

ASC Versus Hospital for Glaucoma Surgery

How I minimize the pain regarding my choice.

BY ADAM C. REYNOLDS, MD

I have a private practice as a glaucoma subspecialist, including about 50% general ophthalmology. I treat complex glaucoma cases including the pediatric/developmental glaucomas. Like many ophthalmologists in private practice, I spend most of my operating days in a physician-owned ambulatory surgery center (ASC) of which I am part owner. I prefer performing the majority of my surgeries in this setting due to familiarity, efficiency, and my ability to control multiple factors, and to work according to my preferences. There are some surgical cases, however, that are poorly suited to, or are unable to be scheduled in, an ASC. I am often frustrated when these circumstances occur, but they are a reality of the surgical ophthalmology services I provide. In this article, I share my personal experience and strategies that have helped my staff and me cope with the difficulties of this frustrating—and sometimes painful—reality.

WHY CHOOSE A HOSPITAL?

Patients' Safety and Comfort

Patients' safety in higher-risk situations, especially when general anesthesia must be used, is a common reason for a hospital-based venue for surgery, although my ASC handles many cases that require anesthesia. Patients' comfort levels and familiarity from previous experience in the hospital setting sometimes lead to requests for repeat surgeries there, even when the ASC is perfectly capable of safely accomplishing the procedure.

Pediatric Cases

In my practice, the most consistent reason for handling a case in the hospital is that the patient is under 2 years old. Other factors, particularly coding and reimbursement issues, may lead to an older pediatric patient's being treated in the hospital. For example, a primary trabeculotomy with an external approach attempting a 360° suture type of technique is much easier and probably safer to try using the iTrack cath-

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eter (iScience Interventional). Using a canaloplasty code (66174: canaloplasty without stent) in this instance may not be proper for this procedure. Using a trabeculotomy code (66185) may be more appropriate, but the reimbursement for that code in an ASC does not cover the significant cost of the catheter.

Coding, Reimbursement, and Insurance Plans

Because reimbursement for OR-related charges is significantly higher in a hospital for the same code compared with the ASC, reimbursement for surgery performed in a hospital does not generate financial losses as it would for the ASC. Several years ago, I was implanting regular tube shunts (66180) for Medicare and Medicaid patients in the hospital setting; the costs of the equipment and the implant itself were not well covered with lower reimbursements for ASCs. This issue currently has been resolved but is still a potential problem.

Preferred site contracts for surgeries with certain insurance plans, in particular for hospital employees and their dependents, have become more common. Patients who have these plans face significantly higher out-of-pocket copayments for procedures performed in an ASC. The overall costs to the insurer, however, even when taking into account the out-of-pocket costs to the patient, are often lower when the surgery is performed in the

ASC versus the hospital. The out-of-pocket costs to the patient usually are the determining factor, however, and often trump other concerns.

WHY CHOOSE AN ASC?

Efficiency

Efficiency is a concern for many of surgeons who juggle their time between the ASC and hospital. I often anticipate performing surgery in the hospital as a “painful” ordeal due to the greater amount of time spent working and preparing for the case in that setting. Hospitals, however, are better suited for the very rare high-medical-risk patient who will possibly have problems even with very mild sedation. The factors that lead to less efficiency in the hospital versus an ASC include unfamiliarity with the hospital’s OR staff and their unfamiliarity with me. Hospitals intrinsically have greater bureaucratic policies that can slow down efficiency.

Anesthesia

In my experience, preparing patients for surgery in the hospital takes longer than in an efficiently run ASC. For instance, in the hospital I work with most often, every patient has to have a separate preoperative anesthesia evaluation in addition to my clinic’s preoperative evaluation. It is very important to ensure that all pertinent medical issues are communicated before preoperative anesthesia appointments. In the past, there have been several instances when surgeries were delayed for hours or even cancelled due to anesthesiologists not being aware of key information until the patient was being prepared for surgery.

Managing Difficult Cases

Inherently, more complex procedures, including pediatric patients who require general anesthesia and often more complicated documentation in the hospital setting, also lead to more OR time. Whenever I can, I use the surgical scrub technician from my ASC; I make sure the case can be scheduled when she is available if I have lead time. I also maintain certification for that technician at the hospital facilities I use.

Naturally, this strategy adds to my overhead slightly. It has helped with almost every case, and the added cost has proven to be well worth it. My technician is familiar with both hospital ORs where I work, she is well respected by the staff in those settings, and she knows where to find equipment when the hospital staff has problems. She also brings backup surgical instrument trays and other equipment from my ASC to hospital cases. It is crucial to ensure that the technician is familiar with the surgical setting involved. This strategy

probably has contributed to more time saved and frustration averted regarding hospital-based surgeries than any other single policy that I have instituted.

IN CASE OF EMERGENCY: COMMUNICATION IS KEY

Emergencies happen, even excluding “on-call” cases. Educating and working with the hospital’s OR staffs by holding a few lunchtime in-service talks, or scheduling private meetings with OR directors, have been well worth the time and effort. Going over the basics of the surgeries I perform—from patient and microscope positioning to sequencing to instrumentation, all the elements I take for granted in the ASC—has saved me a great deal of time and frustration.

BE PREPARED

It is important to keep the pull lists updated, make sure the items on those lists are available, and update the basic pre- and postoperative orders for cases. I recall several instances of being delayed for more than the normal length of an entire surgical case searching for the proper instrument tray or cautery instrumentation, helping unfamiliar hospital staff set up a vitrectomy or phaco machine, or just looking for some basic sutures.

I have become more flexible over the years with using different instrumentation and sutures. In retrospect, however, these situations could have easily been prevented with the minimal communication and effort that I now use. Not surprisingly, the best advice is to be proactive rather than reactive.

CONCLUSION

For my practice, operating in the hospital setting instead of an ASC is sometimes disruptive and painful for both my clinical staff and me. I could choose to refer hospital-based cases to a colleague, but for many reasons, both personal and strategic for my multisub-specialty group practice, I have chosen to maintain this part of the practice. Proactively engaging the hospital’s OR staff as well as recruiting a familiar surgical technician to accompany the surgeon outside of the ASC for surgery can result in fairly smooth hospital-based procedures. ■

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