American Society of Anesthesiologists®

Critical Care and Anesthesia Services Payment Reform (CCASPR)

Issue

Medicare payment rates should be adjusted in a targeted manner for physicians and other professionals providing care to COVID-19 patients.

- Medicare payment rates for physician services are based upon a "typical" procedure for a "typical" patient. COVID-19 patients and their conditions are not typical, nor is the care required to treat them.
- The CARES Act included a hospital provision that created a 20% DRG payment add-on for the treatment of COVID-19 patients. The add-on does not apply to physicians.
- A similar enhancement is necessary for physicians and other professionals providing critical care and anesthesia services to COVID-19 patients.

Explanation

- Physician payments should accurately align with the increased work and intensity of the care required, the risk to the provider of the care and the need to pay for important, yet currently unbillable, other physician services.
- COVID-19 patients require a higher level of medical skill and effort to treat.
  - Hospitalized COVID-19 patients are gravely ill. The virus infects patients' respiratory systems which can result in pneumonia and in severe cases, acute respiratory distress syndrome (ARDS) and death. The virus can also damage other vital organs, triggering a full range of complications, including heart and kidney failure.
  - Most (91.5%) patients hospitalized with COVID-19 have underlying medical conditions, including high blood pressure, obesity, diabetes, or heart disease (CDC).
- Physicians providing critical care and anesthesia services are at significant personal risk of infection and must take additional steps to protect themselves and their colleagues.
  - Services involving a patient's mouth and airway, such as intubation and other airway-related services, are particularly hazardous.
  - To protect themselves and their patients and preserve their viability to treat patients, professionals must wear personal protective equipment (PPE) that complicates care delivery. Extra work and time is required for the safe donning, doffing, and handling of the PPE in addition to direct clinical care.
- Medicare should recognize other important physician activities such as the need for at least two providers to assist in "proning" a patient (placing the patient on the stomach while on a ventilator); this service is not currently billable.

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Legislative Requests

1. **Medicare Physician Fee Schedule Add-on Payment for Certain Professional Services Provided to Critically Ill Patients During the Public Health Emergency**

Request:

For specified professional services furnished to critically ill individuals, increase Medicare payments for critical care service codes by increasing total RVUs 20 percent for the duration of the public health emergency. Specified services eligible for the payment increase are described by the following CPT codes: Critical Care CPT codes 99291 and 99292; Ventilation Management CPT codes 94002 and 94003; Emergency Intubation CPT code 31500; Placement of Invasive Monitoring Lines CPT codes 36620, 36556 and 93503, and Transesophageal Echocardiography CPT codes 93312-93318 and 93355.

Rationale:

Medicare payment for individual physician professional services is based on assessments of physician work and practice and malpractice expenses relative to a typical patient. Patients with COVID-19 diagnoses do not represent typical patients or the associated clinical needs to support them. Time, intensity and associated costs are all considerably higher. Current Medicare payment rates for critical care, ventilation management, emergency intubation, placement of invasive monitoring lines and transesophageal echocardiography services do not capture the complexity of providing care to patients critically ill during this public health emergency. Moreover, treating patients who have or are suspected to have COVID-19 increases physician exposure to and risk of disease. Increasing relative values and payment by 20 percent for services specific to the treatment of patients critically ill with COVID-19 begins to better compensate anesthesiologists and associated clinicians for the work required to provide these services as well as the increased risks that these providers face.

Spec language:

"With respect to physician services for critical care, ventilation management, emergency intubation, placement of invasive monitoring lines and transesophageal echocardiography provided during the emergency period, the Secretary of the Department of Health and Human Services shall increase the relative value (as determined in section 1848(c)(2)) for each service described herein by 20 percent. The Secretary shall identify such services provided to such beneficiaries through the use of procedure codes, modifiers, or other such means as may be necessary."

Legislative Language:

Section 1848(c) of the Social Security Act (42 U.S.C. 1395w–4(c)) is amended by adding at the end the following new clause:

"(8) ENHANCED PAYMENT FOR CERTAIN PHYSICIAN SERVICES PROVIDED TO CRITICALLY ILL PATIENTS DURING THE COVID-19 PUBLIC HEALTH EMERGENCY.—Notwithstanding any other provisions of law, with respect to physician services that are critical care, ventilation management, emergency intubation, placement of invasive monitoring lines and transesophageal echocardiography services provided during the emergency period described in section 1135(g)(1) beginning on January 27, 2020, the Secretary shall increase the relative value as established under this section by 20 percent. The Secretary shall identify such services through the use of procedure codes, modifiers, or other such means as may be necessary. The increase established herein shall be effective for such services with dates of service on or after January 27, 2020 through the duration of the emergency period. The preceding sentences shall not be applied in a budget neutral manner."

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2. Medicare Physician Fee Schedule Add-on Payment for Anesthesia Services During the Public Health Emergency

Request:

For anesthesia services performed during the public health emergency, a 20 percent increase to the conversion factor for anesthesia services for the duration of the public health emergency.

Rationale:

Current Medicare payment rates for anesthesia services do not capture the complexity of providing care -and particularly not to critically ill patients during this public health emergency. Moreover, providing anesthesia services to patients who have or are suspected to have COVID-19 increases physician, nurse anesthetist and anesthesiologist assistant exposure to and risk of disease. Increasing the conversion factor for anesthesia services by 20 percent for services will better reflect the work required to provide anesthesia services to these patients as well as the increased hazards to physicians and other providers when performing anesthesia services during the public health emergency.

Spec language:

"With respect to anesthesia services paid under Section 1848 and provided during the emergency period, the Secretary of the Department of Health and Human Services shall increase the separate conversion factor for anesthesia services described under section 1848(d)(1)(D) by 20 percent. The Secretary shall identify such services provided to such beneficiaries through the use of procedure codes, modifiers, or other such means as may be necessary."

Legislative Language:

Section 1848(d)(1)(D) of the Social Security Act (42 U.S.C. 1395w–4(d)(1)(D)) is amended by adding at the end the following new sentence:

Notwithstanding the previous sentence, with respect to anesthesia services provided during the emergency period described in section 1135(g)(1) beginning on January 27, 2020, the Secretary of the Department of Health and Human Services shall increase the separate conversion factor for anesthesia services by 20 percent. The Secretary shall identify such services through the use of procedure codes, modifiers, or other such means as may be necessary. The increase established herein shall be effective for anesthesia services with dates of service on or after January 27, 2020 through the duration of the emergency period. The preceding sentences shall not be applied in a budget neutral manner."

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3. Incentives for Ensuring Access to Patient Care During the COVID-19 Public Health Emergency

Request:

Require CMS to establish new Healthcare Common Procedure Coding System (HCPCS) codes to enable anesthesiologists to report and be paid for patient care services provided during the public health emergency that are not otherwise reportable.

Rationale:

The current public health emergency has altered how critical care is provided. Prior to the public health emergency, critical care services which include intubation and extubation were performed and billed by a single physician. However, due to the unique risks in providing these services to patients during the public health emergency, multiple physicians are now required to provide care for the same patient at the same time. Additionally, prone positioning, a tool known to be beneficial in patients with acute respiratory distress syndrome and now shown to be an effective adjuvant therapy in patients with COVID-19, requires focused participation by multiple physicians to be effective and to avoid risks. These services are essential to the care and management of patients. Establishing a HCPCS code to allow multiple physicians to report their adjunctive critical care services and to facilitate payment, will allow anesthesiologists and others to be compensated for furnishing these services, be it performing as a second member of an intubation team, part of the team "proning" a patient or otherwise providing unreportable but essential care.

Spec Language:

"With respect to adjunctive critical care services, defined as services provided by a physician who does not have primary responsibility for the patient, during the public health emergency, the Secretary of the Department of Health and Human Services shall adopt a new Healthcare Common Procedure Coding System (HCPCS) code to describe each 15 minutes of such physician services provided to a hospital inpatient. The service will be billed by individual physicians on a per beneficiary basis. Payment for such services shall only be made for critical care services that are not otherwise paid. Such payments shall not be subject to beneficiary cost-sharing."

Legislative Language:

Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended by adding at the end the following new clause:

"(t) PAYMENT FOR ADJUNCTIVE CRITICAL CARE SERVICES DURING THE COVID-19 PUBLIC HEALTH EMERGENCY — With respect to adjunctive critical care services, defined as critical care services provided by a physician who does not have primary responsibility for the patient, during the emergency period described in section 1135(g)(1) beginning on January 27, 2020, the Secretary of the Department of Health and Human Services shall adopt new Healthcare Common Procedure Coding System (HCPCS) code(s) to describe each 15 minutes of such physician services provided to a hospital inpatient. Payment for such services shall only be made for critical care services that are not otherwise paid. Such payments shall not be subject to beneficiary cost-sharing. The code(s) and payment established herein shall be effective for such services with dates of service on or after January 27, 2020 through the duration of the emergency period. The preceding sentences shall not be applied in a budget neutral manner."

REQUEST:

Congress should include CCASPR provisions in the next COVID-19 legislative package.

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