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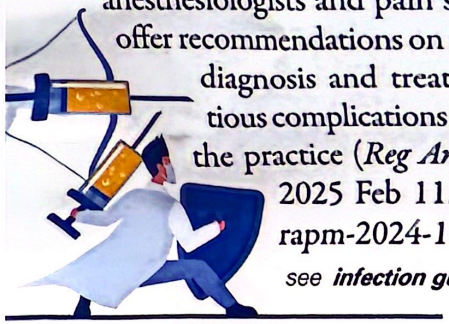
ASRA Releases First-Ever Infection Control Guidelines

Focus on Risk, Diagnosis and Treatment of Infectious Complications

For the first time in its 50-year history, the American Society of Regional Anesthesia and Pain Medicine (ASRA) has released a comprehensive set of consensus practice guidelines dedicated to infection control for regional anesthesia and pain medicine. The guidelines, published in January, are the first explicitly tailored to regional anesthesiologists and pain specialists, and offer recommendations on risk mitigation, diagnosis and treatment of infectious complications associated with the practice (*Reg Anesth Pain Med* 2025 Feb 11. doi:10.1136/rapm-2024-105651).



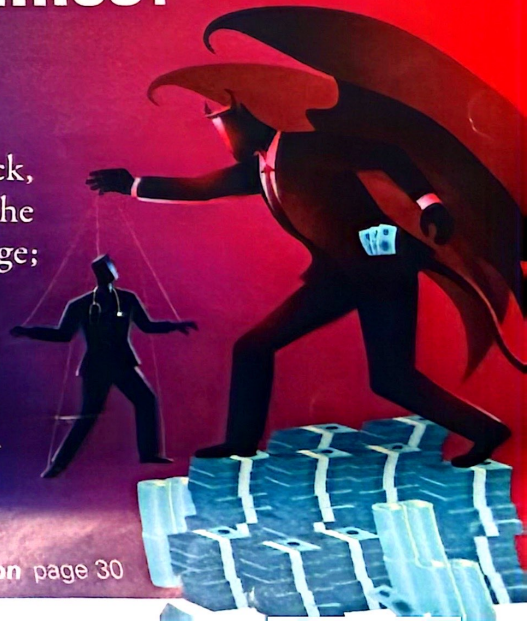
see **infection guidelines** page 34

A Murdered CEO, Anesthesia Reimbursement (Almost) Restricted and Ubiquitous Corporate 'Greedflation': Signs of the Times?

By David Sherer, MD

A healthcare company executive is shot in the back, murdered in cold blood; an angry populace chafes at the rising costs of health insurance and denials in coverage; and a privately held insurance company schemes to fatten its bottom line by restricting reimbursement for anesthesia services. In the parlance of that god-awful, hackneyed expression, "there's a lot to unpack."

The new year has opened with so many dramatic and daunting changes that it is difficult to fully digest their impact. The January issue of *Anesthesiology News* proclaimed on the front



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GREEDFLATION

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"Anthem Backpedals on Controversial Anesthesia Policy, but Questions Remain." The January/February edition of *AARP Bulletin* asked: "Where Have All The Doctors Gone?" And to attempt to "unpack" what this year has witnessed or holds in store, all a person has to do is read the daily news and attempt to make sense of it all.

But a few things stand out that seemingly most Americans can agree upon. Things cost too damned much. It is truly difficult to get a timely appointment with a primary care physician, and the wait is worse if you need a specialist. And profits for many health insurers soar while patients get denied vital coverage, and reimbursement to physicians tanks. There's a lot of well-deserved anger and frustration out there, and one has to ask: When and how will any of this end?

When one examines the jarring events of recent months, three themes run through the narrative. They are money, power and a disconnect based on ignorance. The unending quest for money and power everyone understands; they are as old as politics itself. The third theme bears some explanation.

As I have alluded to in my previous articles in *Anesthesiology News*, the traditional goals and mindsets of those who practice the healing arts and sciences and those who merely wish to profit from the delivery of those services could not be more disconnected.[1] Based in part on educational upbringing, sheer capitalistic desire and even a differing moral compass, those who are in medicine to make money (and nothing more) operate in stark contrast to those whose altruism—in the form of bettering the health and lives of one's fellow humans while making a respectable living—lies at the core of their very professional existence. This attitude is not unique to medicine; witness the fast food, ultraprocessed food and junk food conglomerates that peddle their health-wrecking wares to a mostly unsuspecting and addicted public.

These disconnects between altruism and money-making for its own sake are, I contend, based on ignorance; ignorance of what it means to truly devote oneself essentially and primarily to the welfare of others. In the case of medical practice, if you were educated and trained in business school to look at medical care merely as a financial opportunity and nothing more, you display a special form of ignorance about the true meaning behind the mission that doctors, nurses and all healthcare workers take upon themselves each day of their working lives. And as wrong, evil and misguided as the murder of UnitedHealthcare CEO Brian Thompson was, there still underlies a casus belli in the minds of many people who feel money-making should never take precedence over the health and welfare of any individual.

Witness this ignorance as it presented itself in the recent attempt by the insurer Anthem to limit anesthesia reimbursement to an arbitrarily set time limit. One must wonder in what universe the people behind the attempt to pull off such a stunt reside. It is hard to know where to begin concerning the "wrongness" of such an effort. The article in January's *Anesthesiology News* summarized it best, quoting the ASA's view that it is merely an "egregious" and "cynical" cash grab.[2] From that article, we read:

"We cannot trust insurers to do right by doctors and patients out of the kindness of their hearts," said Rep. Richard Torres (D-N.Y.). He went on to say: "There is a need for legislation that prevents any insurer anywhere in America from micromanaging the length of anesthesia care in medically necessary surgery."

Consider, also, that there is variation in the rapidity and efficiency with which surgeons perform their work. Dr. A may take two hours and 55 minutes to repair a torn ACL, whereas surgeon B may take one hour and 59 minutes. Who is some bean counter, who has never set foot in an OR and with no knowledge of medicine, to say when to turn off the reimbursement spigot for anesthesia services?

The folks controlling the money at Anthem evidently failed to understand the nuances involved in anesthesia care. A patient with a difficult airway will naturally take much longer to have their airway secured than a patient with an "easy" airway. The establishments of intravenous and arterial access, as well as the placement of central lines and catheters, can take quite a while in some patients, as can the proper performance and setup of peripheral and neuraxial blocks. However, the business school types don't know any of that and clearly don't care. It was only under extreme pressure that they backpedaled their decision (for now) and rescinded the directive.

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According to established sources, physician compensation in general is linked to a concept described as a "CMS work value unit," which refers to the "'work relative value unit,' a component of the relative value unit (RVU) system used by the Centers for Medicare & Medicaid Services (CMS) to determine physician payment based on the time, skill and intensity required to perform a medical service, essentially representing the physician's labor involved in providing that service. It is one of three components of an RVU, alongside practice expense and malpractice expense."[3] Anesthesia compensation is set by CMS using its own set of nuanced formulas.

There is strong input from doctors on a multispecialty committee (RUC, or Relative Value Scale Update Committee) that, along with other professionals, makes recommendations to CMS that eventually formulate the RVUs. It is a complicated process, and I have included the reference if you want to read more about the process.[4]