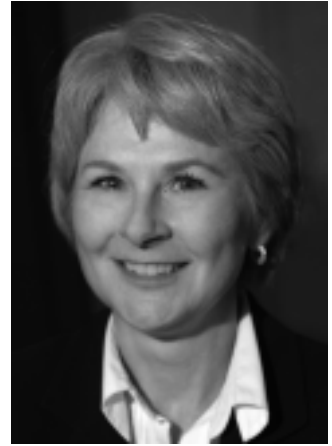


From the CEO

The Sky Almost Fell—Again: Medicare in 2006

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Once again Congress went down to the wire in addressing the planned Medicare physician payment cut of 4.4 percent scheduled to take effect January 1, 2006. In the early morning hours of December 19, the House of Representatives passed the Deficit Control Act of 2005, which included a provision to maintain 2006 Medicare payments at 2005 rates.

Preventing reductions in Medicare physician payments and fixing the flawed Sustained Growth Rate formula is the top priority of the American Medical Association, the ASA and other national medical societies. In order to set the course for fair updates in Medicare physician payments, the SGR must be redefined. During 2006, the Medicare Payment Advisory Commission (MEDPAC), the Congressional advisory commission, is directed to develop a proposal for a new formula for updating physician fees.

Under current law, if Medicare Part B spending in any one year goes up more than the average rate of economic growth in the United States, then physicians and other Part B providers' payment rates are reduced so the following years' total payments comport with the SGR. The formula has nothing to do with the actual cost of providing patients with necessary care, or with the needs of a growing Medicare population. It also does not take into account the cost of adding new benefits, but requires that those services be paid from the amount calculated exclusive of added benefits.

While CMS and Congress have acknowledged the significant flaws in the current SGR formula, there has been little movement to fix the problem. Even those who are sympathetic to physicians have called for any correction (increase) to be tied to quality improvement in the form of Pay for Performance. The P4P concept is to reward physicians who meet certain performance criteria, but it is not clear that any "bonuses" will come from increased funding or if the money will come from withholds on current payments. Fortunately, Congress recognized that a rational P4P element could not be included in the budget package at the 11th hour. For information on the pitfalls of P4P, see Vice Chair for Practice Affairs and District 13 Director Ken Pauker's article in the fall 2005 issue of this *Bulletin*.

From the CEO (cont'd)

A recent *New York Times* article addressed the difficulties physicians face with Medicare cuts at a time when their costs are rising. The article presented the view of CMS officials that doctors often respond to such cuts by performing more services, and that they should not be paid more unless they cooperate with efforts to measure the quality of the care they provide. While some physicians may increase the number of services they provide, it certainly does not hold true for anesthesiologists. In concept physicians have the choice to limit their numbers of Medicare patients, but economic realities may render any choice illusory.

Conversion factors will remain at 2005 levels but are accompanied by additions and deletions of CPT codes. Only a few changes were made to the 2006 ASA Relative Value Guide. Most significant is the rewording of the notes preceding the Obstetric Anesthesia codes:

Unlike operative anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor analgesia.

Professional charges and payment policies should reasonably reflect the costs of providing labor analgesia as well as the intensity and time involved in performing and monitoring any neuraxial labor analgesic.

Methods to determine professional charges consistent with these principles include:

- Basic units plus time units (insertion through delivery), subject to a **reasonable cap**.
- Basic units plus patient contact time (insertion, management of adverse events, delivery, removal) plus one unit per hour for neuraxial analgesia management plus direct patient contact time (insertion, management of adverse event, delivery, removal).
- Incremental time-based fees (e.g., < 2 hrs, 2-6 hrs, > 6 hrs).
- Single fee.

In addition, 01964—anesthesia for abortion procedures—was deleted and replaced with two new codes:

01965	Anesthesia for incomplete or missed abortion procedures	4 basic units + time
01966	Anesthesia for induced abortion procedures	4 basic units + time

From the CEO (cont'd)

Finally, a new statement titled “Distinguishing Monitored Anesthesia Care (MAC) from Moderate Sedation/Analgesia (Conscious Sedation)”* is included in the 2006 ASA RVG:

Monitored Anesthesia Care allows for the safe administration of a maximal depth of sedation in excess of that provided during Moderate Sedation. The ability to adjust the sedation level from full consciousness to general anesthesia during the course of a procedure provides maximal flexibility in matching sedation level to patient needs and procedural requirements. In situations where the procedure is more invasive or when the patient is especially fragile, optimizing sedation level is necessary to achieve ideal procedural conditions.

In summary, Monitored Anesthesia Care is a physician service which is clearly distinct from Moderate Sedation due to the expectations and qualifications of the provider who must be able to utilize all anesthesia resources to support life and to provide patient comfort and safety during a diagnostic or therapeutic procedure.

* “Moderate Sedation/Analgesia (‘Conscious Sedation’) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.” This definition of moderate sedation was extracted verbatim from the “Continuum of Depth of Sedation—Definition of General Anesthesia and Levels of Sedation/Analgesia,” a document that was approved by the ASA House of Delegates on October 13, 1999, and amended on October 27, 2004.

CSA Bulletin Covers for Volume 54

The photograph that appears on the covers of Volume 54 of the *CSA Bulletin* is one of an old dead bristlecone pine tree that the photographer, Gordon Haddow, M.D., discovered while traveling in the White Mountains, east of Bishop, California. The altitude there is approximately 10,000 feet and the picture was taken in late September 2002 around 8:00 a.m. Dr. Haddow used a Nikon F100 camera with a Nikkor 18-35mm zoom lens at 18mm and a red filter. This photographic masterpiece was awarded the “Best of Show” at the 2003 ASA Art Exhibit.