Office Anesthesia Practice

Unregulated practice in physician offices came under increasing scrutiny in the late 1990s. Reports of injury and death in office settings appeared in the media, drawing the attention of the public, as well as legislators and regulators. As of the late 1990s, less than five states had adopted laws and/or rules governing office practice. Now, a majority of states have addressed office practice, and we anticipate that most states will probably address office practice issues in the next few years. Measures that protect patients, such as minimum equipment standards, are certainly laudable. Unfortunately, however, anesthesiologists in many states may well view regulation of the office setting as an opportunity to seek adoption of restrictive provisions concerning CRNAs.

The following table identifies the states that have adopted laws, regulations, position or policy statements or guidelines specifically concerning office anesthesia.[1]

Office Anesthesia Laws/Regulations/Position or Policy Statements/Guidelines[2]

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[1] Laws are adopted by state legislatures. Such laws may include provisions mandating that regulations be adopted implementing the laws. If such provisions are included, the laws would indicate which administrative entity (e.g., the state department of health or board of medicine) has the authority to adopt regulations.

Rules or regulations are adopted by state regulatory boards and can have a significant impact on the practice of nurse anesthesia in the office setting.1 Regulatory boards are administrative agencies responsible for adopting and enforcing rules and regulations. A regulatory board derives this power from an "enabling law," that is, a statute, adopted by a state legislature. A regulation is a specific written policy that has the force of law. To be valid, however, a regulation must be consistent with the enabling law under which it was adopted. To the extent a regulation is inconsistent with its enabling law, the statute will control.

State regulatory boards may also adopt position statements or guidelines or similar interpretive documents. Some states consider such actions impermissible informal rulemaking that avoids the rigors of the formal administrative rulemaking process. If you are unsure what actions regulatory bodies are permitted to take in your state, please consult your state association's lobbyist and/or attorney.

Guidelines may not have the force of law, but often serve as a model, in this case, for office based anesthesia practice. Guidelines communicate what the regulatory board or agency considers to be within the boundaries of professional practice. State law and regulations will dictate whether the board or agency has authority to take disciplinary action against a provider for failing to adhere strictly to the provisions of guidelines. However, "significant deviation" from the guidelines may likely result in investigation and/or sanctions.

A position statement does not have the force and effect of law, similar to guidelines. Position statements are most often used to announce the policy of a regulatory board or agency, to promote certain minimum guidelines, and to highlight safety concerns. Through a position statement, the board or agency can also put the public and the profession on notice of what it considers to be the appropriate standard of care. They are a means of providing direction for practitioners on issues of concern to the board or agency, relevant to protection of the public.

[2] The laws, regulations, position or policy statements, and guidelines were enacted or adopted to apply specifically to physician offices. Other laws, regulations, position or policy statements, or guidelines may

Guide to Abbreviations: In the table below, the abbreviations used are: BOM (board of medicine or its generic equivalent); BON (board of nursing or its generic equivalent); DPR (department of professional regulation or its generic equivalent); and DOH (department of health or its generic equivalent).

Law	Regulations	Position or Policy Statement	Guidelines
Arizona	Alabama (BOM)[3]	Colorado (BOM)[4]	Colorado (BOM)
Arkansas	Arkansas (BOM)	Kentucky (BOM)[5]	Georgia (BOM)[6]
California	Arizona (BOM)	North Carolina[7] (BOM)	Massachusetts (BOM)[8]
Connecticut	California (BOM)	Ohio (BOM)[9]	Michigan
Delaware	Florida (BOM) [10]	Washington (BOM)[11]	New York (DOH)
Illinois	Illinois (DPR)		North Carolina (BOM)
Indiana	Indiana (BOM)		Oklahoma (BOM)
Maryland	Kansas (BOM)		Washington (BOM)
Nevada	Kentucky (BON)[12]		
New York	Louisiana (BOM)		
Rhode Island	Mississippi (BOM)		
Tennessee	Nevada (DOH)		
Texas	New Jersey (BOM)		
Virginia	Ohio (BOM)		
Washington	Oregon (BOM)		
	Rhode Island (DOH)		
	South Carolina (BOM)		

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also affect physician offices (e.g., some ambulatory surgical center (ASC) licensing statutes or regulations may affect some physician offices).

[3] Alabama's regulations include so-called "general guidelines."

[4] The policy statement that the board of medicine adopted includes guidelines.

[5] On June 16, 2011, the Kentucky Board of Medical Licensure published its "Board Opinion Relating to Office-Based Surgery." This opinion includes guidelines for office-based surgery.

[6] The Georgia Composite Medical Board adopted "Guidelines for Office-based Anesthesia and Surgery."

[7] The position statement that the board of medicine adopted includes guidelines.

[8] Endorsed office-based surgery guidelines issued by the Massachusetts Medical Society.

[9] It appears the regulations supersede the position statement. The position statement, however, still appears on the Ohio medical board's website.

[10] In Florida, the adopted rules were originally effective in 1994. In July 2004, in Ortiz v. Dept. of Health, Bd. of Medicine, a Florida appellate court invalidated a rules provision requiring anesthesiologist supervision of CRNAs for Level III surgery in MD offices.

[11] The policy adopted by the Washington Medical Quality Assurance Commission includes guidelines.

[12] The Kentucky Board of Nursing regulations state that CRNA practice shall be in accordance with the standards and functions defined in the AANA's Standards for Office-based Anesthesia Practice, 2001.

Law	Regulations	Position or Policy Statement	Guidelines
	Tennessee (BOM)		
	Texas (BON; BOM)		
	Virginia (BOM		
	Washington (BOM)		
Total	**Total**	**Total**	**Total**
15	**21**	**5**	**8**

Total of number of states that have taken an action in at least one of the categories noted above: 31 (Alabama; Arizona; Arkansas; California; Colorado; Connecticut; Delaware; Florida; Georgia; Illinois; Indiana; Kansas; Kentucky; Louisiana, Maryland, Massachusetts; Michigan; Mississippi; Nevada; New Jersey; New York; North Carolina; Ohio; Oklahoma; Oregon; Rhode Island; South Carolina; Tennessee; Texas; Virginia; Washington).

It is vital that you be vigilant about the possibility of formal regulation of physician office practice in your state. If physician office regulation in your state is considered, the earlier you know about it and can participate, the more likely that you'll be able to influence a favorable outcome. There are three principal ways that states might regulate physician office practice that you'll want to watch for:

1) Boards of medicine adopting regulations, position statements, or guidelines.
2) State legislatures adopting laws concerning physician office practice. Such a law may include provisions mandating that regulations be adopted implementing the law. If such provisions are included, the law would probably describe what administrative entity (e.g., the state department of health or board of medicine) has the authority to adopt such regulations.
3) Departments of health adopting regulations, position statements, or guidelines.

If either your state's board of medicine or department of health proposes formal regulations to regulate physician offices, you will need to evaluate with your state association's legal counsel whether the board or department has jurisdiction to do so. In other words, has the state legislature, either explicitly or implicitly, given the board or department the regulatory authority to regulate physician offices? This is a complicated, but critical question. Unless an administrative entity such as a board of medicine or department of health has regulatory authority to regulate a certain area (e.g., physician offices), regulations are not legally valid.

If your state considers formal regulation of physician offices, you'll want to provide input concerning what kinds of provisions you could support. For example, you could clearly support reasonable office equipment requirements. On the other hand, you certainly

could not support requirements that would serve no other purpose but to restrict physicians from utilizing CRNAs in offices.

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