considered, as table 5 shows.

Table 5: Estimated Payment Differences for the Swan-Ganz Monitoring Procedure
(1988 HCFA Survey)

No. of carriers	Range of payments allowed
8	None
8	Less than $100
8	$100 to $199
8	$200 to $299
7	$300 to $399
0	$400 to $499
2	$500 or more
11	Not available[a]

[a]Eleven carriers reported paying for this procedure but did not specify payment amounts.

HCFA Policy Continues Payment Inconsistencies; Appropriateness Not Demonstrated

HCFA has questioned the equity and appropriateness of payments to anesthesiologists for modifiers and special monitoring procedures. But recent agency policies have continued past practices and, for modifier payments, have perpetuated existing inequities.

Effective March 1, 1989, HCFA

- eliminated separate payments for modifier units but required carriers that had allowed these units to raise conversion factors to compensate anesthesiologists for the resulting payment reductions, and
- required individual carriers to continue their existing payment policies for special monitoring procedures despite the agency's own concern about nonuniform payment policies.

In each case, the result was a continuation of additional payments without HCFA's determining whether such payments were appropriate. HCFA's action might have been appropriate, if by increasing conversion factors by the value of discontinued modifiers and thus adjusting for different dollar conversion factors, it had equalized anesthesia payments. However, our analysis of conversion factors and the effects of modifier payments indicated this was not the case (see p. 4). A HCFA contractor, tasked with examining variation in anesthesiologists' fees, agreed. In a November 1989 report, the contractor stated that in essence HCFA's new policy "lock[s] in historical distortions resulting from carrier discretion to pay (or not to pay) for modifiers."[8]

Although we did not assess whether they were medically justified, payments for modifiers and special monitoring procedures are a departure from Medicare's usual physician reimbursement process. For example, surgeons receive the same compensation for a procedure regardless of the patient's age.

The absence of a relationship between patient age or physical status and anesthesia time indicates that additional anesthesia payments for them are questionable. A possible justification would be that these factors extend the time needed to provide services. But when we analyzed over 1,500 sample cases, we found no consistent relationship. As age increased, anesthesia time either decreased or remained relatively constant for seven of eight procedures. As a patient's physical status worsened, anesthesia time increased for only three of eight procedures. For

[8]Center for Health Economics Research, Geographic Variation in Anesthesiologists' Fees, Final Report, Nov. 1989, p. 1-2. (Research supported by HCFA grant No.17-C-98999/1.)

the sample cases we reviewed, the average anesthesia times for each procedure by age and physical status, respectively, appear in appendixes II and III.

Anesthesiologist and nurse anesthetist organizations have expressed support for reimbursement by all carriers for modifier units and special monitoring procedures. The American Society of Anesthesiologists (ASA) argues that modifiers are a necessary element to measure patient-unique circumstances which, when present, complicate the delivery of anesthesia services. Similarly, ASA states that special monitoring procedures should receive additional reimbursement because they are not the ordinary methods used to accomplish the anesthesiologist's responsibility for maintaining patient vital functions.

HCFA officials have expressed concern, not only with payment inequities among carriers, but also with whether such additional payments are justified. In January 1989, HCFA proposed rules to implement a uniform relative value guide for anesthesiology services. The rules stated that allowing each carrier to continue its current modifier unit policy would continue the variations among carriers and was inconsistent with statutory direction to standardize some anesthesia payment components.[9] In its August 1990 final rule, HCFA expressed concern that continuing various payment practices for special monitoring procedures would result in nonuniform payment policies "for services that represent an integral part of the anesthesia service for a surgical patient." Also, HCFA said, separate modifier payments could establish a precedent for other physician specialties.

Recommendations

We recommend that the Secretary of Health and Human Services direct the Administrator of HCFA to establish a consistent national policy for Medicare payments for anesthesia procedures. As part of the effort to establish a fee schedule for anesthesia services based on the resource-based relative value scale, the appropriateness of any additional payments for modifiers and special monitoring procedures should be assessed. If such payments are not justified, HCFA should ensure that prior carrier payment policies for modifiers and special patient monitoring do not influence payment levels under the fee schedule.

[9]OBRA required HCFA to develop a uniform relative value guide for determining anesthesia base units. More recently, as part of physician payment reform legislation, the Congress required that HCFA use this guide to the extent practicable in establishing a fee schedule for anesthesia services. Fees for physician services, including anesthesia, must be based on a resource-based relative value scale developed by HCFA.

Comments and Our Evaluation

The Department of Health and Human Services (HHS) and ASA provided written comments on a draft of this report. HHS's comments and our evaluation of these comments appear in appendix IV; ASA's, in appendix V.

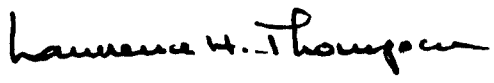
Regarding modifier payments, HHS agreed that the payment inequities may have continued as a result of increasing conversion factors when separate payments for modifiers were discontinued. HHS said that the reduction in conversion factors, required by section 4103 of the Omnibus Budget Reconciliation Act of 1990, will reduce much of the unjustified variation attributable to modifier units. Also, HHS noted, the fee schedule to go into effect beginning January 1, 1992, eventually will eliminate inappropriate variation in payment for anesthesia services. Regarding special monitoring procedures, HHS said it recognizes a need to establish a uniform national policy and plans to do so when implementing the physician fee schedule.

HHS's comments clearly express its intention to institute, under the physician fee schedule, uniform policies for modifier units and special monitoring procedures. Whether differences in carrier recognition of modifier units and special monitoring procedures affect payment levels under the fee schedule depends on the specific methods and data used to set conversion factors for the schedule. Because HHS has not yet made decisions about these factors, we cannot assess whether the issues addressed by our recommendations will be resolved.

Agreeing that HCFA's action to eliminate separate payments for modifiers had the effect of sustaining payment inequities, ASA believes that modifier units should be recognized by all carriers. ASA also said that Medicare policy for paying special monitoring procedures should be consistent and that separate codes should be provided for invasive procedures, such as catheter insertion, performed by anesthesiologists. As does HHS, ASA believes that implementation of a physician fee schedule, beginning in 1992, eventually will eliminate the payment inequities caused by payments for modifier units.

We are sending copies of this report to interested congressional committees and subcommittees, the Secretary of Health and Human Services, and other interested parties. This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues,

who may be reached at (202) 275-5451. Other major contributors to this report are listed in appendix VI.



Lawrence H. Thompson
Assistant Comptroller General

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Abbreviations

ASA	American Society of Anesthesiologists
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OBRA	Omnibus Budget Reconciliation Act of 1987

Objectives, Scope, and Methodology

At nine carriers, we determined carrier payment policies related to anesthesia modifier and special monitoring procedures and verified their responses to a HCFA July 1988 questionnaire that asked Medicare carriers how they reimbursed anesthesia services. We also obtained anesthesia and surgery time data for anesthesia services provided during the period July-December 1987 at 11 hospitals covered by the 9 carriers. Hospitals were judgmentally selected to provide a teaching/nonteaching, rural/urban mix. The carriers and hospitals were:

- Blue Shield of Massachusetts (Brigham and Women's Hospital)
- Travelers Insurance Co. (Greenwich Hospital)
- Pennsylvania Blue Shield (Ashland State General Hospital, Geisinger Medical Center, Milton Hershey Medical Center)
- Prudential Insurance Co.[1] (Haywood County Hospital)
- Florida Blue Shield (St. Vincent's Medical Center)
- Blue Shield of Iowa (Iowa Methodist Medical Center)
- General American Insurance Co. (Jewish Hospital of St. Louis)
- Aetna Life and Casualty Co. (Walter Boswell Memorial Hospital)
- Blue Shield of Northern California (Sequoia Hospital)

We sampled 1,648 cases at these hospitals for 10 procedure codes, which generally represented those with the highest Medicare allowed dollar amounts and comprised about 30 percent of all part B Medicare payments for anesthesia services. The procedures included two heart bypass and two cataract procedures, which we consolidated into one procedure each for analysis. For each sample case, we gathered patient demographic and physical condition data and data related to the surgery performed, such as surgery time and anesthesia time.

To determine how patient age and physical status affected anesthesia time and its three distinct service components (preoperative, surgery, and postoperative times), we analyzed the time data. Preoperative time begins when the anesthesiologist starts to prepare the patient for anesthesia and ends when surgery begins (incision). Surgery time begins at incision and ends when the incision is closed (closure). Postoperative time begins at closure and ends when the anesthesiologist releases the patient to postoperative care personnel. We excluded cases involving patients under age 65 or ASA physical status P1 (a normal healthy patient) or P5 (a moribund patient who is not expected to survive for

[1]The Prudential Insurance Company was the Medicare Part B carrier for North Carolina at the time GAO's review began. However, effective January 1, 1989, EQUICOR became HCFA's contractor for North Carolina's Medicare Part B program.

24 hours with or without the operation) from our analyses because of the small number of cases. From the physical status analysis, we also excluded cases for which physical status was not indicated. After these exclusions, our age and physical status analyses included 1,574 and 1,506 cases, respectively.

We discussed Medicare's reimbursement policies for anesthesia services with representatives of the American Society of Anesthesiologists, the Anesthesia Care Team Society, and the American Association of Nurse Anesthetists. Our work was conducted from October 1989 to August 1990 in accordance with generally accepted government auditing standards.

Average Anesthesia and Surgical Times for Eight Procedures, by Age

Surgical procedure	Anesthesia time component	Anesthesia/surgical time (minutes) by age group		
		65-69	70-74	75+
Total hip replacement	Total anesthesia	216	201	183
	Surgical	147	130	115
	Preoperative	57	56	52
	Postoperative	12	15	16
Femur fracture	Total anesthesia	189	161	142
	Surgical	102	92	72
	Preoperative	74	55	54
	Postoperative	13	14	15
Heart bypass	Total anesthesia	306	315	308
	Surgical	219	228	224
	Preoperative	62	64	60
	Postoperative	25	22	24
Colon	Total anesthesia	202	182	184
	Surgical	150	133	130
	Preoperative	34	33	39
	Postoperative	18	15	16
Gallbladder	Total anesthesia	121	133	152
	Surgical	77	90	97
	Preoperative	29	29	35
	Postoperative	15	13	20
Inguinal hernia	Total anesthesia	108	107	97
	Surgical	67	68	62
	Preoperative	28	28	26
	Postoperative	12	11	10
Prostate	Total anesthesia	98	94	96
	Surgical	53	53	54
	Preoperative	34	32	31
	Postoperative	11	9	11
Cataract	Total anesthesia	85	87	83
	Surgical	45	46	45
	Preoperative	33	34	31
	Postoperative	7	6	7

Average Anesthesia and Surgical Times for Eight Procedures, by Physical Status

Surgical procedure	Anesthesia time component	Anesthesia/surgical time (minutes), by physical status		
		P2[a]	P3[b]	P4[c]
Total hip replacement	Total anesthesia	211	184	159
	Surgical	136	121	92
	Preoperative	59	49	56
	Postoperative	16	14	11
Femur fracture	Total anesthesia	192	145	146
	Surgical	102	78	69
	Preoperative	72	53	64
	Postoperative	18	15	13
Heart bypass	Total anesthesia	243	314	326
	Surgical	174	223	237
	Preoperative	49	65	66
	Postoperative	21	27	23
Colon	Total anesthesia	196	182	215
	Surgical	140	133	151
	Preoperative	39	33	45
	Postoperative	17	15	19
Gallbladder	Total anesthesia	133	144	157
	Surgical	89	93	97
	Preoperative	29	34	39
	Postoperative	15	17	22
Inguinal hernia	Total anesthesia	106	99	107
	Surgical	69	62	62
	Preoperative	26	25	34
	Postoperative	10	12	12
Prostate	Total anesthesia	104	91	101
	Surgical	58	48	54
	Preoperative	33	32	38
	Postoperative	12	11	9
Cataract	Total anesthesia	84	86	92
	Surgical	44	46	63
	Preoperative	34	33	25
	Postoperative	6	8	4

[a]A patient with mild systemic disease.

[b]A patient with severe systemic disease.

[c]A patient with severe systemic disease that is a constant threat to life.

Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

DEC 17 1990

Mr. Lawrence Thompson
Assistant Comptroller General
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Medicare: Need For Consistent National Payment Policy For Special Anesthesia Services." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Medicare: Need for Consistent National Payment Policy for Special Anesthesia Services"

Overview

GAO's draft report discusses Medicare's allowance of additional payments for anesthesia modifiers. These modifiers include patient age and health as well as special monitoring services. According to GAO, these allowances have resulted in payment inconsistencies and inequities. In addition, GAO believes the Health Care Financing Administration's (HCFA's) action in 1989 to discontinue separate modifier payments, while requiring carriers to increase conversion factors by the value of the discontinued modifiers, had the effect of continuing payment inconsistencies. Accordingly, GAO recommends that HCFA establish a consistent, national policy for anesthesia payments.

Section 4048(d) of the Omnibus Budget Reconciliation Act (OBRA) of 1987 requires GAO to study several aspects of anesthesia services, including:

(1) average anesthesia times reported for Medicare payment purposes;

(2) verification of those times from patient medical records;

(3) comparison of anesthesia and surgical times; and,

(4) determination of whether current payments of physician supervision of nurse anesthetists are excessive.

In discussing this provision, the Statement of Managers mentions: "The GAO shall also examine the extent to which physicians bill and carriers recognize modifier units for reimbursement purposes and the appropriateness of such billings."

See comment 1

We have reviewed this draft report. We were disappointed that the report does not contain any information on the (or even any reference to) four aspects of anesthesia payment specified in the statutory language. Rather, this report is exclusively on modifiers.

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Our disappointment is based on the fact that modifiers were eliminated with implementation of the uniform relative value guide on March 1, 1989. Thus, modifiers are no longer an issue. However, the use of time for anesthesia services is still a very relevant issue, especially since the preamble to the regulation implementing the uniform relative value guide announced HHS's intent to eliminate time. Likewise, payment for physician supervision of nurse anesthetists is still a very relevant issue.

We would still very much like to see more detailed analyses of anesthesia time. If GAO has any relevant data on anesthesia time, it would be worth sharing it with HCFA by the end of 1990 so that it could be incorporated into fee schedule regulation deliberations.

While GAO recognizes that modifiers have been eliminated, its conclusion is that the result has been to perpetuate payment inequities among areas. This conclusion must be put in context of the extensive changes in Medicare payment rates for anesthesia services that will take place in 1991 and under the Medicare fee schedule beginning in 1992. Any historical inequities will be adjusted under these provisions.

See comment 2

Additionally, the report confuses the carriers' policy on modifier units with the carriers' policies on specialized medical/surgical services furnished by anesthesiologists during, or as part of, the anesthesia service to the patient. The confusion is caused by the fact that some carriers pay specialized procedures on the basis of "modifier units" multiplied by a reasonable charge conversion factor. If the report is to deal with both issues, we suggest that a clearer delineation be drawn between the elimination of modifier units and continued payment for specialized services.

GAO Recommendation

We recommend that the Secretary of HHS direct the Administrator of HCFA to establish a consistent, national policy for Medicare payments for anesthesia procedures. As part of the effort to establish a fee schedule for anesthesia services based on the Resource Based Relative Value Scale, the appropriateness of any additional payments should be assessed. If not justified, HCFA should ensure that prior carrier payment policies for modifiers and special patient monitoring do not influence payment levels under the fee schedule.

Page 3

Department Comment

See comment 3.

The report does not correctly present HCFA's position on specialized care services. We are aware of the lack of uniformity in carriers' policies with respect to specialized care services. We did acknowledge in the final regulations to implement the uniform relative value guide that this matter is beyond the scope of the uniform relative value guide. The uniform relative value guide treats anesthesia services while the specialized care services represent medical/surgical services. In the Model Fee Schedule Notice published in September 1990, we specifically acknowledged that we need to develop a standardized national policy for specialized care services and presented some options for accomplishing this goal. We will specifically treat this issue in the proposed regulations to implement the physician fee schedule.

The report points out that while HCFA eliminated modifier units, it did not remove the underlying variation in payment due to modifier units. The GAO conducted the analysis to show that on a comparative basis, the conversion factors of carriers who recognized modifier units may be higher than the conversion factors of carriers who did not recognize modifier units. As a result, inequities in payments have been continued under the uniform relative value guide.

We do agree that this result may be true for the limited number of carriers that were surveyed in the GAO study. However, we do not believe it is true for all carriers. In spite of GAO's finding, it is our view that the OBRA 1990 legislation providing for reductions in anesthesia conversion factors will reduce much of the unjustified variation attributable to modifier units or other factors not specifically adjusted during the conversion to the uniform relative value guide. The 1990 legislation provides for a reduction of up to 15 percent in the conversion factors of those carriers whose 1990 conversion factors are greater than their geographic index adjusted conversion factors. Moreover, the physician fee schedule going into effect January 1, 1992, will eventually eliminate inappropriate variation in payment for anesthesia services (i.e., the only variation will be due to the effect of the geographic adjustor).

See comment 4.

Technical Comments

The following are GAO's comments on the letter from the Department of Health and Human Services dated December 17, 1990.

GAO Comments

1. On December 5, 1990, we gave HHS for its comment a draft report discussing Medicare payments for anesthesia time and addressing three of the four study aspects delineated by section 4048(d) of OBRA. An ongoing GAO study is examining the fourth aspect—whether payments for physician supervision of nurse anesthetists are excessive.

2. We modified or added text to more clearly delineate the differences in carriers' payment policy for modifier units and special monitoring procedures.

3. The report points out on page 8 that HCFA has been concerned about the lack of uniformity in paying for special monitoring procedures since early 1989. Additionally, we added text reiterating HCFA's concern about uniformity.

4. HHS also offered several technical comments. We considered these and made revisions where appropriate.

Comments From the American Society of Anesthesiologists

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

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December 14, 1990

Lawrence Thompson
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441 G Street, N.W.
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Dear Mr. Thompson:

The American Society of Anesthesiologists is submitting comments on the General Accounting Office draft report, "Need for Consistent Policy for Special Anesthesia Services." This report examines 1) the use of modifier units in paying for anesthesia services, 2) the use of a related Medicare anesthesia payment factor for special patient monitoring services, and 3) associated HCFA policy changes.

Modifier Units

When HCFA adopted the 1988 ASA Relative Value Guide (RVG) as the uniform RVG for use by all Medicare carriers, they eliminated separate recognition of the ASA physical status and special circumstances modifiers. ASA strongly objected to this decision, which removed an excellent measure of severity of illness and an integral part of the ASA RVG. HCFA's rationale was that not all carriers recognized the same, or even any, modifiers, and that to cover modifiers uniformly could not be done in a budget neutral fashion.

We agree with the GAO's objections to HCFA's methodology in eliminating modifiers. In essence, as described in the GAO report, HCFA eliminated separate recognition of modifiers, yet they increased the local Medicare prevailing conversion factor by the amount estimated to have been paid for the previously recognized modifiers, thus maintaining budget neutrality at the local level. This has, as correctly noted, given us the worst of both worlds: a valuable measure of patient condition has been lost, and payment inequities sustained.

ASA prepared and submitted to HCFA an alternate and improved set of physical status measures: more objective, verifiable, and less expensive. We continue to believe that ASA's proposed

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elimination of the age modifier, and tightened definitions of others, would yield enough budget savings so that our proposed restructuring of the remaining physical status modifiers could easily have been recognized by all the carriers. HCFA rejected the revised modifier structure in part because they could not estimate the costs -- this is interesting since they apparently could estimate the cost of the elimination of modifiers.

In summary, while ASA continues to object to the elimination of physical status modifiers, the faults with HCFA's methodology are made moot by the implementation of RBRVS. As anesthesia conversion factors move toward a national average, beginning January, 1991, the historical payments become meaningless. From a policy and clinical care perspective, however, we stand by the RVG system, including modifiers, as the best measure of anesthesia care. As the RBRVS is further refined, and as severity measures are investigated, we will pursue inclusion of our modifier system.

Specialized Forms of Monitoring

The GAO also addresses the lack of uniformity in HCFA's policy on payment for specialized forms of monitoring, such as Swan Ganz catheters, central venous pressure and arterial lines. The majority of carriers, (44 of 52) allow some additional payments for such services.

ASA agrees with GAO that the Program should have consistent policy regarding specialized forms of monitoring. The September 4, 1990 Model Fee Schedule notice again raised this issue, and ASA responded to HCFA that there must be national recognition of these services. ASA stated:

> We wish to make perfectly clear that ASA is not suggesting that anesthesiologists should be reimbursed for the monitoring of the patient by use of these invasive techniques. Rather, it is the invasive procedure, itself -- a medical act entirely distinct from the administration of the anesthetic -- which merits reimbursement. It is ASA's position that noninvasive monitoring, e.g., pulse oximetry or capnography, is routine, is included in the procedure base units, and should never be billed separately. The specialized invasive procedures, however, are not routine and need is normally determined not by the surgery, but by the individual patient's physical condition.

We think GAO would agree that HCFA should not, as is apparently contemplated, account for these services using methodology similar to that applied to the modifier situation. The Model Fee Schedule notice discusses options for reimbursement of these services, implying that the entire payment system for anesthesiologists would be adjusted, up or down, depending on the coverage decision.

We take strong exception to the methodology proposed by HCFA. There is no justification, from either a financial or policy perspective, to adjust the anesthesia conversion factor to "compensate" for coverage of these procedures:

- These are specialized services which are not required in every patient; adjustment of the conversion factor which will be used for every anesthetic provided to every Medicare patient is entirely inappropriate.

- These procedures are separate and distinct from the anesthetic service; the base units cannot anticipate their inclusion as they are case-specific. (Please also note that there is no additional anesthesia time associated with or billed for these procedures.)

The various codes in question are surgical codes and the payment must be based on the RBRVS payment determined for such codes, without regard to specialty. This will eliminate the payment variations found by GAO.

In summary, ASA would like to see a uniform policy which recognizes the placement of medically necessary invasive monitoring devices. Such placement requires skill and training, entails risk to the patient and liability to the physician.

We appreciate the opportunity to review the draft report.

Sincerely,

Betty P. Stephenson

Betty P. Stephenson, M.D.
President

BPS:kc

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