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Mallampati Score, ASA Physical Status Class, Medical Direction: Should We Overcome The Billable Mirage? Should We Discard The Mandated Redundancies?

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My opinion

The question is whether American Society of Anesthesiologists (ASA)Â is aÂ stakeholderÂ whoÂ is consulted beforeÂ the Centers for MedicareÂ & Medicaid Services (CMS) finalizes and publishesÂ its annual policyÂ about Medicare payments for physician anesthesiologists and other anesthesia providers under the Physician Fee Schedule (PFS) and Anesthesia Fee Schedule (AFS) [1-3]. The question is NOT whether CMS billing guidelines can be mirage or NOT but the question is whether anesthesia providers know what they are walking into while ASA despite representing anesthesia providers may NOT be addressing it. Therefore, instead of pleading the fifth when caught unawares about the reality and real consequences of CMS billing guidelines, anesthesia providers should consider preemptively pleading to ASA to make the below-mentioned case points to CMS so that PFS and AFS can appear as more appropriate reimbursement because both ASA and CMS may be overlooking the elephant in the room whenÂ ASA is only pleading to CMS that CMS is paying anesthesia providersÂ at one-third of the ratesÂ paid by non-CMS payers while CMS is only complaining to ASA that anesthesia providers are charging non-CMS payers three times of CMS rates [4-5]. The price is never right because righting the price is never in sight when the insight is to price at whatever rate that can be negotiated, lobbied and deemed to appear right until the right does not seem right anymore and insight readjusts to once again right the previously righted price. While leaving it up to the CMS as well as ASA to read in between the lines so as to unentangle and free the billing from the mandated redundancies, the humble long overdue pleas are as follows:

- In the era of freely available and freely used video-laryngoscopy, theÂ Mallampati score may have become irrelevant thus leaving the only question to be assessed preoperativelyÂ about whether the patient needs extremely rare awake fiberoptic intubation or NOT according to the clinical judgment of anesthesia providers and NOT just based on patient'sÂ Mallampati score. Therefore, ASA should plead to CMS about discarding any billing weightage accrued to scoring and documenting irrelevant MallampatiÃ score because instead of Mallampati score, anesthesia providers may be essentially judging and grading clinically whether (a) direct laryngoscopy can be safely attempted in the patient, or (b) video-laryngoscopy may be needed for additional safety, or (c) video-laryngoscopy must be used for patient safety, or (d) fiberoptic intubation scopeâ€™s support may be needed for additional safety, or (e) fiberoptic intubation must be performed on awake patient under local anesthesia, or (f) tracheostomy must be performed on awake patient under local anesthesia.
- In the era when even the simplest monitored anesthesia care (MAC)Â office-based procedures get performed at highly sophisticated tertiary healthcare institutions [6], the ASA Physical Status Class documentationÂ may have becomeÂ irrelevant thus leaving the only question to be assessed preoperatively about whether the planned procedure can be safely performed without any unexpected prolonged institutional stay at a particular healthcare institution depending onÂ institution's readiness to deal with any untoward complications unique to patient's unique pre-morbid conditions as well asÂ unique to peri-anesthesia procedure/surgeryÂ itself and NOTÂ based on patient's ASA Physical Status Class. Therefore, ASA should plead to CMS about discarding any billing weightage [7-8] accrued to scoring and documenting irrelevant ASA Physical Status Class especially when physician anesthesiologists as well as other anesthesia providers are similarly invested at least in terms of their training as well as their expertise to equitably provide care for patients of any ASA Physical Status Class until any unexpected prolonged institutional stay or any untoward complications unique to patient's unique pre-morbid conditions as well asÂ unique to peri-anesthesia procedure/surgeryÂ itself happens which may be separately billable anyways only once they actually happened and not when they have been just predicted or expected to happen based on ASA Physical Status Class but never happened despite ASA Physical Status Classâ€™s prediction or expectation.
- Finally, ASAÂ should garner courage to plead to CMS to discardÂ irrelevant documentation of medical directionÂ appearing as separate from medical supervision by negotiating, lobbying and deeming the following changes as an essentiality to freeÂ anesthesia providers from the mandated redundancy called medical direction whichÂ should

be discarded once medical supervision billing has been upgraded and corrected because medical supervision anyways provides theÂ best savings for the society in monetary as well as non-monetary terms which neither physician anesthesiologists seeking 50%-100% per case under medical direction nor other anesthesia providers seeking 80%-100% reimbursements per case by opting out of medical supervision may ever highlight [9-10] despite payers costs and thus societal costs as yearly revenues for inpatient, outpatient and ambulatory surgery center simulations with 1:6 medical supervision being respectively 29%, 18% and 48% lower than as compared with medical direction as well as being respectively 23%, 11% and 44% lower than as compared with either physician anesthesiologists or other anesthesia providers working independently [11]:

- Medical supervision should limit physician anesthesiologists' involvement to a maximum of six concurrent procedures
- Medical supervision should be billed at minimum four base-units per procedure with additional one time-unit if present at intubation plus additional one time-unit if present at extubation thus monetarily justifyingÂ limiting the concurrent procedures' number to six although the savings for payers and thus society will decrease as compared to above-mentioned savings [11]
- Medical supervision should be limited to immediately available [12] capacity of physician anesthesiologist either in-person or via audio-video telemedicine when enroute to procedure room from home or faraway anesthesia delivery site
- Medical supervision should only bill forÂ presence at intubation and extubationÂ and discard billable presence at induction and emergence [13]Â
- Medical supervision may be additionally met when centralized multiunit workstations are being observed and guided on-site or remotely if it is more about the use of minds than hands of physician supervisors assisting other anesthesia providers
- So-called seven mandated criteria for fulfilling medical direction potentially downgraded to seven recommended criteria for fulfilling medical supervision with defined minimum number of criteria out of seven recommended criteria below which no reimbursement at all may not leave criteria open to interpretation for payers as well as providers
- If medical direction is too close to ASA's heart to let it go, it may be futuristic to design HIPAA compliant Medical Direction Robot or Application so that physician anesthesiologists can continuously medically direct other anesthesia providers remotely via audio-visual telemedicine just like tele-presence stroke robotsÂ Â

Summarily, ASA must ask CMS to consider amending its billing guidelines because besides discarding the billability of Mallampati Score as well as the billability of ASA Physical Status Class, discarding the billability of medical direction and advancing the billability of medical supervision [10] may not only save payers and thus society in terms of healthcare dollars [11] but also nullify the shortage of physician anesthesiologists nationally, regionally or locally [14-15] when they are medically supervising six concurrent procedures rather than medically directing four concurrent procedures. Although medical supervision with or without artificially intelligent technologyâ€™s assistance [16-17] may downsize the compensation packages for physician anesthesiologists secondary to downsized reimbursements by payers to their employers, medical supervision may also evolve and make the case to have the logical potential for reduced professional medicolegal liability for physician anesthesiologists as compared to when physician anesthesiologists are medically directing other anesthesia providers.

Reference(s)

1. Anesthesiologists Center. https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center
2. Medicare Claims Processing Manual: Chapter 12 - Physicians/Nonphysician Practitioners. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
3. CMS Manual System: Pub 100-04 Medicare Claims Processing: Transmittal 3747. https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2017downloads/r3747cp.pdf
4. Anesthesia Services: Differences between Private and Medicare Payments Likely Due to Providersâ€™ Strong Negotiating Position. https://www.gao.gov/products/gao-21-41
5. The 33% Problem: Origins and Actions Committee on Economics 33% Workgroup Report ASA Economic Strategic Plan Initiativeâ€”October 2020. https://pubs.asahq.org/monitor/article-abstract/84/12/28/112309/The-33-Problem-Origins-and-Actions-Committee-on?redirectedFrom=fulltext
6. Site-Neutrality Among Medical Payments Can Foster Site-Specificity Among Medical Procedures. https://healthfinancejournal.com/index.php/johcf/article/view/115
7. Annual-National Million Anesthesia Modifier Units Warrant Long-Overdue Development of the American Society of Anesthesiologists Physical Status Application (ASA-PS-APP). https://www.aub.edu.lb/fm/Anesthesiology/meja/Documents/24_1MEJA.pdf
8. Anesthesia Payment Basics Series: #4 Physical Status. https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/anesthesia-payment-basics-series-4-physical-status
9. Darwinâ€™s Law of Natural Selection: Eliminating Medical Direction Anesthesia Delivery Models. https://www.eakc.net/2021/02/28/darwins-law-of-natural-selection-eliminating-medical-direction-anes

thesia-delivery-models/
10. Will Medically Consulting Anesthesiologists Supersede Medically Supervising Anesthesiologists And Replace Medically Directing Anesthesiologists? https://www.webmedcentral.com/article_view/5727
11. Update of Cost Effectiveness of Anesthesia Providers: Final Report. www.lewin.com/content/dam/Lewin/Resources/AANA-CEA-May2016.pdf
12. Definition of ?Immediately Available? When Medically Directing. https://www.asahq.org/standards-and-guidelines/definition-of-immediately-available-when-medically-directing
13. Anesthesia Group Victorious in Whistleblower Lawsuit Based on Reasonable Interpretation of â€œEmergenceâ€•. https://www.anesthesiallc.com/publications/anesthesia-provider-news-ealerts/819-anesthesia-group-victorious-in-whistleblower-lawsuit-based-on-reasonable-interpretation-of-emergence
14. Is There a Shortage of Anesthesia Providers in the United States? https://www.rand.org/pubs/research_briefs/RB9541.html
15. DELAYING RETIREMENT MAY SAVE SOCIETY FROM TAKING CARE OF RETIREES. https://www.bmj.com/content/373/bmj.n1594/rr-4
16. The Legend of Kalidasa Inspiring To Phase Out Overspecialization: Skills vs. Degrees. https://www.webmedcentral.com/article_view/5644
17. Artificial Intelligence And Redundant Specialties. https://www.webmedcentral.com/article_view/5605