SOCIETY FOR AMBULATORY ANESTHESIA
Outpatient • Office Based • Non-Operating Room

ASC Medical Directors & Leaders Virtual Summit
Saturday, January 22, 2022

Review of 2022 Updates Pertinent for Ambulatory Anesthesiologists

BobbieJean Sweitzer, MD, FACP, F-SAMBA, FASA
President, SAMBA
Systems Director, Perioperative Medicine, Inova Health
Professor, University of Virginia

Bobbiejean.sweitzer@inova.org

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Objectives

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Audience members will be more familiar with:

1. Current regulatory changes.
2. Recent literature pertinent to ambulatory anesthesia, especially related to patient access.
3. 2022 implications of Covid-19 for ambulatory anesthesiology.

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ASC Quality Reporting

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- ✓The Ambulatory Surgical Center Quality Reporting (ASCQR) Program is a pay-for-reporting, quality data program administered by the Centers for Medicare & Medicaid Services (CMS)
- ✓ASCs report quality of care data for standardized measures to avoid payment penalty to annual payment updates to payment rates
- ✓ASCs not meeting ASCQR requirements have 2.0 percentage point reduction in annual fee update

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ASC-Quality-Reporting

https://www.federalregister.gov/public-inspection/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

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2022 ASC Quality Measures for 2024 Payment

ASC #	Measure Name	Mandatory/Voluntary
ASC-9	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Mandatory
ASC-11	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Voluntary
ASC-12	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Mandatory
ASC-13	Normothermia Outcome	Mandatory
ASC-14	Unplanned Anterior Vitrectomy	Mandatory
ASC-17	Hospital Visits after Orthopedic ASC Procedures	Mandatory
ASC-18	Hospital Visits after Urology ASC Procedures	Mandatory
ASC-19	Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at ASCs	Mandatory
*New*ASC-20	COVID-19 Vaccination Coverage Among Health Care Personnel	Mandatory

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2023 ASC Quality Measures for 2025 Payment

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✓All of the previous ASC Quality Measures remain
✓Adding these:

ASC #	Measure Name	Mandatory/Voluntary
New ASC-1	Patient Burn	Mandatory
New ASC-2	Patient Fall	Mandatory
New ASC-3	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	Mandatory
New ASC-4	All-Cause Hospital Transfer/Admission	Mandatory

✓For 2023, CMS will require providers to submit measure data via the HQR System (formerly referred to as the QualityNet Secure Portal), rather than via claims
✓**Measures now required for ALL patients, not just Medicare patients**

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2024 Changes

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*NEW*ASC-15a-e	OAS CAHPS Measures	Voluntary

2025 Changes

ASC-11	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	*NEW*Mandatory
ASC-15a-e	OAS CAHPS Measures	*NEW*Mandatory

OAS (Outpatient and Ambulatory Surgery) CAHPS (Consumer Assessment of Healthcare Providers and Systems) measure is burdensome and many ASCs struggle to convince patients to complete any surveys, let alone lengthy 37-52 question surveys

https://www.ahrq.gov/cahps/index.html

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CAHPS Surgical Care Survey Measures

Communication With the Anesthesiologist*

Q20 **Did this anesthesiologist encourage you to ask questions?**
Q22 **Did this anesthesiologist answer your questions in a way that was easy to understand?**
Q24 **Did talking with this anesthesiologist during this visit make you feel more calm and relaxed?**
Q25 **Using any number from 0 to 10, where 0 is the worst anesthesiologist possible and 10 is the best anesthesiologist possible, what number would you use to rate all your care from this anesthesiologist?**

Q3 Before surgery, did anyone in surgeon's office give you all the information you needed about your surgery?
Q10 During office visits before your surgery, did this surgeon spend enough time with you?
Q15 After you arrived at the surgical facility, did this surgeon visit you before your surgery?
Q31 After surgery, did this surgeon listen carefully to you?
Q36 During visits, were clerks and receptionists at the surgeon's office as helpful as you thought they should be?

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Changes to the Inpatient Only List (IPO)

- ✓CMS maintains the IPO list, (a list of services that due to their complexity, CMS only pays for when performed in the inpatient setting
- ✓In 2021 CMS planned to eliminate the IPO list over 3 yrs, removing 298 services from the IPO list in the first phase of elimination
- ✓CMS received a large number of stakeholder comments that the IPO list serves as an important safeguard
- ✓CMS withdrew plans to eliminate the IPO list
  - ✓Adding back to the IPO list the services removed in 2021
  - ✓Did NOT add back to IPO CPT codes 22630 (lumbar spine fusion), 23472 (shoulder reconstruction), 27702 (ankle joint reconstruction) and corresponding anesthesia codes

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ASC Covered Procedures List (CPL)

- ✓In 2021, CMS revised the long-standing safety criteria that were historically used to add procedures to the ASC Covered Procedures List (ASC CPL)
- ✓Adopted a notification process for surgical procedures that can be added to the ASC CPL
- ✓For 2022, CMS is reinstating the criteria for adding procedures to the ASC CPL that were in place in 2020
- ✓CMS is finalizing a nomination process, to begin March 2022, to allow external parties to nominate procedures to be added to ASC CPL
- ✓If CMS determines that a surgical procedure meets requirements to be added to ASC CPL, it will propose adding it to the ASC CPL for 2023

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ASC Covered Procedures List (CPL) Changes

- ✓CMS added 267 surgical procedures to the ASC CPL beginning in 2021
- ✓Removing 255 of 258 procedures proposed for removal
- ✓3 codes proposed for removal but being retained are:
  - ✓CPT 0499T (Procedures Performed on Urethra)
  - ✓54650 (Repair Procedures on the Testis)
  - ✓60512 (Excision Procedures on the Parathyroid, Thymus, Adrenal Glands, Pancreas, and Carotid Body)

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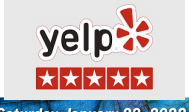
Public Reporting

- ✓Data collected through the ASCQR program is publicly reported so patients with Medicare and other consumers can compare the quality of care provided at an ASC
- ✓ The CMS Provider Data Catalog via data.cms.gov publishes information on the quality of care provided to patients
- ✓Data are generally refreshed bi-annually
- ✓CMS claims that publishing these data can improve facility performance by providing benchmarks for selected clinical areas and public view of facility data
  - ✓This has been challenged!
  - ✓Can the public truly rate medical decisions and quality?



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ASC Requirement for Preop H&P

- ✓CMS no longer requires preop H&P within 30 days (or any time) before ambulatory procedures
- ✓CMS policy defers to ASC policies and operating physician's clinical judgement
- ✓Care should be "tailored to the patient and the type of planned surgery"
- ✓Still require "operating physician to document pre-existing medical conditions and appropriate test results" in the medical record
- ✓Presurgical assessments must include documentation of allergies
- ✓Still require that IF the H&P is done it must be in pt's record before the procedure
- ✓Anesthesia providers still required to do their "preoperative assessment"

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"Surprise medical bills"

- ✓Difference between out-of-network fees and the amount covered by insurance after co-pays and deductible
- ✓Patients often assume that all providers—such as their anesthesiologist—are in-network because their surgeon is
- ✓Data indicates that >90% anesthesia claims are in patients' health plans or "in-network," (limits "surprise medical bills")
- ✓Federal No Surprises Act became law in Sept, 2021 in all 50 states
- ✓Ensures patients only responsible for in-network costs

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It's a surprise bill if:

- ✓Patients do not sign a written consent alerting them that services are out-of-network and not covered by insurance
- ✓During a visit with a participating doctor, an out-of-network provider provides treatment
- ✓An in-network doctor sends a specimen, such as blood to an out-of-network laboratory
- ✓For any other health care services when referrals are required under the plan
- ✓AMA and AHA first filed lawsuit (ASA joined recently)

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H.R.133: Consolidated Appropriations Act "No Surprises Act"

- ✓Created an independent dispute resolution (IDR) process
- ✓MDs & plans can negotiate a dispute resolution within 30 d
- ✓If no resolution they can use arbitration
- ✓Each party submits an offer and arbitrator chooses one
- ✓Same or similar disputed claims can be batched together
- ✓Arbitrator cannot consider CMS payor rates or billed charges
- ✓Arbitrator's decision final
- ✓Loser responsible for fees
- ✓For 90 days MDs & insurers cannot arbitrate for same service/s
- ✓MDs can batch cases & resubmit for arbitration after 90 days

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Preoperative Care for Cataract Surgery: The Society for Ambulatory Anesthesia Position Statement

BobbieJean Sweitzer, MD, FACP, SAMBA-F, FASA,* Niraja Rajan, MD,† Dawn Schell, MD,‡ Steven Gayer, MD, MBA,§ Stan Eckert, MD,‖ and Girish P. Joshi, MBBS, MD, FFARCSI¶

Cataract surgeries are among the most common procedures requiring anesthesia care. Cataracts are a common cause of blindness. Surgery remains the only effective treatment of cataracts. Patients are often elderly with comorbidities. Most cataracts can be treated using topical or regional anesthesia with minimum or no sedation. There is minimal risk of adverse outcomes. There is general consensus that cataract surgery is extremely low risk, and the benefits of sight restoration and preservation are enormous. We present the Society for Ambulatory Anesthesia (SAMBA) position statement for preoperative care for cataract surgery. (Anesth Analg 2021;133:1431–6)

UpToDate revised their guidelines for patients having cataract surgery based on this SAMBA guideline

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The importance of making it easy for patients to have cataract surgery

- ✓>20 million cataract extractions done worldwide annually
- ✓Cataracts are a common cause of blindness
- ✓Visual impairment is associated with increased mortality
- ✓Not being able to see impacts quality of life
- ✓Visual loss associated with cognitive impairment
- ✓Cataracts increase falls, hip fractures, car accidents, health care utilization, social isolation, dependency, nursing home placements and mortality

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Improve patient satisfaction by improving sight!!

- ✓Patients are often elderly with comorbidities
- ✓Most cataracts done with topical or regional anesthesia
- ✓Require minimum or no sedation
- ✓ACC/AHA define cataract as only "truly low risk surgery" requiring NO cardiac risk assessment
- ✓Cataract surgery patients have a 0.014% chance of dying
- ✓It is unlikely that risk can be lowered
- ✓General consensus: cataract surgery is extremely low risk
- ✓Benefits of sight restoration and preservation are enormous

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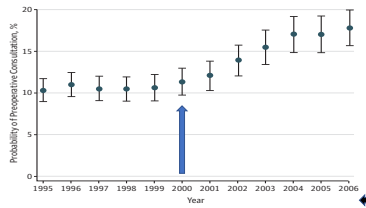
Barriers and wasted resources for patients having cataract surgery

Figure 1. Adjusted Probability of Preoperative Consultation by Calendar Year



2000, Schein: Testing before cataract surgery does not increase safety of surgery

2015: Testing before cataract surgery was frequent and more strongly associated with provider practice patterns than patient characteristics

N Engl J Med 2000;342:168-
N Engl J Med 2015;372:1530-
JAMA Intern Med 2014;174:380-

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Statement on Intravenous Catheter Placement, Venipuncture and Blood Pressure Measurements in the Ipsilateral Upper Extremity after Breast Cancer Surgery with and without Axillary Lymph Node Dissection

SAMBAHQ.org

September 27, 2021

SAMBA supports the placement of intravenous catheters, venipunctures, and blood pressure measurements in an upper extremity ipsilateral to breast cancer surgery with and without axillary lymph node dissection.

References:

Curr Oncol. 2018;25:e305–e310.; J Clin Oncol. 2016;34:691–698.; Lancet Oncol. 2016;17:e392– e405.; Plast Reconstr Surg. 2005;116:2058–2059.; Surg Gynecol Obstet. 1955;100:743–752.; Oncology (Williston Park). 2012;26:242–249.; Breast. 2016;28:29-36.; Anesth Analg 2021;133:707-712.; J Okla State Med Assoc. 2016;109:589-591.; Can Oncol Nurs J. 2019 Jul 1;29(3):194-203.; Br J Nurs. 2020;29:S32-S38.; Ann Surg Oncol. 2017;24:2827–2835.

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Summary

SAMBA Statements

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Bibliographies

GENERAL ARTICLES OF INTEREST | ENT ANESTHESIA | GYNECOLOGICAL ANESTHESIA | PEDIATRIC ANESTHESIA | PATIENT SELECTION | OPHTHALMOLOGIC SURGERY | NON-OPERATING ROOM ANESTHESIA

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