Basics of Anesthesia Reimbursement

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Objectives

- Identify the difference between Professional Fees and Technical Fees
- Identify what Anesthesia Base Units, Time Units, and Modifiers are
- Identify how Anesthesia services are billed and collected
- Identify the reimbursement differences between Medical Direction vs Medical Supervision vs Solo CRNA
- Identify the value you bring to an Anesthesia Group or Hospital

Professional vs Technical Fees

Professional Fees

- Fees associated with physician professional services only
- All CRNA and MDA services are paid from professional fees

Technical Fees

- Fees associated with facility, equipment and supplies etc
- Does not include professional component built in with this charge

Medicare “Parts”

Part B

- All professional fees
- The sheet that has your start and stop times on it.

Part A

- All facility fees.
- The sheet that has specialized equiptment you might use.

Professional fees

- Gastroenterologist charge for performing the colonoscopy
- Anesthesia charge for sedation
- Pathologist charge for biopsy interpretation

Technical fees

- Outpatient center charge which covers all equipment, supplies, facility space and nursing care

Example: Patient has Outpatient Colonoscopy with Anesthesia and Biopsies

How are Anesthesia Pro Fees calculated

- All Anesthesia charges are based on units
- Every case has a base unit amount assigned to it
- Base unit amounts are published yearly and are based on the complexity of the case and the expected workload of the anesthesia provider required to perform the case
- Base units are constant and do not change unless changed in the yearly RVU guide
- Base Units are then added to time units (each 15 minutes is 1 additional unit) and then any modifiers are added

How are Anesthesia Pro Fees calculated (cont'd)

- Modifiers are any special conditions that affect the anesthesia care given.
- After the base units are added to time units plus any modifiers then we multiply that number to the Conversion Factor to determine the billed amount.
- Medicare publishes it's conversion factors yearly and they are specific to the geographical location in which the service was rendered
- Insurance companies negotiate a dollar per unit conversion factor with each anesthesia group and this amount is typically contractually confidential

Formula for Anesthesia Billing

- Base Units + time units + modifiers x conversion factor = Billed Charges
- Colonoscopy example: Colonoscopy CPT code 00810 5 base units. ASA 3 (due to Obesity, DM, HTN) Insurance Medicare took exactly 30 minutes of CRNA time
- Base Units (5) + Time Units (2) + Modifier (1) x Conversion Factor for La (21.00) = $168

Then what happens?

Staffing Model and Billing Ramifications

- THERE ARE SEVERAL DIFFERENT ANESTHESIA STAFFING MODELS USED THROUGHOUT THE UNITED STATES AND LANA/MANA TERRITORY.
  - MD ANESTHESIA ONLY
  - CRNA ANESTHESIA ONLY
  - TEAM APPROACH TO ANESTHESIA

  (CMS and Most Insurers pay the same way and amount for CRNA and MDA only so we will focus on Team Approach)

Medical Direction

- Must comply with the 7 TEFRA conditions for participation
- MDA cannot Direct more than 4 rooms at any one time

Medical Supervision

- MDA does not have to be physically present in the OR
- MDA can supervise more than 4 concurrent cases
- MDA can be performing "other services" such as blocks while cases being performed by CRNA

Team Approach has two options

- Perform a Pre-anesthetic evaluation and examination
- Prescribe the Anesthetic Plan
- Personally participate in the induction and emergence of anesthesia
- Ensures that any procedure not performed by the MDA is performed by a Qualified Anesthetist
- Monitors the course of the anesthetic at frequent intervals
- Remains physically available for immediate treatment and diagnosis of emergencies
- Provides indicated post op anesthesia care

Tax Equity and Fiscal Responsibility Act, 7 Criteria for Medical Direction

Or is it…..

Reimbursement differences between the two

Medical Direction

- CMS splits payment 50-50 between CRNA and MDA
- BCBS now splits payment 60-40 between CRNA and MDA
- In Mississippi it is 70-30
- All other insurance typically pays whoever gets the bill in first 100% of allowable

Medical Supervision

- MDA is allowed to bill 3 units for supervising a case
- If MDA bills under supervision then the CRNA gets still only 50% of case amount
- Billing Modifiers:
  - AA (MDA Only)
  - AD (MDA Supervision)
  - QK (MDA Medical Direction)
  - QZ (CRNA Only)

Case Study: 8 cases/day, per 1 MDA Group/4 CRNA Hospital Employees

Medical Direction

- 8 cases with average 15 units per case with average conversion factor of $30/unit
- ½ cases Medicare ½ Private insurance
- Total reimbursement for the day is $3,600
- MDA gets $1,800 or more*
- CRNAs get $1,800 or less* divided by the 4 of them ($450 each)

Medical Supervision

- Same cases with same payer mix.
- Total reimbursement is $2,520
- MDA gets to bill 3 units per case for $720
- CRNAs still gets 50%= $1,800
- Which model would the MDA group would prefer?

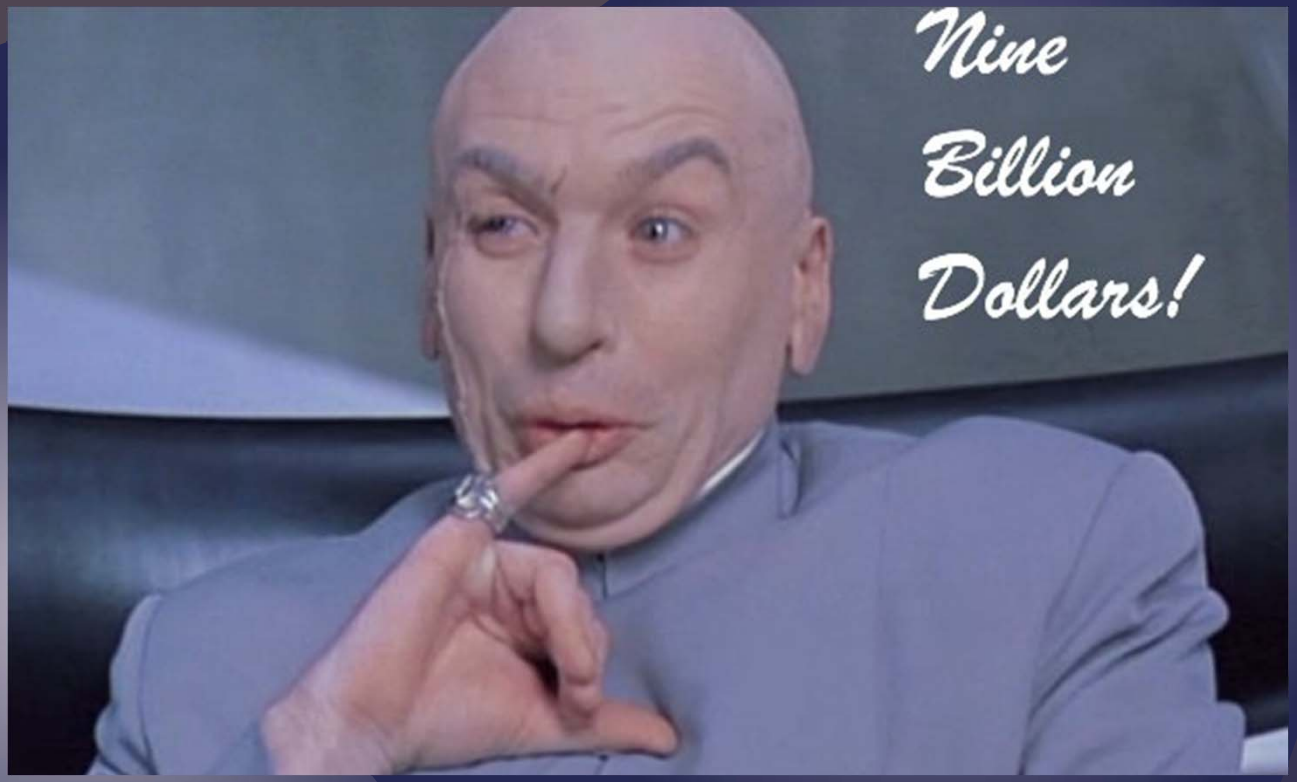
Same Scenario CRNA Only

- The 8 case would still generate the $3,600 of total collections
- Now the 4 CRNAs get to split this amount and each make $900 for the day.
- Now we see the motivation for MDA Direction from the MDA controlled groups
- SO what happens to the CRNAs who were Medically Directed but didn't earn enough to pay for their salary???

Stipend!

Stipend

- Most Hospitals have to pay a stipend to Anesthesia
- Latest data I could find was 57% of Hospitals paid an anesthesia stipend as of 2004. I'm sure that number has only gone up
- By billing under Medical Direction, MDA groups that employ CRNAs can go to administrators and show them that they are unable to collect enough to pay for the high CRNA salaries and demand a stipend to help to pay for the CRNAs.



So what are you worth to your organization?

Q & A

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