CMS anesthesia rules are stiffened

A guest column on regulatory standards.

In mid-December, the Centers for Medicare and Medicaid Services (CMS) issued an 18-page Survey and Certification memorandum that clarifies and adds new requirements and interpretive guidelines for anesthesia services in Medicare-certified hospitals.

Given the Joint Commission’s requirement to mirror CMS regulation, we should anticipate that Joint Commission surveyors will pick up on these expectations in hospital surveys. (Note: The new rules do not apply to Medicare-certified critical access hospitals or ambulatory surgery centers.)

The document attempts once again to define the various forms of anesthesia on the continuum from general anesthesia to basic analgesia. Some of the changed or new requirements apply to all forms of anesthesia, and some apply just to the higher forms of anesthesia (ie, general anesthesia, regional anesthesia, and monitored anesthesia care, or MAC). For that reason, drawing the correct conclusions about what is required is a challenge. Also, some requirements, especially related to pre-moderate sedation assessment back away from what we expect Joint Commission surveyors to look for.

Anesthesia department

The new rules make explicit a requirement for there to be a single anesthesia service or department responsible for developing policies and procedures for all anesthesia services including sedation and analgesia. This department shall also determine the minimum qualifications for each practitioner permitted to provide anesthesia services of all forms in all locations within the hospital. Further, the medical staff bylaws or rules and regulations must include criteria for granting anesthesia clinical privileges.

Evaluation 48 hours prior to surgery

Additionally, the preanesthesia evaluation must now be performed within (or inside) 48 hours prior to surgery; the first dose of anesthesia marks the end of the 48-hour period. The minimum elements of the preanesthesia or presedation evaluation have grown to make explicit what has long been implied:

- a review of the medical history including anesthesia, drug, and allergy history
- an interview and examination of the patient
- a notation of anesthesia risk (eg, ASA score)
- identification of potential anesthesia problems that may cause complications or contraindications to the planned procedure (eg, difficult airway, ongoing infection, limited intravascular access)
- development of a plan for anesthesia including the type of medications
for induction, a plan for maintenance and postoperative care, and discussion of risks and benefits of anesthesia.

Of note, while the interpretive guidelines do require some form of premoderate sedation evaluation, they are clear that the content of the evaluation may differ from a preanesthesia assessment because moderate sedation is not anesthesia.

Thus, the decade-and-a-half-old expectation that the presedation assessment include an evaluation of the airway seems no longer to be required. Furthermore, there is no mention of the expectation to reassess the patient prior to induction of anesthesia or administration of sedation.

It will be interesting to see if these changes stick and whether the Joint Commission will follow suit in allowing us to simplify the presedation assessment and eliminate the reassessment prior to anesthesia or sedation.

Tighter requirement for postanesthesia evaluation

Finally, CMS has pinpointed the earliest point in the patient’s recovery that the postanesthesia evaluation within/inside 48 hours may occur. In 2007, CMS made the subtle change in this regulation to remove the word “inpatient” from the requirement for a postanesthesia recovery evaluation—having the effect of requiring a postanesthesia evaluation for all patients—inpatient and outpatient.

The performance of a postanesthesia evaluation/note has never been particularly problematic for inpatients. Extending this practice to outpatients did not seem to be a problem initially because anesthesia personnel simply conducted the evaluation as they moved the patient from the procedure suite to the recovery room and handed the patient off to the postanesthesia care staff.

Early in 2008, however, CMS began to instruct surveyors to cite hospitals if the evaluation was documented prior to the patient actually recovering from anesthesia. In essence, CMS was citing anesthesia personnel for making a premature postanesthesia evaluation, and in some cases, bordered on citing the more serious charge of fabrication of clinical documentation. In their view, performing the postanesthesia evaluation at the time of arrival to the recovery area was, by definition, premature.

A logistical challenge

In the December 2009 S&C memo, CMS clarified its position by stipulating the following:

- The postanesthesia evaluation must be completed and documented within/inside 48 hours of any surgery involving general, regional, or monitored anesthesia (Note: Once again, this rule does not apply to moderate sedation, only to general, regional, and MAC anesthesia) in both inpatient and outpatient settings.

- The evaluation must be completed by someone qualified to administer anesthesia (ie, not an RN).

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Postanesthesia evaluation

Patient is stable postoperatively and has adequately recovered from anesthesia as described below unless otherwise noted. Patient is determined to have stable airway patency and respiratory function including respiratory rate and oxygen saturation. Patient has a stable heart rate, blood pressure, and adequate hydration. Patient’s mental status is acceptable. Patient’s temperature is appropriate. Pain and nausea are adequately controlled. Refer to nursing notes for vital signs.

Notes: __________________________________________

Signature: ____________________________________

— OR Manager Inc. —
• The 48-hour period begins when the patient is moved into the designated recovery area.
• The evaluation cannot begin immediately upon arrival to the recovery area and cannot occur until after the patient has sufficiently recovered from the effects of anesthesia so as to participate in the evaluation (e.g., answer questions and perform tasks such as moving extremities).
• For outpatients, the evaluation must be completed prior to discharge.

These last 2 points will likely pose a logistical challenge to an anesthesia service because it would seem the only way to accomplish the evaluation within the time frame that begins with having a “sufficiently recovered patient” and ending “prior to discharge” is to have someone from anesthesia assigned to float all day long within the recovery area.

**Documenting the evaluation**

Elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

• respiratory function, including respiratory rate, airway patency, and oxygen saturation
• cardiovascular function, including pulse rate and blood pressure
• mental status
• temperature
• pain
• nausea and vomiting
• postoperative hydration.

One of our clients has devised a simple statement to include on forms or computer screens used to document the postanesthesia evaluation (sidebar).

It would be important that vital signs (via timed nursing notes) be in the record prior to the anesthesia personnel signing and timing this statement so it would be clear to anyone that the anesthesia personnel’s note/conclusion is based on objective vital sign data in the nursing notes.

**A pointed critique**

This may not be the last word. The American Society of Anesthesiologists (ASA) has posted a pointed critique of these new rules (www.asahq.org/news/asanews011810.htm) that raises numerous concerns with the new regulations. In addition, ASA makes the case that the changes were made outside the normal federal rule-making process and thus failed to allow adequate input from the field. All I can say is—stay tuned!

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Access the CMS memorandum at www.asahq.org/Washington/
12-11-09%20RevisedANHospitalInterpretiveGuidelines.pdf

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