AANA
American Association of
NURSE ANESTHESIOLOGY

September 2, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1770-P
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1770-P – Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts Proposed Rule (87 Fed.Reg. 45860 July 29, 2022)

Dear Administrator Brooks-LaSure:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on this proposed rule; Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts (87 Fed.Reg. 45860, July 29, 2022). The AANA makes the following comments and requests of CMS:

- Alleviate the Reimbursement Cuts to Providers, Such as CRNAs
- Support Delay of Proposed Updated MEI Cost Weights

Request for Information: Medicare Potentially Underutilized Services

- Policies Should Promote Full Scope of Practice and Remove Barriers to Access to Care

Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services

- Finalize Proposal to Cover Anesthesia Services for Dental Services and Include those Services Furnished by CRNAs

Telehealth Provisions

- Ensure that Interactive Telecommunications Technology Are Not Used for Anesthesiologist TeleSupervision of Anesthesia Services or For Meeting Anesthesiologist Medical Direction Requirements

Proposed Valuation of Services

- Increase Work RVUs for Somatic Nerve Injections to Account for Work RVU Levels for Ultrasound Guidance
- Ensure that CRNAs are Able to Use and Be Reimbursed for Chronic Pain Management and Treatment Bundles
- Ensure that the Term "Prognosis" is Included as an Option to Providing a "Diagnosis" in Chronic Pain Management Bundles
- Support the Creation of Additional Coding and Payment to Address Acute Pain

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

- Support Expansion of Medicare Coverage for Colorectal Cancer Screenings including Anesthesia Services Provided by CRNAs

QUALITY PAYMENT PROGRAM

- Advertise Changes to the MVPs Through the Quality Payment Listserv and Other CMS Electronic Communications

Proposed Revisions to Previously Finalized MVPs

- Modify IA_PSPA_19 Proposed Activity Description

Promoting Interoperability

- Provide Exceptions to Small Practices and CRNAs in Rural Areas

Request for Information on National Continuing Medical Education (CME) Accreditation Organizations submitting Improvement Activities

- Ensure that CRNAs Have Equal Opportunities as Physicians in Aligning MIPS and MVPs with Efforts to Maintain Licensure and Board Certification Status

Anesthesiology Measure Set

- Retain #076 Prevention of Central Venous Catheter (CVC) – Related Blood Stream Infections in Anesthesiology Measure Set

Request for Information on Quality Payment Program Incentives Beginning in Performance Year 2023

- Extending the 5 Percent Bonus is Critical for Eligible Clinicians to Remain in AAPMs

- Maintain 70 Percent Data Completeness Requirement for CY 2024 and 2025 Performance Periods

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 59,000 CRNAs and SRNAs, representing about 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 50 million anesthetics to patients each year in the United States and are included among the nation's most trusted professions according to Gallup[1]. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services are 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. CRNAs

[1] Gallup "U.S. Ethics Ratings Rise for Medical Workers and Teachers (December 22, 2020), https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx.

also play an essential role in assuring that rural America has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

CRNAs are involved in every aspect of anesthesia services including 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 and recovery. CRNAs also provide acute, chronic, and interventional 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. Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Services. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

Numerous peer reviewed studies have shown that CRNAs are safe, high quality and cost effective anesthesia professionals who should practice to the full extent of their education and abilities. According to a May/June 2010 study published in the journal *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.[2] An August 2010 study published in *Health Affairs* showed no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[3] 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

[2] Paul F. Hogan et al., "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf

[3] B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475. http://content.healthaffairs.org/content/29/8/1469.full.pdf

the world, according to a scientific literature review prepared by the Cochrane Collaboration, the internationally recognized authority on evidence-based practice in healthcare.[4] 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.[5]

The importance of 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.[6] 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.[7] This information highlights the importance of CRNAs who provide high-quality, evidence-based care to millions of Americans living and working in rural and underserved areas. Allowing them to participate in rural emergency hospitals will increase needed access to care for patients who live in these areas.

AANA Request: Alleviate the Reimbursement Cuts to Providers, Such as CRNAs

We were disappointed to see a proposed nearly 4 percent decrease in the anesthesia conversion factor (CF) in this proposed rule. We understand that the Centers for Medicare & Medicaid Services (CMS) is bound by budget neutrality requirements, and that any changes to these

[4] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anaesthetists versus non-physician providers of anaesthesia for surgical patients. *Cochrane Database of Systematic Reviews* 2014, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010357.pub2/abstract

[5] Negrusa B et al. Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications. *Medical Care* June 2016, http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Scope_of_Practice_Laws_and_Anesthesia.98905.aspx.

[6] 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. http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx

[7] Liao, op cit.

requirements would necessitate future Congressional action. However, anesthesia services are currently underfunded, and this disproportionate pay affects patient access to anesthesia care, especially in rural and underserved areas where CRNAs predominate. A study of CRNAs in rural areas that correlated CRNAs with lower-income populations and correlated anesthesiologist services with higher-income populations, 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.[8] In addition, the proposed payment policy changes in this proposed rule will have a negative 1 percent impact on anesthesia payment rates. This cut is especially challenging to providers given inflation is recently at historically high levels.[9] To the extent that CMS does have the ability to alter payment rates, we ask that CMS help lessen the impact of this decrease in the anesthesia CF and to work with Congress to establish an answer. The AANA would be happy to work with the agency in these efforts.

AANA Comment: Support Delay of Proposed Updated MEI Cost Weights

The AANA is appreciative of the agencies efforts to update the Medicare Economic Index (MEI) cost share weights, but we have concerns about the impact that setting the proposed updated MEI cost share weights to the CY2023 payment rates would have on CRNAs. According to Table 148, full implementation of this update would have a negative 8 percent impact on nurse anesthesia payment. We appreciate that CMS has decided not to propose using these weights for the CY 2023 payment, and we do not support the use of the proposed updated MEI cost share weights to calibrate payment rates for use in future Physician Fee Schedule rules. We ask that CMS walk through and work with professional associations, such as the AANA, on viable alternatives.

Request for Information: Medicare Potentially Underutilized Services

[8] Liao CJ, Quraishi JA, Jordan, LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Uninsured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270.

[9]" U.S. Consumer Spending Inched Forward in July, With Inflation Historically High," Wall Street Journal, August 26, 2022.

AANA Request: Policies Should Promote Full Scope of Practice and Remove Barriers to Access to Care

As the agency is seeking recommendations for innovative ideas that will broaden potential solutions to obstacles in accessing underutilized, high value services, the AANA recommends that CMS remove barriers to patients' access to care by ensuring that all APRNs, including CRNAs, practice to their full professional education, skills, and scope of practice. This step will strengthen the healthcare workforce to ensure timely delivery of quality services and care of underutilized services and will address long-standing barriers to strengthening the health workforce, all of which will improve health equity and increase access to care. In particular, CRNAs play an essential role in ensuring that patients in rural America and in areas that are underserved has access to critical anesthesia services, often serving as the sole anesthesia provider in rural hospitals, affording these facilities the capability to provide many necessary procedures.

The importance of CRNA services in rural areas was highlighted in a recent study which examined the relationship between socioeconomic factors related to geography, insurance type, and the distribution of anesthesia provider type.[10] 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 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.

This policy recommendation also corresponds with a recommendation from the National Academy of Medicine's (NAM) report titled *The Future of Nursing: Leading Change, Advancing Health*, which outlines several paths by which patient access to care may be expanded, quality preserved or improved, and costs controlled through greater use of APRNs,

[10] Liao CJ, Quraishi JA, Jordan, LM. Geographical Imbalance of Anesthesia Providers and its Impact on the Unisured and Vulnerable Populations. Nurs Econ. 2015;33(5):263-270. http://www.aana.com/resources2/research/Pages/NursingEconomics2015.aspx

including CRNAs.[11] The NAM report specifically recommends that, "advanced practice registered nurses should be able to practice to the full extent of their education and training."[12]

As part of this policy recommendation, an existing policy barrier we recommend that CMS permanently remove is unnecessary physician supervision requirements as part of the Medicare Conditions of Participation (CoPs) and Conditions for Coverage (CfCs).[13] Permanently removing unnecessary supervision requirements is consistent with Medicare policy reimbursing CRNA services in alignment with their state scope of practice.[14]

Physician supervision requirements can exacerbate the impact on access to care given the labor shortage and the demand for CRNA anesthesia services. A Health Affairs article entitled *A Worrisome Drop in the Number of Young Nurses* highlights the issues we are facing with the nursing workforce. According to the article, "Now, two years into the COVID-19 pandemic, the supply of RNs is under threat again. Using monthly data from the Current Population Survey, our recently published analyses in Health Affairs showed that growth in the RN workforce plateaued during the first 15 months of the pandemic…Extending that analysis through the end of 2021 furthers our concern. New data here, covering the entirety of 2021, show the total supply of RNs decreased by more than 100,000 in one year—a far greater drop than ever observed over the past four decades."[15] Furthermore, the demand for CRNAs are great as evidenced by CMS's own data. Initial data from CMS also showed that during the first three months of the pandemic, CRNAs were among the top 20 most utilized specialty providers.

There is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality and may restrict access and increase cost. Studies have repeatedly

[11] National Academy of Medicine. The Future of Nursing: Leading Change, Advancing Health (Washington, DC: The National Academies Press, 2011); p. 69.

[12] NAM op. cit. p. 7-8.

[13] *See* 42 CFR §§ 482.52, 485.639, 416.42.

[14] 42 CFR §410.69(b), 77 Fed. Reg. 68892, November 16, 2012.

[15] Auerbach, D. et al, A Worrisome Drop in the Number of Young Nurses," HEALTH AFFAIRS FOREFRONT, April 13, 2022, available at: https://www.healthaffairs.org/do/10.1377/forefront.20220412.311784/.

demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*[16] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 22 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the *New York Times* stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."[17] Previously stated, a study published in *Medical Care* June 2016 found no measurable impact in anesthesia complications from nurse anesthetist scope of practice or practice restrictions.[18]

CRNA safety in anesthesia is further evidenced by the significant decrease in liability premiums witnessed in recent decades. In 2022, self-employed CRNAs paid 36.17 percent less for malpractice premiums nationwide when compared to the average cost in 1988. When adjusted for inflation through 2022, the reduction in CRNA liability premiums is an astounding 74.5 percent less than approximately 34 years ago according to Anesthesia Insurance Services, Inc. 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 without any measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[19]

The evidence also demonstrates that the supervision requirement is costly. Though Medicare requires supervision of CRNAs (except in opt-out states) by an operating practitioner or by an anesthesiologist who is immediately available if needed, hospitals and healthcare facilities often misinterpret this requirement to be a quality standard rather than a CoP. The AANA receives reports from the field that anesthesiologists suggest erroneously that supervision is some type of

[16] Dulisse, op. cit.

[17] Who should provide anesthesia care? (Editorial) *New York Times*, Sept. 6, 2010.

[18] Negrusa B et al. op. cit.

[19] Paul F. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169.

quality standard, an assertion bearing potential financial benefit for anesthesiologists marketing their medical direction services as a way to comply with the supervision CoP. When this ideology is established, anesthesiologist supervision adds substantial costs to healthcare by requiring duplication of services where none is necessary. Further, the Medicare agency has clearly stated that medical direction is a condition for payment of anesthesiologist services and not a quality standard.[20] But there are even bigger costs involved if the hospital administrator believes that CRNAs are required to have anesthesiologist supervision.

According to a nationwide survey of anesthesiology group subsidies,[21] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

As independently licensed professionals, CRNAs are responsible and accountable for judgments made and actions taken in his or her professional practice.[22] The scope of practice of the CRNA addresses the responsibilities associated with anesthesia practice and pain management that are performed by the nurse anesthetist as a member of inter-professional teams. The same principles are used to determine liability for surgeons for negligence of anesthesiologists or nurse anesthetists. The laws' tradition of basing surgeon liability on control predates the discovery of anesthesia and continues today regardless of whether the surgeon is working with an anesthesiologist or a nurse anesthetist. [23]

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[20] 63 FR 58813, November 2, 1998.

[21] Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012.

[22] American Association of Nurse Anesthetists. Code of Ethics for the Certified Registered Nurse Anesthetist. Adopted 1986, Revised 2018. See: https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/code-of-ethics-for-the-crna.pdf?sfvrsn=d70049b1_2

[23] Blumenreich, G. Another article on the surgeon's liability for anesthesia negligence. *AANA Journal*. April 2007.

There is strong evidence in the literature that anesthesiologist supervision fails to comply with federal requirements, either the Part A CoPs or Part B conditions for coverage. Lapses in anesthesiologist supervision are common even when an anesthesiologist is medically directing as few as two CRNAs, according to a 2012 study published in the journal *Anesthesiology*,[24] the professional journal of the American Society of Anesthesiologists. The authors reviewed over 15,000 anesthesia records in one leading U.S. hospital, and found supervision lapses in 50 percent of the cases involving anesthesiologist supervision of two concurrent CRNA cases, and in more than 90 percent of cases involving anesthesiologist supervision of three concurrent CRNA cases. This is consistent with over ten years of AANA membership survey data. Moreover, the American Society of Anesthesiologists *ASA Relative Value Guide 2013* suggests loosening further the requirements that anesthesiologists must meet to be "immediately available," stating that it is "impossible to define a specific time or distance for physical proximity." This *ASA Relative Value Guide* definition marginalizes any relationship that the "supervisor" has with the patient and is inconsistent with the Medicare CoPs and CfCs, and with the Medicare interpretive guidelines for those conditions, which require anesthesiologists claiming to fulfill the role of "supervising" CRNA services be physically present in the operating room or suite.

If a regulatory requirement is meaningless in practice, contributes to greater healthcare costs, and is contrary to existing evidence regarding patient safety and access to care, we recommend that CMS remove unnecessary supervision requirements in the Medicare CoPs.

Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services

AANA Request: Finalize Proposal to Cover Anesthesia Services for Dental Services and Include Those Services Furnished by CRNAs

We support CMS's proposal to codify the changes at § 411.15(i) and the proposal to cover anesthesia services for dental services. We request that CMS cover dental anesthesia services

[24] Epstein R, Dexter F. Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics. Anesth. 2012;116(3): 683-691.

being furnished by anesthesia professionals including CRNAs. CRNAs possess the education, training, and skills to provide safe, high-quality, and cost-effective care as members of the multidisciplinary patient-centered dental care team in all settings, including dental offices. CRNAs practice in accordance with their professional scope and standards of practice, federal, state, and local law, and facility policy to provide dental sedation and anesthesia services. Dentists and oral surgeons often work with CRNAs in hospitals and ambulatory surgical centers to provide dental procedures. Furthermore, CRNAs are safe and effective anesthesia professionals who can also improve patient safety in office-based dental practices.

Dental anesthesia has a long history and continues to evolve in terms of techniques, drugs, monitoring, and safety.[25] Dental anesthesia safety is paramount, and it is important to keep patient safety central to the delivery of these services. Challenges to the provision of safe sedation and anesthesia may increase with special populations, including but not limited to, pediatric patients, senior patients, obese patients with related airway issues, and patients with increasing health complexity. The complexity of care required emphasizes the importance of sedation and anesthesia provided by a qualified, licensed anesthesia professional, such a CRNA, who is focused only on patient safety, monitoring, and vigilance.

Telehealth Provisions

AANA Request: Ensure that Interactive Telecommunications Technology Are Not Used for Anesthesiologist TeleSupervision of Anesthesia Services or For Meeting Anesthesiologist Medical Direction Requirements

As CMS continues to seek comment on whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology

[25] American Association of Nurse Anesthesiology, Dental Office Sedation and Anesthesia Care. Park Ridge, IL: American Association of Nurse Anesthesiology, February 2017, https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/dental-office-sedation-and-anesthesia-care.pdf?sfvrsn=ab0049b1_8.

should potentially be made permanent (p. 45901), the AANA cautions against the use of wasteful services in the name of telehealth that would increase costs without improving healthcare access or quality. We stress that one wasteful payment policy to avoid would be reimbursing anesthesiologists that are not providing actual anesthesia care, through billing for remote so-called "supervision" services. This type of remote supervision would not improve access to healthcare for patients and would instead reward providers not actually furnishing healthcare services. CMS also states in the preamble in the 2021 Physician Fee Schedule final rule that they are concerned that virtual presence would not be sufficient "…in complex, high-risk, surgical, interventional, or endoscopic procedures, or anesthesia procedures…such services to be furnished or supervised in person to allow for rapid on-site decision-making in the event of an adverse clinical situation."[26] Furthermore, as there is no evidence of the efficacy and cost-effectiveness of in-person physician supervision requirements,[27] there also is no evidence regarding the benefit for the use of supervision of anesthesia via telehealth.[28] As evidence shows that in-person supervision by physicians does not improve anesthesia outcomes, while it does significantly increase costs; thus it stands to reason that remote supervision would not improve outcomes, while also substantially increasing costs. In these instances, anesthesiologist telesupervision of anesthesia provider services would not meet CMS's current Category 2 criteria for Medicare telehealth services of providing a clinical benefit to the patient. As CMS has noted that Medicare Part B anesthesiologist medical direction is a condition for payment of anesthesiologist services[29] and not quality standards,[30] we also would urge the agency against using interactive telecommunications technology as a way to fulfill any of the seven required steps for payment. We stress that the use of telehealth for these purposes would be wasteful and would constitute inappropriate use. As CMS continues to consider guiderails of the use of

[26] 85 FR 84539, December 28, 2020.

[27] See B. Dulisse and J. Cromwell op cit. and Paul F. Hogan et. al, op cit.

[28] See: Applegate RL, 2nd, Gildea B, Patchin R, et al. Telemedicine pre-anesthesia evaluation: a randomized pilot trial. Telemed J E H ealth. 2013;19:211-6; Cone SW, Gehr L, Hummel R, Merrell RC. Remote anesthetic monitoring using satellite telecommunications and the Internet. Anesthesia and analgesia. 2006;102(5):1463-1467; Dilisio RP, Dilisio AJ, Weiner MM. Preoperative virtual screening examination of the airway. J Clin Anesth. 2014;26:315-7; and Galvez JA, Rehman MA. Telemedicine in anesthesia: an update. Curr Opin Anaesthesiol. 2011;24:459-62.

[29] 42 CFR §415.110 Conditions for payment: Medically directed anesthesia services.

[30] 63 FR 58813, November 2, 1998.

telehealth and any potential use in anesthesia, we also urge that any CMS policy or direction recognize AANA as a major stakeholder in its formulation and that future AANA developed guidelines should be integrated in the determination into Medicare payment policy.

Proposed Valuation of Services

AANA Request: Increase Work RVUs for Somatic Nerve Injections to Account for Work RVU Levels for Ultrasound Guidance

It is not uncommon for CRNAs chronic and acute pain management practitioners to provide somatic nerve injections CPT codes (64415, 64416, 64417, 64445, 64446, 64447, 64448), and when doing so using ultrasound guidance or fluoroscopy. According to the "CY 2021 Utilization Data Crosswalk to CY 2023" published in conjunction with the proposed rule, the data indicate that CRNAs had 68,276 paid claims associated with somatic nerve injections. CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient centered, compassionate and holistic manner across the pain continuum in all clinical settings. By virtue of education and individual clinical experience and competency, a CRNA may practice chronic pain management utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain, including for somatic nerve injections.

Ultrasound guidance or fluoroscopy is required to do these blocks safely and effectively. We do not believe the proposed work RVUs for these codes fully account for the use of these ultrasound guidance or imaging, and providers would take huge cut in reimbursement. These procedures help alleviate the need for opioids. They are critical in the arsenal of compassionate and effective, multimodal pain care, and help in the fight against dependence and abuse of opioid prescriptions. These procedures require the use of imaging. Because fluoroscopy or ultrasound is used with these codes and because CMS is proposing to bundle ultrasound guidance, we request that CMS not devalue these codes and account for the use of imaging. We therefore request that CMS change the proposed bundle work RVU amounts to add in the previous 2022 work RVUs for ultrasound guidance. We also request that arbitrary supervision requirements not be attached to these newly revised codes and that CMS instruct Medicare Administrative

Contractors to continue to allow practitioners to practice and be reimbursed for these procedures to the full regulatory authority granted by Medicare[31] and by CRNAs' respective state practice acts.

AANA Request: Ensure that CRNAs are Able to Use and Be Reimbursed for Chronic Pain Management and Treatment Bundles

We appreciate the development of Chronic Pain Management and Treatment (CPM) bundles and that CMS is accounting for the time and resources involved in attending comprehensively to the needs of beneficiaries with chronic pain. We are concerned that CMS intends to limit these bundles to primary care practitioners. We strongly request that CRNAs are listed as a type provider for CPT codes GYYY1 and GYYY2 and that CRNAs are practicing to the full regulatory authority granted by CRNAs' respective state practice acts. Pain management is central to the scope and practice of a CRNA, and CRNAs play a vital role by providing patient focused, comprehensive pain care in communities throughout the United States. As a main provider of pain management services and as APRNs, CRNAs are uniquely skilled to provide both acute and chronic pain management in a patient-centered, compassionate and holistic manner in all clinical settings. [32] Furthermore, the holistic approach that CRNA pain management practitioners employ when treating their chronic pain patients may reduce the reliance on opioids as a primary pain management modality, thus aiding in the reduction of potential adverse drug events related to opioids.

AANA Request: Ensure that the Term "Prognosis" is Included as an Option to Providing a "Diagnosis" in Chronic Pain Management Bundles

[31] 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.

[32] AANA Chronic Pain Management Guidelines, September 2014, available at:http://www.aana.com/resources2/professionalpractice/Pages/Chronic-Pain-Management-Guidelines.aspx, AANA, Regional Anesthesia and Analgesia Techniques - An Element of Multimodal Pain Management. Guidelines, https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/regional-anesthesia-and-analgesiatechniques-an-element-of-multimodal-pain-management.pdf?sfvrsn=8aac5eb1_6, and AANA Guidelines on A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/a-holistic-approach-to-painmanagement-integrated-multimodal-and-interdisciplinary-treatment.pdf?sfvrsn=f40049b1_4.

We are concerned that the proposed descriptions for CPT codes GYYY1 and GYYY2 use the term "diagnosis" and do not also include the term "prognosis" and that CRNAs could be inappropriately excluded from the use of codes GYYY1 and GYYY2. Chronic pain practitioners, such as CRNAs, support all activities of care as outlined in the proposed descriptions of CPT codes GYYY1 and GYYY2,[33] but we would request that CMS include as an option to providing a "diagnosis" the term "prognosis." As we stated previously in comments to the Physician Fee Schedule proposed rule for CY 2022, Medicare chronic pain providers do not necessarily diagnose patients as these patients can be referred to them for evaluation of pain. These referred patients will already have an ICD-10 coded diagnosis from their primary care or specialist referring for the evaluation. In doing so, the referring practitioner isn't providing all the activities listed in the description for GYYY1. The evaluation provided by the chronic pain provider will usually entail a diagnosis or symptom of pain based on the patient's account, and, for example, radiographic findings of spondylosis or similar diagnosis, and a recommendation to treat this pain.

The term "prognosis" is more in line with what chronic pain practitioners provide. Cohen et al (2019), in answering the question: "Can history and physical examination be used to identify a painful facet joint, or to select people for prognostic blocks?," confirmed that the diagnosis of lumbar facet generated pain relies on a combination of symptomatology, physical examination and confirmation by diagnostic block, a notion supported by multiple pain practitioners. Cohen (2019) also went on to differentiate diagnosis, as the process of identifying a disease, condition, or injury from its signs and symptoms. The term prognosis was defined as the forecasting or likely course of a disease and a method of determining the predictive value of a therapeutic intervention. For these reasons, we urge CMS to amend the CPT description so that the bundles do not solely rely on the activity "diagnosis," but instead also includes "prognosis" as an option to "diagnosis". Lastly, we recommend that chronic pain practitioners, such as CRNAs, still have

[33] See for example: AANA Chronic Pain Management Guidelines, November 2021, available at: https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/chronic-pain-management-guidelines.pdf?sfvrsn=d40049b1_8.

access to the use of CPT codes 99202-99215 as chronic pain providers always provide face-to-face contact time with patients with chronic pain.

AANA Comment: Support the Creation of Additional Coding and Payment to Address Acute Pain

We appreciate CMS's consideration of creating addition coding and payment to address acute pain, and recommend that CMS include separate coding and payment that supports the use of opioid free techniques and ERAS® pathways available in all settings from offices to healthcare facilities. We also recommend that these be made available for use for direct reimbursement by providers, such as CRNAs. The AANA believes that the use of opioid sparing techniques and ERAS® pathways are essential since the risk of opioid dependence and addiction begins with the first exposure. As any E&M associated with the primary anesthetic is already bundled into the reimbursement for the anesthetic provided, and opioid free techniques and ERAS® pathways are not currently reimbursed. Therefore, we recommend that coding be developed and used as a stand-alone or a single unit specialty service in addition to the primary anesthetic.

Multimodal analgesia describes the use of more than one modality or techniques to achieve effective pain control from the preoperative period through initial recovery and return home.[34] A multimodal treatment, instead of the traditional unimodal opioid approach involves the administration of several analgesics with separate mechanisms of action across the perioperative period and/or concurrent field block using local anesthetic, regional or neuraxial analgesia (e.g., paravertebral block with non-opioid analgesia).[35] It is important to take into consideration the complexity of the surgical procedure, patient pain experience history and preferences, anticipated level of postoperative pain, and duration of action of analgesics and local anesthetics when deciding on pain management options for pathway development and for individual patients. Multimodal analgesia may eliminate or significantly reduce the use of opioids and adverse side

[34] Tan M, Law LS, Gan TJ, Optimizing pain management to facilitate Enhanced Recovery After Surgery pathways. Can J Anaesth. Feb 2015;62(2):203-218.

[35] Tan M, Law LS, Gan TJ, op cit.

effects such as respiratory depression, postoperative nausea and vomiting (PONV), and delayed return of gastrointestinal function.[36]

Non-opioid medications include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), systemic lidocaine or ketamine infusion, long-acting local anesthetics, and gabapentinoids (gabapentin/pregabalin).[37] Other modalities using local anesthetics of varying durations of action include surgical site local anesthetic infiltration, field blocks (e.g., transversus abdominis plane (TAP) block), central neuraxial techniques (e.g., epidural and spinal analgesia), and regional blocks.[38] Non-pharmacological analgesia (e.g., acupuncture, music therapy) as well as cognitive-behavioral techniques (e.g., guided imagery, relaxation), may be used as an adjunct to pharmacological methods to support the patient to reduce postoperative pain, anxiety, and use of pain medication.[39]

Using a multimodal approach and specific protocol-driven ERAS® pathways improves patient outcomes by reducing the patient's stress response to surgery, shortening the overall hospital length of stay, and accelerating the return to normal daily function. The anesthesia professional plays a pivotal role in patient/family education by engaging the patient as an active participant in his or her care and the recovery process.[40] Anesthesia professionals continue to build on these activities throughout the Prehospital/Preadmission Phase through patient assessment and evaluation to identify unique elements of the patient's health, pain and anesthesia history that may require modification of the ERAS® pathway to coordinate development of the plan of care with the patient and their primary care and specialty team, as appropriate. The patient's pain management plan of care begins pre-procedure and continues through post discharge using

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[36] Miller ET, Gan TJ, Thacker JK. Enhanced Recovery pathways for major abdominal surgery Anesthesiology News 2014.

[37] Siu-Chun Law L, Ah-Gi Lo E, Gan TJ. Preoperative Antiemetic and Analgesic Management In: Gan TJ, Thacker JK, Miller TE, Scott MJ, Holubar SD, eds. Enhanced Recovery for Major Abdominopelvic Surgery. West Islip, NY: Professional Communications, Inc; 2016:105-120.

[38] Montgomery R, McNamara SA. Multimodal Pain Management for Enhanced Recovery: Reinforcing the Shift From Traditional Pathways Through Nurse-Led Interventions. AORN J. Dec 2016;104(6S):S9-S16.

[39] See: Tan M, Law LS, Gan TJ, op cit. and Montgomery R, McNamara SA, op cit.

[40] Brady KM, Keller DS, Delaney CP. Successful Implementation of an Enhanced Recovery Pathway: The Nurse's Role. AORN J. Nov 2015;102(5):469-481.

opioid-sparing techniques such as regional anesthesia including placement of epidural catheters, targeted peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures. Careful assessment and treatment of acute pain, which may include appropriate opioid prescribing, can decrease the risk of acute pain transitioning to chronic pain or the development of opioid dependency and abuse.[41] We stand ready to further support CMS in the development of additional coding and payment to address acute pain.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

AANA Request: Support Expansion of Medicare Coverage for Colorectal Cancer Screenings including Anesthesia Services Provided by CRNAs

The AANA supports the agency's proposal to expand Medicare coverage for colorectal cancer screenings (CRC) by reducing the minimum age requirement to 45 years and also to expand the definition of CRC tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based CRC screening test returns a positive result. We agree with CMS that this will expand access to essential services and will improve health outcomes for Medicare beneficiaries through prevention, early detection, and more effective treatment and reduced mortality. We ask that CMS continue to cover anesthesia services associated with follow-on screening colonoscopies furnished by anesthesia providers, such as CRNAs. The AANA has an interest in improving patient outcomes by delivering colonoscopies safely, comfortably and efficiently, and we caution the agency not to devalue these codes. Patients recover more quickly from Monitored Anesthesia Care than from other sedation, enabling GI endoscopy proceduralists to provide a dramatically greater number of higher quality procedures than those using alternative forms of sedation.

QUALITY PAYMENT PROGRAM

[41] See AANA Position Statement, "A Holistic Approach to Pain Management: Integrated, Multimodal, and Interdisciplinary Treatment, July 2016, available at: www.aana.com/HolisticPainMgmt.

AANA Request: Advertise Changes to the MVPs Through the Quality Payment Listserv and Other CMS Electronic Communications

We appreciate that CMS is improving transparency in the MIPS Value Pathways (MVP) development process by allowing feedback from the public on new candidate MVPs and on updates to established MVPs. We believe that all clinicians in a specialty should have an equal voice in the creation of measures that affect the quality, cost and outcomes to the patients they serve, and which will affect CRNA future reimbursement. For new candidate MVPs, CMS proposes to post a draft version of the MVP on Quality Payment Program and solicit feedback from the general public for 30 days. It is not clear if whether the agency would simply post on the QPP website for the public to monitor, or if the agency would take additional steps to advertise the opportunity for public comments. We, therefore, recommend and request that CMS advertise further once these new candidate MVPs are posted on the QPP website through electronic communications, such as through the Quality Payment Program listserv. This action will further improve transparency and also better ensure the opportunity for CMS to receive comments.

Proposed Revisions to Previously Finalized MVPs

AANA Request: Modify IA_PSPA_19 Proposed Activity Description

As CMS is proposing to remove IA_PSPA_20 among the inventory of improvement activities for the Anesthesia MVP (p.46841), we have concerns that CMS is replacing it with IA_PSPA_19. While we are appreciative of CMS's effort to remove duplicative improvement activities, IA_PSPA_19 includes in its proposed revised activity description participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program. We recognize that this is not the only pathway to participation for this improvement activity, but American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program is not available to nursing organizations. Therefore, CRNAs may be limited in how they can participate in this activity. If CMS is to propose improvement activities for the Anesthesia MVP, we believe the agency should ensure that the opportunities to participate in them are equal for different providers of the same specialty, and that providers should be afforded to them the same

opportunity for measure achievement points, ultimately meeting scoring performance thresholds. Therefore, we propose that CMS delete from the proposed activity description of IA_PSPA_19 "[p]articipation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program" and replace it with an activity that is open to all providers.

Promoting Interoperability

AANA Request: Provide Exceptions to Small Practices and CRNAs in Rural Areas

As CMS is proposing not to reweight to zero the Promoting Interoperability category for CRNAs for 2023, we would caution that this may be challenging for CRNAs in small practices or rural areas to participate meaningfully in MIPS. We appreciate that CMS has reweighted this category to zero since the inception of the Quality Payment Program to help ensure that CRNAs can actively participate in the MIPS program. Data from the 2020 QPP Experience report, indicates that about 20-30 percent of anesthesia provider participate in the Promoting Interoperability performance category. We would ask that CMS consider offering exceptions to small practices and to CRNAs in rural areas. We also request that CMS clarify how this proposal will affect participation in MVP program and in the Anesthesia MVP, and specifically, whether or not CRNAs would no longer be recognized as a clinician type that qualifies for automatic reweighting of the PI category in MVPs.

Request for Information on National Continuing Medical Education (CME) Accreditation Organizations submitting Improvement Activities

AANA Request: Ensure that CRNAs Have Equal Opportunities as Physicians in Aligning MIPS and MVPs with Efforts to Maintain Licensure and Board Certification Status

We appreciate that CMS in reducing clinician burden by aligning MIPS and MVPs with efforts clinicians undertake to maintain licensure and board certification status. We believe that the process for doing so should be open and equally applied to all clinicians, not just physician specialties. The process should not discriminate on the basis of licensure, such that practitioners who are not physicians, such as CRNAs and other types of APRNs, should have equal opportunities to participate. Therefore, CMS should address how clinicians who are not

physicians can use their continuing education programs to participate in MVPs and MIPs and that their continuing education units count equally to that of physicians' CMEs.

CMS should consider accepting the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) credentialing programs as evidence that CRNAs have completed improvement activities that align with CRNAs' efforts to complete CNEs. Currently, NBCRNA is uploading certification information into the National Council of State Boards of Nursing (NCBSN) database, which provides Boards of Nursing (BON) real time access to current certification credentials as part of the licensure process for CRNAs. Specifics need to be outlined regarding how to include national accrediting organizations, like NBCRNA, that would minimize both the burden to accrediting organizations and clinicians administrative and financial reporting burden.

Anesthesiology Measure Set

AANA Request: Retain #076 Prevention of Central Venous Catheter (CVC) – Related Blood Stream Infections in Anesthesiology Measure Set

We are concerned with CMS's proposal to remove #076 Prevention of Central Venous Catheter (CVC) – Related Blood Stream Infections from the Anesthesiology Measure Set. While this measure has topped out, we still believe that this measure is appropriate for inclusion in the measure set as it is still useful for monitoring patient safety and the impact of patient outcomes. Therefore, we request that CMS retain this measure in the Anesthesiology Measure Set.

Request for Information on Quality Payment Program Incentives Beginning in Performance Year 2023

AANA Comment: Extending the 5 Percent Bonus is Critical for Eligible Clinicians to Remain in AAPMs

The loss of the 5 percent bonus provides little incentive for eligible clinicians to stay in value-based care options within the advanced alternative payment program (AAPM) given that MIPS has the potential for a positive payment adjustment of up to nine percent. Therefore, extending the 5 percent bonus is a critical incentive for eligible clinicians to stay in AAPMs.

AANA Request: Maintain 70 Percent Data Completeness Requirement for CY 2024 and 2025 Performance Periods

We have concerns with CMS's proposal for a 75 percent data completeness requirement for the CY 2024 and CY 2025 performance periods, especially if CMS is no longer automatically reweighting to zero the PI category for CRNAs. This may be particularly challenging for CRNAs in small practices or rural areas. We would request that given this move, that CMS not adopt a 75 percent data completeness requirement for the CY 2024 and 2025 performance periods and maintain the existing 70 percent data completeness requirement.

We thank you for the opportunity to comment on this proposed rule. Should you have any questions regarding these matters, please feel free to contact AANA Senior Associate Director, Federal Regulatory and Payment Policy, Romy Gelb-Zimmer at 202-484-8400, rgelb-zimmer@aana.com.

Sincerely,

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