Physician Supervision over NPs and CRNAs: Myths/Facts

**Myth**: Physician “supervision” over NPs and CRNAs increases patient safety.

**Fact**: We know of no evidence suggesting that physician supervision over advanced practice nurses improves patient safety. In fact, a 2013 report by the federal Agency for Healthcare Quality and Research identified 22 evidenced based strategies that are proven to enhance patient safety and “physician supervision” is not listed. 32 states authorize CRNAs to practice without restrictions. Massachusetts is the only New England state to restrict CRNA licenses. Massachusetts is one of only 13 states in the country and the only New England State with restrictive licensing laws for NPs.

**Myth**: “Supervision” means that a doctor is always around to double check on NP or CRNA practice

**Fact**: Regulations by the MA Board of Registration in Nursing and the MA Board of Registration in Medicine limit supervision to a mandated retrospective review of a sample of the prescriptions written. There is no mandate or clinical requirement, for a physician to be “on site” when care is delivered by an NP or a CRNA.

**Myth**: The public is at risk because NPs and CRNAs do not have the same length of education as do their counterparts in medicine.

**Fact**: While it is true that the duration of education for NPs and CRNAs is not the same as physicians, they are educationally prepared with a minimum of an RN and a Master’s Degree in their related nursing specialty. In addition, they all must maintain national certification and be “authorized” by the Board of Registration in Nursing to practice their specialty. There is no evidence that APRN educational preparation does not prepare NPs and CRNAs to improve patient outcomes in the delivery of care. In fact, many studies document APRN outcomes as equal to or better than, those of physicians.

**Myth**: This bill is an expansion of the scope of practice of a CRNA and NP.

**Fact**: This bill clarifies the authority granted by the Board of Registration in Nursing in conjunction with national standards for the practice that has existed in Massachusetts for many years. The draft is a result of consultation with former House Counsel, Lou Rizolli. This bill does not expand scope of practice; it removes the artificial restrictions on the NP and CRNA license that can be imposed by a “supervising” physician.

**Myth**: If an NP or CRNA wanted to practice medicine, they should go to medical school.

**Fact**: NPs and CRNAs share common scopes of practice and practice standards with medicine, such as in the delivery of primary care and anesthesia care. They practice nursing in these respective specialties, not medicine. This model is not unique, as both MD psychiatrists and PhD psychologists practice in the field of behavioral and mental health and yet, there is no “supervision” requirement for these disciplines. In addition, MGL Chapter 112 s 80B notes: “The standards of care in the ordering of tests, therapeutics and the prescribing of medications, to
which nurses in advanced practice shall be held, shall be those standards which protect consumers, and provide them with safe and comprehensive care, and shall be standards comparable to other professionals, including physicians, providing the same services.”

**Myth:** NPs and CRNAs want to work “independently” and the delivery system is moving towards team based care

**Fact:** The FTC addressed this perfectly in its comments: “The phrase "independent practice" here, and commonly, refers to state regulatory schemes that do not require direct supervision of an APRN by a particular physician for an APRN to deliver services otherwise within his or her scope-of-practice. "Independent practice" does not, however, mean isolated or unregulated practice. Collaboration and professional oversight are the norm in states that do not require direct physician supervision. Patterns of collaboration are independently established by institutional providers, from large hospital systems to small physician practices, to individual practitioners, with the particulars varying according to resources and demands at the point of service, and standards of care, as well as other regulations.” FTC 1.17.14

**Myth:** With health care becoming more and more data driven, the NP and CRNA services provided are readily identifiable.

**Fact:** “Supervision” is often used as a proxy for payment. Physician practices can be paid at a higher rate when services performed by the NP are billed under MD provider numbers. The amount of care actually rendered by NPs and CRNAs is likely significantly underrepresented in data collected by the All Payer Claims Data Base.

**Myth:** Nurses are seeking this change to get more reimbursement.

**Fact:** This bill does not change any insurance or billing statutes. The removal of physician supervision was not sought in Chapter 224 of the Acts of 2012 because it focused on payment reform. This bill is focused on removing barriers that are experienced by NPs and CRNAs when supervision is used to limit or control what services they MAY perform, rather than what services they CAN perform.

**Myth:** “Physician supervision” requirements do not affect the cost of care.

**Fact:** In 2001, CMS ruled that “supervision” of a CRNA was not needed for the purposes of billing for anesthesia care for Medicare beneficiaries. So in those states, that did not have a “supervision” legal requirement, the Governor could “opt-out” of that requirement. Because we now have over a dozen years of experience on both quality of care and costs to compare those states with a “supervision” of CRNA or of CRNA delivery only, what we can confidently tell you is that the care delivery is no different whether the CNRA is “supervised” or not, but that the same care can be as much as 33% higher in a supervised model1, where physicians get reimbursed for “supervising” up to 4 CRNAs at one time, for care they do not deliver.

**Myth:** The public wants a doctor for their care.

**Fact:** The public can choose a doctor. Since 2008, the public can also choose an NP as their primary care provider. Many support NPs and the literature substantiates that care delivered by NPs and CRNAs is equal to or better than that delivered by physicians, especially in terms of patient satisfaction.

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1 Hogan, Paul et al, Nursing Economics, “Cost Effectiveness of Anesthesia Providers”, May-June 2010/Vol. 28/No. 3 pp. 159 – 169.
**Myth:** Physicians and Advanced Practice Nurses are adversaries.

**Fact:** In clinical practice, physicians and NPs and CRNAs work well together. However, all health care services need not be “led” by a physician at all times. At times, a social worker, pharmacist, nurse or even a chaplain may be the appropriate team leader for an individual’s care. The National Center for Quality Assurance has recognized in its certification of Patient Centered Medical Homes (PCMH) that a patient’s medical home can appropriately be led by an NP. This is also true of the MA PCMH demonstration.

**Myth:** Physicians are liable for the care delivered by an NP or CRNA.

**Fact:** Massachusetts NPs and CRNAs carry their own professional liability insurance and are held accountable to national standards for nursing practice for the care they deliver and to the requirements of the Board of Registration in Nursing. This statement is unfounded.

**Myth:** Guidelines for practice between a physician and an individual NP or CRNA are needed to assure that care is safely delivered.

**Fact:** Massachusetts is one of only New England state to require joint promulgation of regulations and “guidelines” between the Board of Medicine and the Board of Nursing. The MA Board of Nursing is capable of regulating the nursing profession and those that specialize in advanced practice roles. Health care professionals routinely collaborate with members of the health care team and there is no evidence that written joint guidelines increases patient safety.

**Myth:** “Supervision” and joint promulgation of regulations for advanced practice nurses upon agreement with the Board of Registration in Medicine must be a professionally respectful and productive process.

**Fact:** In recent years, the Board of Registration in Medicine together with organized medicine has used this statutory provision to create obstacles for the Board of Nursing, NPs and CRNA. These include:

- stalling the updating of the nursing regulations of advanced practice nurses for more than 9 years;
- confusing funeral directors on the ability of NPs to sign death certificates, even though NPs have pronounced death for more than a decade;
- proposing billing regulations under MassHealth that would have prevented a surgeon from getting paid for anesthesia care if the surgeon worked with a CRNA to provide anesthesia care to their patient;
- attempting to limit the “supervision of issuing prescriptions” by a CRNA to only an anesthesiologist (MD specializing in anesthesia); and
- trying to move towards full supervision of the practice of nurse anesthesia, during the implementation of the CRNAs authority to issue prescriptions to patients.

**Myth:** Removing Supervision and Joint Regulatory Promulgation must be a new concept.

**Fact:** Removal of these barriers is not a new concept and has been advocated by the National Council of State Boards of Nursing. Further, the model has gained national support from the Institute of Medicine, the AARP, the Robert Wood Johnson Foundation, the Josiah Macy Foundation, the National Governor’s Association and the Federal Trade Commission. In Massachusetts there is also support from every nursing organization, AARP-MA. Atrius Health, AIM, the Leap Frog Group, NFIB, the Mass Retailers Association and the Mass League of Community Health Centers.