RVUs for Anesthesiology Services

Anesthesiologists' services had been compensated according to a "relative value guide" before the implementation of the Medicare payment schedule. This approach has continued with some modifications. The Anesthesiology Base Units and Geographically Adjusted Dollar Anesthesia Conversion Factors are available at

https://www.cms.gov/center/provider-type/anesthesiologists-center

Anesthesia Base Units

Medicare payments for anesthesiology services are based on the American Society of Anesthesiologists (ASA) Relative Value Guide with some of the basic units adjusted by the CMS. Two hundred and seventy-six anesthesia codes correspond to the anesthesia services for more than 4000 surgical, endoscopic, and radiological procedures. Each service is assigned a base unit. The base unit reflects the complexity of the service and includes work provided before and after reportable anesthesia time. The base units also cover usual preoperative and postoperative visits, administering fluids and blood that are part of the anesthesia care, and monitoring procedures.

Because the base units reflect all but the time required for the procedure, they are added to a time factor for each service that an anesthesiologist provides. Under the 1991 Final Rule, anesthesia time starts when the physician begins to prepare the patient for induction and ends when the patient is placed under postoperative supervision when the anesthesiologist is no longer in at-tendance. Time for each procedure is divided into 15-minute increments and is assigned a unit value of 1 and is added to the base units. The time units account for the time from continuous hands-on-care to transfer of the patient to post-anesthesia care personnel. Currently, each 15 minutes of time is equal to1 unit of time according to CMS. The sum of the base and time units are then multiplied by the geographically adjusted dollar–anesthesiology CF to arrive at the final payment for each service. For example, if a state had a geographically adjusted dollar-anesthesia CF of $20.58, Medicare would allow $226.38 in that state for anesthesia for intraperitoneal procedures in the upper abdomen (CPT code 00790), which takes one hour.

$$(7 \text{ base units} + 4 \text{ time units}) \times 20.58 = \$226.38$$

Because the resource-based relative value scale (RBRVS) payment system continues to use the uniform relative value guide, CMS did not need to rescale the guide to conform with the RBRVS; instead, it only needed to establish a separate CF for anesthesiology that would appropriately integrate payments for these services with payments for services on the Harvard scale. To compute this CF, CMS determined the difference between the average payment under the old base- and time-unit system and the average payment that would result from using Harvard work RVUs for 19 anesthesia services surveyed by Harvard. The 1992 anesthesiology CF represented a reduction of 42% in the work component of anesthesiology services, but an overall reduction from the 1991 CF of 29% across all components. The anesthesia work RVUs for 1997 increased by 22.76% as a result of the Five-Year Review, which translated into a 15.95% increase in the anesthesia CF. As a result of the second Five-Year Review efforts, CMS announced an increase to the work portion of the anesthesia CF of 2.10%, effective in 2003.

In 2007, at the request of CMS, RUC reviewed the work of the post-induction anesthesia period, considered how increases in the work of pre- and post-anesthesia services would affect all anesthesia services, and determined how and whether to apply the evaluation and management (E/M) update to anesthesia procedures. After this review, RUC determined that the work of anesthesia services is undervalued by approximately 32%. As a result of this review, CMS agreed with RUC's recommendations and increased the work of anesthesia services by 32% in 2008.