

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE COVERAGE AND  
REIMBURSEMENT FOR MONITORED  
ANESTHESIA CARE**



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# EXECUTIVE SUMMARY

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## PURPOSE

This report reviews the adequacy and implementation of Medicare's coverage and reimbursement instructions for monitored anesthesia care (MAC).

## BACKGROUND

Modern medical technology has brought about vast improvements in surgical and other invasive techniques. This new technology allows more procedures to be done in hospital outpatient departments (OPDs), ambulatory surgical centers (ASCs) and doctors' offices.

This trend and advances in anesthesia techniques, have produced changes in the nature of anesthesia services. Traditionally, the most common form of surgical anesthesia involved the use of anesthetic drugs which rendered the patient unconscious. Currently, many patients receive local anesthesia during which they remain conscious. When an anesthesiologist takes part in the care of a patient under local anesthesia and renders certain specified services, the service is referred to as "monitored anesthesia care" (MAC).

The HCFA defines MAC as the intraoperative monitoring of the patient's vital physiological signs, in anticipation of the need for general anesthesia or of the development of adverse physiological patient reaction to the surgery. It also includes a pre-anesthetic evaluation, administration of any necessary medications and provision of indicated post-operative anesthesia care. The HCFA stipulates that MAC is not automatically covered and "must be reasonable and medically necessary under the given circumstances."

Medicare data for 1988 shows allowed charges for all anesthesia services of \$1.1 billion. However, as claims for general or MAC are not differentiated, the amount allowed for MAC is not known. There are, nevertheless, indications that MAC amounts are considerable. For example, allowed charges in 1988 for anesthesia associated with cataract surgery amounted to \$144 million, about 90% of which was probably for MAC.

## SCOPE AND METHODOLOGY

To assess implementation of HCFA's coverage instructions, Medicare carriers' documents were reviewed to determine the steps taken to adjudicate MAC claims. Also, Federal Employee Health Benefit plans and the private plans of Medicare carriers were provided with HCFA's definition of MAC and we compared their coverage and reimbursement policies to Medicare. Finally, physicians under contract to the OIG reviewed a random sample of 1162 medical records to provide insights into operative events relating to the use of anesthesia services. The stratified

sample, selected for a different OIG study, consisted of an equal number of procedures performed in OPDs and ASCs in 10 states.

## **FINDINGS**

### ***HCFA's MAC Instruction Is Not Being Implemented By Carriers***

Carriers have not implemented HCFA's instructions that MAC "must be reasonable and necessary under the given circumstances." Most carriers have not informed the medical community of coverage limitations and have no method to distinguish MAC claims from other anesthesia claims, a prerequisite to the coverage determination process.

### ***Actual Services Rendered Do Not Meet Coverage Guidelines***

The results of the medical review of records do not support the coverage instruction premise for MAC. General anesthesia was rarely administered and the need for anesthesiologists' medical intervention was minimal.

### ***Reimbursement Was Inappropriate In Approximately 1 Of 4 Cataract Cases Based On Lack Of Documentation***

In 159 (25 percent) of 645 reviewed cataract procedures performed under MAC, payment was inappropriate because either pre-anesthesia evaluation and/or monitoring of vital signs were not documented as required for reimbursement. Projecting this error rate to the universe from which claims were sampled and assuming an equal distribution in the error rate for the full year, an estimated \$14.0 million in inappropriate allowed charges was made in 1988 in ten States.

### ***Other Insurers Have More Restrictive MAC Coverage And Payment Standards***

A survey of other health insurers shows that ten (22 percent) Medicare carriers' private business health insurance plans and fifteen (68 percent) of 22 FEHB plans have more restrictive coverage and reimbursement policies than Medicare.

A 1986 OIG study found that services provided during MAC differed substantially from those provided during general anesthesia. Based on this finding it was recommended that HCFA should reimburse MAC at a lower rate than general anesthesia. HCFA did not accept the OIG recommendation and currently pays for MAC and general anesthesia at the same amount.

## RECOMMENDATIONS

### *HCFA should:*

- *require carriers to develop and implement a claims review process to apply existing MAC coverage instructions,*
- *strengthen MAC guidelines by adding procedures for case-by-case coverage, as currently required for anesthesia claims related to transvenous pacemaker surgery and/or by providing objective criteria for MAC coverage such as the use of ASA's physical status categories, and*
- *study the appropriateness of paying the same amount for MAC and general anesthesia in view of the fact that other insurers are more restrictive.*

The HCFA agrees with our recommendations regarding claims review and coverage but does not agree to study the appropriateness of the amount it pays for MAC. We continue to believe such a study is needed. The HCFA's comments and the OIG response appears as an appendix to the report.

# INTRODUCTION

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## PURPOSE

This report reviews the adequacy and implementation of Medicare's coverage and reimbursement instructions for monitored anesthesia care (MAC).

## BACKGROUND

### *Trends in Anesthesia Services*

Modern medical technology has brought about vast improvements in surgical and other invasive therapeutic and diagnostic techniques. These advances have produced shifts from traditional incisional surgery to procedures utilizing laser technology, electric shockwave and fiberoptic endoscopic instruments. Arthroscopic surgery, lithotripsy and coronary balloon angioplasty are a few examples. New technology has also made it possible for invasive procedures to be done more frequently on an ambulatory basis in outpatient departments, ambulatory surgical centers and doctors' offices.

The wide range of available advanced operative techniques as well as advances in anesthesia techniques have been instrumental in producing changes in the nature of anesthesia services. Traditionally, the most common form of surgical anesthesia involved the use of anesthetic drugs which rendered the patient unconscious and insensible to pain. Under general anesthesia, these drugs often suppress patients' ability to maintain their own life functions, thus making the anesthetist responsible for keeping the patient alive by monitoring vital physiological signs and diagnosing and treating any deviations which may arise. Currently, many patients receive forms of anesthesia which do not involve loss of consciousness, thus allowing the patients to maintain their own life functions. (For ease in reading, the generic term anesthetist is used throughout this report except where distinctions are necessary for the sake of accuracy. In practice, anesthesia services are rendered by anesthesiologists, other qualified physicians, certified registered nurse anesthetists [CRNA's] and anesthesiologist assistants [AA's].)

The use of local anesthesia has become a prevalent choice of physicians in an increasing number of surgical procedures. Local anesthesia is frequently administered by physicians performing the procedure rather than by an anesthetist. Ophthalmologists, cardiologists, gastroenterologists and surgeons are a few examples of specialists who often inject local anesthetics or apply topical agents to render the area insensible to pain. In some of these instances the local anesthesia may be supplemented with a drug such as valium, taken orally or intravenously, to sedate the patient. In these situations the patient is conscious and may or may not be attended by an anesthetist. When an anesthetist takes part in the care of the patient and certain specified services are rendered, the service is referred to as "monitored anesthesia care" (MAC).

## *Medicare Coverage And Reimbursement For MAC*

In April 1986, the OIG issued a report entitled "Medicare Reimbursement for Anesthesia Services" (OAI-02-00010). The purpose of the study was to clarify the nature and prevalence of local/standby anesthesia (currently referred to as MAC) and examine and evaluate related Health Care Financing Administration (HCFA) reimbursement policies and practices. Based on a review of medical records for over 1,000 beneficiaries who underwent either cataract surgery, pacemaker implants or inguinal hernia repairs, the study found that the practice of substituting MAC for general or regional anesthesia was growing. Currently, reimbursement is the same amount for MAC and general anesthesia.

That study's evaluation of anesthesiologists' responsibilities in providing MAC, as compared to those responsibilities when general anesthesia is administered, led OIG to conclude that the nature of MAC services were sufficiently different to warrant a distinct definition of the service and that it should be reimbursed at a lower amount. In practice, eight Medicare carriers were found to be reimbursing MAC at a lower amount and 41 carriers were paying for MAC at the same level as general anesthesia.

Differences in carrier reimbursement policies, at that time, were attributed to a lack of national policy and to whether they adopted the American Society of Anesthesiologists' (ASA) guidelines for MAC (full general anesthesia value) or the California Relative Value Scale (CRVS) "anesthesia ground rules" (charges based on extent of services rendered).

In a final notice in the October 7, 1986 Federal Register, HCFA established special reasonable charge payment limits for all anesthesia services furnished during cataract surgery. But, it did not adopt the broader OIG recommendation to reduce payments for MAC irrespective of the surgical procedure performed. Rather, HCFA indicated that it would further study its overall policy regarding reduced reimbursement for MAC.

The HCFA did respond favorably to the OIG recommendation regarding the need to better define the service by substituting the term "monitored anesthesia care" for local/standby anesthesia, defining the nature of MAC, and stipulating that MAC is not automatically covered. Section 8310.1E of the Medicare Carriers Manual (June 1987) specifies that MAC "must be reasonable and medically necessary under the given circumstances." The instruction (underline emphasis added) states:

Monitored anesthesia care involves the intraoperative monitoring by a physician, or by a qualified individual under the medical direction of a physician, of the patient's vital physiological signs, *in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction* to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated post-operative anesthesia care.

*... The fact that the physician personally furnished or medically directed the monitored anesthesia care does not automatically mean the monitored anesthesia care is a covered.*

*Part B service.* The monitored anesthesia care service must be reasonable and medically necessary under the given circumstances.

In addition, HCFA instructed carriers (Section 8312.1F) to reimburse MAC in the same manner and amount as they pay for administration of general anesthesia when MAC is performed in its entirety.

To date, MAC coverage policy has been supplemented only by a July 1988 HCFA instruction (MCM Coverage Issue 35-79) to carriers containing coverage guidelines for MAC and general anesthesia, associated with transvenous pacemaker surgery. It instructs carriers to provide coverage "only if documentation of medical necessity is provided on a case-by-case basis."

### ***Medicare Reimbursement***

Medicare data for 1988 shows allowed charges for all anesthesia services of \$1.1 billion. However, as claims for general anesthesia or MAC are not differentiated, the amount allowed for MAC is not known. There are, nevertheless, indications that MAC amounts are considerable. For example, allowed charges in 1988 for anesthesia associated with cataract surgery amounted to \$144 million, about 90% of which was probably for MAC.

## **SCOPE AND METHODOLOGY**

To assess implementation of HCFA's coverage instructions, Medicare carriers were requested to provide copies of: (1) provider information bulletins conveying anesthesia coverage limitations for MAC and transvenous pacemaker claims, (2) related billing instructions to providers, and (3) claims processing procedures and instructions used in making coverage determinations on MAC claims. These documents were reviewed to determine whether carriers had taken the necessary steps to properly process anesthesia claims subject to coverage restrictions.

Federal Employee Health Benefit plans and the private plans of Medicare carriers were requested to provide information on their coverage and reimbursement for MAC, as defined by HCFA. Documents were reviewed to determine similarities and differences when compared to Medicare's coverage and reimbursement policies.

To gain insights into how HCFA's MAC instruction relates to actual operative events, a stratified random sample of 1162 Medicare beneficiary records (803 cataract procedures, 201 upper GI procedures and 158 colonoscopies) were reviewed by board-certified physicians under contract to the OIG. These patients were evenly split between ASC and OPD settings. The contractor reviewed and reported on such activities as pre-anesthesia examination and evaluation, intraoperative events and post-anesthesia care.

The sample records represented an equal number of patients from hospital outpatient departments (OPDs) and ambulatory surgical centers (ASCs) during the first three months of 1988 in ten States (AZ, CA, FL, IL, LA, MD, NC, OH, PA, TX) with large numbers of ASCs.

The sample was designed for a another OIG study which had as its purpose the evaluation of the quality of care in ambulatory settings. The sample size was based on the number necessary to satisfy specific testing criteria (i.e., power confidence level and detectable difference) established for studies on medical outcome and necessity.

# FINDINGS

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## **HCFA's MAC AND PACEMAKER INSTRUCTIONS HAVE NOT BEEN IMPLEMENTED BY MOST CARRIERS**

A review of documents provided by 45 carriers representing 56 payment jurisdictions, covering the period June 1987 through April 1989, indicates that they have not implemented the instructions in MCM Section 8310.1E (June 1987) which specify that MAC "must be reasonable and necessary under the given circumstances" and is not automatically covered.

- Only 15 (33 percent) carriers informed the medical community of these coverage provisions.
- Only seven (16 percent) carriers established special billing instructions requiring identification on the claim form that the billed anesthesia service was for MAC; *but*, only two of these carriers use this information in adjudicating MAC claims. Such identification is necessary in order to apply MAC coverage limitations.

Carrier implementation of pacemaker instruction (MCM Coverage Issue 35-79) has been somewhat better.

- Twenty-six (58 percent) of the carriers have medical review procedures to determine coverage for pacemaker implant anesthesia claims.
- Carriers with procedures to make coverage determinations for transvenous pacemaker procedures vary in their approaches. For example, one carrier has determined that anesthesia services associated with these procedures are medically necessary in all cases. In contrast, another requires claims for this procedure to contain the ASA physical status ranking which classifies patients into six levels based upon health condition. The physical status level is used to help make coverage determinations.

## **ACTUAL SERVICES RENDERED DO NOT MEET COVERAGE GUIDELINES**

The results of an OIG medical review do not support the coverage premise for MAC services contained in MCM Section 8310.1E. In this section, HCFA describes MAC services as involving intraoperative monitoring of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.

The medical review determinations on 1162 patients' medical records (803 cataract extractions and 359 upper and lower GI endoscopies) found, in those cases where MAC was billed, that the need for anesthesiologists' medical intervention was minimal.

- Only 3 of 760 medical records for planned MAC cataract procedures (43 began under general anesthesia) contained notes indicating an anticipated need for general anesthesia and *only one* procedure was actually converted from local to general anesthesia.
- There were *no* adverse physiologic reactions documented in any cataract procedure performed with MAC. Two planned procedures were cancelled preoperatively due to hemorrhaging caused by the injection of local anesthesia.
- Of the 359 endoscopy procedures, two colonoscopies were done under general anesthesia and 20 (11 upper GI and 9 colonoscopy) had associated claims for MAC. In its report, the medical review contractor noted that “patients undergoing endoscopies do not require monitored anesthesia care by anesthesiologists or CRNAs, although they do need monitoring by registered nurses or other personnel trained in monitoring and resuscitation techniques.”

Additionally, during the course of the inspection, it was learned that one carrier conducted a special 1989 utilization review study of MAC services provided during cataract surgery, including an in-depth review of four anesthesiologists who frequently billed for MAC in cataract surgeries. Its anesthesia consultant determined medical necessity for MAC using such factors as age of patient, anticipated duration of the procedure, serious medical problems such as chronic obstructive pulmonary disease, and other factors. The study found that 65 percent of the sample reviewed lacked documented medical necessity.

#### **REIMBURSEMENT WAS INAPPROPRIATE IN APPROXIMATELY 1 OF 4 CATARACT CASES BASED ON LACK OF DOCUMENTATION**

- The medical record review showed that 44 of the 803 cataract extractions were performed under general anesthesia and 759 under local anesthesia. Carrier claims payment data shows that 645 (85 percent) of the 759 procedures had associated anesthesia bills (299 hospital outpatient department [OPD] and 345 ambulatory surgical center [ASC] bills) and among these:

*In 148 cases (23 percent), there was no documentation that pre-anesthetic examinations and evaluations were performed.*

*In 109 cases (17 percent), there was no documentation of monitoring of patients' vital physiological signs.*

*In 176 cases (27 percent), there was no postoperative anesthesia note.*

- In 159 cases (25 percent), because either pre-anesthesia evaluation and/or monitoring of vital signs (two key MAC services) were not documented as having been provided as required for reimbursement, payment was found to be inappropriate. This finding should not be interpreted to imply that services were not actually provided. Of these inappropriately paid claims, 67 (22 percent error rate) of the MAC cases were performed in OPDs and 92 (27 percent error rate) were performed in ASCs. Projecting these error rates to the universe from which claims were sampled, an estimated \$3.5 million was inappropriately reimbursed for the three month period in the ten states. Assuming an equal distribution in the error rate for the full year, this annualizes to \$14.0 million in 1988.
- Failure to document the provision of one expected service was frequently accompanied by failure to document others; 129 medical records lacked notes that showed *any* of the three expected services were provided.

## **OTHER INSURERS HAVE MORE RESTRICTIVE MAC COVERAGE AND PAYMENT STANDARDS**

A 1986 OIG study found that services provided during MAC differed substantially from those provided during general anesthesia. Based on this finding it was recommended that HCFA should reimburse MAC at a lower rate than general anesthesia. HCFA did not accept the OIG recommendation and currently pays for MAC and general anesthesia at the same amount. However, other insurers were often found to be more restrictive than Medicare.

### ***Medicare Carriers' Private Business Plans***

Ten (22 percent) Medicare carriers' private business health insurance plans have more restrictive coverage and reimbursement policies than Medicare.

- Four do not provide coverage for MAC
- Four pay a lower amount for MAC than for general anesthesia
- One limits coverage to patients with a concurrent "hazardous" medical condition.
- One limits coverage to five surgical procedures or any procedure requiring IV sedation. Coverage is also provided for patients with severe systemic diseases which are a constant threat to life (ASA physical status P-4).

A carrier private business plan, which also is an FEHB insurance plan, has identified over 700 procedures for which the services of an anesthesiologist are not customarily required. Claims for these procedures are denied unless documentation is provided to support the medical necessity for an anesthesiologist.

### ***Federal Employee Health Benefit Plans***

Fifteen (68 percent) of 22 FEHB plans are more stringent.

- Six do not cover MAC.
- Six cover only if IV medication is administered by an anesthesiologist.
- Three pay for distinct identified services rather than global anesthesia services.

# RECOMMENDATIONS

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## **HCFA SHOULD REQUIRE CARRIERS TO IMPLEMENT EXISTING MAC INSTRUCTIONS INCLUDING:**

- Informing the medical community as to what is required to qualify as MAC, and that coverage is not automatic but must be reasonable and necessary under the given circumstances.
- Requiring that MAC is specifically identified on the claim form as the anesthesia service rendered.
- Establishing medical review procedures and policies for MAC claims.

## **HCFA SHOULD STRENGTHEN EXISTING MAC GUIDELINES BY:**

- adding procedures, upon consultation with medical specialty societies, for case-by-case coverage, as currently required for anesthesia claims related to transvenous pacemaker surgery;

and/or,

- providing objective criteria for MAC coverage such as the use of ASA's physical status categories.

**HCFA SHOULD STUDY THE APPROPRIATENESS OF PAYING THE SAME AMOUNT FOR MAC AND GENERAL ANESTHESIA IN VIEW OF THE FACT THAT OTHER INSURERS ARE MORE RESTRICTIVE.**

# APPENDIX

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Comments of the Health Care Financing Administration on the OIG Draft Report and the OIG Response to the HCFA's Comments

## RECOMMENDATION I

HCFA should require carriers to implement existing MAC instructions including:

- *Informing the medical community as to what is required to qualify as MAC, and that coverage is not automatic but must be reasonable and necessary under given circumstances.*
- *Requiring that MAC is specifically identified on the claim form as the anesthesia service rendered.*
- *Establishing medical review procedures and policies for MAC claims.*

### *HCFA Comment*

We agree in part with this recommendation. HCFA will bring the issue of MAC to the attention of the carrier medical directors who formulate the medical review procedures and policies for all claims. We will follow up on the development and implementation of more stringent review policies in this area. As the OIG study shows, some carriers currently have specific medical review policies regarding standby anesthesia for pacemaker insertion. Such policies would provide a useful model for other procedures.

However, we do not agree, at this time, that MAC care should be identified on the claim form. HCFA will consider such action only after the carrier medical directors have completed their proposed course of action.

### *OIG Response*

We are pleased to note that HCFA will follow up on development and implementation of more stringent review policies for MAC. However, we do have concerns about the difficulty of implementing review policies without having claims for MAC services specifically identified. Therefore, we will withhold further judgment until we have been apprised of the results of HCFA's consultation with its medical directors.

## RECOMMENDATION II

HCFA should strengthen existing MAC guidelines by:

- *adding procedures, upon consultation with medical specialty societies, for case-by-case coverage, as currently required for anesthesia claims related to transvenous pacemaker surgery; and/or*
- *providing objective criteria for MAC coverage such as the use of American Society of Anesthesiologists' physical status categories.*

### *HCFA Comment*

We agree with the intent of this recommendation and plan to explore ways to strengthen MAC guidelines. We will consult our Coverage/Payment Technical Advisory Group about requiring case-by-case determinations for cataract extractions and endoscopies, as well as for other procedures. It would be helpful if OIG would supply us with the list of 700 procedures that a private plan identified as not customarily requiring the services of an anesthetist, and for which claims were denied unless medical necessity was documented.

### *OIG Response*

We are pleased to provide HCFA with a copy of the requested list of procedures identified by a private plan.

## RECOMMENDATION III

HCFA should study the appropriateness of paying the same amount for MAC and general anesthesia in view of the fact that other insurers are more restrictive.

### *HCFA Comment*

We do not concur with this recommendation. We believe that it is not supported by the findings in this report. The report compares the MAC policies of Medicare to the policies of the Federal Employee Health Benefits Plans (FEHBPs) and the Medicare Carriers' Private Business Plans (MCPBPs) and concludes that the other plans have more restrictive coverage and reimbursement policies. However, the comparison would only be valid if the FEHBPs and MCPBPs define MAC in the same way as Medicare. Although the presentation in the report suggests that all FEHBPs and at least ten MCPBPs define MAC identically, there is no evidence in the report to support this. In addition we have reservations about adopting a recommendation that is based solely on the payment policies of other plans. We believe it is more important to establish that MAC is, indeed, a less resource-intensive surgical procedure than general anesthesia.

It would also have made comparisons more meaningful to know whether these other plans lowered cataract anesthesia base units as Medicare did in January 1987. If these other plans recognize time units only, but have a higher conversion factor and a higher base unit for cataract anesthesia than Medicare, this would likely result in a higher payment allowance than Medicare, even though it appears that these plans have a more restrictive policy. We suggest that OIG address these concerns and also provide additional details on how these plans generally ensure lower or no payment for monitored anesthesia care. Specifically, the study should cover what special codes, modifiers or other administrative processes these plans use to allow them to pay at a lower level.

### *OIG Response*

The HCFA has voiced several concerns about adopting this recommendation. We believe, nevertheless, that there is sufficient evidence and information available to support it. The evidence and information includes, but is not limited to, our comparative analysis of other insurers policies, HCFA's previous position to differentiate payment for MAC, and, lastly, statutory provisions requiring HCFA to develop a physician fee schedule based on resource costs.

The HCFA's first concern with accepting our finding is that the comparison of private plans with Medicare would only be valid if the private plans define MAC in the same way as Medicare. In response, we wish to note that our methodology in soliciting responses from FEHBPs and MCPBPs was designed to assure valid comparisons based on identical definitions. In gathering the information from FEHBPs we provided them with HCFA's definition to assure common understanding of the definition of MAC. Similarly, we arranged for Medicare carrier staff who are knowledgeable of HCFA's definition to obtain the related coverage and reimbursement information from their private business plans. In those instances where responses were not definitive, we held discussions with respondents to assure that the identical definition was used.

The HCFA also expressed reservations about accepting a recommendation based solely on the payment policies of other plans. We had only recommended conducting a study, not actually changing policy unless the study indicated the appropriateness of the need for a change. More importantly, in this regard, we wish to point out that in HCFA's response to our 1986 inspection report (OAI-85-2-010), HCFA concurred with our recommendations that general anesthesia and MAC would be reimbursed at different rates. The HCFA indicated that it was considering a proposed regulatory change that would accomplish the intent of the OIG recommendations. Additionally, HCFA had committed itself to studying this payment issue in the October 7, 1986 issue of the Federal Register in response to our April 1986 OIG report.

The HCFA believes it is important to establish that MAC is, indeed, a less intensive-resource procedure than general anesthesia. We assume that this position is based on the provisions of OBRA 89 which require DHHS to develop a fee schedule for physician services based on resource costs. As we understand that HCFA has adopted the ASA Uniform Relative Value Guide which does not distinguish between resource costs for MAC and general anesthesia, we are uncertain of HCFA's intent.

With respect to HCFA's comments regarding cataract anesthesia base units and how other plans administer their coverage and payment policies, we will provide HCFA with our list of the MCPBPs and FEHBPs with more restrictive coverage and payment standards.

### ***HCFA'S General Comments***

#### **Scope**

- *The stated purpose of this report was to review the adequacy and implementations of Medicare's coverage and reimbursement instructions for MAC. However, the report only covered MAC associated with cataract surgery and endoscopic procedures. Of the medical records reviewed, 69 percent were associated with cataract anesthesia and the remaining 31 percent were associated with anesthesia related to endoscopic procedures. Further, only 6 percent of the endoscopic procedures involved MAC. We recommend that OIG either retitle and rewrite the report to indicate that this report is a study of MAC for cataract services or expand the report to cover all other procedures using MAC.*

#### **OIG Response**

- *As stated in the Scope And Methodology section of this report, our inclusion of medical review findings of cataract procedures, Upper GI procedures and colonoscopies was designed to gain insights into actual operative events in assessing the adequacy of HCFA's coverage instruction for MAC. The choice of these procedures does not mean that our study of the adequacy and implementation of Medicare's coverage and reimbursement for MAC was limited to these procedures.*
- *HCFA correctly notes that only a small percentage of the endoscopic procedures performed involved MAC. We have revised the report to indicate that 20 of the 359 endoscopy procedures had associated claims for anesthesia. Discussions with several gastroenterologists revealed that they provide, or direct the provision of, MAC for almost all these procedures. In these instances MAC services of the physician endoscopist, registered nurse or other personnel trained in monitoring and resuscitation techniques are not usually billed by physicians as a separate service.*

#### **Documentation**

- *The report indicates that the payment was inappropriate in approximately 1 in 4 cataract cases based on lack of documentation. However, the report should make it clear that this finding does not necessarily imply that anesthesia providers did not furnish claimed MAC services. Rather, the absence of*

*documentation may reflect a failure to document services actually provided or a failure to include this documentation with the medical record reviewed by the OIG contractor. This lack of precision in distinguishing the reason for the absence of documentation also calls into question the accuracy of OIG's projection of \$14 million in inappropriate payment for MAC, such payments cannot be directly translated into projected future savings; a more stringent review process for MAC might rather improve the anesthesia documentation.*

**OIG Response**

- *We have revised the report to assure that the finding does not imply that services were not actually rendered. However, lack of documentation is sufficient cause to examine the case further.*

**Detail**

- *We would recommend that the report include more detail on such items as the number of outpatient departments (OPDs) and ambulatory surgical centers (ASCs) that were sampled and whether inadequate documentation was a problem for certain OPDs/ASCs, or was it representative across all OPDs/ASCs. It would also be helpful to include the method the medical record contractor used to identify anesthesia activities. These items could be incorporated into the appendix or incorporated into the body of the report itself.*

**OIG Response**

- *We are happy to make our work papers containing information on OPDs, ASCs and contractor methodology available to HCFA.*

