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MEDICAL DIRECTION

WITH UP TO 1:4 PHYSICIAN ANESTHESIOLOGIST/CRNA RATIOS AND THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) REQUIREMENTS

The American Society of Anesthesiologists endorses a model with physician anesthesiologists heavily involved in key portions of every anesthetic procedure. The anesthesia care team (ACT) model has multiple disadvantages when developing efficiency-driven anesthesia services. The ACT, with its explicit hierarchical physician-led structure, artificially restricts the contributions of CRNAs by not utilizing all available anesthesia providers to the full extent of their training and licensure, which ultimately increases healthcare costs. For example, in the ACT model, labor costs are inflated by mandating a maximum ratio of 1:4 physician anesthesiologist to CRNAs. Although the ACT model appears to provide enough anesthesia staffing, it actually limits access to operating room time for patients and surgeons because the physician anesthesiologists do not staff rooms. Resources that could be allocated for additional CRNAs to open more operating rooms are instead used on highly compensated physician anesthesiologists who provide no direct patient care. Furthermore, there is no scientific evidence that the ACT model increases patient safety or quality of care[1], but there is strong evidence that the ACT model increases costs to the healthcare system.[2]

Another consideration is that care delivered through a Medical Direction model is reimbursed under Medicare Part B and is subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) regulations. TEFRA requires physician anesthesiologists to document their involvement in all seven key portions of an anesthetic delivery. Failure to meet all seven steps disqualifies the anesthesiologist from billing for medical direction. Further, the Medical Direction model is subject to potential lawsuits under the False Claims Act when the strict requirements associated with TEFRA regulations for medical direction are not met or not documented under Medicare Part B regulations. There are many examples of False Claims cases where the hospital and/or anesthesia group has been implicated in fraud due to failed Medical Direction billing.

The ACT model often prevents CRNAs from performing techniques they are fully qualified to perform such as peripheral nerve block or other pain procedures. Such restrictions may offer reimbursement-related advantages to anesthesiologists.[3] However, they not only undermine the value CRNAs offer but also may affect the ability to recruit and retain CRNA staff. Restrictions on clinical autonomy for CRNAs is associated with lower job satisfaction, increased compliance risks under TEFRA, and decreased efficiency when lower ratios of CRNAs to physicians are used to reduce those risks.[4]

REFERENCES

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