ASA Analysis of New Anesthesia Interpretive Guidelines for Hospitals

On December 11, 2009, CMS issued final revisions to the hospital interpretive guidelines that pertain to anesthesia services. While ASA is concerned that these changes may not have followed provisions in the Administrative Procedures Act and will address this issue as well as other concerns in regards to the revisions with CMS, it is important that you understand the key changes and implications. All references are to the CMS Publication S&C-10-09-Hospital available at: http://www.asahq.org/Washington/12-11-09%20RevisedANHospitalInterpretiveGuidelines.pdf

- **The revisions only apply to non-critical access hospitals** [not critical access hospitals (CAHs) or ambulatory surgical centers (ASCs); pg. 1 of S&C-10-09-Hospital]

- The interpretive guidelines **delineate between anesthesia** (medication to produce a loss of pain, movement, function and memory and/or consciousness) **and analgesia** (relief of pain by blocking pain receptors). (pg. 5)

- **CRNAs are specifically permitted to administer labor epidurals for the purpose of analgesia without physician supervision**. However, if anesthesia effect is necessary for delivery, supervision is required. (pg. 7)

- Hospitals are required to establish policies and procedures defining provision of these services which are consistent with State scope of practice law. (pg. 8)

- **One Anesthesia Service** - all anesthesia services provided by the hospital (including all departments on all campuses and off-site locations where anesthesia services are provided) must be organized into "one anesthesia service" (i.e., department) and directed by an MD or DO. (pg. 8)
  - The anesthesia service (department) must develop policies and procedures on provision of ALL anesthesia services (including analgesia) and minimum qualifications for each practitioner permitted to provide ALL anesthesia services. (pg. 8)
  - The medical staff bylaws or rules and regulations (new) must include criteria for determining anesthesia service privileges to all practitioners. (pg. 12)

- **Immediately Available Specifically Defined** - guidelines now define "immediately available" (pg. 11, 12) to mean that the anesthesiologist must be:
  - Physically located within the same area as the CRNA or AA
    - E.g., in the same operative suite, same labor and delivery unit, or same procedure room
  - Not otherwise occupied in a way that prevents the anesthesiologist from immediately conducting hands-on intervention, if needed

- **Pre-anesthesia Evaluation** – must be performed within 48 hours prior to any surgery (administration of first dose of anesthesia marks end of 48 hours) with general, regional or monitored anesthesia. Elements for evaluation have expanded. (pg. 14-15)

- **Postanesthesia Evaluation** – must be completed and documented within 48 hours of any surgery involving general, regional, or monitored anesthesia in both inpatient and outpatient settings. (pg. 17)
  - Time begins when patient is moved into the designated recovery area. (pg. 17)
  - Evaluation cannot begin immediately upon arrival to the designated recovery area and cannot occur until after patient has sufficiently recovered from the effects of anesthesia so as to participate in the evaluation (e.g. answer questions and perform tasks) (pg. 17-18)
  - For outpatients – must be completed prior to discharge even if 48 hours is later (pg. 18)