KANSAS ASSOCIATION OF NURSE ANESTHETISTS

My name is Larry Finley and I am President of the Kansas Association of Nurse Anesthetists (KANA) and an independent Certified Registered Nurse Anesthetist (CRNA) in Emporia, KS. I am writing to provide supplemental testimony in opposition to HB 2295 and SB 223, providing for licensure of Anesthesiologist Assistants (AAs) in Kansas.

The following are some reasons why KANA opposes anesthesiologist assistants (AA's) in Kansas:

1) No critical shortage of CRNA's in Kansas (Exhibit A,B,C):
   a) KS ranks #12 in the nation for providers per 100,000 population which exceeds the provider supply in all of our surrounding states.
   b) Several KU grads in 2019 migrated out of state for lack of employment in KS.
   c) In 2017 and 2018, the proponents testified to House Health and Human Services Committee that the shortage was at KUMC. In 2019, KU Hospital only hired 1 CRNA graduate. What happened to the critical shortage?
   .

2) With AAs in the state, damage will occur to CRNA educational programs in Kansas:
   a) Well established CRNA programs exist at the University of Kansas (KU) and Newman University (NU).
   b) Damage will occur to these 2 historic programs by:
      i) Limiting education training sites (operating rooms) at large tertiary facilities in Kansas City and Wichita. The employment of anesthesiologist assistants and assistant training will reduce CRNA training sites limiting the number of Student Registered Nurse Anesthetists (SRNA's) that can be accommodated. This is evidenced in Missouri at Children's Mercy Hospital, St. Luke's Health System and Springfield hospitals. The CRNA training program at Missouri State University in Springfield, MO experienced a significant reduction in training sites in 2010-2012. MSU now has to ask their SRNA's to travel to more than50 different clinical sites within MO and KS to obtain their education with the closest rotation site being 32 miles from Springfield.
      ii) For KU to maintain a competitive CRNA program, it must not lose clinical sites at KUMC.
   c) This reduction of SRNA training sites will have a long-term negative impact on the supply of CRNA's to meet the anesthesia workforce demands in both urban and rural Kansas.

P.O. Box 4006, Lawrence, KS 66046
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3) Dependent anesthesiologist assistants are not cost effective (Exhibit D,E,F,G,H):
   a) Anesthesiologist (MDA) medical direction of dependent anesthesiologist assistants (QK/QX) with a ratio of 1:2-4 demands increased hospital subsidies to MDA controlled practices.
   b) MDA's utilizing the non-medically directed billing (QZ) for the independent CRNA with no supervision ratio requirements is more efficient and lowers the subsidies to MDA controlled practices from both public and private hospitals. According to Medicare data, in 2016 over half of CRNA anesthesia delivery in Kansas was billed as (QZ) non-medically directed. The most efficient anesthesia model is for CRNA provided anesthesia.

4) Fraudulent billing risk (Exhibit I,J,K):
   a) Dependent anesthesiologist assistants must be medically directed by only an MDA.
   b) Medical direction of the dependent anesthesiologist assistants is regulated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rules that require the MDA to be present for the start and stop of anesthesia and be available for crucial times during the anesthetic.
   c) Medical direction of 4 anesthesiologist assistants by 1 MDA encourages the occurrence of Medicare fraud. Studies indicate that in the vast majority of cases, there is NOT compliance with the TEFRA requirements of Medicare. The reason for this is that anesthesiologist assistants can only work in a dependent medically directed anesthesia care team (ACT) model.[1]
   d) Fraudulent billing puts hospitals at risk for losing CMS part A reimbursement due to non-compliance with the Conditions of Participation (CoP) that the Centers for Medicare and Medicaid Services (CMS) mandate.
   e) This lapse of medical direction compliance could increase the liability of the surgeon and hospital if MDA not available.

5) Anti-competitive (Exhibit L):
   a) CRNA's can practice independently in Kansas either in an ACT or solo practice.
   b) CRNA's compete with MDA's for anesthesia practices.
   c) Anesthesiologist assistants are dependent upon MDA medical direction and are not competitors being added to the market place.
   d) CRNA's cannot supervise anesthesiologist assistants, limiting their ability to compete for practices that utilize these assistants, and giving anesthesiologists a competitive advantage in the market place.
   e) MDA's can minimize CRNA competition by utilizing only dependent anesthesiologist assistants.

The only realistic solution to any perceived shortage of CRNA's is to continue to protect our current CRNA programs from undo harm and permanent damage by not allowing AA legislation in KS. KANA has offered to work with the proponents of AA legislation to achieve an increase in CRNA output in Kansas in order to address many shortage issue. That offer has thus far been rejected. Currently, KU graduates 24 CRNAs per year, which will increase to be 30 in 2021 and then 36 in 2022 (50% increase). Newman University graduates 20 CRNAs per year now and plans to grow to 25/year as needed (26% increase). This will result in an overall 40% increase output of CRNA's to meet future demand in Kansas (Exhibit M).

Thank you for your time and consideration.

Sincerely,

Larry W. Finley, DNAP, CRNA
President, KANA

REFERENCES:

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

Exhibit A

State	Anesthesia providers	Providers per 100,000 people	RANK
North Dakota	337	44.3	1
South Dakota	384	43.5	2
West Virginia	764	42.3	3
DC Metro	271	38.6	4
Pennsylvania	4638	36.2	5
Minnesota	2007	35.8	6
Maine	464	34.7	7
Tennessee	2340	34.6	8
Alabama	1656	33.9	9
Louisiana	1544	33.1	10
Ohio	3731	31.9	11
Kansas	**926**	**31.8**	**12**
Michigan	3170	31.7	13
Missouri	**1914**	**31.2**	**14**
North Carolina	3218	31.0	15
New Hampshire	420	31.0	16
Kentucky	1377	30.8	17
South Carolina	1547	30.4	18
Delaware	287	29.7	19
Nebraska	563	29.2	20
Massachusetts	1997	28.9	21
Connecticut	1017	28.5	22
Mississippi	821	27.5	23
Wisconsin	1570	27.0	24
Georgia	2812	26.7	25
Vermont	165	26.3	26
Arkansas	769	25.5	27
UNITED STATES	**81345**	**24.9**	
Rhode Island	263	24.9	28
Florida	5289	24.8	29
Virginia	2075	24.4	30
Idaho	425	24.2	31
Maryland	1406	23.3	32
New York	4508	23.1	33
Texas	6573	22.9	34
Colorado	**1280**	**22.5**	**35**
Illinois	2831	22.2	36
Indiana	1478	22.1	37
Iowa	693	22.0	38
Oklahoma	**857**	**21.7**	**39**
New Jersey	1871	21.0	40
Montana	221	20.8	41
Alaska	153	20.7	42
New Mexico	432	20.6	43
Washington	1435	19.0	44
Wyoming	109	18.9	45
Oregon	779	18.6	46
Arizona	1329	18.5	47
Utah	541	17.1	48
Hawaii	215	15.1	49
Nevada	432	14.2	50
California	5441	13.8	51

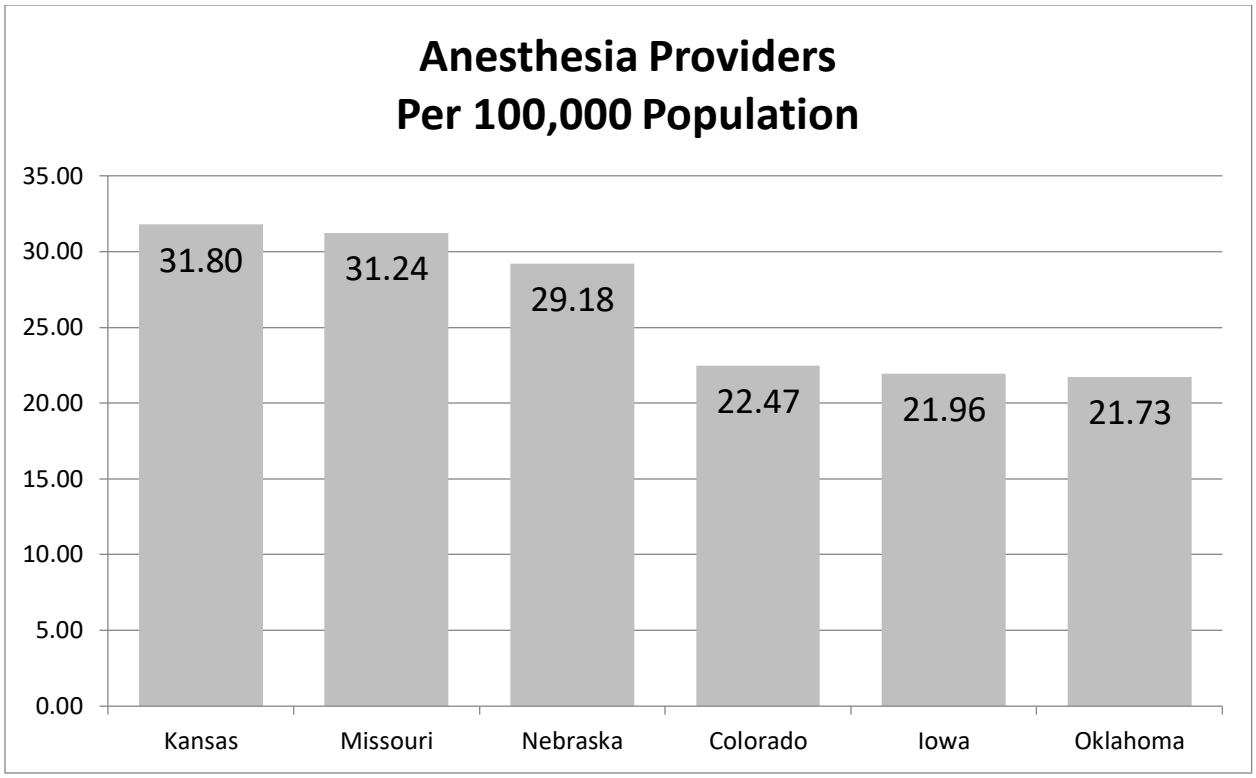


Chart created by Hein Governmental Consulting utilizing 2018 Census Estimate data and 2018 Physician Compare data - which consists of Medicare claims in the last 12-months & enrollments in the last 6-months.

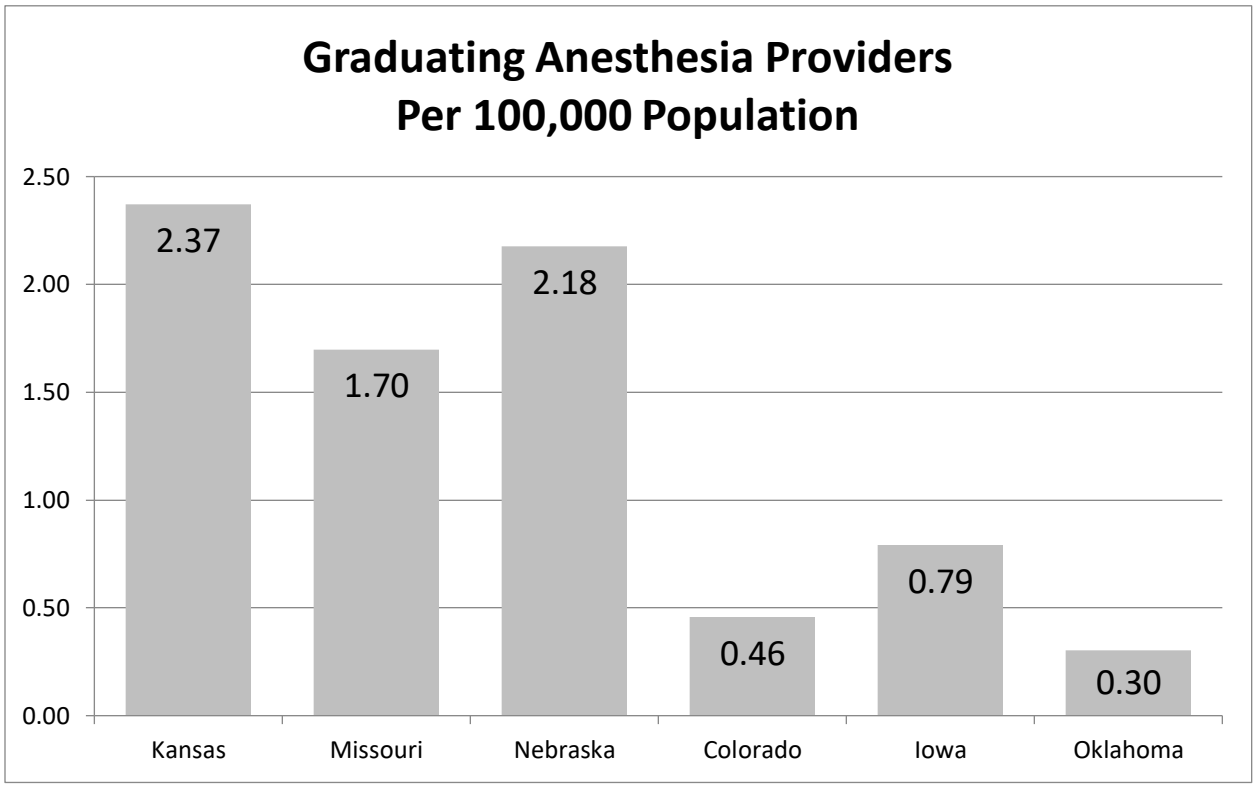
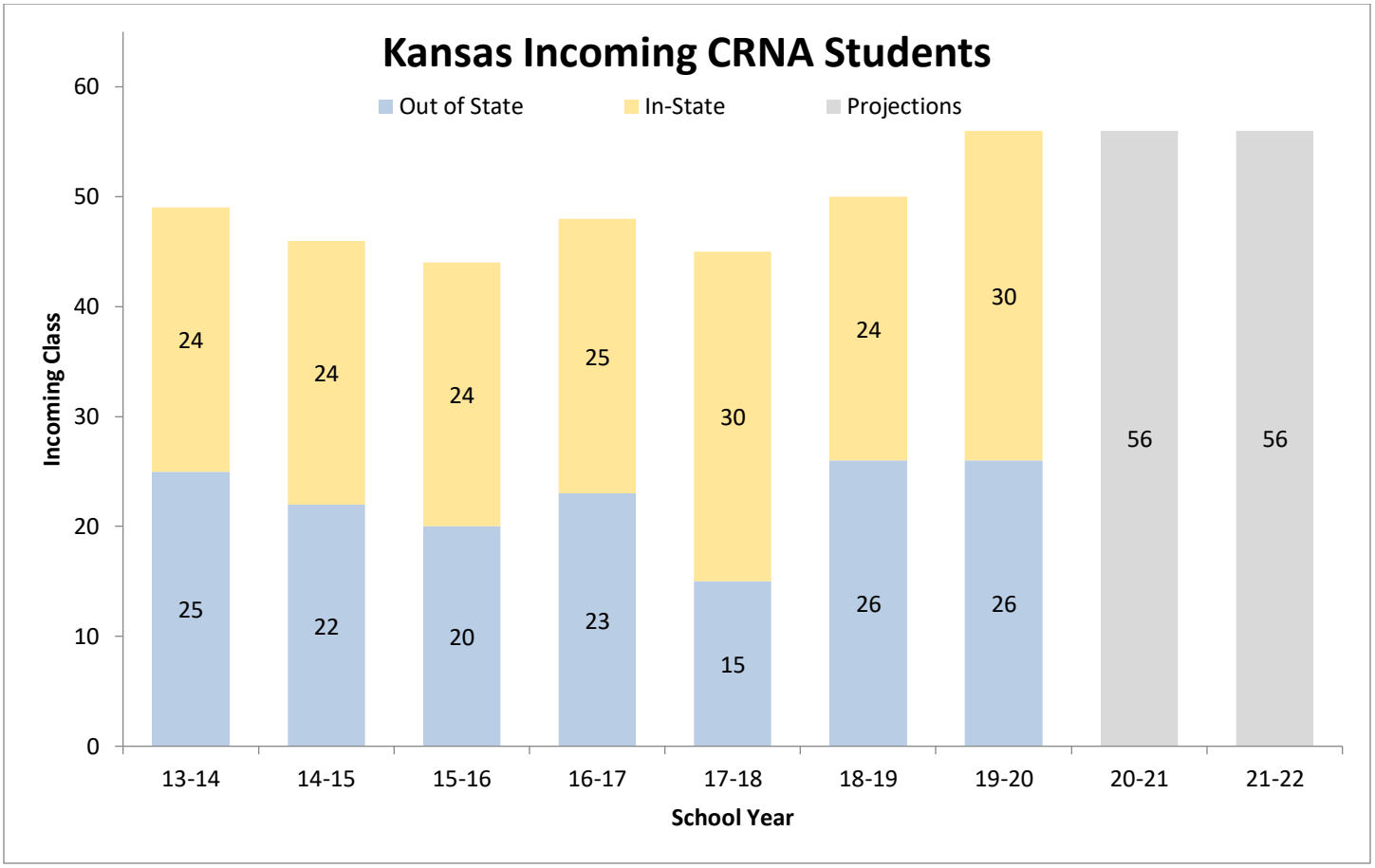
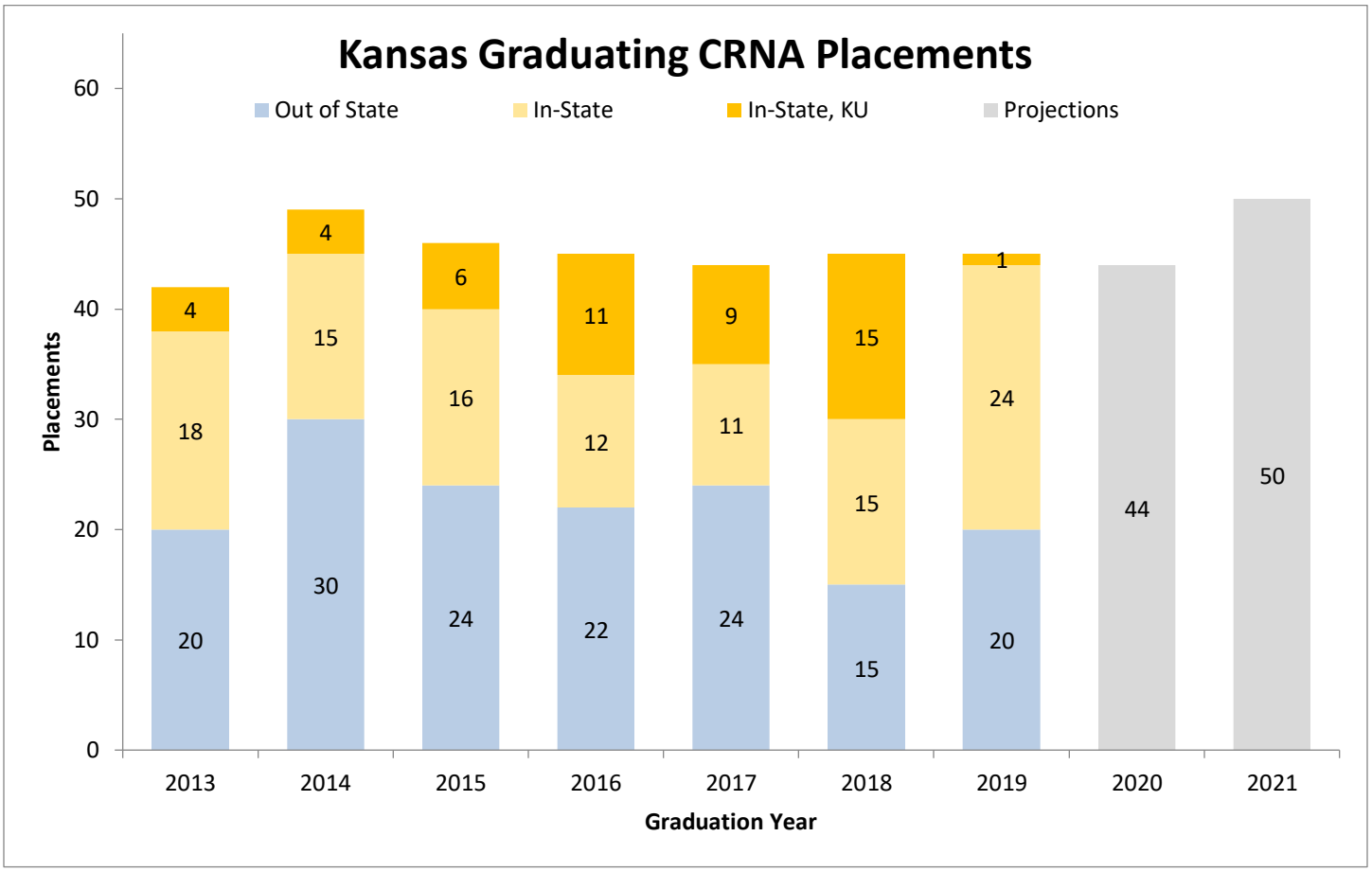


Chart created by Hein Governmental Consulting utilizing 2018 Census Estimate data and publicly available information regarding MDA residency programs, CRNA programs, & AA programs.





Created by Hein Governmental Consulting utilizing data collected by the University of Kansas and Newman University CRNA Programs.

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.

AANA
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CRNAs

Certified Registered Nurse Anesthetists

Are the Most **VERSATILE** and **COST-EFFECTIVE ANESTHESIA PROVIDERS**

Cost Effectiveness of Anesthesia Models

Autonomous/CRNAs Collaborating with Surgeons

12

Staffing Cost[2]

2.00M

CRNAs Collaborating with Anesthesiologists

12 1

Staffing Cost[2]

2.40M

Physician Anesthesiologist Only

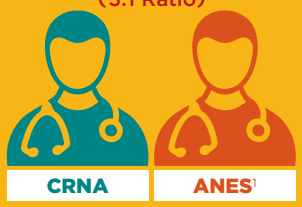
12

Staffing Cost[2]

5.04M

Anesthesia Care Team

(3:1 Ratio)



12 4

Staffing Cost[2]

3.68M

- CRNAs are qualified to work in any practice setting/model
- CRNAs are not required to practice under a physician anesthesiologist; by law, CRNAs can work independently of OR together with physician anesthesiologists
- CRNAs have a proven safety record
- CRNAs in Anesthesia Care Team Model ensure **NO LOSS IN REVENUE, NO RISK OF FRAUD**, no delays in delivery of care even when there is a supervision lapse (up to 70%[3] of the time) **as long as QZ billing is utilized**
- In such cases, the facility simply bills exclusive of the anesthesiologist for the procedure (QZ vs. medical direction). **The QZ modifier is exclusive to CRNAs**

1 Physician anesthesiologist

2 Staffing costs are based on salary only. The median CRNA salary ($166,540) was taken from the 2018 AANA Compensation and 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

3 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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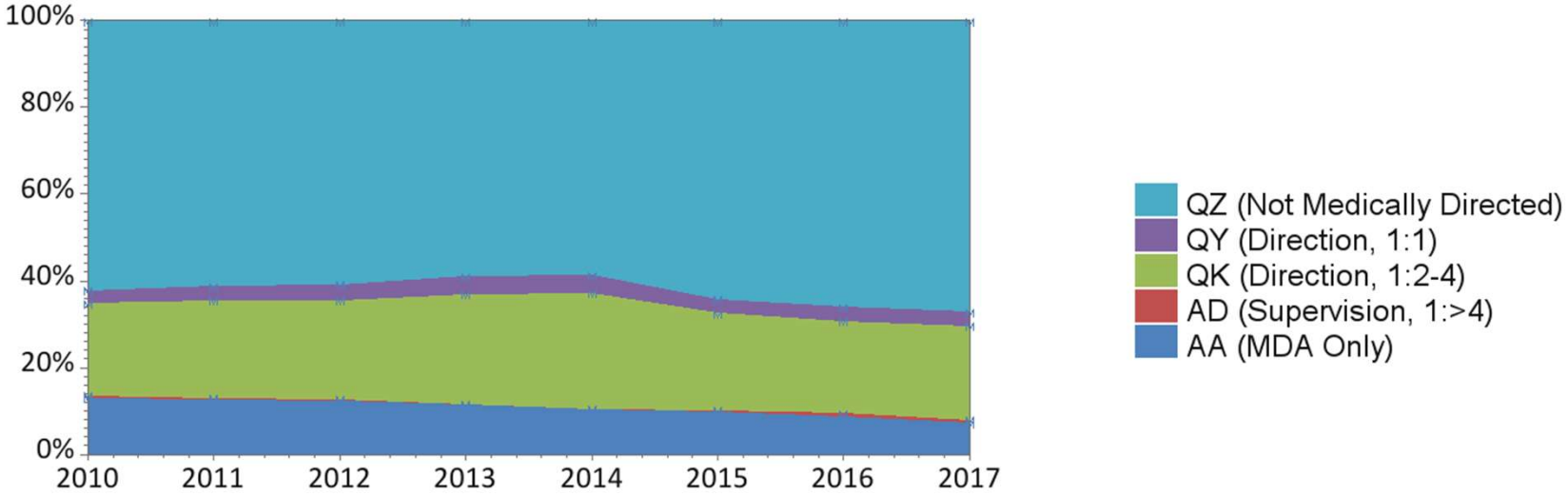
Anesthesia Modifier Trends 2010-2017 Kansas



	2010	2011	2012	2013	2014	2015	2016	2017
QZ (Not Medically Directed)	62.0	61.0	60.7	58.8	58.6	64.0	65.8	67.0
QY (Direction, 1:1)	3.0	3.3	3.5	4.1	4.1	3.3	3.3	3.3
QK (Direction, 1:2-4)	21.2	22.4	22.9	25.4	26.7	22.4	21.2	21.6
AD (Supervision, 1:>4)	0.5	0.5	0.4	0.1	0.1	0.3	0.8	0.7
AA (MDA Only)	13.2	12.8	12.4	11.6	10.5	10.0	8.8	7.4

Source: Medicare Physician/Supplier Procedure Summary Files

WHAT KANSAS LAWMAKERS NEED TO KNOW ABOUT

CRNAs vs. AAs

There is no shortage of Certified Registered Nurse Anesthetists (CRNAs) or physician anesthesiologists to provide safe, high-quality anesthesia care to patients in Kansas. Currently, anesthesiologist assistants (AAs) are not a recognized healthcare provider in Kansas for *many reasons*.

CRNAs Independent, safe, cost-effective—ensure access to care	AAs Dependent, unproven, costly—do not improve access to care
CRNAs...and anesthesiologists ***can work independent of one another OR together*** by law to ensure patients access to surgical, obstetrical, emergency and pain management services in rural and urban locations across the state.	**AAs...*cannot work independently;*** they can ***only work under the direct supervision[1] of an anesthesiologist,*** dramatically limiting ***where*** and ***when*** they can provide patient care.
CRNAs...are educated and trained to ***work independently*** (without an anesthesiologist).	**AAs...**are educated and trained to ***assist*** anesthesiologists.
CRNAs...*may* work in an anesthesia care team (with an anesthesiologist), but ***are not required*** to do so.	**AAs...*must*** work in an anesthesia care team with an anesthesiologist.
CRNAs...working in a care team will ***continue to provide patient care*** if there is a ***lapse in supervision.***[2]	**AAs...*legally cannot provide patient care*** if there is a ***lapse in supervision.***
CRNAs...*provide quality care despite lapses in supervision.* In such cases, the facility simply bills ***exclusive of the anesthesiologist*** for the procedure (***QZ vs. medical direction***).	**AAs...*cannot provide care without direct supervision***, leading to possible ***case delays*** or even ***unauthorized independent practice, regulatory violations, and accreditation jeopardy for facilities***.

Other CRNA Advantages

Since 2000, multiple research studies confirm that CRNAs are ***safe, high-quality*** anesthesia providers—***as safe as physician anesthesiologists.***

The ***most cost-effective anesthesia delivery model*** is a CRNA working independently; the most expensive is one anesthesiologist supervising another provider.

CRNAs: Ensuring patients access to safe, cost-effective anesthesia care

1 As used in this document, "supervision" also refers to "medical direction" under TEFRA (Tax Equity and Fiscal Responsibility Act of 1982).

2 "Lapse in supervision" is the inability of a supervising anesthesiologist in an anesthesia care team to be physically present at "bedside" during required (most important) aspects of a case as specified under TEFRA.

Kansas Association of Nurse Anesthetists

kana.org

The Honorable Brenda Landwehr

Please accept this letter in support for the Certified Registered Nurse Anesthetists (CRNA) in Kansas who work in the overwhelming majority of hospitals in this state.

If anesthesia assistants (AA) are licensed to work in Kansas, Medicare reimbursement rules will require that they be directly supervised by a physician anesthesiologist in a ratio that cannot exceed 4 AAs per physician. Most insurers follow this CMS policy.

Based on 2018 surgical volume data from the Kansas Hospital Association and Certificate of Need volume thresholds for adding operating rooms in Michigan, there are only 17 hospitals in Kansas with enough surgical volume to fully staff four or more operating rooms on a routine basis. Most if not all of these hospitals staff their operating rooms with a combination of physicians and CRNAs because of cost concerns and the reality that they could probably never recruit and retain that many physicians.

If those hospitals adopt the AA model, it will cost patients, insurers and taxpayers an estimated $84 million more than a model using 1 physician and 3 CRNAs working autonomously to staff the same 4 rooms. With our state's focus on rising healthcare costs, we do not need another "solution" that adds cost without improving quality or access. (See Exhibit A included with this letter).

The CRNA training programs at the University of Kansas and Newman University have expressed to the Kansas Legislature their concern that licensing AAs in Kansas will inevitably lead to less training sites in Kansas for CRNAs. The number of sites are essentially fixed, so adding AA students at the very time that our CRNA programs have expanded is counter-productive to those efforts and will eventually lead to a contraction of these CRNA programs and a reduction in the number of CRNAs available to the 87 hospitals in Kansas who do not have enough volume to utilize AAs. The result will be increased anesthesia staffing costs in those hospitals as well as in the 17 who could potentially use AAs.

The only compromise sure to increase the number of anesthesia providers in Kansas without increasing healthcare costs and without the potential for making staffing problems worse for 84% of the surgical hospitals in Kansas is for physicians, hospitals and training programs to continue to work together and redouble our efforts to increase the number of graduates coming out of our CRNA training programs.

Our Legislators should stay the course and take no action on AA licensure.

Thank you for giving me the opportunity to speak to this important issue.

Robert Wright, CEO
Newman Regional Health
BS, MBA, CPA, Fellow in the Health Care Financial Management Association

EXHIBIT A

COMPARISON OF ANESTHESIA STAFFING MODELS CONTRIBUTION MARGIN

					Physicians & CRNAs Doing Cases		
		Physician Only	Supervised AAs	CRNA Only	Physician	CRNA	TOTAL
Staffed Operating Rooms		4	4	4	1	3	4
Same Case Mix ASA Reimbursement:	2018 MGMA Median/Provider						
Physician	$566,498.00	$2,265,992.00			$566,498.00		$566,498.00
Medical Direction - 50% of Physician ASA	$283,249.00		$1,132,996.00				
CRNA ASA	$566,498.00			$2,265,992.00		$1,699,494.00	$1,699,494.00
Total Reimbursement		**$2,265,992.00**	**$1,132,996.00**	**$2,265,992.00**	**$566,498.00**	**$1,699,494.00**	**$2,265,992.00**
Staffing Model Costs:							
Base Salary	2018 MGMA Median	$446,962.00	$165,732.00	$174,049.00	$446,962.00	$174,049.00	
X Benefit %		20.00%	30.00%	30.00%	20.00%	30.00%	
Benefit Costs		$89,392.40	$49,719.60	$52,214.70	$89,392.40	$52,214.70	
Salary & Benefits		$536,354.40	$215,451.60	$226,263.70	$536,354.40	$226,263.70	
X 4 Weeks PTO %		7.69%	7.69%	7.69%	7.69%	7.69%	
Paid Time Off Coverage Cost		$41,258.03	$16,573.20	$17,404.90	$41,258.03	$17,404.90	
Provider Cost by Type		$577,612.43	$232,024.80	$243,668.60	$577,612.43	$243,668.60	
X Operating Rooms		4	4	4	1	3	4
Total Salary & Benefits		$2,310,449.72	$928,099.20	$974,674.40	$577,612.43	$731,005.80	$1,308,618.23
Supervising Physician Sal.& Ben.			$577,612.43				
Physician Primary Call	20% of Houly Base Rate X Call Hours	$241,359.48					
Physician Secondary Call	10% of Base Houly Rate X Call Hours		$120,679.74		$120,679.74		$120,679.74
AA Primary Call	20% of Houly Base Rate X Call Hours		$89,495.28				
CRNA Primary Call	20% of Houly Base Rate X Call Hours			93,986.46		$93,986.46	$93,986.46
Total Cost		**$2,551,809.20**	**$1,715,886.65**	**$1,068,660.86**	**$698,292.17**	**$824,992.26**	**$1,523,284.43**
Contribution Margin		($285,817.20)	($582,890.65)	$1,197,331.14			$742,707.57
Contribution Margin per OR		**($71,454.30)**	**($145,722.66)**	**$299,332.79**			**$185,676.89**
Less: Physician/CRNA Shared Staffing Model			$185,676.89				
Contribution Margin Variance per Operating Room			**($331,399.56)**				
Annual Hours On-Call:							
Weeknight Call	254 nights x 12 hours	2,952	2,952	2,952	2,952	2,952	2,952
Weekend Call	104 days x 24 hours	2,496	2,496	2,496	2,496	2,496	2,496
Holiday Call	7 days x 24 hours	168	168	168	168	168	168
Total Hours on Call		**5,616**	**5,616**	**5,616**	**5,616**	**5,616**	**5,616**

CONTRIBUTION MARGIN VARIANCE

(Net Professional Fee Collections - Direct Staffing Costs)

MEDICALLY DIRECTED AA MODEL vs PHYSICIAN and CRNA SHARED STAFFING MODEL

KANSAS HOSPITAL ASSOCIATION SURGICAL CASE VOLUME	**2018**	**2018**	**2018**	**Cases/1042**	**($331,400) per Room**
1,042 Cases = 1 Operating Room Required	**In Pt**	**Out Pt**	**Total**	**= OR Rooms**	**Margin Variance**
The University of Kansas Health System - Kansas City, KS	16,576	35,269	51,845	49.76	($16,488,899)
Advent Health Shawnee Mission - Shawnee Mission, KS	8,857	20,656	29,513	28.32	($9,386,380)
Olathe Health - Olathe, KS	4,177	21,552	25,729	24.69	($8,182,908)
Wesley Healthcare - Wichita, KS	11,157	12,178	23,335	22.39	($7,421,515)
Ascension Via Christi Hospitals St. Francis - Wichita, KS	10,495	10,520	21,015	20.17	($6,683,657)
Stormont Vail Health - Topeka, KS	6,160	14,583	20,743	19.91	($6,597,150)
Menorah Medical Center - Overland Park, KS	5,158	13,113	18,271	17.53	($5,810,950)
Overland Park Regional Medical Center - Overland Park, KS	4,987	6,892	11,879	11.40	($3,778,024)
LMH Health - Lawrence, KS	1,506	8,301	9,807	9.41	($3,119,040)
Hays Med, The University of Kansas Health System - Hays, KS	2,107	7,206	9,313	8.94	($2,961,927)
University of Kansas Health System St. Francis Campus - Topeka	1,917	6,399	8,316	7.98	($2,644,839)
St. Catherine Hospital - Garden City, KS	1,671	6,306	7,977	7.66	($2,537,023)
Saint Luke's South Hospital - Overland Park, KS	2,417	3,837	6,254	6.00	($1,989,036)
Children's Mercy Hospital Kansas - Overland Park, KS	32	5,111	5,143	4.94	($1,635,691)
Salina Regional Health Center - Salina, KS	1,844	2,922	4,766	4.57	($1,515,789)
Ascension Via Christi Hospital Pittsburg - Pittsburg, KS	446	4,204	4,650	4.46	($1,478,896)
Labette Health - Parsons, KS	893	3,350	4,243	4.07	($1,349,453)
Contribution Margin Variance					**($83,581,179)**

Exhibit I

Follow 7 Rules for Billing Anesthesia Medical Direction

Print Post

By Marcella Bucknam, CPC, CPC-H, CPC-P, CPC-I, CCC, COBGC, CCS-P, CCS

When anesthesiologists work with other qualified anesthesia providers, such as certified registered nurse anesthetists (CRNA) and anesthesia assistants (AA), they must follow special documentation requirements to be paid for their medical direction of the case.

The medical direction rules apply when an anesthesiologist works with one to four other qualified providers in overlapping cases. If more than four cases overlap, even for a single minute, this is considered to be medical supervision. Most payers will not reimburse the anesthesiologist for this service. The rules also may be different in teaching hospitals, where residents are involved in patient care.

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

1. Perform a pre-anesthetic examination and evaluation.

The anesthesiologist must personally perform an exam and evaluation prior to the anesthetic session. Although there are no specific rules about what must be evaluated or examined, it's not sufficient simply to document that an exam was performed. The specific system(s) or body area(s) examined and the findings also must be documented.

2. Prescribe the anesthesia plan.

The anesthesiologist must personally decide on the appropriate anesthetic for the procedure (e.g., general anesthesia, regional block, monitored anesthesia care [MAC], etc.), and must document that decision.

3. Personally participate in the most demanding procedures in the anesthesia plan, including (if applicable) induction and emergence.

The anesthesiologist must be in the room and must participate in induction and emergence when those are elements of the service provided. If there are other demanding aspects of the service, depending on the type of anesthesia, the anesthesiologist must be in the room during those services and must document his or her presence and participation.

This requirement can be challenging for a busy anesthesiologist with several cases kicking off at the same time; however, if the anesthesiologist cannot be in the room for one of these "most demanding" elements of the case, he or she cannot bill for medical direction (or the entire case).

4. Ensure a qualified individual performs any procedures in the anesthesia plan that the anesthesiologist does not personally perform.

There are no specific special documentation requirements for this element, but the anesthesiologist must be aware that everyone who participates in the anesthesia care is qualified to perform the service. Everyone who participates in the service must sign in to the case, appending his or her license or certification (e.g., MD, CRNA, AA).

5. Monitor the course of anesthesia administration at frequent intervals.

Although it is not necessary for the anesthesiologist to be in the room for the entire case, he or she must provide appropriate monitoring throughout the case. Monitoring means actual presence in the room where anesthesia is being administered.

6. Remain physically present for all key and critical portions of the procedure, and be available for immediate diagnosis and treatment of emergencies.

The sixth rule is the one that seems to trip up anesthesiologists most often. Because the anesthesiologist is providing direction for several cases, and may have new cases starting while other patients are being transported to the post-anesthesia care unit, and still have other ongoing cases, it's easy for him or her to break medical direction by providing personal anesthesia services to one patient while directing patients in other rooms.

To meet the medical direction requirements, the anesthesiologist cannot be personally providing anesthesia care or handling other services that take more than a few minutes, or that take him or her out of the immediate area where the anesthesia services are being provided.

There are a limited number of services that can be performed without breaking the medical direction rule to remain present and available during the case, including:

- Addressing an emergency of short duration in the immediate area
- Administering an epidural or caudal anesthetic to ease labor pain
- Periodically (rather than continuously) monitoring an obstetrical patient
- Receiving patients entering the operating suite for surgery
- Checking on or discharging patients in the recovery room
- Handling scheduling matters

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not otherwise available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and are not billable as medical direction.

7. Provide post-anesthesia care as indicated.

Anesthesia time continues to run, and the anesthesiologist remains responsible for the patient, until the care of the patient is transferred to another caregiver. The anesthesiologist should document any services performed during post-anesthesia time, especially if the patient requires more care due to adverse reactions. Even if the patient is doing fine, the anesthesiologist is expected to document, at a minimum, that the patient is safe to transfer to someone else.

The anesthesiologist must personally document the above seven components. It's not adequate if someone else documents that he or she did the work, or was present. This information must be documented whenever the anesthesiologist is performing medical direction, no matter what type of anesthesia or analgesia is provided, including MAC.

Some payers may require documentation of these elements for all anesthesia services, even when the anesthesiologist is personally providing the anesthesia service without medical direction.

Other than the anesthesiologist not being allowed to document the required information before the service is performed, there are no specific rules about how monitoring must be documented. For paper records, an anesthesiologist might initial the chart tracking the patient's vital signs, administration of drugs, and other information each time he or she comes into the room and checks on the patient. In electronic records, the anesthesiologist may add a statement that he or she was present for monitoring each time he or she is in the room checking on the patient, or may document at the end of the record that he or she monitored the patient throughout the course of the case. Either solution is acceptable.

Marcella Bucknam, CPC, CPC-H, CPC-P, CPC-I, CCC, COBGC, CCS-P, CCS, is internal audit manager at Chan Healthcare. She is the long-time consulting editor for *General Surgery Coding Alert*, and has presented at five AAPC National Conferences.

United States Department of Justice

Exhibit J

THE UNITED STATES ATTORNEY'S OFFICE
WESTERN DISTRICT of MICHIGAN

Department of Justice

U.S. Attorney's Office

Western District of Michigan

FOR IMMEDIATE RELEASE Thursday, October 10, 2019

Traverse City Practice Pays Over $600,000 To Resolve False Claims Act Allegations Regarding Anesthesia Billing

GRAND RAPIDS, MICHIGAN – U.S. Attorney Andrew Birge announced today that Traverse Anesthesia Associates, P.C. ("TAA"), and six of its anesthesiologists, agreed to pay the United States $607,966 to resolve allegations, under the federal False Claims Act, that they falsely submitted certain anesthesia claims to Medicare. TAA is a medical professional corporation that provides anesthesiology and pain management services at a number of hospitals and outpatient sites in the Traverse City region. The United States specifically contended that, for certain claims billed as medically directed anesthesia services, TAA and its anesthesiologists did not meet the regulatory requirements and conditions of payment for billing those services as medically directed.

This case resulted from a civil lawsuit filed by two whistleblowers who previously worked as employees at TAA. The lawsuit, known as a qui tam action, was filed under the False Claims Act, which allows private whistleblowers to bring lawsuits on behalf of the United States and receive a share of any recoveries. In this case, the Government partially intervened in the whistleblowers' lawsuit. The whistleblowers will collectively receive over $120,000 of the settlement proceeds. The qui tam case is docketed as *United States, et al. ex rel. Stone, et al., v. Traverse Anesthesia Associates, P.C., et al.*, No. 1:18-cv-1416 (W.D. Mich.).

"Those who provide medical services to Medicare beneficiaries and then bill for those services, must ensure compliance with Medicare's billing requirements," said U.S. Attorney Birge. "My office investigates allegations of fraudulent billing and will enforce compliance with Medicare's regulations. Billing Medicare for one level of service, while providing another, is exactly the type of activity that my office will aggressively pursue."

This case was investigated by the U.S. Department of Health & Human Services, Office of Inspector General, and the U.S. Attorney's Office for the Western District of Michigan. Assistant U.S. Attorney Andrew J. Hull represented the United States.

The claims resolved by the settlement are allegations only. There has been no determination of liability.

END

A-0416
§482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

Interpretive Guidelines §482.52

The provision of anesthesia services is an optional hospital service. However, if a hospital provides any degree of anesthesia service to its patients, the hospital must comply with all the requirements of this Condition of Participation (CoP).

The hospital's anesthesia services must be integrated into the hospital-wide QAPI program.

The anesthesia services must be under the direction of a qualified MD/DO. The hospital's medical staff establishes criteria for the qualifications for the director of the anesthesia services in accordance with State laws and acceptable standards of practice. A single anesthesia director must be responsible for the single hospital-wide anesthesia service.

The single anesthesia service is responsible for all anesthesia administered in the hospital. The anesthesia service must be organized and staffed in such a manner as to ensure the health and safety of patients.

Survey Procedures §482.52

- Request a copy of the organizational chart for anesthesia services. Determine that a doctor of medicine or osteopathy has the authority and responsibility for directing the administration of all anesthesia throughout the hospital.

- Request evidence of the director's appointment. Review the position description. Confirm that the director's responsibilities include at least the following:

  - Planning, directing, and supervising all activities of the service

  - Establishing staffing schedules, including written on-call schedule for anesthesia coverage when the department is normally closed

  - Monitoring of the quality and appropriateness of the anesthesia patient care

- Evidence of responsibility for anesthesia services delivered in all areas of the hospital where applicable:

  - Operating room suite(s), both inpatient and outpatient;
  - Obstetrical suite(s);
  - Radiology department;
  - Clinics;

- Outpatient surgery areas.

- Verify that anesthesia services is integrated into the hospital-wide QAPI program.

A-0417
§482.52(a) Standard: Organization and Staffing

The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by –

(1) A qualified anesthesiologist;
(2) A doctor of medicine or osteopathy (other than an anesthesiologist);
(3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
(4) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

§482.52(c) Standard: State Exemption

(1) A hospital may be exempted from the requirement of physician supervision of CRNAs as described in paragraph (a)(4) of this section, if the State in which the hospital is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law.

(2) The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission.]

(5) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

Interpretive Guidelines §482.52(a)

The medical staff bylaws must include criteria for determining the privileges to be granted to an individual practitioner and a procedure for applying the criteria to individuals requesting privileges. The hospital must specify the anesthesia privileges for each practitioner that administers anesthesia, or who supervises the administration of anesthesia by another practitioner. The privileges granted must be in accordance with State law and hospital policy. The type and complexity of procedures for which the practitioner may administer anesthesia,

or supervise another practitioner supervising anesthesia, must be specified in the privileges granted to the individual practitioner. When a hospital permits operating practitioners to supervise CRNA administering anesthesia, the medical staff must specify in the statement of privileges for each category of operating practitioner, the type and complexity of procedures that category of practitioner may supervise. Individual operating practitioners do not need to be "privileged" to supervise a CRNA.

A dentist, oral surgeon, or podiatrist may administer anesthesia in accordance with State law, their scope of practice and hospital policy. The anesthesia privileges of each practitioner must be specified. Anesthesia privileges are granted in accordance with the practitioner's scope of practice, State law, the individual competencies, education and training of the practitioner and the practitioner's compliance with the hospital's credentialing criteria.

A CRNA may administer anesthesia when under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed (unless supervision is exempted in accordance with §482.52(c)). An anesthesiologist's assistant may administer anesthesia when under the supervision of an anesthesiologist who is immediately available if needed. " Immediately available" to intervene includes at a minimum, that the supervising anesthesiologist or operating practitioner, as applicable, is:

- Physically located within the operative suite or in the labor and delivery unit;
- Prepared to immediately conduct hands-on intervention if needed; and
- Not engaged in activities that could prevent the supervising practitioner from being able to immediately intervene and conduct hands-on interventions if needed. The operating practitioner is considered immediately available when he/she is conducting surgery on the patient. CMS does not require a second operating practitioner whose function is to supervise the CRNA.

Survey Procedures §482.52(a)

Review the qualifications of individuals authorized to deliver anesthesia.
Determine that there is documentation of current licensure or current certification status for all persons administering anesthesia.

A-0418

§482.52(b) Standard: Delivery of Services

Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient:

Interpretive Guidelines §482.52(b)

- Policies at a minimum address:

September 3, 2019
Joseph Rodriguez
Why State Legislatures Should Continue Say "No" to Anti-Competitive AA Bills
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September 3, 2019

Why State Legislatures Should Continue Say "No" to Anti-Competitive AA Bills

Joseph Rodriguez
September 3, 2019

(This post is the first in a series and is meant to serve as a broad overview of the topic.)

Across the country, physician anesthesiologists (medical doctors specializing in anesthesia, or “MDA”) have been submitting Anesthesiologist Assistant (AA) legislation with increasing frequency, reportedly with plans for every state in the next few years. AAs have a clear anti-competitive impact.

Why it matters:

AAs are used as market-control tools to limit competition in the anesthesia market, increasing overall health care costs, decreasing access and choice, creating a negative impact locally for patients and communities, and more broadly for the healthcare system.

Background:

- AAs are an assistant profession that have statutory (state law authority) to practice in 14 states and Washington DC. They practice with weaker authority (i.e. physician delegation) in a few other states. Unlike Physician Assistants that practice general medicine under the supervision of any type of physician, AAs cannot practice outside of direct supervision of a MDA. In a deviation from other anesthesia professionals, AAs have no required medical background.
- While AAs have been in existence since the 1960s, MDAs only began to promote them in recent years, seemingly in response to increased competition from CRNAs.

The Anti-competitive Impact:

- CRNAs and MDAs are two professionals with different backgrounds (advanced nursing, medicine). Competition exists within each and between the two professions.
- Because the anesthesiology scope of a CRNA and MDA is identical, when AAs are allowed to practice only with the MDA, it gives MDAs an unlevel playing field – a clear market advantage.
- CRNAs cannot utilize AAs, meaning that CRNAs are placed on an uneven playing field with MDAs, despite offering the same anesthesia service*.
- On a related note, AAs allow MDAs to increase their case revenue by 200%, which creates a huge profit incentive for pushing these pieces of legislation.

> "AAs allow MDAs to increase their case revenue by 200%, which creates a huge profit incentive for pushing these pieces of legislation."

Workforce Issue Solution:

One reason MDAs frequently cite as a reason to this legislation is high demand for anesthesia services. A look past the surface though, reveals it is a problem of their own creation.

In MDA-owned groups, MDAs limit the clinical/facility privileges of CRNAs. By limiting the privledges of CRNAs, they of course create shortages – and subsequently they ask state legislatures for an assistant (the AA) which only the MDA controls. The long-term play is complete market control, especially in the most lucrative markets.

If the desire is to address any perceived workforce problem, a simple fix to the workforce issue is to encourage fuller utilization of CRNAs, as is the trend across the country. This solution would fix any workforce problem (locally or nationally) almost immediately, rather than taking up years of time in state legislatures.

Conclusion:

State legislatures should continue to say "no" to AAs, as they have 22 times in the last 3 years. The public would be best served by supporting the two current major anesthesiology professional: CRNAs & MDAs.

Investing in and removing barriers for current anesthesiology professionals is a better use of resources than a multi-year legislative battles, and the needed creation of a bureaucracy for anesthesia assistants that offer relatively little value for citizens. In doing so, state legislatures can ensure high quality anesthesia services for their constituents, more choices for health care facilities, as well as increased access to care and lower costs.

**Physicians and CRNAs are not identical. One is a medical doctor or doctor of osteopathy, the other is an advanced practice registered nurse. Each has a separate license which authorizes them to perform functions unique to their license. However, the general scope of anesthesia services offered is the same, with normal individual variations.*

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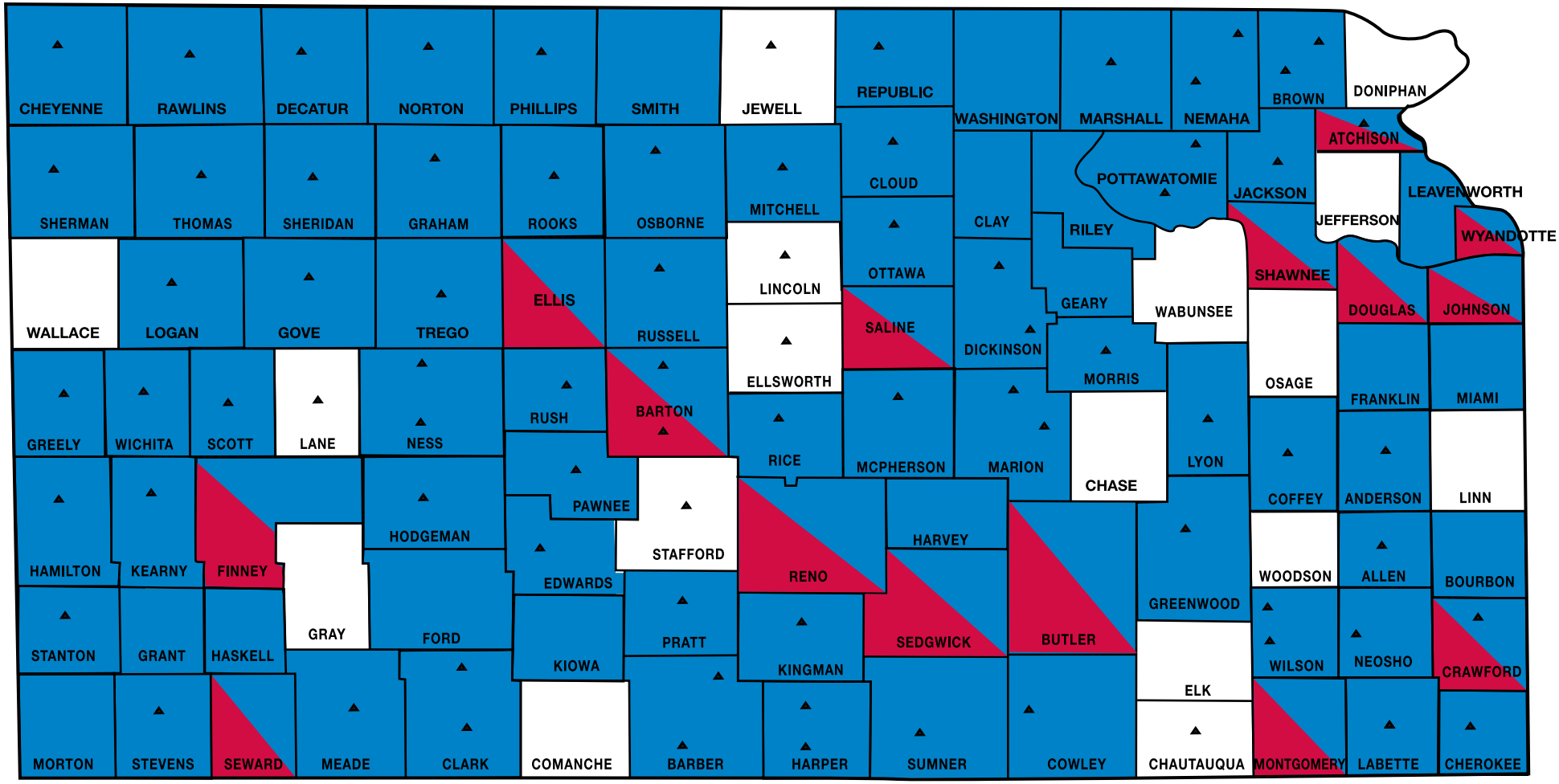
KANSAS ANESTHESIA PROVIDERS

Exhibit M

Coverage by Counties



Kansas Hospital Association Stat Book and
Blue Cross Blue Shield of Kansas Provider Directory

CRNA | **CRNA** and **Anesthesiologist** | **No Anesthesia Providers** | ▲ **Critical Access Hospital**