

Anesthesiologist Assistants: Practical Practice Points

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Anesthesiologist assistants (AA) were created in the 1960s by J.S. Gravenstein, M.D. and John E. Steinhaus, M.D. for the purpose of extending the reach of anesthesiologist-directed care. AA educational programs require the medical director to be a board certified anesthesiologist, and the AA program must be affiliated with a medical school that meets the criteria for an anesthesiology residency program. Trained in the anesthesiologist's environment and taught the practice philosophy of the anesthesiologist, AAs support the anesthesia care team (ACT) and only practice with the medical direction of an anesthesiologist.

Expansion of AA practice has been methodical due to a limited number of graduates and the ever-present opposition of the nurse anesthetists. However, as Bob Dylan said, "the times they are a changing ..." So is the prominence of the AA within the ACT. With ASA recognition and endorsement of AAs as valuable members of the ACT, AAs now practice in 17 states and the District of Columbia. In clinical practice within the anesthesiologist-led anesthesia care team, AA scope of practice is the same as the nurse anesthetist. However, many stark differences exist between the two non-physician anesthesia practitioners when they are compared on philosophy of education and practice. NAs' education is grounded in nursing philosophy, they consider anesthesia the practice of nursing, and conceptually believe that anesthesiologist oversight of patient care is unnecessary and limits their practice. In contrast, the AA profession was created by anesthesiologists desiring to create an improved anesthesia care team mid-level provider grounded in the paramount importance of anesthesiologist-led anesthesia care. At every level of AA education, anesthesiologists have the opportunity

for heavy influence. And clinically, from credentialing and licensing to anesthesia care delivery, anesthesiologists have direct oversight and are integrally involved. Because of the ideal alignment of purpose and practice between anesthesiologists and the AAs, this synergistic relationship extends beyond educational and clinical arenas and into the political realm. The American Academy of Anesthesiologist Assistants (AAAA) aligns itself side-by-side with the ASA on issues of mutual importance and demonstrates this irrefutably by strong support of the ASAPAC, serving on the ASAPAC Executive Board and carrying unified messaging while lobbying in state capitals and Washington, D.C.

In states that allow AA practice via the delegatory authority provided to physicians through the state Medical Practice Act, AA scope of practice may simply be limited to duties within the scope and training of the individual AA that are delegated by the supervising anesthesiologist. Other states may provide authority for AA practice through specific legislation creating licensure for AAs. The scope of AA practice may be defined by several entities, including statute, state medical board, facility credentialing body and the supervising anesthesiologist. State legislative statutes may include scope of practice language, but often allow regulations to be promulgated by the medical board. State medical boards may require a practice agreement between the AA and the supervising anesthesiologist affirming that the AA will only practice under the medical direction of the anesthesiologist or a suitable alternate anesthesiologist. Additionally, credentialing bodies may require a delineation of privileges outlining the scope of AA practice within the individual facility. The combination of each possible definition of AA practice should be scrutinized to ensure compliance with all statutes, rules and regulations.

AAs can be found throughout the states currently allowing AA practice providing the highest quality care in the ACT setting. Working under the medical direction of an anesthesiologist, AA practice locations include, but are not limited to, outpatient ambulatory centers, large teaching institutions and private hospitals. AAs provide anesthesia for all types of cases, including pediatrics, cardiac and procedures outside of the O.R. Dedicated first and foremost to excellent patient care through the ACT concept, AAs have assimilated and thrived in previously all M.D./D.O. practices, teaching institutions and ACT practices employing nurse anesthetists.





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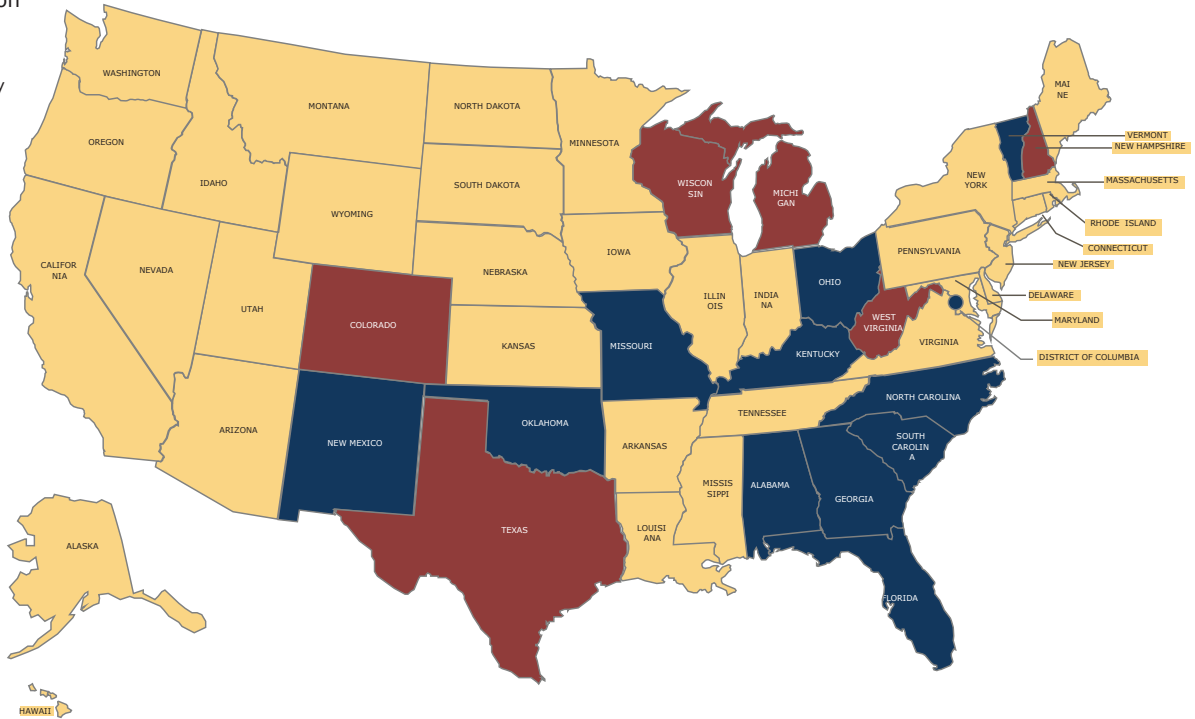


AMERICAN ACADEMY OF ANESTHESIOLOGIST ASSISTANTS
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Anesthesiologist Assistant Work States

Practice Authorization

-  Licensure
-  Delegatory Authority



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The Code of Federal Regulations officially recognizes AAs as qualified anesthetists for both the Department of Veterans Affairs and the Centers for Medicare & Medicaid Services (CMS). When seeking reimbursement for services provided by an AA, one should confirm the acknowledgement of AAs as authorized practitioners with private insurance companies to avoid confusion and also use care to provide the proper modifier if necessary. The acceptable ratio to qualify for medical direction under CMS rules is a maximum of 4:1. For CMS, the “QK” modifier is utilized (in conjunction with “QX”) when the anesthesiologist concurrently medically directs two, three or four AAs or CRNAs, or any combination of the two types of anesthetists. The “QY” modifier (in conjunction with “QX”) should be used when the anesthesiologist medically directs one AA or CRNA and no concurrent cases. It should be understood that all seven steps of medical direction apply when submitting a claim for medical direction of either an AA or CRNA. Student AAs should work directly with and alongside an AA, resident, fellow, CRNA or attending

anesthesiologist. As such, there is no appropriate CMS modifier for medical direction of an AA student. State statutes and medical board rules should be consulted to confirm adherence to state laws and regulations regarding supervision ratios.

Malpractice insurance for AAs is readily available. Whether an individual policy or incorporating an AA's coverage into a corporate policy, AA malpractice insurance is on par with that of nurse anesthetists practicing in the ACT model under the medical direction of an anesthesiologist.

Thanks to the reputation of excellent care provided by AAs, the efforts of the AAAA and the unrivaled support of the ASA, AAs have defined their role as valuable members of the ACT. Armed with some practical practice information about AAs, I encourage ACT practices and M.D./D.O.-only practices considering the implementation of some ACT to take a serious look at AAs and what they can do for you and your practice.