CRNA Fee for Service Database

In Partial Fulfillment of the Requirements

For the Degree of

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ABSTRACT

This pilot study was initiated to develop a database of Certified Registered Nurse Anesthetists (CRNAs) participating in fee for service (FFS). The working hypothesis estimates this population as 1%-4% of all CRNAs; 550-2,200 respectively. There are no known databases available and no benchmarks have been established for commercial reimbursement rate comparisons.

Objective: To develop a FFS CRNA database comprising at least 10% of the total estimated population.

Method: The pilot study commenced September 2020 and extended through January 30, 2021. Characteristics associated with FFS CRNAs were identified as independent practice, owner/partner of CRNA or joint CRNA/physician group, or works without anesthesiologists. A Qualtrics survey was deployed utilizing nonprobability, snowball sampling to target CRNAs matching these characteristics. The survey was comprised of 3 questions that required an affirmative answer to at least 1 of the 2 predefined criteria for selection. Survey links were published on targeted social media sites and directly emailed to 2,692 CRNAs who selected shared characteristics on the AANA membership profile.

Results: 568 responses; 328 were eligible from 43 states.

Conclusion: Pilot study results met objectives with a database comprising 15%-60% of the FFS population estimate.

Keywords: fee for service, CRNA independent practice, reimbursement, payers, QZ

INTRODUCTION

This pilot study was initiated to develop a database of Certified Registered Nurse Anesthetists (CRNAs) participating in fee for service (FFS). Many studies exist that address CRNA salaries and other compensation benefits when practicing as an employee or an independent contractor.[1] However, there are no published studies that address CRNAs or CRNA-led practices that rely on compensation from revenue sources tied to FFS billing. The total number of CRNAs who participate in FFS is estimated as 1%-4% of the more than 55,000 CRNAs who are licensed and certified.[2] Currently, there is no database selective to this subset of CRNAs and reimbursement benchmarks have never been established. The purpose of database development is for use in follow-up research, as the primary resource for study focused on CRNA reimbursement benchmarks.

REVIEW OF LITERATURE

CRNAs have been providing anesthesia to patients in the United States for more than 150 years. The CRNA credential originated in 1956; today, CRNAs perform more than 50 million anesthetics each year. The American Association of Nurse Anesthesiologists (AANA) is a professional practice association comprised of 63,000 CRNAs and student nurse anesthetists, making up 90% of all CRNAs.[3] The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) estimates more than 55,000 CRNAs are currently certified, licensed, and practicing in the United States.[2] CRNAs provide all types of anesthesia services in all practice settings and geographical locations.

Developing a database for this specific population is a complex process. There is no clear method for segregating FFS CRNAs from the general CRNA population. Claim submission databases have been utilized in the past to separate CRNAs providing FFS through the QZ

modifier. These methods have failed to recognize that the QZ modifier no longer represents independently practicing CRNAs.[4,5] Nowadays, physician-led practices utilize the QZ modifier, even though anesthesiologists (ANs) are working in the same facility, to ensure maximum reimbursement without the payment concerns associated with failing medical direction requirements.[6,7] Due to widespread use of the QZ modifier for these purposes, it is no longer effective as a single resource in identifying nonmedically directed CRNAs involved in FFS.[4,5] Instead, these claims may more accurately reflect the number of procedures failing medical direction requirements by physician-led practices than procedures provided by independently practicing CRNAs.[7]

Hospitals and surgery centers have increasingly turned to CRNAs for safe, cost-effective alternatives to traditional physician-led anesthesia delivery models.[8,9] Anesthesia delivery by CRNAs is often the only viable economic option for facilities running fewer than 4 rooms. In these situations, case volume reimbursement is insufficient to support an AN directing multiple CRNAs. Facilities are outsourcing anesthesia services to CRNA groups equipped in all aspects of care, including the complexities associated with anesthesia billing. Consequently, an increased number of CRNA-led groups are seeking participation with commercial payers as “in-network” providers.

The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989.[10] CRNAs are the *only nursing specialty* authorized by Medicare Part B to receive direct reimbursement *at 100% of the physician fee schedule,* while all other nursing specialties receive a lesser percentage.[11]

The commercial insurance industry is a highly competitive, profit-driven enterprise that relies on the longstanding practice of transactional secrecy and nondisclosure agreements when

negotiating provider rates. These secrecy laws arise from antitrust legislation designed to prevent "price-fixing" practices by groups of providers attempting to leverage higher rates by colluding with one or more of its competitors.[12] Unlike Medicare, commercial payers do not offer uniform or set rates to their participating providers. Nondisclosure payer policies prevent participating providers from comparing rates. The lack of transparency associated with commercial rate negotiations makes it nearly impossible for CRNA providers to know if their rate negotiations are market competitive or equitable to physician counterparts when providing the same service.

Although these laws were intended to eliminate abuse by providers, an unintended consequence benefits the commercial insurance industry. Negotiations shrouded in secrecy leave specific providers such as CRNAs vulnerable to exploitation and discrimination without any evidentiary means to support a claim of this nature. The Affordable Care Act requires commercial payers to reimburse providers nondiscriminately regardless of licensure when performing the same service.[13] This law promotes competition and consumer choice by prohibiting discrimination policies that reduce patient access to care. Regardless, commercial payers have been known to reimburse CRNAs significantly less than physician counterparts using "licensure" as the basis for this rationale rather than performance and quality.

The American Society of Anesthesiologists (ASA) has overcome some challenges associated with these antitrust secrecy laws by performing anonymous yearly reimbursement rate surveys for its physician members.[14] These surveys are constructed in compliance with antitrust laws and give valuable insights that are critical for contract negotiations. Commercial rates published in these ASA surveys are reflective of the national average rates negotiated by physician-led practices for all billing modifier codes. CRNA-led practices have no similar surveys and no

benchmarks established for comparison that selectively isolate the QZ modifier associated with non-medically directed CRNA services.

In October 2020, the Departments of Health and Human Services (HHS), Treasury, and Labor issued the "transparency in coverage" final rule.[15] The rule imposes new transparency requirements on group health plans and health insurers in the individual and group markets that went into effect January 1, 2021. This rule may require insurers and providers to remove gag clauses and other restrictions from their contracts going forward, which could make competitor rates publicly available.[16] Until these rates become available, it is important for CRNAs to establish their own benchmarks for commercial reimbursement rates for comparison when negotiating rates.

The Medicare regulation update, as part of a November 2012 final rule,[17] further clarified the authorization of direct reimbursement of CRNA services within the provider's state scope of practice by stating, "Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist…who is legally authorized to perform the services by the State in which the services are furnished."[18-20] CMS provides relevant reasoning in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law.

METHODS

The Missouri State University Institutional Review Board (IRB) determined this project to be IRB exempt. The following shared characteristics associated with FFS database selection were identified: (1) working in independent practice, ie, owner/partner of CRNA or joint CRNA/physician group; (2) working as an independent contractor; (3) or working in settings

without ANs. A Qualtrics survey was deployed utilizing nonprobability, snowball sampling to target CRNAs on various sites which might include higher numbers of CRNAs matching these generalized characteristics (Appendix A). The survey tool was designed to further refine characteristics from "generalized" to those more specific to FFS CRNAs. The survey consisted of 3 questions that isolated these characteristics. Two of the 3 questions established eligibility criteria. An affirmative answer to at least 1 of these 2 questions established eligibility. Survey links were directly emailed to 2,692 AANA CRNAs who self-identified with shared characteristics on the membership profile.[21] The survey link was distributed anonymously and was not tied to the location from which it was accessed; participant contact information was voluntarily submitted (see Appendix B).

Characteristics

Shared generalized characteristics of FFS CRNAs

1. Independent contractor;
2. Independent practice as commonly seen in an owner/partner of CRNA group or an owner/partner of a joint CRNA/physician group; and
3. Works independently without ANs.

Specific characteristics of FFS CRNAs

1. Contracts with commercial insurance payers and government programs such as Medicare and Medicaid for the provision of nonmedically directed anesthesia services under the QZ modifier;
2. Provides FFS billing for self or for other CRNAs; and
3. Has access to billing reports that include case volume, type of procedures, payer contracts, contracting rates, total units billed, and accounts receivable.

Qualtrics Survey

The following 3 questions served to further refine the population from "shared" to more specific characteristics among FFS CRNAs. An affirmative answer to either Q1 or Q13 defines eligibility and isolates these specific characteristics. CRNAs meeting eligibility were offered the option to voluntarily opt into the database. Q12 further filters those eligible to determine the CRNA's level of involvement in the "hands-on" provision of care.

Each question defines nonmedically directed (QZ) services as CRNA administration of anesthesia without AN medical direction.

- **Q1:** Do you have access to billing reports that show CRNA commercial insurance claims data for nonmedically directed (QZ) anesthesia services?
- **Q12:** Do you, or the group you work for, provide nonmedically directed (QZ) anesthesia services?
- **Q13:** Do you, or the group you work for, bill commercial insurance companies directly for nonmedically directed (QZ) anesthesia services?

Nonrandomized Targeted Sites

Multiple target populations were selected for survey link distribution, including AANA and social media groups, billing companies with CRNA clients, and state presidents for membership distribution. The AANA distributed the survey through direct email solicitations to 2,692 members identified with "shared" characteristics through membership profile information.[21]

The total was calculated by taking the numbers within these groups and removing duplicate entries. Members who had previously opted out of future surveys were removed (see Table 1).

Table 1. Target populations and final sample for direct email dissemination

Profile Source	Employment Arrangement	Count
	Independent contractor for CRNA-only group	488
	Independent contractor for hospital	467
	Independent contractor for joint CRNA/physician group	710
	Independent contractor for office/clinic	175
	Owner/partner of CRNA-only group	633

	Owner/partner of joint CRNA/physician group	131
	Other	110
Profile Source	**Answered "Never" to "Do you work in an anesthesia care team model where the anesthesiologist medically directs the CRNA?" on the clinical profile.**	1,968
	Duplicates	-1028
	Opt-out of All Surveys	-962
	Grand Total Surveyed Via AANA	2,692

Other targeted sites included Facebook and AANA Connect. Billing companies forwarded the link to their CRNA clients, and several state association presidents sent the survey to all the state members. A landing page was developed on the Excel Anesthesia website with detailed information regarding the study and a link to the Qualtrics survey. A link to the landing page was created and also used in follow-up reminders posted on the social media sites and within direct email correspondence. Appendix B includes copies of the lead letters of solicitation disseminated through various media sources and emails as well as follow-up correspondence aimed at optimizing responses.

FFS-CRNA Population Estimate: 1%-4%

The total population of FFS CRNAs is unknown. A baseline estimate of this population subset is necessary for establishing the sample size criteria. The pilot study working hypothesis estimates the FFS population as 1%-4% of the 55,000 CRNAs currently licensed and certified nationwide.[2] This equates to a population subset of 550 to 2,200 CRNAs respectively. This assumption is further supported by the CRNA totals found in 2 separate groups sharing generalized characteristics in the AANA profile section, which included 1.4%-3.6% of the total CRNA population.

- Owner/partners of CRNA-led practices and owner/partners of joint CRNA/physician-led practices. The total is 764, or 1.4% of the CRNA population.

- CRNAs selecting “Never” to the question, “Do you work in an Anesthesia care team model where the AN medically directs the CRNA?” The total is 1,968, or 3.6% of the CRNA population.

Pilot Study – Sample Size Criteria

Due to lack of information relating to the total population, a conventional sample size cannot be applied. In order to establish measurable criteria for the pilot study, a database comprising at least 10% of the estimated population subset will be considered representative for future research. A sample size of 55-220 CRNAs will comprise a 10% sample of the total population estimated as 550-2,200 CRNAs.

RESULTS

The survey was initiated in September 2020 and extended through January 30, 2021. There were 568 responses, of which 328 were deemed eligible. This result is equivalent to 15%-60% out of the estimated total population range of 1%-4%. Eligible responses were collected from 43 states; 7 states and the District of Columbia (Alaska, Connecticut, Delaware, Mississippi, Nevada, Vermont, and West Virginia) had no contributing responses. More than 60% of total responses were collected by 9 states. Texas and Kansas had an outsized response, far in excess of the percent CRNA population (see Appendix C for results).

DISCUSSION

Of greatest concern in undertaking this pilot study was the estimated total population and the sample size since there was no available data that provided information relative to these numbers. Without a reliable estimate of the total population, it is challenging to assemble a representative sample with any degree of confidence. It is understood that the larger the sample, the smaller the margin of uncertainty (confidence interval) around the results. However, because this subset of the CRNA population is hypothesized to be small, a large sample size was not

possible. Although FFS CRNAs share generalized characteristics with other independently practicing CRNAs, these CRNAs lack the aforementioned 3 specific characteristics that separate these 2 types of providers. Unfortunately, those characteristics were not available for resource sample selection.

Given these shortcomings, the FFS CRNA population was estimated to range from 1%-4%. This estimate was derived by looking at the numbers of CRNAs self-identifying as either (1) an owner of a CRNA group or CRNA/physician group, or (2) a CRNA selecting "Never" to questions asking if they worked with ANs. It was hypothesized that these 2 groups shared characteristics that closely matched those of FFS CRNAs. The numbers obtained from these groups further supported the author's initial hypothesis solely based on 25 years' experience working and managing an all CRNA FFS practice.

Owners of CRNA practices and joint owners of CRNA/physician practices can be reliably considered as FFS CRNAs; these numbers were equivalent to 764, or 1.4%. Conversely, CRNAs in the "Never" group, although working independently, may not be similarly representative of FFS CRNAs and may instead work in critical access hospitals or other settings where billing is performed on their behalf. Each of these 2 groups likely contains crossover entries as duplicates. Since the duplicates were not identified by the characteristic selected, it is not possible to ascertain which members self-identified with more than 1 group. Many CRNAs may provide services in both types of settings—sometimes under the medical direction of an AN, and other times providing FFS without medical direction. Some group practices provide services in all practice setting types, ie, supervised, nonmedically directed, FFS, and invoice. To ensure the highest probability of success, the higher end of the population range of 4% was selected. This

would allow for some leeway by ensuring the sample size would be large enough to obtain the 10% sample, as set forth in the pilot study measurement criteria.

Targeted Sample Populations

Of the generalized characteristics identified, the term "independent contractor" is perhaps the most broadly used and widely misinterpreted. This term lacks selectivity and distinction specific to independent practice as well as FFS practices. CRNAs practicing as independent contractors often self-ascribe as independent practitioners simply because they erroneously assume independent practice means controlling their own practice schedule and benefits rather than any reference to AN supervision or autonomy.

The AANA has attempted to separate these various employment arrangements through the membership profile section completed by active CRNAs. Although this separation indicates the number of CRNAs working in nonemployee relationships, it does not accurately reflect those CRNAs who may work under both employment arrangements, ie, part-time employee and part-time independent contractor. The selection options offered do not provide flexibility for those CRNAs who work in multiple settings, both with and without medical direction while participating in FFS billing in some areas of the practice. Lastly, independent practice does not describe who is performing the billing or who is the beneficiary of the payments.

State Responses

Eligible responses were collected from 43 states; 7 states and the District of Columbia (Alaska, Connecticut, Delaware, Mississippi, Nevada, Vermont, and West Virginia) had no contributing responses. More than 60% of total responses were collected by 9 states. Texas and Kansas had an outsized response, far in excess of the percent CRNA population (See Appendix

C, Graphics C1 and Table C-6). Driving factors contributing to increased responses do not appear to be related to state opt-out status and may more accurately reflect the following influential conditions:

- Peer-to-peer influence from public endorsement given by professional leaders in support and promotion of the project among Facebook groups;
- Targeted emails delivered directly to state associations, (Texas, Kansas, and Missouri participated in direct survey distribution to their members); and
- Targeted emails to CRNAs who had already responded to the survey with contact information. CRNAs who had already responded and been found to be eligible were sent direct follow-up emails to request assistance in promoting participation among their peers.

The ranges afforded some leeway in determining the sample size and the results yielded a sample size encompassing 15%-60% of the total estimated population. Although there are many limitations that are identified as described and separately in the following discussion, the resulting database that was developed is a successful start and meets the overall study objective.

Resource Limitations

It is important to recognize that not all CRNAs complete and maintain up-to-date selections on the AANA membership profile and that not all CRNAs are AANA members.

Survey Tool Limitations

Because the survey was deployed through an anonymous link, the responses were not attributable to any specific target group. Selection bias, population estimates, and participants previously opting out all contributed to study limitations. In addition, specific questions in the Qualtrics survey tool did not address whether the CRNAs provided QZ services without the presence or involvement of an AN. However, these questions were not applicable to initial database development efforts, as they will be addressed and accounted for in the survey tools used for follow-up research related to reimbursement. Finally, the Qualtrics survey yielded many

responses that may have been eligible but had no accompanying contact information. It is unclear whether the data tool did not allow respondents to enter contact information or if they chose not to provide this information. All efforts to investigate were met with a nondefinitive result as to the reasons this issue occurred.

Recommendations

It is imperative that the subset of CRNAs participating in FFS billing be identified and maintained as a critical resource for reimbursement studies. To expand on this initial pilot study database, each state should initiate a short follow-up survey directed at its members since peer-to-peer influences appeared to increase response rates. Upon AANA membership renewal, a brief practice survey is recommended that includes 3-5 practice related questions as a renewal requirement. These surveys will ensure FFS CRNA numbers remain up-to-date. Stronger efforts to contact top billing companies that actively participate in CRNA billing and large anesthesia management companies participating in CRNA FFS contracts would also greatly increase relevant response rates.

CONCLUSION

Ongoing CRNA reimbursement studies are dependent on a well-developed sample population of FFS CRNAs. The characteristics of a CRNA who performs FFS billing is not mutually exclusive to CRNAs who self-ascribe to independent practice. FFS CRNAs are always involved in some form of independent practice and bill under the QZ modifier. Conversely, very few independently practicing CRNAs participate in FFS billing. Relying on large claim databases for purposes of identifying this population subset is not a viable option. Ongoing maintenance of a representative FFS database is a laborious process that must be prioritized.

Reimbursement for anesthesia services is inherent to the advancement of cost-effective CRNA services. Fair market commercial reimbursement rates are essential for a successful anesthesia practice. Reimbursement issues that arise cannot be fully understood or addressed without data collection and analysis. Even though strong arguments reinforce the necessity for parity among the 2 provider categories, payers are observed to enforce disparate reimbursements policies that unfairly disadvantage the CRNA practice. These policies threaten CRNA business productivity and hinder the ability to maintain profitability essential to the ongoing delivery of cost-effective anesthesia care.

Further study related to reimbursement must continue with ongoing benchmark development and geographical trending analyses to afford CRNA businesses the resources necessary to negotiate advantageous rates and achieve measurable success. The healthcare system relies on cost-effective anesthesia care and CRNAs are well positioned to provide it. Although CRNAs that bill directly for services represent a small percentage of the overall profession, these CRNAs are on the front lines, directly experiencing the immediate effects of legislative changes aimed at limiting the CRNA scope of practice. It is important to provide these CRNA business practices with the necessary resources for advantageous contract negotiation and early problem identification, which ultimately will improve practice success and improve patient access to care.

The purpose of this project was to develop a database of CRNAs involved in commercial insurance contract negotiation and direct billing for use as a resource in future reimbursement research. The reimbursement survey will serve as a means to establish reimbursement benchmarks specific to the CRNA practice and identify specific commercial insurance policies affecting parity in payment under the QZ modifier. The establishment of this database through

this pilot study requires further development and expansion to fulfill accurate and ongoing reimbursement related study. These studies are relevant to future professional strategies aimed at optimizing CRNA parity in reimbursement and improving patient access to cost-effective health care.

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APPENDIX A

Qualtrics Survey

CRNA Billing Database

Published

Q5

CRNA-Billing Database Survey (Est. ~1 min.)

The CRNA profession currently has *NO benchmarks showing the average commercial reimbursement rates.* It is believed that CRNA commercial rates are well below the rates of physician anesthesiologists when providing the same services, but without data, there is no evidence this practice exists. This information is critical for negotiating advantageous rates.

My name is Jean Covillo, and I am a CRNA who has practiced the last 25 years as a managing partner of an all CRNA group. This survey will be conducted as part of my capstone project for the DNAP. **Our goal is to develop a select database** of CRNAs specifically involved in billing "fee for service" in order to encourage participation in *a landmark survey* aimed at identifying the national average commercial insurance reimbursement rates for CRNAs practicing without medical direction. The results of this landmark survey will be made available to those willing to participate in this important research. Please help us develop this select database by participating in this short (1 minute) survey.

Contact information will never be shared or linked to any third party for marketing purposes. The results of this initial survey may be used in reports, presentations, or publications, but your name will not be used. The results will only be shared in aggregate form with CRNA researchers.

Data from this survey will be kept for 3 years in a password-protected data file at MSU. The benefits of participating will be the development of benchmarks for CRNA commercial insurance reimbursement. If you have any questions concerning the research study, please contact Jean Covillo: covillo333@live.missouristate.edu, or 816-807-9333. If you have questions about your rights as a research subject, you can contact the MSU Office of Research Administration 417-836-5972 or researchadministration@missouristate.edu. By clicking the begin study button, you are consenting to take part in this study.

- Begin Study

Q12

Do you, or the group you work for, provide ***nonmedically directed*** (QZ) anesthesia services? ***"Nonmedically directed (QZ) services"*** are defined as CRNA administration of anesthesia **without *anesthesiologist*** medical direction.

- Yes

- No

Q13

Do you, or the group you work for, bill commercial insurance companies directly for ***nonmedically directed*** (QZ) anesthesia services? ***"Nonmedically directed (QZ) services"*** are defined as CRNA administration of anesthesia **without *anesthesiologist*** medical direction.

- Yes
- No

Q1

Do you have access to billing reports that show CRNA commercial insurance claims data for ***nonmedically directed*** (QZ) anesthesia services? ***"Nonmedically directed (QZ) services"*** are defined as CRNA administration of anesthesia **without *anesthesiologist*** medical direction.

- Yes
- No

Q4

Enter your contact information in the fields below so that you can be included as a valued resource in our **CRNA** commercial reimbursement survey. Participation will ensure you are given access to the results from the data collected.

First Name

Last Name

State of Residence

Q7

Please Enter Your Email Address

Email Address

Q6

Please Re-Enter Your Email Address

Import Questions From...

Create a New Question

Add Block

End of Survey

APPENDIX B

AANA Targeted Emails to Select Members

If you, or a CRNA company you work for, bills "fee for service" please click on the link and complete this 1-minute survey.

The purpose of this survey is to establish a database of CRNAs involved in billing commercial insurance for nonmedically directed, QZ services. CRNAs meeting the eligibility criteria will be asked to enter contact information for the purpose of inclusion in the upcoming CRNA national reimbursement survey. You may click on the link below now or read more about why this is important.

https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

WHY IS THIS IMPORTANT?

The CRNA profession currently has **NO benchmarks** showing the national average commercial reimbursement rates. The ASA performs yearly national average assessments of reimbursement rates negotiated by physician anesthesiologists and makes this information available to its members. This data is critical for negotiating advantageous rates with commercial insurance companies. **CRNAs who negotiate commercial insurance contracts are at a distinct disadvantage without similar information obtained from their CRNA peer providers. Although current law was enacted to prevent provider discrimination**, it is believed that CRNA commercial rates are well below the rates of physician anesthesiologists when providing the same services. **Our goal is to develop a select database** of CRNAs specifically involved in billing "fee for service." This database will be utilized in our upcoming national CRNA reimbursement survey. Participating in this survey is critical to establish these

benchmarks from which future growth and development of the CRNA profession can be achieved.

https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

This invitation does not imply any endorsement of the survey research and/or its findings by the AANA. The survey contents and findings are the sole responsibility of the individual conducting the survey.

Social Media Groups-Facebook Group Initial Post

Our goal is to develop a select database of CRNAs specifically involved in billing "fee-for-service" in order to develop the resources necessary to develop benchmarks related to CRNA reimbursement rates and study commercial insurance policies associated with the QZ modifier.

The CRNA profession currently has NO benchmarks showing the national average commercial reimbursement rates and this must change! It is believed that CRNA commercial rates are well below the rates of physician anesthesiologists when providing the exact same services, but without data, there is no evidence this practice exists. The ASA performs yearly national average assessments of reimbursement rates negotiated by physician anesthesiologists and makes this information available to its members. This data is critical for negotiating advantageous rates with commercial insurance companies.

If you bill "fee-for-service" to Commercial Insurance Payers, click on the link and add your name to the database!

https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

WHY IS THIS IMPORTANT?

The CRNA profession currently has **NO benchmarks** showing the national average commercial reimbursement rates.

CRNAs who negotiate commercial insurance contracts are at a distinct disadvantage without similar information obtained from their CRNA peer providers. Although current law was enacted to prevent provider discrimination, it is believed that CRNA commercial rates are well below the rates of physician anesthesiologists when providing the same services. **Our goal is to develop a select database** of CRNAs specifically involved in billing "fee for service." This database will be utilized in our upcoming national CRNA reimbursement survey. Participating in this survey is critical to establish these benchmarks from which future growth and development of the CRNA profession can be achieved.

https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

AANA-Connect Social Media

We Need Your Help! Please Add Your Name to Our CRNA Billing Database – This takes less than 1 Minute!

How much are we worth? Commercial insurance companies do not think we are worth much.

The ASA recently published a 2019 survey that shows the national “Average Commercial Fee” rates paid for Anesthesia Services to be $70/Point. This study only involves groups that include physician anesthesiologists. What if I told you, CRNAs average significantly less when billing commercial insurance without an anesthesiologist member of their group? Would you believe an average of $45/point or < $45/point?

Would you be concerned if you knew GI physicians received $500 for a 10-minute EGD provided by a CRNA, yet when that same CRNA billed for the same exact service to the same insurance company received $120? It is my experience that Anesthesiologists, GI physicians,

Ophthalmologists and other physicians are able to contract with commercial insurances for significantly higher rates for anesthesia services than a CRNA can and the secretive methods employed by the negotiating process results in exploitation and quite frankly extortion of the CRNA provider. There is currently no data available to show what the average commercial fee rates are for CRNAs billing QZ in a group without physicians. I would like to see a comparable study done!

This is concerning to me for many reasons but active legislation that aims to eliminate "surprise billing" could have a huge impact on CRNAs if this is not immediately addressed. Most legislation includes an option that forces all providers to simply accept what insurance pays or if out of network, accept rates consistent with 125% Medicare; approximately which would be about $25/point. The law addressing provider discrimination has not been effective because it has no teeth. There is no consequence for insurance companies and the secrecy surrounding the various rates prevent anyone from proving it is occurring.

We are establishing a database of CRNAs who bill commercial insurance companies directly. These participants will be included in our upcoming reimbursement survey. We need your help! Only 300 CRNAs have participated so far. Can you help us reach 500? Please take 1 minute to add your name to our database by clicking on the link provided. The survey takes less than a minute. Once completed you will be added to the database to be used in the upcoming reimbursement study. The reimbursement study can then be forwarded for completion by whoever does your billing. All responses will be anonymous. Please help us reach 500!

https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

Facebook Group Follow-up Post

Only a few days remain to “Opt-In” to the CRNA Commercial Insurance Reimbursement Survey! This study has never been done before and your participation will contribute significant information relating to billing and reimbursement. Click on the Anonymous link below to see if you are eligible! Survey takes ~1 minute -and do not forget to enter your contact info if you are found to be eligible- or read more for additional information:

https://missouristate.co1.qualtrics.com/.../SV...

We need CRNAs who are involved in direct billing commercial insurance to enter their information into our database so you can be included in the upcoming CRNA Reimbursement Survey. We have about 2 more weeks to establish the necessary sample size for accurate results and we need more volunteers! CRNA Reimbursement Rates have NEVER been studied or compared to rates received by Anesthesiologists. The ASA performs yearly surveys, but these surveys do not look at rates negotiated for QZ by an all CRNA practice-where rates are either contracted at a significantly lower rate or receive a percentage reduction to the anesthesiologist rate. In partial requirement of my doctorate, my advisers Jeanie Skibiski and Maria Poepsel and I are working to remedy that. To participate you may click here or read more for additional information: https://missouristate.co1.qualtrics.com/.../SV...

The study will provide the profession with a wealth of data to be used in establishing the national average reimbursement benchmarks, and also address important CRNA specific reimbursement issues, ie, the CRNA impact of commercial insurance policies that reduce CRNA reimbursement or discriminate against the QZ modifier when recognizing eligibility.

I would like to give a special Shout Out to Any State Presidents who are hopefully seeing this, we would really appreciate it if you could copy the post and send it to the membership directly via email or PM me and I can send you the lead letter! Although some of the work we

are putting in will be used to gain my doctorate, a lot of this information is just incredibly important for us all especially when negotiating insurance contracts and keeping the CRNA practice productive and competitive in the market. Most understand the importance of this research.

BUT we need more participants!

We have had a lot of help but could use more. We received more than 20 CRNAs from both Kansas and Missouri due to promotion by the state presidents thanks to efforts by Larry Finley, Carol Kemna, Juan Quintana, and Larry Hornsby have also stepped up and through their promotion we have gotten more than 50; 25 Texas participants and 20-30 other CRNAs as these great guys promoted it on FB several months ago. Recently Yana Krmic has offered to help, and many others have stepped up. For those of you who have-I thank you!

But we are hitting a lull and we need your help-please share and promote! Our sample currently contains 250 CRNAs, which is a good start, but I know there are more than 250 CRNAs nationwide that perform their own billing or are involved in CRNA billing. The AANA has been extremely supportive of our efforts. They have sent the link to a sample of 2000 members and are in the process of reviewing our project for grant funding. We will be collaborating with the AANA new Reimbursement Committee, and have spoken at length with Jan Mannino who has been very helpful. I would also like to give a quick shout out to Jan and the rest of the Reimbursement Committee members for their willingness to devote time and effort on this important topic. We will be working hard to do whatever we can to assist you and are extremely supportive of all of your efforts and dedication.

So, Get Busy! Please click, complete and share! There are 3 questions that will establish eligibility. CRNAs that are considered eligible will be asked to enter contact information and

will be included in the upcoming Reimbursement Survey. Our goal is to reach at least 1000 participants.

If you have clicked on this link in the past, and thought you were eligible, but you were not asked for contact information, please try again. We had a few glitches in our initial rollout, and I would rather have duplicate entries, then miss you entirely. Please help us get these numbers up!

https://missouristate.co1.qualtrics.com/.../SV...

MISSOURISTATE.CO1.QUALTRICS.COM

CRNA ~ Billing Database

Targeted Emails to State Presidents

Greetings State Presidents,

We are reaching out directly to state associations and state presidents in hopes of gaining assistance in a very important CRNA reimbursement project! We need your help. We are developing a national database of CRNAs involved in direct billing of commercial insurance for QZ services. This database is necessary to the successful outcome of a reimbursement survey, which will be implementing in the upcoming months. This survey is aimed at establishing benchmarks for CRNA commercial reimbursement rates. We are also studying QZ commercial insurance policy issues affecting CRNAs across the nation.

You can help increase this response rate by forwarding this link to your statewide membership. This is an anonymous link to a 1-minute survey.

https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

The following is a copy of the Email lead letter that accompanies the link that can be copied and pasted into your membership correspondence. Thank you for any assistance and feel free to Email me if you have any questions.

If you, or a CRNA company you work for, bills "fee for service" please click on the link and complete this 1-Minute Survey.

The purpose of this survey is to establish a database of CRNAs involved in billing commercial insurance for nonmedically directed, QZ services. CRNAs meeting the eligibility criteria will be asked to enter contact information for the purpose of inclusion in the upcoming CRNA national reimbursement survey. You may click on the link below now or read more about why this is important.

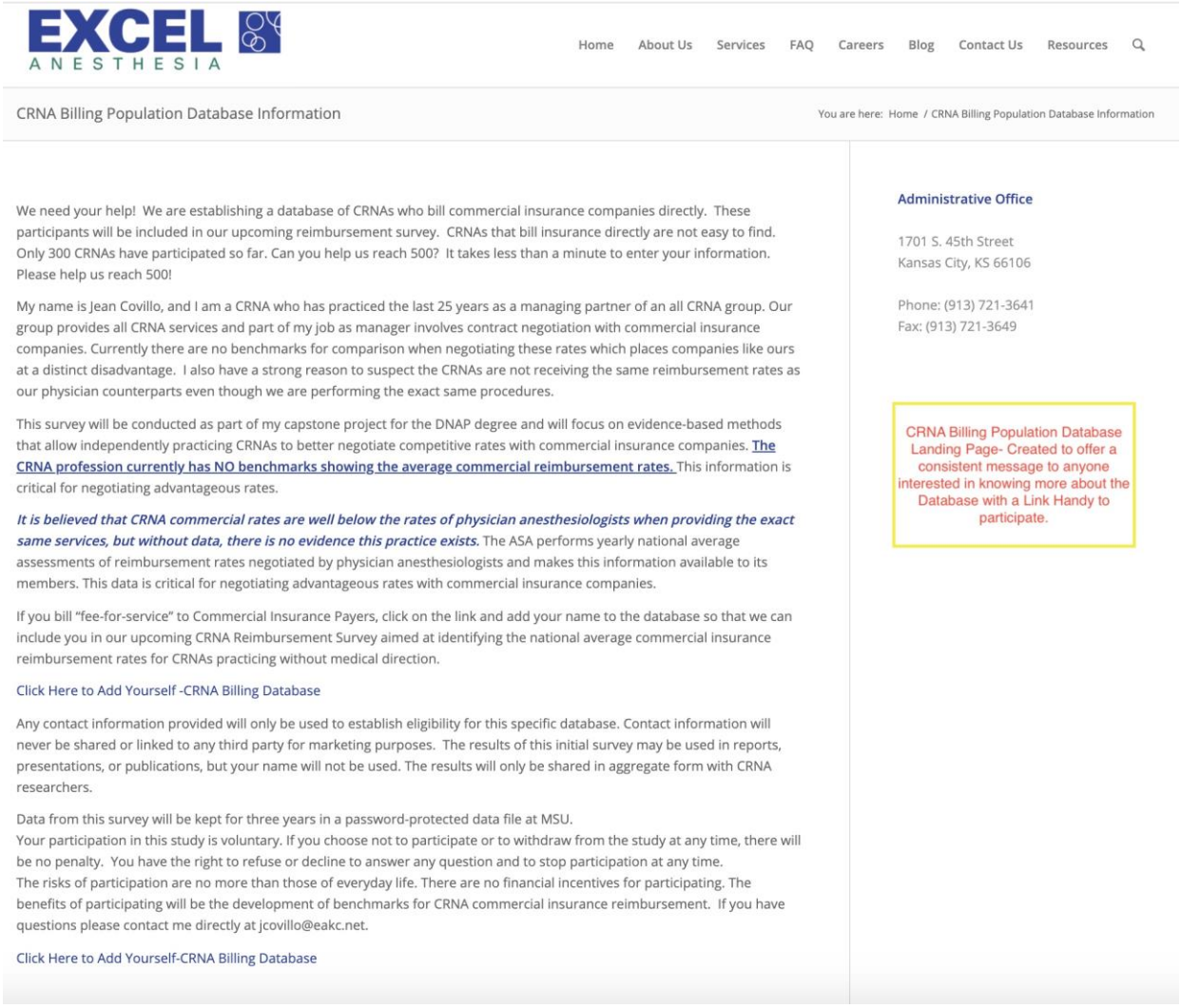
https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

WHY IS THIS IMPORTANT?

The CRNA profession currently has **NO benchmarks** showing the national average commercial reimbursement rates. The ASA performs yearly national average assessments of reimbursement rates negotiated by physician anesthesiologists and makes this information available to its members. This data is critical for negotiating advantageous rates with commercial insurance companies. **CRNAs who negotiate commercial insurance contracts are at a distinct disadvantage without similar information obtained from their CRNA peer providers. Although current law was enacted to prevent provider discrimination**, it is believed that CRNA commercial rates are well below the rates of physician anesthesiologists when providing the same services. **Our goal is to develop a select database** of CRNAs specifically involved in billing "fee for service." This database will be utilized in our upcoming national CRNA reimbursement survey. Participating in this survey is critical to establish these benchmarks from which future growth and development of the CRNA profession can be achieved.

https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrlX

Landing Page



Follow-Up Emails Directed to Respondents

EXCEL ANESTHESIA

Jean Covillo <jcovillo@eakc.net>

Help me Increase Your State's Responses -"CRNA QZ Billing Database "

1 message

Jean Covillo <jcovillo@eakc.net> Sat, Dec 5, 2020 at 10:25 AM
To: Jean M Covillo <JCOVILLO@eakc.net>
Bcc: 0209smpicirillo@gmail.com, 4sooners1@cox.net, afedan@mac.com, Aknuths_mike@hotmail.com, albert007rn@yahoo.com, amckenzie2001@gmail.com, Amhall11@smumn.edu, anthonyfrance@bellsouth.net, awlkangel@aol.com, bcandregg@mac.com, blueskyanesthesiology@gmail.com, brittany.romano09@hotmail.com, buttepain@gmail.com, chadwjohns@gmail.com, clarkcrna@hotmail.com, Cloud.anesthesia.1@gmail.com, dailey@mjmanesthesia.com, darcy.burzynski@me.com, David.mwaura@gmail.com, Debbie Barber <Dbarber721@aol.com>, dchubbard538@hotmail.com, Drice@anestpartners.com, dustindelaney110@msn.com, ebcrna@gmail.com, Fortywinksanesthesia@outlook.com, Gacrna@yahoo.com, gauvin@anesprof.com, gpedersen409@gmail.com, Gurneyk@charter.net, hilt0028@gmail.com, howard@goodwinandsnyder.com, hvlashmet@gmail.com, jake.bevilacqua@gmail.com, JanetDSayer@gmail.com, jboyercrna@gmail.com, jessicaheinrich1@hotmail.com, jlhuss_99@yahoo.com, jnulty3@gmail.com, joelsch@live.com, joelswift.crna@gmail.com, jthwatchfulcare@me.com, Kanugent@outlook.com, Karlcarlson20@gmail.com, Kbasm67krueger@gmail.com, kimmerle62@hotmail.com, krmicya@icloud.com, Kyle.ross.jones@gmail.com, Laura@701anesthesia.com, lbazey@gmail.com, ldanesthesia@yahoo.com, Letitiameglancrnapc@yahoo.com, maynardtim@hotmail.com, Mfshulo@mac.com, midwestanes@aol.com, mike_the_gasser@verizon.net, mitchferne@comcast.net, Michael Perry <mkpain@aol.com>, MIramboanesthesia@gmail.com, Mmccullough@ucarepartners.com, mrwray@comcast.net, nknape@comcast.net, Orrcrna@comcast.net, Pam@bpwpc.net, paulscrna@gmail.com, pcr1966@gmail.com, Premieranesswpa@gmail.com, Reed@nmanesthesia.com, renebouquet91@gmail.com, rlinford@comcast.net, rlmcgee@me.com, Rmishler68@gmail.com, robertlwhitehurst@mac.com, roundtrip@me.com, Sandmanpkcrna@gmail.com, Screamingdm@yahoo.com, shatch55@gmail.com, Shimjae@yahoo.com, spikeman914@yahoo.com, TaylorCRNA@comcast.net, Teamdegen@hotmail.com, thanson@cebridge.net, tjeimers22@gmail.com, tjtonniges@yahoo.com, todd8683@gmail.com, trg.crna@gmail.com, Txkrumm@yahoo.com, Tracy Young <tyoung@ypsanesthesia.com>

First, I received your information and I want to thank you for taking the time to opt in to the CRNA database so that we can include you in our upcoming CRNA Commercial Insurance Reimbursement survey! I know you are busy but I am really hoping you can help me with your state turnout. I have only received about 300 eligible responses (of which only a few came from your state). For this study to be worth anything we need buy-in! Some states have done well and others like yours unfortunately have not.

I work in Kansas and Missouri so I was able to reach out directly to influential CRNAs within the state through our state presidents and through them, received an excellent response. As you can see in the responses shown below, Kansas and Missouri have had a phenomenal response simply because I knew the right people to ask. If I could possibly persuade you to do this for me, **our response rate would skyrocket!** I am only asking you to forward this to your CRNA peers and your state president so that we can get a bigger turnout. Again, this survey link is only being used to collect the contact information of CRNAs billing commercial insurance companies for non medically directed QZ services. The database will then be used to initiate the reimbursement study. I just need more participants and I know they are out there, if I couldn't only get your help in reaching them!

The reimbursement study will be extremely valuable. It has never been done before. Most of my CRNA colleagues that bill commercial insurance directly for QZ services without the presence of an anesthesiologist believe the CRNA commercial rates are markedly less than our physician counterparts. Without data, we have no way to prove this or fix it. Discrimination against CRNAs by commercial insurance companies is illegal but again, without data there is no way to prove it is happening. I will insert the link to the survey and also attach the cover E-mail with the hope that you can get your state president to forward it to the membership. I will also insert the table of responses so that you can see the number your state has contributed and a separate link that will take you to our website that gives more detailed information. Thank you very much for any help you can give! Here is the direct link to the database:
https://missouristate.co1.qualtrics.com/jfe/form/SV_8udOvBNaMEJjrIX

If you would like more information regarding this study you can click on this link which will also help direct you to the survey itself. https://www.eakc.net/info-crna-billing-database/

 # CRNA Participants By State

APPENDIX C

Results: Tables and Graphs

Table C1. Timeline Responses by Month

Response Timeline by Month	
Sep-20	2
Oct-20	297
Nov-20	123
Dec-20	135
Jan-21	11
Totals	568

Table C2. Response Summary

Response Summary	Count
Total Responses to the Survey	621
Duplicates	-53
Total Responses after Duplicates removed	**568**
Eligible Respondents (answered yes to either Q13 or Q1)	**328**
Ineligible Respondents (answered no to both Q13 and Q1)	240

Table C3. Responses by Question

Survey Question and Responses	Count Yes	Count No	Total
Q12-Do you, or the group you work for, provide nonmedically directed (QZ) anesthesia services?	337	4	341
Q13-Eligibility Do you, or the group you work for, bill commercial insurance companies directly for nonmedically directed (QZ) anesthesia services?	324	17	341
Q1-Do you have access to billing reports that show CRNA commercial insurance claims data for nonmedically directed (QZ) anesthesia services?	227	114	341

Table C4. Eligible Responses

ELIGIBLE RESPONSES		
Response Groupings Q12, Q13, Q1	**Count**	**Remarks**
Yes, Yes, Yes	223	Works without Medical Direction, participates in billing and has access to reports
Yes, Yes, No	100	Works without Medical Direction, participates in billing but has no access to billing reports
Yes, No, Yes	4	Works without Medical Direction and does not participate in billing but has access to billing reports. These respondents likely work for a critical access hospital or a group providing services in an ACT setting while others in the respondent's group practice provide QZ billable services. Another possibility would be the respondent as an owner/partner of a billing company.
No, Yes, No	1	The CRNA does not work without medical direction but does work in a group that participates in billing. This CRNA does not have access to billing records and probably will not be helpful to this database, unless they are able to forward the survey link to others that he/she knows that can complete the survey.
Total Eligible	**328**	

Results Table C5. Ineligible Responses

INELIGIBLE RESPONSES		
Response Groupings Q12, Q13, Q1	**Count**	**Remarks**
Yes, No, No	77	Does work in a nonmedically directed setting but is not associated with a group that bills for QZ or able to obtain any billing reports
No, No, No	163	Did not respond affirmative to any question
Total Ineligible	**240**	

Graphic C1. Weighted Response by State

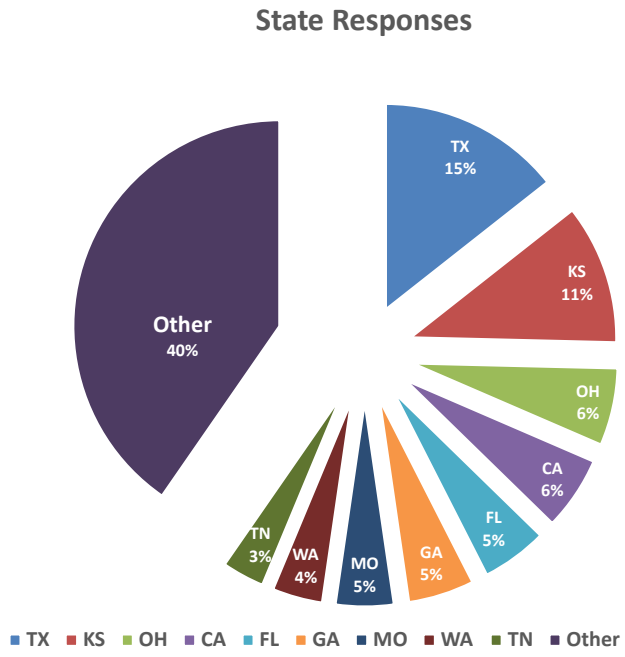


Table C6. Results Weighted Response by State

Highest Response States	Opt-Out Status	% Total CRNA Population	Responses by State	% Total Responses
TX		8%	47	14%
KS	X	2%	36	11%
OH		5%	21	6%
CA	X	3%	19	6%
FL		8%	17	5%
GA		3%	17	5%
MO		3%	15	5%
WA	X	1%	13	4%
TN		4%	11	3%
Total Responses from Top 9 States			196	60%
Other States (34 responding)			132	40%
All Eligible Responses from 43 States			328	100%