LCB File No. R181-09RP1 Proposed Regulations Public Workshop

Suggestions received before, during and after the workshop. Public workshop held via videoconference in Las Vegas and Carson City on May 2, 2013.

Carson City Participants (2)

Las Vegas Participants (2)

Summary of Input Provided

The Nevada Ambulatory Surgery Center Care Association commented as follows:

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-Section 4, NASCA is a strong supporter of programs and policies that work towards reducing the spread of infections in health care facilities. ASCs that participate in the Medicare program already have to comply with the requirements under *42 CFR 416.51 Conditions for coverage—Infection control,* which states:

(b) *Standard: Infection control program.* The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is—

(1) Under the direction of a designated and qualified professional who has training in infection control;

(2) An integral part of the ASC's quality assessment and performance improvement program; and

(3) Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.

-Section 6, The additional record keeping requirements related to each procedure performed is of concern. First, ASCs already keep records in each patient's file regarding the majority of this information. Secondly, we need to ensure that this is only kept for reasons related to ensuring patient safety and not information that would be turned over and made public for proprietary reasons or reasons that would violate privacy laws.

-Section 9, A 30 day requirement for a physical examination would mirror regulations under Medicare 42 CFR 416.52(a) and is supported by NASCA.

-Section 10, NASCA supports removal of this language that was an administrative burden and served no real purpose.

-Section 15, NASCA feels that the language specifying the types of supplies that must be present on a mobile cart could be restrictive. As part of standard medical practices, universally accepted quality standards and guidelines surgery centers are required to have the necessary equipment and supplies on hand for each type of patient that is treated and procedure that they have credentialed their medical staff to perform. Our suggestion would be to have language similar to:

"Each facility licensed under this section should have accessible on a mobile cart, the necessary drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures that also takes into effect any underlying medical conditions for that patient"

-Section 18, NASCA is in support of polices that require compliance with nationally accepted standards of care as a way to improve surgical results, improve patient safety and outcomes.

-Section 21, By requiring that the person responsible for administering anesthesia not have any other duties during that time unless relieved by someone who has similar privileges would increase patient safety by ensuring that a qualified individual is always present when anesthesia is being administered.

-Section 22, This requirement also mirrors language used by Medicare under section 42 CF$ 416.41 and is supported by NASCA.

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-Section 7, NASCA strongly feels that this change while done with good intentions would cause more problems by placing strict definitions in regulation as to how surgery is defined. For example, a simple Botox injection which is an *enhancement of tissue* would be considered a surgical procedure. NASCA would recommend that this language be stripped from the regulatory proposal since there is no real reason for a definition to be in regulatory language in the first place.

-New section regarding NAC 449.993, With the increased use of fluoroscopy by pain management practices, many ASCs are using qualified and trained individuals under the supervision of a physician. The change in language as written would have a negative effect on many smaller ASCs who don't have the resources to have a full time radiological technologist on staff, but instead have a qualified 'technician' operate the device under supervision.

Thus we would ask that either:

1. This change be tabled for further study, or
2. We give ASCs the ability to provide fluoroscopy services by any trained and qualified staff member that the ASCs has credentialed and can also show a certain level of training while under the direct supervision of a licensed physician.

Others commented as follows:

-Section 9, Three issues as follows:

1. Define presurgical evaluation.

Recommendations include: The presurgical evaluation is conducted by provider performing the procedure. It is the physical evaluation and documentation of the reason/need for the surgery, surgical risks, patient's risks, urgency for the surgery, summary of findings and recommendations.

2. If the History and Physical is performed by the surgeon (physician's only) within 7 days of the surgery, the presurgical evaluation can be waived as the H&P will encompass both.

3. Change wording, presurgical evaluation conducted by a physician within 7 days immediately preceding the date of his surgery. Recommend this be changed to, presurgical evaluation conducted by provider performing the surgical procedure within 7 days of the procedure to include day of procedure.
Reasoning: A Podiatrist, Dentist, PA or ANP would not be able to conduct their presurgical evaluation. Many anesthesiologists do not feel comfortable nor want to be legally responsible for performing this function. Also, many providers can see a patient for an elective procedure many months prior. They may not see the patient again until the day of surgery. If the wording remains 7 days preceding the surgery the patient would have to see the provider or physician prior to going to the outpatient facility incurring thus incurring another visit and cost.
-Errata New section regarding NAC 449.993, The new proposed language change in NAC 449.993 #4 from a Radiology "Technician" to "Technologist" will greatly financially impact our facility along with several other ASC's. Currently, only a physician can run the fluoroscopy machine. However, we have a "technician" who is in charge of radiation safety, training, documentation, bringing the machine into the room and set up. They can be paid much less than a technologist who has a degree and is a specialist in the field. Due to the sporadic amount of use of the "technician" we have trained one of our full time staff to be the "technician" when needed. This is an extra duty of his job. If the language is changed to "technologist" we will need a licensed person who can only perform this duty. Due to the sporadic use of this person, they would need to be "on call". So a person who potentially can do the job at $15/hr versus someone at $26-$35/hr, plus stand by pay plus time and a half when they come in would not be fiscally reasonable for our facility that only performs 350-400 cases a year with approximately 50-75 of those cases needing a "tech" to assist the physician with fluoroscopy.
Reasoning: A radiology technician is called upon to produce clear, concise x-ray images for physicians. The technician prepares the patient for the procedure, and maintains the x-ray equipment. While producing the best possible image is a fundamental part of the technician's job, minimizing radiation exposure to the patient, their coworkers, and themselves is also critical. The technician must ensure that the imaging equipment is performing well, that all precautions against exposure have been taken, and that the patient is receiving the best possible exposure prevention during the procedure. While taking an image, the technician must address any difficulties in order to produce the clearest image for the physician's diagnostic requirements.
In addition to being responsible for all of the above, a radiologic technologist is also tasked with being an expert for their particular field of specialty. Technologists specialize in computed tomography (CT scans), magnetic resonance imaging (MRI scans), mammography, bone

densitometry, and fluoroscopes (imaging of various soft tissues within the body). Both technicians and technologists may also manage patient records, evaluate equipment purchases, manage department work schedules, or even manage an entire radiology department.
-Errata New section regarding NAC 449.993, This new section should be greatly expanded to allow RN's and licensed surgical tech's under the direct presence of a physician or surgeon in the OR for the following reasons:

First, the technology of fluoroscopy has been dramatically improved in recent years. The improved imaging technology allows excellent visualization with minimum radiation. For patients, the amount of radiation exposure can be comparable to the amount of radiation received from flying in an airplane at high altitudes. Also it is very easy to operate the new machines with all of the safety features included in the computerized systems.

Second, because of the increased safety regarding radiation exposure and improved image, fluoroscopy machines are becoming popular in many physician offices, much like ultrasound machines. As more accurate procedures and less costly options by patients are requested, there will be more use of fluoroscopy machines in outpatient settings.

Third, in 25 years of medical practice using fluoroscopy machines for pain management procedures in the state of Nevada, this physician does not recall any documented problems associated with over exposure of radiation by the use of fluoroscopy machines on patients or staff. Nor does this physician recall any unusual clinical problem associated with the use of a fluoroscopy machine.

Fourth, there are many small ambulatory surgery centers in the state of Nevada who do not have enough cases to hire a full time radiological technologist on staff. These centers have to use contracted radiological technology services to use fluoroscopy to perform procedures in the OR. This adds several problems:

A. There is substantial increased cost to the patient for very minimum service.

B. Down time for entire OR staff and surgeon waiting for the arrival of a radiological technologist has a substantial economic impact to small business of low volume ambulatory surgery center.

Request a new subparagraph "d" after the sentence: "Only the following individuals may operate a fluoroscopy machine:" that says, "d) RN or licensed OR technician with documented training in radiation safety, under the direct supervision of physician or surgeon present in the room at the time of fluoroscopy use."