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Workers' Compensation Commission

MEMORANUM

TO: **COMMISSIONERS**

FROM: **Gary Cannon**
Executive
Director

DATE: **January 23, 2023**

RE: **Medical Services Providers Manual (MSPM)**

Attached you will find four documents provided by FairHealth in preparation of updating the Medical Services Provider Manual (MSPM) for 2023. They are

Summary of Proposed Changes
Fee Schedule Analysis
Analysis of Anesthesia Conversion Factor
"ASA Monitor" published by the American Society of Anesthesiologists (ASA)

The documents are provided as information only. Staff recommends the Commission approve following timeline for the approval of the changes to the MSPM 2023:

January 24	Provide FairHealth documents to stakeholders
January 24	Publish Notice of Public Hearing on February 13, 2023
February 13	Public Hearing at Commission Business Meeting
March 13	Approval of MSPM 2023
April 1	Effective Date of MSPM 2023

Representatives of FairHealth will attend the Public Hearing February 13 via Zoom to review the proposed changes with the Commission.

Summary of Proposed Changes

2023 Medical Services Provider Manual

January 3, 2023

FAIR Health has reviewed the policies in the fee schedule under the direction of the South Carolina Workers' Compensation Commission (WCC). This is a preliminary version of the summary and will be updated when final changes are approved.

The codes in the fee schedule will be made current by including codes established for 2023 and deleting obsolete codes. Maximum allowable payment (MAP) amounts will be updated based on the conversion factors adopted by the Workers' Compensation Commission. In addition to administrative changes such as updating copyright dates, code ranges, numerical examples and URL links, substantive changes to the text, which are outlined below, are included in the proposed version of the 2023 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2022.

Where applicable, new text is underlined and deleted text is marked with a ~~strikethrough~~.

1. **Fee Schedule Layout (Page 31)** – Language relating to state-specific codes that were assigned new code numbers in 2021 was deleted, as 2023 is the third fee schedule since this change was adopted:

   - State-specific code. This code is unique to South Carolina Workers' Compensation Commission. ~~Note that state-specific codes have been assigned new code numbers in the *2021 Medical Services Provider Manual.*~~

2. **Maximum Allowable Payment (Page 31)** – Language about codes paid based on individual consideration (IC) was moved for clarity.

   Maximum Allowable Payment
   The maximum allowable payment (MAP) is listed for each service. ~~Some services have been assigned IC (individual consideration) in the MAP column.~~ Payment is determined by the payer based upon submitted documentation. For certain procedures in this Schedule, a distinction is made in the maximum allowable price based on the setting of the service. In these cases, prices are set for both office and facility settings. This distinction is based on the higher cost to the physician in providing the service in the office (non-facility) setting. Facility settings include hospitals, ambulatory surgical centers, and skilled nursing facilities. Those fees listed under the MAP Non-Fac column represent services provided in an office and other non-facility settings. The MAP Fac column lists the MAP for services rendered in a facility setting.

   Some services have been assigned IC (individual consideration) in the MAP column. Payment is determined by the payer based upon submitted documentation. Other services may be listed with the value of "NC" (not covered) and should not be billed or reimbursed. Additional information

regarding IC and NC can be found in Chapter 1. Overview and Guidelines in the subsection titled "Services Without Maximum Allowable Payment (MAP) Amounts."

3. **Section 1. Evaluation and Management (E/M) Services (Page 35)** – the AMA introduced changes to the E/M guidelines in 2023, extending a 2021 revision in coding for office visits to hospital and observation services, consultations, nursing facility and home and residence services. Time or medical decision making (MDM) may now be used to select the appropriate code for use with these services. The E/M section of the 2023 MSPM has been updated accordingly. In addition, a link has been included to provide easy access to an AMA publication on the updated E/M guidelines.

Documentation must support the level of E/M service reported.
For complete instructions on identifying and billing E/M services, please refer to the Evaluation and Management Services Guidelines of the 2023 CPT book or https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.

Evaluation and Management Time
~~Beginning in 2021, t~~ Time alone may be used to select the appropriate code level of office or other outpatient evaluation and management services (CPT 99202-99205 and 99212-99215), inpatient and observation care, (CPT 99221-99223, 99231-99236 and 99238-99239), nursing facility services (99307-99310 and 99315-99316) and home and residence services (99341-99345). Consultation codes (CPT 99242-99245 and 99252-99255) are not reimbursable under the MSPM.

~~For office visits and other outpatient visits, time is based on the amount of time spent face to face with the patient and not the time the patient is in an examining room.~~

~~For inpatient hospital care, time is based on unit floor time. This includes the time the physician is present on the patient's hospital unit and at the bedside rendering services. This also includes time spent reviewing the patient's chart, writing additional notes, and communicating with other professionals and/or the patient's family.~~

~~Additional codes may be reported with the office or other outpatient visit codes to indicate a prolonged visit.~~

~~Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service. The appropriate time should be documented in the medical record when it is used as the basis for code selection.~~

Certain categories of time-based E/M codes that do not have levels of services based on MDM (e.g., Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/ caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care provider(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care provider(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Physician/other qualified health care provider time includes the following activities, when performed:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/ caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

4. **Section 6. Medicine and Injections (Page 386) –** to match text that was updated in the 2022 MSPM Pharmacy section, a sentence about a secondary source of AWP was added.

INJECTABLE PHARMACEUTICALS

Payment for injection codes includes the supplies usually required to perform the procedure, but not the medications. Injections are classified as subcutaneous, intramuscular, or intravenous. Subcutaneous (SC) injections and intramuscular (IM) injections are billed using CPT code 96372; intravenous (IV) injections are billed using CPT code 96374. Each of these CPT codes has been assigned a basic MAP amount, as listed in the *Medical Services Provider Manual.*

When an injection is given during an E/M service, the cost of providing the injection is included in the payment for the E/M service and must not be billed or paid separately. The cost of the injectable pharmaceutical may be billed using the appropriate HCPCS code listed in this section. If a HCPCS code for the injectable pharmaceutical does not exist, use CPT code 99070 and price

the drug at its average wholesale price (AWP) as contained in the current edition of Medi-Span published by Wolters Kluwer Health. Where the AWP of a medication is not published by Medi-Span, the IBM Micromedex RED BOOK may be used as a secondary source.

5. **Section 9. HCPCS Level II (Page 456) –** the explanation for HCPCS modifiers was re-organized for clarity.

HCPCS Modifiers
Many durable medical equipment items can be purchased in new or used condition, or rented. The following modifiers are used to identify each of these transactions. ~~The applicable modifiers are~~:

NU New equipment

RR Rental (use the RR modifier when DME is to be rented)

UE Used durable medical equipment

The following additional modifiers also may be used with HCPCS codes:

AU Item furnished in conjunction with a urological, ostomy or tracheostomy supply

AV Item furnished in conjunction with a prosthetic device, prosthetic or orthotic

AW Item furnished in conjunction with a surgical dressing

KC Replacement of special power wheelchair interface

KL DMEPOS item delivered via mail

~~**NU New equipment**~~

~~**RR Rental (use the RR modifier when DME is to be rented)**~~

TC Technical Component
Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure code.

~~**UE Used durable medical equipment**~~

Fee Schedule Analysis

January 17, 2023

FAIR Health appreciates the opportunity to assist the South Carolina Workers' Compensation Commission in updating the Medical Services Provider Manual (MSPM). This analysis uses medical call data (2021 dates of service) provided by the National Council on Compensation Insurance, Inc. (NCCI) and South Carolina maximum allowable payment (MAP) amounts to review conversion factors and propose MAP values for the 2023 fee schedule.

FAIR Health received paid amounts from NCCI for the 2021 calendar year, aggregated at the procedure code/modifier level. FAIR Health used the data from 2021 to:

1. Compare 2021 actual spending to projected amounts based on 2021 fee schedule MAPS.
2. Project spending for 2022.
3. Project spending for 2023 based on multiple conversion factor alternatives.

2021 Paid Data and Frequencies

The following is a summary of the 2021 data received from NCCI:

NCCI Data - 2021 Calendar Year (Before Validation)

Service Type	Total Paid	Total Charged	Transactions	Units
Ambulance*	$2,371,218.55	$4,667,734.52	12,399	206,783
Anesthesia**	$1,291,497.60	$7,717,020.80	4,596	507,656
CPT (Less Anesthesia)	$55,822,746.23	$121,599,253.43	648,869	908,406
HCPCS (Less Ambulance)	$19,498,988.20	$27,880,277.39	75,532	751,570
Total	$78,984,450.58	$161,864,286.14	741,396	2,374,415

*Assumes most units are miles

**Assumes most units are minutes

Data Used in the Analysis

FAIR Health used the following methodology to analyze the NCCI data and project future payments based on fee schedule MAPs:

- The NCCI paid data from 2021 were used to determine the number of occurrences (frequency) for each service.
- Services were reviewed at the procedure code/modifier level to account for differences in paid amounts based on fee schedule MAP amounts and policies. For example:
    - The occurrences for codes reported with modifier 26 and TC were projected separately, based on the MAP amounts in the fee schedule.
    - HCPCS Codes reported with modifiers NU (new), UE (used) and RR (rental) were projected separately based on the occurrences in the NCCI data and fee schedule MAP values.
    - Records with other modifiers or with modifiers NU, UE and RR appended to codes where these modifiers are not applicable and/or expected were considered as though the records did not contain modifiers.
    - Services containing modifiers that are paid at adjusted amounts according to South Carolina policies (e.g., assistant surgeon modifiers 80-82 and AS) were projected based on 2021 occurrences and adjusted MAP amounts.

2021 Spending

Actual spending from 2021 based on the NCCI data was compared to projected spending based on 2021 fee schedule MAP values.

	2021			
Category	**Frequency**	**Payments (NCCI)**	**Fee Schedule Projections**	**Ratio of Payments to Fee Schedule**
Evaluation and Management	112,994	$ 13,312,184.62	$ 15,048,651.48	88.46%
HCPCS Level II	410,402	$ 5,573,099.71	$ 7,222,429.70	77.16%
Medicine and Injections	12,094	$ 1,231,688.31	$ 1,339,229.93	91.97%
Pathology and Laboratory Services	9,980	$ 366,686.53	$ 416,946.12	87.95%
Physical Medicine	688,013	$ 23,168,834.68	$ 32,300,770.93	71.73%
Radiology	45,687	$ 4,397,877.11	$ 4,340,276.83	101.33%
Special Reports and Services	1,050	$ 57,431.53	$ 63,971.63	89.78%
Surgery	30,485	$ 11,665,646.16	$ 12,320,732.87	94.68%
Total	**1,310,705**	**$ 59,773,448.65**	**$ 73,053,009.49**	**81.82%**

2022 Projections

- Total dollar amounts were projected based on 2021 occurrences and 2022 relative value units (RVUs).
- Using these frequencies and RVUs, FAIR Health projected the estimated spending based on 2022 fee schedule MAP values, including the 9.5% cap on MAP increases and decreases compared to the prior year, where applicable.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia.

Category	Frequency	Total RVUs	2022 Fee Schedule Projections
Evaluation and Management	112,994	326,958.09	$ 16,001,092.26
HCPCS Level II	255,327	145,181.36	$ 7,408,982.54
Medicine and Injections	12,094	26,702.10	$ 1,365,906.33
Pathology and Laboratory Services	9,980	8,138.14	$ 419,195.67
Physical Medicine	688,013	627,952.21	$ 32,200,607.71
Radiology	45,687	83,434.31	$ 4,306,236.17
Special Reports and Services	1,050	1,241.15	$ 63,920.64
Surgery	30,485	241,612.89	$ 12,398,198.79
Total	**1,155,630**	**1,461,220.25**	**$74,164,140**

2023 Projections and Alternate Conversion Factors

- The projections of paid amounts for the 2023 fee schedule are based on 2021 frequencies and 2023 RVUs, to which the current conversion factor of 51.5 is applied. Projections based on other conversion factors: 50, 52, 53 and 54 are also provided. The cap of +/- 9.5% of the prior year's MAP value for each service was applied, when appropriate, in providing these projections.
- Certain 2023 MAP values used for these projections were calculated based on the following assumptions:
    - If a service is not valued in the Medicare Physician Fee Schedule, FAIR Health determined whether the service was valued by another Medicare fee schedule (e.g., the Clinical Laboratory, DMEPOS or Average Sales Price drug fee schedule). FAIR Health used Medicare values in the analysis whenever a Medicare value was available.
    - If Medicare did not provide a professional value in *any* fee schedule for a service, FAIR Health gap filled the value using RVUs calculated by FAIR Health based on our repository of private claims data.
    - FAIR Health does not gap fill values for new codes effective January 1, 2023, that were not valued by Medicare. FAIR Health requires a minimum threshold of claims for a procedure before we can establish an RVU. FAIR Health will evaluate these codes for the 2024 MSPM to determine if we are able to value these codes at that time.

2023 Projections – Current and Alternate Conversion Factors

			2023 Projections (including +/- 9.5% Cap)				
Category	**Freq.**	**2023 RVUs**	**CF=50**	**CF=51.5 (Current)**	**CF=52**	**CF=53**	**CF=54**
Evaluation and Management	112,776	330,865	16,514,044	**16,928,454**	17,017,019	17,153,633	17,253,748
HCPCS Level II	257,063	155,483	7,728,349	**7,716,638**	7,724,922	7,741,174	7,757,999
Medicine & Injection	12,094	26,801	1,330,864	**1,368,213**	1,380,358	1,404,617	1,428,360
Pathology & Laboratory	9,980	8,547	426,989	**421,970**	425,721	432,528	438,586
Physical Medicine	688,013	636,302	31,800,576	**32,694,245**	32,990,235	33,573,037	34,134,522
Radiology	45,687	83,867	4,200,677	**4,325,351**	4,366,778	4,449,819	4,532,819
Special Reports	1,050	1,247	62,365	**64,237**	64,859	66,086	67,279
Surgery	30,438	245,237	12,207,905	**12,556,833**	12,672,813	12,904,816	13,136,290
Total	1,157,101	1,488,348	74,271,768	**76,075,941**	76,642,705	77,725,710	78,749,603

Upon approval of a conversion factor for 2023, FAIR Health will provide an updated Medical Services Provider Manual, which will include all approved changes in policies and a final set of rate tables.

Please let us know if you have any questions.

Analysis of Anesthesia Conversion Factor

January 3, 2023

The South Carolina Workers' Compensation Commission requested FAIR Health to review the conversion factor that determines reimbursement for anesthesia services under the South Carolina Medical Services Provider Manual.

FAIR Health reviewed the anesthesia conversion factor from several aspects:

- Comparison to Medicare
- Comparison to private health insurance
    - Billed charges
    - Contracted amounts
- ASA survey results from 2022
- Comparison to other states' workers' compensation fee schedules

The current anesthesia conversion factor in the South Carolina Medical Services Provider Manual (MSPM) is $30.00. The anesthesiology maximum allowable payment (AMAP) is the sum of the Basic MAP amount plus the Time Value Amount payment. The Basic MAP amount is set in the fee schedule based on the conversion factor x base units. The Time Value amount is calculated based on the $30 conversion factor x each 15-minute time unit.

For example:
CPT 01380 – anesthesia for all closed procedures on knee joint

	60-Minute Surgery (4 Time Units)	120-Minute Surgery (8 Time Units)
Basic MAP (3 base units)	$ 90.00	$ 90.00
Time Value Amount	$ 120.00	$ 240.00
Total AMAP	$ 210.00	$ 330.00

Medicare

CMS reduced the Medicare anesthesia conversion factor slightly in 2022 to maintain budget neutrality for professional fees. As a result, the South Carolina anesthesia conversion factor of $30 compares slightly more favorably to the CMS conversion factor than it did last year. The comparison below is based on the Medicare conversion factor published in the 2023 Final Rule.

	Anesthesia – National Comparison	Anesthesia – South Carolina Comparison	Other Professional Services
South Carolina Conversion Factor	$30.00	$30.00	$51.50
2021 Medicare Conversion Factor	$21.1249 (National)	$20.49 (Adjusted by CMS for South Carolina)	$33.8872
Ratio	142%	146%	152%

Private Health Insurance

FAIR Health collects data for anesthesia services from private payors (more than 50 payors contribute data for services performed in South Carolina) and uses this data to develop benchmarks, including benchmarks for anesthesia conversion factors. Insurers and administrators that participate in the FAIR Health Data Contribution Program are required to submit all of their data; they cannot selectively choose which data to contribute to FAIR Health. We are providing benchmarks for anesthesia conversion factors in two different ways:

- Charge benchmarks based on the non-discounted charges billed by providers before any network discounts are applied; and
- Allowed benchmarks that reflect network rates that have been negotiated between the payor and the provider.

The benchmarks below are based on anesthesia services in the FAIR Health database provided in the state of South Carolina. Charge benchmarks are based on claims from July 2021 through June 2022 and allowed benchmarks are based on allowed amounts from claims incurred from January through December 2021. These are the latest releases available at the time of developing this report.

		Conversion Factor Percentile							
Type	Release	Average	5th	10th	15th	20th	25th	30th	35th
Billed Anesthesia	Nov 2022	134.24	50.65	65.98	75.36	81.04	91.75	104.85	111.48
Allowed Anesthesia	Aug 2022	63.21	28.04	34.88	40.78	46.23	51.65	54.59	57.30

		Conversion Factor Percentile						
Type	Release	40th	45th	50th	60th	70th	80th	90th
Billed Anesthesia	Nov 2022	117.31	124.49	135.89	150.31	165.60	174.66	192.03
Allowed Anesthesia	Aug 2022	60.00	60.34	60.70	68.63	75.00	81.34	85.00

The benchmarks for allowed anesthesia may be compared to the South Carolina conversion factor, as the allowed line represents the amounts allowed by payors under their network contracts. This aligns to what is paid to anesthesiologists and certified registered nurse anesthetists (CRNAs) for patients covered by workers' compensation.

In this analysis, a $30 conversion factor falls between the 5th and 10th percentiles for private insurance. That means that between 90% and 95% of the allowed values in the FAIR Health database are equal to or greater than $30. The 50th percentile (conversion factor of $60.70) is the median conversion factor value in the private insurance data and the average allowed conversion factor benchmark is $63.21.

ASA Survey Results for Commercial Fees Paid for Anesthesia Services

The American Society of Anesthesiologists (ASA) publishes an annual study on conversion factors. FAIR Health downloaded the 2021 study from the ASA website at https://pubs.asahq.org/monitor/article-abstract/86/10/1/136987/Commercial-Fees-Paid-for-Anesthesia-Services-2022

According to the publication, the ASA surveys anesthesiology practices across the country, asking them to report the conversion factors for up to five of their largest commercial managed care contracts. This study publishes the results of that survey, which are normalized based on 15-minute time units, which is the same time unit used by South Carolina in the MSPM.

South Carolina practices are included in the Southeast Region in the ASA survey.

	National		Southeast Region		South Carolina	
Conversion Factor	2021	2022	2021	2022	2021	2022
Low	25.65	19.38	36.00	19.38	50.00	40.00
Median	78.00	78.00	92.00	94.50	73.30	85.18
Average	85.23	85.42	98.64	95.69	88.43	88.65
High	292.00	300.00	292.00	300.00	162.00	134.00

State Workers' Compensation Fee Schedules

FAIR Health reviewed anesthesia conversion factors documented in state workers' compensation fee schedules effective in 2022.

State	Conversion Factor (per 15-minute time unit)
South Carolina	**$30.00**
Alabama	$60.10
Arizona	$61.00
Colorado	$44.18
Florida	$29.49
Georgia	$62.03
Kentucky	$78.53
Louisiana	$50.00
Maryland	$22.81
Mississippi	$75.00
North Carolina	$58.20 – first 60 min $30.75 – after 60 min
North Dakota	$68.27
Ohio	$41.71
Oklahoma	$54.00
Tennessee	$75.00
Virginia (6 regions)	$51.48 - $82.59

FAIR Health assists Colorado, Georgia, Kentucky, Mississippi, North Carolina, North Dakota, Oklahoma and Tennessee in updating their fee schedules. As we are doing for the South Carolina Workers' Compensation Commission, FAIR Health provides research and analysis to support decision making. FAIR Health does not make or recommend fee schedule changes.

Summary

FAIR Health presents this analysis to the Commission to assist with decision making. In summary:

- The current South Carolina anesthesia conversion factor is $30 or 146% of the 2023 Medicare conversion factor for South Carolina and 142 of the national Medicare conversion factor.
- The ratio of the South Carolina workers' compensation anesthesia conversion factor to the Medicare conversion factor is slightly less than the 152% ratio of the conversion factor for other professional services ($51.50) in comparison to Medicare ($33.8872). However, the MAP amounts in the MSPM may also be limited by the +/- 9.5 percent cap on increases or decreases each year, and the formula-based conversion factors for professional services other than anesthesia would not be applicable to those services.
- The $30 South Carolina conversion factor is low in comparison to contracted amounts paid through private health insurance as reflected in FAIR Health benchmarks and ASA survey results.
    - The mean and median conversion factor benchmarks developed by FAIR Health, which are based on data contributed for services performed in South Carolina, are lower than the ASA survey results, which are based on up to five of the largest commercial contracts reported by anesthesiology practices responding to the ASA survey.
- South Carolina's $30 conversion factor falls within the range of conversion factors used by other states' workers' compensation programs; however, it is on the low end of the range.

A copy of the ASA publication *ASA Survey Results for Commercial Fees Paid for Anesthesia Services – 2022* can be obtained from the ASA website at https://pubs.asahq.org/monitor/article-abstract/86/10/1/136987/Commercial-Fees-Paid-for-Anesthesia-Services-2022.

American Society of Anesthesiologists

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THE LEADING SOURCE FOR PERIOPERATIVE HEALTH CARE NEWS

ASA Survey Results:

Commercial Fees Paid for Anesthesia Services – 2022

Stanley W. Stead, MD, MBA, FASA
Sharon K. Merrick, MS, CCS-P

ASA is pleased to present the annual commercial conversion factor survey for 2022. Each summer, we survey anesthesiology practices across the country. We ask them to report up to five of their largest managed care (commercial) contract conversion factors (CFs) and the percentage each contract represents of their commercial population, along with some demographic information. Our objectives for the survey are to report to our members the average contractual amounts for the top five contracts and to present a view of regional trends in commercial contracting.

Summary

Based on the 2022 ASA commercial conversion factor survey results, the national average commercial conversion factor was $85.42, ranging between $81.22 and $89.52 for the five contracts. The

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Biased Signaling in G-Protein-Coupled Receptors: The μ Opioid Receptor

Richard Simoneaux Steven L. Shafer, MD, FASA
Editor-in-Chief

In 2012, the Nobel Prize in Chemistry was awarded to Robert J. Lefkowitz, Howard Hughes Medical Institute/Duke University Medical Center, and Brian K. Kobilka, Stanford University School of Medicine, for "groundbreaking discoveries that reveal the inner workings of… G-protein-coupled receptors" (asamonitor.pub/3Cb1vVL).

G-protein-coupled receptors are a group of proteins consisting of seven transmembrane strands that connect receptors on the inside and outside of the cell membrane. These proteins serve the vital function of allowing communication between the intra- and extracellular environments. G-protein-coupled receptors represent the largest family of mammalian proteins, and

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The 33% Problem: A Discussion With Hospital Executives

Catlin Nalley

It is one of the most enduring challenges faced by the specialty and one unique to anesthesiology – the discrepancy in Medicare payments for anesthesia services known as the "33% Problem". Whereas Medicare rates for other specialties represent between 75% and 85% of their commercial payment rates, payment for anesthesia services are less than one-third of commercial rates. In fact, it has been determined by some that the real number is likely now in the mid-20% range. ASA's economic experts have been working ceaselessly to address this issue since the early 1990s, soon after the flawed Resource-Based Relative Value Scale was established in 1992. Today, ASA continues to devote significant resources to the 33% Problem, including through our Payment Progress Initiative (asamonitor.pub/3Qi9WTk), and the issue has been explored extensively in the *ASA Monitor* (asamonitor.pub/3AmE76F).

This month, the *Monitor* reached out to two anesthesiology thought leaders who have long been intimate with the 33% Problem as both clinicians and health care executives. Below, Joanne Conroy, MD, President and CEO of Dartmouth-Hitchcock Health, and David Reich, MD, President and COO of The Mount Sinai Hospital, offer insights and possible solutions to the specialty's lingering 33% Problem.

As a hospital executive, what is your perspective on the "33% Problem?"

Dr. Conroy: "This is not a new issue. It has been going on for years, and there are several factors at play. Number one, I'm not sure that people completely understand anesthesiology billing, which is very

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Commercial Fees

Continued from page 1

national median remained at $78.00, ranging between $75.12 and $81.12 for the five contracts (Figure 1, Table 1). In the 2021 survey, the mean conversion factor ranged between $79.04 and $90.23 for the five contracts, and the median ranged between $74.00 and $81.50. In contrast, the current national Medicare conversion factor for anesthesia services is $21.5623, or about 25.24% of the 2022 overall mean commercial conversion factor.

Figure 1 shows the frequency in percent and distribution of contract values. In order to show all the values in limited space, we are using a broken axis for all plots. The ranges plotted are $0-$220, with a break indicated by solid lines and then $290-$300. The estimated normal distribution is the solid blue line. We have added a box-and-whiskers plot of the same data immediately below the histogram. The left and right whiskers delineate the minimum and maximum values. The box represents the interquartile range, the left edge of the box is the 25th percentile, the vertical line in the box is the median, and the right edge of the box is the 75th percentile. The solid diamond in the box is the mean.

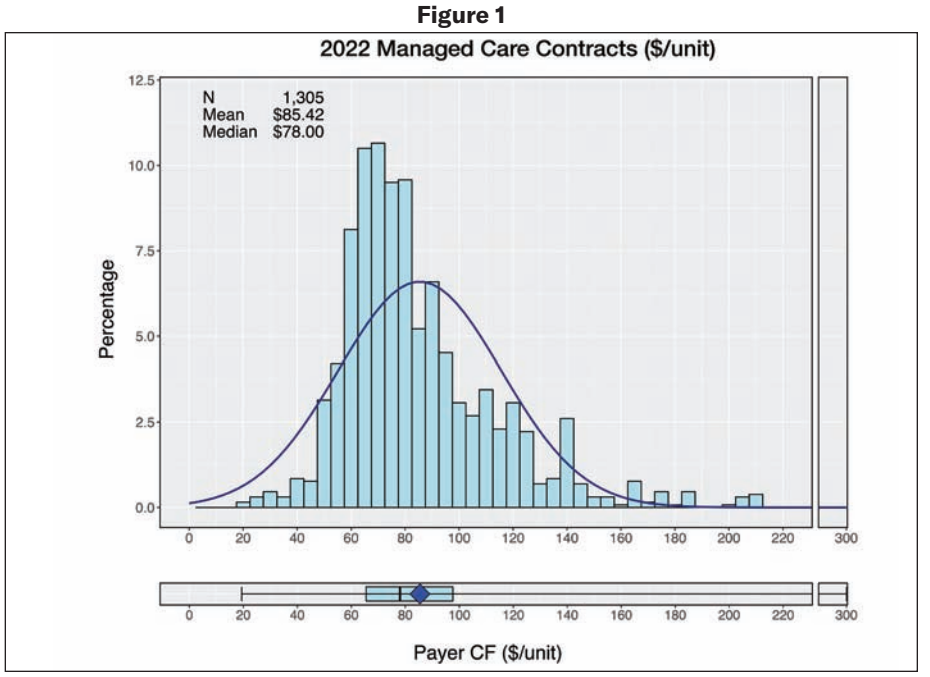
Table 1 provides the overall survey results by reported managed care contract. As with previous surveys, we requested that participants submit data on five commercial contracts. Most practices submitted three or more contracts. The 2022 survey reflects valid responses from 312 practices in 46 states and Washington, D.C. The 2021 survey results included data from 219 practices in 47 states and D.C.

Table 1: National Managed Care Anesthesia Conversion Factors ($/unit), 2022

Conversion Factors	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Mean	$81.22	$83.55	$87.08	$89.52	$87.75	$85.42
Minimum	$25.00	$22.08	$25.00	$19.38	$28.51	$19.38
25th Percentile	$65.00	$65.00	$65.88	$68.74	$68.90	$65.47
Median	$75.12	$76.55	$79.35	$81.12	$80.38	$78.00
75th Percentile	$91.19	$95.00	$102.68	$105.28	$102.45	$97.63
Maximum	$300.00	$300.00	$209.98	$209.98	$209.98	$300.00
# of Contracts	312	295	264	232	202	1,305
% of Responses	22.14	10.31	6.05	3.97	2.64	10.07

Source: ASA 2022 CF Survey. Note: Percent of Managed Care is the average reported and may not total 100%.

Figure 1



Methodology

The survey was disseminated in June and July 2022. To comply with the principles established by the Department of Justice (DOJ) and the Federal Trade Commission (FTC) in their 1996 Statements of Antitrust Enforcement Policy in Health Care, the survey requested data that were at least three months old. In addition, the following three conditions must be met:

1. There are at least five providers reporting data upon which each disseminated statistic is based, and
2. No individual provider's data represents more than 25% on a weighted basis of that statistic, and
3. Any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

To comply with the statements, we are only able to provide aggregated data. Since some states did not respond, and other states had insufficient response rates, we are unable to provide specific data for all states. We term "Eligible States" those that submitted sufficient data to be compliant with DOJ and FTC principles and provide state-specific data for only those states. We have 27 Eligible States this year.

This is the 12th year that we offered the survey electronically through the website www.surveymonkey.com. ASA urged participation through various electronic mail offerings, including ASA committee listserves, ASAP (all-member weekly e-mail digest), Vital Signs, the Monday Morning Outreach, communications to state component societies and our Anesthesia Administators and Executives (AAE) members, and via the ASA website.

The responses to the survey represented 332 unique practices. However, due to respondents providing incomplete data, we excluded 20 responses from the overall analysis. Our results are based on the data from 312 practices.

Results

Table 2 presents respondent information for 277 practices (35 practices did not provide us with complete practice demographics) in the analytic sample per Major Geographic Region as identified by the

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Table 2: Respondent Information by Major Geographic Region, 2022

Region	Practices Reporting[1]	Cases	Units	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
Eastern	51	2,832,001	29,858,044	12,355.3	15.5	2,642.6	1,832.6 (1,152.5)	99.7 (70)
Midwest	65	2,109,416	24,442,422	15,425.2	11.6	1,566.8	1,270.6 (493.0)	267.8 (5)
Southern	89	4,337,900	34,252,713	20,520.6	14.1	2,543.9	3,100.5 (746.5)	706.5 (2)
Western	72	2,893,125	35,218,564	12,999.3	11.7	3,470.6	772.2 (9.0)	222.6 (7)
ALL	277	12,172,442	123,771,742	15,685.3	13.2	10,223.8	6,975.9 (2,401.0)	1,296.5 (84)

Source: ASA 2022 CF Survey. (Number in brackets indicates the number of non-employed FTEs). Results are rounded to nearest tenth.
[1] Note: 277 of the 312 practices reported case, unit or FTE data.

Table 3: Respondent Information by Minor Geographic Region, 2022

Region	Practices Reporting[1]	Cases	Units	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
CAAKHI	19	1,166,307	14,192,563	22,845.5	12.4	1,119.2	115.0 (0.0)	42.0 (0)
Eastern Midwest	54	1,479,234	16,212,960	19,640.8	10.9	998.9	1,089.8 (311.0)	182.8 (5)
Lower Midwest	38	1,299,453	10,205,372	17,456.9	10.3	810.5	951.8 (109.5)	157.9 (1)
Mid Atlantic	11	544,065	5,730,688	15,499.9	32.0	444.2	486.5 (46.5)	9.0 (20)
North Atlantic	23	1,460,200	14,854,448	10,055.5	10.6	1,378.7	845.5 (148.0)	64.8 (0)
Northeast	7	249,910	2,117,176	14,905.9	9.7	279.6	230.2 (100.0)	1.0 (50)
Northwest	18	639,330	8,015,461	10,594.2	10.9	768.4	308.1 (4.0)	36.0 (7)
Rocky Mountain	35	1,087,488	13,010,540	8,333.3	12.0	1,583.0	349.1 (5.0)	144.6 (0)
Southeast	52	3,362,578	28,475,009	18,303.2	16.9	2,163.7	2,098.2 (1,495.0)	573.5 (1)
Upper Midwest	20	883,877	10,957,526	14,922.2	12.7	677.6	501.8 (182.0)	85.0 (0)
ALL	277	12,172,442	123,771,742	15,685.3	13.2	10,223.8	6,975.9 (2,401.0)	1,296.5 (84)

Source: ASA 2022 CF Survey. (Number in brackets indicates the number of non-employed FTEs). Results are rounded to nearest tenth.
[1] Note: 277 of the 312 practices reported case, unit or FTE data.

Table 4: Conversion Factor Adjustment Based on Time Units, 2022

Time Units	Time Units/Case	Sum of Base and time Units	CF Value Ratio based for 15-minute units
10-minute time units	6.9762	12.2120	1.2352
12-minute time units	5.8135	11.0493	1.1176
15-minute time units	4.6508	9.8866	1.0000

Source: Mean Minutes per Case and Base Unit taken from is based on data from the 2020 CMS Physician/Supplier Procedure Summary (PSPS) Master File ("Master File"). (https://data.cms.gov/search?keywords=Physician%2FSupplier%20Procedure%20Summary)

[1] Mean Base Units: 5.2358
[2] Mean Minutes/Case: 69.7623

Table 5: Respondents Having Flat Fee Components, 2022

Region	Flat Fee (Any)	Labor & Delivery	Cataract	Endoscopy	Pain	Other
Eastern	25	1	0	0	3	7
Midwest	38	12	0	3	0	4
Southern	45	9	0	9	9	11
Western	32	2	2	3	0	7
ALL	140	24	2	15	12	29

Source: ASA 2022 CF Survey. (Others include cosmetic and plastic surgery, bundled surgical procedures, TEE, Total Joint Replacement, spine surgery, general surgery, organ trasnplant, radiation oncology, invasive monitoring and open heart surgery.)

Figure 2

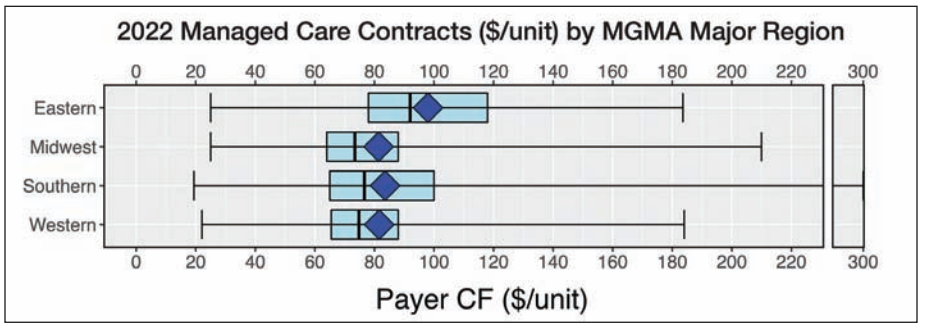

Table 6: Major Region Managed Care Anesthesia Conversion Factors ($/unit), 2022

	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Eastern	n = 59	n = 57	n = 54	n = 48	n = 39	n = 257
Mean	$93.78	$96.54	$96.79	$103.32	$101.64	$98.00
Minimum	$30.02	$29.50	$25.00	$27.50	$28.51	$25.00
25th Percentile	$74.45	$79.20	$77.25	$82.90	$79.25	$78.00
Median	$90.75	$90.00	$93.60	$93.50	$95.00	$92.00
75th Percentile	$109.70	$114.00	$119.50	$120.50	$120.85	$118.00
Maximum	$167.00	$175.05	$168.61	$180.83	$183.59	$183.59
Midwest	n = 70	n = 66	n = 59	n = 55	n = 47	n = 297
Mean	$76.06	$80.40	$83.37	$84.97	$84.13	$81.40
Minimum	$25.00	$25.00	$50.00	$47.05	$43.00	$25.00
25th Percentile	$65.50	$60.38	$62.90	$63.50	$64.00	$64.00
Median	$70.62	$72.53	$75.00	$72.00	$80.58	$73.44
75th Percentile	$79.75	$88.00	$92.89	$85.33	$88.52	$87.99
Maximum	$209.98	$209.98	$209.98	$209.98	$209.98	$209.98
Southern	n = 104	n = 97	n = 83	n = 72	n = 66	n = 422
Mean	$79.60	$81.37	$86.85	$86.39	$85.81	$83.56
Minimum	$33.00	$38.00	$29.00	$19.38	$45.00	$19.38
25th Percentile	$62.00	$64.00	$65.23	$68.00	$69.00	$65.00
Median	$74.21	$74.50	$79.50	$79.00	$78.38	$76.62
75th Percentile	$90.25	$95.00	$105.80	$107.12	$108.50	$100.00
Maximum	$300.00	$300.00	$163.53	$138.44	$141.00	$300.00
Western	n = 79	n = 75	n = 68	n = 57	n = 50	n = 329
Mean	$78.53	$79.26	$82.88	$86.22	$82.87	$81.59
Minimum	$31.00	$22.08	$50.00	$54.00	$58.00	$22.08
25th Percentile	$65.00	$63.75	$66.31	$70.00	$66.40	$65.50
Median	$73.54	$73.00	$74.90	$75.83	$75.00	$74.80
75th Percentile	$83.19	$85.00	$92.60	$90.00	$85.17	$88.00
Maximum	$184.00	$184.00	$184.00	$184.00	$184.00	$184.00

Source: ASA 2022 CF Survey.

Medical Group Management Association (MGMA) (asamonitor.pub/30PLj9B). These regions are as follows:

- Eastern: CT, DE, DC, ME, MD, MA, NH, NJ, NY, NC, PA, RI, VT, VA, WV
- Midwestern: IL, IN, IA, MI, MN, NE, ND, OH, SD, WI
- Southern: AL, AR, FL, GA, KS, KY, LA, MS, MO, OK, SC, TN, TX
- Western: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

These 277 practices employ or contract with 10,223.8 full-time equivalent (FTE) physician anesthesiologists, 6,975.9 FTE nurse anesthetists, and 1,296.5 FTE anesthesiologist assistants (AAs). The practices also work with an additional 2,401.0 FTE nurse anesthetists and 84 FTE AAs for whom the practice does not directly pay compensation (i.e., facility hires or contracts the nurse anesthetist or AA).

Figure 3

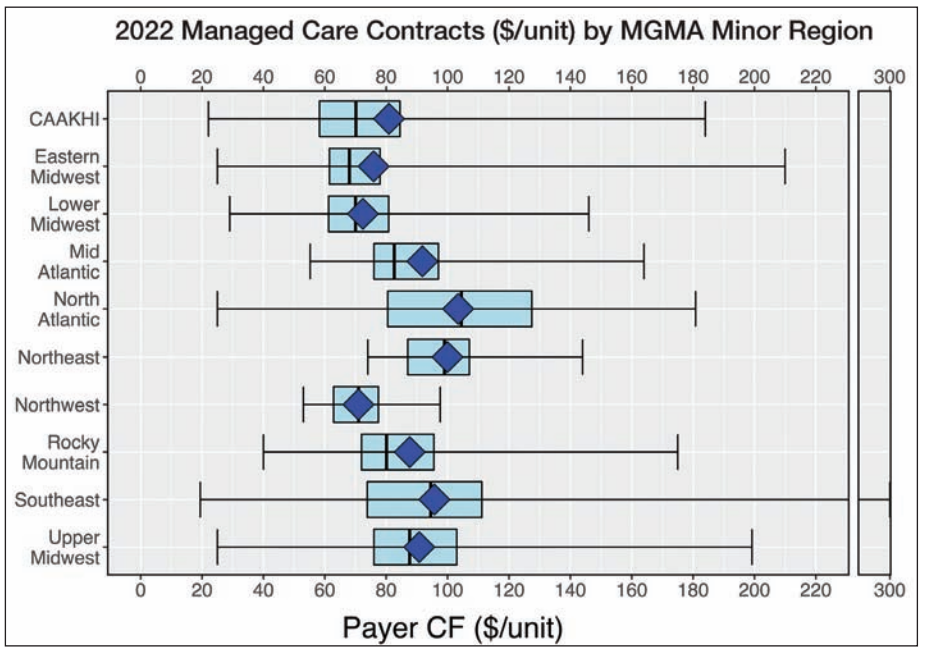

Table 7: Minor Region Managed Care Anesthesia Conversion Factors ($/unit), 2022

MGMA Minor Region	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
CAAKHI	90	$22.08	$58.25	$70.12	$80.88	$84.49	$184.00
Eastern Midwest	251	$25.00	$61.50	$68.00	$75.90	$78.00	$209.98
Lower Midwest	179	$29.00	$61.24	$70.00	$72.40	$80.79	$146.04
Mid Atlantic	60	$55.20	$76.00	$82.62	$91.79	$97.00	$164.00
North Atlantic	113	$25.00	$80.50	$104.50	$103.46	$127.44	$180.83
Northeast	41	$74.00	$87.01	$99.00	$99.96	$107.10	$144.00
Northwest	83	$53.00	$62.86	$71.00	$70.96	$77.45	$97.60
Rocky Mountain	156	$40.00	$71.94	$80.10	$87.65	$95.55	$175.00
Southeast	240	$19.38	$73.83	$94.50	$95.69	$111.17	$300.00
Upper Midwest	92	$25.00	$76.00	$87.64	$90.77	$103.00	$199.20

Source: ASA 2022 CF Survey.

The 277 practices reported a total of 1,305 managed care contracts. This is more than the 933 contracts reported last year.

Table 3 provides the same respondent information by Minor Geographic Region as identified by the MGMA.

- CAAKHI: CA, AK, HI
- Eastern Midwest: IL, IN, KY, MI, OH
- Lower Midwest: AR, KS, LA, MO, OK, TX
- Mid Atlantic: DC, DE, MD, VA, WV
- North Atlantic: NJ, NY, PA
- Northeast: CT, MA, ME, NH, RI, VT
- Northwest: ID, OR, WA
- Rocky Mountain: AZ, CO, MT, NM, NV, UT, WY
- Southeast: AL, FL, GA, MS, NC, SC, TN
- Upper Midwest: IA, MN, ND, NE, SD, WI

A total 1,246 of the contracts are based upon a 15-minute unit, 27 upon a 12-minute unit, and 32 are based upon a 10-minute unit. None were based upon an 8-minute unit. We normalized all contract conversion factors with 10- and 12-minute time units to the typical 15-minute time unit using an adjustment factor of 1.2352 for 10-minute units and 1.1176 for 12-minute units (Table 4).

The adjustment factors are calculated as ratios based on the mean time and mean base units per case. To make these calculations, we have used the CMS Physician/Supplier Procedure Summary (PSPS) data set, which represents over 21 million anesthesia claims (asamonitor.pub/3dpa9Wz).

The mean time was 69.7623 minutes, and mean base units per case were 5.2358 base units. Making the same calculations described above, the adjustment factors are similar to last year: 1.223 for 10-minute units and 1.112 for 12-minute units. We did not have any 8-minute units reported in last year's survey. Of note, the mean time has increased by 5.66 minutes since last year's mean time of 64.0949 minutes.

Groups continue to report flat fee contracts for certain procedures. One hundred forty (140) of the 241 groups (58.1%) responding to this question negotiated at least one flat fee contract (71 practices did not respond). Twenty four (24) of the 140 groups that reported having flat fees (17.1%) have flat fee contracts for Labor and Delivery. This is much less than last year's rate of 44.8% that reported flat fee contracts for Labor and Delivery in 2021.

Table 6 reports the conversion factor by MGMA Major Region. Contract 1

Continued on next page

Commercial Fees

Continued from previous page

reflected the highest percentage of the reported commercial business, Contract 2 reflected the second highest percentage, and so on. Thus, when looking at the data, you can see that Contract 1 not only reflects the greatest number of responses (312) but also the highest average percentage of managed care business (22.14%, Table 1). We also reported the total number of responses for each contract in Table 1. Figure 2 shows the contract data for each major region as a box-and-whiskers plot.

We had a sufficient data sample to provide detailed information for all 10 MGMA Minor Regions (Figure 3). Table 7 shows contract data for the minor regions.

This is the eighth year we are presenting state-specific data. Although we had respondents from 46 states and D.C, only 27 states were identified as eligible states (Figure 4, Table 8). Eligible states were those that complied with the DOJ and FTC requirements listed above. We believe by providing this data, we can encourage more participation in the 2023 CF study and increase the state-level detail of our reporting.

Observations

Based on our review of the analysis, the most interesting findings include:

- The national average conversion factor increased to $85.42, while the median matched last year's median of $78.00. The range of mean values narrowed from a range of $79.04-$90.23 in 2021 to a range of $81.22-$89.52 in 2022.
- As was the case in our 2018-2021 surveys, the Eastern Region has the highest mean this year. The Eastern Region mean in 2021 was $93.16, and this year it is $98.00.
- The highest conversion factor reported was $300.00. In 2021, the highest conversion factor reported was $292.00.
- In the 2021 survey, the Medicare conversion factor was 25.30% of the overall commercial mean. In this year's survey, it has fallen slightly to 25.24%.

Conclusions

Our sample size for this year's survey was higher than last year, continuing to represent a significant portion of U.S. practicing anesthesiologists, nurse anesthetists, and AAs. We were pleased to have respondents report across a broad geographic basis, 46 states, and Washington, D.C., allowing us to provide detailed regional responses. The number of practices reporting allowed us to report state-specific data from 27 states – nine more than last year. Most practices included complete demographic information, and we are hopeful that this trend will continue and all respondents will supply complete information in future surveys.

We will continue to monitor the trends in the commercial conversion factor survey results and will launch the survey again in June 2023. It is important that as many practices as possible participate in the 2023 survey to help us obtain an accurate representation of the anesthesia commercial conversion factor. We hope that a significant growth in participants will allow us to publish data for every state. We look forward to your future participation and thank all the practices that contributed to the 2022 results. ■

Table 8: Eligible States Managed Care Anesthesia Conversion Factors ($/unit), 2022

State	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
AL	23	$19.38	$61.50	$65.00	$68.85	$72.00	$136.51
CA	72	$22.08	$56.72	$71.62	$81.02	$84.14	$184.00
CO	26	$69.00	$81.25	$98.34	$100.67	$116.08	$138.60
FL	72	$48.00	$98.50	$121.67	$117.91	$127.16	$300.00
GA	40	$52.00	$72.75	$86.00	$84.98	$100.69	$130.00
IA	22	$72.08	$79.00	$81.83	$85.32	$85.66	$119.38
IL	36	$47.00	$58.09	$74.13	$113.59	$176.02	$209.98
IN	37	$32.00	$58.00	$72.00	$69.99	$78.00	$121.00
KS	28	$61.00	$70.00	$77.00	$76.68	$81.00	$95.70
KY	46	$45.00	$64.25	$70.00	$70.12	$72.00	$94.91
LA	29	$47.00	$54.00	$62.00	$70.64	$78.75	$120.00
MI	77	$43.00	$60.00	$64.00	$64.84	$65.50	$131.75
MN	22	$25.00	$88.26	$97.62	$92.00	$105.12	$118.61
MO	22	$52.00	$62.92	$71.00	$68.68	$74.00	$87.00
MT	23	$54.00	$63.50	$66.00	$70.89	$77.00	$91.80
NC	43	$51.00	$69.05	$85.00	$90.43	$96.15	$183.59
NY	71	$45.00	$87.17	$117.42	$111.75	$135.60	$180.83
OH	55	$25.00	$69.12	$76.00	$75.54	$82.38	$115.00
OK	38	$38.00	$55.00	$62.00	$61.40	$65.50	$81.58
PA	24	$25.00	$57.94	$61.15	$66.47	$88.29	$139.50
SC	21	$40.00	$72.00	$85.18	$88.65	$106.66	$134.00
TN	39	$35.00	$83.12	$97.00	$93.50	$108.50	$117.34
TX	57	$29.00	$70.00	$82.00	$81.24	$94.00	$146.04
UT	40	$64.75	$72.00	$75.91	$81.26	$90.12	$111.82
VA	35	$64.00	$78.02	$84.91	$90.28	$94.76	$164.00
WA	65	$53.00	$61.50	$68.00	$69.74	$77.99	$96.00
WI	35	$57.00	$82.00	$93.00	$100.39	$119.00	$199.20

Source: ASA 2022 CF Survey.

Figure 4