Legal Considerations for CRNAs in Delaware

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Certified Registered Nurse Anesthetists (CRNAs) play a crucial role in the healthcare system, providing high-quality anesthesia care to patients across various settings. However, like any specialized profession, CRNAs face unique legal challenges in the United States (U.S.). From licensure issues to scope of practice concerns, this article addresses the legal landscape CRNAs navigate daily. Lastly, legal considerations related to Medicare Billing for different anesthesia care team models are explored.

Licensure is fundamental for CRNAs to practice in the U.S. Each state has its licensing board, and CRNAs must adhere to state-specific regulations to obtain and maintain licensure. The process involves completing accredited education programs, passing the National Certification Exam (NCE), and meeting additional state requirements. Licensure requirements vary across states, which pose additional considerations for those who wish to practice in multiple states or relocate for career opportunities.

The National Council of State Boards of Nursing (NCSBN) has made strides in promoting licensure compact agreements between states, aiming to streamline the process and facilitate interstate practice for healthcare professionals. Delaware has long been part of the Nurse Licensure Compact (NLC). In 2021, Delaware was the second state to pass legislation allowing for the APRN Compact 2021. However, the APRN Compact can only be implemented once seven states join the Compact (Nurse Licensure Compact (NLC), 2024).

Despite many challenges, CRNAs benefit from legal protections and advocacy efforts. The American Association of Nurse Anesthesiologists (AANA) and the Delaware Association of Nurse Anesthetists (DANA) actively engage in legislative initiatives at both the state and federal levels to advance CRNA interests. These efforts include advocating for favorable scope of practice laws, addressing reimbursement issues, and promoting policies that recognize the unique skills and contributions of CRNAs in the healthcare system. CRNA scope of practice is another area fraught with legal considerations. While CRNAs are highly skilled and trained to administer anesthesia, the extent of their practice can vary from state to state. Some states, like Delaware, grant CRNAs full practice autonomy, allowing them to work independently without physician supervision, while others impose varying levels of supervision or collaboration.

Specific to Delaware, in 2021, after multiple advocacy efforts, House Bill 141 removed all Board of Medicine oversight over Advanced Practice Registered Nurses (APRNs) and eliminated the restrictive transition-to-practice period for newly graduated APRNs. Currently, all Delaware APRNs are granted full practice authority upon licensure. Additionally, Delaware APRNs have full prescriptive authority, wherein they can prescribe medications, including controlled substances, without physician approval (Quinn, 2021). Furthermore, in 2023, Governor Carney opted out of physician supervision of CRNAs in Delaware as a Condition of Participation in Medicare Part A. Governor Carney wrote a letter to the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services stating the following:

I attest that I have consulted with the Delaware Board of Nursing and Board of Medicine about issues related to access to and the quality of anesthesia services in Delaware. I have concluded that it is in the best interests of Delaware citizens to opt out of the current physician supervision requirement, as provided in the federal regulations, and that the opt-out is consistent with Delaware law. This letter constitutes my formal notification of the State of Delaware opt-out. (AANA, 2023, para. 2)

This recent advancement of opt-out status in Delaware allows hospitals and

other organizations to reevaluate and make informed decisions about their anesthesia care models, particularly when considering how anesthesia services are delivered and reimbursed. While Delaware CRNAs can practice without a collaborative agreement with a physician, some hospital policies may limit CRNAs' ability to bill independently for their services. Additionally, some anesthesia groups in Delaware bill Medicare under a medical direction care team model, where the physician anesthesiologist directs anesthesia care for up to four concurrent anesthesia procedures, supervising up to four CRNAs if they meet specific requirements.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 outlined these Medicare medical direction requirements. When billing under a medical direction model, physician anesthesiologists must attest that they meet the following seven requirements (Tax Equity and Fiscal Responsibility Act, 1982).

1. Perform a pre-anesthetic examination and evaluation and document it in the medical record.
2. Prescribe the anesthesia plan.
3. Personally participate in the most demanding procedures in the anesthesia plan —including induction and emergence, if applicable — and document this.
4. Ensure that any procedures in the anesthesia plan are performed by a qualified anesthetist.
5. Monitor the course of anesthesia administration at frequent intervals and document that they were present during some portion of the anesthesia monitoring.
6. Remain physically present and available for immediate diagnosis and treatment of emergencies.
7. Provide indicated-post-anesthesia care and document it.

For clarity, these are billing requirements and are not meant to imply increased patient safety. Research shows there is no difference in anesthesia care outcomes when the anesthesia is provided by a CRNA or physician anesthesiologist (Dulisse & Cromwell, 2010; Negrusa et al., 2016). The TEFRA requirements intended to ensure that the physician anesthesiologist was involved in all the concurrent cases they billed for their services. When billing for medical direction, the fee is split 50% to the physician anesthesiologist and 50% to the CRNA. In a study conducted by physician anesthesiologists, at supervision ratios of 1:2, there were lapses in TEFRA/supervision requirements 35% of the days, and at a ratio of 1:3, there were lapses of supervision 99% of the days (Epstein & Dexter, 2012).

The results of this study beg the question of whether these cases reflect medical direction TEFRA supervision lapses across the country and how many cases are billed under medical direction with an attestation that the seven TEFRA requirements were met. Additionally, CRNAs in Delaware and across the U.S. might wonder if they could be liable under the False Claims Act (FCA) if their anesthesia services are billed under Medical Direction, but the seven TEFRA requirements were unmet. An anesthesiologist could be liable for Medicare fraud by submitting a bill for medically directed services, knowing they did not adhere to all the seven TEFRA requirements. Depending on the situation, though unlikely, the CRNA who allowed their services to be billed in the medical direction model but knew that the seven TEFRA requirements were not met could be liable in an FCA situation (Silberman, 2014).

As highly educated anesthesia professionals, CRNAs should avoid being complicit in billing models that falsely attest to meeting the requirements. Silberman (2014) stated, "no one is obligated to be a whistleblower, and blowing the whistle on wrongdoing comes with its own share of trials and tribulations" (p.12). However, CRNAs are often employed by hospitals or anesthesia groups and might be unaware of the billing policies or practices, which does not protect them from being involved in an FCA claim.

In conclusion, CRNAs should educate themselves on the complexities and requirements of anesthesia billing models and ask questions about services billed under their name to make informed decisions about their employment. Anesthesia groups that bill for medically directed care and find they cannot meet the TEFRA requirements can maintain a care team model while billing for non-medically directed care (Quaraishi et al., 2017). Billing for independent CRNA services is consistent with Delaware laws and regulations; it can offer anesthesia groups flexibility in delivering high-quality, safe anesthesia while complying with Medicare regulations (Covillo et al., 2024; Dulisse & Cromwell, 2010; Quaraishi et al., 2017). ■

References online:
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