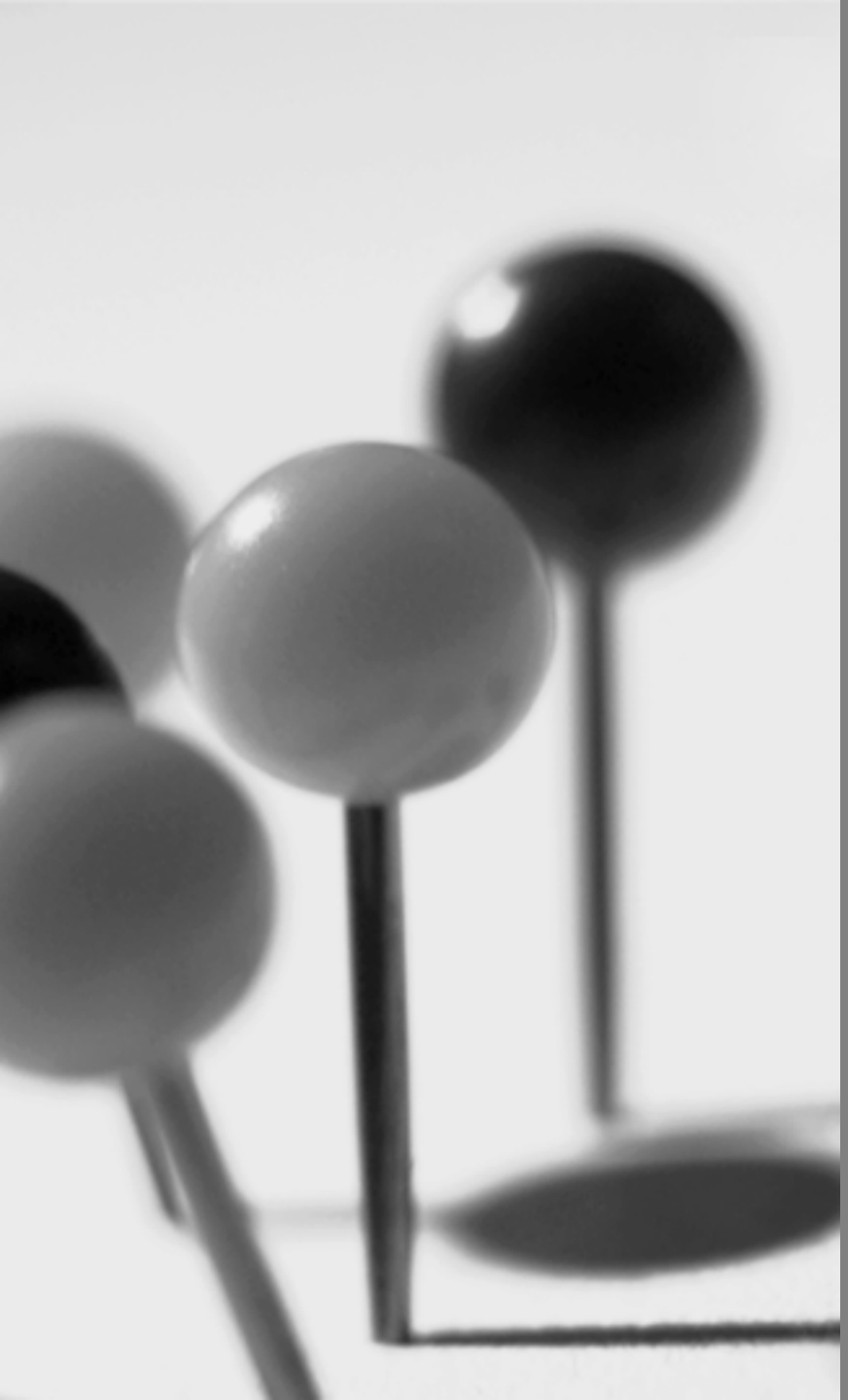

ANESTHESIA RVU'S: MUST WE BE DIFFERENT THAN EVERYONE ELSE?

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DISCLOSURES

- If we don't change and anesthesia becomes the poor nursing cousin of the medical community, I will lose my nice job
- I wasn't all that …..appreciated…. when I served on the ASA Task Force on Payment Methodology because I said the same things 8 years ago.

Goals

- Suggest a coherent scheme to move Anesthesia to RBRVS billing
- Pay anesthesiologists more for more complex care
- Provide value for higher levels of certification, not for ability to bill
  - Pre-empt CRNA independent practice by making it not any more profitable than working in the care team
  - Value board certification
- I did not have the resources to calculate the national effect of these changes, but should sane remuneration and the long term economic health of our specialty be held hostage to current salaries?

Simple truths

- Our payment scheme is different than those of 600,000 other physicians, including similar critical care specialties like intensivists and ER docs

Simple Truths

- Our payment scheme rewards time primarily
- What about RVU differentials? Well, when you consider a AAA (15u) takes 5-10 times as long as a colonoscopy(5u), base units are insufficient compensation in big cases.
- Any change to this is bad for people who make a ton of money taking care of healthy patients

Simple Truths

- Our payment scheme rewards time without regard to how hard the work is during the time billed
  - AAA vs colonoscopy

AAA vs Colonoscopy

AAA vs colonoscopy10_20.xlsx

Simple Truths

- Our payment scheme rewards time without regard to who is doing it
  - BECAUSE we don't differentiate the tough cases we MAKE the case for opt-out and CRNA independent practice
    - The army has CRNA's practicing without us, but there usually is a doc to call……
    - And they do minor cases on healthy people with supposedly limited problems
    - And the army pays the doc to "hang out"

Simple Truths

- Our payment scheme rewards time without regard to who is doing it
  - BECAUSE the ASA refuses to acknowledge there is a difference between board certified docs and those without certification, it lessens the value of a board certified physician supervising or doing complex cases compared to others

Simple Truths

- We lose the support of other physicians because they don't understand how we get paid, AND we make a lot of money

CPT Decision Making

Evaluation and Management (E/M) Services Guidelines

Table 1
Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Types of Decision Making
minimal	minimal or none	minimal	straightforward
limited	limited	low	low complexity
multiple	moderate	moderate	moderate complexity
extensive	extensive	high	high complexity

FIVE BY FOUR SOLUTIONS:

- CPT recognizes five types of presenting problems, which drives illness decision making (page 7, 2010 guide)
  - Minimal
  - Self limited or minor
  - Low severity
  - Moderate severity
  - High severity

Five by Four Solutions

- CPT recognizes FOUR types of medical decision making (page 10, 2010 guide)
  - Straightforward
  - Low complexity
  - Moderate complexity
  - High complexity

Five by Four Solutions*

- We would mirror this preop (5 presenting types of patients) and intraop (4 levels of complexity of decision making/management)
- "Critical care and other E and M services may be provided to the same patient on the same date by the same physician"

*Nascent thoughts on this were driven by the Lema 3 by 3 model which married preop complexity and case complexity with gradation in payment

Billing Pt Evaluation

- Ditch the ASA classification for payment reasons. Use it to define complexity.
  - Five presenting classes of patients
    - ASA 1
    - ASA 2
    - ASA 3 or 6
    - Multiple ASA 3 co-morbidities or ASA 4
    - Multiple ASA 3/4 co-morbidities or ASA 5

Billing Pt Evaluation

- By definition 99231-99235
  - ASA 1
  - ASA 2
  - ASA 3 or 6
  - ASA multi-3
  - ASA Multi-3/4 or 5
- This more accurately describes the level of thinking we must do and values appropriately higher expertise
- All preops are "new" c/w ER evaluations
- Need to be able to confirm preop clinic nursing evaluations, repeating critical parts

Billing PACU Care

- To bill or not to bill, that is the question.
- OF COURSE! It ain't included unless we do nothing (which is usual).
- If we see the patient, we bill for established patient visit with corresponding preop or intraop complexity (higher one if conflicting) with appropriate documentation each time.

Billing Time

- Ditch the ASA RVU guide EXCEPT as an indicator of physiologically complex cases
  - Four types –
    - 3-6 units – office face time payment
    - 7-10 units – critical care
    - 10-13 units – critical care
    - > 14 units – pediatric critical care
  - Cannot bill more than one of these at a time. Concurrent cases are standby payments
  - > 14 unit cases - pedi critical care billing - (open AAA, heart, liver tx) is reduced to critical care if you cover more than that one case

Billing Time

- "Time reported as critical care is the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit" - pg 21 CPT 2010
- While coffee drinking, more thinking
- Have centralized monitor beam data into the coffee room

TIME AND CRNA'S

- Supervise as many as you want – no limit. Let CRNA's practice MORE independently ***with*** us, side by side, brothers and sisters together
- Pay the CRNA's the same (office face time) whether they are doing independent healthy patients alone or sick patients as part of the care team
- Back-up of CRNA care without direct MD involvement is valued AND paid (once each time period) in addition to any direct E&M or supervisory work

Codes to Use and Comparative Values

- AAAC_Lubarsky 2.xlsx

AAA vs. Colonoscopy – New

- AAAC_Lubarsky 3.xlsx

Additional Features

- Like critical care, other CPT coded services are bundled or not as dictated by CMS
- Like Emergency medicine –all patients are considered new, and time requirements for E&M codes are not applied
- Like Anesthesia now, CRNA's are reimbursed as part of the care team without inflating value of service ,to any particular patient (is this right? Isn't a care team more eyes on the patient?)
- Unlike now, I suggest that non-board certified physicians would be paid no higher than CRNA rates and would be discouraged from doing complex cases

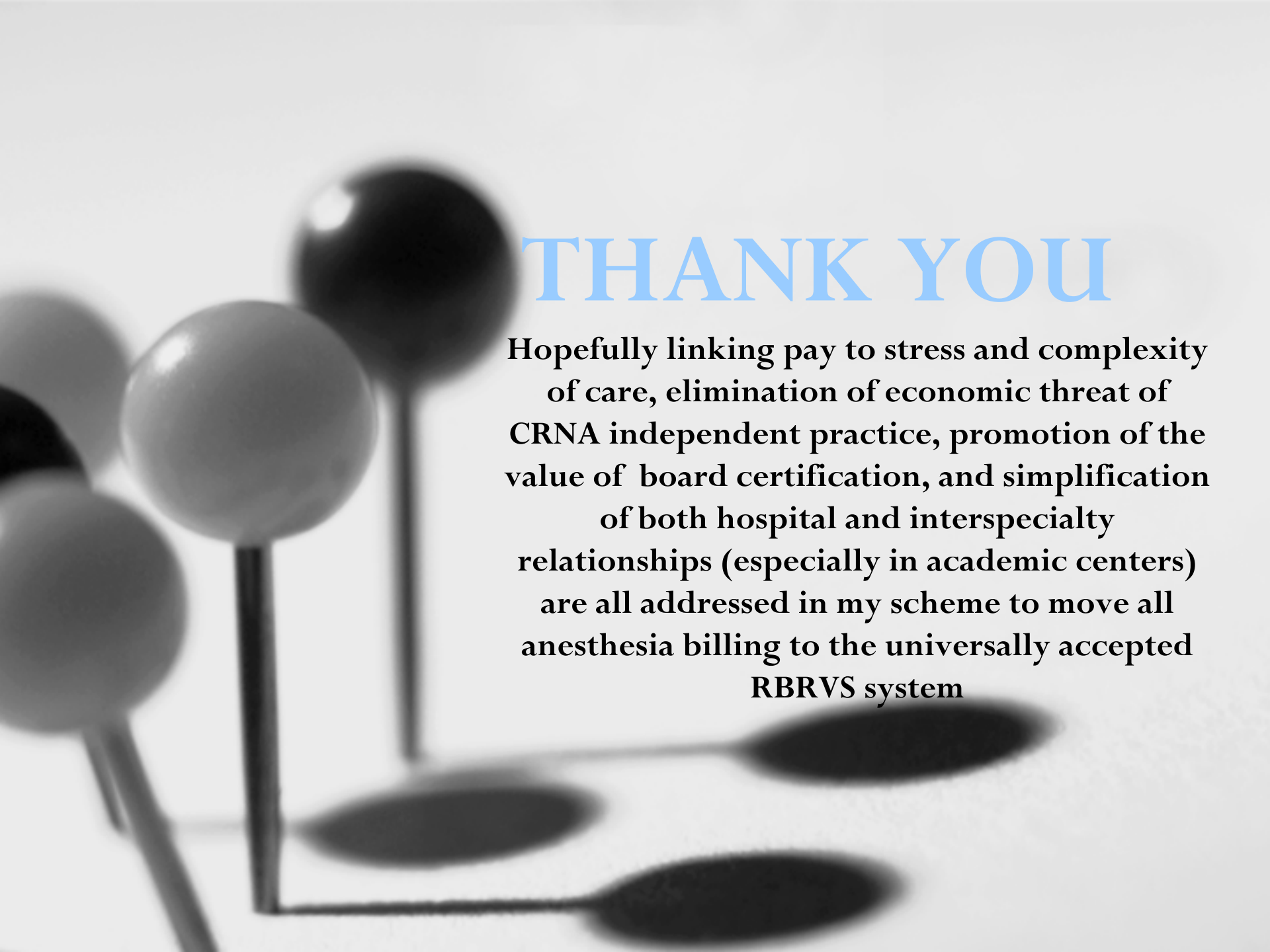
Additional Features

- Every hospital, ambulatory center or office giving anesthesia with CRNA's must either have a board certified anesthesiologist in-house/within 3 minutes*

  OR

- Set up telemedical conference capability to board certified anesthesiologist for any patient unless ASA 1 or 2 (low complexity co-morbidities) AND low physiologic complexity procedure to evaluate (and get paid!)

**Exclusion for academic medical centers for faculty foreign physicians determined by the chair to be equivalent; functional pathway for ANY licensed foreign physician or current non-certified anesthesiologist to become certified*



THANK YOU

Hopefully linking pay to stress and complexity of care, elimination of economic threat of CRNA independent practice, promotion of the value of board certification, and simplification of both hospital and interspecialty relationships (especially in academic centers) are all addressed in my scheme to move all anesthesia billing to the universally accepted RBRVS system