Ambulatory surgery centers (ASC) are gearing up to comply with the newly revised Medicare Conditions for Coverage (CfCs). The revised conditions, issued Oct 30, 2008, are effective May 18, 2009.

ASCs accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC) are also preparing to meet its 2009 standards, which have some significant changes. The compliance date is March 1. The Joint Commission’s 2009 ambulatory care standards were effective Jan 1.

AAAHC has been working with the Centers for Medicare and Medicaid Services (CMS) on the standards for its deemed status surveys (sidebar).

AAAHC, the Joint Commission, and the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) have “deemed status” from CMS for accrediting ambulatory care organizations, meaning the government considers ASCs who meet their standards also to meet Medicare requirements. ASCs can also be licensed by state agencies.

Meeting new CfCs

Some new CfCs raise practical challenges, and ASC managers are asking how to comply. Among these are the new patient rights and history and physical requirements.

The ASC Association addressed these issues in a comment letter to CMS in December. Though the CfCs are final, changes could be addressed in further rulemaking or in interpretive guidelines CMS issues for state surveyors.

Patient rights

Managers see logistical difficulties in meeting some of the new patient rights requirements.

The CfCs require ASCs to provide patients or their representatives with “verbal and written notice of the patient’s rights in advance of the date of the procedure, in a language and manner that the patient or the patient’s representative understands.” ASCs must also provide written notice in advance of physician ownership and of the policy on advance directives.

The ASC Association raised 3 objections to these conditions:

• It’s not clear why both written and verbal notices of patient rights are required.

• It’s not always practical to provide this information in advance of the date of the procedure, especially when surgery is scheduled on short notice or on an urgent basis. Examples are patients who need fractures set as soon as possible or who need retinal surgery. An ASC could be at least in technical violation of the advanced notice requirement if it allows the procedure to be performed on the same day, even though that is in the patient’s best interest, the association points out.

• Written notice of patient rights is not practical in every case for ASCs that treat diverse populations who speak multiple languages.

The association notes that Medicare’s hospital Conditions of Participation, in contrast, require hospitals only to “inform” patients of their rights and to disclose physician ownership at the beginning of the patient’s stay or visit.

“We continue to believe similar flexibility should be applied in the ASC conditions,” the ASC Association’s president, Kathy Bryant, wrote in the CMS letter.
A practical solution

In some ways, the new CfCs are requiring ASCs to return to the way they practiced in the past, notes Barbara Ann Harmer, RN, BSN, MHA, of Healthcare Consultants International, Inc, who consults on ASC accreditation.

As a way to meet the notice requirement, she suggests providing a patient packet that includes the required notices.

“This would be given out by the physician’s office that is scheduling the procedure on behalf of the facility,” she notes. Then the verbal notice can be given during a preprocedure phone call to the patient.

The packet should include a form for the patient to sign and date stating that the notices have been given verbally and in writing.

“If the patient forgets to bring the form, they would need to complete it upon admission to the facility,” she says.

Harmer does not favor mailing the information to the patient, though that is an option.

Patient assessments

In another new requirement, the CfCs say patients must have a comprehensive history and physical “not more than 30 days before the scheduled surgery.”

The ASC Association says that, while an “appropriate and current” presurgical assessment is “unquestionably essential,” it believes the assessment does not always need to be performed within the 30-day window. An example is the patient who has a bilateral procedure, such as cataract surgery or carpal tunnel repair, which may be weeks apart. The patient might need a comprehensive exam before the first procedure, but a more limited exam might be sufficient before the second procedure. But the way the CfCs are currently worded would require a comprehensive exam for both.

As an alternative, the association suggests that CMS adopt AAAHC’s more practical standard for presurgical assessment, which says: “An appropriate and current history, including a list of current medications and dosages if known, physical examination, and preoperative diagnostic studies, are incorporated into the patient’s medical record prior to surgery.”

Alternatively, the association suggests CMS could update its interpretive guidelines to say exceptions to the comprehensive exam may be appropriate in situations such as bilateral, repetitive, or rescheduled procedures.

Infection control, disaster planning

Two other CfCs that have raised questions are disaster planning and infection control.

The disaster plan must be in writing and coordinated with state and local authorities, as appropriate.

The ASC Association points out that in many cases, ASCs that submit their plans to local authorities will not receive a response from the authorities about coordination. The association requests that CMS make it clear that ASCs can meet the requirement by submitting a plan to the authorities.

The CfCs also require ASCs to have an ongoing infection control program for preventing, controlling, and investigating infections. ASCs must also document that they have implemented nationally recognized infection control guidelines. The ASC Association asks CMS to clarify that ASCs under common ownership and control may use a single infection control professional, as CMS states in the preamble to the final rule.

The ASC Association’s comment letter is at www.ascassociation.org.

AAAHC prepares for CfCs

In preparation for the new Medicare CfCs, AAAHC is working with CMS to finalize AAAHC/CMS information for organizations and surveyors. Pending final approval from CMS, AAAHC says it will notify ASCs and surveyors about the new information.

Michon Villanueva, AAAHC’s assistant director of accreditation services, says AAAHC welcomes the changes to the CfCs, most of which have not been updated since 1982. She notes that the revised CfCs are more reflective of current practice in areas such as the definition of an ASC, infection control, and patient rights. ASCs with questions about the new requirements may call AAAHC at 847/853-6060.

The 2009 AAAHC standards handbook is scheduled to be available in late February. The 2009 standards are effective March 1. The standards revisions from 2008 are posted at www.aaahc.org. The handbook does not include information about the new CfCs, but Villanueva says AAAHC will post information about the new requirements on its website before the CfCs’ May 18, 2009, effective date.