CALIFORNIA ORTHOPAEDIC ASSOCIATION

Concurrent/Overlapping Surgeries

Background

New Guidelines

Managing Risks

PAPER OBJECTIVE

To educate and update orthopaedic surgeons on new developments and policies involving Concurrent or Overlapping Surgeries.

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Background

The practice of surgeons being involved in concurrent/overlapping surgeries is a well-known practice for busy surgeons, particularly in trauma community, and academic centers. Concurrent surgeries are probably most common in academic centers where there are residents and fellows assisting in surgeries.

The practice was not so well-known to surgical patients until recently when the Boston Globe published an article describing the experience of one patient undergoing spine surgery where his surgeon was involved in doing concurrent surgeries at Massachusetts General Hospital in Boston. The patient had a bad outcome emerging paralyzed after the surgery which has resulted in a medical malpractice lawsuit against the surgeon. The patient claimed was that he was unaware that his surgeon would be involved in another surgery and that his bad outcome was a result of his surgeon not being focused solely on his surgery.

This prompted the Chair of the U.S. Senate Finance Committee, Senator Orrin Hatch, to request information from 20 teaching hospitals as to the total number of concurrent surgeries at each hospital from 2011 to 2015 broken down by medical specialty. Senator Hatch also requested from the hospitals their policies about whether the patient is informed prior to the surgery if their surgeon will be involved in concurrent surgery.

Staff of the Finance Committee also met with representatives of the American College of Surgeons and the American Hospital Association to discuss their policy on this issue. The U.S. Attorney also launched a federal investigation into the practice.

These discussions uncovered controversy among surgeons as to whether concurrent surgery is appropriate. The following potential problems were cited:

- Surgeons performing concurrent surgeries were not able to respond quickly when an urgent need arose.
- Patients waited under anesthesia for extended periods of time waiting for the surgeon.
- Patients suffered complications.

Massachusetts General Hospital disputed each of these points and reported that their internal studies found no significant differences in complication rates between overlapping and non-overlapping surgeries.

Medicare allows surgeons to perform concurrent operations, but requires them to be present for the "critical or key portions" of each surgery. Medicare leaves it up to the surgeon to decide what is the"critical" portion of the surgery.

During these discussions, it is important to remember the differences between the definition of a concurrent and overlapping surgery.

Concurrent surgeries are defined as:

"Concurrent surgeries" are those surgeries in which "the critical or key components of the procedures for which the primary attending **surgeon** is responsible are occurring all or in part at the same time."

Overlapping surgeries are defined as:

"Overlapping surgeries" involves the coordination of various **procedures** for a single **surgeon** or teams of **surgeons** throughout the day, so that preparation and procedure for one patient begins in one room as the care of another patient finishes in another room.

New Guidelines

This recent discussion has led to the following new policy statements/guidelines for concurrent/overlapping surgeries:

- **Massachusetts General Hospital** posted a summary entitled, "What is Concurrent /Overlapping Surgery?"
  They cited the following reasons why overlapping surgery is used:
  - Trauma – overlapping is essential in emergency situations
  - Optimal Use of the OR rooms and operating team
  - Access – greater access to certain surgical specialists
  - Timeliness and availability of vital services
  - Education – allows for broader educational activities for fellows and residents.

- **American College of Surgeons** (ACS) updated their *Statements on Principles in April, 2016* with a section that makes clear that surgeons should not conduct two procedures simultaneously. "A primary attending surgeon's involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is not appropriate."

  The guidance comes in a section on the "intraoperative Responsibility of the Primary Surgeon," which includes new language on concurrent, overlapping, and multidisciplinary operations. The ACS is unequivocal about a surgeon operating on two patients in two rooms and moving from one to the other as necessary. That situation should never happen. There are some situations, however, in which the ACS says it is acceptable for the surgeon to have two patients undergoing surgery at the same time.

  "In general, the patient's primary attending surgeon should be in the operating suite or be immediately available for the entire surgical procedure. There are instances consistent with good patient care that are valid exceptions. However, when the primary attending is not present or immediately available, another attending surgeon should be assigned as being immediately available."

  Some leeway is given for overlapping operations, such as when the key or critical elements of the first operation have been completed and there is no reasonable expectation that there will be a need for

the primary attending surgeon to return to that operation. In that situation, the ACS says that it is acceptable for the surgeon to hand off that patient to a qualified practitioner who performs non-critical components of the first operation, such as wound closure, while the surgeon goes to another room and begins surgery on a second patient.

The surgeon also can have a second patient's surgery begun by another practitioner and step in to perform the critical elements and completing the first patient. In that situation, however, the ACS says that the surgeon must assign immediate availability in the first operating room to another attending surgeon because the surgeon may not be able to leave the second patient if trouble arises with the first patient,

The ACS guidelines indicate that the patient should be informed of the surgeon's involvement in more than one procedure at a time.

The ACS guidelines are available: https://www.facs.org/about-acs/statements/stonprin#anchor172771

- **Senate Finance Committee Report** released in December, 2016 provided an overview of the issue, included a definition of the "critical portions of an overlapping surgery," their findings after surveying the 20 teaching hospitals and listed their concerns.

  The Critical Portions of an Overlapping Surgery is defined In the Senate Finance Committee Report as follows:

  > **"**Although defined slightly differently, both CMS and ACS guidance permit each surgeon to determine which portions are critical. This position is intended to recognize both the expertise of the individual surgeon in making such a determination and that the critical portions can vary based upon the expertise of the residents, fellows, or technicians assisting in the operation or by the condition of the patient. CMS and ACS guidance do state that the opening and closing of the surgical site is generally not critical and ACS guidance goes farther by noting that the critical portions are those in which the essential technical expertise and surgical judgment of the surgeon is required to achieve *an optimal patient outcome*."

  The report notes that some patient advocates have identified other criteria that should be used to define the critical components. For example, some organizations have stated that any work on the target organ should be designated as critical. Others believe that any work undertaken beneath the subcutaneous tissues—that is, the innermost layer of the skin—should be designated as critical. Other more extreme positions include that the entire surgery should be considered critical. Specifically, some contend that CMS should only reimburse for surgeries in which the surgeon is present in the operating room from the time the surgery is initiated until the final closure is completed.

Committee staff recognizes that these additional approaches are not exhaustive and that other practices should be considered and examined. However, Committee staff finds merit in the approach whereby, to the extent practicable, surgical departments with a hospital's medical staff develop guidelines that identify the critical components of particular procedures, while accounting for the individualized clinical judgment the surgeon must bring to each case. This approach seems to strike an appropriate balance by recognizing potential differences between and within hospitals and surgical departments but also by establishing and communicating common practices or norms for all surgeons within a hospital. As hospitals continue to refine their concurrent and overlapping surgical policies, they should determine whether to undertake similar efforts to define the critical portions of surgeries as an institution.

Committee Concerns:

Concerns over concurrent and overlapping surgeries have only recently come to the attention of hospitals and much of the public. The first large-scale discussion of the issue began in late 2015 and ACS issued its guidance in April 2016. The Committee staff commends the steps that some hospitals and surgeons have taken in a relatively short timeframe to address many of the concerns surrounding concurrent and overlapping surgeries. All 20 of the teaching hospitals contacted by the Committee modified their existing policies or created new hospital-wide policies specific to concurrent and overlapping surgeries, or were in the process of doing so. Furthermore, all 17 of the hospitals that recently revised their policies now have specific policies that generally prohibit concurrent surgeries and enumerate the circumstances under which their surgeons may perform overlapping surgeries. However, the Committee staff analyzed only a small portion of the policies from the nation's approximately 4,900 hospitals, of which approximately 1,000 are teaching hospitals, and those policies reviewed ranged in their thoroughness. Furthermore, Committee staff notes that concerns surrounding concurrent and overlapping surgeries are not limited to teaching hospitals, and apply to other settings that perform operations such as non-teaching hospitals and ambulatory surgery centers, though the number of overlapping surgeries performed in those setting may be much lower than those performed in teaching hospitals. Thus, the Committee staff continues to have concerns in the following areas:

1. **Patient safety**.

With respect to patient safety, while evidence on the practice—safe or otherwise—of concurrent or overlapping surgeries is lacking, the absence of data does not mean that there is no risk and the need to ensure patient safety and informed consent, as acknowledged by the ACS, is too important to ignore. With the revised ACS guidance, hospitals and the various oversight bodies have an opportunity to strengthen their policies surrounding the practice of concurrent and overlapping surgeries. ACS guidance provides a good starting point and the Committee staff would encourage hospitals and other health care institutions that perform surgeries and accept Medicare and Medicaid payments to take the following steps:

a. Develop a concurrent and overlapping surgical policy that

clearly prohibits the former and regulates the practice of the latter consistent with the ACS guidance.

b. Formally identify the critical portions of particular procedures, to the extent practicable, as well as those portions unsuitable for overlap.

c. Develop processes to ensure that patient consent discussions result in a complete understanding by the patient that her/his surgery will overlap with another patient's; develop materials such as frequently asked questions; and educate their patients ahead of their surgeries, giving them enough time to review materials and fully consider their options.

d. Prospectively identify the backup surgeon when overlapping surgeries are scheduled.

e. Develop mechanisms to enforce the established concurrent and overlapping surgical policies and monitor and enforce their outcomes. In addition, CMS should modify its regulations or survey processes and direct the accrediting organizations to modify their hospital standards or survey processes to ensure that hospitals' eligible for payment from Medicare or Medicaid have policies that are consistent with ACS's revised guidance on concurrent and overlapping surgeries.

2. Improper payments.

The Committee staff has two concerns with respect to the billing of concurrent and overlapping surgeries. First, CMS has not taken any steps to determine whether the existing billing requirements applicable to teaching physicians in hospitals are or are not being followed despite a history of problems in this area. Second, CMS's billing requirements are applicable only to teaching physicians operating in hospitals. There are no billing requirements in place that would prevent a surgeon from billing for two or more concurrent surgeries in hospitals outside of a teaching scenario, such as when a physician is assisted by a technician, or in nonhospital settings, such as in ambulatory surgery centers. As a result, the Committee staff recommends that:

a. The HHS OIG should undertake an evaluation to review the controls in place to ensure that hospitals and physicians are appropriately billing for physician services provided by teaching physicians.

b. The Administrator of CMS should review the agency's billing requirements for services performed by teaching physicians to determine if those requirements should be established for other surgical facilities and scenarios

Click hear to read the entire Finance Committee report.
http://www.coa.org/docs/WhitePapers/sfinancereport.pdf

Managing the Risks

Simply disallowing overlapping surgery scheduling is neither practical nor desirable. Many of the risks are not unique to concurrent surgeries, but rather arise from the more general –and necessary- practice of allowing residents, physician assistants, or other qualified surgical providers, to perform portions of the operation. Training younger physicians in performing procedures is necessary in almost every medical specialty. But concurrent surgeries may be especially concerning to patients because of the suspicion that safety has

been compromised not for the noble purpose of advancing medical training but to accommodate the schedule of a busy surgeon or to maximum revenue. Addressing that discomfort and minimizing risks requires careful management of surgical scheduling at a level that may be absent at many U.S. institutions today.

Surgical scheduling is largely at the discretion of surgical facilities, which may or may not have a formal policy establishing what is permissible. However, regulations issues by the Centers for Medicare and Medicaid (CMS) provide that, in order to bill Medicare for overlapping surgeries, attending surgeons in teaching settings "must be present for the critical or key portions of both operations." When a teaching physician is absent for the noncritical parts of the operation, he or she much arrange for another qualified surgeon to be immediately available to intervene. Billing in violation of these rules constitutes fraud and may result in substantial fines and penalties. State licensure boards may also investigate surgeons who perform concurrent operations in a manner that could threaten patient safety.

Because the CMS rules do not define what constitutes a critical part of the operation, they allow considerable room for discretion. However, it may be difficult to formulate a satisfactory blanket definition of critical. Patient-specific factors may make parts of an operation that usually involve little risk quite complex.

Action Recommended:

1. Work with your hospital to establish appropriate policies on overlapping surgeries.
2. Surgeons involved in overlapping surgeries should clearly document in the hospital and patient medical record that they were present during the "critical portion of the operation."
3. Clearly document in the hospital and patient medical record who was the attending surgeon in the surgery. If the attending surgeon leaves the room and the physician assistant finishes the case, but the surgeon is still immediately available, he/she remains the attending surgeon throughout the event. If the attending surgeon leaves the room and is not available to come back to the operating room, then you should document the attending surgeon who was available to provide any necessary care when the primary attending surgeon was not present in the room.
4. The documentation should be in the form of an attestation. Below is some attestation language for you to consider using in your documentation:

ATTESTATION:

My date of service is xxxxxx**.** I was present for and performed critical parts of the surgery. Myself, or an attending surgeon that I designated, was immediately available throughout all portions of the surgery. I am personally involved in the management of the patient. I agree with the findings and care plans as documented.