CRNA Practice in California
Relative to Standardized Procedures

I. The CANA Practice Division has been asked to answer the question, do nurse anesthetists practice under standardized procedures?

The answer is no, CRNAs do not practice under standardized procedures.

Per the California Board of Registered Nursing (BRN), "*Standardized procedures are the legal mechanism for registered nurses, nurse practitioners to perform functions which would otherwise be considered the practice of medicine.*" (NPR-B-20 12/1998). Standardized procedures are required when an RN provides a treatment outside their scope of practice, performing a function which is normally provided by a physician. The administration of anesthesia services is the practice of *nursing* when administered by a Certified Registered Nurse Anesthetist (CRNA), not the practice of medicine. When a physician anesthesiologist administers anesthesia, it is considered the practice of medicine. Inherent in the definition of standardized procedures is that they are necessary when an RN performs a function considered to be the practice of medicine. Because anesthesia administered by a CRNA is the practice of nursing, the BRN has not included nurse anesthetists in any part of their explanation or templates for standardized procedures.

The language in the Nursing Practice Act provides the authority for nurse anesthetists to administer anesthesia services as follows:

2725 (b) (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

Per this section, CRNAs may select and administer medications deemed necessary to provide the treatment (anesthesia) if the treatment is ordered by a physician, dentist, podiatrist or clinical psychologist.

In California, an order from a *physician* or *operating practitioner* (MD, DO, DDS, DPM, or clinical psychologist) is required for nurse anesthetists to provide anesthesia and pain management services. A variety of mechanisms are accepted and widely used to connote the order for CRNA services including, but not limited to: booking of a case by an operating practitioner; a surgery department in a healthcare facility publishing a schedule of procedures that require anesthesia; or use of a check-box system which states the operating practitioner orders "*CRNA anesthesia services" or "the CRNA to administer the anesthesia and select and administer the drugs."* Once the order is obtained, the CRNA is already educated, trained and certified to select and administer the type of anesthetic and all drugs and agents necessary to implement the anesthesia or pain management plan. No standardized procedures or further orders are necessary.

The Nurse Anesthetist Act (Civil Code 2825) describes the certification requirement for CRNAs. This section of regulation does not state the term standardized procedures even once, because nurse anesthetists do not function under standardized procedures. The Nurse Anesthetist Act states: "*The utilization of a nurse anesthetist to provide anesthesia services in an acute care facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist or podiatrist."* (BP2825 09/1998). CRNAs are generally re-credentialed and privileged by healthcare facilities on a biannual basis and all anesthesia services provided by nurse anesthetists are then approved by the medical staff.

California Attorney General John Van de Kamp addressed the issue of CRNAs and standardized procedures in 1984. This opinion stands today (67 Ops.Cal.Atty.Gen. 122, supra.):

Question: *"May a Certified Registered Nurse Anesthetist lawfully administer regional anesthetics pursuant to a "standardized procedure."*

Conclusion: "*We conclude that a registered nurse and thus a Certified Registered Nurse Anesthetist may lawfully administer a regional anesthetic when ordered by and within the scope of licensure of a physician, dentist, podiatrist or clinical psychologist but* ***not*** *pursuant to a "standardized procedure" as defined in section 2725."*

file:///C:/Users/MCLRE/Downloads/John%20Van%20DeCamp%20opinion%201984%20-%2083-1007.pdf

Finally, the California Appellate Court described the authority of CRNAs to administer an anesthetic without physician supervision and did not refer to standardized procedures. The court clearly stated that a physician's order was all that was required (pp 12):

"The plain language of section 2725, subdivision (b)(2) authorizes CRNA's to administer medications (including anesthesia) necessary to implement a treatment "ordered" by a physician. It does not say –and it has never said– that anything more than a physician's order is required. While the Nursing Practice Act does not define the term "order," we find guidance in a definition provided by the Pharmacy Law. (§§ 4000 et seq.) An 'order,' entered on the chart or medical record of a patient registered in a hospital or a patient under emergency treatment in the hospital, by or on the order of a practitioner authorized by law to prescribe drugs [i.e., a physician], shall be authorization for the administration of a drug . . . . (§ 4019.) There is nothing in the Nursing Practice Act to indicate a different meaning of the term "order" is intended in that statutory scheme. It is a general rule of statutory construction to construe words or phrases in one statute in the same sense as they are used in a closely related statute pertaining to the same subject. (In re Do Kyung K. (2001) 88 Cal.App.4th 583, 589; Estate of Hoertkorn (1979) 88 Cal.App.3d 461, 465-466.)"

The Appellate Court also refers to the discussion of standardized procedures in the 1984 Van de Kamp opinion regarding nurse anesthesia practice (pp 15):

"We also find the Attorney General's seminal 1984 opinion persuasive. The precise issue the Attorney General was asked to address was whether a CRNA could provide anesthesia pursuant to a protocol established by a "standardized procedure," as opposed to a treatment regimen ordered by a physician for a specific patient. The opinion contains an informative discussion on the CRNA scope of practice and also discusses several Supreme Court cases relied upon by appellants to support their assertion that the Governor's opt-out decision was contrary to California law. (67 Ops.Cal.Atty.Gen. 122, supra.) The Attorney General concluded that, while a CRNA could not lawfully administer an anesthetic under standardized procedures, a CRNA was legally authorized by section 2725, subdivision (b)(2) to administer all forms of anesthesia on the sole condition that the anesthesia be "ordered" by a physician, dentist or podiatrist acting within the scope of his or her license. (67 Ops.Cal.Atty.Gen., supra, p. 123.)"

II. The CANA Practice Division has also been asked how CRNA scope of practice is defined and governed, since CRNAs are not permitted to administer anesthesia under standardized procedures in California.

California CRNA practice is defined and governed by the following entities, at minimum:

1. **California Law: Business and Professions Code**

A. 2725 (b) (2) Nursing Practice Act: states that a nurse may function in a role that has common and accepted usage; that the nurse may administer medications to provide a treatment ordered by a physician; and that some functions provided by physicians overlap with functions provided by nurses.

B. 2825 Nurse Anesthetist Act: states a CRNA must be nationally certified and refers to the American Association of Nurse Anesthetists (AANA) for Scope of Practice and Standards.

2. **Board of Registered Nursing (BRN)**

The BRN has broad oversight of, and is the sole agency formally responsible for defining nursing practice and interpreting regulations regarding nursing practice. The language of the law for nurses in the Business and Profession Code (i.e. Nursing Practice Act and Nurse Anesthetist Act) is translated into regulatory language of the BRN.

3. **California Code of Regulations** – e.g. Title 22 Social Security, Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies, Chapter 1. General Acute Care Hospitals, Article 3. Basic Services:

§ 70231. Anesthesia Service Definition.
§ 70233. Anesthesia Service General Requirements.
§ 70235. Anesthesia Service Staff.
§ 70237. Anesthesia Service Equipment and Supplies.
§ 70239. Anesthesia Service Space.

4. **Centers for Medicare & Medicare Services (CMS)**

California is an "opt-out" state per CMS in accordance with Medicare Part A. All CRNAs are exempted from physician supervision in California, although individual healthcare facilities may elect to require CRNA supervision or medical direction if they so desire.

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Spotlight.html

A. Medicare Part A – Facility Reimbursement

Healthcare facilities (hospital and ambulatory surgery centers) in **non**-opt-out states may only participate in Medicare Part A and receive reimbursement if CRNAs are "supervised" by a physician, dentist or podiatrist. Medicare allows states to opt out of this requirement if the Governor consults with the state boards of nursing and medicine, determines that opting out is in the best interests of its citizens, and writes a letter to CMS requesting a state exemption from CRNA supervision. California was exempted from Medicare Part A supervision of CRNAs in 2009. A total of seventeen states and the U.S. territory Guam have opted out since the federal rule was adopted in 2001.

B. Medicare Part B - Provider Billing

Modifier	Code for:	Must be reported to indicate who performed the anesthesia service:
QZ	**CRNA**	CRNA service performed **without** medical direction *or* medical supervision
AA	**MDA**	Anesthesia services performed personally by a physician anesthesiologist
AD	**MDA**	Medical supervision by a physician anesthesiologist: **five or more** concurrent procedures.
QK**	**MDA**	Medical direction by a physician anesthesiologist: **2, 3 or 4 maximum** concurrent procedures
QY**	**MDA**	Medical direction by a physician anesthesiologist for **one** CRNA
QX**	**CRNA**	CRNA service with medical direction by a physician anesthesiologist

** MEDICAL DIRECTION **REQUIRES** A PHYSICIAN ANESTHESIOLOGIST TO PERFORM THE SEVEN STEPS OF TEFRA IN ORDER TO BE PAID THE ANESTHESIA FEE

Medical Direction vs. Supervision Billing: CANA Practice Division, 02-26-2018

1) **Non-Medically Directed CRNA** (Billing Code QZ)

There are **no** workflow restrictions and **no** supervision requirements for CRNA non-medical direction billing, which may be used for both independent-practice CRNAs and CRNAs who are supervised.

2) **Supervision** - by operating practitioner: MD, DO, DDS, DPM

This billing modality places **no restrictions** on the Anesthesia Care Team (ACT) model workflow and no ratio limits of MDAs/CRNAs. The only requirement is that the "supervisor" be immediately available in the facility to respond to emergencies. *There is no billing code assigned to this model; supervised anesthesia cases are typically billed QZ.*

3) **Medical Direction** - physician anesthesiologist billing *only* (Billing Codes QK, QY, QX)

This billing model *pays the physician anesthesiologist to perform seven mandatory requirements of Medical Direction Billing* established by the federal **Tax Equity and Fiscal Responsibility Act** (TEFRA) of 1982 and limits the physician anesthesiologist/CRNA ratio to 1:4.

Medical Direction Billing pays 50% of the anesthesia fee to the CRNA and 50% to the physician anesthesiologist, *thus limiting the maximum fee obtainable by the anesthesiologist to **200**% of the combined billing fees for four concurrent cases.*

TEFRA Requirements for Medical Direction Billing – *to receive Medicare Part B payment, the "directing" physician anesthesiologist must perform and document the following 7 services:*

1. Prescribe the anesthesia plan: general, regional, local, or sedation.
2. Perform the pre-operative anesthesia assessment.
3. Personally participate in the most demanding parts of the case including induction and emergence.
4. Ensure all anesthetic procedures are performed by a qualified provider.
5. Monitor the course of the anesthetic at frequent intervals.
6. Remain physically present for emergencies.
7. Perform the post-op anesthetic evaluation.

4) **Medical Supervision** - physician anesthesiologist billing *only* (Billing Code AD)

This billing model pays the *physician anesthesiologist* for Medical Supervision services with **no** requirement to perform the seven elements of TEFRA. Payment for medical supervision requires a **minimum** of 5 concurrent cases. This billing modality is rarely used because it pays 50% of the anesthesia fee to the CRNA while the anesthesiologist is only paid 3 base case units, or a maximum of 4 if present for induction of anesthesia, thus leaving money "on the table."

5. **Healthcare facility accrediting bodies**

CRNAs have served as Licensed Independent Practitioners (LIPs) in California for decades prior to the Medicare opt-out. The Joint Commission (TJC) and other healthcare accrediting bodies acknowledge CRNAs as LIPs in accordance with the CMS supervision exemption: https://www.jointcommission.org/standards_information/jcfaq.aspx?ProgramId=5&ChapterId=74&IsFeatured=False&IsNew=False&Keyword&print=y If the CRNA is not credentialed as a LIP by a healthcare facility, TJC requires the CRNA to verify concurrence of the anesthesia plan (general, regional, sedation, local) with a LIP. TJC accepts the operating practitioner requesting the type of anesthetic when booking a case as concurrence with the anesthesia plan. Operating practitioner check-boxes are also widely used for this purpose.

6. **Local Facility Bylaws & Policies**

There is no federal or California state agency which restricts CRNA practice. Facility bylaws may confer LIP status to CRNAs and permit full scope of practice authority or require supervision or medical direction as they prefer.

7. Case Law

California was exempted by CMS from CRNA supervision by Governor Schwarzenegger in 2009. Subsequently, the California Society of Anesthesiologists (CSA) and the California Medical Association (CMA) sued the Governor, claiming the supervision exemption or "opt-out," was not valid in California. CANA stepped in as an intervenor in the trial and the California Hospital Association served as amicus curiae. The lawsuit was overturned by the California Superior Court and upon appeal, was also overturned by the California Appellate Court. CSA and CMA subsequently appealed to the California Supreme Court which denied further trial or review. When describing the authority of CRNAs to administer anesthesia without physician supervision, the Appellate Court never referred to standardized procedures. *The Appellate Court clearly stated a physician's order is all that is required.*

http://www.thehealthlawfirm.com/uploads/Cal%20Society%20Anesthesilogists%20v%20SC%20San%20Fran.pdf

8. CRNA Scope of Practice

CRNAs adhere to the professional practice standards of the American Association of Nurse Anesthetists (AANA) first adopted in 1974:

https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/standards-for-nurse-anesthesia-practice.pdf

The following legal memorandum explains CRNA practice in the state of California:

http://canainc.org/compendium/pdfs/CRNA%20Scope%20of%20Practice%20Memorandum_Mayer%20Brown%209232014.pdf