Nebraska Association of Nurse Anesthetists

December 3, 2022

To the members of the Anesthesiologist Assistants Technical Review Committee,

Our group would like to comment and provide responses to Dr. Kassel and the applicant group's letter and questions submitted November 22, 2022.

It is understood that the application is intended for the licensure of AAs. In the proponent's application, the applicants specifically state on page 18, "Nebraska does not currently have a CAA program within the state, but there is strong interest in locating a program in Nebraska if licensure is approved". While this may not be the only goal of the application, with only 3000 AAs in the United States, a school would seem necessary to establish any number of AAs in Nebraska.

We thank the applicant group for their thoughtful questions regarding the **shortage of training sites for student registered nurse anesthetists.** Questions are addressed below:

Applicant question: Are there currently any deficiencies noted in specialty cases for trainees?

Answer: The open heart cases are the most difficult, and sometimes (3 times this summer) a CRNA student has not met the minimum requirements at the completion of their scheduled open heart rotation. Pediatric cases for children less than 2 years old have also been difficult with some students not meeting the minimum at the completion of their scheduled rotations.

Applicant Questions: With 35 clinical sites for student nurse anesthetists, what is preventing these students from getting specialty cases at these sites? UNMC residents are only rotating at two (UNMC and Children's) so there currently is no other student at the other 33.

Answer: The specialty cases including open heart, thoracotomies, craniotomies, obstetrics, pediatrics, and trauma cases are not available at many clinical sites. For example, there are 4 sites for open heart cases and 4 sites for craniotomies. Availability of these cases are limited. There are many ORs every day with orthopedic cases or general surgery cases, but the specialty cases are at a much lower number. Nurse anesthesia students from Bryan, Clarkson, Mount Marty and the University of Kansas all place CRNA students in Nebraska. Students from multiple programs often utilize the same clinical sites at the same time. The programs plan and coordinate student rotations with the goal of all students obtaining the experiences they need.

Applicant Question: If there is not a significant shortage of non-physician anesthesia providers, why are both nurse anesthetists' schools in Nebraska planning for increased class sizes in the future?

Answer: Due to institutional hospital policy which does not reflect state and federal regulatory healthcare policy, institutional inefficiencies at some large urban centers are contributing to a perceived shortage of anesthesia personnel. Highly trained and educated anesthesia providers are side-lined from the workforce by providing "supervision" to providers who have no state or federal mandate requiring said supervision. Additionally, the gasworks numbers provided in the applicant's proposal included duplications of employment advertisements. The answer to a need for more anesthesia providers in Nebraska is to educate and matriculate more independent CRNAs and physician anesthesiologists as they have the independence to deliver anesthesia in both rural and urban Nebraska.

Applicant Statement: The nurse anesthetist profession and the organization that accredits nurse anesthetists' programs have created one of the major issues that they cite. Their accreditation standards do not allow CAAs to train nurse anesthetist students, even though nurse anesthetists are allowed to train AA students. If their accrediting body would change this policy, student nurse anesthetists would not be impacted at all by having CAAs practice in their state.

Answer: CRNA students cannot be trained by anyone except a CRNA or anesthesiologist. In order to become an independent anesthesia provider, a CRNA student must demonstrate a series of skills and abilities during their clinical experience. The CRNA student must be observed and evaluated by a clinical preceptor with the knowledge and experience to judge if the standard has been met. If the standard is not met, then the preceptor must provide guidance to the CRNA student so that they develop into an independent provider. Only an independent anesthesia provider can do this.

Applicant question: The Nebraska Association of Nurse Anesthetists information on the reduction in enrollment is based on speculation. If you look at actual data relating to CRNA programs in Indiana and Missouri, that data shows an increase or constant number of nurse anesthetist students. CAAs have practiced in Indiana and Missouri for many years, and both states have AA educational programs in place.

Answer: The nurse anesthesia programs have a long history of assessing availability of clinical placements, and planning based on these assessments. With this experience the nurse anesthesia programs have accurately predicted and planned clinical placements. While student numbers in Indiana and Missouri have not decreased, their CRNA student numbers are small relative to their population and numbers of practicing CRNAs. For example, Indiana has a population of 6.8 million with 40 CRNA students at 2 programs. If Nebraska had the same ratio of CRNA students per population (population 1.96 million) as Indiana, there would be 12 CRNA students in our state.

If there were the same number of CRNA students per population in Indiana as in Nebraska, currently there would be 142 CRNA student graduates/year in Indiana. In Nebraska, there are 41 CRNA students per 1.96 million population, and if Indiana had the same ratio, they would have 142 CRNA students per 6.8 million population. By this measure, Indiana is missing over 100 CRNA student graduates each year.

The incorrect comments in the letter from the applicant group regarding the risk for **Medicare fraud** reinforce the increased liability for fraud. It can be tedious to understand the intricacies of medical direction billing and as the vast majority of hospitals in Nebraska have no experience with the requirements; it could be misconstrued that the AD billing modifier could be utilized to fall back on, should medical direction and TEFRA criteria not be met. According to the article published by the ASA on payment and practice management from 2016, which has been submitted, **AAs work only under medical direction and medical supervision does not apply. Medical direction is limited to no more than 4 concurrent cases. The AD modifier is only to be used when a physician is supervising more than 4 concurrent cases. Therefore, the AD modifier cannot be utilized when medical direction criteria are not met**. The options are fraudulent billing as medical direction or to lose the revenue completely.

The AD billing modifier cannot be used as a fallback for hospitals to bill for anesthesia services when anesthesiologists fail to meet Medicare's medical direction requirements under TEFRA.

Furthermore, when it comes to a facility seeking payment from Medicare for an anesthesiologist who fails the 7 TEFRA requirements of medical direction over AAs, **Medicare explicitly prohibits payment on the anesthesiologist portion of a case when there is a failure in medical direction**. **The Medicare Processing Manual states that if an anesthesiologist "leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients would not meet the requirements for payment at the medically directed rate." Medicare Claims Processing Manual, Chapter 12, §40.9(C). The AD modifier, or any modifier, cannot be used as a fallback for failed medical direction.**

Lastly, Medicare data shows that in practice the AD modifier is barely used throughout the country. Therefore, it cannot be claimed that it is widespread practice for facilities to use the AD modifier as a fallback means of billing Medicare when an anesthesiologist fails medical direction under TEFRA.

The 2012 Epstein and Dexter study did reference the medical direction of CRNAs and not AAs. The study was performed in a restrictive medical direction anesthesia care team model, which is the same model in which an AA practices. Below are the Critical portions which Epstein used from Table 2 in the study:

1) Induction of GA
2) Post incision after regional or neuraxial block Invasive line placement following induction of GA
3) Turning patient between supine and prone
4) Neuraxial block supervision prior to entering the OR
5) Neuraxial block after entering the OR
6) Regional block for postoperative analgesia placed in block room
7) Emergence from GA

Epstein and Dexter reference Medicare requirements and also make this statement: "In the United States, invoicing Medicare for professional anesthesia services requires that the anesthesiologist 'personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence, where indicated.' Consequently, all patients are supervised in accordance with Medicare rules".

The statement "personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence, where indicated.", is directly word for word out of the TEFRA rules and "Consequently, all patients are supervised in accordance with Medicare rules" While TEFRA is not specifically referenced, clearly the critical portions studied in Epstein and Dexter correlate with TEFRA requirements.

Thank you for this opportunity to address these questions and to clarify the nuances of medical direction anesthesia billing. If there are further questions, please do not hesitate to bring them forward.

Thank you to the technical review committee for taking the time to thoroughly review these letters and some of the indirect, secondary impacts that AAs can have on a rural state.

Sincerely,

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Immediate Past President NANA