



American Association of  
**NURSE ANESTHESIOLOGY**

June 29, 2026

**Submitted electronically via Partnership@cms.hhs.gov**

The Honorable Mehmet Oz, MD, MBA  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

**RE: Section 6220 Provider Directory Meeting–Written Comment**

Dear Administrator Oz:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on Section 6220 Provider Directory Meeting. AANA makes comments in the following areas:

- Topic 1: Data and “Source of Truth” For Directory Information
- Topic 2: Verification Approaches, Update Cadence, and Removal of Non-Participating Providers
- Topic 3: Accuracy, Score Methodology, Sampling, Reporting, and Transparency

AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 69,000 CRNAs and SRNAs, representing about 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 58.5 million anesthetics to patients each year in the United States. Since 1989, CRNAs have been Medicare Part B providers, billing Medicare directly at 100% of the Physician Fee Schedule (PFS). CRNAs must be board certified and must participate in continuing education and recertification every 4 years to practice.

As independently licensed professionals, CRNAs are responsible and accountable for making judgments and taking actions in their professional healthcare practice.<sup>1</sup> CRNAs provide expert anesthesia and pain management care across diverse clinical settings and are trained and licensed to care for all patients, including those with complex medical conditions. In some states, CRNAs are the sole anesthesia providers

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<sup>1</sup> AANA Code of Ethics for the Certified Registered Nurse Anesthetists, July 18, available at: [https://issuu.com/aanapublishing/docs/code\\_of\\_ethics\\_for\\_the\\_certified\\_registered\\_nurse\\_?fr=sZGY1YTU2NDAxMjU](https://issuu.com/aanapublishing/docs/code_of_ethics_for_the_certified_registered_nurse_?fr=sZGY1YTU2NDAxMjU).

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in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.<sup>2</sup>

### **Topic 1: Data and “Source of Truth” For Directory Information**

#### **AANA Comment: Include CRNAs and Account for All CRNA Sub-Specialties and Dual Degrees**

As the Centers for Medicare & Medicaid Services (CMS) is implementing provider data accuracy requirements, AANA believes that it is imperative that Medicare Advantage (MA) organizations capture and display information for advanced practice registered nurses (APRNs) including CRNAs the same as they do physicians. In doing so, CMS should ensure that MA organizations are not discriminating against provider types based on licensure<sup>3</sup> and that patients can find and locate an APRN just as easily as they can to find a physician. MA organizations should be required to ensure that their directory information is inclusive of CRNAs and APRNs, their respective specialties independent of their primary taxonomy code, dual degrees, and nursing-related board certifications as well. This information should be included as core fields instead of being optional fields.

In the case of CRNAs, in addition to providing anesthesia services, CRNAs also provide acute, chronic, and interventional pain management services. However, commercial payers, including MA organizations, do not always recognize CRNAs for all these services despite the services being within their scope of practice in a given state, and this could translate into the information that is provided by the MA organization. If a particular subspecialty or service is not listed for CRNAs, patients will get an incomplete and inaccurate list of providers available for services, which hampers improving access to medically necessary anesthesia and pain management services, especially in rural and underserved areas. This is especially troubling as CRNAs are the predominant anesthesia providers in underserved areas and are more likely to work in areas with lower median incomes and larger populations of citizens who are unemployed, uninsured, and/or Medicaid beneficiaries when compared with physician counterparts.<sup>4</sup> Fields containing CRNA sub-specializations, independent of their primary provider taxonomy code, will help patients identify providers ensuring access to the closest available healthcare services.

The directory information fields should also account for CRNAs who hold dual degrees as well. For instance, a CRNA who also is certified as a Nurse Practitioner should be able to have both designations accounted for. Furthermore, the fields should recognize fellowship trainings and CRNA board certifications that are accredited by the National Commission for Certifying Agencies (NCCA).

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<sup>2</sup> For further information see: <https://www.aana.com/about-us>.

<sup>3</sup> 42 USC § 1395w-22(b)(2)

<sup>4</sup> Liao CJ, Qurashi JA, Jordan LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. *Nurs Econ*. 2015;33(5):263-270.

## **AANA Comment: Underlying Provider Taxonomy Code Set Does Not Account for the Various Subspecialty Designations for CRNAs**

Currently, the National Plan and Provider Enumeration System's (NPPES) underlying provider taxonomy code set does not account for the various subspecialty designations that CRNAs may pursue and have expertise in and for which may be part of a CRNA's scope of practice in a state. The National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code Set only recognizes CRNAs as "Nurse Anesthetist, Certified Registered." This makes it challenging for CRNAs to identify subspecialty codes. This also is an issue with CAQH Provider Data, which respondents at the stakeholder meeting reported relying upon. The CAQH portal uses a drop down menu for specialty, which does not allow for CRNAs to pick pain management as a primary specialty.

To resolve this matter, we recommend that CMS extend the designation given to the RN level to the providers who deliver the service. The NUCC does recognize pain management as a nursing subspecialty through 163WP0000X, "Registered Nurse - Pain Management," but this branch stops at the RN level and never extends up to the CRNA classification. CMS does recognize and reimburse CRNAs for independently providing pain management services under the Medicare Part B.<sup>5</sup> And, CRNAs who provide pain management services have served as subject-matter experts on pain management for CMS panels.<sup>6</sup> As CMS also does offer crosswalks to pain management taxonomies for physicians with CMS specialty codes 09 (Interventional Pain Management) or 72 (Pain Management), CMS could also establish a pain-specific specialty designation usable by CRNAs or an interim crosswalk.

### **Topic 2: Verification Approaches, Update Cadence, and Removal of Non-Participating Providers**

AANA is supportive of CMS's efforts to remove ghost providers from directory information so that patients have up-to-date information for providers. Some respondents suggested using claims data to verify providers, and AANA would be supportive of that approach for current practitioners. However, depending on timing of the update cadence, use of claims data could be problematic for some newly entrants might not yet have established claims. In those cases, we recommend verifying information against fellowship trainings and CRNA board certifications that are accredited by the National Commission for Certifying Agencies (NCCA).

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<sup>5</sup> 77 Fed. Reg. 68892, 69005 et seq., Nov. 16, 2012, amending 42 CFR §410.69(b). Certified Registered Nurse Anesthetists scope of benefit. <http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf>.


<sup>6</sup> See for example [https://cgsmedicare.com/pdf/Multijurisdictional\\_CAC\\_Facet\\_Joint\\_and\\_Medial\\_Nerve\\_Branch\\_Procedures\\_5-28-2020.pdf](https://cgsmedicare.com/pdf/Multijurisdictional_CAC_Facet_Joint_and_Medial_Nerve_Branch_Procedures_5-28-2020.pdf), [https://www.wpsgha.com/uploads/1153c634\\_ce2a\\_4e68\\_97e7\\_2e6de6cc02ec\\_04\\_27\\_2023\\_multijurisdictional\\_cac\\_transcript\\_5c\\_c7ddda7c.pdf](https://www.wpsgha.com/uploads/1153c634_ce2a_4e68_97e7_2e6de6cc02ec_04_27_2023_multijurisdictional_cac_transcript_5c_c7ddda7c.pdf), and <https://www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf>.

### **Topic 3: Accuracy, Score Methodology, Sampling, Reporting, and Transparency**

APRNs including CRNAs could have incomplete data directory information because they have been known to be left out of directories for not being doctors. To resolve this matter, MA organizations should be required to capture and display information for CRNAs and APRNs, their respective specialties, dual degrees, and nursing-related board certifications as well. This information should be included as core fields instead of being optional fields.

Thank you for the opportunity to comment on this request for information. Should you have any questions regarding these matters and to schedule a meeting, please contact AANA Director of Regulatory Affairs, Romy Gelb-Zimmer at 202-484-8400, [rgelb-zimmer@aana.com](mailto:rgelb-zimmer@aana.com).

Sincerely,

A handwritten signature in black ink that reads "Jeff E. Molter". The signature is written in a cursive style with a large, stylized initial "J".

Jeff Molter, MBA, MSN, CRNA  
President, AANA

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer