The Medicare CRNA Pain Care Rule and You

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The Medicare access to CRNA pain care rule published Nov. 1 and effective Jan. 1, 2013, affects every CRNA practice—not just those involved in chronic pain management. But before we reveal why, let’s look at the videotape.

Two Medicare Administrative Contractors (MACs) serving 17 states acted in 2011 to deny Medicare direct reimbursement of CRNA chronic pain management services, reversing years of Medicare payment practice and policy, and impairing patient access to care. They especially affected rural and frontier America where so many people count exclusively on CRNAs for anesthesia and pain management services. By publishing bulletins online without advance public notice, hearing, or public comment, the Noridian and Wisconsin Physician Services (WPS) MACs stopped covering many Medicare patients’ epidural steroid injections and other common services CRNAs provided within their state scope of practice.

The MACs acted even after Medicare had for decades recognized and reimbursed CRNAs for “anesthesia and related care,” defining “related care” so that it “may include the insertion of Swan Ganz catheters, central venous pressure lines, pain management, emergency intubation, and the preanesthetic examination and evaluation of a patient who does not undergo surgery.”1 Moreover, a critical aspect of the anesthesia care continuum is pain management, and providing acute and chronic pain management services is within CRNA professional scope of practice. And the need is great. A recent Institute of Medicine analysis of pain in the U.S. found that 100 million Americans suffer from chronic intractable pain at an annual healthcare and economic cost near two-thirds of $1 trillion, and that not nearly enough healthcare professionals are available to assess and care for those patients effectively.2

But that was then. Fast forward a year and a half—through AANA’s entire Protect My Pain Care campaign that drew so many patients and healthcare professionals to take action.

Instead of a policy denying reimbursement for CRNA care, an AANA-supported Medicare final rule states, “Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.”3 The agency also said in its descriptive preamble, “In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states.”

What does this mean for CRNAs?

It means that Medicare recognizes and will reimburse CRNAs for chronic pain management services, so long as they are within CRNA scope of practice in the state where they are furnished. (However, the policy is not retroactive to those services the two MACs denied during 2011-12.)

More than that, and important for every CRNA, Medicare recognizes and will reimburse for any Part B CRNA service within CRNA scope of practice in a state, so long as that service meets all the other ordinary Medicare requirements—that the service is medically necessary, upon a Medicare beneficiary, and so forth. In doing so, Medicare follows this recent Institute of Medicine recommendation for Congress: “Include coverage of advanced practice registered nurse services that are within the scope of practice under applicable state law, just as physician services are now covered.”4

Though the final rule was backed by thousands of patients, nurses, physicians, hospital executives, and CRNAs, and representatives of associations representing hospitals, rural health advocates, nurses, APRNs, CRNAs, and the largest consumer organization in the U.S., the AARP, not everyone is as thrilled as the AANA is with this outcome. American Society of Interventional Pain Physicians (ASIPP) head Laxmaiah Manchikanti, MD, was quoted saying, “This rule will increase fraud and abuse, controlled substance abuse, addiction and overuse, leading to numerous fatalities.” And the American Society of Anesthesiologists publicly “rebuked” (!) Medicare for its decision. They are trying to overturn this important new access to pain care policy in Congress, in regulatory agencies, and in the states. Though ASA and ASIPP claim it costs too much, that it will encourage deadly drug diversion through “pill mills,” and that only medical doctors can perform such services, all three opposition claims fail.

With respect to cost, the Medicare final rule preamble states, “Our final rule clarification recognizes local variation in state scope of practice, which does not diverge significantly from current practice. Therefore, we estimate no significant budgetary impact from this proposed change.”

With respect to “pill mills,” CRNA chronic pain management services help combat this significant public health and law enforcement problem in several ways. First, the chronic pain management services provided by CRNAs—injections of various types, most commonly—often alleviate patient need for prescription medications. Second, Medicare payment policy does not affect whether CRNAs may prescribe medications; that policy, known as prescriptive authority, is governed by the states, which have long overseen CRNA anesthesia and pain management services. Third, the AANA is a contributing partner to Drug Enforcement Agency (DEA) and other government agency efforts to advance evidence-based risk evaluation and mitigation strategies (REMS) to combat drug diversion and misuse. Well aware of this growing problem of “pill mills” and trafficking of prescription drugs, the AANA and
CRNAs are committed to patient and public safety.

And with respect to CRNAs preparation to provide these services, nursing and role-specific advanced practice education provides CRNAs with the foundation of knowledge and skill required to deliver chronic pain management services. CRNAs develop their expertise through multiple routes that frequently include one or more aspects of formal fellowship, informal fellowship, mentorship and direct supervised practice. Methods employed to impart this knowledge involve didactic education, continuing education, hands-on supervised laboratory experience, practicums in imaging and radiation safety, and other educational methods. By virtue of education and individual clinical experience, a CRNA possesses the necessary knowledge and skills to employ therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of acute and chronic pain.

Like many healthcare services including anesthesia itself, chronic pain management is a service provided by both CRNAs and physicians, and so it is both the practice of nursing and of medicine. Medicare now recognizes that fact in full, and American patients and healthcare are better for it – and so is the profession of nurse anesthesia, thanks to you.


References
3. 42 CFR §410.69(b), as amended by the Nov. 1, 2012, CY 2013 Physician Fee Schedule Final Rule.

Nov. 6 Election Outcomes for CRNAs

The people’s action on Nov. 6 in the national elections resulted in the reelection of President Barack Obama and continued divided government in Washington, with two more Democrats in the Democratic-majority Senate, and seven more Democrats in the Republican-majority House of Representatives. What are the initial assessments for CRNAs?

• The Affordable Care Act health reform law will continue to be implemented, and will continue to be subject to change and periodic controversy like any other law. The next steps in the implementation of the Act involve the establishment of state-based exchanges for marketing health coverage in states, the expansion of the Medicaid program in many states to cover persons up to 133 percent of the federal poverty level, and execution of the AANA-backed provider nondiscrimination provision effective January 2014.

• The CRNA-PAC saw a significant validation of its effectiveness for CRNAs, as some 94 percent of candidates receiving CRNA-PAC contributions won their elections.

• Key wins for CRNA-PAC backed candidates included: Reps. Lois Capps (D-CA) and Diane Black (R-TN) who are leading nurses in Congress, Sen. Sherrod Brown (D-OH), Sen. Jon Tester (R-MT), Sen.-elect Deb Fischer (R-NE), and Sen.-elect Martin Heinrich (D-NM). All of these lawmakers had CRNAs active in their campaigns, and know CRNAs and their interests in Washington to help promote patient safety and access to care.

• More election results and CRNA impacts were outlined at the AANA Fall Assembly Leadership Academy in November. See the CRNA-PAC’s report to the membership at http://www.caretobecounted.org/election-center/our-success (requires AANA member login and password).