

November 06, 2023

LISA P. RHODES
Chief Administrative Officer
Perioperative and Procedural Services
8794

**Subject: *Overlapping Surgery Policy
Report 2023-15***

The final report for Overlapping Surgery Policy, Report 2023-15, is attached. We would like to thank all members of the department for their cooperation and assistance during the review.

Because we were able to reach agreement regarding management action plans in response to the audit recommendations, a formal response to the report is not requested. The findings included in this report will be added to our follow-up system. We will contact you at the appropriate time to evaluate the status of the management action plans.

UC wide policy requires that all draft reports be destroyed after the final report is issued. We also request that draft reports not be photocopied or otherwise redistributed.

Christa Perkins
Director
Audit & Management Advisory Services

Attachment

cc:	Judy Bruner	Patty Maysent
	Alexander Bustamante	Michael McHale
	John Carethers	Seema Mohamedy
	Lori Donaldson	Pierre Ouillet
	Brendan Kremer	Robin Schaefer
	Christopher Longhurst	Ron Skillens
	Elizabeth Malachowski	Sarah Suskauer
	Veronica Marsich	Ruth Waterman

UC San Diego

AUDIT & MANAGEMENT ADVISORY SERVICES

Overlapping Surgery Policy
Report No. 2023-15
November 2023

FINAL REPORT

Performed By:

Mareline Godfrey, Senior Auditor
John Teevan, Manager

Approved By:

Christa Perkins, Director

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I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a review of the Overlapping Surgery Policy as part of the approved audit plan for Fiscal Year 2022-2023. The objective of our review was to evaluate whether internal controls provide reasonable assurance that processes and practices related to overlapping surgery and associated monitoring are effective and in compliance with UC San Diego Health (UCSDH) policy, and conform to professional standards and regulatory requirements.

Based on our review, we concluded that internal controls related to Policy implementation and associated monitoring practices could be improved to provide reasonable assurance that processes are effective and in compliance with UCSDH policy, and conform to professional standards and regulatory requirements. We noted that Perioperative Services has established a compliance monitoring process, that includes prospective and retrospective reviews, and departmental procedures were enhanced to incorporate the new process.

However, we noted opportunities for improvement in training and monitoring practices to ensure practices are in full compliance with the Policy, and improve accountability. Based on our review, we noted instances where documentation of the requirements for transparency, identification of backup surgeon, or presence for key and critical portions was not always present in the files reviewed, or did not always conform to the Policy.

We also noted that Perioperative Services is still in its early stage of monitoring compliance and have not included consideration of billing in their monitoring process. Inclusion of the billing component when reviewing compliance could help ensure Overlapping Surgery cases comply with CMS billing requirements; in particular, with regards to documentation of the surgeon's presence for the key and critical portion of the procedure and use of appropriate modifiers. Moreover, we noted instances where a surgeon may have participated in potentially billable clinical activity during the performance of a surgical procedure. The current process for reporting to Department Chairs has also not been completed at the frequency required by the Policy, and criteria for escalation of non-compliance was unclear.

Furthermore, we also noted some areas where policy interpretation was inconsistent, including whether Skin Time is considered key and critical which can impact the determination of whether a case is concurrent. Management also indicated that an attestation in the operative note stating that the surgeon was present during the procedure or for the entirety of the procedure is acceptable, which varies slightly from the Policy requirement since the attestation does not specify the key and critical portion.

Finally, we also noted that OCP rolled out a mandatory training to surgeons to ensure Policy requirements are met and in compliance with CMS billing requirements. There was feedback that the training from OCP and Perioperative Services may vary in the interpretation of the Policy related to the documentation of the surgeon's presence for the key and critical component of the procedure, as required by the Policy. Management Action Plans to address these findings are summarized below.

A. Adherence to Policy Requirements

1. Perioperative Services will continue to partner with OCP to identify strategies for ensuring compliance with UCSDH policy and CMS billing requirements on overlapping surgery, including incorporation of the billing component in the compliance review workflow.
2. Perioperative Services has performed thorough re-education of one surgeon, and appropriate Department Chair to address the two clinic visits billed concurrently during a surgical procedure.
3. OCP should will evaluate the two clinic visits billed concurrently and determine if any billing adjustments should be completed.
4. Perioperative Services will present options to the Perioperative Executive Committee (PEC) for criteria and frequency for escalation of continued non-compliance to UCSDH clinical leadership.
5. Perioperative Services will ensure monthly reports are provided at PEC meetings and forward detailed reports to the Department Chairs monthly as the Policy requires.

B. Alignment of Policy and Practices

1. Perioperative Services has drafted amendments to the policy and will work with OCP to obtain approval from EGB and other appropriate bodies.
2. Perioperative Services will partner with OCP to re-educate attending surgeons on policy requirements, including that attending surgeons need to be present for key and critical elements, and that the operative report needs to specifically document what these elements were. All surgeons will be required to complete the OCP training module.
3. Perioperative Services will ensure that the revised Overlapping Surgery Policy, once fully approved and published, is communicated to UCSDH surgeons.

Observations and related management action plans are described in greater detail in section V. of this report.

II. BACKGROUND

Audit & Management Advisory Services (AMAS) has completed a review of the Overlapping Surgery Policy as part of the approved audit plan for Fiscal Year 2022-2023. This report summarizes the results of our review.

In September 2022, UC San Diego Health (UCSDH) implemented UCSDH Policy (UCSDHP) 384.1 Overlapping Surgery Policy¹ (Policy) to reinforce commitment to ensuring the best possible outcome for patients undergoing surgery at UCSDH hospitals. The Policy places emphasis on conformance to legal and regulatory requirements and intraoperative responsibility of the primary surgeon in the practices of “concurrent” and “overlapping” surgery. The Policy was a result of a collaborative effort between Perioperative and Procedural Services (Perioperative Services) and the Office of Compliance and Privacy (OCP), to ensure alignment with the principles of the American College of Surgeons (ACS) and available guidance from the Center for Medicare and Medicaid Services (CMS). A mandatory training was rolled out by Perioperative Services in July 2022 to ensure awareness and compliance. Physicians and clinical staff members completed a training course on new Policy requirements in August 2022 with 100% compliance. The training includes a knowledge assessment to ensure comprehension, and was incorporated into onboarding and annual training requirements for all involved physicians and clinical staff.

Overlapping Surgery

The Policy defines Overlapping Surgery as an “operation or procedure in which the actual operating time overlaps with the actual operating time of another operation or procedure performed by the same surgeon. However, the key and critical components do not overlap.” The Policy also illustrates an Overlapping Surgery in an example as shown in the following figure:

Figure 1: Overlapping Surgery Example

Overlapping Surgery: An Example



Source: UCSDHP 384.1

There are three requirements to participate in an Overlapping Surgery as described in the Policy:

1. Documentation of Transparency:

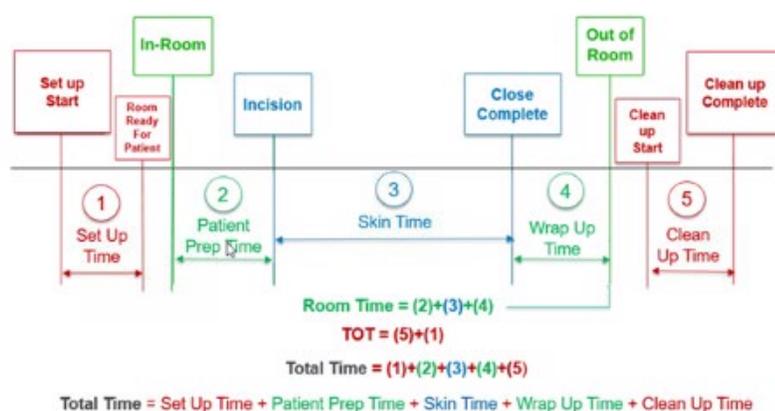
¹ UCSDHP 384.1 Overlapping Surgery has been approved by the Perioperative Executive Committee (PEC), UCSDH Health Executive Governing Board (EGB), Nursing Policy and Procedures Committee (NPP), Nurse Executive Committee (NEC), and Medical Staff Executive Committee (MSEC).

- a. Informed Consent/Consent: Patients whose elective procedures are scheduled or expected to overlap with that of another patient must be informed by the primary attending surgeon prior to the planned procedure and provide written consent indicating their knowledge that their surgery is anticipated to overlap with another. Documentation of this discussion should be detailed in the informed consent. This document should clearly state that the primary surgeon will be present for the key and critical elements of the procedure.
2. Backup Surgeon:
 - a. Need to identify a credentialed, second attending surgeon, who can be immediately available;
 - b. Backup surgeon needs to be identified in the interval note;
 - c. Operating Room (OR) teams need to be aware of the assigned backup surgeon.
3. Key and Critical Element(s):
 - a. Primary (attending) Surgeon needs to be present for key and critical element(s);
 - b. The attending surgeon needs to document that they were present for the key elements and specify these elements in the operative note.

Perioperative Services monitors compliance by identifying overlapping cases based on procedure start and stop times, as outlined by the Policy. The actual procedure or operating time is reflected as the Incision Start and Incision Close times in Epic. In the Perioperative Services compliance monitoring workflow, this is also referred to as “Skin Time.”

Perioperative Services is tasked with operationalization and monitoring compliance with the new Policy. To monitor compliance, Perioperative Services performs prospective and retrospective reviews. During the prospective review process, possible overlapping cases are flagged each Wednesday, based on scheduled² cases the following week for each surgeon using estimated In Room Time and Out of Room time³. Perioperative Services described the five components of a case time in the following chart.

Figure 2: Components of Case Time



- EPIC Averages are used to schedule times 1/2/4/5
- Surgeon request is used to schedule 3 (or elect to schedule per Epic time average) UC San Diego Health

Source: Perioperative and Procedural Services Scheduling Biweekly Update

² Perioperative and Procedural Services Scheduling Team oversees the surgery schedule for all UCSDH operating rooms.

³ On the Date of Service, Nursing staff in Perioperative Services document the actual times a surgeon enters and exits a surgical suite in Epic.

The surgeons with possible overlapping cases scheduled for the following week are alerted via email with a reminder of the three requirements described in the Policy. The weekly report is sent to the Perioperative Services Leadership Triad (Triad)⁴ every Friday.

During the retrospective review, a Triad member reviews the weekly report and verifies whether actual overlap existed based on Skin Time. The report is updated to mark all actual overlapping cases based on Skin Time, and documentation of the other elements are evaluated, which includes patient consent and backup surgeon. These requirements are presumed to be complete prior to the surgery, and that the surgeon should be immediately available should the surgeon leave the OR for the overlapping case.

Perioperative Services has produced reports since the Policy was issued to summarize results of possible non-compliance for overlapping cases identified as part of the prospective and retrospective reviews. The reports are presented quarterly to the Perioperative Executive Committee. Per the Policy, a copy should also be shared with respective Department Chairs monthly. The cumulative Perioperative Services report from September 2022 through February 2023 identified 61 of 109 overlapping cases that were potentially out of compliance. Those 61 cases were attributed to eight surgeons who were notified of these results.

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our review was to evaluate whether internal controls provide reasonable assurance that processes and practices related to overlapping surgery and associated monitoring are effective and in compliance with UCSDH policy, and conform to professional standards and regulatory requirements. In order to achieve our objective, we performed the following:

- Reviewed pertinent documents and information related to the Policy, including:
 - UCSDHP 384.1 Overlapping Surgery Policy,
 - UCSDHP 339.1 Informed Consent,
 - UCSDHP 750.2 Conflict of Interest Disclosure for Staff and Clinicians,
 - UCSDH Professional Billing Guidance for Non-ACGME Fellows,
 - UCSD GME Policy 027 Non-ACGME Accredited Fellowships,
 - Statement of Principles of ACS,
 - Relevant CMS guidance and Senate Finance Committee Staff Report and measures, and
 - Relevant Perioperative Services department policies, procedures, and reports;
- Interviewed the following:
 - Division Chief of Gynecologic Oncology in the Department of Obstetrics, Gynecology, and Reproductive Sciences, and Perioperative Services Leadership Triad Member,
 - Director of Operational Excellence, Perioperative and Procedural Services, and
 - Associate Director, Billing Compliance, Office of Compliance and Privacy;
- Evaluated a judgmental sample of surgery cases identified in the Perioperative Services report as overlapping for the period September 2022 – February 2023 and performed the following:
 - Examined relevant medical records and documentation to determine whether documentation conformed with Policy requirements for overlapping surgery, and

⁴ The Perioperative Services Leadership Triad directs operations across all locations, improve quality and service, and lead the perioperative redesign efforts. Members include the Perioperative and Procedural Services Chief Administrative Officer, Department Chair of Anesthesiology, and Chief of the Division of Gynecologic Oncology in the Department of Obstetrics, Gynecology, and Reproductive Sciences.

- Reviewed billing data for surgeons with cases that overlapped at procedure time, as well as In Room and Out of Room time, to determine whether surgeons participated in another billable event during performance of a surgical procedure.

IV. CONCLUSION

Based on our review, we concluded that internal controls related to Policy implementation and associated monitoring practices could be improved to provide reasonable assurance that processes are effective and in compliance with UCSDH policy, and conform to professional standards and regulatory requirements. We noted that Perioperative Services has established a compliance monitoring process, that includes prospective and retrospective reviews, and departmental procedures were enhanced to incorporate the new process.

However, we noted opportunities for improvement in training and monitoring practices to ensure practices are in full compliance with the Policy, and improve accountability. Based on our review, we noted instances where documentation of the requirements for transparency, identification of backup surgeon, or presence for key and critical portions was not always present in the files reviewed, or did not always conform to the Policy.

We also noted that Perioperative Services is still in its early stage of monitoring compliance and have not included consideration of billing in their monitoring process. Inclusion of the billing component when reviewing compliance could help ensure Overlapping Surgery cases comply with CMS billing requirements; in particular, with regards to documentation of the surgeon's presence for the key and critical portion of the procedure and use of appropriate modifiers. Moreover, we noted instances where a surgeon may have participated in potentially billable clinical activity during the performance of a surgical procedure. The current process for reporting to Department Chairs has also not been completed at the frequency required by the Policy, and criteria for escalation of non-compliance was unclear.

Furthermore, we also noted some areas where policy interpretation was inconsistent, including whether Skin Time is considered key and critical which can impact the determination of whether a case is concurrent. Management also indicated that an attestation in the operative note stating that the surgeon was present during the procedure or for the entirety of the procedure is acceptable, which varies slightly from the Policy requirement since the attestation does not specify the key and critical portion.

Finally, we also noted that OCP rolled out a mandatory training to surgeons to ensure Policy requirements are met and in compliance with CMS billing requirements. There was feedback that the training from OCP and Perioperative Services may vary in the interpretation of the Policy related to the documentation of the surgeon's presence for the key and critical component of the procedure, as required by the Policy.

These observations are discussed further in the balance of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

A.	Adherence to Policy Requirements
The Policy was not consistently adhered to in overlapping surgery cases, and the documentation of the requirements within Epic was not in strict compliance with the Policy.	
Risk Statement/Effect	
Non-compliance with policy increases risks in patient safety risk and with CMS billing requirements, and could result in complaints, grievances, lawsuits, and possibly fines and penalties.	
Management Action Plans	
A.1	Perioperative Services will continue to partner with OCP to identify strategies for ensuring compliance with UCSDH policy and CMS billing requirements on overlapping surgery, including incorporation of the billing component in the compliance review workflow.
A.2	Perioperative Services has performed thorough re-education of one surgeon, and appropriate Department Chair to address the two clinic visits billed concurrently during a surgical procedure.
A.3	OCP will evaluate the two clinic visits billed concurrently and determine if any billing adjustments should be completed.
A.4	Perioperative Services will present options to the Perioperative Executive Committee (PEC) for criteria and frequency for escalation of continued non-compliance to UCSDH clinical leadership.
A.5	Perioperative Services will ensure monthly reports are provided at PEC meetings and forward detailed reports to the Department Chairs monthly as the Policy requires.

A. Adherence to Policy Requirements – Detailed Discussion

The Policy states that surgeons participating in overlapping surgeries must ensure all three requirements are satisfied and documented. In addition, overlapping surgeries that are reasonably expected to be concurrent (where critical elements of the two cases will be occurring simultaneously) are expressly not allowed except in emergent situations.

Policy Requirements to Participate in Overlapping Surgeries

As part of the compliance monitoring process, Perioperative Services verifies whether the requirements for the documentation of transparency and a backup surgeon are present in all procedures that are expected to overlap based on the schedule, and when the actual procedure overlapped based on Skin Time. However, verification of documentation of the surgeon’s presence for the key and critical portion of the procedure remains to be a challenge. We noted the following:

1. The Perioperative Services Report for September 2022 and February 2023 indicated 172 potential overlapping cases, and 79 actual overlapping cases reviewed. The report identified cases that were

potentially non-compliant when actual cases that overlapped based on Skin Time did not have documentation of transparency, and a backup surgeon was not identified. However, based on the report, it was not clear whether the documentation of the surgeon's presence for the key and critical element for each procedure was complete. *Table 1* summarizes the Perioperative Services Report indicating the number of cases that completed each requirement for overlapping surgery.

Table 1: Perioperative Services Report – September 2022 through February 2023

Requirements Reviewed	Potential Overlapping Cases based on schedule (Prospective Review)	Actual Overlapping Cases (Retrospective Review)
Documentation of Transparency (Informed Consent / Consent)	134 (78%)	79 (72%)
Backup Surgeon	95 (55%)	61 (56%)
Key and Critical	Not Applicable	Not Indicated
# of Cases Reviewed	172	109

Source: Perioperative Services

Based on interviews with Perioperative Services, there is an expectation that the requirements are satisfied and documented prior to the actual procedure. If the actual procedure overlapped with another case based on Skin Time, the following should be satisfied:

- a. the patient should have been consented;
- b. the backup surgeon should have been identified; and
- c. the key and critical portion of the procedure should have been performed prior to the surgeon leaving the OR for another case, and that the surgeon is within the vicinity to be immediately available.

Perioperative Services explained further that when the primary attending surgeon leaves the OR in the first case and enters the OR for the second case overlapping with the first, it is presumed that the surgeon is still within the vicinity and therefore could be immediately available. However, the surgeon's immediate availability is not confirmed when the procedure begins for the second case. In addition, there is a presumption by Perioperative Services that the incision start and closure are key and critical. Therefore, the surgeon is expected to complete the incision closure before leaving the OR of the first case. In any case, a backup surgeon should have already been designated to perform the rest of the procedure when the primary attending surgeon leaves the OR. As a result, it was unclear how the current monitoring process confirms that the primary attending surgeon is immediately available when there is an overlap between the first case's incision closure completion time and the second case's incision start time.

2. Based on our review of 29 cases judgmentally selected from the Perioperative Services Report for the period September 2022 through February 2023, 21 (72%) of these cases were actual overlapping cases based on Skin Time. We noted gaps in documentation for the required elements for overlapping cases. *Table 2* below summarizes our sample review and verification of required documentation which indicates the number of cases that includes documentation of the requirements for overlapping surgery, with notes on each area to follow.

Table 2: AMAS Sample Review

Requirements Reviewed	Potential Overlapping Cases based on schedule	Actual Overlapping Cases
Documentation of Transparency	21 (72%)	17 (81%)
Backup Surgeon	6 (21%)	6 (29%)
Key and Critical	17 (59%)*	12 (57%)*
# of Cases Reviewed by AMAS	29	21

* Documentation indicated that attending surgeon is present for the procedure, or the entirety of the procedure.

- a. Documentation of Transparency – 81% (17/21) compliance. When patient consent was present, documentation used a template with language indicating that the key/critical portion was described to the patient in detail, and the backup surgeon was identified and will be present in the event that the attending surgeon steps out for a case that overlaps. However, there was no specific case information documented for the key and critical portion, or the name of backup. Based on discussion with Perioperative Services, the language in the template was approved by the Health Counsel of the UCSD Office of Campus Counsel (Health Legal). We found four instances where documentation was missing one or more elements of the required documentation.
- b. Backup surgeon – 29% (6/21) compliance. Per discussion with Perioperative Services, the backup surgeon should have been identified prior to the Date of Service (DOS). We found two cases wherein the Perioperative Services Report indicated this requirement was met; however, we did not find this information documented in the interval notes for most of the cases we reviewed.
- c. Key and Critical Elements – 57% (12/21) compliance. For the key and critical portion, we reviewed patient records to verify documentation in the operative notes that the surgeon was present for the key and critical portion. In many cases, we found that the surgeon documented in the operative notes that they were either present for the procedure, or the entirety of the procedure. In those cases, the surgeon was out of the room before the incision close was complete. However, documentation was not specific on the key and critical portion as required by the Policy. Perioperative Services indicated that this language is acceptable and the surgeon just needs to document they were present for the key and critical portion per discussion with Health Legal. This is discussed further in *Finding B*.

Other Billable Activities

The Policy's definition of immediate availability requires the surgeon not be engaged in other billable activities, such as managing a clinic template, unless another attending surgeon has assumed primary responsibility such as in a multi-panel procedure. Also, the billing component is not included in the Perioperative Services monitoring review workflow for conformance with CMS billing requirements, such as 82⁵ and GC⁶ when qualified residents and non-ACGME fellows assist⁷.

⁵ Modifier 82 is required if a non-ACGME fellows assists in the procedure.

⁶ A GC modifier must be used by teaching physicians to identify residents aiding in patient care and services on claims.

⁷ Based on our review, the GC modifier was used appropriately; however, we identified one instance where a non-ACGME fellow assisting in the procedure billed with modifier 82, and the fellow was not fully credentialed to perform the procedure.

We evaluated our sample of 29 cases based on surgeon in and out of room times to verify when the primary attending surgeon left the OR to perform another surgery and whether the surgeon engaged in another billable event. We noted that, in some cases, the surgeon left the OR prior to the completion of incision closure, otherwise known as the procedure stop time. Perioperative Services explained that it is not unusual for surgeons to leave the OR when an incision closure begins as residents complete the incision closure process; however, it is expected that the primary surgeon remains in the vicinity to be immediately available, or that a backup surgeon has been designated to oversee the non-critical portion of the procedure.

We identified two instances where outpatient clinic visits were billed under the surgeon’s name for scheduled clinic visits during the period the surgeon was performing a surgery and was in and out of the OR. This was noted in the Spine Surgery specialty where procedures are usually performed in stages, and in Ophthalmology. In the billing data for an Ophthalmology sample, there was no overlap in incision or skin time stamp. While cases only overlapped during surgeon in-room and out-of-room times, a billed outpatient visit took place during the periods of two ongoing surgical cases that overlapped based on surgeon in-room and out-of-room time stamps.

Policy Requirements for Audit/Compliance

The Policy requires that Perioperative Services provide department chairs with a monthly report on compliance. There was no escalation process for non-compliance noted in the Policy.

During our review, Perioperative Services confirmed that the reports are expected to be sent to the respective Department Chairs. However, as Perioperative Services continue to improve reports and monitoring practices, the monitoring process and reporting has only been completed and shared with Department Chairs twice since September 2022. The reports have also been presented quarterly to the Perioperative Executive Committee.

B.	Alignment of Policy and Practices
We identified instances when training and practices do not completely align with Policy requirements.	
Risk Statement/Effect	
Misalignment of policy and practices creates confusion and inconsistencies, and contributes to challenges that increase the risk for non-compliance.	
Management Action Plans	
B.1	Perioperative Services has drafted amendments to the policy and will work with OCP to obtain approval from EGB and other appropriate bodies.
B.2	Perioperative Services will partner with OCP to re-educate attending surgeons on policy requirements, including that attending surgeons need to be present for key and critical elements, and that the operative report needs to specifically document what these elements were. All surgeons will be required to complete the OCP training module.
B.3	Perioperative Services will ensure that the revised Overlapping Surgery Policy, once fully approved and published, is communicated to UCSDH surgeons.

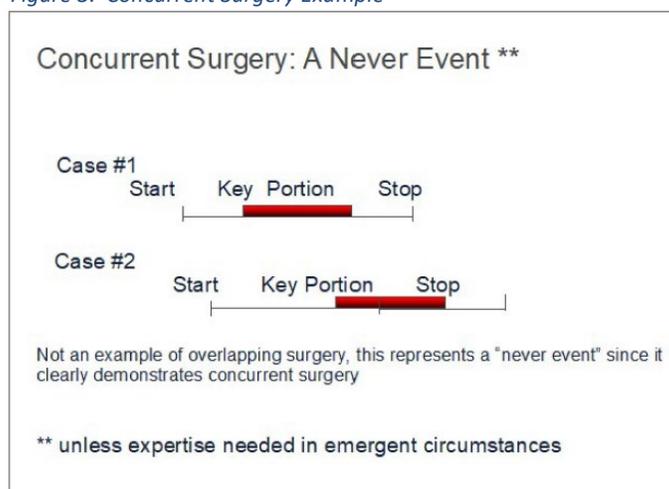
B. Alignment of Policy and Practices – Detailed Discussion

Policy Interpretation on Overlapping Cases

Overlapping cases are described in the Policy whereby the actual operating time overlaps with the actual operating time of another. We confirmed with Perioperative Services that Skin Time is considered to be the same as procedure time or operating time. The Perioperative Services report indicates actual overlapping cases based on Skin Time. Perioperative Services also indicated that the Skin Time is considered the time within which the key and critical portion is performed during the procedure. As a result, if the other requirements are not completed, Perioperative Services mark these cases for potential non-compliance as indicated in the Perioperative Services Report.

However, if the portion of the procedure at any point within the Skin Time, marked as incision start and closure times, is considered key and critical, then actual overlapping cases identified in the Perioperative Report could be concurrent since the Policy requires that the key and critical element should not overlap, which is only allowed in emergent situations. The Policy included the following figure as an example to demonstrate a concurrent surgery.

Figure 3. Concurrent Surgery Example



Source: UCSDHP 384.1

Policy Interpretation on Key and Critical

The Policy states that the primary attending surgeon or their designated "backup" is required to be present during all "critical and key" components of the operation. However, the key and critical portion is not clearly described in the Policy, and there is no clear guidance from regulatory agencies on this definition. The key and critical portion can change intraoperatively, depending on several factors that require the surgeon's technical expertise, judgement and ethical responsibility to achieve an optimal patient safety outcome. The Policy does require that the attending surgeon document that they were present for the key elements and specify these elements in the operative note. During our review of sample cases summarized in *Table 2*, we observed that in 12 (57%) overlapping cases noted based on Skin Time, the surgeons documented in the operative notes that they were present "during the procedure", or "for the entirety of the procedure." However, there was no specific

description of the key or critical portion for which they were present. Based on our review, we noted the following:

1. Documentation of Surgeon's Presence During Key and Critical Portion: Perioperative Services indicated that while the surgeon is expected to be present throughout the procedure, it is common practice that the surgeon leaves prior to the completion of incision closure, and enters another OR to begin or initiate a second procedure. And the procedure in the second OR should not begin while the incision closure for the first procedure is not complete, except in case of an emergency. In those cases, it can be reasonably expected that the surgeon is immediately available. However, leaving the OR prior to the completion of incision closure, if considered critical, does not appear consistent with the Policy. OCP referenced ACS which indicates that when all key and critical portions are complete the primary attending surgeon may leave the OR for the second case, and the designated backup must be physically present to perform the noncritical components of the first operation.
2. Documentation of Key and Critical Elements: Based on interviews with Perioperative Services and consultation with OCP, Perioperative Services considers the current practice acceptable, based on their discussion with Health Legal. The surgeons only need to document they were present for the key and critical portion and need not specify the key and critical elements. OCP has indicated that this practice is not entirely consistent with the Policy requirement, and increases the risk of non-compliance with CMS billing requirements.

Policy Training

Perioperative Services compliance training materials described the Policy content including key definitions and the three essential elements to participate in overlapping surgery. It provided a summary of what surgeons need to complete to ensure compliance as follows:

- a. Informed consent/consent - document in medical record;
- b. Identify backup surgeon - document in the interval note on day of surgery, and communicate with the team; and
- c. Key and critical elements - need to be present. Attending needs to personally document in the operative note.

In May 2023, a new mandatory training was also rolled out by OCP on the Policy to all physicians who answered "yes" to indicate whether they perform surgeries. OCP references the principles of ACS in their training materials whereby the primary attending surgeon is personally responsible for the patient's welfare throughout the operation. In general, the patient's primary attending surgeon should be in the operating suite or be immediately available for the entire surgical procedure.

Based on our interviews, the OCP training may differ compared to the Perioperative Services training rolled out to surgeons; in particular, the interpretation of the Policy related to the documentation of the surgeon's presence for the key and critical component of the procedure differs between the trainings.

We were advised that Perioperative Services is also in the process of rolling out the training to all procedural areas, and have reached out to OCP to evaluate any gaps in their training materials and interpretation of the Policy.