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## STANDARDS FOR ACCREDITATION OF NURSE ANESTHESIA EDUCATIONAL PROGRAMS

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2004 Standards for Accreditation of Nurse Anesthesia Educational Programs
Preface

The educational standards for nurse anesthesia programs represent the work of many individuals and groups that are affected by them, including certified registered nurse anesthetist (CRNA) practitioners and educators; nurse anesthesia students; administrators and faculty of colleges and universities; hospital administrators; state boards of nursing; the staff of the U.S. Department of Education (USDE); the Council for Higher Education Accreditation (CHEA), and other nationally recognized accreditation agencies; members of the councils on certification, recertification, and public interest in anesthesia; and the Board of Directors of the American Association of Nurse Anesthetists (AANA). Special recognition must be given to members of the Assembly of School Faculty of Nurse Anesthesia and to those on the AANA Education Committee for their continuing efforts to promote, support, and encourage the Council's objectives of quality assessment and enhancement in nurse anesthesia education through the accreditation mechanism.

Suggestions for future revisions should be forwarded to:

    Council on Accreditation of Nurse Anesthesia Educational Programs
    222 South Prospect Avenue, Suite 304
    Park Ridge, Illinois 60068-4001
The Value of Accreditation

Accreditation is an activity that has long been accepted in the United States, but it is generally unknown in most other countries because they rely on governmental supervision and control of educational institutions. The accomplishments and outstanding successes in the education of Americans can be traced in large part to the reluctance of the United States to impose governmental restrictions on institutions of postsecondary education and to the success of the voluntary American system of accreditation in promoting quality without inhibiting innovation. The large percentage of Americans who benefit from higher education, the reputation of U.S. universities for both fundamental and applied research, and the widespread availability of professional services in the United States all attest to the high quality of postsecondary education and the success of the accreditation system that the U. S. institutions and professions have devised to promote quality.

Accreditation is a peer process whereby a private, nongovernmental agency grants public recognition to an institution or specialized program that meets or exceeds nationally established standards of acceptable educational quality. A guiding principle of accreditation is the recognition that institutions or specialized programs have a right to expect that they will be evaluated in the light of their own stated purposes, as long as those purposes are educationally appropriate and fall within the recognized scope of the accrediting body.

There are two fundamental reasons for accreditation: (1) to ensure quality assessment and (2) to assist in quality improvement. Accreditation, which applies to institutions or programs, must be distinguished from certification and licensure, which apply to individuals. Accreditation cannot guarantee the quality of individual graduates, but it can provide reasonable assurance of the context and quality of the education that is offered.

Accreditation provides services that are of value to several constituencies:

The public receives:

1) reasonable assurance of the external evaluation of a program and its conformity with general expectations in the professional field;
2) identification of programs that have voluntarily undertaken explicit activities directed at improving their quality and their successful execution;
3) improvement in the professional services available to the public, resulting from the modification of program requirements to reflect changes in knowledge and practice that are generally accepted in the field;
4) less need for intervention by public agencies in the operations of educational programs, because of the availability of private accreditation for the maintenance and enhancement of educational quality.

Students benefit from:

1) reasonable assurance that the educational activities of an accredited program have been found to be satisfactory and meet the needs of students;
2) assistance in transferring credits among programs and institutions;
3) a uniform prerequisite for entering the profession.

Programs receive:

1) the stimulus needed for self-directed improvement;
2) peer review and counsel provided by the accrediting agency;
3) enhancement of their reputation, because of the public’s regard for accreditation;
4) eligibility for selected governmental funding programs and private foundation grants.

The profession realizes:

1) a means for participation of practitioners in establishing the requirements for preparation to enter the profession;
2) a contribution to the unity of the profession by bringing together practitioners, educators, students, and the communities of interest in an activity directed toward improving professional preparation and practice.


History of Nurse Anesthesia Accreditation

On June 11, 1930, Agatha Hodgins, a nurse anesthetist, set forth her ideas regarding the essentials of a national organization for nurse anesthetists. They included (a) organization of a special group; (b) establishment of educational standards; (c) development of a state registration mechanism; (d) lobbying to practice without unwarranted criticism; and (e) improving the quality of work through study and research. She became the force behind establishing an organization dedicated to meeting the needs of the first nursing specialists. One of the initial objectives of the National Association of Nurse Anesthetists (whose name was later changed to the American Association of Nurse Anesthetists) was to develop the mechanics for establishing a program to evaluate schools of nurse anesthesia.

An Education Committee was established in 1933, which was charged with the development of educational standards, maintenance of a central bureau, and compilation of lists of approved schools and qualified instructors. The minimum standards called for a course of 4 months' duration, 250 anesthesia cases, and 75 hours of classroom instruction. The work of this committee over the next two decades resulted in revision of the guidelines for the course of study and development of the essentials for approval of nurse anesthesia schools. In addition to nursing at the postsecondary level, the course of study has developed into a full 2- to 3-year program requiring extensive preparation in the advanced sciences and supplemented by a clinical practicum in healthcare facilities that can provide a broad range of clinical experiences.

The formal accreditation program began in 1952 with the endorsement of the American Hospital Association (AHA) and advisement from its Council on Professional Practice. In 1955, AANA was listed by the U.S. Commissioner of Education as the recognized agency for accreditation of nurse anesthesia schools.

The accreditation function was transferred to the AANA's Council on Accreditation of Nurse Anesthesia Educational Programs in 1975, in response to a major revision of the U.S. Office of Education criteria. The revised criteria reflected many of the sociopolitical concerns of the time: (1) public accountability, (2) conflicts of interest, (3) consumer protection, (4) nondiscriminatory practices, (5) due process, and (6) community of interest involvement. These criteria mandated a structural change in the AANA that resulted in the formation of three semiautonomous councils -- accreditation, certification, and practice (now known as the Council for Public Interest in Anesthesia). These councils were granted full functional and operational autonomy over the next 3 years, after proving their effectiveness in performing their respective responsibilities. A fourth council, recertification, was established in 1978 to serve as the monitoring body for the continuing education of nurse anesthetists. The Council on Accreditation of Nurse Anesthesia Educational Programs has existed since 1978 as an autonomous, multidisciplinary body under the corporate structure of the AANA, representing the various publics within the nurse anesthesia community of interest in which the profession resides. The 12 members of the Council represent...
the following groups: (1) nurse anesthesia educators and practitioners, (2) nurse anesthesia students, (3) health care administrators, (4) universities, and (5) public members. All members have been vested with full decision making and voting powers with the exception of the nurse anesthesia student who shall serve as a non-voting member of the Council.

The Council on Accreditation of Nurse Anesthesia Educational Programs has been continuously recognized by the U.S. Department of Education (USDE) since 1975, as well as by the Council on Postsecondary Accreditation or its successor, the Commission on Recognition of Postsecondary Accreditation (CORPA), since 1985. The Council for Higher Education Accreditation assumed CORPA’s recognition functions in 1997. The scope of accreditation was clarified by the USDE in 1993 and by CORPA in 1994 to delete reference to generic programs and specify nurse anesthesia programs that prepared graduates at the certificate, baccalaureate, master’s, and doctoral degree levels. In 1997, the scope was revised to delete baccalaureate programs that no longer existed. Currently, the Council is identified by the USDE as a nationally recognized accrediting agency for the accreditation of institutions and programs of nurse anesthesia at the post master's certificate, master's, or doctoral degree levels in the United States, its territories, and protectorates.

A number of requirements in the 1994 standards were written to comply with regulations that carried out provisions of the 1992 reauthorization of the Higher Education Act. In passing the law, Congress increased USDE's oversight of institutions that receive federal student aid by implementing more stringent requirements for the USDE, state governments, and accrediting agencies, such as the Council on Accreditation of Nurse Anesthesia Educational Programs. The impetus for the new requirements was an unacceptably high national rate of graduates who failed to repay their federal student loans. As a result of the new requirements, many accrediting agencies lost USDE recognition because their accreditation was not needed to obtain federal monies. Regulations were adopted that specified new areas for accreditation review, such as tuition in relation to the subject matter taught, default rates in student loan programs, records of student complaints, and job placement rates.

The reason why the Council maintains USDE recognition falls under the legislative mandate that calls for the USDE to identify reliable authorities for the quality of training that is offered by educational institutions and programs as the basis for ascertaining eligibility for federal funding under selected legislation. The Council maintains CHEA recognition to demonstrate its effectiveness in assessing and encouraging improvement and quality in programmatic accreditation. The Council also subscribes to the Code of Good Practice for accrediting organizations through membership in the Association of Specialized and Professional Accreditors (ASPA).
Mission, Purposes, and Objectives of the Council on Accreditation of Nurse Anesthesia Educational Programs

Mission Statement

The Council’s mission is to (1) grant public recognition to nurse anesthesia programs and institutions that award post master’s certificates, master’s, and doctoral degrees that meet nationally established standards of academic quality (quality assessment) and (2) assist programs and institutions in improving educational quality (quality enhancement).

The goals of the Council are to:

1. Pursue its mission, goals and objectives and conduct its operations with integrity.
2. Advise, formulate, and/or adopt standards, criteria, policies and procedures for the accreditation of nurse anesthesia educational programs, subject to review and comment by all constituencies that are significantly affected by them.
3. Foster academic quality in educational programs.
4. Utilize evaluation to measure a program's degree of success in meeting programmatic objectives and accreditation requirements within the context of its institutional mission and resources.
5. Encourage innovations in program design and/or experimental programs that are based on sound educational principles.
6. Ensure responsiveness to its communities of interest including, but not limited to students, programs, and the public.
7. Foster student achievement and continuous program improvement as a basis of promoting quality nurse anesthesia services to the public.
8. Incorporate public involvement in its decision making related to quality and accountability.

The objectives of the COA are to:

1. Promulgate standards of accreditation for nurse anesthesia graduate programs with input from the communities of interest.
2. Periodically assess programs for compliance with accreditation standards through annual reports, self-studies, site visits, and progress reports.
3. Confer and publish accreditation decisions for programs and institutions of nurse anesthesia.
4. Require programs to routinely provide reliable performance and information data to the public.
5. Write policies and procedures defining the accreditation process and procedure.
6. Facilitate the development of new nurse anesthesia programs.
7. Offer consultation concerning nurse anesthesia education to enhance academic quality.
8. Conduct collaborative reviews with other accrediting agencies.
9. Conduct discussions with federal and state governmental agencies concerning accreditation.
10. Participate in a systematic self-assessment of the standards, policies, and procedures of accreditation to ensure accuracy and reliability.
11. Provide accurate information concerning the accreditation process and its accredited programs.
12. Consider legitimate allegations from complainants concerning the accreditation process.
13. Employ appropriate and fair procedures in decision-making.
14. Ensure the academic quality of distance and traditional educational offerings.
The Accreditation Process

The Council on Accreditation is responsible for establishing the standards for accreditation of nurse anesthesia educational programs, subject to consideration of the revisions by the communities of interest. The standards address: (I) governance, (II) resources (III) program of study, (IV) program effectiveness, and (V) accountability. The standards have been under review and have been subject to periodic major and minor revisions since they were established. Compliance with the standards forms the basis for the Council’s accreditation decisions.

Certain criteria have been ascertained to have major significance regarding educational quality. Failure to fully comply with one or more of these criteria is considered to be of critical concern in decisions regarding nurse anesthesia program accreditation and is marked with an asterisk (*). The Council reserves the right to identify other areas or criteria. The accreditation process for established programs is based on the self-evaluation study document prepared by the program and on an on-site review by a team of two or three reviewers. The process is repeated at intervals up to 10 years. A summary report of the review is presented to the Council for an accreditation decision. New programs that seek accreditation status must successfully complete an initial accreditation review, admit students, and undergo a subsequent review after the first students graduate.

Ongoing oversight by the Council is provided between formal programmatic reviews. Programs are required to advise the Council and get approval of major changes. The Council also investigates situations brought to its attention that may affect a program’s accreditation status. Each program is required to complete and submit an annual report.

In a broad sense, accreditation of nurse anesthesia educational programs provides quality assurance concerning educational preparation through continuous self-study and review. The ultimate goals of the accreditation program are to improve the quality of nurse anesthesia education and provide competent anesthetists for healthcare consumers and employers. Graduation from an accredited program is a prerequisite for eligibility for national certification, and it is also used as a criterion by licensing agencies, employers, and potential students in the decisions they make and in determining eligibility for government funding.
STANDARDS FOR ACCREDITATION OF NURSE ANESTHESIA EDUCATIONAL PROGRAMS

COUNCIL ON ACCREDITATION OF NURSE ANESTHESIA EDUCATIONAL PROGRAMS

To be considered for Council on Accreditation of Nurse Anesthesia Educational Programs (COA) accreditation, a nurse anesthesia program must demonstrate that it develops and implements the necessary mechanisms to comply with five educational standards.

**Standard I: Governance**

INSTITUTIONAL GOVERNANCE RESULTS IN THE EFFICIENT OPERATION OF THE NURSE ANESTHESIA PROGRAM, PROMOTES EDUCATIONAL EXCELLENCE AND SUPPORTS NEEDED CHANGE THROUGH THE IMPLEMENTATION OF ITS MISSION AND PHILOSOPHY. THE INFRASTRUCTURE FACILITATES ATTAINMENT OF PROGRAM GOALS AND OBJECTIVES AND INVOLVES ITS COMMUNITIES OF INTEREST.

**CRITERIA**

A1. The mission and/or philosophy of the conducting institution's governing body promotes educational excellence and supports the nurse anesthesia program within a graduate framework.

A2. The organizational relationships of the institution, academic unit, and program are clear, support the objectives of the program, and facilitate needed change.

A3. The governance structures in which the program functions facilitate appropriate involvement and communication among and between faculty, students, administrators, the public, and its communities of interest.
A4. The governing body appoints a CRNA as program administrator with leadership responsibilities and authority for the administration of the program. The CRNA administrator must be qualified by experience and have an earned graduate degree from an institution of higher education accredited by a nationally recognized accrediting agency.

A5. The governing body appoints a CRNA, qualified by graduate degree, education, and experiences to assist the CRNA program administrator and, if required, assume leadership responsibilities. This individual must have an earned graduate degree from an institution of higher education accredited by a nationally recognized accrediting agency.

A6. The program appoints a CRNA, master’s degree preferred, or anesthesiologist coordinator for each clinical site with defined responsibilities for students.

A7. The conducting organization completes a legally binding written agreement that outlines the expectations and responsibilities of all parties when an academic or clinical affiliation is established or two or more entities with unshared governance enter into a joint arrangement to conduct a program.

A8. The academic institution identifies an appropriate liaison at the academic site when it enters into an affiliation with a nurse anesthesia program.

A9. A program of nurse anesthesia has current written policies and procedures that facilitate its efficient and effective operation.

A10. The institution’s and/or program’s committee structure is appropriate to meet program objectives, and includes public, student, and faculty participation.

A11. An accredited program is required to act in accordance with the Council’s policies and procedures for accreditation.

* Failure to fully comply with one or more of these criteria is considered to be of critical concern in decisions regarding nurse anesthesia program accreditation.

** Doctoral degrees will be required for the CRNA program administrators (program administrator and assistant program administrator) in all doctoral programs by 2018. All degrees must be awarded by a college or university that is accredited by a nationally recognized institutional accreditor.

*** Master’s degrees are required for CRNA clinical coordinators by 2014.
**Standard II: Resources**

**THE CONDUCTING INSTITUTION DEMONSTRATES THAT RESOURCES ARE SUFFICIENT TO PROVIDE ONGOING COMMITMENT AND SUPPORT OF THE NURSE ANESTHESIA PROGRAM.**

**CRITERIA**

* B1. Resources are adequate to promote effective teaching and student learning and to achieve the program’s stated outcomes within the context of the institutional mission.

B2. There is a budget that provides evidence of adequate funding for nurse anesthesia education.

B3. The CRNA program administrator provides input into the budget process to ensure adequate resources are available for the program.

* B4. The conducting institution(s) demonstrates ongoing commitment to and support of both the clinical and academic components of the nurse anesthesia program by providing adequate:

  a. Financial resources to comply with accreditation standards.
  b. Physical resources including facilities, equipment, and supplies.
  c. Learning resources including clinical sites, library, technological access and support.
  d. Numbers of qualified faculty for clinical, classroom instruction and scholarly activities.
  e. Support personnel.
  f. Student services (see Glossary: student services).

B5. The conducting institution provides sufficient time and resources to permit faculty to fulfill their teaching, scholarly activities, service, administrative and clinical responsibilities.

* Failure to fully comply with one or more of these criteria is considered to be of critical concern in decisions regarding nurse anesthesia program accreditation.
Standard III: Program of Study

THE PROGRAM CURRICULUM IS RELEVANT, CURRENT, COMPREHENSIVE, AND MEETS COMMONLY ACCEPTED NATIONAL STANDARDS FOR SIMILAR DEGREES. THE TEACHING-LEARNING ENVIRONMENT PROMOTES THE ACHIEVEMENT OF EDUCATIONAL OUTCOMES DRIVEN BY THE MISSION OF THE INSTITUTION AND FOSTERS STUDENT LEARNING, PROFESSIONAL SOCIALIZATION, AND FACULTY GROWTH. THE CURRICULUM PREPARES GRADUATES FOR THE FULL SCOPE OF NURSE ANESTHESIA PRACTICE.

CRITERIA

C1. The program’s curriculum builds upon prior nursing education and professional experiences, is congruent with the mission of the institution and is designed so that students benefit from the program.

* C2. The faculty designs a curriculum that awards a master’s or higher-level degree to graduate students who successfully complete graduation requirements.**

C3. The program sets forth the curriculum in a logical manner with sequential presentation of classroom and clinical experiences.

C4. The nurse anesthesia program must be a minimum of 24 months in length or its part-time equivalent.

C5. The educational environment fosters student learning and promotes professional socialization.

C6. The educational environment provides opportunities for faculty development.

C7. The program designs a curriculum that enables graduates to attain certification in the specialty.

C8. The program designs, when appropriate, an experimental/innovative curriculum that enables graduates to attain certification in the specialty.

C9. The content of the curriculum is appropriate to the degree or certificate earned.

C10. The curriculum meets commonly accepted national standards for similar degrees.

C11. Distance education programs and courses satisfy accreditation standards and achieve the same outcomes as traditional educational offerings.
C12. The educational environment promotes academic quality as evidenced through a variety of indicators (see Glossary: academic quality).

* C13. The program enrolls only baccalaureate prepared students who meet admission criteria. Admission requirements include:

  a. Registration as a professional nurse in the United States, its territories or protectorates.
  b. At least one year of experience as a RN in an acute care setting (see Glossary).

* C14. The basic nurse anesthesia academic curriculum and prerequisite courses focus on coursework in anesthesia practice: pharmacology of anesthetic agents and adjuvant drugs including concepts in chemistry and biochemistry (105 hours); anatomy, physiology, and pathophysiology (135 hours); professional aspects of nurse anesthesia practice (45 hours); basic and advanced principles of anesthesia practice including physics, equipment, technology and pain management (105 hours); research (30 hours); and clinical correlation conferences (45 hours).

C15. The didactic curriculum includes three (3) separate comprehensive graduate level courses in advanced physiology/pathophysiology, advanced health assessment, and advanced pharmacology.***

C16. The amount of advanced standing or transfer credits awarded by the degree granting institution is clearly stated and publicized.

C17. The clinical curriculum provides students with opportunities for experiences in the perioperative process that are unrestricted, and promote their development as competent safe nurse anesthetists.

* C18. The nurse anesthesia clinical curriculum prepares the student for the full scope of current practice in a variety of work settings and requires a minimum of 550 clinical cases including a variety of procedures, techniques, and specialty practice (see Appendix).

* C19. The program provides opportunities for students to obtain clinical experiences outside the regular clinical schedule by a call experience or other mechanism.

C20. The program demonstrates that it has achieved its stated outcomes.
C21. The program demonstrates that graduates have acquired knowledge, skills and competencies in patient safety, perianesthetic management, critical thinking, communication, and the competencies needed to fulfill their professional responsibility.

a. Patient safety is demonstrated by the ability of the graduate to:

1. Be vigilant in the delivery of patient care.
2. Protect patients from iatrogenic complications.
3. Participate in the positioning of patients to prevent injury.
4. Conduct a comprehensive and appropriate equipment check.
5. Utilize standard precautions and appropriate infection control measures.

b. Individualized perianesthetic management is demonstrated by the ability of the graduate to:

1. Provide care throughout the perianesthetic continuum.
2. Use a variety of current anesthesia techniques, agents, adjunctive drugs, and equipment while providing anesthesia.
3. Administer general anesthesia to patients of all ages and physical conditions for a variety of surgical and medically related procedures.
4. Provide anesthesia services to all patients, including trauma and emergency cases.
5. Administer and manage a variety of regional anesthetics.
6. Function as a resource person for airway and ventilatory management of patients.
7. Possess current advanced cardiac life support (ACLS) recognition.
8. Possess current pediatric advanced life support (PALS) recognition.
9. Deliver culturally competent perianesthetic care throughout the anesthesia experience (see Glossary: culturally competent).

c. Critical thinking is demonstrated by the graduate’s ability to:

1. Apply knowledge to practice in decision-making and problem solving.
2. Provide nurse anesthesia care based on sound principles and research evidence.
3. Perform a preanesthetic assessment and formulate an anesthesia care plan for patients to whom they are assigned to administer anesthesia.

4. Identify and take appropriate action when confronted with anesthetic equipment-related malfunctions.

5. Interpret and utilize data obtained from noninvasive and invasive monitoring modalities.

6. Calculate, initiate, and manage fluid and blood component therapy.

7. Recognize and appropriately respond to anesthetic complications that occur during the perianesthetic period.

8. Pass the Council on Certification of Nurse Anesthetists’ (CCNA) certification examination in accordance with CCNA policies and procedures.

d. Communication skills are demonstrated by the graduate’s ability to:

1. Effectively communicate with individuals influencing patient care.

2. Utilize appropriate verbal, nonverbal, and written communication in the delivery of perianesthetic care.

e. Professional responsibility is demonstrated by the graduate’s ability to:

1. Participate in activities that improve anesthesia care.

2. Function within appropriate legal requirements as a registered professional nurse, accepting responsibility and accountability for his or her practice.

3. Interact on a professional level with integrity.

4. Teach others.

5. Participate in continuing education activities to acquire new knowledge and improve his or her practice.

6. Demonstrate knowledge of wellness and chemical dependency in the anesthesia profession through completion of content in wellness and chemical dependency. (see Glossary: Chemical Dependency and Wellness for recommended content)****

* Failure to fully comply with one or more of these criteria is considered to be of critical concern in decisions regarding nurse anesthesia program accreditation.
** The COA will not consider any new master’s degree programs for accreditation beyond 2015. Students accepted into an accredited program on January 1, 2022 and thereafter must graduate with doctoral degrees.

*** All programs must meet this criterion by 2015.

****All programs must meet this criterion by January 1, 2013.
**Standard IV: Program Effectiveness**

PROGRAM EFFECTIVENESS IS EVIDENCED (1) IN THE QUALITY OF STUDENT, ALUMNI, AND FACULTY ACHIEVEMENT THAT FURTERS THE INSTITUTION’S MISSION, PHILOSOPHY AND OBJECTIVES, (2) BY A COMMITMENT TO CONTINUOUS SELF-ASSESSMENT, AND (3) BY HOW IT ENHANCES THE EDUCATIONAL PROCESS.

**CRITERIA**

D1. The institution and/or program utilizes systematic evaluation processes to assess achievement in the following areas:

a. The quality of the didactic, clinical and research curriculum.
b. A teaching and learning environment that promotes student learning.
c. Faculty contributions to teaching, practice, service, and scholarly activities.
d. The competence of graduates entering anesthesia practice.
e. Alumni involvement in professional activities.
f. Institutional/program resources.
g. Student and faculty services.

D2. The program has a written plan for continuous self-assessment that promotes program effectiveness, purposeful change and needed improvement.

D3. The program relies upon periodic evaluations from its communities of interest to determine program effectiveness:

a. Student evaluations of the program, courses, classroom instruction, clinical instruction, and clinical sites.
b. Faculty evaluations of the program.
c. Employer evaluations of recent graduates.
d. Alumni evaluations of the program.
e. Evaluations of the program by external agencies.
D4. The program utilizes evaluation data from all sources to monitor and improve program quality and effectiveness and student achievement:

a. Student evaluations, formative and summative, are conducted by the faculty to counsel students and document student achievement in the classroom and clinical areas.

b. Student achievement is documented through self-evaluation.

c. Outcome measures, including graduation rates, grade point averages, Council on Certification of Nurse Anesthetists’ (CCNA) Certification Examination pass rates and mean scores, and employment rates and employer satisfaction are used to assess the quality of the program and level of student achievement.

d. The program’s evaluation plan is used to continuously assess compliance with accreditation requirements and to initiate corrective action should areas of noncompliance occur or recur.

* Failure to fully comply with one or more of these criteria is considered to be of critical concern in decisions regarding nurse anesthesia program accreditation.
Standard V: Accountability

THE PROGRAM DEMONSTRATES ACCOUNTABILITY AND INTEGRITY TO ITS COMMUNITIES OF INTEREST INCLUDING THE PUBLIC, STUDENTS, FACULTY, THE CONDUCTING INSTITUTION(S), AND EXTERNAL AGENCIES.

CRITERIA

* E1. The program evidences truth and accuracy in the following areas: advertising, student recruitment, admissions, academic calendars, program length, tuition and fees, travel requirements, catalogs, grading, representation of accreditation, and faculty accomplishments.

E2. The program identifies, publishes, and distributes the rights and responsibilities of the following entities as they relate to the program: patients, applicants, students, faculty, conducting and affiliating institutions, and the accrediting agency.

E3. The program annually publishes accurate information about its programmatic accreditation status, the specific academic program covered by the accreditation status, the name, address, and telephone number of the Council; and for the most recent graduating class the attrition, employment of graduates within six months of graduation, and the certification examination pass rate for first time takers.

* E4. Complaints, grievances and appeals are resolved in a timely and equitable manner affording adequate due process.

* E5. The program defines and uses policies and procedures that are fair and equitable and do not discriminate on the basis of race, color, religion, age, gender, national origin, marital status, disability, sexual orientation, or any factor protected by law.

* E6. The program defines and uses policies and procedures regarding academic integrity in all of its educational activities.

* E7. The program maintains accurate cumulative records of educational activities.

* E8. The program forbids the employment of nurse anesthesia students as nurse anesthetists by title or function.

* E9. The program limits students’ commitment to the program to a reasonable number of hours to ensure patient safety and promote effective student learning. (see Glossary: Reasonable time commitment)
E10. The program restricts clinical supervision in nonanesthetizing areas to credentialed experts who are authorized to assume responsibility for the student (see Glossary: credentialed expert).

* E11. The program restricts clinical supervision of students in anesthetizing areas to CRNAs and/or anesthesiologists with institutional staff privileges who are immediately available in all clinical areas. Instruction by graduate registered nurse anesthetists or physician residents is never appropriate if they act as the sole agents responsible for the student.

* E12. The program ensures that students and CRNA faculty including clinical instructors are currently licensed as registered professional nurses in one jurisdiction of the United States and CRNAs are certified/recertified by the Council on Certification/Recertification of Nurse Anesthetists.

* E13. The clinical supervision ratio of students to instructors must be coordinated to insure patient safety by taking into consideration: The student’s knowledge and ability; the physical status of the patient; the complexity of the anesthetic and/or surgical procedure; and the experience of the instructor (see Glossary).

* Failure to fully comply with one or more of these criteria is considered to be of critical concern in decisions regarding nurse anesthesia program accreditation.
Additional criteria for the Standards regarding:

## Practice-Oriented Doctoral Degrees

1. Faculty members demonstrate competency in scholarly and professional work in the relevant discipline (Standard III).

2. Doctoral students have sufficient access to appropriately credentialed faculty (Standard II).

3. There is an established assessment procedure to verify competence in pertinent scholarship skills relevant to the area of academic focus (Standard III).

4. The post-baccalaureate curriculum is a minimum of 3 years of full-time study or longer if there are periods of part-time study (Standard III).**

5. The requirements for the practice-oriented doctoral degree are significantly beyond those required for a master’s degree (Standard III).

6. Doctoral students master additional theory, knowledge and scholarship skills relevant to the area of academic focus by demonstrating the following competencies (Standard III):

   **Biological Systems, Homeostasis and Pathogenesis**
   a. Analyzes best practice models for nurse anesthesia patient care management through integration of knowledge acquired from arts and sciences within the context of the scope and standards of nurse anesthesia practice.
   b. Uses a systematic outcomes analysis approach in the translation of research evidence and data in the arts and sciences to demonstrate they will have the expected effects on nurse anesthesia practice.

   **Professional Role**
   a. Demonstrates ability to undertake complex leadership roles in nurse anesthesia.
   b. Demonstrates ability to provide leadership that facilitates intraprofessional and interprofessional collaboration.
   c. Integrates critical and reflective thinking in leadership style.
   d. Demonstrates ability to utilize a variety of leadership principles in the management of situations.

   **Healthcare Improvement**
   a. Uses evidence based practice to inform clinical decision making in nurse anesthesia.
   b. Evaluates how public processes impact the financing and delivery of healthcare.
   c. Develops and assesses strategies to improve patient outcomes and quality of care.
Practice Inquiry
a. Demonstrates the ability to assess and evaluate health outcomes in a variety of populations, clinical settings, and systems.
b. Demonstrates ability to disseminate research evidence.
c. Completes a scholarly work that demonstrates knowledge within the area of academic focus.

Technology and Informatics
a. Uses information systems/technology to support and improve patient care and healthcare systems.
b. Critically evaluates clinical and research databases used as clinical decision support resources.

Public and Social Policy
a. Advocates for health policy change to improve patient care and advance the specialty of nurse anesthesia.

Health Systems Management
a. Analyzes the structure, function and outcomes of healthcare delivery systems and organizations.
b. Analyzes business practices typically encountered in nurse anesthesia delivery settings.
c. Analyzes risk management plans based on information systems to promote outcome improvement for the patient, organization and community.

Ethics
a. Applies ethically sound decision-making.
b. Informs the public of the role and practice of the doctoral-prepared CRNA and represents themselves in accordance with the Code of Ethics for CRNAs.
c. Fulfills the obligation as a doctoral-educated professional to uphold the Code of Ethics for CRNAs.

**Note: Shorter programs of study can be submitted for consideration when accompanied by supporting rationale that ensures compliance with accreditation standards.**
Additional criteria for the Standards regarding:

**Research-Oriented Doctoral Degrees**

1. Doctoral students are prepared to advance theory and knowledge of the discipline in which the degree is awarded (Standard III).

2. Doctoral students develop advanced scholarship skills and generate research relevant to the discipline (Standard III).

3. Doctoral students complete a dissertation or equivalent scholarly work that constitutes an original contribution to the knowledge within the discipline (Standard III).

4. Faculty members demonstrate competency for scholarly and professional work in the relevant discipline (Standard III).

5. Doctoral students have sufficient access to appropriately credentialed faculty (Standard II).

6. There is direct assessment of doctoral student achievement, including extensive comprehensive examinations conducted by recognized scholars in the discipline, to verify the knowledge and skills that constitute mastery in the discipline (Standard III).

7. There are established examination and assessment procedures to verify competence in pertinent research skills (Standard III).

8. Doctoral students defend the final dissertation or equivalent scholarly work before acknowledged scholars in the discipline (Standard III).

9. The curriculum is a minimum of 5 years in length post-baccalaureate or a minimum of 4 years in length post-master’s of full-time study or longer if there are periods of part-time study (Standard III). **

10. Adequate resources such as teaching and research assistantships, internal and external funding or federal grants are available to support the research mission of the academic unit (Standard II).

11. There is support for research essential for degree purposes (Standard II).

12. The educational environment encourages scholarly research (Standard II).

13. Faculty are provided sufficient time and resources for scholarship and the conduct of research (Standard II).
14. The requirements for the research-oriented doctoral degree are significantly beyond those required for a master’s degree and a practice-oriented doctoral degree (Standard III).

** Note: Shorter programs of study can be submitted for consideration when accompanied by supporting rationale that ensures compliance with accreditation standards.
Additional criteria for the Standards regarding:

**Graduate Degree Programs for CRNAs**

1. Anesthesia must be referenced in the title of the graduate degree offered and/or a significant component of the curriculum includes anesthesia-related material (Standard III).

2. The curriculum for a master’s or doctoral degree program for CRNAs is similar to the requirements for an equivalent degree that prepares registered nurses for entry into nurse anesthesia practice (Standard III).

3. The length of the approved program of study must be appropriate for the CRNA graduate student to complete the degree requirements for the master’s degree, practice-oriented doctoral degree, or research-oriented doctoral degree program (Standard III).

*(see Glossary: Graduate Degrees for CRNAs)*
Additional criteria for the Standards regarding:

**Federally Mandated Requirements**

The criteria listed in this section are those required of all accrediting agencies in order to be in compliance with the Higher Education Act (HEA) of 1965, as amended by the HEOA in 2008. Many requirements have also been included in the Council’s policies and procedures.

1. The program and/or its conducting institution reviews the default rates in the student loan programs under Title IV of the Higher Education Act, based on the most recent data provided by the U.S. Secretary of Education.

2. The program’s conducting entity demonstrates compliance with an institution’s responsibilities under Title IV of the Higher Education Act, including: results of financial or compliance audits and program reviews and other information that the U.S. Secretary of Education may request.

3. The program provides evidence that students are made aware of their ethical responsibility regarding financial assistance they receive from public or private sources.
Appendix

The minimum number of anesthesia cases is 550.

<table>
<thead>
<tr>
<th>CLINICAL EXPERIENCES</th>
<th>Minimum Required Cases</th>
<th>Preferred Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Class II</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Classes III &amp; IV</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Class V</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>TOTAL CASES</td>
<td>550</td>
<td>650</td>
</tr>
</tbody>
</table>

**PATIENT PHYSICAL STATUS**

<table>
<thead>
<tr>
<th>Class</th>
<th>Minimum Required Cases</th>
<th>Preferred Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric 65 + years</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Pediatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric 2 to 12 years</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>Pediatric (less than 2 years)</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Neonate (less than 4 weeks)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Trauma/Emergency (E)</td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>Obstetrical management</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Analgesia for labor</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>
**CLINICAL EXPERIENCES**

<table>
<thead>
<tr>
<th></th>
<th>Minimum Required Cases</th>
<th>Preferred Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prone</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Lithotomy</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Lateral</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Sitting</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Intra-abdominal</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Extrathoracic</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Extremities</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Perineal</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Extracranial</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Intracranial</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Oropharyngeal</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Intrathoracic</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>Heart</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Lung</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Neuroskeletal</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td>10</td>
<td>20</td>
</tr>
</tbody>
</table>

**POSITION CATEGORIES**

<table>
<thead>
<tr>
<th>Position</th>
<th>Minimum Required Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prone</td>
<td>20</td>
</tr>
<tr>
<td>Lithotomy</td>
<td>25</td>
</tr>
<tr>
<td>Lateral</td>
<td>5</td>
</tr>
<tr>
<td>Sitting</td>
<td>5</td>
</tr>
</tbody>
</table>

**ANATOMICAL CATEGORIES**

- Intra-abdominal: 75
- Extrathoracic: 15
- Extremities: 50
- Perineal: 15
- Extracranial: 15
- Intracranial: 5, 20
- Oropharyngeal: 20
- Intrathoracic: 15, 40
  - Heart: 5, 10
  - Lung: 5
- Neck: 5, 10
- Neuroskeletal: 20
- Vascular: 10, 20

1 Count all that apply.
<table>
<thead>
<tr>
<th>METHODS OF ANESTHESIA</th>
<th>Minimum Required Cases</th>
<th>Preferred Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>General anesthesia</td>
<td>350</td>
<td></td>
</tr>
<tr>
<td>Induction, maintenance, and emergence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous induction</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Inhalation induction</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Mask management</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Laryngeal mask airways (or similar devices)</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Tracheal intubation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Oral</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>b. Nasal</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Total intravenous anesthesia</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Emergence from anesthesia</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Regional techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Administration $^2$ (total of a, b &amp; c)</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>a. Spinal</td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>b. Epidural</td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>c. Peripheral</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Monitored anesthesia care</td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>

$^2$ Students must have experience in each category.
<table>
<thead>
<tr>
<th>PHARMACOLOGICAL AGENTS</th>
<th>Minimum Required Cases</th>
<th>Preferred Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhalation agents</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Intravenous induction agents</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Intravenous agent - muscle relaxants</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Intravenous agent - opioids</td>
<td>200</td>
<td></td>
</tr>
</tbody>
</table>

| ARTERIAL TECHNIQUE                              |                        |                           |
| Arterial puncture/catheter insertion            | 25                     |                           |
| Intra-arterial BP monitoring                    | 25                     |                           |

| CENTRAL VENOUS PRESSURE CATHETER               | 5                      | 10                        |
| Placement ³ (total of a & b)                   |                        |                           |
| a. Actual                                      |                        |                           |
| b. Simulated                                   |                        |                           |
| Monitoring                                     | 15                     |                           |

| PULMONARY ARTERY CATHETER                      | 5                      |                           |
| Placement                                     |                        |                           |
| Monitoring                                    | 10                     |                           |

³ Simple models and simulated experiences may be used to satisfy this requirement.
<table>
<thead>
<tr>
<th>CLINICAL EXPERIENCES</th>
<th>Minimum Required Cases</th>
<th>Preferred Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravenous catheter placement</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mechanical ventilation</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Pain management (acute/chronic)</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Alternative airway management techniques (total of 1 &amp; 2) (see Glossary: alternative airway management techniques)</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>1) Fiberoptic techniques (total of a, b &amp; c)</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>a) Actual placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Simulated placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Airway assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Other techniques</td>
<td>5</td>
<td>25</td>
</tr>
</tbody>
</table>

3 Simple models and simulated experiences may be used to satisfy this requirement.
Glossary

**Academic faculty** - Instructors who are responsible for providing didactic instruction in their individual areas of expertise.

**Academic quality** - The presence of appropriate outcomes resulting from faculty teaching, student learning, research and professional practice. Academic quality requires an effective learning environment and sufficient resources for faculty and students to obtain the objectives of the program and meet accreditation standards.

**Accreditation** - A peer process whereby a private, nongovernmental agency grants public recognition to an institution or specialized program of study that meets or exceeds nationally established standards of acceptable educational quality.

**Acute care experience** - Work experience during which an RN has developed as an independent decision-maker capable of using and interpreting advanced monitoring techniques based on knowledge of physiological and pharmacological principles.

**Agreement** - An exchange of a formal, written understanding between two or more entities that agree to provide appropriate academic and/or clinical learning experiences for students. Requirements should be outlined in sufficient detail to state clearly the expectations of the agreement and to protect the rights of the parties involved.

**Alternative airway management techniques** - Alternative airway management techniques include fiberoptic intubation, light wand, retrograde tracheal intubation, combitube, trans-tracheal jet ventilation, gum elastic bougie/tracheal tube changer, esophageal obturator airway, LMA guided intubation and cricothyroidotomy.

**Ambulatory/Outpatient** - Patients who are discharged from the facility within 23 hours or less following admission and surgery.

**Anesthesia care plan** - A written or verbal description of a proposed plan for the administration of an anesthetic, based on the known and anticipated needs of an individual patient during the perioperative period.

**Anesthesiologist** - A doctor of medicine (MD) or doctor of osteopathy (DO) who has successfully completed an approved anesthesiology residency program and has been granted active hospital staff membership and full hospital staff privileges in anesthesia.

**Appeal** - In cases where sanctions may be imposed against a student or faculty member, the right to a fair hearing before an impartial body should be granted in accordance with published rules and procedures. Students should be allowed to appeal any decision that suspends or dismisses them from a program or that delays their graduation.
Call - A planned clinical experience outside the normal operating hours of the clinical facility, for example, after 5 p.m. and before 7 a.m., Monday through Friday, and on weekends. Assigned duty on shifts falling within these hours is considered the equivalent of an anesthesia call, during which a student is afforded the opportunity to gain experience with emergency cases.

Certification - The process whereby a nongovernmental agency grants recognition to an individual who has voluntarily met predetermined qualifications specified by the agency.

Chemical Dependency and Wellness – Chemical dependency is substance related disorders characterized by chronicity and progression that threaten wellness. Wellness is defined as a positive state of the mind, body, and spirit reflecting a balance of effective adaptation, resilience, and coping mechanisms in personal and professional environments that enhance quality of life. The wellness/chemical dependency curriculum must be an evidence-based program of study which could include but is not limited to the following five key conceptual components:

1. Importance of Wellness to Health Care Professionals: Describe the integration of healthy lifestyles, adaptive coping mechanisms for career stressors, and an awareness of chemical dependency risk factors and pathophysiology.
2. Healthy Lifestyles: Describe attitudes, behaviors, and strategies (i.e., healthy nutrition, exercise, sleep patterns, and critical incidents’ stress management) that create a positive balance between personal and professional life for personal wellness.
3. Coping Mechanisms: Describe adaptive or maladaptive strategies and/or behaviors employed by individuals to reduce the intensity of experienced stress.
4. Identification and Intervention: Describe needed awareness of the symptoms of chemical dependency, appropriate strategies for successful intervention, treatment, and aftercare.
5. Re-Entry into the Workplace: Broadly describes components of successfully returning to anesthesia practice. These components include the frameworks for returning to administrative, academic or clinical anesthesia practice, strategies to reduce the likelihood of relapse, and elements of lifestyle adaptation that lead to a healthy balance of professional work and physical, emotional, and spiritual health.

Clinical experience - Supervised clinical activities in which the student gets to use the knowledge he or she has acquired in the clinical and/or academic phases of the program.

Clinical faculty - The CRNA or anesthesiologist who is responsible for teaching nurse anesthesia students during the perioperative period and for evaluating their clinical progress. When students are administering anesthesia, such instructors must be CRNAs or anesthesiologists with staff privileges in anesthesia.

Clinical supervision – Clinical oversight of graduate students in the clinical area that does not exceed two graduate students to one CRNA or anesthesiologist. In the case of medical direction, where the anesthesiologist medically directs 4 concurrent procedures, the ratio of graduate students to CRNA must not exceed 2:1.
Commonly accepted national standards - Standards that are generally recognized as determining quality of similar degrees by the larger community of higher education in the United States.

Community of interest - A body of individuals who are directly affected by nurse anesthesia education and/or practice, including nurse anesthesia students, faculty, staff, patients, employers, institutions, the public, and higher education community.

Competency for entrance into practice - Verification by the program that a student has acquired knowledge and skills in patient safety, perianesthetic management, critical thinking, communication and professionalism.

Conducting institution - The legal entity (institution or organization) that assumes sole, primary, or shared responsibility for the conduct of a program, including budgetary support, and is responsible for ensuring that the program has complied with accreditation requirements.

Course - A unit of study that exists in an academic discipline, such as anatomy and physiology of the respiratory system, pediatric anesthesia, etc.

Credentialed expert – An individual awarded a certificate, letter or other testimonial to practice a skill in an institution. The credential must attest to the bearer’s right and authority to provide services in the area of specialization for which she or he has been trained. Examples are: a pulmonologist who is an expert in airway management; an emergency room physician authorized by an anesthesia department to assume responsibility for airway management; or a neonatologist who is an expert in airway management.

CRNA program administrator (CRNA Program Director) - A CRNA with an appropriate graduate degree who by position, responsibility, and authority is actively involved in the organization and administration of the entire program of nurse anesthesia. The graduate degree must be from an institution of higher education accredited by a nationally recognized accrediting agency.

CRNA assistant program administrator (CRNA Assistant Program Director) - A CRNA with an appropriate graduate degree who by position, responsibility, and authority actively assists the program administrator in the organization and administration of the entire program of nurse anesthesia. The graduate degree must be from an institution of higher education accredited by a nationally recognized accrediting agency. The assistant program administrator must be qualified to assume the responsibilities of the program administrator if required.

Culturally competent - Utilizing variable approaches in assessing, planning, implementing and administering anesthesia care for patients based on culturally relevant information.

Curriculum - All experiences, clinical or didactic, that are under the direction of the program. The planned educational input, process, outcomes, and evaluations designed to enable the student to acquire the experiences specified in the program's philosophy, goals, and objectives.
Due process - A legal and ethical principle whereby nurse anesthesia faculty and students are guaranteed treatment in accordance with reasonable, clearly defined rules and have the right to fair treatment, based on published standards, procedures, and the provisions of an appeals or grievance procedure.

Employment of nurse anesthesia graduate students - Anesthesia care provided by a graduate student outside the planned curriculum is considered employment as a nurse anesthetist, whether or not the care is reimbursed. Employment is permitted in a position other than anesthesia, as long as the student is not represented in any manner, such as by a name tag, uniform, and/or signature, to be a nurse anesthetist.

Evaluation – A systematic assessment that results in data that are used to monitor and improve program quality and effectiveness.

Experimental curriculum - A curriculum that is being tested to determine whether it will produce expected outcomes that may or may not become permanent.

Faculty - A body of individuals entrusted with instruction, including the teaching staff, both clinical and academic, and any individuals involved in teaching or supervising the educational experiences/activities of students on a part-time or full-time basis.

Formative evaluations - Student assessments that help identify problems and areas that require improvement, as well as measure progress and achievement of objectives.

Full scope of practice - Preparation of graduates who can administer anesthesia and anesthesia-related care in four general categories: (1) preanesthetic preparation and evaluation; (2) anesthesia induction, maintenance and emergence; (3) post-anesthesia care; and (4) perianesthetic and clinical support functions (Reference: “Scope and Practice for Nurse Anesthesia Practice, “ available from AANA, Park Ridge, IL).

Graduate Degrees for CRNAs - A degree awarded to a CRNA who has fulfilled the requirements for a master’s degree, practice-oriented doctoral degree, or research-oriented doctoral degree. The primary purpose of the graduate degree is to enable the CRNA to complete additional study and coursework beyond those required for graduation from a nurse anesthesia program and entry into practice as a nurse anesthetist. The curriculum for a graduate degree for CRNAs is similar to the requirements for an equivalent degree that prepares registered nurses for entry into nurse anesthesia practice. The length of study is generally shorter depending upon the amount of advanced standing or transfer credits awarded by the degree granting institution.

Grievance - Any complaint that arises from the participation of a student or faculty member in a nurse anesthesia program.

Immediately available - A CRNA or physician anesthesiologist must be present in the anesthetizing location where a graduate student is performing/administering an anesthetic and available to be summoned by the graduate student.
Indicators of success- Documentation of student achievement and attainment of a program’s established outcome criteria. Examples of ways to measure success include 1. Identifying: (a) the number of students who complete the program, (b) the number of graduates that pass the National Certification Examination for Nurse Anesthetists in accordance with the COA’s Certification Examination policy, and (c) the number of graduates who secure employment within 6 months post-graduation; 2. Conducting graduate (alumni) evaluations to assess the program’s ability to prepare nurse anesthetists who are competent and capable of functioning in a variety of anesthesia settings; 3. Conducting employer evaluations to assess the program’s ability to prepare nurse anesthetists who are competent and capable of functioning in a variety of anesthesia settings.

Innovative curriculum - A new or creative way to introduce a curriculum or program that may become permanent. Programs that are developed to prepare broad-based, competent nurse anesthetists but do not necessarily comply with Council's requirements pertaining to specific class hours or the details of the practical experiences.

Institution - A senior college or university, hospital, corporation, or other entity with an appropriate state license or a government-sponsored agency involved in the conduct of a nurse anesthesia educational program. An educational institution that is accredited in its entirety (as a whole), including nurse anesthesia certificate programs and single-purpose institutions.

Legal requirements - Examples include (1) evidence that a program accepts its responsibilities under Title IV of the Higher Education Act, as demonstrated through its compliance with accreditation standards and by its attempts to lower default rates in federal student loan programs; (2) evidence that a nurse anesthesia program is legally authorized to operate; and (3) evidence that a professional complies with licensure and certification requirements prescribed by legislation or regulation.

Licensure - A process whereby a governmental agency grants permission to individuals to practice their occupation as a way of providing reasonable assurance that public health, safety, and welfare will be protected.

Mask management - A general anesthetic that is administered by mask, exclusive of induction.

Master’s degree requirement - Programs must award a master's or higher degree to each graduate. A waiver of this requirement may be requested for valid reasons. Granting of the waiver is solely at the discretion of the Council.

Nationally recognized accrediting agency - An accrediting agency that is recognized by the U.S. Secretary of Education as a reliable authority as to the quality of training offered by educational institutions and/or programs. This includes regional institutional accrediting agencies, national institutional accrediting agencies, and specialized accrediting agencies.
**Nondiscriminatory practice** - The practice of treating all individuals, including applicants, without regard to race, color, national origin, gender, religion, age, marital status, physical or mental handicap or disability, sexual orientation, or any legally protected factor. Although an applicant should not be required to provide information regarding his or her race, color, national origin, sex, religion, age, marital status, physical or mental handicap or disability, or any other legally protected factor, he or she can provide such information on a voluntary basis. According to federal law, an applicant may be asked if he or she can perform the essential tasks or functions of an anesthetist, as long as all other applicants are asked the same question. (Reference Title VII of the Civil Rights Act of 1964 and the Americans With Disabilities Act.)

**Nurse anesthesia graduate student** - A registered professional nurse who is enrolled in an educational program that is accredited by the Council for the purpose of acquiring the qualifications necessary to become certified in the specialty of nurse anesthesia.

**Objectives** - Future-oriented purposes and goals that a nurse anesthesia educational endeavor seeks to fulfill.

**Outcomes** - Evidence that demonstrates the degree to which a program's purposes and objectives have been achieved, including the attainment of knowledge, skills, and competencies by students. Outcomes are operational definitions of objectives and must be assessed in relation to them.

**Perianesthetic management** - Anesthesia care and management of patients, including preoperative, intraoperative, and postoperative care. Preoperative care includes the evaluation of patients through interview, physical assessment, and a review of records. Intraoperative care includes administration of anesthetics, decision-making, and recordkeeping. Postanesthesia care includes evaluation, monitoring of physiological functions, and appropriate intervention when a patient is emerging from anesthesia and surgery.

**Personnel** - Persons employed by a conducting institution to provide necessary services, such as teaching and secretarial support, for the operation of a nurse anesthesia program.

**Postanesthetic Assessment** - Review of all available patient data and validation of anesthesia outcomes.

**Practice-oriented doctoral degree** - The primary purpose of the practice-oriented doctoral degree is to prepare registered nurses for professional practice as nurse anesthetists who have additional knowledge in an area of academic focus. The curriculum for a practice-oriented doctoral degree is typically a minimum of 36 calendar months in length of full-time study or longer if there are periods of part-time study. The Doctor of Nurse Anesthesia Practice (DNAP) and Doctor of Nursing Practice (DNP) are examples.

**Preanesthetic Assessment** - Review of all available patient data prior to initiating anesthesia.
Professional Aspects – Courses and activities that are specific to the profession of nurse anesthesia including but not limited to (1) the business of anesthesia and practice management; (2) reimbursement methodologies and payment policies; (3) substance abuse; (4) professional ethics; (5) quality improvement; (6) structure and function of the AANA; and (7) professional advocacy, practice standards and regulations (non-governmental, governmental).

Program - An educational curriculum that is designed to provide both didactic and clinical components to prepare a competent nurse anesthetist. The word program is commonly used for all types of nurse anesthesia schools including programs and institutions. In the case of a branch campus, program refers to an educational unit within a larger institution such as a university.

Program design - A graphic representation of the course of study, including all the components of the program, clinical, academic, research, call, affiliations, study time, and the total committed time by quarter or semester.

Public member - A member of a committee who is selected to ensure that consumer concerns, public and patient, are formally represented and to curb any tendency to put program priorities before public interest. Such members should be selected at large, and they cannot be current or former members of the healthcare profession or current or former employees of the institution that is conducting the program. This also excludes anyone who might be perceived to have divided loyalties or potential conflicts of interest, such as a relative of an employee or former employee.

Reasonable time commitment - A reasonable number of hours to promote effective student learning should not exceed 70 hours per week averaged over four weeks. This time commitment includes time spent in class and in clinical, preparing for class and clinical, in-house call time, and, when taking call from home, time spent in the operating room, averaged over four weeks. This should include a 10 hour rest period between scheduled clinical shifts.

Recertification - A process whereby the Council on Recertification of Nurse Anesthetists grants recognition to CRNAs who have met the predetermined criteria specified by the Council. It is intended to advance the quality of anesthesia care provided to patients and to ensure that nurse anesthetists maintain their skills and remain up to date on scientific and technological developments.

Research-oriented doctoral degree - The primary purposes of the research-oriented doctoral degree are to prepare registered nurses for professional practice as nurse anesthetists and as researchers capable of generating new knowledge and demonstrating scholarly skills. The curriculum for a research-oriented doctoral degree is typically a minimum of 5-7 years in length past the baccalaureate degree or 4-5 years in length past the master’s degree of full-time study, or longer if there are periods of part-time study. The Doctor of Philosophy (PhD) and Doctor of Nursing Science (DNSc) are examples.
Scholarly activities - A series of accomplishments and/or achievements that require and contribute to overall critical thinking, analysis, decision-making, and innovative skills and competencies by faculty/students. Scholarly activities contribute to the achievement of the missions/goals of the academic unit and parent institutions. Examples of scholarly activities may include but are not limited to: new or innovative teaching/learning strategies; peer reviewed presentations at local, state, national and/or international levels; publish peer review articles and/or book chapters/books; investigator in research studies; participant in fellowships, internships; adviser/committee member on research committees; data analysis, collection, and utilization for program maintenance, modification or revision; leadership roles in professional organizations; attends research focus groups and research conferences; development of non-print media.

Self-assessment - A process that starts with the institutional or programmatic self-study, a comprehensive effort to measure progress based on previously accepted objectives and outcome measures. The self-study considers the interests of the communities of interest, including students, faculty, administration, and graduates.

Shared governance - A formal arrangement in which two or more organizations or institutions are controlled by a single administrative authority. Written affiliation agreements are not necessary between entities that participate in shared governance arrangements.

Sitting position - Any position in which the torso is elevated from the supine position 45 to 90 degrees and the torso is higher than the legs.

Standard precautions - An approach to infection control based on the concept that human blood and certain human body fluids are treated as if they are known to be infectious for HIV, HBV, or other bloodborne pathogens.

Strategic plan - A written guide that is used to direct the effective operation of a nurse anesthesia program and to promote academic quality.

Student services - Assistance offered to students, such as financial aid, health services, insurance, placement services, and counseling.

Summative evaluations - Summative evaluations describe a student's achievement at the completion of a period or unit of learning activity and include both expected and unexpected outcomes.

Supervision – (see Clinical Supervision).

Title IV Higher Education Act (HEA) program requirements - Federal requirements for programs that participate in student loan programs authorized under Title IV of the Higher Education Act, known as Federal Family Education Loan (FFEL) programs. Examples: Federal Stafford Loan; Federal PLUS; Federal Supplemental Loans for Students; and Federal Consolidation Loans.
Unshared governance - A formal arrangement in which two or more organizations or institutions are controlled by separate administrative authorities. Written affiliation agreements are necessary between entities that participate in unshared governance arrangement.
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2004 Standards for Accreditation of Nurse Anesthesia Educational Programs
STATE OF LOUISIANA  
COURT OF APPEAL  
FIRST CIRCUIT  
NO. 2008 CA 0813  
SPINE DIAGNOSTICS CENTER OF BATON ROUGE, INC.  
VERSUS  
LOUISIANA STATE BOARD OF NURSING THROUGH LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS, AND AUGUST J. RANTZ, III  

Appealed from the  
19th Judicial District Court  
in and for the Parish of East Baton Rouge, Louisiana  
Trial Court No. 536,009  
Honorable Janice Clark, Judge  

** * * * * *  
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PLAINTIFFS-APPELLEES  
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* * * * *

BEFORE: PETTIGREW, McDONALD, AND HUGHES, JJ.
Pettigrew, J.

In the instant case, appellants challenge the trial court's judgment granting injunctive relief in favor of plaintiffs. Following this court's review of the record and relevant law, we affirm in part and reverse in part.

**FACTS AND PROCEDURAL HISTORY**

On March 24, 2005, August J. Rantz, III, a certified registered nurse anesthetist ("CRNA"), submitted a petition for an advisory opinion to the Louisiana State Board of Nursing ("the LSBN"), which requested a response to the following query:

Whether it is within the scope of practice for a CRNA to perform procedures involving the injection of local anesthetics, steroids and analgesics for pain management purposes, including, but not limited to, peripheral nerve blocks, epidural injections (62310), and spinal facet joint injections (64470 & 64472) when the CRNA can document education, training and experience in performing such procedures.

After considering Rantz's petition, the LSBN's practice committee submitted a recommendation to the LSBN that it was within the scope of practice for CRNAs to perform such procedures under the direction and supervision of a physician.

Prior to the LSBN's consideration of the practice committee's recommendation, Spine Diagnostics Center of Baton Rouge, Inc. ("Spine Diagnostics") filed a "Petition For Injunctive Relief And For Declaratory Judgment," seeking to enjoin the LSBN from adopting the committee's recommendation, to prevent Rantz from practicing interventional pain management, and to prevent Rantz from performing anesthesia-related management unless by physician order and under the direct and immediate supervision of a physician. Additionally, Spine Diagnostics prayed that the trial court issue a declaratory judgment finding that the practice of "pain management" constitutes the "practice of medicine." At its December 7, 2005 board meeting, the LSBN amended the recommendation of the practice committee, and adopted the following statement:

That it is within the scope of practice for the CRNA to perform procedures under the direction and supervision of the physician involving the injection

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1 The Louisiana Society of Anesthesiologists has intervened in the litigation praying for the same relief sought by Spine Diagnostics.
of local anesthetics, steroids and analgesics for pain management purposes, peripheral nerve blocks, epidural injections, and spinal facet joint injections when the CRNA can document education, training and experience in performing such procedures and has the knowledge, skills, and abilities to safely perform the procedures based on an order from the physician.

The statement was subsequently published on the LSBN's web site as well as in its quarterly publication, *The Examiner*.

Following the LSBN's adoption of the above statement, Spine Diagnostics filed a first supplemental and amending petition, contending the LSBN was attempting to promulgate a "rule" within the meaning of the Louisiana Administrative Procedure Act ("LAPA") that "has not been properly adopted and promulgated and should be declared invalid." Thereafter, at Spine Diagnostics' request, the Louisiana State Board of Medical Examiners ("the LSBME") issued an Advisory Opinion regarding interventional pain management by CRNAs. In its opinion, the LSBME indicated that CRNAs could provide anesthetics for acute pain associated with surgery, but opined that the procedures at issue for interventional pain management purposes constituted the practice of medicine that could only be performed by a physician.

After a two-day hearing on Spine Diagnostics' request for injunctive relief, the trial court took the matter under advisement. The court subsequently rendered judgment denying the request for injunctive relief, but noted that the request for declaratory judgment would proceed via ordinaria in accordance with the case management order. Thereafter, Spine Diagnostics filed a writ application with this court seeking review of that judgment. We granted certiorari for the limited purpose of reviewing the judgment denying Spine Diagnostics' request for injunctive relief, insofar

3 We note it was not necessary that Spine Diagnostics exhaust all administrative remedies prior to seeking injunctive relief in connection with its action for declaratory judgment. See La. R.S. 49:963(E).

3 In the opinion, the LSBME noted, in pertinent part, as follows:

...the injection of local anesthetics, steroids and analgesics, peripheral nerve blocks, epidural injections and spinal facet joint injections, when used for interventional pain management of patients suffering from chronic pain, constitute the practice of medicine, are not delegable by a physician to a non-physician by physician prescription, direction or supervision, and may only be performed in this state by a physician licensed to practice medicine in Louisiana.
as that request alleged the LSBN had promulgated a "rule" within the intendment of the
LAPA without following the procedural requirements therein.

In an unpublished decision rendered on December 28, 2006, this court reversed
the trial court's judgment and issued a preliminary injunction in favor of Spine
Diagnostics. **Spine Diagnostics Center of Baton Rouge, Inc. v. Louisiana State
Bd. of Nursing ex rel. Louisiana Dept. of Health and Hospitals, 2006-0554 (La.
3/16/07), 952 So.2d 702, 703 ("Spine Diagnostics I").** In so doing, we noted, in
pertinent part, as follows:

Thus, Spine Diagnostics has made a *prima facie* showing that the LSBN
statement substantively expands the scope of practice for CRNAs into an
area where they have not traditionally practiced, i.e., chronic or
interventional pain management. Such a substantive expansion of the
scope of practice clearly constitutes a rule within the meaning of La. R.S.
49:951(6). Further, although the LSBN contends the statement is limited
in scope, the actual language of the statement approved by the LSBN
does not limit its application to Rantz alone, and is capable of being
applied to every CRNA who has the requisite knowledge, skills, and
abilities to perform the procedures at issue. CRNAs are able to freely
access the statement insofar as it was published in *The Examiner* and on
the LSBN's website.

Given these circumstances, we find Spine Diagnostics has made a
*prima facie* showing that the statement adopted by the LSBN insofar as it
relates to chronic or interventional pain management is a rule within the
meaning of the LAPA. Since it is undisputed that the requirements of the
LAPA were not met, Spine Diagnostics is entitled to a preliminary
injunction enjoining enforcement of the statement adopted by the LSBN at
its December 7, 2005, board meeting, and enjoining Rantz from practicing
chronic or interventional pain management procedures pursuant to the
authority of that statement.

On June 29, 2007, Spine Diagnostics filed a second supplemental and amending
petition, adding Raymond R. Smith, Jr., a CRNA who had admitted to performing
interventional pain management procedures in violation of the Medical Practice Act, the
Nurse Practice Act, and other general and equitable laws. Spine Diagnostics also
alleged that the LSBN attempted to circumvent this court's December 28, 2006 ruling by

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4 Spine Diagnostics subsequently moved to voluntarily dismiss Mr. Smith from this action, without prejudice. Judgment granting said dismissal was signed by the trial court on October 25, 2007.
urging House Bill 684 and Senate Bill 322. On July 9, 2007, the Louisiana Association of Nurse Anesthetists ("LANA") sought to intervene in this matter as of right. On October 15, 2007, LANA was permitted to intervene in the proceedings.

The trial on Spine Diagnostics' request for declaratory judgment, permanent injunction, and contempt was held on November 29 and 30, 2007, and December 3, 2007. Thereafter, the trial court took the matter under advisement and, on January 10, 2008, rendered judgment in favor of Spine Diagnostics as follows:

The Court ORDERS, ADJUDGES and DECREES, the following in connection with the declaratory judgment:
1. The statement issued by the LSBN substantively expands the scope of practice for CRNAs into an area where they have not traditionally practiced, i.e. chronic or interventional pain management.
2. The practice of interventional pain management is not within a CRNAs scope of practice.
3. The practice of interventional pain management is solely the practice of medicine.
4. The opinion issued by the LSBN is an effort to substantively expand CRNA scope of practice and is an improper attempt at rule making.

IT IS FURTHER ORDERED, ADJUDGED and DECREED that in connection with the permanent injunction:
1. A permanent injunction issue prohibiting the LSBN from enforcing the statement.
2. A permanent injunction issue prohibiting August Rantz, III from performing chronic interventional pain procedures in connection with the LSBN statement.
3. The LSBN shall remove the advisory opinion from its website.
4. The LSBN shall post the judgment of this Court on its website and publish it in the LSBN publication, The Examiner.

IT IS FURTHER ORDERED, ADJUDGED and DECREED that
1. LSBN is taxed with all costs associated with these proceedings;
2. LSBN is taxed with all expert costs and fees;
3. LSBN is taxed $7,500.00 in litigation costs pursuant to LA R.S. 49:965.1(A);
4. LSBN is taxed with costs of all deposition transcripts.

According to the record, Senate Bill 322 was proposed as an attempt to amend La. R.S. 37:930(A)(3) relative to the practice of nursing to provide that it is within the scope of practice of a CRNA to perform certain pain management procedures, including peripheral nerve blocks, epidural injections, and spinal facet joint injections, when the CRNA can document education, training, and experience in performing such procedures.

On January 17, 2008, the trial court signed an amended judgment, which was identical in substance to the judgment rendered on January 10, 2008. According to the record, the amended judgment was necessary only to correct a clerical error because the original judgment indicated it had been signed on January 10, 2007, when in fact the judgment had been rendered on January 10, 2008.
It is from this judgment that the LSBN and LANA have appealed.\(^7\)

In its appeal, the LSBN assigns the following specification of errors:

1. The Trial Court erred in ruling that Spine Diagnostics met its burden of proof to obtain a permanent injunction enjoining the Nursing Board's Advisory Opinion on the basis that it constituted a "rule" which should have been promulgated in accordance with the LAPA.

2. The Trial Court erred in ruling that Spine Diagnostics had met its burden of proof to obtain a permanent injunction enjoining the Nursing Board's Advisory Opinion on the basis that it substantively expands the scope of practice for CRNAs into an area where CRNAs have not traditionally practiced, i.e., chronic or interventional pain management.

3. The Trial Court erred in ruling that Spine Diagnostics had met its burden of proof to obtain a mandatory injunction requiring the removal of the Advisory Opinion from its website and ordering publication of the judgment on the Nursing Board's website and in its quarterly publication, \textit{The Examiner}.

4. The Trial Court erred in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management under the direction and supervision of a physician to be beyond the traditional scope of practice for CRNAs.

5. The Trial Court erred in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management under the direction and supervision of a physician to be solely the practice of medicine.

6. The Trial Court erred in awarding Spine Diagnostics up to $7,500 in reasonable litigation expenses pursuant to La. R.S. 49:965.1 and other fees/costs for its expert witnesses and the taking of depositions.

Similarly, LANA sets forth the following on appeal for our review:

1. The trial court committed legal error in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management pursuant to a physician's order beyond the scope of CRNA practice.

2. The trial court committed legal error in declaring the practice of injecting local anesthetics, steroids and analgesics for chronic pain management pursuant to a physician's order to be solely the practice of medicine.

3. The trial court erred in finding the Nursing Board's advisory opinion is an improper attempt at rule-making.

\(^7\) Both the LSBN and LANA originally sought to suspensively appeal the trial court's judgment. However, the trial court denied the requests for suspensive appeals, and instead granted both parties devolutive appeals. \textit{Amici Curiae} briefs on behalf of the American Association of Nurse Anesthetists, the Louisiana Association of Nurse Practitioners, the American Nurses Association, the Louisiana Alliance of Nursing Organizations, the Louisiana Hospital Association, and the National Council of State Boards of Nursing, Inc. have also been filed for this court's review.
4. The trial court erred in finding that the Nursing Board advisory opinion substantively expands the scope of practice for CRNAs into an area where CRNAs have not traditionally practiced, i.e. chronic or interventional pain management.

**LAW OF THE CASE DOCTRINE**

On appeal, the LSBN and LANA both argue that the advisory opinion issued by the LSBN in response to Rantz's petition was nothing more than a declaratory order, which is provided for in La. R.S. 49:962, not a rule within the meaning of the LAPA.\(^8\) Thus, they assert, the trial court erred in finding that the LSBN's advisory opinion was an improper attempt at rule-making. In response, Spine Diagnostics contends that the LSBN and LANA are attempting to relitigate issues previously decided by this court. Spine Diagnostics maintains that these arguments are pretermitted by the law of the case doctrine as they have been briefed, argued, and decided by this court.


In **Louisiana Land and Exploration Company v. Verdin**, 95-2579, pp. 3-4 (La. App. 1 Cir. 9/27/96), 681 So.2d 63, 65, *writ denied*, 96-2629 (La. 12/13/96), 692 So.2d 1067, *cert. denied*, 520 U.S. 1212, 117 S.Ct. 1696, 137 L.Ed.2d 822 (1997), this court discussed the law of the case doctrine and its application as follows:

The law of the case principle is a discretionary guide which relates to (a) the binding force of a trial judge's ruling during the later stages of trial, (b) the conclusive effects of appellate rulings at trial on remand, and (c) the rule that an appellate court ordinarily will not reconsider its own rulings of law on a subsequent appeal in the same case. It applies to all prior rulings or decisions of an appellate court or the supreme court in the same case, not merely those arising from the full appeal process. Re-argument in the same case of a previously decided point will be barred where there is simply a doubt as to the correctness of the earlier ruling. However, the law of the case principle is not applied in cases of palpable

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\(^8\) Louisiana Revised Statutes 49:962 provides as follows:

Each agency shall provide by rule for the filing and prompt disposition of petitions for declaratory orders and rulings as to the applicability of any statutory provision or of any rule or order of the agency. Declaratory orders and rulings shall have the same status as agency decisions or orders in adjudicated cases.
error or where, if the law of the case were applied, manifest injustice would occur.

The reasons for the law of the case doctrine is to avoid relitigation of the same issue; to promote consistency of result in the same litigation; and to promote efficiency and fairness to both parties by affording a single opportunity for the argument and decision of the matter at issue.

When an appellate court considers arguments made in supervisory writ applications or responses to such applications, the court's disposition on the issue considered usually becomes the law of the case, foreclosing relitigation of that issue either at the trial court on remand or in the appellate court on a later appeal. However, where a prior disposition is clearly erroneous and will create a grave injustice, it should be reconsidered. [Citations omitted.]

In considering this doctrine and its applicability herein, we note that the arguments and issues raised by the LSBN and LANA in this regard appear to be indistinguishable from those presented to the trial court in the original request for injunctive relief and again to this court in the writ application in Spine Diagnostics I. In fact, a review of our opinion in Spine Diagnostics I reveals this court previously considered the LSBN's authority to issue declaratory orders and advisory opinions pursuant to La. R.S. 49:962, thoroughly reviewed arguments concerning La. R.S. 37:930 as it relates to this issue, and concluded that the LSBN's statement, insofar as it relates to chronic or interventional pain management, was a rule that required compliance with the procedural requirements of the LAPA. Although ably argued on appeal, a review of the instant record reveals that this court's previous ruling was without error. Thus, by operation of the law of the case doctrine, we decline review of these issues on appeal.

**SCOPE OF PRACTICE ISSUE**

The central issue to be decided in this appeal is whether procedures involving the injection of local anesthetics, steroids and analgesics for pain management purposes, peripheral nerve blocks, epidural injections, and spinal facet joint injections are within the scope of practice of CRNAs or whether these procedures are considered the practice of medicine and can only be performed by a physician licensed to practice medicine in Louisiana. The issue before us is res nova.
The statutory provisions governing practice by a CRNA are found in La. R.S. 37:390. Louisiana Revised Statutes 37:930(A) provides that CRNAs are authorized to administer local anesthetics under the direction and supervision of a physician.9 In 2004, the Louisiana Legislature statutorily recognized the importance of CRNAs in providing anesthetics to Louisiana residents when it added paragraph (G) to La. R.S. 37:930. This provision provides, in pertinent part, as follows:

G. (1) The Louisiana Legislature hereby finds that:

(a) Certified Registered Nurse Anesthetists (CRNAs) have been selecting and administering anesthesia in Louisiana and the United States for over one hundred years.

......

(e) Nurse anesthetists receive rigorous clinical and academic training, requiring a bachelor's degree from an accredited school of nursing and one year of professional nursing experience in an acute care setting prior to being considered for entrance to an accredited twenty-four to thirty-six month nurse anesthesia educational program.

(f) CRNAs administer the majority of anesthetics in Louisiana and all of the anesthetics in many parts of the state.

(g) Multiple studies have demonstrated that CRNAs are safe, accessible, and cost-effective providers of anesthetics.

(h) CRNAs are critical providers of quality anesthesia services in the health care delivery system in this state.

(i) An adequate supply of CRNAs in Louisiana is vital to continued access to safe, cost-effective health care for the citizens of Louisiana.

......

9 Louisiana Revised Statutes 37:930(A) provides as follows:

A. No registered professional nurse shall administer any form of anesthetic to any person under their care unless the following conditions are met:

(1) The registered nurse has successfully completed the prescribed educational program in a school of anesthesia which is accredited by a nationally recognized accrediting agency approved by the United States Department of Health, Education, and Welfare;

(2) Is a registered nurse anesthetist certified by a nationally recognized certifying agency for nurse anesthetists following completion of the educational program referred to in Paragraph (1) of this Subsection and participates in a continuing education program of a nationally approved accreditation agency as from time to time required which program shall be recognized as the Continuing Education Program for Certified Registered Nurse Anesthetists; and

(3) Administers anesthetics and ancillary services under the direction and supervision of a physician or dentist who is licensed to practice under the laws of the state of Louisiana. [Emphasis added.]
CRNAs are trained and legally authorized to administer all types of anesthetics in all settings while AAs [Anesthesiologist assistants] are limited by the type of anesthetics they can administer and the settings in which they are authorized to perform their services.

On appeal, the LSBN and LANA argue that Spine Diagnostics failed to prove by a preponderance of the evidence that the LSBN's statement expands the scope of practice for CRNAs into areas where CRNAs have not traditionally practiced. Noting an overlap between various practitioners, including nurses, and the practice of medicine, the LSBN and LANA contend that interventional pain management is not solely the practice of medicine. Moreover, they maintain that had the legislature intended to exclude CRNAs from performing interventional pain management procedures, language concerning the restriction could have simply been added to La. R.S. 37:930 to accomplish same.

To the contrary, Spine Diagnostics asserts that the evidence presented at the trial on the merits supports the trial court's ruling that the LSBN's statement expands the scope of practice for CRNAs into an area not traditionally practiced. Spine Diagnostics argues that (1) CRNAs do not have an established history of performing interventional pain management procedures; (2) CRNAs do not have the education, training, or accreditation to safely and effectively perform these procedures; (3) studies demonstrate decreased safety, competency, and efficacy when these procedures are performed by CRNAs; (4) CRNAs have no regulatory mechanism or process to assess their competency, training, or education; (5) no verifiable need exists for CRNAs in this area of practice; and (6) CRNA practice in this area will negatively impact public health and safety.

As previously mentioned, this matter was tried over three days before the trial court. After hearing from the witnesses and considering the documentary evidence presented by the parties, the trial court entered a declaratory judgment finding that the statement issued by the LSBN expanded the scope of practice for CRNAs into an area where they have not traditionally practiced, i.e., chronic or interventional pain management. The trial court further declared that the practice of chronic or
interventional pain management is not within the scope of practice of a CRNA, but rather is solely the practice of medicine.

Appellate courts review a trial court’s decision to grant or deny a declaratory judgment using the abuse of discretion standard. Mai v. Floyd, 2005-2301, p. 4 (La. App. 1 Cir. 12/6/06), 951 So.2d 244, 245. Factual findings made by the trial court are reviewed using the manifest error or clearly wrong standard. Rosell v. ESCO, 549 So.2d 840, 844 (La. 1989).

The trial court also issued a permanent injunction prohibiting the LSBN from enforcing its statement and prohibiting Mr. Rantz from performing chronic interventional pain procedures in connection with the LSBN statement and a mandatory injunction ordering the LSBN to remove the statement from its website, post the judgment of the trial court on its website, and publish the judgment in its publication, The Examiner.

The issuance of a permanent injunction takes place only after a trial on the merits, in which the burden of proof must be founded on a preponderance of the evidence. State Machinery & Equipment Sales, Inc. v. Iberville Parish Council, 2005-2240, p. 4 (La. App. 1 Cir. 12/28/06), 952 So.2d 77, 81. A mandatory injunction, so named because it commands the doing of some action, similarly cannot be issued without a hearing on the merits. The jurisprudence has established that a mandatory preliminary injunction has the same basic effect as a permanent injunction, and therefore may not be issued on merely a prima facie showing that the party seeking the injunction can prove the necessary elements; instead, the party must show by a preponderance of the evidence at an evidentiary hearing that he is entitled to the preliminary injunction. Concerned Citizens for Proper Planning, LLC v. Parish of Tangipahoa, 2004-0270, p. 7 (La. App. 1 Cir. 3/24/05), 906 So.2d 660, 664. The standard of review for the issuance of a permanent injunction is the manifest error standard. Cathcart v. Magruder, 2006-0986, p. 18 (La. App. 1 Cir. 5/4/07), 960 So.2d 1032, 1041. Under this standard, the issue to be resolved by a reviewing court is not whether the trier of fact was right or wrong, but whether the fact finder’s conclusion was a reasonable one. Stobart v. State through Dept. of Transp. and
**Development**, 617 So.2d 880, 882 (La. 1993). Thus, if the trial court's findings are reasonable in light of the record reviewed in its entirety, this court may not reverse, even if convinced that had it been sitting as trier of fact, it would have weighed the evidence differently. *Parish of East Feliciana ex rel. East Feliciana Parish Police Jury v. Guidry*, 2004-1197, p. 15 (La. App. 1 Cir. 8/10/05), 923 So.2d 45, 53, *writ denied*, 2005-2288 (La. 3/10/06), 925 So.2d 515.

The trial court heard from many medical experts regarding the scope of practice issue. Dr. Laxmaiah Manchikanti, the single most published author in the United States on interventional pain management techniques, was accepted by the court as an expert in interventional pain management with special expertise in credentialing, education, training, research, access, and scope of practice. Dr. Manchikanti developed the definition of interventional pain management that is accepted by the United States Congress today. He testified at length concerning the level of training needed to perform interventional pain management procedures, indicating that the health and safety of the patients warrants the enhanced skills of a duly licensed and trained medical physician. Dr. Manchikanti opined that interventional pain management procedures are not traditionally within the scope of practice for a CRNA.

Dr. John Dombroski testified as an expert in the field of anesthesiology, internal medicine, and pain medicine, and was allowed to express an opinion with respect to the scope and practice of medicine in those areas of medicine as they interface with other healthcare professionals such as CRNAs. Dr. Dombroski stated unequivocally that CRNAs should not be allowed to be performing interventional pain management procedures as they have never had the proper training required to do so. He indicated that the patients deserve the best care possible, including a proper medical diagnosis and the correct assessment by a duly licensed and trained medical physician.

The trial court also was provided testimony from Dr. Gabor Racz via deposition. Dr. Racz is an anesthesiologist who is currently working as a professor. He has taught both physicians and CRNAs. Dr. Racz is a highly decorated physician, having been listed in the "Best Doctors in America" and receiving the lifetime achievement award
from the American Society of Interventional Pain Physicians. He is also the President of the World Institute of Pain. Dr. Racz testified that under no circumstances should a CRNA be allowed to perform interventional pain management procedures. He added that if CRNAs wish to do these procedures, they have every right to "avail themselves to the training, and whatever it takes to be an interventional pain physician." Dr. Racz opined that nurses do not practice to a physician level and that a medical diagnosis differs from a nursing diagnosis.

Dr. Frank Falco was accepted as an expert in the field of physical medicine. He is also board certified in rehabilitation, pain medicine, and sports medicine. Dr. Falco testified regarding the requirements of a pain medicine fellowship training program. He explained that the assessment of a chronic pain patient is very complex and is not "simply putting a needle in someplace and injecting some solution in that area." Dr. Falco noted further:

The pain fellow must understand based on a history tailored towards the pain patient and the physical examination, that is, a complete examination involving the neurological assessment, a musculoskeletal assessment, a psychological assessment, reviewing of all of the diagnostic data, the CT, the xray, the MRI, the electrodiagnostic studies, and then making a diagnosis based upon the evaluation and then laying out a treatment plan. We have three fellows in our ACGME Accredited Pain Medicine Fellowship. They are constantly supervised for the entire twelve months. They get four months of inpatient training.

When asked if CRNAs had any role to play in the chronic pain management arena, Dr. Falco responded that although CRNAs are excellently trained in providing anesthesia services for surgery under the direction of an anesthesiologist, "[t]hey do not have the training that allows them to include in their scope of practice the management of chronic complex pain." Dr. Falco opined that it would be "practicing medicine with a license, without the proper training," which could lead to significant complications not only from the procedures themselves, but also from the patients being mismanaged. Dr. Falco concluded that without going to medical school, CRNAs cannot receive the training needed to be able to competently perform these procedures.

Jack Neary, a CRNA from New Hampshire, testified that he performs interventional pain management procedures unsupervised. He acknowledged that he
has no training in radiology or neurology. Mr. Neary noted further that he knows of no regulations or guidelines of any sort that apply nationally to institutions to assess the competency, ability, credentials or skill sets of CRNAs with respect to interventional pain management procedures. From his perspective, once a CRNA gets their certificate and the proper training, and feels comfortable with a procedure, they can do it. With regard to the scope of practice for CRNAs in New Hampshire, Mr. Neary testified that the New Hampshire Board of Nursing has found that certain interventional pain management procedures are within the scope of practice of a CRNA licensed in New Hampshire.

Christine Langer testified regarding the educational requirements of a CRNA. Ms. Langer is an instructor who trains CRNAs at the Louisiana State University School of Nursing. She indicated she does not teach a section called "interventional pain management," noting that the majority of her teaching focuses on training CRNAs for the hospital setting. Ms. Langer agreed that there is a distinct difference between acute pain treatment in a hospital or surgical setting and chronic interventional pain management. She also acknowledged that at the time a student acquires a CRNA certificate, absent anything else, no student in Louisiana is competent to perform interventional pain management procedures. Ms. Langer testified that she is not aware of any post-certification competency benchmarks for CRNAs related to interventional pain management procedures. She agreed that CRNAs cannot make medical diagnoses.

Barbara Morvant, the Executive Director for the LSBN, testified concerning the licensing and credentialing of CRNAs in Louisiana. She explained that in its role as a licensing agency, the LSBN credentials CRNAs for entry level practice, and provides for re-certification requirements in their field of nurse anesthesia practice. The LSBN also investigates any complaints that may be filed against CRNAs. When asked specifically about the LSBN statement in question and whether the LSBN had any mechanism or system designed to verify or in any way assess whether a CRNA has the documented education, training, experience, knowledge, skills, and abilities to safely perform
interventional pain management procedures, Ms. Morvant acknowledged that it has no such system in place.

Jackie Rowles is the President-Elect of the American Association of Nurse Anesthetists and is a practicing CRNA in Indiana. She has been performing interventional pain management procedures for almost five years. Ms. Rowles agreed that she cannot make a medical diagnosis, only a nursing diagnosis. She explained, however, that when her patients come to her for treatment, they have already been seen by a physician and have a diagnosis. Ms. Rowles acknowledged that there are no guidelines for assessing the competency, skill set, abilities, or training needed for CRNAs to begin performing interventional pain management procedures. Rather, she opined that a CRNA should be allowed to perform these procedures once the CRNA has had the "necessary education, training, and feels like they have the necessary skills."

Kathleen Wren, a CRNA with a Master of Science in nursing, testified regarding her twenty-three years of experience as CRNA, practicing in eight different states including Louisiana. During her career as a CRNA, she established three pain clinics and three rural hospitals, in Nebraska and Iowa. Her pain clinics provided anesthetic blocks for chronic pain patients. Ms. Wren stated that in her experience as a CRNA, the injection of steroids and analgesics for pain management purposes, including peripheral nerve blocks, epidural injections, and spinal facet joint injections, have always been a part of the practice of CRNAs in the states she practiced in, including Louisiana. However, Ms. Wren later admitted that she never practiced interventional pain management in Louisiana. In her opinion, it is within the scope of practice of a properly trained nurse anesthetist to perform interventional pain management procedures outside of the hospital setting. When asked whether she was aware of any certification beyond the CRNA licensing process or any type of regulatory process in place that would tell the public whether a particular CRNA has met a threshold standard of competency, Ms. Wren stated that she believed that was a function of the LSBN.

Rusty Smith, a CRNA in Louisiana, testified that he performs interventional pain management in Louisiana and has done so for several years. Mr. Smith indicated that
while he has been performing epidural injections for chronic pain relief for approximately twenty years, it is just in the last four years of his practice that he has begun offering spinal facet joint injections related to chronic pain management. He does these procedures exclusively at an ambulatory surgery center in Vidalia, Louisiana. His largest referring physician for interventional pain management procedures is Dr. Russ Fairbanks. When a patient comes to him from Dr. Fairbanks, the patient has been examined and diagnosed. Mr. Smith indicated that when submitting codes to Medicare and Medicaid, he uses the diagnosis submitted by Dr. Fairbanks. When asked if he continued with these interventional pain management procedures even after learning of the preliminary injunction that was in place concerning the LSBN’s statement, Mr. Smith stated that to his knowledge, the injunction was only against Mr. Rantz. In fact, Mr. Smith indicated that even after the preliminary injunction had been ordered, Ms. Morvant, the Executive Director of the LSBN, told him that there was nothing that would prevent him from continuing in his practice.

Dr. Fairbanks, accepted by the trial court as an expert in the field of orthopedics, testified regarding his relationship with Mr. Smith. According to Dr. Fairbanks, over the last five years he has referred approximately three or four patients a week to Mr. Smith for interventional pain management procedures.\(^\text{10}\) Dr. Fairbanks testified that after he sees the patient and makes a diagnosis, he refers the patient to Mr. Smith who then works under his direction. However, Dr. Fairbanks admitted that he is not in the operating suite when Mr. Smith performs these procedures. In fact, Dr. Fairbanks indicated that there may even be times when he is not in the facility when the procedures are being performed. Dr. Fairbanks stated that he has never had any complaints from his patients regarding the treatment they have received from Mr. Smith. Although Dr. Fairbanks denied having any direct financial ties with Mr. Smith, he

\(^{10}\) We note that Mr. Smith did not testify during trial as to the number of interventional pain management procedures he performed. However, after the trial on the merits, there was a contempt hearing concerning a subpoena duces tecum that Mr. Smith had failed to respond to prior to trial. The motion for contempt against Mr. Smith was ultimately dismissed, and the parties entered into a stipulation that from 2004 to 2007, Mr. Smith performed a total of twelve interventional pain management procedures at the ambulatory surgical center in Vidalia.
did acknowledge that he owns a percentage of the surgery center in Vidalia where Mr. Smith performs the procedures. Dr. Fairbanks also noted that there is an interventional pain medicine physician in Natchez, Mississippi, which is only five miles from his surgery center in Vidalia. We have thoroughly reviewed the record before us and find no abuse of discretion by the trial court in its declaratory judgment in favor of Spine Diagnostics finding that the statement issued by the LSBN expanded the scope of practice for CRNAs into an area where they have not traditionally practiced and finding that the practice of interventional pain management is not within the scope of practice of a CRNA, but rather is solely the practice of medicine. Moreover, with the foregoing legal precepts in mind, and having reviewed the evidence considered by the trial court below, we are satisfied that Spine Diagnostics met its burden of proof on the permanent injunction and the mandatory injunction. The trial court's judgment regarding same is reasonable, supported by the record, and not manifestly erroneous.

AWARD OF REASONABLE LITIGATION EXPENSES AND OTHER COSTS TO SPINE DIAGNOSTICS

The LSBN argues on appeal that the trial court erred in awarding Spine Diagnostics $7,500.00 in reasonable litigation expenses pursuant to La. R.S. 49:965.1 plus an award for other fees/costs associated with expert witnesses and depositions. Spine Diagnostics argues that pursuant to La. Code Civ. P. art. 1920,\(^\text{11}\) the trial judge has great discretion in awarding costs and its judgment should not be disturbed absent an abuse of discretion. See \textit{MCI Telecommunications Corp. v. Kennedy}, 2004-0458, p. 11 (La. App. 1 Cir. 3/24/05), 899 So.2d 674, 681. Based on applicable law and jurisprudence, we reverse that portion of the judgment that awarded Spine Diagnostics any fees/costs in excess of the $7,500.00 provided for in La. R.S. 49:965.1.

\(^{11}\) Article 1920 provides as follows:

\begin{quote}
Unless the judgment provides otherwise, costs shall be paid by the party cast, and may be taxed by a rule to show cause.
Except as otherwise provided by law, the court may render judgment for costs, or any part thereof, against any party, as it may consider equitable.
\end{quote}
Spine Diagnostics' request for litigation expenses and the trial court's award were based on La. R.S. 49:965.1(A). It provides, in pertinent part, as follows:

When a small business files a petition seeking: ... (2) judicial review of the validity or applicability of an agency rule, ... the petition may include a claim against the agency for the recovery of reasonable litigation expenses. If the small business prevails and the court determines that the agency acted without substantial justification, the court may award such expenses, in addition to granting any other appropriate relief.

"Reasonable litigation expenses" are defined as "any expenses, not exceeding seven thousand five hundred dollars in connection with any one claim, reasonably incurred in opposing or contesting the agency action, including costs and expenses incurred in both the administrative proceeding and the judicial proceeding, fees and expenses of expert or other witnesses, and attorney fees." La. R.S. 49:965.1(D)(1) (Emphasis added.); State ex rel. Louisiana Riverboat Gaming Com'n v. Louisiana State Police Riverboat Gaming Enforcement Div., 99-2038, p. 4 (La. App. 1 Cir. 9/22/00), 768 So.2d 284, 286, writ denied, 2000-2926 (La. 1/5/01), 778 So.2d 598. To qualify for this relief, a "small business" must meet the criteria defined by the Small Business Administration in Section 13 of the Code of Federal Regulations, Part 121. La. R.S. 49:965.1(D)(2). A physician's office with annual receipts of less than $9 million is considered a "small business" under the applicable regulation. 13 C.F.R. §121.201.12 At the hearing on the preliminary injunction, Dr. John Burdine, owner of Spine Diagnostics, testified that Spine Diagnostics' annual receipts total less than $9 million per year. A review of the record before us reveals that this testimony was not contradicted. Thus, Spine Diagnostics meets the eligibility requirements set forth in the statute.

Because La. R.S. 49:965.1 provides for an award for reasonable litigation expenses, it is penal in nature. It is a well-settled rule of statutory construction that penal statutes must be strictly construed and their provisions shall be given a genuine construction according to the fair import of their words, taken in their usual sense, in

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12 Effective August 26, 2008, 13 C.F.R. 121.201 was amended to provide that a physician's office must now have annual receipts of less than $10 million to be considered a "small business."
connection with the context and with reference to the purpose of the provision. *Doc's Clinic, APMC v. State ex rel. Dept. of Health and Hospitals*, 2007-0480, p. 32 (La. App. 1 Cir. 11/2/07), 984 So.2d 711, 732, *writ denied*, 2007-2302 (La. 2/15/08), 974 So.2d 665. Pursuant to the clear language of this statute, any award for reasonable litigation expenses is limited to $7,500.00 and is inclusive of any and all costs, fees, and expenses associated with opposing or contesting the agency action. Thus, there can be no award over and above the $7,500.00 for other expert fees and deposition costs such as those awarded by the trial court in this matter. Accordingly, we affirm the $7,500.00 award for litigation expenses and reverse that portion of the judgment awarding "all costs associated with these proceedings;" "all expert costs and fees;" and "costs of all deposition transcripts."

**CONCLUSION**

For the above and foregoing reasons, we reverse that portion of the trial court's judgment awarding "all costs associated with these proceedings;" "all expert costs and fees;" and "costs of all deposition transcripts." In all other respects, we affirm. All costs associated with this appeal are assessed equally against the Louisiana State Board of Nursing and the Louisiana Association of Nurse Anesthetists.

**AFFIRMED IN PART; REVERSED IN PART.**
CRNA Practice and Chronic Pain Management – Revised

This article from "Medicare B News," Issue 273 dated October 6, 2011 is being updated to include an additional CPT codes 62270 and 0213T-0218T, to inform providers of two mass adjustments and to notify Idaho CRNAs of implementation of these guidelines. We want to ensure that our provider and supplier community has access to recent publications that contain the most current, accurate, and effective information available.

Certified Registered Nurse Anesthetists (CRNAs) may provide anesthesia and related services to Medicare patients consistent with their State scope of practice, training and clinical privileges. Settings may include outpatient hospital, Ambulatory Surgical Center (ASC) or office/free-standing clinic. These practitioners also may insert arterial lines and draw blood gases, place peripherally inserted central venous catheters (PICCs and CVPs) consistent with the formal guidelines and instructions as well as skills assessment provided to CRNAs during their training.

Epidural injections and other forms of nerve blockade are reimbursed as part of the anesthetic management when used as the primary route of anesthesia or obstetrical analgesia. In addition, if the CRNA is an Advanced Registered Nurse Practitioner (ARNP) or Clinical Nurse Specialist (CNS), or working incident to a physician or Non-Physician Practitioner (NPP), nerve blocks may be reimbursed as part of the physician's or NPP's (Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant) management of a patient with chronic pain.

Chronic Pain
Pain is the common symptomatic manifestation of a wide range of underlying medical conditions. Chronic pain is a disease state in and of itself; and induces neuroanatomic, neurohumoral, pharmacodynamics and pharmacokinetic changes in the affected individual. Widely diverse injuries and medical illnesses may directly damage the peripheral and/or central nervous system and ultimately involve multiple body systems and manifest as chronic pain. Chronic pain induces or is accompanied by significant effects on mood, neuroendocrine and other bodily systems' function. Reasonable treatment of the chronic pain disorder begins with a detailed medical assessment aimed at developing a diagnosis or diagnostic evaluation plan which will then lead to an appropriate and comprehensive therapeutic plan.

The comprehensive therapeutic plan may but not necessarily include interventional pain techniques, such as, nerve blockade. The assessment skills required for the
evaluation of the chronic pain state and consequent therapy are not part of the CRNA training curricula. There are no guidelines or skills assessment available for development of the necessary medical diagnostic and therapeutic skills for CRNAs, unlike MDs, NPs and CNS.

Covered Services
Washington CRNAs are dually trained, licensed and credentialed as NPs and may be reimbursed for any services that an NP is allowed to provide, including diagnostic and therapeutic services. All other NAS contracted states will allow only the below CPT ranges for CRNAs. This code range was fully implemented into the claim processing system on August 2, 2011.

- **Type of Service (TOS) 7 codes (anesthesia)**
  - Append QX or QY modifier
- **TOS 2 codes** – 31500, 36410, 36600, 36620, 36555, 36556, 36568, 36569, 62273
  - Without the QX or QZ modifier
- **TOS 2 codes** – 62270, 62310, 62311, 62318, 62319, 64400-64530
  - Append the 59 modifier
  - Do not need the QX or QZ modifier
- **TOS 1 code** – 01996
  - Without the QX or QZ modifier
- **TOS 4 codes**
  - 76937 when billed by itself without the QX or QZ modifier; does not need a 59 modifier
  - 77003 when billed without the QX or QZ modifier with any of the TOS 2 codes listed above EXCEPT they will be denied when billed with CPTs 64479-64484, 64490-64495
- **TOS 9 codes** – 0213T-0218T
- **PQRI codes**

Claim Denials
CRNAs that have been denied for the above listed CPT codes may perform one of the following two options. (Any services outside the above CPT range that were performed by a CRNA will remain denied.)

1. Rebill the claims that have a date of service that is within the one year timely filing guideline; **this is the best and quickest method to receive payment for these services.**
2. Contact Phone Reopenings at 800-279-5331 or complete a Written Reopening for any claims that are outside the one year timely filing guideline.

CPT codes, descriptors and other data are copyright 2012 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply. This article applies to all NAS administered states unless otherwise noted in the article.
Mass Adjustments
Two mass adjustments were performed for the recently added codes. This mass adjustment was performed for only CRNAs. **No other provider specialties were affected.**

- CPT 62270 – Mass adjusted for denied services processed from 01/01/11 to 06/18/12. This mass adjustment was completed on 06/19/12 and all adjustments should be finished processing. If you believe you have denied claims that the mass adjustment did not adjust, you may do one of two options:
  1. If the date of service is less than one year from the current date, rebill the claim. **Note:** This is the best and quickest method to receive payment for these services.
  2. If the date of service is more than one year from the current date, contact the Provider Contact Center at 877-908-8431 and a representative will review your claim and reprocess the claim if needed.

- CPTs 0213T-0218T – Mass adjusted for denied services processed from 01/01/11 to 07/24/12. **Note:** This mass adjustment was requested on 07/24/12 and providers should allow a minimum of 60 days from this date to follow one of the two options listed above.

Idaho CRNA Providers
This article serves as a notice to Idaho CRNA providers that these guidelines will be placed into effect 45 days from the posting of this article on September 14, 2012.
Certified Registered Nurse Anesthetist (CRNA) Practice and Chronic Pain Management

Section 1861 of the Social Security Act defines services of a Certified Registered Nurse Anesthetist (CRNA) to mean anesthesia services and related care furnished by a certified registered nurse anesthetist, which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished. This legislative statute forms the basis for the coverage of CRNA services by the Medicare program. Services meeting this definition are billable to Medicare when all medical necessity criteria have been met.

Anesthesia Services

The definition of anesthesia services is based on American Society of Anesthesiologists most recent set of practice guidelines (Anesthesiology 2002; 96:1004-17). Anesthesia services are divided into 2 categories, anesthesia and analgesia.

Category 1: Anesthesia, specifically including
- General anesthesia
- Regional anesthesia
- Monitored anesthesia care (MAC), including deep sedation

Category 2: Sedation/analgesia, specifically including
- Topical or local anesthetic
- Minimal sedation
- Moderate sedation/analgesia ("Conscious Sedation")

Related Care

CMS Internet Only Manual (IOM) 100-04 - Medicare Claims Processing Manual: Chapter 12, Section 140.4.3 - Payment for Medical or Surgical Services Furnished by CRNAs. In addition to the services that a CRNA may bill for when they are related to anesthesia care provided "Related to" is defined as occurring before, during or immediately after the administration of anesthesia. These services may include insertion of central venous pressure lines, pain management, emergency intubation, and the pre-anesthetic examination and evaluation of a patient who does not undergo surgery.

Chronic Pain Management

Chronic pain is a common symptomatic manifestation of a wide range of underlying medical conditions. Treatment of the chronic pain disorder begins with a detailed medical assessment, aimed at developing a diagnosis or diagnostic evaluation plan, which will then lead to an appropriate and comprehensive therapeutic plan. The assessment should include evaluation of the chronic pain state and the development of the consequent plan of care not part of the CRNA training curricula. If the CRNA is an Advanced Registered Nurse Practitioner (ARNP) or Clinical Nurse Specialist (CNS) or working incident to a physician or Non-Physician Practitioner (NPP) epidermal injections may be reimbursed incident to the physician’s or NPP’s (NP, PA) management of a patient with chronic pain when such services are medically reasonable and necessary.

Billing the Appropriate Contractor

The CMS Internet-Only Manual (IOM) 100-04 - Claims Processing Manual, Chapter 12, Sections 250.3.3.1 and 250.3.3.2 include information regarding billing for CRNA anesthesia services. The HCPCS code range in this section contains the anesthesia HCPCS codes that CRNAs may bill. The regulation does not include a HCPCS code range for the additional services that a CRNA may bill for as defined by CMS Internet Only Manual (IOM) Publication 100-04 - Medicare Claims Processing Manual: Chapter 12, Section 140.4.3 Critical Access Hospitals (CAH) should use the rules listed below to determine the appropriate form to use when billing for CRNA services.

If a CAH meets the criteria for a pass-through exemption, is interested in selecting the Method II option, it can choose this option for all outpatient professional services except the Certified Registered Nurse Anesthetist (CRNA) and still retain the approved CRNA exemption for both inpatient and outpatient professional services of CRNAs. With an approved exemption, the CAH can choose to give up its exemption for both inpatient and outpatient professional services of CRNAs in order to include all CRNA outpatient professional services along with those of all other professional services under the Method II option. By choosing to include the CRNAs under Method II for outpatient services, the CAH loses its CRNA pass-through exemption for all of the outpatient CRNA services. In the case, the CAH would have to bill the Part B carrier for the CRNA outpatient professional services.

All payments for CRNA services are subject to cost settlement. If a CAH that meets the criteria for a pass-through exemption is not interested in selecting the Method II option, the CAH can still receive the CRNA pass-through under the standard option (Method I).

Method I

Billing requirements:
- Method I - without a pass-through exemption - bill professional services using CMS-1500 and technical services using CMS-1450
Type of Bill (TOB) = 85X and 11X
Revenue code 037X for CRNA technical services
Revenue code 0964 for professional services

Method II - Receiving the CRNA Pass-Through
Billing requirements
    CMS-1450
    TOB = 85X
    Revenue code 037X for CRNA technical services
    Revenue code 0964 for CRNA professional services

Method II - Gave Up CRNA Pass-Through Exemption (or Never Had Exemption)
Billing requirements
    CMS-1450
    TOB = 85X
    Revenue code 037X for CRNA technical services
    Revenue code 0964 for CRNA professional services
BCBSNC Pain Management Education Criteria

In addition to the credentialing criteria previously listed (ie, application, malpractice insurance, etc.), Providers must meet the required education criteria detailed below:

- Provider must be Board Certified or Board Eligible (Residency/Fellowship Trained) in one of the following specialties:
  - Anesthesiology
  - Physical Medicine Rehab
  - Neurology
  - Psychiatry
  - Fellowship in Pain Medicine (Board Certified/Eligible for Subcertification of Pain Medicine by an ABMS Board)

AND