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Compliance Today - August 2018
Overlapping surgeries: Compounding regulatory requirements and risks

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Overlapping surgeries — when one surgeon is responsible for two procedures that overlap in time — is a practice that has recently gained increased national attention from the media, patients, and government, among others. Many institutions throughout the country elect to permit the practice of overlapping surgeries to varying degrees, with significant differences in policies and processes. Although some view overlapping surgeries as an important vehicle for operating room efficiency, facilitating the ability of specialized surgeons to see more patients and promoting the progressive autonomy of residents in teaching institutions, those critical of the practice often argue that overlapping surgeries pose risks to patients and that informed consent processes do not adequately apprise patients of such practices.

The practice of overlapping surgeries presents a risk continuum with unique risks for different types of institutions. For example, overlapping surgeries present heightened risks for teaching hospitals, because those surgeries are governed by specific Medicare payment requirements. Although non-teaching institutions may currently face less risk from a payment perspective, those organizations must still consider other risks such as those related to informed consent, industry best practices, and reputational harm. Further, institutions that perform a high number of overlapping surgeries may find themselves higher on the risk continuum than organizations where overlapping surgeries are rare.

This article is a follow-up to an article on overlapping surgeries that was published in Compliance Today in May 2016. This article aims to provide an overview of applicable authority for both teaching and non-teaching institutions, as well as explore compliance risks and recent enforcement developments. It will also discuss practical considerations and key questions to consider relevant to both the teaching and non-teaching contexts as you examine these complex issues in light of increased scrutiny and expected enforcement activity.

SNAPSHOT: KEY OVERLAPPING SURGERY TRENDS

- Enhanced regulatory and enforcement attention
- Significant media and public interest in topic
- Physicians (including anesthesiologists and residents) as whistleblowers
- Ability for examination of technical billing practices to snowball into quality of care and informed consent issues
- Complex and challenging area to assess controls and implement auditing
- Compliance strategies are not one size fits all

Overview of overlapping surgery authorities

Overlapping surgeries may occur in the teaching setting (often with the assistance of resident surgeons) or the non-teaching setting. With respect to teaching settings, the Centers for Medicare & Medicaid Services (CMS or Medicare) regulations dictate certain requirements that must be followed for billing.[1] In the non-teaching context, Medicare regulations do not explicitly address overlapping surgeries, but call for providers to follow practices delineated by other applicable authorities, including industry groups such as the American College of Surgeons (ACS).[2]

In the teaching setting, Medicare requires that the teaching physician be present during all critical/key portions of both overlapping operations and personally document in the medical record that they were physically present during the critical/key portion(s) of both procedures.[3] Importantly, Medicare provides the teaching physician with the discretion to determine which part(s) of the procedure are key/critical. In addition, Medicare requires that if the teaching physician is not present during non-key/critical portions of the procedure, he/she must be immediately available to return to the procedure. If the teaching physician is not immediately available, he/she must arrange for another qualified surgeon to be immediately available to assist the resident in the first case, if the need arises. Notably, certain concepts in the Medicare authority do not have detailed definitions and appear to leave considerable discretion to the providers.

In April 2016, the American College of Surgeons updated its Statements on Principles (ACS Principles), which includes guidance regarding overlapping surgeries applicable to both the teaching and non-teaching setting.[4] The ACS Principles are very similar, although not identical, to the Medicare billing regulations for teaching surgeries. For instance, the ACS Principles define the term "concurrent" surgeries to mean two procedures under the same attending surgeon where the key/critical portions of both procedures overlap, and states that such practices are not appropriate. Medicare does not define concurrent surgeries but will not pay for such scenarios in the teaching setting because teaching surgeons are required to be present for the key/critical parts of all procedures. (We note that the May 2016 Compliance Today article uses the terms "concurrent" and "overlapping" interchangeably, but that such terms now have distinct meanings). The ACS Principles also address additional concepts, such as best practices for patient informed consent controls.

In addition, it is possible that states could have additional requirements relevant to overlapping or concurrent surgeries. For example, the Massachusetts Board of Registration in Medicine and associated agencies recently considered new regulations that would implement additional documentation requirements for instances when a surgeon is not present for part of an operation.[5]