August 15, 2016

Electronic Submission via patientrelationshipcodes@cms.hhs.gov

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: CMS Patient Relationship Categories and Codes

Dear Mr. Slavitt:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to comment on the CMS draft list of patient relationship categories and codes. The AANA makes the following comment and request:

- Recommend adding a sixth patient relationship category that specifically recognizes non-patient facing providers and recognizes the essential anesthesia services that CRNAs provide

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, and AANA membership includes more than 49,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 40 million anesthetics to patients each year in the United States. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.
CRNA services include providing a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. According to a May/June 2010 study published in the journal of *Nursing Economic*$, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.¹ Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.² Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.³ Most recently, a study published in *Medical Care* June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.⁴

CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. The importance of

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¹ Paul F. Hogan et. al, “Cost Effectiveness Analysis of Anesthesia Providers.” *Nursing Economic*$. 2010; 28:159-169.


CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography and insurance type and the distribution of anesthesia provider type.\textsuperscript{5} The study correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations. Of particular importance to the implementation of public benefit programs in the U.S., the study also showed that compared with anesthesiologists, CRNAs are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries.\textsuperscript{6}

**AANA Request: Recommend Adding a Sixth Patient Relationship Category that Specifically Recognizes Non-Patient Facing Providers and Recognizes the Essential Anesthesia Services that CRNAs Provide**

We note that the Centers for Medicare & Medicaid Services’s (CMS) proposal for the five patient categories do not apply to CRNA anesthesia services. As indicated in the draft proposal, CMS is considering adding a sixth patient category specific for non-patient-facing clinicians, and we support such a proposal and recommend that the category be defined as follows:

*(vi) non-patient facing providers that furnish items and essential services to the patient that are mandatory and medically necessary during an episode of care or procedure.*

A sixth patient relationship category would be in keeping with CMS’ recognition of specialties such as anesthesia, whose providers are considered non-patient facing clinicians but whose services are nonetheless essential to surgery and managing a patient’s pain. According to our analysis of the 2014 Medicare Provider Utilization and Payment data, 98.7\% of CRNAs billed for anesthesia services CPT codes 00100-01999, which CMS determined to be non-patient-facing codes for 2016. Furthermore, as the patient relationship category will be used to attribute patients and episodes to clinicians as part of the Resource Use performance category under Merit Incentive Payment System (MIPS), we request that CMS must ensure that the sixth patient

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\textsuperscript{6} Liao, op cit.
relationship category include an episode group that accounts for the true cost of furnishing anesthesia care services for a particular episode of care or procedure.

The addition of a sixth patient relationship category for non-patient facing providers should ensure that resource use is attributed to the proper clinician. In creating patient relationship categories for an episode of care, we request that CMS distinguish between providers that make the medical decisions that dictate how patient care is to be provided and non-patient facing provider specialties like anesthesia whose contact, relationship and services furnished to a patient is usually limited to the perioperative window including the inpatient stay. Anesthesia professionals, such as CRNAs, do not select their patients or the surgical procedures, which generally falls on the surgeons who determine the surgical procedure or diagnosis codes for reimbursement. Instead, anesthesia professionals determine the anesthesia procedure that best suits the patient needs for the perioperative event, including acute pain management, and we believe that it would be appropriate to attribute the costs of these services to these anesthesia professionals.

We thank you for the opportunity to comment on the draft list of patient relationship categories and codes. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Juan F. Quintana, DNP, MHS, CRNA
AANA President

cc: Wanda O. Wilson, CRNA, PhD, AANA Executive Director
Frank J. Purcell, AANA Senior Director of Federal Government Affairs
Romy Gelb-Zimmer, MPP, AANA Associate Director Federal Regulatory and Payment Policy