

Remodeling Anesthesia Delivery



Eliminating Anesthesia Subsidies

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As CMS is considering measures of efficiency, Excel Anesthesia LLC offers insight, along with cost-effective recommendations, for remodeling the anesthesia care delivery practice model. These suggestions take a closer look at the various existing anesthesia practice models, especially those requiring subsidies. Literature indicates that CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, (1) without any measurable difference in the quality of care between CRNAs and other anesthesia providers, or by type of anesthesia delivery model. (2)

The standard anesthesia care team model utilizes “medical direction” billing, by anesthesiologists with a ratio of one anesthesiologist per a maximum of four CRNAs/AAs. Increasingly, facilities and stakeholders are examining safe, cost-effective alternatives to offset the growing prevalence of unnecessary anesthesia subsidies. Armed with the facts, many are opting for a total Remodel of the traditional “anesthesia care team”, by implementing the model of care that is best suited for their specific patient clientele; saving millions without sacrificing patient safety.

This is not meant to imply anesthesiologists are not needed nor considered necessary in some facilities; rather the existing “medical direction anesthesia care team model” is not cost-effective and alternatively has not been shown to be a safer model. (2) When facilities choose to utilize anesthesiologists, they can do so more cost-effectively by removing ratio restrictions, (1:4) as long as they are utilizing CRNAs. Anesthesiologists must supervise/medically direct AAs at no greater than a 1:4 ratio. Consequently this approach takes advantage of more CRNAs at a lesser expense, while reducing the expense of the total number of anesthesiologists. This enables both the anesthesiologist and the CRNA to each provide billable services individually, resulting in each receiving 100% of the awarded reimbursement rather than splitting this same amount by 50%, which occurs in the “medical direction model” or an even lesser amount as found in the “supervision model”.

In summary, the costs incurred by facilities utilizing the medically directed anesthesia care team model are by far, the highest and most inefficient of all models utilized. The following describes some of the reasons why:

MEDICAL DIRECTION - 7 Steps Must Be Completed by Anesthesiologists to Qualify for Medicare reimbursement

- Under the medical direction practice model, the medical directing anesthesiologist must complete seven steps in order to bill for this modality. CMS has clearly stated that medical direction is a condition for payment for anesthesiologist services and **not** a quality standard. (4) One of the seven necessary steps for making a medical direction claim includes being “present at induction”, yet oftentimes this is delayed. For every minute spent waiting for an anesthesiologist to arrive and be “present at induction”, some of the costliest resources in the hospital are wasted. The clock is running on the surgeon, circulating nurse, scrub tech, and nurse anesthetist waiting in the operating room. Waiting costs cascade throughout the day, postponing the surgery schedule to require overtime and on-call staff, delaying the surgeon’s rounds to affect patient care and discharge of the patient from the healthcare facility. Waiting costs also add opportunity costs, diverting needed resources from other patient care.
- Another of the seven necessary steps in making a medical direction claim includes the anesthesiologist being “present at emergence from anesthesia”. However, strong evidence in the literature shows that anesthesiologists fail to comply with federal requirements, either the Part A conditions of participation or Part B conditions for coverage. ***Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal Anesthesiology,*** (5) the professional journal of the American Society of Anesthesiologists. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found

supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, **and in more than 90 percent of cases involving anesthesiologist supervision** of three concurrent CRNA cases. According to the 2012 AANA Annual Membership Survey, anesthesiologists are present for emergence for only 5 percent of medically directed cases. The combined costly delays associated with case start times and keeping a patient anesthetized until the anesthesiologist arrives for emergence results in sky rocketing hospital and surgery center costs and an overall devastating loss in profitability and sustainability.

- Failure to comply with all 7 steps results in the inability to bill Medicare as “medical direction” resulting in the need to bill “supervision by anesthesiologist or Non- medical Direction”. Supervision results in a reduction of claim amount, reduction of claim reimbursement, and danger of oversight leading (billing Medical Direction vs. Supervision) to an increased risk of Medicare audit, loss of Medicare provider eligibility for participation (part-A and part-B); and in some cases may lead to an investigation of fraud. (8)

SUBSIDIES:

- According to a nationwide survey of anesthesiology group subsidies, (6) 98.8 percent of responding hospitals reported that they paid an anesthesiology group subsidy. Hospitals pay an average of \$160,096 per anesthetizing room, to anesthesiology groups; an increase of 13 percent since the previous survey in 2008. Translated into concrete terms, a hospital with 20 operating rooms pays an average of **\$3.2 million in anesthesiology subsidies**. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing, which also adds to the costs the hospital must pay.

REIMBURSEMENT:

- Anesthesiologist Assistants (AAs) are UNABLE to provide service without an anesthesiologist supervising or medically directing. The ratio of Anesthesiologists to AAs cannot exceed one anesthesiologist to four AAs, which is the same ratio for CRNAs, however CRNAs can work non-medically directed with no ratio requirements. (7)(8)
- When AAs provide service as “medically directed”, the reimbursement is the same as a “medically directed” CRNA. (8)
- CRNAs ARE able to provide service WITHOUT an anesthesiologist “medically directing/supervising” and are reimbursed by Medicare for the procedure at the same rate as an anesthesiologist working alone or the total combined payment reimbursement of both an anesthesiologist and CRNA under “medical direction”. (8)

MEDICARE BILLING REIMBURSEMENT RULES

Delivery Model	CRNA	Anesthesiologist
Anesthesiologist alone		(Base units + Time Units) * Conversion factor
CRNA Non-Medically Directed	(Base units + Time Units) * Conversion factor	
Medical Direction	(Base units + Time Units) * Conversion factor *0.5	(Base units + Time Units) * Conversion factor *0.5
Supervisory	(Base units + Time Units) * Conversion factor *0.5	Maximum of Four units- regardless of time

*Time Units: 1 Time Unit = 15 Minutes

*Conversion Factor: Specific to Region (Average is \$18.00/ Unit)

SALARY COST:

- Anesthesiologist-\$336,000/yr (1)
- CRNA-\$170,000/yr (1)
- AA-\$170,000/yr (7)

RECOMENDATIONS:

- INCREASE the utilization of Non-Medically Directed CRNAS (Non-medically directed by an anesthesiologist) in order to eliminate overall expense, reduce the risk of Medicare fraud/and or reduced billing amounts due to supervision ratios.
- REDUCTION/ Replacement of the number of consulting anesthesiologists with more CRNAs.
- Consider on-site Anesthesiologists to provide other billable services while remaining immediately available for consultation if the facility considers it necessary and the patient clientele warrants it.
- Reduction or elimination of AA employees since they are incapable of billing for services as “non- medically directed” and therefore would not be able to provide service under this cost-saving model. (8)

SUMMARY:

Healthcare facilities are looking for sustainable, safe and efficient alternatives to reduce the overall healthcare costs. CRNAs acting independently provide anesthesia services at the lowest economic cost, and net revenue is likely to be positive under most circumstances. The supervisory model is the second lowest cost, but reimbursement policies limit its profitability. The non-medically directed CRNA is the only model likely to have positive net revenue in venues of low demand, such as may be found in rural hospitals or facilities in which there are fewer rooms or patient volume. (1)

Other models, including medical direction models where one anesthesiologist directs two to four CRNAs are likely to require subsidies in cases where overall demand is not consistent with full utilization of facilities. In facilities where demand is high and relatively stable, the medical direction 1:4 model is relatively stable however once the operating rooms begin to diminish in volume as is typical throughout the day, it quickly becomes very costly and inefficient. The medical direction 1:1 model is almost always the least efficient model. (1)(4) Finally, if the facility chooses to follow the non-medically directed model, AAs cannot be utilized, as they are only eligible to provide service under an anesthesiologist medically directed model. (7)(8)

Taken with the average expense of an anesthesiologist salary at close to twice that of a CRNA, the loss of net revenue, and the addition of subsidies, it is no wonder healthcare facilities are taking another look at the overall structure and remodeling their anesthesia department.

(1) Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” Nursing Economics. 2010; 28:159-169.

(2) Brian Dulisse, Jerry Cromwell, “No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians.” Health Affairs. August, 2010.

(3) 42 CFR §415.110(a), Conditions for payment: Medically directed anesthesia services.

(4) 63 FR 58813, November 2, 1998. American Association of Nurse Anesthetists
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(5) Epstein R, Dexter F. Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics. Anesth. 2012;116(3): 683-691.

(6) Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012. American Association of Nurse Anesthetists
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(7) American Academy of Anesthesiologist Assistants, 2013 Website: www.anesthetist.org/faq#salaries

(8) CMS Manual System; Pub 100-04 Medicare Claims Processing; transmittal 2716; 140.3.3-Billing Modifiers
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2716CP.pdf>