AAs Anesthesiologist Assistants

INFLEXIBLE STAFFING STRUCTURE POTENTIAL REDUCED REVENUE

AAs are **only** able to provide anesthesia care **under the direct supervision** of a physician anesthesiologist.

Physician anesthesiologists can only bill for AAs when medical direction criteria are met.

AAs Cannot Work Autonomously

AAs Cannot Collaborate with Surgeons Or Proceduralists

Medical Direction (QK) TEFRA[1] Compliance Capability

(2:1 Ratio)

AA + ANES[2]

12 + 6

Staffing Cost[3]

4.52M

Failed Medical Direction (QK) Defer to Supervision (AD) Billing

(3:1 Ratio)

AA + ANES[2]

12 + 4

Staffing Cost[3]

3.68M

Significant Risk For Medicare Fraud

Reduced Revenue

- **AAs must work** in an Anesthesia Care Team Model generally billed under Medical Direction billing model with no more than a 4:1 ratio (57 FR 33878, July 1992); However, the more costly, inefficient 2:1 ratio is more commonly used.
- AAs are trained to **assist physician anesthesiologists** and **lack the staffing flexibility** needed in today's dynamic healthcare delivery systems. First starts in the morning and complications may result in delays **or even fraudulent practice or billing with potential jeopardy for facilities**. One study found physician anesthesiologists did not meet TEFRA rules 35% for 2:1 and 99% for 3:1 ratios.[4]
- CMS has **denied AAs** billing for services as performed autonomously. A physician anesthesiologist who fails to meet medical direction TEFRA[1] rules **must bill using the AD modifier and lose revenue** of up to 50%.

1 Tax Equity and Fiscal Responsibility Act of 1982

2 Physician anesthesiologist

3 Staffing costs are based on salary only and provider staffing cost ratios are comparable when using median CRNA salary ($166,540) according to 2018 AANA Compensation & Benefits Survey. Salary costs for physician anesthesiologists are based on the 75th pctl salary ($420,284) according to HR Reported data as of March 29, 2018 form Salary.com

4 Epstein R, Dexter F. (2012). Influence of supervision ratios by anesthesiologist on first case starts and critical portions of anesthetics. Anesthesiology, 116(3):683-691.

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