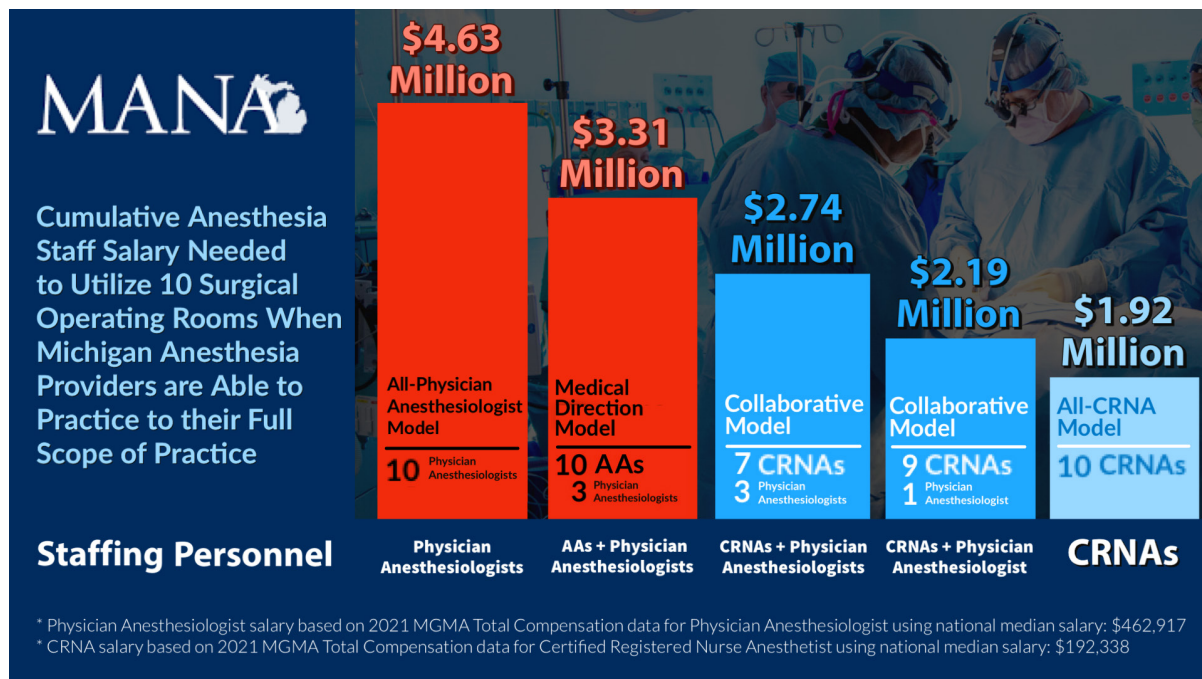


EFFICIENCY-DRIVEN ANESTHESIA MODELING: OPTIMIZING CRNA STAFFING IN MICHIGAN



In July of 2021, Public Act 53 was passed by majority vote into law and formally eliminated any requirement that a Certified Registered Nurse Anesthetist (CRNA) must work under direct physician supervision in the State of Michigan. On May 10, 2022, Gov. Whitmer followed up on this historic and majority legislation by signing a letter to the Centers for Medicare and Medicaid (CMS) opting Michigan out of the federal billing regulation also stipulating physician supervision of CRNAs which has eliminated any suggestion of federal requirement for supervision of CRNAs. Removing these previous barriers to CRNA practice provides superior access to care for all of Michigan while allowing hospitals the opportunity to select the anesthesia delivery model which best suits their needs - optimizing their anesthesia workforce and securing the safest yet affordable care for their patients. Below and listed in order of cost efficiency, from most to least, are summaries of anesthesia practice models currently in use across Michigan.

CRNA ONLY MODEL: The most cost-effective anesthesia delivery model. CRNAs work independently in communication with the surgical team to deliver safe, high-quality patient-centered care. This model delivers extremely high value to the facility with no risk of regulatory violations. CRNA services are submitted to payers with the modifier QZ (CRNA non-medically directed).

COLLABORATIVE ANESTHESIA MODEL (QZ): CRNAs and anesthesiologists (MDAs) work as collaborative and equal partners to personally provide anesthesia services that benefit the healthcare system and the patients they serve. This model delivers a high value to the facility with no risk of regulatory violations that would arise with direction/supervision. MDA services are submitted to insurers with the modifier AA (MDA personally performed services), and CRNA services are submitted to insurers with the billing modifier QZ (CRNA non-medically directed).

ANESTHESIA CARE TEAM MODEL (ACT): CRNAs work under the “medical direction” of an MDA. This model delivers the lowest overall value to the facility because of the financial limitation of a 1:4 MDA:CRNA ratio required for highest reimbursement. There is a higher risk of regulatory penalties under the Federal False Claims Act if the seven requirements of TEFRA are not met. In this model, MDAs must personally 1) perform the pre-anesthetic evaluation and exam; 2) Prescribe the anesthesia plan, 3) Personally participate in the most demanding parts of the anesthetic including induction and emergence; 4) Ensure a qualified individual perform any procedures the MDA does not personally perform; 5) Monitor the course of anesthesia at frequent intervals; 6) Remain physically present for key and critical portions of the procedure and be immediately available for emergencies; and 7) Provide post-anesthesia care as indicated. The absence of any one during a specific time interval would disqualify an entire department from being able to bill under Medical Direction.