Medicare Agency Issues New Interpretive Guidelines for Hospital Anesthesia Services

The Medicare agency on Jan. 19 issued new Medicare Part A interpretive guidelines for aspects of hospital anesthesia services, plus a cover memo and a “frequently asked questions” (FAQ) document, making several changes to the updates that the agency had issued within the past year and affecting elements of CRNA practice. The guidelines’ cover memo dated Jan. 14 indicates that the guidelines are effective immediately. This initial update for AANA members provides a preliminary summary of the changes and links to the guidelines documents themselves; AANA members are urged to read the new guidelines.

What are Medicare Hospital Interpretive Guidelines?
Medicare Part A hospital conditions of participation interpretive guidelines are policy documents issued by the Centers for Medicare & Medicaid Services (CMS) that elaborate upon Medicare regulatory requirements. State agency surveyors use the interpretive guidelines to review hospitals for compliance with Medicare regulations. Hospital administrators, risk management personnel, and healthcare professionals use the interpretive guidelines to gauge compliance with Medicare regulations. Procedurally, the interpretive guidelines are not subject to a public notice-and-comment rulemaking process as the Medicare conditions of participation regulatory requirements are. Rather, the agency reissues updates to the guidelines from time to time on an irregular schedule. Hospital accrediting organizations like The Joint Commission, which assess facility compliance with the Medicare conditions of participation, may mirror their surveys to the AANA members provides a preliminary summary of the changes and links to the guidelines documents themselves; AANA members are urged to read the new guidelines.

What Changes with the new Guidelines?
An AANA clinical, policy, and regulatory staff team compared the new guidelines against the guidelines of May 2010. The new guidelines post new language in red text, but do not expressly show where previous language was deleted. The new guidelines include several complex changes; where the agency has introduced additional ambiguity, the AANA is following up with the Medicare agency. Thus, relative to the May 2010 guidelines, the AANA’s preliminary review shows that Medicare’s new guidelines:

- Introduce broad new language promoting local determination of who may provide analgesia or sedation to whom, replacing language that had exempted CRNA labor and delivery analgesia from the Medicare physician supervision requirement even in non opt-out states. Under the new guidelines, determination of which procedures require anesthesia vs. those that require analgesia, and who is providing those services to whom, is now made by each hospital using nationally recognized guidelines. There is considerable ambiguity in several aspects of the new language in this area that the AANA is addressing with the Medicare agency. The AANA has provided CMS with “Considerations for Policy Development 4.2, Registered Nurses Engaged in the Administration of Sedation and Analgesia” (link at the end of this article) with a request that the agency add it to the agency’s reference list in the agency’s FAQ document. With respect to labor and delivery epidurals, the hospital anesthesia services pictograph from the May 2010 guidelines does not appear in the Jan. 2011 edition, and the new guidelines introduce ambiguity to how labor and delivery epidurals should be classified.

- Substantially edit previous portions regarding sedation, now referencing anesthesia and analgesia services as a “continuum” with no “bright line” separating the two, and linking sedation up to moderate sedation in the analgesia column. The agency deleted previous references to the drug propofol under the category of deep sedation and made considerable refinements to provisions that address sedation by nonanesthesia professionals.

- Change the provisions describing the director of anesthesia services, specifically indicating that the individual be one person who is a medical doctor or doctor of osteopathy, and deleting from the director’s listed responsibilities the requirement for “establishing anesthesia staffing schedules.” (The Medicare regulatory requirement that the director of anesthesia services be a medical doctor or doctor of osteopathy remains unchanged. Further, no federal requirement or guideline requires that the director of anesthesia services be an anesthesiologist.) The new guidelines also provide greater detail for the anesthesia services’ linkage with hospital quality assessment and performance improvement systems (QAPI), and set further expectations that anesthesia services policies and procedures involve collaboration with other hospital disciplines such as surgery, pharmacy, and nursing.

- Elaborate on who may conduct preanesthesia and postanesthesia evaluations and when, and adjusts timelines for documentation. Notably, the guidelines now spell out some aspects of the preanesthesia evaluation may be conducted upon a patient more than 48 hours, but not more than 30 days, before his or her procedure. Those “30-day” items include notation of anesthesia risk, identification of particular anesthesia problems, and development of the plan for the patient’s anesthesia care.
What Was Not Changed in the New Guidelines?

• The guidelines did not change any underlying Medicare regulation. These are changes to the interpretive guidelines intended to advise surveyors on hospital compliance with Medicare conditions of participation, and to advise Medicare hospitals on how to comply. Changes in regulation require a public notice-and-comment rulemaking process, including publication in the Federal Register.

• The guidelines on who may provide anesthesia services, including administration by a CRNA, were not changed. Nor did the guidelines change the state opt-out process. Because these guidelines apply to regulations other than those supervision regulations from which a state may opt out, the new guidelines apply in all states and the District of Columbia.

• The guidelines also did not make any changes to those involving the intraoperative anesthesia record.

• The guidelines apply to hospitals participating in the Medicare and Medicaid programs only, and have not changed CMS guidelines governing other facilities such as critical access hospitals and ambulatory surgery centers participating in the Medicare program.

The AANA is following up with the Medicare agency with several questions about the new interpretive guidelines, and will produce a further document that will address common questions and issues that arise among CRNAs.