

INTEGRATING ANESTHESIOLOGIST ASSISTANTS INTO YOUR PRACTICE:

WHAT YOU NEED TO KNOW

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I Introduction

Incorporation of Anesthesiologist Assistants (AA) into your practice will involve an alteration in practice modality from either personally-performed anesthesiologist practice to a medically-directed team format or the introduction of a second type of non-physician provider into an already established care team practice utilizing nurse anesthetists. Either change brings a new paradigm of anesthesia delivery and a distinct set of challenges. The purpose of this document is to provide instruction and guidance to anesthesiology practices that intend to integrate AAs. This document is a guide; specific issues related to incorporation of AAs will vary depending upon state and hospital regulations.

II Credentialing and Privileging

- A. Hospital and Facility:** Initiating the credentialing process for allowing AAs to work in a hospital and in other facilities, such as ambulatory surgery centers (hereinafter, all are termed “facilities”), is multi-procedural and requires significant time. It is smart and time-saving to involve early on the facility’s attorney, director of compliance, and/or director of credentialing in these issues and tasks.
1. Credentialing can occur only after the facility’s bylaws recognize AAs as an approved healthcare practitioner. The process to amend the bylaws should be initiated by an anesthesiologist on staff. Review the facility’s existing bylaws, especially those governing allied health practitioners, to ensure that the proposed amendments do not conflict with any current bylaws.
 2. The process usually will involve more than one meeting of the facility’s credentialing committee, medical staff and/or governing board. Intermediate steps, such as presenting the changes to the bylaws committee (if one exists) may be necessary. The anesthesiologist directing the effort should have strong knowledge of AA education and training, state statutes, medical board rules, and existing facility bylaws regarding allied health practitioners.
 3. The easiest means of creating an AA credentialing process is to have the bylaws mirror the existing language concerning Physician Assistant (PA) credentialing. For example, if the bylaws state that

“PAs must be NCCPA-certified,” change the language to state that “AAs must be certified by the National Commission for Certification of Anesthesiologist Assistants (NCCAA).”

4. Privileges for AAs should mirror those that apply to the department’s nurse anesthetists when they are working in a medically-directed anesthesia care team mode. If there are no nurse anesthetists within the facility, the scope of AA practice should at least follow the scope of AA training and not conflict with any existing AA statutes in your state. Privileges for AAs should indicate that they must work under the medical direction of an anesthesiologist. An example of typical AA responsibilities is in Appendix A.
5. The Department of Anesthesiology Policies and Procedures also must be changed to reflect the adoption of AAs into the practice. Any reference to nurse anesthetists also should include AAs. The term “anesthetists” might optimally be defined to include both practitioners to be used collectively. All pertinent paperwork (records, charge slip) also should include AAs for documentation purposes.

B. Payer: Completely separate from the process of allowing AAs to work in the facility is the need to ensure that anesthesia services provided by AAs receive payment. This process is distinct from the credentialing process for the facility. In this instance, the term credentialing is used by medical insurance companies to describe the process whereby individual practitioners are approved by the insurance company for payment. All medical insurance companies with whom the anesthesiology group contracts for services should be contacted and asked for forms to credential their AAs.

As with other anesthesia practitioners within the group, each AA must be individually credentialed by each insurance company. Usually a form specific to AAs is necessary as many insurance companies will not accept a form where ‘CRNA’ has been marked through and ‘AA’ inserted. Check with each insurance company. If an application to credential an AA is rejected, initiate an appeals process. The anesthesiology group or facility must contact the insurance company and explain that AAs are recognized anesthesia practitioners and entitled to payment by the insurance company for their services.

The Health Care Credentials and Data Collection Act requires standard forms be used to collect credentials data commonly requested by health care plans and health care entities. The extent to which a health care entity, health care plan, or hospital requires a health care professional to submit the applicable information is within the discretion of the health care entity, health care plan, or hospital. Such documentation may include:

1. Information verifying graduation from an accredited and approved anesthesiologist assistant program

2. Work history
3. Hospital Privileges
4. State licensure verification
5. Verification of passing the certifying exam of the National Commission on Certification of Anesthesiologist Assistants (some states permit temporary licensure for 6-12 months while results are pending)
6. Statement/documentation about:
 - a. Physical and Mental Health Status
 - b. Lack of impairment due to chemical dependency/substance abuse
 - c. History of loss of license, certification, or registration
 - d. Felony convictions
 - e. Loss or limitations of privileges
 - f. Disciplinary actions
 - g. Professional liability claims history

C. Summary of AA Education: Qualified AA program applicants possess a baccalaureate degree and have completed all of the premedical course work required by the typical United States medical or osteopathic school. Though minor differences between programs may exist, generalized admission requirements for students seeking entrance into an AA program include:

1. Bachelor's degree from an accredited institution with a premedical sciences track,
2. Two semesters of biology with laboratory,
3. Two semesters of vertebrate anatomy and physiology (or other advanced biology) with laboratory,
4. Two semesters of general chemistry; one semester of organic chemistry; a second semester of organic chemistry or biochemistry with laboratory,
5. Two semesters of general physics with laboratory,
6. Two semesters of advanced college mathematics including calculus, and
7. Either the Medical College Admissions Test (MCAT) or the Graduate Records Admissions Test (GRE),

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits AA training programs. The American Society of Anesthesiologists is a CAAHEP member and participates in the accreditation processes for three health professions— anesthesiologist assistant, respiratory therapy and emergency medical technician-paramedic. CAAHEP, the largest accrediting organization in the health sciences field, reviews and accredits over 2000 educational programs in nineteen occupations.

CAAHEP re-approved the "Standards and Guidelines for Anesthesiologist Assistant Education" most recently in 2009. These standards are composed and submitted by the Accreditation Review Committee on Education for the Anesthesiologist Assistant (ARCAA). ARC-AA is composed of representatives from the American Academy of Anesthesiologist Assistants (AAAA), and the American Society of Anesthesiologists (ASA). Anesthesiologists from ASA work along with AA representatives from AAAA to define the educational process that produces a competent AA graduate. This partnership of professional organizations has ensured an integral role for anesthesiologists in AA education. This in turn echoes the anesthesiologist / AA relationship in the anesthesia care team.

Accredited AA training programs include a minimum of 24 months in a Master's level program and the programs must be based at, or in collaboration with, a university medical school department of anesthesiology and academic anesthesiologist physician faculty. Each AA program must have at least one director that is a licensed, board-certified anesthesiologist. Main clinical sites must be academic medical centers. An average of 600 hours of classroom/laboratory education, 2600 hours of clinical anesthesia education, and more than 600 anesthetics administered, including all types of surgery, are typically required to successfully complete AA training.

Upon completion of an accredited AA program, a student may achieve certification by passing a board examination administered by the National Commission for Certification of Anesthesiologist Assistants (NCCAA). This examination is administered and scored by the National Board of Medical Examiners as part of services contracted to NCCAA. NCCAA awards a time-limited certificate to each candidate who successfully completes the Certifying Examination. To maintain certification, AAs must a) complete 40 hours of CME every two years and b) pass a written test, the Continuing Demonstration of Qualification Exam, every six years.

D. Malpractice

For employees of a physician practice, coverage is usually available for nurses and other staff, sharing limits with the employer at no additional premium. However, some employees such as anesthesiologist assistants and nurse anesthetists sometimes require individual coverage at an additional premium. Any application completed for Malpractice insurance coverage should detail your employees and you should determine if all your employees are covered. If there is more than one health care professional in a group, coverage for the entity is usually given its own policy limits and the premium charge is usually about 10% of what all of the insureds in the group are paying.

Similar to an anesthesiologist, when an anesthesiologist assistant is an employee of the facility, the facility usually provides medical malpractice insurance or self-insures its practitioners. If an anesthesiologist assistant is not a facility employee, but works with a practice that has facility privileges, the practice usually provides this coverage. If the anesthesiologist assistant is a subcontractor who has facility privileges, the anesthesiologist assistant usually provides and maintains his/her own medical malpractice insurance.

E. Delegatory Authority

“Delegate” means to transfer authority for the performance of a medical task to an unlicensed person. Anesthesiologist assistants may be either licensed directly or practice under the license of an anesthesiologist via delegatory authority. In general, under delegatory authority Anesthesiologists may delegate those tasks or duties involved in the practice of anesthesiology to qualified individuals such as AAs, as long as the anesthesiologist is immediately available and the anesthesiologist retains ultimate responsibility for the care of the patient.

Specific language on delegatory authority differs from state to state and practices considering employment of AAs should consult the state board of medicine. In general, delegatory authority may exist in either recognition by the board of medicine or in a statute in the state’s medical practice act. It is well accepted in various medical specialties, including anesthesiology, that the board of medicine may grant a physician the authority to delegate tasks or duties related to the practice of medicine to qualified individuals so long as the physician a) remains ultimately responsible to the patient and b) assures that the individual performing the tasks is qualified to do so.

Whether Anesthesiologist Assistants are directly licensed or practice under a licensed anesthesiologist according to the principle of delegation, an anesthesiologist always medically directs an AA within the Anesthesia Care Team model. Independent and autonomous AA practice is at odds with the purpose of the AA profession.

III Clinical Practice

Anesthesiologist Assistants (AAs) are highly skilled health professionals who work under the direction of licensed anesthesiologists to implement anesthesia care plans prescribed by anesthesiologists. AAs work exclusively within the Anesthesia Care Team (ACT) environment as described by the American Society of Anesthesiologists (ASA).

Anesthesiologist Assistants and nurse anesthetists are both defined as “non-physician anesthetists” within the Centers for Medicare & Medicaid Services (CMS) section of the Code of Federal Regulations.

A. What does the ASA say about AAs?

ASA has stated its position on the function of the Anesthesia Care Team and the role AAs can assume in that model. The ASA has published two statements addressing the role of AAs; both statements are on the ASA website, www.asahq.org:

1. Statement on the Anesthesia Care Team: according to the ASA statement on the Anesthesia Care Team, anesthesia care personally performed or medically directed by an anesthesiologist constitutes the practice of medicine. Certain aspects of anesthesia care may be delegated to other properly trained and credentialed professionals, comprising the Anesthesia Care Team.

The Anesthesia Care Team statement states “delegation and direction should be specifically defined by the anesthesiologist director of the Anesthesia Care Team and approved by the hospital medical staff. Although selected functions of overall anesthesia care may be delegated to appropriate members of the Anesthesia Care Team, responsibility and direction of the Anesthesia Care Team rests with the anesthesiologist.” Members of the medically directed anesthesia care team may include anesthesiology residents as well as non-physicians such as anesthesiologist assistants and nurse anesthetists.

2. Statement on Recommended Scope of Practice of Nurse Anesthetists and Anesthesiologist Assistants

B. Communication Protocols

Consistent and reliable communication between the anesthesiologist and AA is critical to success of the care team. One key element for success of the care team is a defined communication protocol that delineates expectations for how often and in what format colleagues will communicate.

An effective protocol between the anesthesiologist and AA requires that the two individuals understand the format of the information exchange as well as the expected interval between updates. Traditional methods of communication include direct phone call, digital pager, or over-head intercom systems. However, with the advent of new technology, text and instant messaging (IM) platforms may show some utility in communication plans as well. The

communication protocol also should clarify how often the anesthetist will contact the attending anesthesiologist or the anesthesiologist will visit the operative suite. Of equal importance is that the AA communicates when there is a change in patient condition or surgical course.

IV Billing, Coding and Compliance

Groups wishing to incorporate AAs should pay particular attention to billing and compliance guidelines surrounding AA care. When providing anesthesia services, AAs must work with anesthesiologist oversight, as specified under the laws of the state where the anesthesiologists and AAs practice.

A. Medical Direction and Medical Supervision

Anesthesiologists participating in medical direction for the first time will need to learn about the billing terms “medical direction” and “medical supervision” as well as the requirements and documentation for each. Under CMS rules, medical direction involves a higher level of anesthesiologist involvement than medical supervision. The payment for medical direction equals full base and time while that for medical supervision is a flat rate of three or four units. In order to bill for medical direction, the physician must medically direct qualified anesthesia providers in two, three or four concurrent cases and perform the seven specific requirements delineated in Box 1 below. Qualified providers include CRNAs, AAs, residents or combinations of each. CMS regulations stipulate that an anesthesiologist may direct up to four AAs, although state statute and/or medical practice acts may dictate otherwise. Also, teaching rules reduce the number of concurrent cases allowable.

Each case performed under medical direction is reimbursed at 100 percent of the Medicare allowed amount, which is calculated by adding the base unit for the anesthesia code to the total time units for the procedure (total anesthesia time/15, rounded to the nearest tenth) and multiplying by your geographically adjusted anesthesia conversion factor (or managed care conversion factor). The payment is divided equally between the anesthesiologist and the anesthetist. Where the anesthetist and the anesthesiologist work for the same entity, this split billing is a simple bookkeeping operation.

B. Coding Modifiers

The “QK” modifier is used to identify the anesthesiologist’s medical

direction of two, three or four concurrent cases. The “QY” modifier identifies an anesthesiologist’s medical direction of one CRNA. The “QZ” modifier is reported only when nurse anesthetists perform non-medically directed cases and, as this mode of practice is not available to AAs, this code is never attached to AA delivered cases.

C. Documentation of Medical Direction

When shifting from personally performed to Anesthesia Care Team (ACT) practice, one of the most important aspects of consideration are the various responsibilities assumed by the now supervising anesthesiologist. For each medically directed case, the anesthesiologist must perform and document the following (Box 1):

BOX 1: REQUIREMENTS FOR MEDICAL DIRECTION

1. Perform a pre-anesthetic examination and evaluation;
2. Prescribe the anesthesia plan;
3. Personally participate in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
4. Ensure that any procedure in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide the indicated post anesthesia care.

If the anesthesiologist fails to perform and document any of the above requirements, then the service is not considered medical direction.

When medically directing an AA or CRNA, the anesthesiologist may perform other activities only as allowed by CMS (Box 2). A number of regional CMS carriers have allowed a few additional exceptions, including placement of vascular catheters and preoperative and postoperative nerve blocks and epidurals.

BOX 2: ALLOWABLE CONCURRENT ACTIVITIES DURING MEDICAL DIRECTION

1. Addressing an emergency of short duration in the immediate area.
2. Administering an epidural or caudal anesthetic to ease labor pain.
3. Periodic rather than continuous monitoring of an obstetrical patient.
4. Receiving patients entering the operating suite for the next surgery.
5. Checking on or discharging patients from the post anesthesia care unit.
6. Coordinating scheduling matters.

C. Definition of “Immediately Available”

One of the most critical requirements for medical direction is that the anesthesiologist must remain immediately available, by proximity and circumstance, to resume personal care of the patient should conditions dictate. In October, 2012 the ASA House of Delegates approved the following definition of immediately available:

“A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet their medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through careful coordination among anesthesiologists of the same group or department. Differences in the design and size of various facilities, severity of patient illnesses, and the complexity and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity”

D. More information

- . An excellent overview of anesthesia medical direction billing and coding can be found in “Billing for Anesthesia Services and the QZ Modifier: A Lurking Problem” (Byrd, JR, Merrick, SK, Stead, SW. ASA Newsletter, 75:6, 36-38, 2011). In depth information is found in the Medicare Claims Processing Manual (Chap 12: Physician and Non-Physician Providers, Section 50: Anesthesiology Services)

V Public Relations

The success of any attempt to introduce Anesthesiologist Assistants (AA) into a practice will depend greatly on whether the anesthesiologists have explained clearly their motivations and goals to a number of different parties. In this section, we will describe with whom a practice should communicate about AAs and what messages the practice should develop prior to introducing AAs into the practice.

- A. Define clearly your goals** in bringing AAs on board. Prepare to explain how bringing on AAs will lead to achievement of the goals.
1. Cost Effectiveness: are you trying to reduce personnel expense while maintaining or increasing quality of care?
 2. Clinical Goals. Define the benefits:

- i. Flexibility in OR scheduling and staffing
- ii. Freeing up an anesthesiologist to serve in a perioperative capacity
- iii. Support the Anesthesia Care Team: AAs are trained to work under the direction of an anesthesiologist

B. Identify the key players with whom you must speak about AAs AND recognize that the arguments used will vary between each party

1. Other anesthesiologists-your partners- can be the most skeptical of a new type of provider. Their skepticism may result from many factors, including:
 - i. Not understanding the training and qualifications of AAs. You need to tell them about AA training and describe success stories in practices that use AAs. Consider bringing in an anesthesiologist from a practice that already uses AAs to speak about the benefits.
 - ii. Believing AAs are going to seek independent practice. You need to remind them that AAs work only under the medical direction of an anesthesiologist and cannot work independently or under any other physician.
 - iii. The Anesthesia Care Team model is unsafe. This argument likely will come up in a practice in which the anesthesiologists are personally performing their own cases. It is a huge culture shift when a practice moves from personal performance to medical direction. Reassure your partners that this model accounts for 70% of the anesthetics administered daily in the U.S. and has a track record of safety. Consider implementing the change slowly, with anesthesiologists who are more open to change, and in an area of the practice that is low pressure.
 - iv. Not understanding how this change will benefit not just the anesthesiologists directing the AAs, but the entire group. Again, you have to define your goals clearly. Are you reducing personnel costs? Creating more clinical efficiency by freeing up the anesthesiologists for preoperative assessment or placement of blocks? Reducing the need for anesthesiologists to work post-call?

- b. **Surgeons:** your surgical colleagues will need to understand how this change will benefit them and their patients.
 - c. **Administrators:** you will need to describe how this change will improve operational efficiency, reduce expense, and increase patient and surgeon satisfaction
- C. **Resources:** there are numerous resources on the ASA and AAAA websites describing Anesthesiologist Assistants: their history, education and training, and qualifications as midlevel anesthesia providers. These resources will help educate your colleagues, hospital staff, and administrators about AAs and how they can benefit an anesthesiology practice.

VI RESOURCES

A. Websites

1. www.asahq.org
2. www.anesthetist.org
3. www.cms.gov
4. www.aa-nccaa.org

B. Statements and Guidelines

1. **ASA Statement on Comparing Anesthesiologist Assistant and Nurse Anesthetist Education and Practice**
2. **ASA Definition of “Immediately Available” when Medically Directing**
3. **ASA Statement on the Anesthesia Care Team**
4. **AAAA Statement on the Anesthesia Care Team**

Appendix A— Typical AA Clinical Responsibilities

Under the medical direction of an anesthesiologist, AA privileges may include, but are not limited to, the following:

- a. Making the initial contact with a patient to obtain a preliminary preanesthetic health history, perform an appropriate preanesthetic physical examination, and record pertinent data in an organized and legible manner for review by the anesthesiologist. These activities help define the patient's current physical status as related to the planned anesthetic.
- b. Performing or assisting in the conduct of diagnostic laboratory studies as appropriate, such as drawing arterial and venous samples.
- c. Establishing noninvasive and invasive routine monitoring modalities as directed by the anesthesiologist.
- d. Assisting in the application and interpretation of advanced monitoring techniques such as pulmonary artery catheterization, electroencephalographic spectral analysis, echocardiography, and evoked potentials
- e. Assisting in inducing, maintaining, and altering anesthesia levels, administering adjunctive treatment and providing continuity of anesthetic care into and during the postoperative period.
- f. Assisting in the use of advanced life support techniques such as high frequency jet ventilation and intra-arterial cardiovascular assist devices.
- g. Assisting in making postanesthesia patient rounds by recording patient evaluations, compiling and recording case summaries, and transcribing standing and specific orders.
- h. Performing evaluation and treatment procedures essential to responding to life-threatening situations, such as cardiopulmonary resuscitation, on the basis of established protocols
- i. Assisting in the performance of duties in intensive care units, pain clinics, labor and delivery, and other settings, as directed by the anesthesiologist and consistent with their training, education, and scope of practice.
- j. Assisting in the clinical instruction of others.