

ASA Director's Summer 2010 Report

**"I'm from the Government and
I'm here to help."**

*"The nine most terrifying words
in the English language ..."*
— Ronald Reagan

*By Mark Singleton, M.D., ASA Director
for California*



The Patient Protection and Affordable Care Act (PPACA) and its companion Health Care and Education Reconciliation Act of 2010 were passed by Congress after unprecedented national public debate, and signed into law by President Obama on March 23 and March 30, respectively. The fallout from this meteoric legislation, an undeniable historic achievement for this President and the Democrat majority Congress, will continue for the next decade and beyond as various provisions of the Act come into effect or are modified by further legislation. How the healthcare landscape in America looks after the dust settles over the next few years is the subject of many predictions, but it is certain to dramatically alter all of our practices of anesthesiology. For now there seems to be almost a numbness in Washington on the subject of healthcare reform, as if our elected leaders are simply exhausted by what went into the enactment of this monumental set of laws. The failure to dismantle and replace Medicare's Sustainable Growth Rate Formula, which has become a ludicrous and unworkable basis for physician payments, is a prime example of this impotence. Over the coming years, unfamiliar concepts and terms like "value based purchasing," "accountable care organizations" (ACOs), and the Independent Payment Advisory Board (IPAB) will come to be intimately known by all of us. ASA has a superb team of professionals dedicated to the analysis of the regulatory impact of all of this, and this team consists of Jason Byrd, Chip Amoe, Sharon Merrick and Loveleen Singh. I highly recommend Mr. Byrd's article in the June 2010 *ASA Newsletter*: "The Regulatory Tsunami Awaits." In addition, CSA's own Stan Stead, Chair of the ASA Committee on Economics, presented a powerful analysis of the potential impact of the PPACA to our specialty, at both the ASA Legislative Conference in Washington in April, and again last month at the CSA Annual Meeting in Costa Mesa.

A more immediate regulatory event with which the ASA has been dealing for the past six months is the release in December 2009 of the revised Interpretive Guidelines (IGs) pertaining to the CMS Conditions of Participation (CoPs)

ASA Director's Report (cont'd)

for hospital anesthesia services. These revised IGs establish some important regulations and concepts which will likely be incorporated into future Joint Commission surveys. Some highlights are:

All services along the continuum of anesthesia services ... must be organized under a single Anesthesia Service, which must be directed by a qualified physician and consistently implemented in every hospital department and setting that provides any type of anesthesia services.

A distinction is made between "Anesthesia" and "Analgesia" with special implications for obstetrical anesthesia. Anesthesia

... involves the administration of a medication to produce a blunting or loss of: pain perception; voluntary and involuntary movement; autonomic function; and memory and/or consciousness, depending on where along the central neuraxial (brain and spinal cord) the medication is delivered. In contrast, analgesia involves the use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system. The patient does not lose consciousness, but does not perceive pain to the extent that may otherwise prevail. During labor and delivery, the provision of acute analgesia (i.e., relief of pain, via an epidural or spinal route) is not considered "anesthesia," and a CRNA administering these forms of anesthesia services does not require supervision by the operating practitioner or anesthesiologist.

Pre-anesthesia evaluation:

- Must occur within 48 hours of procedure
- Expanded elements of evaluation, including potential anesthesia problems (difficult airway, ongoing infection, limited IV access), additional evaluation, and anesthesia care plan (e.g., type of medications).
- Timing issues and re-evaluation immediately prior to anesthesia

The intraoperative anesthesia record must include:

- Name, dosage, route, and time of administration of drugs and anesthesia agents
- Techniques used and patients position(s), including the insertion/use of any intravascular or airway devices

ASA Director's Report (cont'd)

- Any complications, adverse reactions, or problems occurring during anesthesia (symptoms, vital signs, treatments, and response)

Postanesthesia Evaluation:

- Within 48 hours (of arrival in recovery area) “generally would not be performed immediately” on arrival in PACU
- Required elements: respiratory function, cardiovascular function, mental status, temperature, pain, nausea and vomiting, and postoperative hydration
- Patient participation

ASA President Alex Hannenberg, and other ASA leaders have been, and continue to be, engaged in discussions with CMS over obvious problems with these revised IGs. The clear lack of understanding of the physiology of sympathetic blockade inherent in epidural “analgesia” would seem to be an easy one, but CMS appears to be least willing to reconsider this ruling. They suggest instead that it be dealt with through a “local solution” within individual institutions. It looks like politics all over again.

Templates are now available to help anesthesiologists meet these new CMS Interpretive Guidelines for hospital Conditions of Participation in the members section of the ASA Website. For the clarification of the Interpretive Guidelines for the Anesthesia Services, go to <http://www.asahq.org/Washington/UpdatedCMSIGs5-21-10.pdf>.

Save the Date!

**2011 Winter CSA Hawaiian Seminar
January 24-28, 2011**

**Hyatt Regency Maui Resort & Spa
Ka'anapali Beach, Maui**

<http://www.csahq.org/up-more.php?id=39>