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Transitioning to the Anesthesia Care Team

WHITEPAPER

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Among the many current trends in the anesthesiology specialty is an increasing pressure on private practice groups who deliver anesthesia care utilizing the all-anesthesiologist staffing model to convert to the anesthesia care team approach. The American Society of Anesthesiologists (ASA) describes the anesthesia care team model as “anesthesiologists supervising resident physicians in training and/or directing qualified non-physician anesthesia providers in the provision of anesthesia care.” "Qualified non-physician anesthesia providers" here refers to Certified Registered Nurse Anesthetists (CRNAs) and Anesthesia Assistants (AAs). One might also include in this definition Student Registered Nurse Anesthetists (SRNAs) when those students are utilized in a direct patient care delivery role. Collectively, I will refer to residents and qualified non-physician anesthesia providers in this article as "residents/extenders." The ASA goes on to say that physicians in these models can delegate monitoring and appropriate tasks while retaining overall responsibility for the patient. In a nutshell, the anesthesiologist oversees all key elements of the anesthetic provision in the anesthesia care team model, but may allow residents/extenders to perform any number of elements of the care delivery during the pre-, intra- and post-operative stages while under that anesthesiologist oversight.

Pressures may arise from within a practice as private practice anesthesiologists seek ways to maintain income levels

The genesis for these "pressures" is much more often than not economic in nature. Pressures may arise from within a practice as private practice anesthesiologists seek ways to maintain income levels in the face of eroding payor mixes and underutilized anesthetizing locations. Or it may come from outside the practice, frequently as a result of contract negotiations whereby hospital administrators demand reductions in the cost of anesthesia care delivery and seize on the care team model as a possible means of shrinking hospital financial support payments. While I have found that converting to an anesthesia care team, in some situations, does not lower the overall cost of anesthesia care delivery, there are many scenarios where it does. The purpose of this article is not to outline the various scenarios referenced here, or debate the short or long-term wisdom, or political ramifications, of a conversion to care team anesthesia. Instead, my objective is to discuss some of the interpersonal, business and philosophical challenges facing groups who have made the decision to abandon their all-anesthesiologist model and implement the anesthesia care team.

Anesthesia Care Teams are not “One Size Fits All”

No single anesthesia care team model is ideal for all hospitals or all anesthesia practices. There are several variables that must be considered and weighed in any initial staffing model design. Perhaps the first and most important definition to agree upon is the resident's/extender's scope of practice, i.e., clearly delineating their clinical role as well as the role that the anesthesiologist will play in the team approach.

Arguably, one end of the scope continuum is rigid adherence to delivery under a "medical direction" model as defined by the Center for Medicare and Medicaid Services (CMS). The opposite end (subject to program accreditation standards when utilizing residents/CRNAs) might be an approach that grants the residents/extenders significant latitude for clinical decision-making, with anesthesiologist involvement limited to situations where the resident/extender seeks clinical assistance or counsel. Over the last ten years of consulting with very successful care team anesthesia groups, I have encountered a very wide range of data points on the scope of practice continuum.

Billing Considerations

In an all-anesthesiologist care delivery model, billing is straightforward (as much as professional anesthesia services can be). In a care team arrangement, the payors' claim format and adjudication demands have to be considered because a failure to comply can result in diminished revenue. Thankfully, Medicare's rules and policies are easy to understand and consistently applied nationally. But in some parts of the country, state Medicaid programs pay extenders at a different rate than a personally performing anesthesiologist, and some routinely deny claims filed under non-anesthesiologist NPI numbers. Most commercial payors, however, make it their practice, like Medicare, to pay the full allowed amount, regardless of how the care was delivered....anesthesiologist only, CRNA only, medically directed team approach, etc. The problem arises from the fact that not every commercial payor understands, or can electronically adjudicate anesthesia care claims accurately, when medical direction services are provided.....despite their claims to the contrary. Therefore, a thorough discussion in advance with your billing operation, or someone who understands care team billing in your state, is paramount.

Compliance

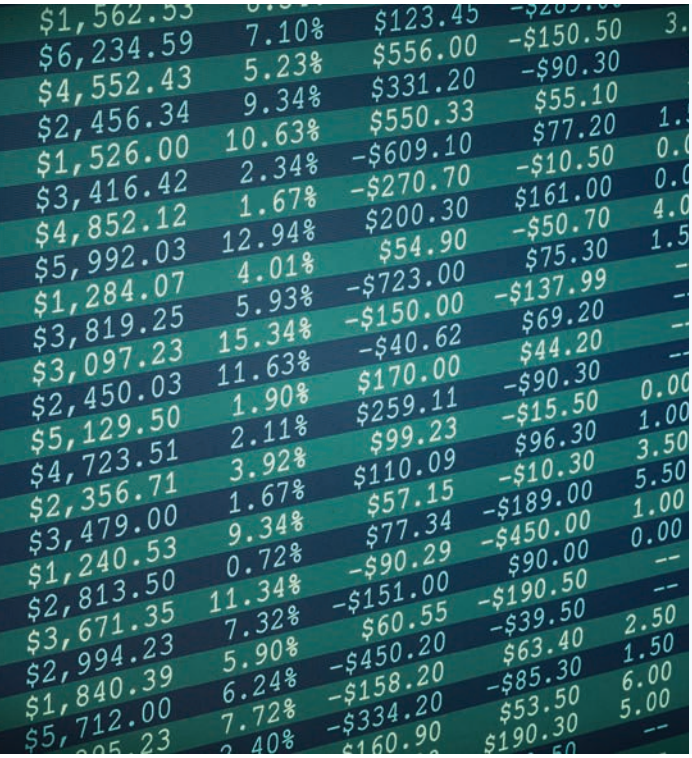
Like scope of practice and billing decisions, the compliance landscape becomes more muddled when an all-anesthesiologist group introduces extenders into the mix. If "medical direction" is the care delivery modality selected, whether due to its real or perceived patient safety advantages or some other reason, the clinical care documentation "bar" is raised significantly.

The American Society of Anesthesiologists and Medicare have agreed on seven elements that must be performed and documented on every single case for the anesthesiologist to bill his or her medical direction services. Most other payers also require this same level of documentation when claims for medical direction services are submitted:

1. Perform a pre-anesthetic examination and evaluation.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures in the anesthesia plan, including (if applicable) induction and emergence.
4. Ensure a qualified individual performs any procedures in the anesthesia plan that the anesthesiologist does not personally perform.
5. Monitor the course of anesthesia administration at frequent intervals.
6. Remain physically present for all key and critical portions of the procedure, and be available for immediate diagnosis and treatment of emergencies.
7. Provide post-anesthesia care as indicated.

Sadly, the clarity provided by Medicare as to the exact meaning of many of the terms above is lacking, though it is better than twenty years ago. Still, each practice, in conjunction with an anesthesia-knowledgeable compliance attorney and/or consultant will have to fill in the definition gaps, at least for purposes of educating all group anesthesiologists, in order to ensure the application of the medical direction guidelines consistently by everyone. Attestations of performance of the seven elements, when appropriate, must be formulated for electronic anesthesia records, while form re-design will become a necessity to capture element performance documentation, if paper is still used for charting peri-operative anesthesia care.

A medical direction approach also requires that care team anesthesiologists never simultaneously direct more than four (4) cases. To do so is not illegal, or non-compliant as long as the "AD" claim modifier is appended, but it does result in severe payment reductions by Medicare and some other payors to the medically directing anesthesiologist.



Physician Compensation Algorithms

I have found that most, though not all, anesthesiologist-only groups employ a compensation system that, in one or more ways, rewards higher productivity with higher payment. Although even these all-doctor groups may define "productivity" differently, especially when it comes to valuing labor epidural time, non-time based services (lines, blocks, etc.) and patient acuity, those same income division formulas may become unworkable in a care team environment. Fundamental questions arise such as, "Who is more productive, an anesthesiologist personally performing cases for ten (10) hours or an anesthesiologist overseeing four (4) extenders for ten (10) hours?" And, if the latter anesthesiologist is deemed more productive, how much should his or her compensation differ from the former anesthesiologist in my example?

Compensation and Fringe Benefits for Physician Extenders

Introducing a new tier of employees paid relatively high, but still below anesthesiologist levels, can trigger legal implications in the design of company fringe benefits plans, especially health insurance and retirement programs. Early discussions with insurance and financial advisors are critical to understanding the economic impact to the practice in terms of costs over and above salaries, not to mention potential constraints on fringe benefit program designs that these new employees may prompt.

Pay practices such as whether to pay overtime (often not even on the radar of all-anesthesiologist groups), exactly when overtime hours begin, beeper call pay amounts if applicable, weeks of paid vacation time and how much, if any, financial responsibility for health insurance premiums will rest with the extenders, are all questions that need to be answered well before these new hires begin working.

Finally, employee morale dictates that all personnel decisions affecting extenders be applied consistently to counter any inevitable charges of favoritism, or even wrongful termination. Resulting questions that may arise include:

- Should we designate a CRNA/AA "Chief" to help manage this new employee group?
- Should we appoint a "physician liaison" as a point person to field/triage extender questions?
- Should we create, and fund, a formal extender recruiting plan to ensure a steady supply of qualified candidates for our extender program where the turnover rate is likely to be higher than what has been experienced with anesthesiologists?
- Does the practice complexity sparked by the care team conversion warrant the hiring of a full time practice manager?
- Who should be tasked with the creation/authoring of an Employee Handbook which codifies our personnel policies and guidelines to serve as a tool for consistent application of rules?

CRNAs have worked independently, collaboratively, and under the medical direction oversight of anesthesiologists for decades. While the track record for medically directed AAs is not nearly as long, both physician extender groups are near-universally acclaimed as vital members of the anesthesia care team, helping to ensure access to high-quality professional anesthesia care across the country, from remote critical access hospitals to large, nationally renowned medical centers. A well-planned and well thought through strategy for introducing extenders into a formally all-anesthesiologist practice can be a successful undertaking in many respects over and above the potential economic benefits.

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