The Important Role of CRNAs in a Complex Staffing, Regulatory, and Reimbursement Environment

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Introduction

The demand for anesthesiologists (MDAs) and certified registered nurse anesthetists (CRNAs) continues to rise across the United States. According to the Merritt Hawkins’ 2013 Review for Physician and Advanced Practitioner Recruiting Incentives, MDAs are still in high demand, despite not ranking among the top 20 recruited specialties reviewed during the study. Merritt Hawkins attributes this largely in part to the increasing use of CRNAs, who now administer 65% of all anesthesia services nationwide.

This article discusses the role of CRNAs in the context of the evolving state and regulatory framework surrounding CRNA supervision. To begin, CRNAs are much less costly to employ than MDAs. Moreover, empirical data suggest that there is no increase in risk to a patient when CRNAs perform anesthesia services independently of a physician. Given the ability of states to opt out of the Centers for Medicare & Medicaid Services (CMS) requirement that a physician supervise CRNAs, it is important to reconsider the role of CRNAs in the health care setting from a strategic, financial, and regulatory perspective. While the reimbursement model is somewhat complex, CRNAs can and have proven to be a valuable asset to the hospital staffing model.

Understanding How CRNAs Fit into the State and Federal Regulatory Framework

To highlight the principal role CRNAs play in a health care organization, it is worth noting that CRNAs administer more than 34 million anesthesia services to patients each year in the United States, in a variety of health care settings and rural areas. CRNAs also outnumber their MDA counterparts. According to the Bureau of Labor Statistics, approximately 35,430 CRNAs and 30,200 MDAs were employed in the United States as of May 2013.

Incorporating CRNAs into a staffing model with MDAs can be complex, particularly in light of the supervision opt-out caveat contained in the federal regulations. CMS published a Final Rule in the November 13, 2001 Federal Register stating that the operating physician or an MDA must supervise CRNAs. However, the Final Rule also allows states to “opt out” or be “exempted” from this same federal requirement. To opt out, the state’s governor must send a letter to CMS attesting to the following:

- The state’s governor has consulted with the state’s boards of medicine and nursing about issues related to access and the quality of anesthesia services in the state;
- It is in the best interests of the state’s citizens to opt out of the current federal physician supervision requirement; and
- The opt-out is consistent with state law.
As CMS further states in its Final Rule, once the governor submits the letter to the CMS Administrator, the letter will be accepted at “face value” without further scrutiny by CMS of the governor’s underlying rationale for selecting the opt-out.8

The lack of uniformity among states with respect to the decision to opt out may be concerning to some. However, the opt-out has spurred positive developments in the health care practice setting. At a minimum, from a quality and patient-safety perspective, a recent study found no evidence suggesting any increase in patient risk associated with anesthesia services provided by unsupervised CRNAs.9 Moreover, many organizations have already developed a team care model for delivering anesthesia services. Integrating CRNA anesthesia services typically supports the organization’s model, which takes into account the organization’s finances, state regulations, hospital bylaws, and culture.10 Approximately 80% of hospitals pay a subsidy to anesthesia groups to help ensure that continuous, high-quality coverage is provided.11 As the demand for MDAs has grown, so has the frequency and dollar amount of the subsidies paid. Because CRNAs cost less to employ than MDAs and deliver quality care, arguably, integrating CRNAs into an organization’s staff model provides a financial benefit to any health care organization.

“Supervised States” and “Unsupervised States”

States that have not opted out of the federal supervision requirements are commonly referred to as medically directed states or “supervised states.” Proponents of supervision requirements believe that allowing CRNAs to practice without supervision increases the likelihood of harm to patients, as CRNA training differs from the training MDAs receive. However, as previously noted, no conclusive data exist linking independently performed CRNA services to poor health outcomes. Moreover, having the option to opt out of the supervision requirement does not mean that all organizations in that state are exercising this option.12 Individual health care organizations are at liberty to impose stricter supervision requirements.

As of April 2012, however, 17 states had opted out of the federal supervision requirement. Below, Figure 1 depicts these “unsupervised states” along with the year each state opted out.13 The majority of the states (14 of the 17) that chose to opt out did so within the first four years of the Final Rule’s publication, and at this point, no additional states appear to be considering the opt-out. Alternatively, supporters of states without physician supervision, or non-medically directed states, argue that the lack of any supervision requirement increases patients’ access to care, particularly in rural and medically underserved areas, while simultaneously reducing expenses.
Reimbursement

Medicare reimbursement for CRNA services is tied largely to a physician’s degree of involvement. The following subsections identify the three major Medicare Part B reimbursement models for CRNA services: (A) non-medically directed CRNA services; (B) medically directed CRNA services; and (C) medically supervised CRNA services. Subsection (D) identifies an additional payment model available in certain circumstances under Medicare Part A.

A. Non-Medically Directed CRNA Services

For non-medically directed CRNA services, Medicare Part B reimburses at 100% of a Medicare fee through the Medicare anesthesia fee schedule. This payment is the same amount an MDA would receive performing the same service alone.

B. Medically Directed CRNA Services

For Medicare reimbursement, it is important to distinguish between medically directed CRNA services and medically supervised CRNA services. In general, medically directed services require more involvement from physicians. Medical direction occurs when physicians attest that they did the following: (1) performed a pre-anesthetic examination and evaluation; (2) prescribed the anesthesia plan; (3) personally participated in the most-demanding procedures in the anesthesia plan, including induction and emergence; (4) ensured that a qualified anesthetist performed any procedures in the anesthesia plan that the physician did not perform; (5) monitored the course of anesthesia administration at frequent intervals; (6) remained physically present and available for immediate diagnosis and treatment of emergencies; and (7) provided indicated post-anesthesia care. These seven requirements reflect conditions imposed on physicians by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. When the physician satisfies the seven TEFRA requirements for medical direction, Medicare Part B reimburses at 100% of the Medicare fee through the Medicare anesthesia fee schedule. The CRNA is paid 50% of the fee and the medically directing physician is paid the remaining 50%.

B. Medically Supervised CRNA Services

Medically supervised services occur when both the physician and CRNA are involved in the anesthesia services, but the physician’s level of involvement cannot be classified as medically directed services. A physician would be considered to be supervising (and not directing) if the physician cannot attest to all seven TEFRA elements, if the physician furnishes supervision for more than four CRNA procedures concurrently, or if the physician performs services that are not permitted when medically directing.

Overall, Medicare Part B reimburses medically supervised CRNA services at a lower rate than medically directed services. For medically supervised services, a CRNA is reimbursed at 50% of the Medicare fee through the anesthesia fee schedule—the same amount the CRNA would receive for services provided that are medically directed. The physician involved in the medically supervised services is not reimbursed according to the anesthesia fee schedule. Instead, the physician is paid three base units per procedure (and potentially one time unit if an MDA is present at induction of service) regardless of the service and such service’s Medicare fee. Therefore, the medical supervision model enables Medicare to pay less than the full 100% of the Medicare fee by reimbursing supervising physicians at a lower rate than their CRNA counterparts. CRNAs are reimbursed at 50% regardless of whether they are medically directed or medically supervised.

The three reimbursement models above highlight the benefit of incorporating CRNAs into a health care organization’s staffing model in terms of maximizing Medicare reimbursements. Table 1 below, which provides a summary of Medicare Part B’s reimbursement for CRNA services, highlights this point more clearly.

<table>
<thead>
<tr>
<th>Type of CRNA Service</th>
<th>CRNA</th>
<th>Physician</th>
<th>Total Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medically Directed</td>
<td>100%</td>
<td>n/a</td>
<td>100%</td>
</tr>
<tr>
<td>Medically Directed</td>
<td>50%</td>
<td>50%*</td>
<td>100%</td>
</tr>
<tr>
<td>Medically Supervised</td>
<td>50%</td>
<td>Three base units per procedure and one time unit if present at induction of service**</td>
<td>&gt; 50%</td>
</tr>
</tbody>
</table>

* Physician must attest to the seven TEFRA requirements and only receives 50% reimbursement rate for supervising no more than four CRNAs concurrently.

** Physician’s reimbursement for medically supervised CRNA services is not based on Medicare’s anesthesia fee schedule.
Conclusion

CRNAs, who now administer more anesthesia services in the United States than MDAs, are in high demand. Until 2001, a federal requirement prevented CRNAs from practicing independently. However, the Final Rule CMS published on November 13, 2001 allows states to choose whether to “opt out” or be “exempted” from this requirement. As previously described, 17 states have opted out of the requirement thus far, doing so arguably because they believe that opting out of the supervision requirement increases patient’s access to care and reduces costs. From a provider perspective, employing CRNAs to perform services independently greatly reduces anesthesia expenses for the provider. For non-medically directed services in particular, CRNAs are reimbursed at the same rate as their MDA counterparts, while costing the provider less to employ than the MDA. In addition to expense savings for providers, there appears to be no conclusive evidence linking independently performed CRNA services to increased patient risk. In sum, CRNAs are capable of performing high-quality services at a lower expense to providers, while the cost to Medicare remains the same or slightly less than when MDAs provide the services.

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1 A CRNA is a registered nurse who satisfies state licensure requirements for non-physician anesthetists, has graduated from a nurse anesthesia program accredited by the Council on Certification of Nurse Anesthetists (COA) or its predecessor, and has passed the certification exam administered by COA. 42 C.F.R. § 410.69(b).
3 Id.
7 Id. at 56763–69 (codified at 42 C.F.R. § 482.52(c)).
8 Id. at 56766.
9 Brian Dulisse & Jerry Cromwell, No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians, 29 Health Aff. 1469, 1469–75 (2010). This study examined 500,000 individual cases involving the provision of anesthesia services by unsupervised CRNAs.
12 As CMS stated in its Final Rule, while states may individually exercise the option to opt out, this does not preclude hospitals from enforcing stricter supervision standards. Hospital Conditions of Participation: Anesthesia Services, 66 Fed. Reg. 56762, 56765 (Nov. 13, 2001).
14 Medicare Part B consists of two types of services: medically necessary services and preventive services. Medically necessary services are considered to be services or supplies that are both needed to diagnose or treat a medical condition and meet accepted standards of medical practice. Preventive services include health care that aims to prevent illness or encourage early detection, when treatment is more likely to be effective. For example, Medicare Part B covers clinical research, ambulance services, mental health services, durable medical equipment, and limited outpatient prescription drugs.
16 42 C.F.R. § 415.110(a)(1)(i)-(vii). See also CMS MD/CRNA Transmittals, Trans. No. 50(C)-(K), Payment at the Medically Directed Rate, supra note 15.
18 CMS has clarified that, where a single anesthesia procedure involves both a physician and a medically directed CRNA, payment for the service of each is 50% of that which would have been allowed had the anesthesiologist performed the services alone. Id.
19 CMS MD/CRNA Transmittals, Trans. No. 50(C), Payment at the Medically Directed Rate, supra note 16.
20 MDA/CRNA Transmittals, supra note 15, 123.
21 See generally CMS MD/CRNA Transmittals, Trans. No. 50(C)-(K), supra note 16.
23 CMS MD/CRNA Transmittals, Trans. No. 50(D), Payment at Medically Supervised Rate, supra note 15.
24 Am. Ass’n of Nurse Anesthetists, Fact Sheet, supra note 13.