LOW VALUE CARE:

THE USE OF PREOPERATIVE CLEARANCE PRIOR TO CATARACT SURGERY – PART 3

Jerry R. Frank, MD

Senior Vice President and Chief Medical Officer

V1.0

EmblemHealth

WHAT IS THE IMPACT OF MEDICAL CLEARANCE FOR CATARACTS?

As of 2011:

- 1.7M cataract procedures performed annually with a cohort of 440K showing a spend of over $17M versus a similar cohort not having surgery over the same time period*
  - No numbers available for work up of spurious results or impact of the complications with any intervention as part of the workup
- In 2016 I performed a Google search of surgical facilities performing cataract surgery and randomly selected 100 listings
  - Ninety-two sites clearly listed the need to have “medical clearance from your physician”
  - Some sites were more specific with regards to the need for an ECG, specific lab work and one still documented a requirement for a chest x-ray
  - Most sites that were part of a hospital system required that clearance be performed by a physician with privileges at the facility or that testing be done at the facility lab
- From July – October 2017, EmblemHealth had approximately 4000 unique members having cataract surgery
  - Estimated spend on pre-surgical clearance during that period was approximately $1.8M

**Preoperative Medical testing in Medicare Patients Undergoing Cataract Surgery. Chen et al. NEJM Apr. 16 2015 372:1530-1538*

CHOOSING WISELY

Most recent recommendations:

- Don't perform preoperative medical tests for eye surgery unless there are specific medical indications (AAO)
- Don't perform routine electrocardiography screening as part of pre-operative or pre-procedural evaluations for asymptomatic patients with low perioperative risk of death or myocardial infarction (ACC)
- Don't obtain preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology (ACP)
- Avoid admission or preoperative chest X rays for ambulatory patients with unremarkable history and physical exam (ACS)
- Avoid routine preoperative testing for low risk surgeries without a clinical indication (ASCP)
- Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal (ASA)
- Don't obtain baseline diagnostic cardiac testing (trans-thoracic/esophageal echocardiography – TTE/TEE) or cardiac stress testing in asymptomatic stable patients with known cardiac disease (e.g., CAD, valvular disease) undergoing low or moderate risk non-cardiac surgery (ASA)
- Don't perform routine pre-operative testing before low-risk surgical procedures (Soc For Gen IM)

PHYSICIAN ROUNDTABLE

In early 2019 we held a physician roundtable regarding the use and value of medical clearance

Attendance:

- Chairman of Surgery and Chief of Vascular services at a large midtown hospital and Division Chief for a large health system
- Ophthalmologist in private practice and former president of the state medical society
- Anesthesiologist employed at a large health system who is a founding partner of the largest anesthesia group in the US
- Family physician in private practice and the president of a large physician group

PHYSICIAN ROUNDTABLE

KEY DISCUSSION ITEMS

- What is medical clearance?
  - Risk optimization and stratification
  - Medical protection
  - A way to give back referrals
  - Medical culture/hospital culture/a culture no one wants to change
  - Almost never of value, but is required by the system and bucking the system is hard
  - Sometimes anesthesia needs information, but that information tends to be of low value
  - Not really “clearance”, but a validation of co-morbidities
- Practical approach and comments:
  - There are too many stakeholders in this system
  - If I am performing the procedure, I don’t want to think about the patient’s past history, and I don’t want the responsibility of risk of a complication
  - If all the information is present before the procedure the surgery will not be canceled
  - Helps to address appropriate anesthesia plan

PHYSICIAN ROUNDTABLE

- What can physicians do to change the system?
  - Speak to other physicians about standards
  - Risk that some cases just wont be done without clearance
  - Work with hospitals and nursing staff to change policies
  - Refer to places that do not require pre-operative workup

- What role should payers have in the process
  - Provide guidelines
  - Conduct education programs
  - Modify contracts to not pay for services when not medically necessary

SOLUTIONS

- Extensive education
  - Work with organized medicine to educate members
  - Educate members about what is necessary for minor procedures
  - Direct to physician education
- Prior authorization for preoperative clearance
  - Limited to members who really need it
- Steerage to facilities who agree to follow guidelines on preop clearance
- Audits and claw-backs

QUESTIONS?

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