



Statement by the American Association of Oral and Maxillofacial Surgeons Concerning the Management of Selected Clinical Conditions and Associated Clinical Procedures

Bundling Payment for Anesthesia Services

It is the position of the American Association of Oral and Maxillofacial Surgeons (AAOMS) that an oral and maxillofacial surgeon (OMS) who both performs surgery and administers moderate sedation, deep sedation or general anesthesia with his or her anesthesia team should be reimbursed for both if he/she has the requisite education, training and required state license and/or permits to perform these services. This document supports a separate benefit allowance for operator administered anesthesia/sedation when performed by the oral and maxillofacial surgeon and the OMS anesthesia team. The AAOMS Statement on the OMS Scope of Practice further outlines the residency training of an OMS.

Pain control and management of anxiety have been an important part of the practice of oral and maxillofacial surgery since the inception of the specialty. This involves various techniques of local and regional anesthesia, and all forms of sedation, and general anesthesia. The unique training of oral and maxillofacial surgeons eminently qualifies them, in concert with their surgical and anesthesia team members, to administer the continuum of sedation, including general anesthesia, while simultaneously performing the surgical procedure.

When an OMS performs both a surgical procedure and administers general anesthesia, he/she is acting within the scope of his/her training and licensure. In fact, in almost every state, the OMS is delivering anesthesia under a distinct and separate permit which is granted and regulated by the respective state's dental licensing board. This is a specific additional permit requirement for the administration of sedation and general anesthesia by a clinician who is not a medical anesthesiologist. These requirements are a direct result of advocacy efforts dating from 1976 when the AAOMS Committee on Anesthesia developed model regulations for the administration of anesthesia by dentists, and worked with state dental and OMS societies as well as state dental boards to enact these regulations.

It is the position of the AAOMS that third party insurers should recognize the unique training, qualifications, and office facilities of the OMS in which they deliver concurrent anesthesia and surgical services, just as do most states by virtue of this separate permit process. This is a time-proven, safe, and cost-effective approach to delivery of these services. Furthermore, third party payors and government agencies have recognized the significant decrease in costs when services are provided in a non-facility setting.

Neither CPT nor CDT coding guidelines mention moderate sedation, deep sedation or general anesthesia as being included in the global surgical package, except for a select group of procedure codes listed in Appendix G of the CPT. The codes listed in Appendix G include moderate sedation as part of the procedure. It would be inappropriate to report moderate sedation separately when submitting claims for any of the procedures listed in Appendix G. None of the codes listed in Appendix G are currently utilized by the OMS. The CDT coding guidelines support the separate reporting of surgical procedures and moderate sedation, deep sedation or general anesthesia by the same physician as they clearly state in the beginning of the Oral and Maxillofacial Surgery section that "local anesthesia is usually considered to be part of Oral and Maxillofacial Surgical procedures."

Furthermore, CPT coding guidelines also state that a "local infiltration, metacarpal/metatarsal/ digital block or topical anesthesia" is included in a surgical package. In fact, CPT coding guidelines instruct the

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use of modifier 47 to “report general anesthesia provided by a physician also performing the service for which the anesthesia is being provided.” Most procedure codes, unless noted in the code descriptor, do not include anesthesia, therefore use of the modifier 47 allows the surgeon to report the separate work and expense of providing the anesthesia service in addition to the surgical procedure.

Additionally, as of January 1, 2006 CPT has six new codes for reporting moderate sedation services. Three of these codes (99143, 99144, and 99145) have been designed specifically for reporting moderate sedation when “provided by the same physician performing the diagnostic or therapeutic service that the sedation supports.” These CPT codes were developed to include the physician work, practice expense, and liability expenses associated with performing moderate sedation services, all of which are not captured in the relative value of most surgical procedures. (Except those listed in Appendix G.) To date the RVUs for work, practice expense and malpractice insurance for these procedures have not been published by Medicare. Medicare (CMS) has allowed the local Medicare carriers to determine the reimbursement levels and at some future date Medicare will review and rule on the national reimbursement levels.

The AAOMS feels strongly that coverage policies should include benefits for OMS operator administered anesthesia. There is an obvious and additional practice expense associated with providing this anesthesia service. Failure to recognize this additional expense, and allow for anesthesia reimbursement will render the OMS incapable of providing this service. Subsequently, it will result in a shift of current office-based procedures to the more costly settings of outpatient surgery centers and hospitals. This will only serve to compound patient and third-party costs by adding facility fees and the fees associated with separate provider anesthesia services. The resultant expense and significant inconvenience will ultimately create dissatisfaction among our patients and the beneficiaries of third party plans.

It is important that consideration be given to quality of patient care, as the stress and anxiety often associated with surgery will only be magnified by the inconvenience and additional cost of hospital or day surgery admission.