Medicare Conversion Factors and Coding Changes for 2007

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In a December 2006 cliff-hanger, Congress passed H.R.6111, the Tax Relief and Health Care Act of 2006, reducing the 2007 cut in the national Medicare anesthesia conversion factor (CF) from the projected 13.7 percent to about 8.9 percent. As always, the actual anesthesia CF will vary between localities because of geographic differences in practice costs. A copy of the final 91 locality CFs will appear on the ASA Website as soon as the Washington Office receives the new numbers. Meanwhile, anesthesiologists and their administrators should consult the Web sites of their local Medicare carriers.

The legislation froze the overall conversion factor, which applies to pain medicine, invasive monitoring lines, visits and all other procedures besides anesthesiology services at last year's value, $37.90. Since most anesthesiologists provide a mix of these services, total Medicare payments to anesthesiologists will drop about seven percent next year, somewhat less than the anesthesia CF change alone would suggest.

Eliminating the five-percent reduction that the Sustainable Growth Rate (SGR) update formula would otherwise have dictated represented a significant (if incomplete) victory for ASA, the American Medical Association and other physician organizations that spent the year engaged in extraordinary efforts to improve Medicare payment. For further information on the legislative endgame, see the *Washington Report* on page 4.

While Medicare physician payment has generally been frozen at last year's levels, there have been shifts between specialties. These relative variations reflect the impact of changes in the work values assigned to a number of individual procedures under the last Five Year Review of the Fee Schedule as well as changes in the methodology by which the Centers for Medicare and Medicaid Services (CMS) calculates practice expense values. Anesthesiology is one of the specialties facing large cuts despite the Tax Relief and Health Care Act of 2006 because of these two factors. Thus 7.5 percent of our 2006 Medicare payments will go to fund the increases in work valuation obtained by many other specialties This is what is known as

Locked Anesthesia Carts? No More

ASA is delighted to report success — at long last — in its efforts to persuade CMS that anesthesia carts may safely be kept unlocked while in a "secure area." Beginning on January 26, 2007, anesthesia carts need not be locked as long as they are in secure areas such as active, staffed operating rooms, critical care units and labor and delivery suites.

Anesthesiologists and their hospitals have long been frustrated by the Medicare Conditions of Participation (COP) regulation, enforced through JCAHO surveys, requiring anesthesia carts to be locked between cases whenever "authorized personnel" are not present in the room. ASA met with CMS officials in 2004 to discuss the problem of potentially delayed access to vital medications. When as a result CMS proposed a change in the regulation, we submitted formal comments to CMS strongly supporting the change and encouraged ASA members to send in their own letters.

We hope that the new regulation, published on November 27 and emphasizing a "secure area" rather than a "locked storage area for anesthesia drugs other than narcotics, will put an end to the difficulties of complying with a rule that did not protect patients. The CMS rewrite of the regulation removes a serious patient safety risk: requiring locked anesthesia carts could potentially cost precious seconds—or more—when anesthesiologists must treat their patients in emergency situations.

Also related to anesthesiology, the November 27 final rule amends another COP regulation to permit the postanesthesia evaluation for inpatients to be completed and documented by any individual qualified to administer anesthesia, instead of only the individual who administered the anesthesia.

A copy of the regulation is available on the ASA Web site, <www.ASAhq.org/Washington/Unlockedanesthesia carts.pdf>. Please consult the "Practice Management" column in the February 2007 issue of the Newsletter for a discussion of the practical implications of the new rules and for sample guidelines with which you can help your hospitals adopt new policies on anesthesia medication security.

"budget neutrality." Second, anesthesia services lose another 1.5 percent because our practice expenses are primarily indirect rather than direct (billing and other overhead costs as opposed to clinical supplies.) The Centers for Medicare and Medicaid Services (CMS) chose a methodology for establishing practice expense relative values that bases everything on direct costs, over the protests of all the specialties for whom the hospital is the primary site of service.

If any of the health plans with which ASA members participate attempt to change their payments on the basis of the new Medicare physician fee schedule, it will be important to know that the Medicare cuts reflect Medicare budget mechanisms only – not the true relative value of the work or costs involved in providing anesthesia services.

CPT® Code Changes Effective January 1, 2007

A number of CPT® coding changes appear in the 2007 Current Procedural Terminology (CPT®) and, together with their base units, in the ASA RVG™ and Crosswalk® books. Anesthesiologists' practice management systems should be updated to reflect all of these changes, which are described fully in Table 2 below:

1. *Anesthesia.* There are two new anesthesia codes and one deleted code.
2. *Ventilation management.* Ventilation management codes 94656 and 94657 have been deleted and replaced by codes that specify the place of service.
3. *Gastric bypass.* Anesthesia for gastric bypass, code 00797, has been assigned 11 base units, thanks to the many ASA members who completed surveys for the valuation of this service.
4. *Fluoroscopic guidance.* Codes for reporting fluoroscopic guidance have been renumbered. The values assigned to these codes have not been changed.

If you have not already purchased or ordered your copies of the 2007 editions of the CROSSWALK and Relative Value Guide, please contact the ASA Publications Department at 847-825-5586 or place your order on-line at <www2.ASAhq.org/publications>.

Table 2: CPT Code Changes for 2007

Status	CPT® Code	Descriptor	Base Unit Value
New	00625	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; not utilizing one-lung ventilation	13
New	00626	Anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach; utilizing one-lung ventilation	15
Deleted	01995	Regional intravenous administration of local anesthetic agent or other medication (upper or lower extremity)	5
Deleted	94656	Ventilation assist and management, initiation of pressure or volume present ventilators for assisted or controlled breathing; first day	8
Deleted	94657	Ventilation assist and management, initiation of pressure or volume present ventilators for assisted or controlled breathing; subsequent days	5 (per day)
New	94002	Ventilation assist and management, initiation of pressure or volume present ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	8
New	94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	5 (per day)
Assigned base units	00797	Anesthesia for intraperitoneal procedures in upper abdomen, including laparoscopy; gastric restrictive procedure for morbid obesity	11
Deleted *and* Re-numbered	+75998 +77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), for removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position)	
Deleted *and* Re-numbered	76003 77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	
Deleted *and* Re-numbered	76005 77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction	