Exhibit
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Oregon Society of Anesthesiologists

TO: **Fred Bruyns**
Rules Coordinator, DCBS

FR: **Kate Ropp, MD**
President, Oregon Society of Anesthesiologists

RE: **Proposed rulemaking on Chapter 436,**
Amendment of rules governing medical fees and payment, medical services, and managed care.

The Oregon Society of Anesthesiologists (OSA), which is a professional statewide organization of physician anesthesiologists committed to promoting the highest level of safety and value for our patients and the highest quality of anesthesia care in Oregon through access to physicians in the medical specialty of anesthesiology, would like to submit the below comments in response to the proposed rulemaking on Chapter 436, Amendment of rules governing medical fees and payment, medical services, and managed care.

Our comments are specific to the amendments to 436-009-0040 and the requirements for billing QK, QY and QX modifiers.

There are existing restrictions as to what anesthesiologists can and cannot do while medically directing in the Medicare Claims Processing Manual in Chapter 12, Section 50:

A physician who is concurrently furnishing services that meet the requirements for payment at the medically directed rate cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, periodic (rather than continuous) monitoring of an obstetrical patient, receiving patients entering the operating suite for the next surgery, checking or discharging patients in the recovery room, or handling scheduling matters, do not substantially diminish the scope of control exercised by the physician and do not constitute a separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met.

Notably, the proposed rules are much more restrictive. For example, “services” is not defined. If this refers to billable services it does not account for services necessary for the performance of an anesthetic (arterial line, CVP, etc.), or routine or emergent care in the post-anesthesia care unit. Services like evaluating a patient or performing a procedure on a patient in a pain clinic while simultaneously medically directing is not considered to be an allowable activity. The OSA suggests aligning these rules with those in the Medicare Claims Processing Manual in Chapter 12, Section 50.

Additionally, these proposed rules state that payment for modifiers QK, QY and QX are at 50% of the applicable fee schedule amounts, but this does not account for the rare cases where it is medically necessary for a CRNA and a physician anesthesiologist to be actively engaged and treating a patient through all or part of a procedure. For cases like this, CMS allows for full payment of each provider if the physician uses the AA modifier and the CRNA uses the QZ modifier and each submit the proper documentation (Section 140.4.2 in https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2716CP.pdf). The OSA suggest that a similar exception is made here.

The OSA is unclear as to the intent for this rule. If the intent is to make sure that the CRNAs get paid separately for their contributions, then we recommend that it only apply to CRNAs who have a different tax ID than the medically directing physician. This would certainly simplify things for groups where the CRNAs and MDs/DOs are in the same group where internal arrangements address compensation, while still addressing the legitimate need for the CRNA not financially integrated with the MD/DO to get paid for the work they have performed. Our recommendation will also reduce the number of claims needed to be processed by the Worker’s Compensation program and would reduce confusion for patients who often do not understand why they are receiving multiple bills for, what to them, is the same anesthesia service.

The proposed rule is silent on how one should report cases personally performed by the anesthesiologist. Medicare requires use of the AA modifier for these cases. Many private payers do not require use of this modifier. OSA requests guidance on how to report personally performed cases by the anesthesiologist.

Finally, the proposed rule also does not address how to handle teaching cases. Because Medicare helps fund graduate medical education, Medicare has established payment policies and reporting requirements for resident and nurse anesthetist teaching cases. Since the Worker’s Compensation program does not separately fund education, the OSA requests clarification on whether the proposed rule applies to teaching cases. If it does apply, we request further clarification on how to report these cases.