PHYSICIAN-LED ANESTHESIA CARE

In Texas, there are several healthcare professionals who play a role in your anesthesia care during medical procedures. Physician Anesthesiologists provide care by either personally administering the anesthetics and monitoring the patient's status or by leading an Anesthesia Care Team (ACT). The ACT is made up of a physician anesthesiologist who directs or supervises care by Certified Anesthesiologist Assistants (CAA) or Certified Registered Nurse Anesthetists (CRNA).

Texas Statute: Texas law includes physician delegation and supervision requirements, which are codified in the Medical Practice Act at Tex. Occ. Code sections 157.001 and 157.058. Further, Attorney General Opinion No. JC-0117 (1999) reinforces the need for physician supervision consistent with sound medical judgement,[1] and Attorney General Opinion KP-0353 (2021) reinforces delegation requirements under Tex. Occ. Code 157.058 and "the need to comply with all other applicable statutes, regulation, bylaws, ethical standards, and a physician's own professional judgement.[2]

CMS Rule: Centers for Medicare and Medicaid Services (CMS) rules require physician supervision of anesthesia services provided by a certified registered nurse anesthetist (CRNA) as a Medicare condition of participation, meaning all health care facilities that serve Medicare patients are required to have a physician supervise the administration of an anesthetic performed by a CRNA.[3] However, the CMS rules allow state Governors to "opt-out" of the supervision rule for their state.

Opting Texas out of CMS supervision requirements would lower the standard of medical care for Medicare patients and create a two-tiered system of haves and have-nots. Access to physician-led anesthesia care should be the standard of care for all Texans, not just those with private insurance.

Protecting Vulnerable Patients:

An independent, peer-reviewed study of anesthesia or surgical complications showed the presence of a physician anesthesiologist prevented 7 deaths per 1,000 cases.[4]

The same study found deaths due to complication (failure to rescue) were higher when CRNAs practiced independently.

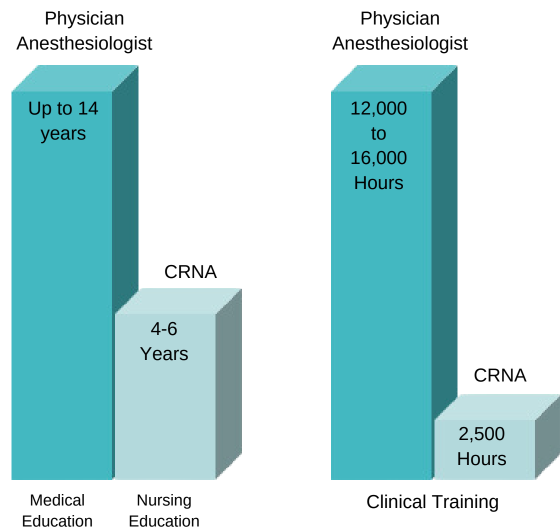
A minority of states have opted-out of the federal requirement for physician supervision of CRNAs in Medicare facilities. In states that have opted out of the CMS requirement, studies consistently show **no increase in patient access to care**.

Patients in opt-out states travel the same distance to receive anesthesia care as patients living in non-opt-out states. An analyses of over 1.1 million Medicare patients traveling for five common elective procedures and two emergency surgeries showed patients in opt-out states **did not have increased access to surgical care and anesthesia services.**[5]

An analysis of 2.3 million patients with appendicitis, bowel obstruction, gallstone removal and hip fracture from 1998 to 2010 showed patients in opt-out states **were not** more likely to be admitted for care, nor were they less likely to suffer from a ruptured appendix.[6]

In fact, anesthesia utilization growth rates are higher in most states that have **not** opted-out of CMS requirements for physician supervision.[7] A review of rural hospitals in opt-out states and their availability of CRNA services found **no increase** in the likelihood of CRNA services in hospitals, **even when looking at the most rural hospitals.** The chance that rural hospitals in opt-out states use CRNAs is lower than that of non-opt-out states.[8]

With up to 14 years of medical education and up to 16,000 hours of clinical training, physician anesthesiologists receive double the education and five times the clinical training of certified registered nurse anesthetists (CRNAs). The difference can save a life.



1. Tex. Attorney Gen. Op. No. JC-0117 (1999).
2. Tex. Attorney Gen. Op. No. KP-0353 (2021).
3. Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services (2001).
4. Silber JH, Kennedy SK, et al. Anesthesiologist Direction and Patient Outcomes. Anesthesiology 2000; 93:152–163.
5. Sun EC, Dexter F, Miller TR, Baker LC. “Opt out” and access to anesthesia care for elective and urgent surgeries among U.S. Medicare beneficiaries. Anesthesiology. 2017;126(3):461-471.
6. Sun E, Dexter F, Miller TR. The effect of “opt-out” regulation on access to surgical care for urgent cases in the United States: evidence from the National Inpatient Sample. Anesth Analg. 2016;122(6):1983-1991.
7. Sun EC, Miller TR, Halzack NM. In the United States, “opt-out” states show no increase in access to anesthesia services for Medicare beneficiaries compared with non-”opt-out” states. A A Case Rep. 2016;6(9):283-285.
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