

# Legal Issues in Nurse Anesthesia Practice

This document was prepared to assist policymakers, health care administrators, health care insurers, and the public to obtain an understanding of nurse anesthesia practice issues, including legal matters affecting the practice of anesthesia by Certified Registered Nurse Anesthetists (CRNAs). It is not intended to be comprehensive, but rather to serve as a brief overview and summary of selected legal and regulatory issues. A more extensive exploration of legal issues in nurse anesthesia practice can be found in the publication titled: "Professional and Legal Issues of Nurse Anesthesia Practice" listed as a reference at the end of this document.

Early legal challenges to nurse anesthesia practice were based on whether nurse anesthetists were illegally practicing medicine. Landmark decisions in Kentucky (1917) and California (1936) established that nurse anesthetists were practicing nursing, not illegally practicing medicine.

CRNAs are professional registered nurses licensed to practice nursing who have become anesthesia specialists by taking a graduate curriculum which focuses on the development of clinical judgment and critical thinking. CRNAs are qualified to make independent judgments relative to all aspects of anesthesia care based on their education, licensure, and certification. Nurse anesthetists are legally responsible for the anesthesia care they provide.

CRNAs provide anesthesia, working with anesthesiologists, other physicians such as surgeons, and, where authorized, podiatrists, dentists, and other health care providers. The laws of every state permit CRNAs to work directly with a physician or other authorized health care professional without being supervised by an anesthesiologist. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) does not require anesthesiologist supervision of CRNAs nor does Medicare.

Some states require that nurse anesthetists be supervised or directed by a physician (such as a surgeon), dentist or podiatrist. Those who seek to discourage physicians from working with nurse anesthetists have incorrectly asserted that a supervising physician becomes liable for the negligent acts of the CRNA. A physician or authorized provider is not automatically liable when working with a CRNA, nor is the physician immune from liability when working with an anesthesiologist.

The principles governing the liability of a surgeon or obstetrician when working with a CRNA are the same as those governing the liability of a surgeon or obstetrician when working with an anesthesiologist. Whether or not a surgeon or obstetrician will be held liable for the negligence of the anesthetist depends on the facts of the case, not on the nature of the license of the anesthesia provider. Generally, the courts do not look at the status of the anesthesia provider, but at the degree of control the physician exercises over the anesthetist — whether that anesthetist is a CRNA or an anesthesiologist. The issue in each case is the extent

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to which the physician has control over the anesthesia administrator. Thus, a court may render different conclusions for cases that involve a physician working with a CRNA— or, for that matter, a physician working with an anesthesiologist — if the physician controlled the CRNA in one case but not in another.

Even where state laws require physician supervision of CRNAs, there is no requirement that a supervising physician control the acts of a CRNA. State laws do not require control, and mere supervision is insufficient to make the supervisor legally responsible for the negligence of a CRNA. The CRNA is the expert in anesthesia and supervising physicians, other than anesthesiologists, are not expected to have as much knowledge of anesthesia as the CRNA.

Medical staff bylaws which prevent CRNAs from being able to practice to the full extent of their professional authority as granted by state laws or regulations are traps for unwary hospitals. Such restrictions have denied some patients access to the full scope of anesthesia techniques which should be made available to them, ultimately increasing the cost of anesthesia services. These restrictions have no basis in practice and are sometimes not followed when patient interests or operating room efficiency demand it. Should there be a problem during a procedure when these policies were not followed, the patient may claim that the hospital or institution was negligent for failing to follow its own requirements, creating a basis for a lawsuit for what may have been an otherwise non-negligent and unavoidable incident.

### References

*Professional and Legal Issues of Nurse Anesthesia Practice*. Park Ridge, Illinois. American Association of Nurse Anesthetists: 1989.

Blumenreich GA, Wolf BL. Restrictions on CRNAs imposed by physician-controlled insurance companies. *AANA Journal*. 1986;54:538-539.

# Nurse Anesthetists and Anesthesiologists Practicing Together

Anesthesia is a recognized specialty in both medicine and nursing. Approximately 80% of Certified Registered Nurse Anesthetists (CRNAs) work as partners in care with anesthesiologists, while the remaining 20% function as sole anesthesia providers working and collaborating with surgeons and other licensed physicians. The American Association of Nurse Anesthetists (AANA) supports both practice models and believes that quality outcomes are excellent in both.

The AANA supports mutual respect and open, forthright relations between CRNAs and anesthesiologists working in a collaborative fashion.

When CRNAs and anesthesiologists work together to provide patient care, the following are key concepts:

1. CRNAs are responsible for their actions in the care of patients and in the provision of anesthesia services.
2. CRNAs practice according to their licensure, certification and expertise.
3. The anesthesiologist is the medical specialist who provides perioperative services and functions collaboratively with the CRNA in the provision of anesthesia and related services.
4. Patient care needs should dictate appropriate personnel resources of both anesthesiologists and CRNAs, rather than predetermined numerical ratios.

The anesthesia and related services provided by either the CRNA or the anesthesiologist when working together include, but are not limited to:

- Performing and documenting a preanesthetic assessment and evaluation of the patient, including ordering and administering preanesthetic medications, and requesting consultations and diagnostic studies.
- Developing and implementing the anesthesia care plan.
- Selecting and initiating the planned anesthetic technique which may include general, regional, or local anesthesia, or sedation.
- Selecting and administering anesthetics and adjunct drugs and monitoring the patient's responses to surgery or anesthesia.
- Selecting, applying, and inserting appropriate non-invasive and invasive monitoring modalities for continuous evaluation of the patient's physical status.
- Managing the patient's airway and pulmonary status.
- Managing emergence and recovery from anesthesia.
- Providing postanesthesia follow-up evaluation and care, including discharge of patients from a postanesthesia care area.

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- Ordering, initiating or modifying pain relief therapy.
- Responding to emergency situations by providing airway management, administration of emergency fluids or drugs, and advanced cardiac life support techniques.

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### Reference

Nurse Anesthetists and Anesthesiologists Practicing Together. In: *Professional Practice Manual for the Certified Registered Nurse Anesthetist*. Position Statement No. 1.9. Park Ridge, Illinois: American Association of Nurse Anesthetists. Adopted August 1996. Revised November 1996.

# CRNA Scope of Practice

Certified Registered Nurse Anesthetists (CRNAs) are licensed professional registered nurses who have obtained, through additional education and successful completion of a national examination, certification as anesthesia nursing specialists. CRNAs are qualified to make independent judgments relative to all aspects of anesthesia care, based on their education, licensure, and certification. The practice of anesthesiology by nurses has been recognized by the courts as the practice of nursing since 1917.

As anesthesia professionals, CRNAs provide anesthesia and anesthesia-related care upon request, assignment, or referral by a patient's physician (or other health care professional authorized by law), most often to facilitate diagnostic, therapeutic, or surgical procedures. In other instances, the referral or request for consultation or assistance may be for management of pain associated with obstetrical labor and delivery, management of acute or chronic ventilatory problems, or management of acute or chronic pain through the performance of selected diagnostic or therapeutic blocks or other forms of pain management.

The scope of practice of CRNAs includes, but is not limited to, the following:

- Performing and documenting a preanesthetic assessment and evaluation of the patient, including requesting consultations and diagnostic studies; selecting, obtaining, ordering, and administering preanesthetic medications and fluids; and obtaining informed consent for anesthesia.
- Developing and implementing an anesthetic plan.
- Initiating the anesthetic technique which may include: general, regional, local, and sedation.
- Selecting, applying, and inserting appropriate non-invasive and invasive monitoring modalities for continuous evaluation of the patient's physical status.
- Selecting, obtaining, and administering the anesthetics, adjuvant and accessory drugs, and fluids necessary to manage the anesthetic.
- Managing a patient's airway and pulmonary status using current practice modalities.
- Managing emergence and recovery from anesthesia by selecting, obtaining, ordering, and administering medications, fluids, and ventilatory support.
- Discharging the patient from a postanesthesia care area and providing postanesthesia follow-up evaluation and care.
- Implementing acute and chronic pain management modalities.
- Responding to emergency situations by providing airway management, administration of emergency fluids and drugs, and using basic or advanced cardiac life support techniques.
- Additional nurse anesthesia responsibilities which are within the expertise of the individual CRNA.

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## CRNA Scope of Practice

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In a survey of practice conducted among anesthesiologists and CRNAs in 1986 by the Center of Health Economics Research, it was found that CRNAs perform the same range of anesthesia tasks and activities as anesthesiologists.

CRNAs provide anesthesia, working with anesthesiologists, other physicians such as surgeons, and, where authorized, podiatrists, dentists, and other health care providers. The laws of every state permit CRNAs to work directly with a physician or other authorized health care professional without being supervised by an anesthesiologist. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) does not require anesthesiologist supervision of CRNAs nor does Medicare. In some cases, a provider or payor or a medical staff bylaw may require anesthesiologist supervision, however, these decisions are not based on legal requirements nor are they justified by concerns about the quality of care (see "Quality of Nurse Anesthesia Practice" paper). Regardless of supervision, the CRNA is legally responsible for the anesthesia care provided. Anesthesia has been a proper nursing function for more than 100 years, and nurse anesthetists practice in every state.

Clinical privileging is a form of credentialing utilized by hospitals and other facilities to authorize selected health care providers, including CRNAs, to provide specific patient care services. Having such privileges provides the health care provider with an opportunity to practice within that facility under the conditions specified in the privileges. Clinical privileging requirements are usually developed by the medical staff through bylaws.

JCAHO requires physician members of the medical staff to be credentialed and privileged. According to JCAHO, nurse practitioners, physician assistants, and CRNAs may be credentialed and privileged through the hospital's medical staff bylaw process or the institution's human resource credentialing process. It is the health care facility's choice to determine which credentialing and/or privileging process should be utilized for these practitioners.

Guidelines for granting clinical privileges to the CRNA and a prototype of an application for clinical privileges may be found in *The AANA Guidelines for Clinical Privileges* available from the American Association of Nurse Anesthetists, 222 South Prospect Avenue, Park Ridge, Illinois.

CRNAs practice in every clinical setting including tertiary care centers, major university medical centers, community hospitals, free-standing clinics, physician offices, surgicenters, as well as Veterans Administration Medical Centers and the U.S. Military. CRNAs are sole providers of anesthesia in more than 70% of rural hospitals in America. They administer approximately 65% of the 26 million anesthetics given in the United States annually, either as sole providers or working in collaboration with anesthesiologists.

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### References:

- Scope and Standards for Nurse Anesthesia Practice*. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1996.
- Professional and Legal Issues of Nurse Anesthesia Practice*. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1989.
- Rosenbach ML, Cromwell J: A profile of anesthesia practice patterns. *Health Affairs*, 1988; 7 (4): 118.
- The American Association of Nurse Anesthetists Guidelines for Clinical Privileges*. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1996.
- Joint Commission on Accreditation of Healthcare Organizations. *Joint Commission Perspectives*. St. Louis, Missouri: Mosby Year Book, Inc. September/October. 1995.

# Executive Summary

Nurse anesthetists have been providing quality anesthesia services in this country for more than a century. The longevity of their practice can be attributed directly to their commitment to excellence and patient safety, their willingness to provide services when and where needed, and the provision of those services at reasonable cost.

This series of documents was prepared to assist policymakers, health care administrators, health care insurers, and the public to better understand the role of nurse anesthetists and their potential to reduce health care costs while maintaining high quality health care. The following documents highlight important aspects of the nurse anesthesia profession.

## **History of Nurse Anesthesia Practice**

### **Nurse Anesthesia Education**

### **CRNA Scope of Practice**

## **Quality of Nurse Anesthesia Practice**

## **Cost Effectiveness of Nurse Anesthesia Practice**

### **Nurse Anesthesia Reimbursement**

## **Legal Issues in Nurse Anesthesia Practice**

## **Nurse Anesthetists and Anesthesiologists Practicing Together**

Today, Certified Registered Nurse Anesthetists (CRNAs) working with anesthesiologists, physicians such as surgeons and, where authorized, podiatrists, dentists, and other health care providers, administer approximately 65% of all anesthetics given each year in the United States. CRNAs provide anesthesia for every age and type of patient, utilizing the full scope of anesthesia techniques, drugs, and technology which characterize contemporary anesthesia practice. They work in every setting in which anesthesia is delivered: tertiary care centers, community hospitals, labor and delivery rooms, ambulatory surgical centers, diagnostic suites, and physician offices. CRNAs are the sole anesthesia providers in more than 70% of rural hospitals, affording anesthesia and resuscitative services to these medical facilities for surgical, obstetrical, and trauma care.

Early in their history, nurse anesthetists were challenged by lawsuits claiming they were illegally practicing medicine. Landmark decisions in Kentucky (1917) and California (1936) established that they were, in fact, practicing nursing, not medicine. Today, more than 27,000 CRNAs practice in all 50 states, providing anesthesia services to all segments of the population including substantial numbers of Medicare, Medicaid, public employee, veteran, and indigent populations.

CRNAs are well versed in the health care trends sweeping this country including

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a restructured health care system of managed care. CRNAs strongly support comprehensive health care reform, increasing affordability, maximizing patient access, and promoting anesthesia payment reform which controls cost and maintains quality. CRNAs support patient choice. The nurse anesthesia profession advocates continued support for public and institutional policy which enables maximum utilization of CRNAs and their ability to work within their full and legal scope of practice. Their record of patient safety is excellent.

Nurse anesthetists are educated in the specialty of anesthesia at the graduate level that encompasses an integrated program of academic and clinical study. Based on their sophisticated body of knowledge, CRNAs are licensed and certified to practice anesthesia. In addition, they must meet the requirement of recertification every two years. As such qualified providers, CRNAs are eligible to receive reimbursement for their services directly from Medicare, nearly half of all Medicaid programs, Civilian Health and Medical Program of Uniformed Services (CHAMPUS), and a multitude of private insurers and managed care organizations.

The American Association of Nurse Anesthetists (AANA) is the sole professional association of the nation's nurse anesthetists. Founded in 1931, the AANA has issued educational and practice standards and guidelines, developed and implemented a certification and mandatory recertification program, and developed a nationally recognized program for accreditation of nurse anesthesia educational programs. Since 1975, credentialing of nurse anesthesia educational programs and the credentialing of nurse anesthetists has been a function of the AANA autonomous multidisciplinary councils. The AANA is actively involved in the development of federal and state health care policy and offers consultation and other data sources regarding CRNA practice to both public and private entities. Specific information on the practice of nurse anesthetists not found in this series of white papers is available from the American Association of Nurse Anesthetists, 222 South Prospect Avenue, Park Ridge, Illinois, 60068-4001. Phone: (847) 692-7050. Fax: (847) 692-6968.

# History of Nurse Anesthesia Practice

Nurses were the first professional group to provide anesthesia services in the United States. Established in the late 1800s, nurse anesthesia has since become recognized as the first clinical nursing specialty. The discipline of nurse anesthesia developed in response to requests of surgeons seeking a solution to the high morbidity and mortality attributed to anesthesia at that time. Surgeons saw nurses as a cadre of professionals who could give their undivided attention to patient care during surgical procedures. Serving as pioneers in anesthesia, nurse anesthetists became involved in the full range of specialty surgical procedures, as well as in the refinement of anesthesia techniques and equipment.

The earliest existing records documenting the anesthetic care of patients by nurses were those of Sister Mary Bernard, a Catholic nun who assumed her duties at St. Vincent's Hospital in Erie, Pennsylvania in 1887. The most famous nurse anesthetist of the nineteenth century, Alice Magaw, worked at St. Mary's Hospital (1889), in Rochester, Minnesota. That hospital, established by the Sisters of St. Francis and operated by Dr. William Worrell Mayo, later became internationally recognized as the Mayo Clinic. Dr. Charles Mayo conferred upon Alice Magaw the title of "mother of anesthesia," for her many achievements in the field of anesthesiology, particularly her mastery of the open-drop inhalation technique of anesthesia utilizing ether and chloroform and her subsequent publishing of her findings.

Together, Dr. Mayo and Ms. Magaw were instrumental in establishing a showcase of professional excellence in anesthesia and surgery. Hundreds of physicians and nurses from the United States and throughout the world came to observe and learn their anesthesia techniques. Alice Magaw documented the anesthesia practice outcomes at St. Mary's Hospital and reported them in various medical journals between 1899 and 1906. In 1906, one article documented more than 14,000 anesthetics without a single complication attributable to anesthesia. (*Surgery, Gynecology and Obstetrics*, 3:795.)

In 1909, the first formal educational programs preparing nurse anesthetists were established. In 1914, Dr. George Crile and his nurse anesthetist, Agatha Hodgins, who became the founder of the American Association of Nurse Anesthetists (AANA), went to France with the American Ambulance group to assist in planning for the establishment of hospitals that would provide for the care of the sick and wounded members of the Allied Forces. While there, Hodgins taught both physicians and nurses from England and France how to administer anesthesia.

Since World War I, nurse anesthetists have been the principal anesthesia providers in combat areas of every war in which the United States has been engaged. During the Panama action, only nurse anesthetists were sent with the fighting forces. Nurse anesthetists have been held as prisoners of war, suffered combat wounds during wartime service, and have lost their lives serving their country. The names of two CRNAs killed in the Vietnam War are engraved on the Vietnam Memorial Wall in Washington, DC. Military nurse anesthetists have been honored and dec-

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orated by the United States and foreign governments for outstanding achievements, dedication to duty, and competence in treating the seriously wounded.

Although nurse anesthesia educational programs existed prior to World War I, the war sharply increased the demand for nurse anesthetists and, consequently, the need for more educational programs. Nurse anesthetists were often appointed as directors of anesthesia services in both the public and private sectors. In academic health centers, they were frequently responsible for the education of other nurses, medical interns, and physicians. Among the notable early programs of nurse anesthesia were: Johns Hopkins Hospital in Baltimore, the University Hospital of the University of Michigan in Ann Arbor, Charity Hospital in New Orleans, Barnes Hospital in St. Louis, and Presbyterian Hospital in Chicago. In 1922, Alice Hunt, a nurse anesthetist at Peter Bent Brigham Hospital in Boston, was invited by Dr. Samuel Harvey, professor of surgery, to join the Yale Medical School faculty as an instructor of anesthesia with academic rank. She accepted that position, eventually retiring from that institution in 1948.

Founded in 1931, the AANA is the professional association representing more than 27,000 nurse anesthetists nationwide. The AANA promulgates education, and practice standards and guidelines, and affords consultation to both private and governmental entities regarding nurse anesthetists and their practice. The AANA Foundation supports the profession through award of education and research grants to students, faculty, and practicing CRNAs.

The AANA developed and implemented a certification program in 1945 and instituted mandatory recertification in 1978. It established a mechanism for accreditation of nurse anesthesia educational programs in 1952, which has been recognized by the U.S. Department of Education since 1955. In 1975, the AANA was a leader among professional organizations in the United States by forming autonomous multidisciplinary councils with public representation for performing the profession's certification, accreditation, and public interest functions. Today, the CRNA credential is well recognized as an indicator of quality and competence.

The national office of the American Association of Nurse Anesthetists is located in Park Ridge, Illinois. The Association's federal affairs office is maintained in Washington, DC.

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### References:

- Bankert M. *Watchful Care: A History of America's Nurse Anesthetists*. New York: Continuum. 1989.  
Thatcher VS. *History of Anesthesia with Emphasis on the Nurse Specialist*. Philadelphia: JB Lippincott Company. 1953.

# Nurse Anesthesia Education

The educational preparation of Certified Registered Nurse Anesthetists (CRNAs) is conducted in approximately 90 accredited programs throughout the United States and Puerto Rico. These programs are offered at the graduate level in or in association with traditional institutions of higher education, most commonly in schools of nursing or health sciences. The American Association of Nurse Anesthetists (AANA) was at the forefront of the movement to require graduate education at the master's degree level for advanced practice nurses. The Council of Accreditation of Nurse Anesthesia Educational Programs (COA) has mandated that all programs offer a master's degree by 1998. Education programs are accredited by the COA, and it, in turn is recognized by the U.S. Department of Education.

Program curricula are governed by the accreditation standards of the COA. The specialty curriculum requires that students develop expert clinical judgment skills and critical thinking capabilities that prepare the nurse anesthetist to provide the full scope of anesthesia practice as defined by the profession. The educational curriculum in the anesthesia specialty ranges from 24 to 36 months in an integrated program of academic and clinical study. The academic curriculum consists of a minimum of 30 credit hours of formalized graduate study in those courses listed below (it should be noted, however, that most of the graduate programs range from 45 to 65 credit hours). The anesthesia component of the curriculum includes:

- Advanced anatomy, physiology, and pathophysiology
- Biochemistry and physics related to anesthesia
- Advanced pharmacology
- Principles of anesthesia practice
- Research methodology and statistical analysis
- Research or other scholarly endeavor

Clinical residencies afford supervised experiences for students during which time they are able to learn anesthesia techniques, test theory, and apply knowledge to clinical problems. Each graduate is required to complete a minimum of 450 cases. All programs provide around 1,000 hours of hands-on clinical experience for their students. Students gain experience with patients of all ages who require medical, obstetrical, dental, and podiatric interventions. Clinical experience provides the students with the use and application of a broad variety of anesthesia techniques and monitoring modalities.

Admission requirements to a nurse anesthesia educational program include:

- Bachelor of Science in Nursing (BSN) or other appropriate baccalaureate degree
- License as a Registered Nurse (RN)
- Minimum of one year of acute care nursing experience

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Graduates of accredited nurse anesthesia educational programs must meet all requirements prescribed by the Council on Certification of Nurse Anesthetists in order to write the national examination for certification as a nurse anesthetist. Those who successfully pass this rigorous examination are qualified to practice as a CRNA. Recertification, which includes a practice and continuing education requirement, must be met every two years. From the commencement of the professional education in nursing, a minimum of seven years of education and training is involved in the preparation of a CRNA.

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### Reference

*Qualifications and Capabilities of the Certified Registered Nurse Anesthetist*. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1992.

## Anesthesia

CRNAs are key to resolving access problems associated with geographic distribution of anesthesia providers.



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CERTIFIED  
REGISTERED  
NURSE  
ANESTHETISTS

## WHAT ARE CRNAs?

Certified Registered Nurse Anesthetists are advanced-practice nurses certified to administer anesthesia in settings ranging from medical offices to hospital surgical units. They may, depending on where they work, also have authority to independently prescribe medication used within the scope of their practice. The practice of anesthesia is a recognized specialty within both the nursing and medical professions. In Wisconsin, approximately 400 CRNAs provide anesthesia services. Members must be certified by a national standards organization, an affiliate of the national organization, the American Association of Nurse Anesthetists (AANA).

Anesthetists were the first clinical nurse specialists and the first professionals to provide anesthesia services in the United States. Formal training programs started in the late 1800s and demand increased dramatically with the carnage of World War I. While some doctors had also practiced anesthesia, the formalization of physician education in the field didn't become prevalent until after World War II. The perception was that physicians should also specialize in anesthesia, which had been a relatively untapped area for them.



Anesthesiologists (doctors specializing in anesthesia) and CRNAs act in the same capacity in delivering anesthesia services. The difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive medical education, while CRNAs receive nursing education. However, the anesthesia part of the education is very similar for both providers. CRNAs and anesthesiologists are both educated to use the same procedures in the provision of anesthesia and related services.

In 29 of the 65 Wisconsin counties which provide anesthesia services, CRNAs work independently as sole practitioners of anesthesia care. In other instances, they work in conjunction with anesthesiologists as a team, or side by side as anesthesia care providers.

Nurse anesthetists have been the principal anesthesia providers in combat areas in all the armed conflicts the U.S. has engaged in since 1917. In World War II, the ratio was 17 nurse anesthetists to each physician anesthetist. In Vietnam, it was about 3:1, and in the Panama campaign, only CRNAs went abroad.

CRNAs were the first specialty nursing group to receive direct Medicare reimbursement for their services under the federal budget act of 1986. They accept mandatory assignment and do not bill patients for costs over Medicare limits. CRNAs are also recognized as providers and reimbursed through Medicaid in the state of Wisconsin.

**Nurse anesthetists, the first providers of anesthesia, have been administering anesthesia for more than 100 years.**

# WISCONSIN

