

April 12, 2020

The Honorable Alex M. Azar, II
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

The American Society of Anesthesiologists (ASA) is proud of how physician anesthesiologists and all members of the anesthesia care team are tirelessly working to meet the challenges of caring for patients inflicted with COVID-19. Like all of medicine, our members are doing so while facing professional and personal economic challenges, some of which we expect to be addressed via the \$100 billion Public Health and Social Services Emergency fund established within the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

The mandated cessation of elective procedures has put the viability of anesthesia practices, and by extension the surgical and critical care capacity of American hospitals and other health care facilities, in significant jeopardy. Good public policy requires that we ensure adequate staffing to reestablish America's operating rooms at the end of the COVID-19 pandemic. In support of our anesthesiologists, we recommend specific mechanisms to provide economic support for our practices.

Due to the unique aspects of our medical education, training, and expertise, anesthesiologists are contributing to the COVID-19 battle in unique ways, which need to be specifically recognized in economic relief efforts.

- Anesthesiologists have expertise in airway management and intubation and are one of the leading care givers for those requiring intensive care services.
- Many anesthesiologists have formal fellowship training in critical care medicine and work, in normal times, as critical care physicians. However, even anesthesiologists who have not completed a fellowship are serving as intensivists during this crisis based on their experience and training as anesthesiologists.
- With experience in ventilator management in the operating room, anesthesiologists working in the ICU environment are adapting their anesthesia machine ventilators to meet clinical needs, as well as modifying anesthesia ventilators and oxygen delivery systems to optimize oxygen levels in these critically ill patients. This work, which is essential to patient care and staff safety, is not compensated by the Centers for Medicare & Medicaid Services (CMS) or other payers under traditional payment methods.

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- Since many of the sickest patients have other medical co-morbidities, anesthesiologists are caring for both the acute problems related to COVID-19 as well as managing underlying medical conditions of these critically ill patients.

The unusual and challenging circumstances of the pandemic could not have been foreseen and were not considered when many anesthesia and critical care services were valued under the Medicare Physician Fee Schedule (MPFS) and by other payers.

- Anesthesiologists are performing services and procedures under hazardous circumstances that dramatically increase the risks and complexities of the services.
- COVID-19 patients who require ventilatory support frequently cough or otherwise expel aerosolized fluids during insertion of a breathing tube, exposing the anesthesiologist to an aerosolized virus – a risk that is further enhanced when appropriate PPE is limited.
- As these patients are already in severe respiratory distress, intubation is performed using a rapid sequence induction technique that requires an even higher level of skill.
- Anesthesiologists also perform invasive line placement, patient turning, resuscitation from cardiac arrest, ventilator management and other ICU care. Most of this work, which is essential to patient care and staff safety, is not compensated by the Centers for Medicare & Medicaid Services (CMS) or other payers under traditional payment methods.

In recognition of the above, we offer the following recommendations:

I. Payment for loss of work:

Via a grant process, issue immediate payment to anesthesia professionals in an amount that will compensate them for their loss of work. ASA members are reporting a 70% reduction in the volume of services they normally provide with the cancellation of non-essential surgeries and procedures, and we anticipate this loss to continue through at least the next 90 days. A formula to determine payment to each individual professional (anesthesiologist, anesthesiologist assistant, nurse anesthetist) is:

Payment to be issued to each anesthesia professional = (most recent published national average MGMA salary * 70%/365)*90

Rationale: The payment is intended to revive physician practices that are facing economic challenges due to the postponement and cancellation of non-essential services and the precipitous decline in revenue. The first round of CARES Act payments released by the U.S. Department of Health and Human Services are based upon Medicare A and B payments to providers. Due to a unique payment disparity, Medicare anesthesia payment rates are not a reasonable mechanism to maintain anesthesiologists' practices and the nation's surgical and critical care capabilities. ASA recommends the use of the MGMA benchmark.

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II. **Recognition of increased work/risk/complexity of care provided for COVID-19 patients:**

A. **Enhanced payment rates for professional services provided for COVID-19 patients similar to the increased weighting recently assigned to the applicable diagnosis-related groups (DRG) that drive payments to hospitals for these patients.** We recommend a 20% add-on to the current MPFS amount for the duration of the public health emergency (PHE) for anesthesiologists. This could be effectuated by reporting the CPT code that describes the service and a HCPCS modifier (to be established) to indicate that this is COVID-related care. Commercial payers should do this as well.

Applicable services should include:

- a. Critical Care: CPT codes 99291, 99292
- b. Ventilation Management: CPT codes 94002, 94003
- c. Emergency Intubation: CPT code 31500
- d. Placement of Invasive Monitoring lines
 - i. Arterial lines: CPT code 36620
 - ii. Central lines: CPT code 36556
 - iii. Pulmonary artery catheters: CPT code 93503
- e. Transesophageal Echocardiography: CPT codes 93312-93318, 93355

B. **Enhanced payment to reflect the increased hazards associated with general anesthesia should also receive the 20% add-on for anesthesia professionals (anesthesiologist, anesthesiologist assistant, nurse anesthetist).** As intubation and extubation are components of general anesthesia and patients undergoing a non-elective surgical procedure must be presumed to be positive for COVID-19, payment for these anesthesia services should be similarly enhanced by a 20% increase to the MPFS payment during the PHE. Again, commercial payers should follow suit.

Rationale: These payment changes are intended to capture the significant increase in risk and complexity associated with providing care for COVID-19 patients and suspected patients.

III. **Alternative Payment Mechanism:**

An anesthesia group may choose to receive, in lieu of I. and II. above, a daily payment to recognize both the front-line direct patient care activities and the unbillable work that is integral to hospital and health system abilities to meet COVID patient needs. This could be accomplished by paying a daily rate based on local market rates for each physician anesthesiologist, anesthesiologist assistant, and nurse anesthetist for each day they work for the duration of the Public Health Emergency.

Rationale: Currently, many anesthesiologists and other professionals are providing a broad range of billable and unbillable services in support of facility operations to address the pandemic. Such services could include, but are not limited to, conversion of operating

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rooms to critical care units, anesthesia machine conversion and operation, and leading and participation in intubation teams.

ASA thanks you for your time and consideration. We appreciate your leadership and are ready to work with you to address this unprecedented health crisis. If you have any questions, please do not hesitate to contact me at M.Peterson@asahq.org or Manuel Bonilla, Chief Advocacy and Practice Officer of the ASA, at m.bonilla@asahq.org.

Sincerely,

A handwritten signature in black ink that reads "Mary D. Peterson, MD". The signature is written in a cursive, flowing style.

Mary Dale Peterson, M.D., MHA, FACHE, FASA
President, American Society of Anesthesiologists