

President's Page

An Unequal Playing Field: Who can afford 24/7 Obstetrical Anesthesiology Coverage?

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Hospitals, patients, and obstetricians are demanding 24/7 labor epidural and emergency coverage but, in most situations, reimbursement does not cover the costs. It is extremely difficult to provide 24/7 coverage, especially in units with low delivery rates. How “low” is low? It depends on the number of deliveries, insurance mix (full pay indemnity, discounted fee-for-service, capitation, Medi-Cal, no pay), cesarean section rate, epidural rate, and the cost of providing a dedicated anesthesiologist. In my practice with approximately 2,500 deliveries annually, our reimbursement does not cover the cost of providing 24/7/365 dedicated OB anesthesiologist coverage.

Some smaller hospitals, especially those with fewer than 800 surgical procedures/year, are defaulting to nurse anesthetists to provide coverage. Why? A big reason is that under existing Medicare Part A regulations, certain rural hospitals are permitted to pay for the services of nonphysician anesthetists, but not anesthesiologists, on a reasonable-cost basis with reimbursement from the federal government.¹ The nurse anesthetist may be employed or work under contract with the hospital. This provision is intended to induce nurse anesthetists to locate in rural areas; there are no such inducements for anesthesiologists.

This has become an issue in California. I recently received the following e-mail from an anesthesiologist practicing at a rural less than 100-bed hospital in Southern California. In his e-mail he writes:

Recently, the CEO of the hospital told our group that he wants to hire CRNAs to administer labor epidurals in L & D, and wants us to “supervise” them while we are doing cases in the operating room.

My question: Is that really an acceptable practice, in California, for an anesthesiologist to administer anesthesia in one room and “supervise” a CRNA in L & D? Personally, I do not think so, but I would like to know CSA’s stand on this issue, so I have something to back up my claim.

After consulting with CSA Legal Counsel and the CSA Legislative Advocates, I responded with an abridged version of the following information.

In California, the Federal Anesthesia Services Condition of Participation for hospitals, which requires physician supervision of CRNAs, **remains in effect** for any hospital which is participating in the Medicare and Medicaid programs; the patients involved **do not** have to be Medicare/Medicaid patients.

President's Page-Cont'd

Part 482.52 states:

Anesthesia must be administered only by

- a. a qualified anesthesiologist;
- b. a doctor of medicine or osteopathy (other than an anesthesiologist);
- c. a dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
- d. **a CRNA who is under the supervision** of the operating practitioner or of an anesthesiologist who is **immediately available** (*emphasis mine*) if needed; or
- e. an anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed.

Federal law does not define "supervision" or "immediately available." However, it is reasonable to expect the CRNAs to have immediate access to a physician for diagnostic or medical oversight and intervention. Section 1861(r) of the Social Security Act requires hospitals to have physicians available at all times. Optimally, the supervising operating practitioner or other licensed physician should be specifically trained in the sedation, anesthesia and rescue techniques appropriate to the type of sedation or anesthesia being provided and to the surgery being performed.²

Being "**immediately available**" to satisfy the Conditions of Participation is not the same as providing "medical direction" or "medical supervision" as described in the Medicare Carrier's Manual Conditions for Payment.³ "Immediately available" simply means that an identified supervising physician is immediately available.

"**Medical Direction**" occurs if the anesthesiologist personally performs the seven activities described in the Table: Medicare Payment Conditions for Medical Direction of Anesthesiology Services (p. 9). If all seven activities are performed, then the anesthesiologist may bill Medicare for medical direction. The good news is that Medicare does allow an anesthesiologist to administer a labor epidural while concurrently providing medical direction in the operating room. The ASA also uses these seven activities to describe medical direction of the Anesthesia Care Team.⁴ "**Medical Supervision**" for Medicare billing purposes means that the anesthesiologist is medically active in the CRNA's care of the patient, but has not performed all seven of the activities, or the anesthesiologist is involved in providing care for more than four concurrent procedures.

In California, the CRNA's scope of practice is based on California Business and Professions Code Section 2725(b) of the Nursing Practice Act which states that **a nurse may administer medications and therapeutic agents only when they are ordered by and within the scope of licensure of a physician, dentist, podiatrist,**

President's Page-Cont'd

trist or clinical psychologist. The California Nurse Anesthetist Act does not expand the CRNA scope of practice beyond this.

Who is responsible for the acts/omissions of the CRNA? The California Nurse Anesthetist Act specifically states that "a nurse anesthetist shall be responsible for his or her own professional conduct and may be held liable for those professional acts."⁵ However, if the hospital or the physician becomes medically involved in the work (i.e., intervenes in the patient's care) of the CRNA, then the hospital or physician could be held liable for the patient's outcome along with the CRNA. The hospital or physician is also liable for their own acts or omissions in providing medical care and treatment and for being available and responsive to the CRNA. If the hospital employs the CRNA, it assumes a measure of liability for the CRNA's acts, as is the case for all employees. In addition, the Centers for Medicare and Medicaid Services (CMS) point out that the patient's medical and/or surgical care continues to be the responsibility of his or her assigned physician.⁶

What is the answer for the above e-mail?

If an anesthesiologist is **personally** providing anesthesia in the operating room and the CRNA is performing an epidural in Labor and Delivery, then the anesthesiologist is not immediately available to physically respond to the needs of the patient in L & D. However, the obstetrician could be the supervising physician if he/she is immediately available and willing to undertake this role. The obstetrician should make sure that they have medical liability coverage for these added responsibilities.

If the anesthesiologist is medically directing or supervising a CRNA or resident in the operating room, according to Medicare, the anesthesiologist could administer or supervise the administration of a labor epidural.

References

- ¹ February 2003 ASA Newsletter
- ² American College of Surgeons Guidelines for Office Based Surgery 2003
- ³ Medicare Carrier Manual, Part 3 Claims Process, Sections 4830 and 15018
- ⁴ ASA Anesthesia Care Team Statement www.asahq.org
- ⁵ California Business and Professions Code Section 2828 of the Nurse Anesthetists Act
- ⁶ 66 Federal Register 56766 (November 13, 2001); discusses the final rule on physician supervision of CRNAs.

**Table
Medicare Payment Conditions
for Medical Direction of Anesthesiology Services**

Medical direction occurs if the physician medically directs qualified individuals in two, three or four concurrent cases and the physician performs the activities described as follows:

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

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, **administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous monitoring of an obstetrical patient**, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met.

More information may be found at <http://www.asahq.org/Washington/pmfaq.htm#2>.