Fee Schedule Analysis

January 13, 2021

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 (2019 dates of service) provided by the National Council on Compensation Insurance, Inc. (NCCI) and South Carolina maximum allowable payment (MAP) amounts to develop conversion factors and propose MAP values for the 2021 fee schedule.

FAIR Health received paid amounts from NCCI for the 2019 calendar year, aggregated at the procedure code/modifier level. FAIR Health used the data from 2019 to:

1. Develop a "fee schedule-neutral" conversion factor designed to reflect a similar level of spending based on 2020 MAP amounts; and
2. Project paid amounts for 2021 based on multiple conversion factor alternatives.

For 2021, CMS increased RVUs for office visits for new and established patients, CPT codes 99202-99205 and 99212-99215. These codes reflect some of the most frequently performed services in the South Carolina workers' compensation program. To maintain budget neutrality and offset the increased reimbursement for evaluation and management services, CMS significantly reduced the 2021 conversion factors for both professional services and anesthesia. The South Carolina statutory cap of +/- 9.5% on changes from rates from the prior year's MSPM in part controls some of these changes. The updated RVUs and South Carolina caps on rate changes are embedded in the projections presented below.

On December 27, 2020 the Consolidated Appropriations Act, which includes pandemic relief and national budget provisions, was signed into law. The Act includes provisions that defer use of a complexity adjustment for evaluation and management procedures and mandates an increase to the Medicare conversion factors for 2021. To comply with these changes and maintain budget neutrality, CMS recalculated the conversion factors for 2021, which were updated on January 7.

The information in this report is based on conversion factors published by CMS on January 7, 2021.

2019 Paid Data and Frequencies
The following is a summary of the 2019 data received from NCCI:

NCCI Data Call - 2019 Calendar Year (Before Validation)

Service Type	Total Paid	Total Charged	Transactions	Units
CPT (Without Anesthesia)	$56,724,510.07	$121,604,885.32	693,636	962,897
Anesthesia*	$1,595,861.29	$9,166,281.92	6,072	666,175
HCPCS (Without Ambulance)	$16,816,157.03	$24,016,642.04	69,062	1,595,262
Ambulance**	$2,613,438.44	$4,792,517.52	13,917	346,230
Total	$77,749,966.83	$159,580,326.80	782,687	3,570,564

* Assumes most units are minutes

** Assumes most units are miles

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 2019 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 (assistant surgeon modifiers 80-82 and AS) were projected based on 2019 occurrences and adjusted MAP amounts.

Fee Schedule-Neutral Conversion Factor- 2020 Projections
- Total dollar amounts were projected based on 2019 occurrences and 2020 RVUs.
- Using these frequencies and RVUs and incorporating the +/- 9.5% cap on MAP increases and decreases compared to the prior year where applicable, FAIR Health calculated a conversion factor designed to maintain spending at the 2019 level for each service area.
- The total fee schedule budget neutral conversion factor is 41.09.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia data.

2020 Projections

Category	Frequency	Total 2020 RVUs	NCCI Payment	Budget Neutral Conversion factor
Evaluation and Management	127,182	307,602	$13,815,061.31	44.91
HCPCS Level II	179,967	147,573	$5,044,921.00	34.19
Medicine & Injection	14,830	28,971	$1,336,460.26	46.13
Pathology & Laboratory	12,064	9,758	$499,016.75	51.14
Physical Medicine	705,857	622,537	$22,684,937.91	36.44
Radiology	51,896	89,301	$4,571,755.77	51.19
Special Reports	1,114	1,281	$58,787.28	45.89
Surgery	34,520	253,559	$11,997,981.53	47.32
Total	1,127,430	1,460,582	$60,008,921.81	41.09

The relatively low conversion factor in this analysis is influenced by payments that are lower than fee schedule MAPs for certain high frequency codes in the physical medicine and HCPCS service areas. The lower payments in the physical medicine section may be related to network contracts. Payment for boxes of alcohol wipes and pairs of electrodes at rates lower than fee schedule MAPs may be influencing the conversion factor for the HCPCS section. In addition, NCCI paid data reflect significant payments for codes that are paid based on "individual consideration".

Because the HCPCS and Physical Medicine sections have high frequencies relative to other service areas, these anomalies have a large influence on the budget neutral conversion factor.

Comparison of Alternate Conversion Factors – 2021 Projections

- The projections of paid amounts for the 2021 fee schedule are based on 2019 frequencies and 2021 RVUs, to which conversion factors of 48.85* (equal to 140% of the CMS conversion factor), 49, 50, 50.3 (the current South Carolina conversion factor), 51 and 52 were applied. The cap of +/- 9.5% of the prior year's MAP value for each service was applied, when appropriate, in providing these projections.

  * While not mandated, the South Carolina conversion factor has generally been targeted to 140% of the CMS conversion factor (or 48.85)

- The 2021 MAP values used for these projections include certain changes in how services not covered under the Medicare Professional Fee Schedule were valued:
  - 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 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 FAIR Health benchmark values or FAIR Health's FH® Medicare GapFill PLUS product.
  - FAIR Health does not recommend that the State establish gap fill values for new codes effective January 1, 2021 that were not valued by Medicare. Setting a gap fill value before actual claims information has been received could set an inappropriate baseline against which the +/-9.5% cap would be applied in future years. FAIR Health will evaluate those codes and, based on the claims received during calendar year 2021, propose gap fill values for the 2022 MSPM.

2021 Projections

Category	Total $ 2021 with CF = 48.85	CF48.85	Total $ 2021 with CF = 49	CF49	Total $ 2021 with CF = 50	CF50	Total $ 2021 with CF = 50.3	CF50.3	Total $ 2021 with CF = 51	CF51	Total $ 2021 with CF = 52	CF52
Evaluation and Management	$16,580,930	45.50	$16,597,120	45.5	$16,704,653	45.8	$16,736,705	45.9	$16,792,843	46.1	$16,841,034	46.2
HCPCS Level II	$7,586,940	51.10	$7,592,333	51.1	$7,628,523	51.3	$7,639,381	51.4	$7,664,718	51.6	$7,699,361	51.8
Medicine & Injection	$1,521,768	48.50	$1,524,799	48.6	$1,544,866	49.3	$1,550,826	49.5	$1,562,423	49.8	$1,576,597	50.3
Pathology & Laboratory	$503,374	49.30	$504,869	49.4	$513,738	50.3	$516,728	50.6	$523,477	51.2	$529,189	51.8
Physical Medicine	$31,026,622	48.80	$31,109,533	48.9	$31,671,765	49.8	$31,840,650	50.0	$32,231,889	50.7	$32,791,291	51.5
Radiology	$4,532,432	49.10	$4,545,890	49.2	$4,634,765	50.2	$4,661,234	50.5	$4,717,725	51.1	$4,782,935	51.8
Special Reports	$65,075	48.90	$65,270	49.0	$66,565	50.0	$66,952	50.3	$67,860	51.0	$69,150	52.0
Surgery	$12,921,333	49.00	$12,959,079	49.1	$13,209,367	50.1	$13,284,334	50.4	$13,454,249	51.0	$13,677,471	51.8
Grand Total	**$74,738,474**	**48.26**	**$74,898,893**	**48.36**	**$75,974,242**	**49.06**	**$76,296,810**	**49.27**	**$77,015,184**	**49.73**	**$77,967,028**	**50.34**

Upon approval of a conversion factor for 2021, FAIR Health will provide an updated Medical Services Provider Manual, which will include any approved changes in policies and a final set of rate tables.

Please let us know if you have any questions.

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Summary of Changes

2021 Medical Services Provider Manual

January 13, 2021

FAIR Health has completed the revisions to the fee schedule under the direction of the South Carolina Workers' Compensation Commission (WCC). The codes in the existing fee schedule have been brought current by including codes established for 2021 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 and URL links, substantive changes to the text, which are outlined below, are included in the proposed version of the 2021 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2020.

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

1. **Chapter II. General Policy**

Copies of Reports and Records (Page 9) - Language is updated to provide clarity and match the Copies of Reports and Records text on page 483 of in Section 8, Special Reports and Services.

COPIES OF REPORTS AND RECORDS
Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity. (See Appendix A for S.C. Code Section 42-15-95 and Regulation 67-1301.)

~~The maximum charge for providing records and reports other than for substantiating medical necessity is $25.00 for a clerical fee plus $0.65 per page for the first 30 pages *in* **Print or Electronic** *format*, and $0.50 per page thereafter provided *in an electronic format*, which may not exceed $150.00 per request, plus sales tax, and actual cost for postage to mail the documents. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A.~~

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are $0.65 per page for the first 30 pages provided in *electronic format*, and $0.50 per page thereafter provided *in an electronic format, which may not exceed $150.00* per request, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).)

However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are $0.65 per page for the first 30 *printed* pages, and $0.50 per *printed* page thereafter, *which may not exceed $200.00 per request*, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

A facility or provider may charge a patient or the patient's representative no more than the actual cost for duplicating an x-ray film or digital image. Actual cost means the cost of materials and supplies used to duplicate the x-ray film or digital image and the labor and overhead costs associated with the duplication.

Providers who use a medical records company to make and provide copies of medical records or x-ray images must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

2. **Part II: Fee Schedule**

Icons (page 31) – Language is added to the icon for state-specific code to bring attention to a change in code numbers for state specific codes. An additional icon, an asterisk (*), has been added to identify codes that are eligible to be performed via telemedicine.

∞ 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*.

* Telemedicine-eligible code. This code may be reimbursed when provided via telemedicine.

Telemedicine Policy (page 32) – A temporary telemedicine policy is inserted after the Surgical Assistant section.

Telemedicine

Telemedicine is the use of electronic information and telecommunication technologies to provide care when the provider and patient are in different locations. Technologies used to provide telemedicine include telephone, video, the internet, mobile app and remote patient monitoring. Services provided by telemedicine are identified by the use of location code 02 (telemedicine) and Modifier 95, Synchronous Telemedicine Service, on the bill.

Certain services that are eligible for reimbursement under the *South Carolina Medical Services Provider Manual* when provided by telehealth during the COVID-19 pandemic emergency are identified with an asterisk (*) in the rate tables. Telemedicine may not be used for emergent conditions. The maximum payment for telemedicine services is 100% of the billed charge, not to exceed the non-facility maximum allowable payment (MAP) listed in the rate tables. Service level adjustment factors are applicable based on the licensure of the healthcare professional providing the telemedicine service.

Additional services may be provided via telemedicine with pre-authorization by the payer.

The location for the telemedicine service is defined as the location of the patient/injured worker. Providers must be licensed to practice in South Carolina and telemedicine services may be provided by physicians, physician assistants, psychologists, nurse practitioners, physical therapists, occupational therapists, speech therapists and social workers. Telemedicine activities provided by physical therapy assistants and occupational therapy assistants must be supervised and directed by a physical therapist or occupational therapist, as appropriate, whose license is in good standing in South Carolina.

The South Carolina Workers' Compensation Commission will determine the expiration date of this policy, which will be aligned with the suspension of the COVID-19 Pandemic Emergency.

If the pandemic emergency is lifted prior to March 31, 2022, telemedicine services may be provided with pre-authorization through March 31, 2022.

3. **Section 1: Evaluation and Management (E/M) Services (Page 33)**

Language is included to reflect a change to E/M office visits for new and established patients (CPT 99202-99205 and 99211-99215), effective January 1, 2021, which are defined based on the level of medical decision making defined for each service or the total time spent on the date of service.

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 ~~2020~~ 2021 CPT book.

~~E/M service descriptors have seven components. These components are: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time.~~ The appropriate level of E/M service is based on the level of medical decision making defined for each service or the total time spent on E/M services on the date of service.

Evaluation and Management Time
~~The times listed in the code descriptors are averages. Actual time spent by the provider may be slightly higher or lower depending upon the actual clinical circumstances; however, providers should select the CPT code that best describes the amount of time actually spent.~~ Beginning in 2021, time alone may be used to select the appropriate code level of office or other outpatient evaluation and management services, codes 99202-99205 and 99212-99215. 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.

~~Time is used as the controlling factor to select a level of service when more than 50 percent of the patient encounter is spent in counseling and coordination of care. Time spent counseling and the extent of the counseling and/or coordination of care must be documented.~~

4. **Section 3: Surgery (Page 69)**

Correcting a typographical error in the numbering of modifiers for bilateral and multiple procedures.

~~51~~ 50 Bilateral Procedure

~~52~~ 51 Multiple Procedures

5. **Section 8: Special Reports and Services**

Special Reports (Page 483) – Update the language in the first two paragraphs as follows:

A special report may be billed and paid when the provider furnishes information above and beyond that which is required by Commission policy or by the laws and regulations of the South Carolina Workers' Compensation Act. ~~Special Reports~~, CPT® code 99080, special reports, should not be used to bill for completing a report which is included in the CPT descriptor of the service provided ~~or for reporting the results of an impairment rating made during an E/M service.~~ However, CPT code 99080 *may* be billed in conjunction with, and in addition to, CPT code 99455, work related or medical disability examination, to report the results of an impairment rating ~~made~~ developed during the examination.

Payment for a special report is $55.00 for a checklist-type report which requires a review of the medical record, and $70.00 for a written report or for completing the Commission's Form 14B. Prepayment for form or report completion is prohibited.

The purpose of WCC Form 14B Physician's Statement is to consolidate medical information, already existing in the patient's medical file, onto a single, easily referenced document. The Form 14B is a summary of information generated from the patient's previous medical exams, including the diagnosis, date of maximum medical improvement, permanent impairment, work restrictions, retained hardware, and need for future medical care and treatment. The Form 14B must be signed by the treating physician, who is a qualified physician or surgeon.

The Form 14B is required to be submitted when an employer's representative requests an informal conference to approve settlement on a Form 16A pursuant to R.67-802(A)(1)(a); when an employer's representative requests a Form 16A be approved in accordance with R.67-802(A)(2)(a); and when an employer's representative requests an informal conference to approve settlement on a full and final, clincher basis in accordance with R.67-803(B)(1)(a).

The Workers' Compensation Act provides that "…a physician or hospital may not collect a fee from an employer or insurance carrier until the physician or hospital has made the reports required by the Commission in connection with the case." S.C. Code Ann. § 42-15-90(A) (1976, as amended).

Copies of Reports and Records (Page 483) – Update language to provide clarity and match the Copies of Reports and Records language in the General Policies section on page 9.

COPIES OF REPORTS AND RECORDS
Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for

copying costs. Copying charges are $0.65 per page for the first 30 pages provided in ~~Print or~~ *electronic format*, and $0.50 per page thereafter provided *in an electronic format, which may not exceed $150.00* per request, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are $0.65 per page for the first 30 *printed* pages, and $0.50 per *printed* page thereafter, *which may not exceed $200.00 per request*, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.
Providers who use a medical records company to make and provide copies of medical records must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

Medical Testimony (Page 484) – Update to reflect new codes, which are not part of the American Medical Association's (AMA) schema.

MEDICAL TESTIMONY
Medical testimony by personal appearance of a physician, whether before a Commissioner or in a court of law, is reported using ~~CPT code 99075~~ South Carolina specific ~~code 99076~~codes SC001 and SC002. Payment is based on the time spent "in court" only. Time for preparation or travel is not considered when determining payment. Use ~~CPT~~ South Carolina specific code ~~99075~~SC001 to report the initial hour, and South Carolina specific code ~~99076~~SC002 to report each additional quarter hour of medical testimony by personal appearance by a physician. For all other providers, use South Carolina specific code ~~99077~~SC003.

Medical testimony by deposition of a physician is reported using South Carolina specific service codes ~~99072~~ SC004 and ~~99073~~SC005. Use South Carolina specific code ~~99072~~SC004 to report the initial hour and code ~~99073~~SC005 to report each additional quarter hour of medical testimony by deposition of a physician. Time is measured based on the actual time spent in deposition. Time spent reviewing records is not considered when determining payment. For all other providers, use South Carolina specific code ~~99074~~SC006.

6. **Section 10: Pharmacy (Page 691)**

This section stipulates only those policies and procedures that are unique to Pharmacy. Additional policies and procedures that apply to all providers are listed in Part I of this *Medical Services Provider Manual*.

PRESCRIPTION DRUG MONITORING PROGRAM

Treating physicians prescribing medication or drugs must comply with the requirements of Act 91 enacted by the SC General Assembly May 31, 2017.

REIMBURSEMENT

Payment for prescription drugs is limited to the lesser of the amount established by the following formula, or by the pharmacist's or health care provider's usual and customary charge. The formula applies to both brand name and generic drugs. However, all prescriptions must be filled using generic drugs, if available, unless the authorized treating physician directs that it be dispensed as written. Opioids/scheduled controlled substances that are prescribed for treatment shall be provided through a pharmacy. The dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription.

Average Wholesale Price + $5.00

All bills under this section shall be itemized for proper reimbursement. Bills submitted for reimbursement shall be based on the original manufacturer's Average Wholesale Price (AWP) of the drug product on the date the drug was dispensed, and must include the National Drug Code (NDC) of the product dispensed. Medi-Span, published by Wolters-Kluwer Health, or IBM Micromedex RED BOOK, shall be used as the source for determining the average wholesale price (AWP). Where the AWP of a medication is not published by Medi-Span or REDBOOK, any nationally published pharmacy price index may be used as a secondary source. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values. If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20%. Any issue arising as to the source of average wholesale price may be administratively reviewed by the Commission's Medical Services Division.

Any medication or drugs not specifically prescribed by the treating physician shall not be reimbursed. In the event the treating physician recommends and/or prescribes a particular drug or medication that can be purchased over-the-counter (without a prescription), and the injured employee pays for the drug or medication, the injured employee is entitled to reimbursement for the purchase upon submission of the appropriate receipts to the employer/insurance carrier.

The price determined by the formula will be the maximum allowable payment a provider can be paid under the Workers' Compensation Act. In instances where the pharmacy's charge is lower than the maximum allowable payment, or where the pharmacy has agreed by contract with an employer, insurance carrier, or their agent to a contractual amount that is lower than the maximum allowable amount, reimbursement shall be made at the lower amount in accordance with the terms of the contract.

REPACKAGED DRUGS

The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. Bills for repackaged drug products must include the original manufacturer or distributor's stock package NDC used in the repackaging process. Reimbursement for a drug that has been repackaged or relabeled shall be calculated by multiplying the number of units dispensed times the per-unit AWP set by the original manufacturer for the underlying drug, plus a single ~~$5.00~~ dispensing fee of $5.00, **except** where the carrier/payer has contracted for a different amount. A repackaged NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number.

If the original manufacturer's or distributor's stock package NDC information is not provided or is unknown, the payer shall select the most reasonable and closely associated AWP to use for reimbursement of the repackaged drug. In no case shall the repackaged or relabeled drug price

exceed the amount otherwise payable had the drug not been repackaged or relabeled. Supplies are considered integral to the package and are not separately reimbursable. Manufacturers of a repackaged or relabeled drug shall not be considered an "original manufacturer."

COMPOUND DRUGS

All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Compound drugs must be preauthorized for each dispensing. ~~and shall be billed by listing each drug included in the compound by NDC, and calculating the charge for each drug separately.~~ Any compounded drug product billed by the compounding pharmacy or dispensing physician shall be identified at the ingredient level and the corresponding quantity by their original manufacturer's National Drug Code (NDC) when submitted for reimbursement. Payment for compounded prescription drugs shall be ~~based on~~ the sum of the average wholesale price by gram weight ~~fee~~ for each ingredient, plus a single dispensing fee of $5.00. ~~If the NDC for any compounded ingredient is a repackaged medication NDC, reimbursement for the repackaged ingredient(s) shall be calculated as provided above.~~ A compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. ~~No payment shall be required for an ingredient not identified by an NDC.~~ Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed. Any component ingredient in a topical compound medication that is not FDA approved for topical use shall not be reimbursed.

PRESCRIPTION STRENGTH TOPICAL COMPOUNDS

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All ingredient materials must be listed by quantity used per prescription. Continued use (refills) may require documentation of effectiveness including functional improvement. Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category III fee. The 30-day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed. All topical compounds shall be billed using the South Carolina Worker's Compensation Commission code corresponding with the applicable category as follows:

Category I SC0801, $80.00 per 30-day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II SC0802, $160.00 per 30-day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III SC0803, $240.00 per 30-day supply

Any agent(s) other than anti-inflammatory or local anesthetic agents, either alone, or in combination with other anti-inflammatory or local anesthetic agents.

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits packaged by the provider or other source are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I Chapter III of the ~~*2020*~~ *2021 Medical Services Provider Manual.*

Analysis of Anesthesia Conversion Factor

January 13, 2021

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 2020
- 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

For 2021, CMS increased RVUs for office visits for new and established patients, CPT codes 99202-99205 and 99212-99215. To maintain budget neutrality and offset the increased reimbursement for evaluation and management services, CMS reduced the 2021 conversion factors for both professional services and anesthesia. The current South Carolina anesthesia conversion factor of $30 is equal to 139.15% of the 2021 national Medicare anesthesia conversion factor of $21.56 and 144.02% of Medicare's 2021 South Carolina anesthesia conversion factor of $20.83. This relationship is similar to the South Carolina professional conversion factor, which is 144.16% of the Medicare 2021 conversion factor.

On December 27, 2020 the Consolidated Appropriations Act, which includes pandemic relief and national budget provisions, was signed into law. The Act includes provisions that defer use of a complexity adjustment for evaluation and management procedures and mandates an increase to the Medicare conversion factors for 2021. To comply with these changes and maintain budget neutrality, CMS recalculated the anesthesia and professional services conversion factors for 2021.

The information in this report is based on conversion factors that were updated by CMS on January 7, 2021.

	Anesthesia – National Comparison	Anesthesia – South Carolina Comparison	Other Professional Services
South Carolina Conversion Factor	$30.00	$30.00	$50.30
2021 Medicare Conversion Factor	$21.56 (National)	$20.83 (Adjusted by CMS for South Carolina)	$34.8931
Ratio	139.15%	144.02%	144.16%

Private Health Insurance

FAIR Health collects data for anesthesia services from private payors (more than 40 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 select or "cherry pick" 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 based on imputed allowed amounts, which 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 2019 through June 2020 and allowed benchmarks are based on imputed allowed amounts from claims incurred during calendar year 2019.

		Percentiles												
Type	Average	5th	10th	15th	20th	25th	30th	35th	40th	45th	50th	60th	70th	80th	90th
Billed Anesthesia	128.33	50.77	60.64	70.28	79.70	88.65	97.09	104.44	109.89	114.70	119.72	131.95	154.66	172.99	190.32
Allowed Anesthesia	60.14	24.79	29.44	34.13	39.32	43.17	46.66	49.60	52.19	54.39	56.93	62.20	70.24	81.59	88.56

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 approximately aligns to the 10th percentile for private insurance. That means that 90% of the imputed allowed values in the FAIR Health database are equal to or greater than $30. The 50th percentile (conversion factor of $56.93) is the median conversion factor value in the private insurance data and the average allowed conversion factor benchmark is $60.14.

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 2020 study from the ASA website at https://monitor.pubs.asahq.org/journal.aspx. A copy of the ASA Monitor newsletter containing the 2020 survey is appended to this report.

According to the publication, the ASA anonymously 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. That 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. In the 2019 survey, an insufficient number of responses were received to include state-level results for South Carolina.

	National		Southeast Region		South Carolina		
Conversion Factor	2019	2020	2019	2020	2018	2019*	2020
Low	23.73	31.50	33.34	32.00	26.60	N/A	33.00
Median	72.00	73.00	77.00	78.68	80.00	N/A	72.00
Average	77.01	82.14	81.16	87.33	86.77	N/A	82.02
High	256.50	323.22	256.50	184.50	185.00	N/A	162.00

* In 2019, there were too few respondents to report results at the South Carolina state level, so comparisons to 2018 are included.

State Workers' Compensation Fee Schedules

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

State	Conversion Factor (per 15-minute time unit)
South Carolina	**$30.00**
Alabama	$56.82
Colorado	$46.50
Florida	$29.49
Georgia	$60.08
Kentucky	$78.53
Louisiana	$50.00
Maryland	$21.69
Mississippi	$50.00
North Carolina	$58.20 – first 60 min $30.75 – after 60 min
Oklahoma	$48.50
North Dakota	$64.92
Tennessee	$75.00
Virginia (6 regions)	$49.00 - $77.00

FAIR Health assists Colorado, Georgia, Kentucky, Mississippi, North Dakota and Oklahoma in updating their fee schedules. As we are doing for the South Carolina Workers' Compensation Commission, we provide 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 144.02% of the 2021 Medicare conversion factor for South Carolina and 139.15% of the national Medicare conversion factor.
- The ratio of the South Carolina workers' compensation anesthesia to Medicare is generally aligned with the 144.16% ratio of the conversion factor for other professional services ($50.30) in comparison to Medicare ($34.8931). 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 would not be applicable to those services.
- The $30 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 contributions 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 lower end of the range.

A copy of the ASA publication *ASA Survey Results for Commercial Fees Paid for Anesthesia Services – 2020* appears on the following pages.

American Society of Anesthesiologists

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ASA Monitor®

THE LEADING SOURCE FOR PERIOPERATIVE HEALTH CARE NEWS

Remimazolam: Is the Sedative of the Future Here?

Dibash K. Das, PhD

Sedative and anesthetic safety is continuously reviewed as part of quality assessments. Yet, the market for sedation and anesthesia has been short on pharmaceutical development, and standard options for moderate sedation medications have not changed in three decades.

Typically, either propofol or a benzodiazepine (e.g., midazolam) with or without a narcotic (e.g., fentanyl) is used to obtain sedation for procedures. Both strategies have pros and cons. A disadvantage of propofol is the requirement of constant monitoring by an anesthesia provider due to its potential for respiratory- and cardio-depressive effects, which results in additional costs and higher risks, since there is no reversal agent available for propofol to be able to quickly stop sedation if required. For midazolam, although these side effects are less pronounced, there is a slower onset and a longer duration of action that can impact patient throughput and overall efficiency. Consequently, the search for an elusive ideal anesthetic remains.

Remimazolam (BYFAVO™), developed by PAION AG, is a novel moleculer, water-soluble, ultra-short-acting intravenous benzodiazepine that was developed to address the shortcomings of current sedation strategies. A key feature of remimazolam

Continued on page 12

Severe Sequelae, Chronic Headache Linked to PDPH

Jessica Ansari, MD Pamela Flood, MD, MA

Post-dural puncture headache (PDPH) is a well-known complication of neuraxial anesthetic procedures resulting in an acute postural headache within five days of a dural puncture (*Minerva Anestesiol* 2019;85:543-53). Patients generally experience a severe, dull, frontal or occipital headache, often associated with neck pain, tinnitus or

Continued on page 15

ASA Survey Results: Commercial Fees Paid for Anesthesia Services, 2020

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

Summary

Based on the 2020 survey results, the national average commercial conversion factor was $82.14, ranging between $76.09 and $85.75 for the five contracts. The national median increased to $73.00, ranging between $69.00 and $77.25 for the five contracts (Figure 1, Table 1). In the 2019 survey, the mean conversion factor ranged between $73.79 and $80.76, and the median ranged between $69.00 and $78.00. In contrast, the current national Medicare conversion factor for anesthesia services is $22.2016, or about 27.03% of the

Continued on page 26

Payment and Practice Management

Continued from page 1

2020 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-$200, with a break indicated by wavy lines and then $310-$330. 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 survey reflects valid responses from 238 practices in 43 states. The 2019 survey results included data from 270 practices in 43 states.

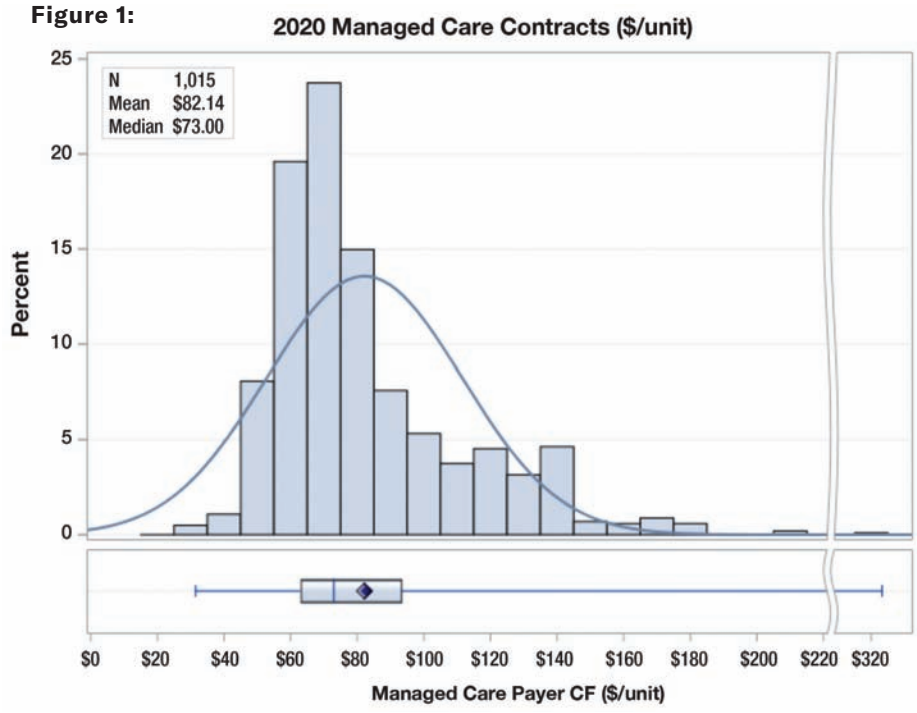
Methodology

The survey was disseminated in June and July 2020. 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 particpants provide 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 represent 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 states that submitted sufficient data to be compliant with DOJ and FTC principles, and we provide state-specific data for only those states. We have 17 Eligible States this year.

Figure 1:



Stanley W. Stead, MD, MBA, FASA
CEO, Stead Health Group, Inc.

Sharon K. Merrick, MS, CCS-P
ASA Director of Payment and Practice Management.

"Based on the 2020 survey results, the national average commercial conversion factor was $82.14, ranging between $76.09 and $85.75 for the five contracts."

This is the tenth year we offered the survey electronically through the website www.surveymonkey.com. ASA urged participation through various electronic mail offerings, including ASA committee list serves, ASAP Weekly (all-member e-mail digest), Vital Signs, the Monday Morning Outreach, communications to state component societies and our Anesthesia Administator and Executive (AAE) members, and via the ASA website.

The responses to the survey represented 246 unique practices. However, due to respondents providing incomplete data, we excluded eight responses from the overall analysis. Our results are based on the data from 238 practices.

Results

Table 2 presents respondent information for 197 practices (41 practices did not provide us with practice demographics) in the analytic sample per Major Geographic Region as identified by the Medical Group Management Association (MGMA) (asamonitor.pub/30PLj9B). These regions are as follows:

Table 1: National Managed Care Anesthesia Conversion Factors ($/unit), 2020

Conversion Factors	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Mean	$76.09	$80.73	$85.30	$85.06	$85.75	$82.14
Low	$33.00	$31.50	$41.00	$39.00	$32.00	$31.50
25th Percentile	$60.72	$63.00	$63.55	$64.00	$65.00	$62.95
Median	$69.00	$72.00	$75.00	$74.75	$77.25	$73.00
75th Percentile	$85.00	$90.00	$98.47	$97.50	$104.00	$93.61
High	$209.75	$166.00	$323.22	$184.50	$211.71	$323.22
Number of Responses	238	227	209	188	153	1,015
Percentage of Managed Care Business	21.1%	9.14%	5.41%	3.65%	2.74%	9.34%

Table 2: Respondent Information by Major Geographic Region, 2020

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
Eastern	35	1,540,302	11,865	10.98	1,555.5	1,056.2 (253.0)	11 (65)
Midwest	42	1,907,427	16,652	10.46	1,171.7	1,200.7 (136.2)	40 (0)
Southern	70	2,990,754	21,244	10.16	1,767.0	2,334.4 (415.0)	491.5 (0)
Western	50	1,930,614	8,742	11.01	2,678.5	503.7 (73)	15 (15)
ALL	**197**	**8,369,097**	**15,310**	**10.58**	**7,172.7**	**5,094.8 (877.2)**	**557.5 (80)**

(Number in brackets indicate the number of non-employed FTEs)
Note: 197 of the 238 practices reported case, unit or FTE data.

- 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 197 practices employ or contract with 7,172.7 full-time equivalent (FTE) physician anesthesiologists, 5,094.8 FTE nurse anesthetists, and 557.5 FTE anesthesiologist assistants (AAs). The practices also work with an additional 877.2 FTE nurse anesthetists and 80 FTE AAs for whom the practice does not directly pay compensation (i.e., facility hires or contracts the nurse anesthetist or AA).

The 238 practices reported a total of 1,015 managed care contracts. This is fewer than the 1,125 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

Nine hundred eighty-two (982) of the contracts are based upon a 15-minute unit, 11 upon a 12-minute unit, 16 are based upon a 10-minute unit and six are based upon an 8-minute unit. We normalized all contract conversion factors with 8- 10- and 12-minute time units to the typical 15-minute time unit using an adjustment factor of 1.4208 for 8-minute units, 1.2404 for 10-minute units and 1.1202 for 12-minute units (Table 4).

Table 3: Respondent Information by Minor Geographic Region, 2020

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
CAAKHI	16	904,090	8,528	13.06	1,332.3	106 (58.0)	0 (0)
Eastern Midwest	37	1,420,934	19,245	11.04	866.0	910.9 (135.0)	40 (0)
Lower Midwest	29	1,332,869	19,921	9.87	928.8	1287 (0)	88 (0)
Mid Atlantic	9	273,780	13,747	13.29	253.1	236.0 (45.5)	0 (0)
North Atlantic	18	1,068,794	11,422	10.51	1,160.7	707.4 (90.5)	11 (65)
Northeast	6	101,307	8,161	9.75	90.5	34.8 (42)	0 (0)
Northwest	18	729,777	9,343	10.09	963.2	314.7 (0)	0 (0)
Rocky Mountain	16	296,747	8,271	10.12	383.0	83.0 (15)	15 (15)
Southeast	40	1,650,512	21,190	10.31	837.4	1034.5 (490)	403.5 (0)
Upper Midwest	8	590,287	6,506	6.66	357.7	380.8 (1.2)	0 (0)
ALL	**197**	**8,369,097**	**15,310**	**10.58**	**7,172.7**	**5,094.8 (877.2)**	**557.5 (80)**

(Number in brackets indicate the number of non-employed FTEs)
Note: 197 of the 238 practices reported case, unit or FTE data.

Table 4: Conversion Factor Adjustment Based on Time Units, 2020

Time Units	Time Units	Sum of Base and Time Units	CF Value Ratio based for 15-minute units
CMS PSPS 2018[1]			
Mean Base Units	5.211		
Minutes/Case	72.405		
8-minute time units	9.051	14.262	1.4208
10-minute time units	7.241	12.452	1.2404
12-minute time units	6.034	11.245	1.1202
15-minute time units	4.827	10.038	1.0000

1. Mean Minutes per Case and Base Unit is determined from the 2018 CMS Physician/Supplier Procedure Summary (PSPS) Master File ("Master File").

   https://www.cms.gov/NonIdentifiableDataFiles/06_PhysicianSupplierProcedureSummaryMasterFile.asp

Table 5: Respondents Having Flat Fee Components, 2020

	Flat Fee (Any)	Labor & Delivery	Cataracts	Endoscopy	Pain	Other
Eastern	21	17	0	3	1	7
Midwest	25	19	0	13	0	1
Southern	32	25	0	6	2	4
Western	10	9	1	4	1	3
Total	**88**	**70**	**1**	**26**	**4**	**15**

Others include cosmetic and plastic surgery, bundled surgical procedures, Total Joint Replacement, spine surgery, general surgery, invasive monitoring and open heart surgery.

"The highest conversion factor reported was $323.22. In 2019 the highest conversion factor reported was $256.50."

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 (asamonitor.pub/3gRrtQD), which represents over 21 million anesthesia claims.

The mean time was 72.405 minutes and mean base units per case were 5.211 base units. Making the same calculations described above, the adjustment factors are very similar to last year: 1.411 for 8-minutes units, 1.235 for 10-minute units, and 1.117 for 12-minute units.

Continued on page 28

Payment and Practice Management

Continued from page 27

Groups continue to report flat fee contracts for certain procedures. Table 5 shows respondents who identified that they had flat fee contracts. 88 of the 158 groups (55.7%) responding to this question negotiated at least one flat fee contract. 44.3% of the respondents have flat fee contracts for Labor and Delivery.

Table 6 reports the conversion factor by MGMA Major Region. Contract 1 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 (238), but also the highest average percentage of managed care business (21.1%, 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.

"In the 2019 survey, the Medicare conversion factor was 28.9% of the overall commercial mean. In this year's survey, it has fallen to 27.03%."

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

This is the sixth year we are presenting state-specific data. Although we had respondents from 43 states, only 17 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 2021 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 $82.14, while the median, $73.00 and the range of mean values increased from a range of $73.79 - $80.76 in 2019 to a range of $76.09 - $85.75 in 2020.
- As was the case in our 2018 and 2019 surveys, the Eastern Region has the highest mean this year. The Eastern Region mean in 2019 was $86.73 and this year it is $97.85.

Table 6: Major Region Managed Care Anesthesia Conversion Factors ($/unit), 2020

	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Eastern	n=47	n=44	n=40	n=38	n=33	n=202
Mean	$91.61	$91.98	$106.37	$101.10	$100.50	$97.85
Low	$53.00	$54.83	$51.00	$45.00	$52.43	$45.00
25th Percentile	$69.00	$68.67	$81.45	$75.00	$72.00	$72.00
Median	$91.24	$90.03	$100.50	$97.00	$89.68	$93.00
75th Percentile	$105.00	$112.42	$123.57	$130.00	$131.00	$120.00
High	$209.75	$144.00	$323.22	$173.60	$211.71	$323.22
Midwest	n=50	n=48	n=45	n=41	n=34	n=218
Mean	$68.34	$72.54	$71.41	$71.47	$68.01	$70.44
Low	$49.37	$46.00	$48.00	$46.62	$47.05	$46.00
25th Percentile	$60.72	$64.00	$60.00	$61.00	$57.00	$60.72
Median	$65.00	$70.13	$69.00	$66.80	$65.00	$67.82
75th Percentile	$72.00	$76.25	$75.00	$74.25	$76.00	$74.25
High	$136.00	$144.00	$136.00	$117.60	$124.00	$144.00
Southern	n=86	n=83	n=75	n=63	n=46	n=353
Mean	$70.87	$80.06	$82.11	$84.14	$87.82	$80.00
Low	$33.00	$42.00	$43.00	$45.00	$32.00	$32.00
25th Percentile	$54.00	$58.00	$60.00	$60.00	$65.00	$59.04
Median	$65.00	$72.00	$72.00	$71.00	$83.41	$72.00
75th Percentile	$83.00	$88.54	$95.00	$102.83	$104.00	$90.50
High	$169.00	$162.00	$184.50	$184.50	$155.00	$184.50
Western	n=55	n=52	n=49	n=46	n=40	n=242
Mean	$78.03	$79.85	$85.73	$85.17	$86.27	$82.70
Low	$40.75	$31.50	$41.00	$39.00	$57.85	$31.50
25th Percentile	$63.20	$62.00	$67.00	$69.00	$68.50	$66.00
Median	$69.75	$71.27	$79.54	$76.96	$76.63	$74.48
75th Percentile	$80.00	$83.62	$95.00	$90.45	$94.63	$90.45
High	$166.00	$166.00	$166.00	$166.00	$166.00	$166.00

Table 7: Minor Region Managed Care Anesthesia Conversion Factors ($/unit), 2020

MGMA Minor Region	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
CAAKHI	79	$39.00	$67.91	$78.73	$94.20	$126.00	$166.00
Eastern Midwest	190	$46.00	$60.00	$64.03	$67.73	$72.50	$144.00
Lower Midwest	140	$40.00	$54.50	$64.19	$70.64	$76.50	$169.00
Mid Atlantic	43	$53.10	$66.17	$75.00	$82.09	$87.00	$169.00
North Atlantic	105	$45.00	$80.00	$100.00	$105.37	$127.00	$323.22
Northeast	40	$51.00	$85.50	$94.96	$97.45	$110.00	$144.00
Northwest	90	$53.00	$64.15	$69.53	$72.45	$77.91	$132.00
Rocky Mountain	73	$31.50	$68.00	$76.00	$82.89	$97.00	$144.00
Southeast	216	$32.00	$65.00	$78.68	$87.33	$104.00	$184.50
Upper Midwest	39	$65.00	$70.00	$74.25	$83.25	$91.00	$136.00

"We will continue to monitor the trends in the commercial conversion factor survey results and will launch the survey again in June."

- The highest conversion factor reported was $323.22. In 2019 the highest conversion factor reported was $256.50.
- In the 2019 survey, the Medicare conversion factor was 28.9% of the overall commercial mean. In this year's survey, it has fallen to 27.03%.

Conclusions

This year's survey was challenged as many practices were coping with the COVID-19 pandemic. Our sample size was slightly less this year, but still represents a significant portion of US practicing anesthesiologists, nurse anesthetists and anesthesiologist assistants. We were pleased to have respondents report across a broad geographic basis, allowing us to provide detailed regional responses. The number of practices reporting allowed us to report state-specific data from 17 states. 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 2021. It is important that as many practices as possible participate in the 2021 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 of the practices that contributed to the 2020 results. ■

Table 8: Eligible States Managed Care Anesthesia Conversion Factors ($/unit), 2020

State	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
AL	12	$55.00	$63.00	$63.00	$71.13	$75.75	$104.00
CA	71	$39.00	$71.00	$82.20	$97.54	$129.29	$166.00
FL	65	$32.00	$74.00	$104.00	$103.98	$127.35	$184.50
GA	52	$49.86	$72.50	$81.88	$87.68	$100.90	$153.00
IN	30	$49.37	$64.00	$74.00	$74.10	$78.00	$114.75
KS	28	$55.00	$65.00	$73.00	$78.83	$80.00	$139.50
LA	38	$42.00	$52.00	$53.50	$53.91	$55.50	$72.00
MI	65	$47.05	$59.45	$60.72	$61.93	$64.00	$131.75
MS	21	$34.00	$50.00	$57.00	$52.60	$58.00	$61.00
NY	55	$45.00	$95.00	$120.00	$122.01	$137.00	$323.22
OH	64	$46.00	$62.75	$69.00	$68.90	$72.67	$144.00
OK	24	$52.00	$60.00	$63.71	$63.88	$67.00	$81.47
PA	33	$50.00	$59.00	$69.36	$74.90	$89.00	$139.50
SC	33	$33.00	$65.00	$72.00	$82.02	$88.54	$162.00
TX	34	$40.00	$60.93	$82.50	$85.21	$117.00	$169.00
UT	20	$31.50	$70.66	$74.50	$74.25	$79.33	$96.75
WA	70	$53.50	$64.00	$69.00	$71.28	$79.00	$104.00

Figure 2:

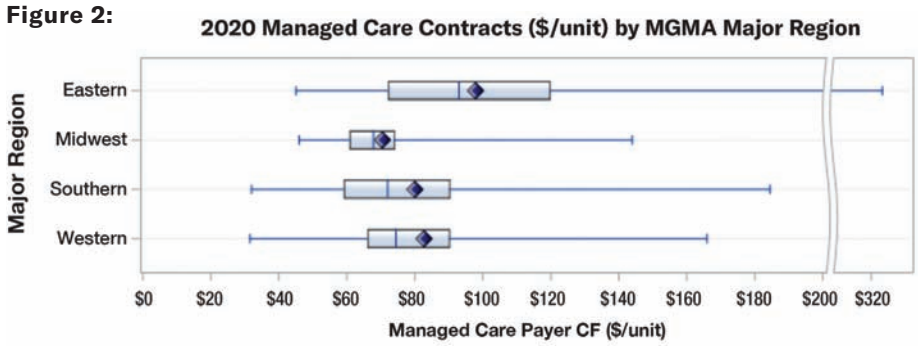


Figure 3:

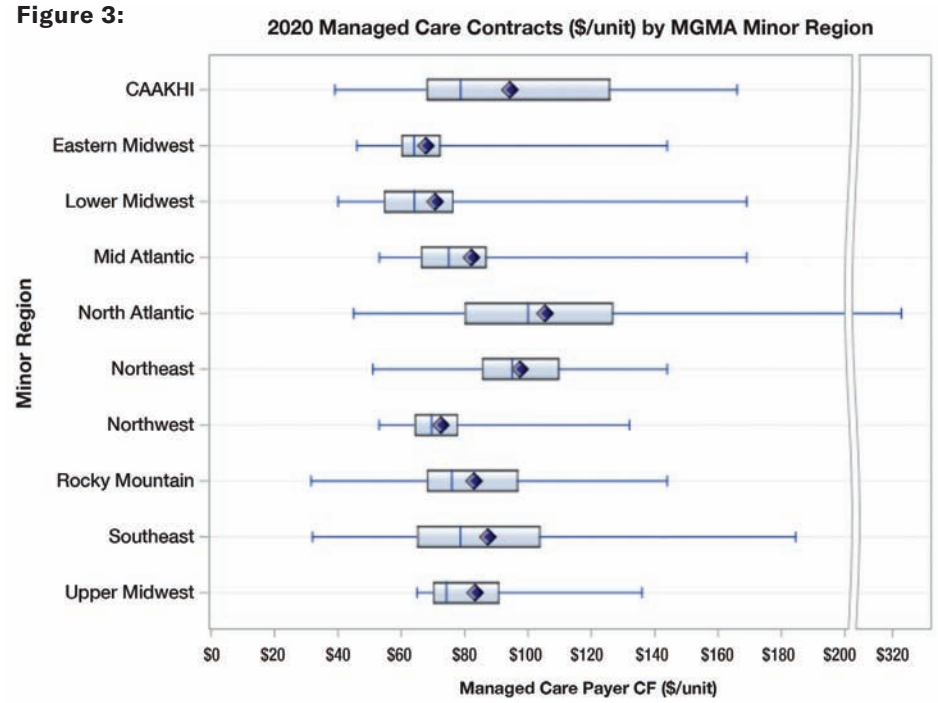


Figure 4: 2020 Managed Care Contracts ($/unit) by Eligible States