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Title: Independent Dispute Resolution Operations (CMS-9897)

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Improving Anesthesia Claims Batching Rules

Previous rules regarding batching of claims into a single dispute were extremely limiting for anesthesia providers. Our largest client, a mid-size, independent anesthesia practice has averaged just 1.3 claims per dispute. IDR entities have awarded them higher reimbursement in 95% of these disputes, but so far the payer has been unwilling to engage in good faith negotiations. Thus, my client must continue relying on the expensive, complex IDR process for the foreseeable future.

A more thoughtful approach to batching rules would allow for this to be a much more efficient and less costly arbitration process for all parties. Fewer disputes would lower the systemwide cost of arbitration by reducing the total IDRE fees paid to resolve these disputes, as well as reduce the ever-growing IDR backlog.

Context: Anesthesia Claims

Anesthesia claims are relatively straightforward to calculate reimbursement. There are three components (or unit types) that are multiplied by a Conversion Factor:

1. Time Units (15 minute increments)
2. Base Units (assigned by Anesthesia CPT system)
3. Physical Status Units (assigned by Anesthesia CPT system)

(Time Units + Base Units + Physical Status Units) x Conversion Factor = Reimbursement Amount

The Conversion Factor is a single $ per Unit which is applied across all Anesthesia CPT codes.

In previous guidance, CMS acknowledges all of these points:

> *What is the appropriate way to batch anesthesia services? Plans and issuers generally calculate payment amounts for anesthesia services by multiplying the rate for the anesthesia conversion factor that has been negotiated between the payer and the provider or facility (expressed in dollars per unit) by (1) the base unit for the anesthesia service code, (2) the time unit, and (3) the physical status modifier unit. The base unit, time unit, and physical status modifier unit are specific to the individual receiving the anesthesia services. The base units are assigned to the services codes for anesthesia services, specifically CPT codes 00100 to 01999. Parties that initiate the Federal IDR process may submit a batched dispute involving anesthesia qualified IDR services that are billed using the same CPT code (for example, all claims with CPT code 01999), even if the qualified IDR services were billed using different time units and physical status modifier units as long as the qualified IDR items and services comply with the batching requirements set forth in 26 CFR 54.9816- 8T(c)(3), 29 CFR 2590.716-8(c)(3), and 45 CFR 149.510(c)(3) as described in question 1 above.*

> *Because qualifying payment amounts (QPAs) 6 for anesthesia services are calculated by multiplying the median contracted rate for the anesthesia conversion factor, indexed for inflation, by the sum of the base unit, time unit, and physical status modifier unit, batched anesthesia qualified IDR services are likely to have multiple QPAs.* [1]

However, restricting the batching to the same anesthesia CPT code is incredibly limiting.

Batching Criteria and Recommendations

Service Code

My anesthesia client has submitted 160+ different anesthesia CPT codes for arbitration. Because a standard Unit system is used for the reimbursement equation, **Initiating Parties should have the flexibility to batch all anesthesia CPT codes together**. The Initiating Party could then group "similar" claims by other relevant criteria for the IDR entity to consider, such as anesthesia specialty (cardiac, pediatrics, etc.) or anesthesia CPT code range.[2] This grouping would allow the Initiating Party to communicate relevant merits for increased reimbursement across a larger swath of "similar" services.

At a minimum, batching by service codes within the same anesthesia CPT code range should be considered for new batching rules. These are pre-defined CPT code ranges by body part.[3]

Again, these recommendations would introduce more efficiency in the system, by allowing an IDRE to make a single determination across a larger volume of similar claims.

Anesthesia	
00100-00222	Anesthesia for Procedures on the Head
00300-00352	Anesthesia for Procedures on the Neck
00400-00474	Anesthesia for Procedures on the Thorax (Chest Wall and Shoulder Girdle)
00500-00580	Anesthesia for Intrathoracic Procedures
00600-00670	Anesthesia for Procedures on the Spine and Spinal Cord
00700-00797	Anesthesia for Procedures on the Upper Abdomen
00800-00882	Anesthesia for Procedures on the Lower Abdomen
00902-00952	Anesthesia for Procedures on the Perineum
01112-01173	Anesthesia for Procedures on the Pelvis (Except Hip)
01200-01274	Anesthesia for Procedures on the Upper Leg (Except Knee)

Figure 1. Subset of anesthesia CPT code ranges

Fully Insured vs Self Insured

Fully-insured plans make up only ~25% of my client's claim volume. Self-insured plans are the majority of their claims, but there are hundreds of different self insured plans.

The Conversion Factor is a contracted rate at the insurance payer level. It applies across all of that payer's plans, regardless of any distinction between fully vs self-insured. For example, a contracted rate with UnitedHealthcare applies to all of its subsidiaries as well, including UMR which administers self-insured plans.

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[1] https://www.cms.gov/files/document/ta-certified-independent-dispute-resolution-entities-august-2022.pdf
[2] https://www.aapc.com/codes/cpt-codes-range/00100-01999/
[3] https://www.aapc.com/codes/cpt-codes-range/00100-01999/

Thus, from an IDR perspective this distinction between fully and self-insured is irrelevant. As stated by CMS in their own guidance (quoted above): "batched anesthesia qualified IDR services are likely to have multiple QPAs" and therefore QPA differences were irrelevant for batching purposes even under the prior batching rules.

Fully insured vs self insured should not be a factor in batching criteria.

Combined Effect of Restrictive Batching

Consider that my client may bill for ~10,000 claims annually with a large commercial insurance payer. In addition to the 160+ anesthesia CPT codes previously discussed, they must further divide within these anesthesia CPT codes by the hundreds of different self-insured plans. And then further divide those by 30 business day periods.

The obvious end result: nearly impossible batching of anesthesia claims.

Relation to Non-Refundable Administrative Fees

Specialties such as anesthesia or radiology have a high volume or claims but lower reimbursement per claims relative to surgeons, for example. When the vast majority of disputes are limited to a single claim, this magnifies the issue with a large non-refundable administrative fee (such as the vacated $350 fee).

Consider a common scenario in anesthesia:

1. Payer initially pays $500 for a claim
2. Provider takes claim to arbitration and asks for a total claim reimbursement of $700
3. IDRE awards the provider the additional $200 (a 40% increase) after reviewing all relevant information submitted by the parties
4. The provider won the $200 but paid out $350 in administrative fees
5. Net of fees, the provider actually lost $150

The 40% increase is a meaningful amount of reimbursement for this provider group, especially when extrapolated across thousands of claims. However, the non-refundable administrative fee renders this financially inaccessible as a result of the limited batching opportunity.

If the provider is able to batch 10, 50, or even 100 claims into a single dispute, the $350 administrative fee is no longer a barrier to fair arbitration. (And the systems incurs fewer IDRE refundable fees, too.)

Outsized Impact on Smaller Practices

Finally, as you consider the prior limitations of batching, please note that smaller provider groups are disproportionately impacted due to their lower volume of claims. A small group with 5 providers and a national group with 1,000 providers will both have 160+ different anesthesia CPT codes and hundreds of different self-insured plans. However, the national group will have more success in batching claims than the smaller group simply due to sheer volume of claims.

Even if both groups win 100% of their arbitration disputes, the smaller group will have lost a significant amount of the financial reimbursement to non-refundable administrative fees due to their inevitably lower claims per dispute ratio.

And this doesn’t even consider the logistical complexity and increased administrative overhead that many of these smaller groups are unable to absorb.

As previously constructed, the prior batching rules disadvantaged smaller groups.