Date: March 20, 2013

Re: **FELRA: Sample Wording for Certain Non-Physician Practitioners**

Segal was asked to draft sample wording, in a way that is consistent with industry practice, to allow the plan to extend payment for certain non-physician practitioners, specifically: Certified Registered Nurse Anesthetist (CRNA), Physician's Assistant (PA), Nurse Practitioner (NP), and Certified Surgical Assistant (CSA). Additionally, Segal was requested to create sample wording to prevent payment of both non-physician practitioners and physicians (MD, DO, DPM) who might try to bill the Plan for the same service on the same date of service. The following chart provides both some background information on payment considerations for non-physician practitioners and also some sample language that can be considered as a starting point for SPD wording. Sample wording appears in blue font.

The SPD could be drafted to include within the covered benefits of the medical plan, a section on general rules for payment of non-physician practitioners such as:

General Rules for Plan Payment of Non-Physician Practitioners:

- The service provided must be a) a covered benefit under the Plan, b) medically necessary (as determined by the Plan Administrator or its designee) and c) provided by a non-physician practitioner in lieu of services performed by a Physician.
- The service must be provided by a non-physician practitioner who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered employee.
- Payment of services to a non-physician practitioner is in accordance with the Plan's "allowed charges," defined as the lesser of:
  a. for network providers, the PPO contracted rate, or
  b. for non-network providers, the amount considered to be usual, customary and reasonable by the Plan or
  c. billed charges.
- Services of a non-physician practitioner will not be payable if a claim from a Physician is received for the exact same service on the same date of service.
- This Plan pays for only one assistant surgeon per covered surgical procedure per date of service.

This wording above could also be expanded to address both Physicians and Non-physician. After this lead-in general rules wording, the SPD could then state the specific reimbursement provisions as outlined in blue font in the chart on the next pages.

<table>
<tr><th>Type of Non-Physician Practitioner</th><th>Background Information</th><th>Sample SPD Wording</th></tr>
<tr><td>Certified Registered Nurse Anesthetist (CRNA)</td><td>In the US, anesthesia services can be provided by a physician (and MD or DO commonly called an anesthesiologist), or by non-physicians, such as a Certified Registered Nurse Anesthetist (CRNA) or an Anesthesia Assistant (AA) who are commonly called “anesthetists”.

A Certified Registered Nurse Anesthetist is a Registered Nurse, properly licensed, with advanced training and certification to render anesthesia. A CRNA can work independently of an anesthesiologist. An Anesthesia Assistant (AA) requires a four year college degree and a two year academic Master’s Program specializing in anesthesia. An AA works only under the supervision of an anesthesiologist.

Medicare (as the largest claims payer in the US) pays CRNA as follows:
• Non-medically directed CRNA services are reimbursed by Medicare Part B at 100% of a Medicare fee through the anesthesia fee schedule. This payment is appropriate when a CRNA provides the entire anesthesia service, or when an anesthesiologist is involved in a case but not to a degree sufficient to warrant a claim for anesthesiologist medical direction.
• Medically directed CRNA services are reimbursed by Medicare Part B at 100% of a Medicare fee through the anesthesia fee schedule, with the CRNA being paid 50% of the fee and the medically directing anesthesiologist being paid the remaining 50% of the fee.
• Medically supervised CRNA services are reimbursed by Medicare Part B at more than 50%, but less than 100%, of a Medicare fee through the anesthesia fee schedule. The medically supervised CRNA is reimbursed 50% of the Medicare fee, while the medically supervising anesthesiologist is reimbursed 2 or 3 base units for each case in which the anesthesiologist is involved.
• To Medicare the term “medical direction” is not the same as supervision, and is instead a level of physician involvement in a case that is greater than supervision (see page 7 of this document).
Most major insures follow Medicare guidelines for anesthesia payment too. National Code Manuals (such as CPT and HCPCS) outline the required provider coding for all claims, including anesthesia services, and these codes help identify the type of anesthesia service rendered.</td><td>Anesthesia services submitted by a Certified Registered Nurse Anesthetist (CRNA) are payable as follows:
• 100% of the claim is considered for payment to the CRNA when the CRNA is the sole provider for the entire anesthesia service;
• 50% of the claim is considered for payment to the CRNA when a portion of the entire anesthesia service was rendered by a combination of CRNA and a physician anesthesiologist. (Anesthesiologist’s claim is also considered for payment at 50%).
Claims are payable in accordance with the Plan’s “allowed charges” for network and non-network providers.

A helpful chart for claims admin staff or to put the SPD might look like this:
<table>
<tr><th>Type of Anesthesia Claim Submitted</th><th>% of Allowed Charges payable by the Plan</th></tr>
<tr><td>Physician Anesthesiologist Performed All the Anesthesia Services</td><td>100%</td></tr>
<tr><td>Non-Physician Anesthetist Performed All the Anesthesia Services</td><td>100%</td></tr>
<tr><td>Physician Anesthesiologist medically directed the CRNA</td><td>50% to the Physician and 50% to the CRNA</td></tr>
<tr><td>Physician Anesthesiologist medically supervised the CRNA</td><td>Physician: 3 base units +1 time unit (if present at induction).
CRNA: 50% of allowed charges.</td></tr>
</table>
</td></tr>
</table>

Type of Non-Physician Practitioner	Background Information	Sample SPD Wording
Nurse Practitioner (NP)	A Nurse Practitioner is a Registered Nurse, licensed by the state, with additional graduate level education and training to reach the level of nurse practitioner. Medicare and most major commercial insurance companies reimburse the services of a Nurse Practitioner. Nurse Practitioners can perform services similar to physicians, such as office visits and can also assist at a surgery. The American College of Surgeons (ACS) has determined that assistant surgeon services are required for the successful completion of certain surgical procedures that have been identified as sufficiently complex or intensive. Providers rendering assistance at surgery (commonly called "Assistant Surgeon" services) must report such services by coding their claim with the modifier 80, 81, 82, or AS, as appropriate: 80 Physician providing assistance in surgery 81 Physician providing minimum assistance in surgery 82 Physician providing assistance in surgery when qualified resident not available AS Non-physician providing assistance in surgery, such as Physician Assistant (PA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS).	When a Nurse Practitioner submits a claim for a covered service (that is not an assistant surgery claim), the claim is considered for payment at 100% of the allowed charge, reduced for appropriate network or non-network status. If a Nurse Practitioner submits a claim having performed services as an assistant at a surgery, the plan will determine if the surgery is a covered benefit and if the use of an assistant was medically necessary. If so, for services as an assistant at surgery the Plan will pay: • For a Nurse Practitioner, 16% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status. • For a Physician, 20% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status. *Note: non-physician practitioners want the same 20% reimbursement as a physician so if the Plan decides to pay them less, say 16%, and the non-physician practitioner is not a network provider, the non-physician practitioners can balance bill the patient. The balance billing could come back to the Plan as a claim appeal.*

Type of Non-Physician Practitioner	Background Information	Sample SPD Wording
Physician Assistant (PA)	A Physician Assistant is a person who has completed a qualified PA program (at least a 26 month program) and passes a national certification exam. Most states also require licensure as a Physician Assistant. Medicare and most major commercial insurance companies reimburse the services of a Physician's Assistant. The American College of Surgeons (ACS) has determined that assistant surgeon services are required for the successful completion of certain surgical procedures that have been identified as sufficiently complex or intensive. Providers rendering assistance at surgery (commonly called "Assistant Surgeon" services) must report such services by coding their claim with the modifier 80, 81, 82, or AS, as appropriate: 80 Physician providing assistance in surgery 81 Physician providing minimum assistance in surgery 82 Physician providing assistance in surgery when qualified resident not available AS Non-physician providing assistance in surgery (such as Physician Assistant (PA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS).	When a Physician Assistant submits a claim for a covered service (that is not an assistant surgery claim), the claim is considered for payment at 100% of the allowed charge, reduced for appropriate network or non-network status. If a Physician Assistant submits a claim having performed services as an assistant at a surgery, the plan will determine if the surgery is a covered benefit and if the use of an assistant was medically necessary. If so, for services as an assistant at surgery the Plan will pay: • For a Physician Assistant, 16% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status. • For a Physician, 20% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status. *Note: non-physician practitioners want the same 20% reimbursement as a physician so if the Plan decides to pay them less, say 16%, and the non-physician practitioner is not a network provider, the non-physician practitioners can balance bill the patient. The balance billing could come back to the Plan as a claim appeal.*

Type of Non-Physician Practitioner	Background Information	Sample SPD Wording
Certified Surgical Assistant (CSA).	Certified Surgical Assistants are individuals who have at least a high school degree or GED and have graduated from a Surgical Assistant Training Program. They are generally not licensed. There is a push for state laws to require insurance companies to cover claims submitted from CSAs but no national trend yet. CSAs are not reimbursed by Medicare and Medicaid. Most insurers do not credential CSAs as network providers, but most commercial insurers do reimburse for CSA services…. generally as non-network providers. As a non-network provider, many insurance companies do not send claim reimbursement directly to the provider, instead they send reimbursement to the patient who is then responsible to send the payment on to the CSA provider. The determination of whether there is an assistant at a surgery and who is performing that service is the responsibility of the primary surgeon. Unfortunately, it happens somewhat frequently that an in-network surgeon uses a non-network assistant. The American College of Surgeons (ACS) has determined that assistant surgeon services are required for the successful completion of certain surgical procedures that have been identified as sufficiently complex or intensive. Providers rendering assistance at surgery (commonly called "Assistant Surgeon" services) must report such services by coding their claim with the modifier 80, 81, 82, or AS, as appropriate: 80 Physician providing assistance in surgery 81 Physician providing minimum assistance in surgery 82 Physician providing assistance in surgery when qualified resident not available AS Non-physician providing assistance in surgery, such as Physician Assistant (PA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS).	When a Certified Surgical Assistant submits a claim having performed services as an assistant at a surgery, the plan will determine if the surgery is a covered benefit and if the use of an assistant was medically necessary. If so, for services as an assistant at surgery the Plan will pay: • For a Certified Surgical Assistant, 16% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status. • For a Physician, 20% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status. *Note: non-physician practitioners want the same 20% reimbursement as a physician so if the Plan decides to pay them less, say 16%, and the non-physician practitioner is not a network provider, the non-physician practitioners can balance bill the patient. The balance billing could come back to the Plan as a claim appeal.*

Putting all the sample suggestions together, a plan amendment might read:

General Rules for Plan Payment of Non-Physician Practitioners:

- The service provided must be a) a covered benefit under the Plan, b) medically necessary (as determined by the Plan Administrator or its designee) and c) provided by a non-physician practitioner in lieu of services performed by a Physician.
- The service must be provided by a non-physician practitioner who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or child of the patient or covered employee.
- Payment of services to a non-physician practitioner is in accordance with the Plan's "allowed charges," defined as the lesser of:
  a. for network providers, the PPO contracted rate, or
  b. for non-network providers, the amount considered to be usual, customary and reasonable by the Plan or
  c. billed charges.
- Services of a non-physician practitioner will not be payable if a claim from a Physician is received for the exact same service on the same date of service.
- This Plan pays for only one assistant surgeon per covered surgical procedure per date of service.

a. Anesthesia services submitted by a Certified Registered Nurse Anesthetist (CRNA) are payable as follows:

Type of Anesthesia Claim Submitted	% of Allowed Charges payable by the Plan
Physician Anesthesiologist Performed All the Anesthesia Services	100%
Non-Physician Anesthetist Performed All the Anesthesia Services	100%
Physician Anesthesiologist medically directed the CRNA	50% to the Physician and 50% to the CRNA
Physician Anesthesiologist medically supervised the CRNA	Physician: 3 base units +1 time unit (if present at induction). CRNA: 50% of allowed charges.

b. When a Physician Assistant (PA) or Nurse Practitioner (NP) submits a claim for a covered service (that is not an assistant surgery claim), the claim is considered for payment at 100% of the allowed charge, reduced for appropriate network or non-network status.

c. If a Physician Assistant, Nurse Practitioner or Certified Surgical Assistant (CSA) submits a claim having performed services as an assistant at a surgery, the plan will determine if the surgery is a covered benefit and if the use of an assistant was medically necessary. If so, for services as an assistant at surgery the Plan will pay:
   - For a Physician Assistant, Nurse Practitioner or Certified Surgical Assistant, 16% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status.
   - For a Physician, 20% of the allowed charge that is payable by the Plan to the primary surgeon, reduced for the appropriate network or non-network status.

HTTP://WWW.LAW.CORNELL.EDU/CFR/TEXT/42/415.110

42 CFR 415.110 - CONDITIONS FOR PAYMENT: MEDICALLY DIRECTED ANESTHESIA SERVICES.

§ 415.110

Conditions for payment: **Medically directed anesthesia services**.

(a) General payment rule. Medicare pays for the **physician's medical direction of anesthesia services** for one service or two through four concurrent anesthesia services furnished after December 31, 1998, only if each of the services meets the condition in § 415.102(a) and the following additional conditions:

(1) For each patient, the physician—

(i) Performs a pre-anesthetic examination and evaluation;

(ii) Prescribes the anesthesia plan;

(iii) Personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence;

(iv) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in operating instructions;

(v) Monitors the course of anesthesia administration at frequent intervals;

(vi) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) Provides indicated post-anesthesia care.

(2) The physician directs no more than four anesthesia services concurrently and does not perform any other services while he or she is directing the single or concurrent services so that one or more of the conditions in paragraph (a)(1) of this section are not violated.

(3) If the physician personally performs the anesthesia service, the payment rules in § 414.46(c) of this chapter apply (Physician personally performs the anesthesia procedure).

(b) Medical documentation. The physician alone inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) of this section have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

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