

# SPHERE

*Quarterly Publication*



NYSSA • The New York State Society of Anesthesiologists, Inc.



**Legislative and Regulatory Advocacy: Giving Members a Voice**

# PGA73

PostGraduate Assembly in Anesthesiology

Fri.-Tues. Dec. 13-17 Marriott Marquis NYC/USA

# 2019

*New York  
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## Inside This Issue:

- 3 President's Message**  
**Educate Your Colleagues About the Benefits of Membership**  
VILMA A. JOSEPH, M.D., M.P.H., FASA
- 5 Editorial**  
**We Are Grateful for Our Volunteers**  
SAMIR KENDALE, M.D.
- 7 From the Executive Director**  
**Healthcare Reform: The Devil Is Always in the Details**  
STUART A. HAYMAN, M.S.
- 11 The NYSSA Government and Legal Affairs Committee: Advocating for All Anesthesiologists**  
JONATHAN S. GAL, M.D., FASA
- 15 Medicare Issues New Guidance on Use of Extrapolation in Audits**  
MATHEW J. LEVY, ESQ., AND  
STACEY LIPITZ MARDER, ESQ.
- 19 Albany Report**  
**Legislative Update**  
CHARLES J. ASSINI, JR., ESQ.
- 26 A Look at the New York State Fair and the NYSSA's Recent Advocacy Efforts**
- 31 Case Report**  
**Minor Details and Major Blood Loss: An Appreciative Inquiry Case Report**  
ARUP DE, M.D., MBA, AND  
LINDSAY GENNARI, M.D.
- 37 Mark Your Calendar for the 17th World Congress of Anaesthesiologists**  
GEORGE SILVAY, M.D., PH.D.
- 43 Resident and Fellow Section**  
**Resident and Fellow Section Introduces New Board Members**  
AMREEN RAHMAN, M.D.
- 47 Membership Update**

# SPHERE

## Editors

Paul M. Wood, M.D. 1948	Vol. 1
Morris Bien, M.D. 1949-1950	Vol. 1-2
Thomas F. McDermott, M.D. 1950-1952	Vol. 2-4
Louis R. Orkin, M.D. 1953-1955	Vol. 5-7
William S. Howland, M.D. 1956-1960	Vol. 8-12
Robert G. Hicks, M.D. 1961-1963	Vol. 13-15
Berthold Zoffer, M.D. (Emeritus) 1964-1978	Vol. 16-30
Erwin Lear, M.D. (Emeritus) 1978-1984	Vol. 30-36
Elizabeth A.M. Frost, M.D. 1985-1988	Vol. 37-40
Alexander W. Gotta, M.D. 1989-1990	Vol. 41-42
Mark J. Lema, M.D., Ph.D. 1991-1996	Vol. 43-48
Douglas R. Bacon, M.D., M.A. 1997-2000	Vol. 49-52
Margaret G. Pratila, M.D. 2000-2006	Vol. 52-58
James E. Szalados, M.D., M.B.A., Esq. 2007-2011	Vol. 59-63
Jason Lok, M.D. 2011-2015	Vol. 63-67
Samir Kendale, M.D. 2016-	Vol. 68-

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Editor:	District
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## President's Message

### Educate Your Colleagues About the Benefits of Membership

VILMA A. JOSEPH, M.D., M.P.H., FASA

As we transition into fall, remember to encourage your colleagues to join the NYSSA. For those in private practice as well as academia, the benefits of membership are considerable.

The PostGraduate Assembly in Anesthesiology (PGA) is a free member benefit that offers continuing medical education credits and an opportunity to participate in workshops (to hone one's skills in things like airway management and ultrasound techniques). In addition, the PGA exhibit hall is a great place to learn about new devices and ask technical questions.

The best part of the PGA is that it is constantly evolving. The format this year has undergone a huge change under the auspices of Drs. Audrée Bendo, Meg Rosenblatt, Linda Shore-Lesserson, and Rose Berkun. The lecture duration has been modified to better retain everyone's undivided attention. There will be dedicated time for lunch and midday symposiums. New topics are being introduced. Overall, the PGA is entering an exciting era.

Other NYSSA member benefits can have a positive impact on physicians both professionally and personally. After receiving American Board of Anesthesiology certification, the next level of distinction for an anesthesiologist is to become a "Fellow" of the American Society of Anesthesiologists (FASA). One of the requirements is to be a member of your state component society (i.e., the NYSSA). All members receive a physician identification badge. NYSSA members are also welcome to attend and present lectures at district meetings. On the NYSSA's website ([www.nyssa-pga.org](http://www.nyssa-pga.org)), members can take the New York state-approved infection control CME course, research various medical missions that are in need of anesthesiologists, and visit the career center. The NYSSA's quarterly publication, *Sphere*, includes articles on interesting topics related to our specialty and is available in hard copy as well as online. Charles Assini Jr., Esq., the NYSSA's legislative representative, offers a free preliminary legal consultation for all NYSSA members as well as lectures on contract negotiation.

The NYSSA also promotes the political interests of anesthesiologists. Important legislative updates/alerts are listed on the website and sent electronically to members. A team of lobbyists and the NYSSA's legislative representative are committed to assuring that state legislators are well-versed on issues that affect our profession. For example, this year we were able to maintain the current scope of practice despite the introduction of legislation that would have benefited nurse anesthetists by allowing them to work in loose collaborative relationships and to bill insurance companies directly. In addition, we introduced legislation on scope of practice that solidifies the New York state health code and restricts the use of the term "anesthesiologist" to those who practice medicine.

On the national level, we sponsor NYSSA members who wish to participate in the ASA's Legislative Conference, where anesthesiologists can speak to federal legislators on issues such as surprise medical billing/out-of-network payments, Centers for Medicare & Medicaid Services reimbursements, resident debt relief, and the ASA's Perioperative Brain Health Initiative.

So when you talk to your colleagues, make sure they are NYSSA members and speak freely about the numerous benefits of membership in the NYSSA. ■

*Thank you*

**NYSSA Supporters**





## Editorial

# We Are Grateful for Our Volunteers

SAMIR KENDALE, M.D.

In this issue of *Sphere*, we continue our journey through the NYSSA committees with a report from the Government and Legal Action Committee. The GLAC, as it is affectionately called, is one of the NYSSA's largest committees, and with good reason: It takes a lot of people to support one of the most prominent and visible parts of the NYSSA mission.

As I mentioned in my editorial in the summer issue of *Sphere*, the goals of the NYSSA are wide-ranging and multifaceted. Because of this, it is essential to the organization that numerous volunteers with a variety of skill sets and backgrounds are involved. It is like building a team or forming a band in that each member has his or her strong suits and talents. Some have excellent organizational abilities and join a committee helping to organize the PGA. Others excel at face-to-face communication and travel to Albany to speak with our legislators. Some are skilled at writing and share their gifts with the Communications Committee. Others wish to share their clinical experience through the Continuing Medical Education Committee or other subspecialty committees. Finally, some have the ability to generate novel ideas or have experience outside of medicine that would prove valuable in any capacity.

Members of the GLAC must always be aware of what is happening legislatively around the state with regard to anesthesiology. They often interface with other state societies as well as national societies. They are responsible for helping to keep the priorities of our specialty known to those who may have considerable influence over what we do every day and how we do it.

These desirable skills are not necessarily unique to our NYSSA teams, but we are always grateful that we have dedicated and capable committee members who keep the NYSSA functioning. If you are reading this editorial or this series of issues about the functions of the NYSSA committees and thinking to yourself, "Hey, I think I would be good at that," or, "Hey, that sounds interesting," I urge you to consider joining an NYSSA committee and sharing your own expertise and perspectives. ■

# NYSSA Delegates to 2019 ASA House of Delegates

All sessions related to the ASA House of Delegates will take place at the Hyatt Regency Orlando (Windemere Ballroom) as follows:

**First Session** 8:00 a.m. — Sunday, October 20, 2019

**Second Session** 8:00 a.m. — Wednesday, October 23, 2019

## **DELEGATES (VOTING)**

1. Dr. Melinda A. Aquino
2. Dr. Audrée A. Bendo
3. Dr. Rose Berkun
4. Dr. David S. Bronheim
5. Dr. Jesus R. Calimlim
6. Dr. Christopher Campese
7. Dr. Michael Eaton
8. Dr. Lawrence J. Epstein
9. Dr. Gregory W. Fischer
10. Dr. Michael J. FitzPatrick
11. Dr. Jonathan S. Gal
12. Dr. Vilma A. Joseph
13. Dr. Jung T. Kim
14. Dr. Tal S. M. Levy
15. Dr. Jason Lok
16. Dr. Elizabeth L. Mahoney
17. Dr. Scott N. Plotkin
18. Dr. Chantal M. Pyram-Vincent
19. Dr. Meg A. Rosenblatt
20. Dr. Daniel H. Sajewski
21. Dr. Steven B. Schulman
22. Dr. Steven S. Schwalbe
23. Dr. Michael B. Simon
24. Dr. Tracey Straker
25. Dr. Lance W. Wagner
26. Dr. Richard N. Wissler

Dr. David J. Wlody — ASA Director, New York State

## **ALTERNATE DELEGATES (NON-VOTING)**

1. Dr. Himani Bhatt
2. Dr. Matthew A. Bresler
3. Dr. Edmond Cohen
4. Dr. Lynn R. Correll
5. Dr. Michael P. Duffy
6. Dr. Melissa A. Ehlers
7. Dr. Julia B. Faller
8. Dr. David S. Fishman
9. Dr. Kevin M. Glassman
10. Dr. Cheryl K. Gooden
11. Dr. Ingrid B. Hollinger
12. Dr. Melissa A. Kreso
13. Dr. Mitchell Y. Lee
14. Dr. Salvatore Mauro
15. Dr. Iyabo O. Muse
16. Dr. Nader Nader
17. Dr. Ketul J. Patel
18. Dr. Sergey V. Pisklakov
19. Dr. Kenneth I. Rosenfeld
20. Dr. Lawrence J. Routenberg
21. Dr. David Seligsohn
22. Dr. Ketan Shevde
23. Dr. Francis S. Stellaccio
24. Dr. Donna-Ann Thomas
25. Dr. Luis E. Tollinche
26. Dr. Rebecca S. Twersky
27. Dr. Ansara Vaz
28. Dr. Salvatore G. Vitale
29. Dr. Stacey A. Watt
30. Dr. Lee H. Winter





**From the Executive Director**

## **Healthcare Reform: The Devil Is Always in the Details**

**STUART A. HAYMAN, M.S.**

With every presidential campaign cycle, we resurrect the debate about our “broken” healthcare system. This means that every presidential candidate must be prepared to discuss his or her ideas regarding the best way to address healthcare reform. As I write this article, there are still more than a dozen candidates vying for the Democratic nomination for president. Some of these candidates are promoting socialized medicine in the form of a single-payer system as the answer. Others are calling for a form of single payer that utilizes our existing government system (i.e., “Medicare for All”). We are also hearing about alternatives such as Medicare buy-in; a combination of public and private or subsidized private options; and reinstating the Affordable Care Act (ACA) as it was originally created.

At the same time we are hearing from Democratic presidential candidates, we are also being told that Senate Republicans are working on their own healthcare solution. Regrettably, we have been hearing this same sound bite from Republicans in the Senate since before the passage of the ACA.

Despite the success of the ACA in reducing the number of uninsured, there remain fundamental problems with the U.S. healthcare system that warrant solutions. According to the Kaiser Family Foundation, as a result of the ACA, “The number of uninsured nonelderly Americans decreased from over 44 million in 2013 (the year before the major coverage provisions went into effect) to just below 27 million in 2016. However, in 2017, the number of uninsured people increased by nearly 700,000 people, the first increase since implementation of the ACA.”<sup>1</sup> Another unfortunate statistic was recently brought to light by the Commonwealth Fund: “Of people who were insured continuously throughout 2018, an estimated 44 million were underinsured because of high out-of-pocket costs and deductibles.”<sup>2</sup> Thus, while the ACA was very successful in many ways, it has not proven to be the panacea many had hoped for.

One of the most significant problems the Affordable Care Act did not address is the lack of price controls on the pharmaceutical industry.

Despite promises from both President Trump and Congress that price gouging would be addressed, no sensible limits have been put on pharmaceutical prices. The most logical assumption is that inaction on this issue is the result of the extreme financial power of pharmaceutical companies and their influence on Capitol Hill. It is estimated that U.S. drug prices are two times higher than comparable drugs in Europe. There are countless stories of U.S. patients who have no choice but to go without needed medications, improperly ration medications, and/or purchase cheaper alternative medications that may not be safe or effective. All of these options put patients' health at substantial risk. Additionally, inflated drug prices are directly correlated with years of preventable health insurance premium inflation.

### **Is a Single-Payer Healthcare System the Answer?**

In April 2019, I attended the annual House of Delegates meeting for the Medical Society of the State of New York. I was very fortunate to hear Dr. Shawn Whatley, a past president of the Ontario Medical Association and the past chairman of emergency services for a regional health center in Toronto, talk about the Canadian single-payer healthcare system. Dr. Whatley is also an accomplished author and a Munk senior fellow at the Macdonald-Laurier Institute in Toronto.

Dr. Whatley summarized the good and the bad associated with Canada's single-payer healthcare. The good includes lower office overhead, only one set of rules to learn since there is only one payer, and doctors need not worry about a patient's ability to pay. On the flip side, however, the bad includes rationed care, lack of access, excessive wait times, care inefficiencies, and mediocrity of care.

Dr. Whatley also discussed the fascination that some U.S. politicians have with the Canadian system. As an example, he identified presidential candidate Sen. Bernie Sanders. Sen. Sanders is a strong proponent of a single-payer, government-run healthcare system. Under Sen. Sanders' proposal, there would be one system for all, meaning that the purchase of additional healthcare services would not be allowed even for those who could afford these services.

In late 2017, Sen. Sanders visited Canada to learn about the Canadian system. This visit, however, was limited to the three top hospitals in very exclusive and affluent neighborhoods in Canada. Apparently, the citizens

in these areas donate hundreds of millions of dollars to supplement these hospitals. Thus, the senator did not receive a balanced view of hospital care in Canada. He didn't see that in the vast majority of hospitals, patients waiting for beds are stranded in crowded hallways. He didn't hear about patients waiting as long as 10 months for tests such as MRIs.

According to Dr. Whatley, practitioners in Canada have known for two decades that, "People with higher socioeconomic status get more care and wait less for it." In his November 6, 2017, blog post "Weekend With Bernie While Canada Waits," Dr. Whatley cited a study published in the *New England Journal of Medicine* that showed that "wealthier patients got 23 percent more heart procedures and had 45 percent shorter wait times than poorer patients, in Ontario." The fact is that single-payer systems such as Canada's do not provide equal levels of care for all their citizens.

Another fact about the Canadian healthcare system that is never mentioned by those touting this solution is the cost associated with a single-payer system. Dr. Whatley cited estimates from the Fraser Institute when stating that while the average cost per person in Canada is \$4,600, "families earning in the top 10 percent pay up to \$40,000 per year."

Like many ideas that are being put forth by our political candidates and elected officials, the devil is in the details. Clearly there are a lot of details about the Canadian system that are being left out of the discussion. While I believe that the vast majority of Americans do wish to see universal healthcare, I don't believe that a Canadian-style single-payer system is the answer. What Canada does provide is a significant amount of data for anyone truly interested in finding a solution that could work in the U.S.

This is a pivotal time for physicians, patients, and the future of medical care delivery in this country. As important stakeholders, you can still make a difference. This discussion should not be driven by legislators and special interests groups, who often fail to consider issues relating to quality or safety. Just as we would not want a system that prioritizes profits over people, we also cannot afford to implement a solution that would result in rationed, substandard care in place of the quality healthcare Americans have come to expect.

Allowing politicians to solve our most pressing healthcare issues without the input of practicing physicians is not acceptable. It is imperative that all NYSSA members read this message as a call to action. It is vital that you

educate and inspire your colleagues and your patients to make their voices heard. I encourage every NYSSA member to get involved in the political process and to support the NYSSA's political activities going forward. At the very least, your financial support of the advocacy efforts undertaken by the NYAPAC and ASAPAC will help ensure that physicians have a seat at the table. ■

#### REFERENCES

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## The NYSSA Government and Legal Affairs Committee: Advocating for All Anesthesiologists

**JONATHAN S. GAL, M.D., FASA**

The Government and Legal Affairs Committee (GLAC) is one of the NYSSA's largest and most active committees. The GLAC chairperson oversees the efforts of as many as 45 additional members, with at least one member from each of the NYSSA's districts. The chairperson serves as an ex-officio member of the NYSSA Executive Committee (with a voice but no vote). In this capacity, he or she is always in contact with the NYSSA's leadership. Additionally, the GLAC chairperson serves as an ex-officio member of the Committee on Economic Affairs.

The mission of the GLAC is to monitor and understand legislation and regulations (at both the state and federal levels) that impact the practice of medicine and, specifically, the specialty of anesthesiology. This is just one part of our mission, however. It is also our responsibility to advocate on behalf of the specialty, the NYSSA members, and our patients. This includes educating and communicating with the membership and our state and federal leaders regarding issues of concern to anesthesiologists. We strive to protect all stakeholders through regulatory and legislative means by working hand in hand with NYSSA and ASA staff, the NYSSA's lobbyist, and the NYSSA's legislative counsel. We are dedicated to supporting and advancing the specialty of anesthesiology and to providing the safest, highest-quality patient care to the citizens of New York state. In addition, the GLAC also considers legal matters pertaining to the specialty that may impact our members. The committee chairperson provides monthly reports to the Executive Committee and biannual reports to the Board of Directors in regard to these matters.

As I write this report, the anesthesia care team remains intact in New York state. Both the New York Assembly and Senate formally adjourned the 2019 legislative session on June 21, with no bills under the umbrella of "safe anesthesia provisions" advancing. This includes bills that pertained to both the title "certified registered nurse anesthetist" as well as those that addressed the specific definition of "scope of practice" in relation to nurse anesthetists.

The NYSSA continues to support and advocate for nurse anesthetists in their effort to gain the title of “CRNA” in New York state; however, we will also continue to insist that the scope of their practice remains as is. While providing nurse anesthetists with this title is important, so is maintaining the safe practice of anesthesiology, which requires nurse anesthetists to practice under physician supervision.

The leaders of the New York State Association of Nurse Anesthetists (NYSANA) have asked to meet with representatives of the NYSSA under the guise of working together to gain CRNA title. At the same time they requested these meetings, however, they were putting out propaganda to their members that disparaged the NYSSA and anesthesiologists while also calling for expanding nurse anesthetist scope of practice.

It is important to understand that it is the goal of the members of NYSANA and the American Association of Nurse Anesthetists (AANA) to practice autonomously, meaning NO physician supervision. It is our position that nurse anesthetist independent practice would put patients at risk. We work in an environment where seconds count. The idea that nurse anesthetists could work “collaboratively” (without any physician supervision and, in some cases, without a physician even required to be present) is not a practice model we could support.



While we are cautiously optimistic about the results of the 2019 legislative session, we also are aware that quite a lot of work is ahead of us. This work begins by learning to navigate the new makeup of the New York state Legislature. The 2018 elections saw the Democratic Party obtaining an even stronger hold on the Assembly and taking over the Senate. This led to an overhaul of Senate committees, starting with their new leadership, and included an almost completely new lineup of legislators on the Assembly Higher Education Committee. We will make a point to engage with these legislators in their districts to ensure they understand the facts related to patient safety and to our issues. Given the risks associated with the delivery of anesthesia, we must work with these legislators to help preserve the physician supervision safety standard, a standard that deserves credit for an increase in positive patient outcomes.

We support this year's version of the safe anesthesia bill, sponsored by Assemblywoman Rodneyse Bichotte and Sen. James Gaughran in the Assembly and Senate, respectively. The bill now includes language that would prohibit the use of the term "nurse anesthiologist" within New York state. Use of this term is part of a nationwide push by the AANA, which has had some success with this effort, namely in New Hampshire and Florida.

For the last two years, the number of NYSSA members participating in our annual Legislative Day in May was the highest it has ever been, resulting in impactful engagement in our issues from leaders in both the Assembly and Senate. The following bills are important to us:

### **SUPPORT**

- A.7100 Bichotte/S.5885 Gaughran — Equal Access to Physician-Led Anesthesia
- A.1154 Stirpi — Identification Transparency for Healthcare Professionals (Photo ID Badge)

### **OPPOSE**

- A.1745 Gottfried/S.2563 Bailey — Collaborative Practice (CRNA)
- A.2898 Gottfried — CRNA Prescription Writing Authority
- A.0176 Cahill — Authorizes Payments by Insurance Companies to Nurse Anesthetists

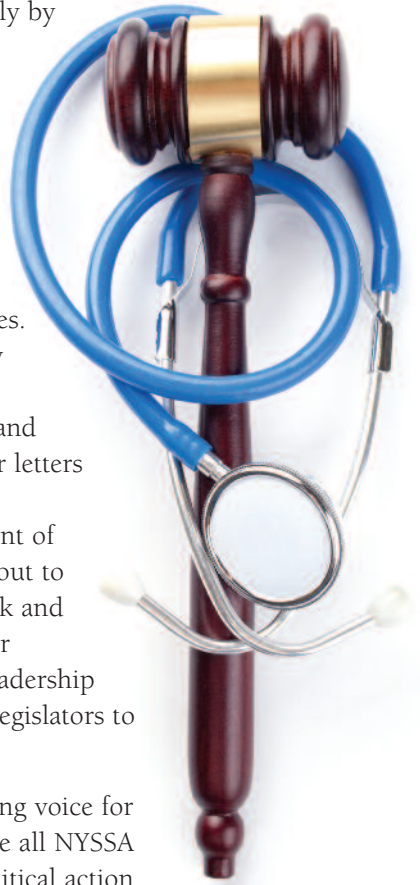
Beyond the legislative arena, the NYSSA GLAC also advocates for members within the private health insurance industry. This year our

advocacy included interacting with Oscar Health and Independent Health Association insurance companies after they put out new clinical guidelines that specifically limit coverage of anesthesia services for healthy patients undergoing endoscopy procedures. These policy changes took effect as of January 1, 2019, for Oscar Health and August 1, 2019, for Independent Health Association. The NYSSA stands by the ASA policy that determinations of medical necessity for anesthesiology services should NOT be made independently by organizations or health insurance plans.

The NYSSA has been working hard to reverse these decisions. We have written to both insurance carriers expressing our strong objections to their making medical decisions. We specifically cited studies that support the efficacy of having an anesthesiologist involved in these procedures. Additionally, we pointed out that these new policies threaten patients' rights, safety and comfort, and they compromise the quality and effectiveness of endoscopic procedures. Our letters were copied to the New York state health commissioner and the deputy superintendent of health insurance. Additionally, we reached out to the Medical Society of the State of New York and individual gastroenterologists to obtain their assistance. A few members of the NYSSA leadership have also been making individual visits to legislators to discuss this issue.

To ensure that we can continue to be a strong voice for New York's anesthesiologists, I strongly urge all NYSSA members to make a contribution to our political action committee, NYAPAC, at [www.nyssa-pga.org/about/donate-to-nyapac](http://www.nyssa-pga.org/about/donate-to-nyapac), and also to the ASA's political action committee, ASAPAC, at [www.asahq.org/advocacy/asapac](http://www.asahq.org/advocacy/asapac). ■

*Jonathan S. Gal, M.D., FASA, is chairman of the NYSSA's Government and Legal Affairs Committee.*





# Medicare Issues New Guidance on Use of Extrapolation in Audits

**MATHEW J. LEVY, ESQ., AND STACEY LIPITZ MARDER, ESQ.**

In today's healthcare climate, many providers have been subject to an audit by the Centers for Medicare & Medicaid Services (CMS) whereby CMS (through one of its contractors) requests a sample of records and subsequently determines that the documentation does not substantiate the codes billed. Accordingly, CMS requests that money previously paid for services rendered be "repaid" by the provider. In some instances, CMS limits the overpayment request to those documents it has actually reviewed; in other instances, CMS takes the amount involved and the corresponding error rate and "extrapolates" that amount to extend over a larger universe of claims spanning several years, resulting in a significantly increased overpayment demand that can be millions of dollars.

While extrapolation certainly does not seem fair, as there is an assumption that the random sample reflects all of a provider's billings regardless of whether the provider changed his or her billing practices, extrapolation has been deemed to be valid, provided contractors use a "statistically valid random sample" and "statistically valid methods." Effective January 2, 2019, CMS provided more details in the Medicare Program Integrity Manual (MPIM) as to when extrapolation is permissible in the calculation of overpayment demands and how its contractors should perform statistical sampling.

CMS historically provided limited guidance with respect to the proper method for extrapolation. As per the MPIM, contractors only had to meet the following six conjunctive requirements: (1) selecting the provider or supplier; (2) selecting the period to be reviewed; (3) defining the universe, the sampling unit, and the sampling frame; (4) designing the sampling plan and selecting the sample; (5) reviewing each of the sampling units and determining if there was an overpayment or an underpayment; and, as applicable, (6) estimating the overpayment.

As per the new guidance, CMS has advised that a contractor shall use statistical sampling when it has been determined that a sustained or

high level of payment error exists (greater than 50 percent or a provider has a history of noncompliance for the same or similar billing issues, or a historical pattern of noncompliant billing practice), or after documented educational intervention has failed to correct the payment error (i.e., through the Targeted Probe and Educate [TPE] program where CMS reviews claims prior to payment).

CMS has also provided additional guidance involving defining the universe, as the MPIM now states that “the sampling frame is the listing of sample units, derived from the universe, from which the sample is selected.” The MPIM has further noted that the universe may include items that are not utilized in the construction of the sample frame.

The revised MPIM also requires the contractor to include a list of all sample units, all universe elements incorporated in the sample units, and the elements of the universe such that the sample units may be reassembled during the replication process.

Contractors are also now required to “maintain all documentation pertinent to the calculation of an estimated overpayment including but not limited to the statistician-approved sampling methodology, universe, sample frame and formal worksheets.”

Under the revised MPIM, contractors must now seek additional approval from CMS prior to issuing a findings letter when the extrapolated overpayment exceeds \$500,000 or an amount that is greater than 25 percent of the provider’s Medicare revenue received within the previous 12 months. In seeking approval, the contractor must provide to CMS for its review a summary of its investigation, prior history, medical review results, and the extrapolated overpayment amount.

Moreover, if during the administrative appeals process claims are reversed from the initial claim determination, contractors are now required to adjust the estimation of the overpayment, which should prevent providers from continuing to be penalized for contractor mistakes that have been previously overturned.

While the new guidance from CMS hopefully will prevent contractors from abusing extrapolation in connection with audits performed on

providers, many providers will still be subject to extrapolation. It is in the best interest of those providers to have the extrapolation methodology reviewed by healthcare counsel and a statistician with experience dealing with CMS overpayments in order to determine if the extrapolation methodology utilized by the contractor is compliant with the new MPIM guidelines and, ultimately, valid. Although the new guidance from CMS provides more potential arguments for statisticians to utilize in challenging the use of extrapolation by contractors, a contractor's failure to comply strictly with these guidelines may not always yield a successful challenge to the extrapolation as per the MPIM. Providers subject to an extrapolated overpayment demand from CMS should still raise these issues in the appeals process, as a successful argument can potentially throw out an extrapolation, resulting in an overpayment demand being significantly reduced.

Should you have any questions regarding audits or the use of extrapolation by CMS, please contact Mathew Levy at 516-926-3320 or [mlevy@weisszarett.com](mailto:mlevy@weisszarett.com). ■

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# Legislative Update

CHARLES J. ASSINI, JR., ESQ.

### NYSSA's 34th Annual Legislative Day in Albany (May 21, 2019)

This year's Legislative Day in Albany included NYSSA members from nearly every district. We greatly appreciate the efforts of these dedicated members to attend this annual event. Based on the strong participation of our members, we were able to schedule appointments with 79 legislators (41 Assembly members and 38 senators) as well as the Assembly Program and Counsel Staff office and the governor's office. Below please find the list of members who registered to attend as well as those who signed in on Legislative Day; we apologize to anyone inadvertently left off this list.

#### **DISTRICT 2**

Dr. Ayesha Arif  
Dr. Giana Bernheim  
Dr. Erica Fagelman  
Dr. Gregory Fischer  
Dr. Jonathan Gal  
Dr. Ingrid Hollinger  
Dr. Sudheer Jain  
Dr. Jung Kim  
Dr. Mark Kim  
Dr. Samantha Lomando  
Dr. Brian Mayrsohn  
Dr. Alexander Mazerov  
Dr. Brittany Reardon  
Dr. Roland Rizzi  
Dr. Ansara Vaz  
Dr. Taylor White

#### **DISTRICT 3**

Dr. David Bronheim  
Dr. Lawrence Epstein  
Dr. Vilma Joseph  
Dr. Joey Mancuso  
Dr. Chantal Pyram-Vincent  
Dr. Dahlia Townsend  
Dr. Matthew Wecksell

#### **DISTRICT 4**

Dr. Ravneet (Sona) Bhullar  
Dr. Robert Eberle  
Dr. Michael FitzPatrick  
Dr. Scott Groudine  
Dr. Adnan Khan  
Dr. Neil Mathur  
Dr. Mercedes Meuli  
Dr. Kimberley Schuller

#### **DISTRICT 5**

Dr. J. Robert Calimlim  
Dr. Pratik Desai  
Dr. Jason Lok  
Dr. Binh Tran

#### **DISTRICT 6**

Dr. Anil Pisharoty  
Dr. Richard Wissler  
Dr. Gregory Yanez

#### **DISTRICT 7**

Dr. Scott Plotkin  
Dr. Robert Semidey  
Dr. Carin Tauriello

#### **DISTRICT 8**

Dr. Christopher Campese  
Dr. Daniel Sajewski  
Dr. Steven Schulman

The involvement of Legislative Day participants this year was critical because of the aggressive lobbying campaign advanced by NYSANA to achieve independent practice. NYSANA’s campaign consists of presenting misinformation to lawmakers. It is imperative to review the memorandum found in the “members only” section of the NYSSA website at [www.nyssa-pga.org/legislativeregulatory-issues](http://www.nyssa-pga.org/legislativeregulatory-issues) titled “Just the Facts – Answering NYSANA Regarding Bill A.7100 (Bichotte)/S.5885 Gaughran Equal Access to Safe Anesthesia.”

NYSANA continues to advocate for enactment of legislation that would permit independent practice for nurse anesthetists — the nurse anesthetist collaboration bill A.1745 (Gottfried)/S.2563 (Bailey). NYSSA’s “grassroots” lobbyists proved again to be of great value because neither bill advanced prior to the end of this year’s legislative session.

Our primary message to lawmakers and their staffs has been to support equal access to physician-led or supervised anesthesia care through the bills introduced by Assemblywoman Rodneyse Bichotte (A.7100) and Sen. James Gaughran (S.5885). We greatly appreciate their leadership in sponsoring this legislation, which preserves the existing safe anesthesia standard. Despite advances in medicine, every procedure and surgery has risks. Given the risks associated with the delivery of anesthesia, we must preserve equal access to physician-led or supervised anesthesia care for all New York patients, which significantly increases the likelihood of positive patient outcomes and can mean the difference between life and death for some patients.

### **Key Points**

- Defeat proposals that remove the physician anesthesiologist from the treatment team, including peri-operative assessment of a patient, preparation of an anesthetic plan, and post-anesthesia care, which is the current statewide requirement that a physician anesthesiologist must either administer anesthesia or supervise a nurse anesthetist (or the operative surgeon must accept responsibility for supervising the nurse anesthetist).
- Defeat proposals creating a two-tier anesthesia delivery system. Without a statewide uniform requirement as it currently exists, hospitals will be free to permit nurse anesthetists to administer anesthesia independently — a decision that would be based on economic considerations and would result in a two-tiered healthcare system.
- Defeat proposals that allow nurse anesthetists broad prescriptive writing authority — at a time when New York state is combating a prescription drug and opioid abuse crisis, it defies common sense to give more than 1,240 nurse anesthetists unrestricted prescriptive authority.

- The current physician-led supervision safety requirement contained in the New York health code is consistent with coordinated, team-based care, including the anesthesia care team, one of the most common, safest, and most cost-effective ways anesthesia care is delivered in New York.

- By granting nurse anesthetists independent practice, healthcare costs will increase. Independent studies have shown that the odds of an adverse outcome are 80 percent higher when anesthesia is provided only by a nurse anesthetist as opposed to a physician anesthesiologist. Adverse outcomes lead to higher costs for patients in both monetary and physical terms when patients require longer hospital stays. Because nurse anesthetists are not qualified to make medical evaluations and judgments, the need in the pre- and post-anesthesia periods for additional consultations and laboratory testing by physician specialists is more likely than when a physician anesthesiologist is involved.

All materials can be found on the “members only” section of the NYSSA website at [www.nyssa-pga.org/legislativeregulatory-issues](http://www.nyssa-pga.org/legislativeregulatory-issues) under the heading “NYSSA’s Annual Legislative Day in Albany 2019.” Following is a list of some of the documents that are available:

1. Memo in support of Bichotte/Gaughran equal access to physician-led or supervised anesthesia care bills (A.7100/S.5885).
2. Memo in opposition to nurse anesthetist collaboration bills A.1745 (Gottfried)/S.2563 (Bailey).
3. Memo in opposition to patient privacy protection bill A.2370 (Dinowitz).
4. Tri-fold brochure outlining issues of importance and memos in support and opposition.

In view of the foregoing developments, as well as other bills listed in the trifold brochure (found online), your involvement in our governmental advocacy plan is essential. As such, if you are scheduling a district meeting in the near future, please consider:

- Updating your district on these initiatives and inviting Stuart Hayman, Bob Reid, or me to address your district.
- Reviewing the NYSSA website for information, including supporting and opposing memorandums on legislation.

### **2019 End of Session Health/Mental Hygiene Update (June 28, 2019)**

I wish to thank Reid, McNally & Savage, the NYSSA’s Albany lobbyists, for providing the following information:

While there were 935 bills passed by both houses this session, outlined below is a summary of the measures advanced by both houses of the Legislature

relating to the health and mental hygiene sectors. Most still require action by the governor before taking effect, as noted in the summaries below.

## **Physician/Health Professionals**

### **Risk Management Course (S.3158 Ramos/A.568 Paulin)**

Provides for a premium reduction for physicians and licensed midwives who complete a risk management strategies course in obstetrics. This bill passed both houses in June but has not yet been delivered to the governor.

### **Professional Certification of Doulas (S.3344B Ramos/A.364B Paulin)**

Authorizes the professional certification of doulas. Defines doula services as continuous emotional and physical support provided throughout labor and birth and intermittently during the prenatal and postpartum periods. This bill passed both houses but has not yet been delivered to the governor.

### **Loan Repayment (S.4269 Rivera/A.5425 Gottfried)**

Directs the Department of Health to form a work group to assess the impact of requiring individual applicants for grants from the Doctors Across New York physician loan repayment and physician practice support programs to use New York's Grants Gateway, the online grant application and contract management system. This bill passed both houses but has not yet been delivered to the governor.

### **Consent for Pelvic Exams (S.1092E Persaud/A.6325C Solages)**

Prohibits the performance of a pelvic examination on an anesthetized or unconscious person who has not provided consent for such examination. This bill passed both houses but has not yet been delivered to the governor.

### **Informed Consent (S.3353 Ramos/A.4988 Paulin)**

Creates a new section of public health law stating that in the case of any healthcare procedure or examination, the fact that the procedure or examination is performed in the course of education or training does not diminish the requirement for informed consent for the procedure or examination. This bill passed both houses but has not yet been delivered to the governor.

### **License Revocation for Loss of Consciousness (S.5225A Gounardes/A.4751A Carroll)**

Builds on existing protections in the law by directing the Department of Motor Vehicles (DMV) to immediately deny or suspend the license of any person about whom the DMV has received evidence of loss of consciousness pending a hearing if the applicant or licensee requests one. This bill passed both houses but has not yet been delivered to the governor.



### **Closure of Health Provider's Office (S.5367 Comrie/A.2349 Perry)**

Includes requirements for the transfer of patient medical records (including access to records by the patient) upon closure of a healthcare provider's office. This bill passed both houses but has not yet been delivered to the governor.

### **Liability Exposure (S.6081 Hoylman/A.2372 Dinowitz)**

Requires a non-settling co-defendant in a tort action to choose whether to reduce his or her liability exposure by the stated settlement amount or the settling tortfeasor's equitable share prior to the first opening statements of the trial. This bill passed both houses but has not yet been delivered to the governor.

### **Recovery Against Third-Party Defendant (S.6552 Skoufis/A.2373 Dinowitz)**

This bill would permit a plaintiff to bypass the defendant he or she sued to collect a judgment from a third-party defendant who or which has been sued by the defendant for contribution or indemnification as a result of the underlying action. This bill passed both houses but has not yet been delivered to the governor. (Please see the bill and introducer's memorandum in support found in the "members only" section of the NYSSA website at [www.nyssa-pga.org/legislativeregulatory-issues](http://www.nyssa-pga.org/legislativeregulatory-issues) under "Recovery Against Third-Party Defendant [S.6552 Skoufis/A.2373 Dinowitz].")

### **Orders Not to Resuscitate (S.4841 Rivera/A.1162A Gottfried)**

This bill would add physician assistants to the list of healthcare professionals authorized to act in relation to orders pertaining to life-sustaining treatments and orders not to resuscitate. This bill would also allow physician assistants to make capacity determinations for purposes of witnessing and implementing healthcare proxies. This bill passed both houses but has not yet been delivered to the governor.

### **Professional Qualifications for Eye Dilation (S.4469B Stavisky/A.3822D McDonald)**

Establishes qualifications for allied eye care providers to be authorized to administer dilating/anesthetic eye drops under the supervision of an ophthalmologist or optometrist. An individual shall meet the following criteria to be eligible: must be over the age of 18; must be under the supervision of a physician; must complete a curriculum and examination approved by SED demonstrating the requisite experience to instill dilating eye drops. This bill passed both houses but has not yet been delivered to the governor.

**Medical Malpractice Exemption Extensions (S.6547 Breslin/A.8345 Lavine)**

Extends exemptions from risk-based-capital requirements for medical malpractice insurers until December 31, 2022. This bill passed both houses but has not yet been delivered to the governor.

**Central Venous Line Care (S.474 Carlucci/A.212 Galef)**

Requires that the caregiver of a patient with a central venous line be consulted prior to patient discharge regarding his or her capabilities and limitations in administering medications and providing proper venous line care. This bill passed both houses but has not yet been delivered to the governor.

**Technical Corrections to Out-of-State Physician Practice Permission Statute (S.1276 Funke/A.2634 Cusick)**

This legislation is a chapter amendment that makes changes to provisions of L.2018, c.519, to clarify provisions relating to disciplinary and regulatory authority over physicians practicing medicine in New York state if they are licensed to practice in another state or territory. This bill was passed in March but has not yet been delivered to the governor.

**Prohibits Patient Health Information From Being Sold by Emergency Service Providers (S.4119 Liu/A.230 Braunstein)**

Provides that no ambulance or advanced life support first response service can sell, disclose, transfer, exchange or use any protected patient information such as name, address, prescriptions, and medical history to any person or entity for the purpose of marketing. Allows the collection, use, transfer, or sale of patient data by zip code, geographic region, or medical specialty for marketing purposes provided it does not contain individual identifying information. This bill passed both houses but has not yet been transmitted to the governor. ■

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and Susan Samudre



SUNY Upstate volunteers  
Drs. David Do (left) and  
Shaigan Iqbal

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Dr. Rose Berkun and U.S. Rep. Tom Reed (New York)



U.S. Sen. Cory Gardner (Colorado) and Dr. Rose Berkun



Dr. David Meyers, New York state Sen. Michael Ranzenhofer, Dr. Rose Berkun, and Dr. Scott Plotkin



(Left to right) U.S. Rep. Brian Higgins (New York), Dr. Rose Berkun, and New York state Sen. Timothy Kennedy

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## Case Report

# Minor Details and Major Blood Loss: An Appreciative Inquiry Case Report

ARUP DE, M.D., MBA, AND LINDSAY GENNARI, M.D.

*This is the third case report in a new Sphere series. We hope that these case reports and discussions will encourage other medical systems to consider reevaluation of their focus in the QA process.*

Appreciative Inquiry (AI) is a method of change management that has been utilized in the business world for some time.<sup>1,2</sup> We have highlighted an AI approach to challenging cases in previous issues of *Sphere*.<sup>3,4</sup> Instead of internalizing blame for bad outcomes, the fundamental belief in AI is that work systems (organizations, personnel, anesthesia care teams) are inherently good and driven to become better. AI recognizes that there is enormous talent, energy and drive within the core of a care team, and through selective recognition and focus on the “good,” the team can become even better. Recent articles in the surgical literature have highlighted the extent to which teamwork and cooperation across the perioperative care team can result in improvements in team morale and anesthesia provider performance, along with better 30-day surgical outcomes such as reductions in both length of stay and postoperative wound infections.<sup>5,6</sup> The quest to elevate care delivery and the perioperative patient experience moves from the Morbidity and Mortality conference perspective — “What have we done wrong?” — to the AI view — “What can we do even better and how can we do that as a high-functioning team?” It is a positive, energizing process. If a monthly AI conference existed to recognize stellar outcomes, it would likely be called “Positivity and Praise.” We present the following case from the AI perspective.

## Case Report

A 32-year-old G4P3 female was scheduled for her fourth repeat cesarean section at 36 weeks gestation. The obstetric and anesthesia teams were aware of the patient’s anterior placenta percreta and that the possibility of gravid hysterectomy was high. The patient was also noted to have baseline anemia with a hematocrit of 28 percent. Due to the high likelihood of significant blood loss secondary to placental invasion into the uterine wall, the patient was cross-matched for six units of packed red blood cells.

The anesthesiologist reviewed the patient's complete prenatal medical record and noted her blood type to be O+. Prior to bringing the patient back to the operating room, the anesthesiologist checked the electronic medical record to confirm that the patient had a current cross-match and that blood was available. The electronic medical record listed the patient's blood type as B+, as well as the number of units that were available. Noting this disparity, the anesthesiologist confirmed with the patient, who was very knowledgeable about her medical history, that her blood type was indeed O+. The obstetrician was notified that there was a discrepancy and agreed to delay the surgery until blood was available due to the high likelihood of intraoperative hemorrhage.

Upon notification by the anesthesiologist, the director of the blood bank immediately retested the sample and determined that the patient's blood type was O+, as originally listed in the prenatal record. It was concluded that the technician had manually entered the wrong blood type into the electronic medical record. If the error had not been caught, the wrong blood products would have been made available and transfused to the patient. Appropriate blood products were prepared, and the patient was brought to the OR.

Intraoperatively, the patient had significant blood loss, requiring eight units of packed red blood cells, eight units of fresh frozen plasma, two units of platelets and one unit of cryoprecipitate. She remained hemodynamically stable throughout the delivery and gravid hysterectomy. Her postoperative course and discharge to home were uneventful.

## **Discussion**

Blood transfusion plays a critical role in the management of severe intraoperative hemorrhage. The risk of hemolytic transfusion reaction secondary to immunologic mismatch between a transfusion recipient and blood donor's red blood cells (RBCs) is small, but not zero. Acute hemolytic transfusion reactions typically occur early during the transfusion, even after the administration of just a few milliliters, or occur within 24 hours post transfusion. Reactions can also be delayed. Delayed reactions are those that occur more than one day following completion of the transfusion and typically occur one to two weeks following transfusion.

The prevalence of acute hemolytic transfusion reactions (AHTRs) has been estimated at approximately one in 70,000 per blood product transfused.<sup>7</sup>

In a report of transfusion-associated deaths in the U.S. from 1976 to 1985, acute hemolysis was the most common cause of death. There were 158 fatalities from AHTRs, 26 fatalities from delayed HTRs (DHTRs), and six fatalities from non-immune hemolysis. Of the AHTRs, 131 (83 percent) were due to ABO incompatibility errors, mostly involving a group O recipient who received non-group O blood.<sup>8</sup> The likelihood of a fatal AHTR is approximately one in 1,972,000 (five per 10 million) per RBC unit.<sup>9</sup>

AHTR is a medical emergency that requires immediate cessation of the transfusion, if still in progress. If suspected, interventions to reduce the risks of serious organ damage to the patient should take place immediately. The initial goals are to determine if hemolysis has occurred, to distinguish among possible causes, and to stabilize the patient. Immediate steps include stopping the transfusion, providing hemodynamic support, and contacting the transfusion service to help with evaluation. The remaining blood and tubing should not be discarded so it may be retested.

The most common cause of AHTR is after RBC transfusion with ABO blood group incompatibility due to clerical error. This was the situation in the case presented above.

ABO-associated AHTRs often occur during the early minutes of the transfusion, although they may not be immediately appreciated, especially if the patient is under anesthesia. An ABO-associated AHTR may be suspected when a patient develops chills, fever, hypotension, hemoglobinuria, renal failure, back pain, or signs of disseminated intravascular coagulation (DIC). The serum or urine may be pink due to the presence of free hemoglobin. In a patient under anesthesia or in a coma, oozing from venipuncture sites due to DIC or change in the urine color to red or brown due to hemoglobinuria may be the only finding.<sup>7</sup>

Some HTRs are preventable, including those due to misidentification of the patient or blood product (such as due to clerical error). Others may be impossible to prevent, such as those due to a low level or weak alloantibody that does not reach the limits of detection on pretransfusion testing.

For further investigation of an acute HTR, a patient's blood sample drawn after transfusion and the blood bag with the remaining donor blood (and the administration device attached) have to be sent to the laboratory. Also, the patient's pretransfusion blood sample and the donor's blood sample

(tube segment) used for the cross-match before transfusion are needed for a complete evaluation. The evaluation of a suspected adverse transfusion reaction should not be performed by the same technician who did blood grouping and cross-match before the transfusion (to avoid repetition of any mistakes). The next step is to check the identity (at least by testing ABO and D) of the patient's pre- and post-transfusion blood samples as well as of the donor's blood from the blood bag and the sample used for cross-match (in the case of an RBC transfusion). If there has been an error in the patient's identification or a sample mix-up or mislabeling of the blood unit, it must be checked at once to determine whether another patient is also at risk of receiving an incorrect blood product. All false results or records must be revised immediately to avoid further errors.<sup>7</sup>

The importance of a respectful team environment and shared understanding of patient goals cannot be overstated. As Cooper et al. demonstrated in their analysis, the daily subjugation of anesthesia staff to behaviors that are rude, dismissive and aggressive resulted in quantifiably worse patient outcomes over a 30-day study period.<sup>5</sup> In recent simulation studies, anesthesia residents subject to a hostile perioperative environment performed poorly on basic patient care tasks in the operating room. These tasks included placement of additional intravenous access and bolusing fluids as needed in the initial management of ongoing surgical blood loss.<sup>6</sup> In the case presented above, the obstetrician was involved and supportive; it is all too easy to imagine a surgeon becoming unpleasant when told that an issue involving the blood bank will likely cause an operative delay.

The anesthesiologist's vigilance was a major factor in the prevention of a severe transfusion reaction in the already challenging scenario presented above. The patience and understanding of the obstetrician to delay the case until proper blood unit allocation was obtained also ensured the safety of the patient. Due to this specific incident, a policy change was made at our institution, requiring two technicians to verify a patient's blood type before entry into the medical record. This simple process change now provides an extra layer of protection for our patients who may require blood transfusions.

From an AI perspective, communication between professionals, mutual respect and shared goals prevented a potentially life-threatening emergency for this patient. By focusing not on production pressures but, instead, on a systemic commitment to patient safety, the healthcare team ensured a good

patient outcome in this case and set an example for unusual cases in the future. We can be hopeful that our colleagues in the obstetrical suites, operating rooms, and non-OR locations will read and internalize the evolving literature that stresses the importance of respect and collegiality through all professional interactions. ■

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# Mark Your Calendar for the 17th World Congress of Anaesthesiologists

GEORGE SILVAY, M.D., PH.D.

The next World Congress of Anaesthesiologists (WCA) will take place September 5-9, 2020, in Prague, Czech Republic.

## History

After the Second World War, anesthesiologists sought to develop international meetings in order to exchange professional experiences and bring the best practices to their colleagues. As time passed, travel became easier, spurring the desire and ability for anesthesia professionals to meet and learn from colleagues around the world.

In 1955, the first World Congress of Anaesthesiologists was held in Scheveningen in the Netherlands. At the conclusion of the educational meeting, the World Federation of Societies of Anaesthesiologists (WFSA)

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was formed. The original 26 societies represented were: Argentina, Austria, Australia, Belgium, Brazil, Canada, Chile, Colombia, Cuba, Denmark, Finland, France, Germany, Great Britain and Ireland, India, Israel, Italy, Netherlands, Norway, Portugal, South Africa, Spain, Sweden, Switzerland, Uruguay, and Venezuela. Additionally, there were 16 countries that participated as observers. The original participating countries agreed the federation should be “exclusively educational, scientific, and charitable in nature” and “to make available the highest standards of anaesthesia, pain medicine, trauma management, resuscitation, and preoperative/critical care medicine to all peoples of the world and to disseminate the same amongst them.”

The WFSA has educational meetings every four years. Since its inception, the number of member societies has grown from 26 in 1955 to 134 in 2016. The WFSA leadership has worked to hold the Congress all around the world:

- 1960 Toronto, Canada (36 societies participated)
- 1964 São Paulo, Brazil (47 societies participated)
- 1968 London, England (59 societies participated)
- 1972 Kyoto, Japan (65 societies participated)
- 1976 Mexico City, Mexico
- 1980 Hamburg, Germany
- 1984 Manila, Philippines
- 1988 Washington, D.C., United States
- 1992 The Hague, Netherlands
- 1996 Sydney, Australia
- 2000 Montreal, Canada
- 2004 Paris, France
- 2008 Cape Town, South Africa
- 2012 Buenos Aires, Argentina

The 16th World Congress of Anaesthesiologists (WCA) was held in Hong Kong in 2016. There were 134 societies participating and more than 9,000 delegates. The WCA serves as a benchmark for the best clinical practice in anesthesiology and aims to be inclusive on an educational, research, logistical and financial basis for all participants.

The 17th Congress of the WFSA will be held in Prague, the capital and largest city of the Czech Republic. Prague is the 14th-largest city in the European Union. It is also the historical capital of Bohemia, situated in the



north-west of the country on the Vltava River. The city is home to about 1.6 million people, while its metropolitan area is estimated to have a population of nearly two million. The city has a temperate oceanic climate with warm summers and chilly winters. Prague is divided by the Vltava River. Nicknamed “the City of a Hundred Spires,” it’s known for its Old Town Square, the heart of its historic core, with colorful baroque buildings, Gothic churches and the medieval Astronomical Clock, which gives an animated hourly show. Completed in 1402, pedestrian Charles Bridge is lined with statues of Catholic saints. The first university in Central, Northern and Eastern Europe was founded in 1348 and is now called Charles University, the oldest Czech university. The 17th century is considered the Golden Age of Jewish Prague. The Jewish community of Prague numbered some 15,000 people, making it the largest Ashkenazic community in the world and the second largest Jewish community in Europe.

The WFSA Congress location will be in the new multifunctional cultural and congress center O2 Universum: Českomoravská 190 00 Prague 9 – Vysočany, Czech Republic. Web: [www.o2universum.cz](http://www.o2universum.cz)

The “program at a glance” is available on the website [www.wcaprague2020.com](http://www.wcaprague2020.com).

A few good things to know if you are attending:

The Czech Republic uses a 220 volt 50Hz system; sockets have the European standard and plugs are three-prong grounded.

The city has public transportation, but you must have a valid ticket prior to boarding. Every registered participant will receive a free public transportation ticket for the duration of the Congress.

The official currency of the Czech Republic is the Czech Crown = Česká koruna (CZK = Kč), which is subdivided into 100 hellers (h). International credit cards are accepted for payment in most hotels, restaurants and shops. Exchange offices and ATM machines are easily available throughout the city and at the Prague International Airport. Payment in cash in EUR is also available in some restaurants and shops; please ask for details on-site. You can find the official exchange rates on the website of the Czech National Bank.

Although English is spoken in all hotels, shops and restaurants in Prague, below are a few basic Czech words and sentences that can be useful during your stay:

## Translations

Ahoj — Hi.

Dobrý den — Hello.

Dobrý večer — Good evening.

Dobrou noc — Good night.

Jak se máte? — How are you?

Mám se dobře — I am fine.

Děkuji — Thank you.

Kolik to stojí? — How much is it?

## Language of the WCA 2020

The official language of the WCA 2020 is English. Translation services will not be provided.

## Shopping

Most shops in Prague are open from 9 a.m. to 6 p.m. Monday through Saturday. Shops in the city are usually open from 9 a.m. to 8 p.m.

Monday through Sunday. ■

*George Silvay M.D., Ph.D., is a professor in the Department of Anesthesiology, Perioperative and Pain Medicine at the Icahn School of Medicine at Mount Sinai in New York.*



**The Anesthesiology Foundation of New York (AFNY) is a 501(c)(3) nonprofit organization whose mission is to improve patient care around the world.**

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**AFNY provides PGA-related scholarships** to anesthesiologists from the developing world who wish to refine their delivery of safe, modern anesthetic care. During the past 26 years, more than 400 anesthesiologists representing 65 countries have enhanced their education and training thanks to the generosity of the NYSSA and its members.

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Stony Brook **Medicine**

# Stony Brook Anesthesiology Alumni Cocktail Reception

Saturday, December 14, 2019  
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## **Marriott Marquis**

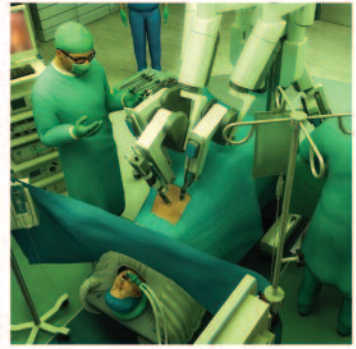
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O'Neill Room - 4th Floor

All Stony Brook current and  
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**Please send your current mailing and email addresses to:  
[SBUH\\_anesthesia\\_alumni@stonybrookmedicine.edu](mailto:SBUH_anesthesia_alumni@stonybrookmedicine.edu).**

**We will send you a small gift and add you to the department's  
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**Visit the Anesthesiology Department Alumni Home Page -  
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This activity contributes to the patient safety CME requirement for Part II: Lifelong Learning and Self-Assessment of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program<sup>®</sup> (MOCA<sup>®</sup>), known as MOCA 2.0<sup>®</sup>. Please consult the ABA website, for a list of all MOCA 2.0 requirements.

This activity contributes to the Part IV: Improvement in Medical Practice requirement of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program<sup>®</sup> (MOCA<sup>®</sup>), known as MOCA 2.0<sup>®</sup>. Please consult the ABA website, for a list of all MOCA 2.0 Part IV requirements and their associated point values.

**Accreditation and Designation Statements:**

The American Society of Anesthesiologists is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The American Society of Anesthesiologists designates this enduring material for a maximum of 5 AMA PRA Category 1 Credits<sup>™</sup>. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



The New York State Society of Anesthesiologists, Inc.

## Residents *and* Fellows

### Resident and Fellow Section Introduces New Board Members

**AMREEN RAHMAN, M.D.**

The NYSSA Resident and Fellow Section (RFS) recently elected new board members for the 2019-2020 academic year. Outgoing president Dr. Cheng-ting Lee graduated from residency at Columbia and is now pursuing a pediatric anesthesiology fellowship. Dr. Erica Fagelman, CA-3 at Mount Sinai, who previously served as president-elect, is the new RFS president. Filling the president-elect vacancy is Dr. Mena Abdelmalak, a rising CA-2 at Mount Sinai. Dr. Britney Reardon from Mount Sinai West and Mount Sinai St. Luke's, who served on the board last year, will continue her commitment to the RFS this year by serving as secretary.

The Resident and Fellow Section plans to continue the tradition of hosting a New York State Conference for Anesthesiology Residents and Fellows (NYSCARF) during the PGA. The event this year will consist of lectures and interactive workshops that span academic and legislative topics and will culminate in a social hour where we will again raise funds for the NYSSA's political action committee (NYAPAC). The RFS aims to foster connections among all New York state anesthesiology residents and fellows. Last year, the newly matched intern brunch was a great success; it will be held once again in the spring for anesthesiology interns starting residency in 2020.

The RFS is also planning on hosting a CA-1 social to bring together new CA-1s as they start their clinical anesthesiology years. Another central goal this year is to host more opportunities for residents and fellows to familiarize themselves with the legislative process in New York. We want to educate our members on the important roles that physicians play in influencing policy outcomes. Our new event coordinators this year who

will be spearheading the above plans are Drs. Matt Stratton (NYU), Mark Kim (Mount Sinai), Ayesha Arif (MSW and MSSSL), and Pamela Chavero (Columbia). Our social media manager, Dr. Samantha Lomando (MSW and MSSSL), will be updating the official Instagram page, @nyssa\_rfs, for those interested in getting the most up-to-date information on RFS happenings and attending future events.

A new board position this year is that of ASA and AMA liaison. This position has been filled by Dr. Brian Mayrsohn (Mount Sinai), who has been heavily involved in the AMA prior to his role in the NYSSA Resident and Fellow Section. Of course, we must not forget our fellows: Dr. Morgan Montgomery, current cardiac anesthesiology fellow at Mount Sinai, and Dr. Greg Yanez, current pain management fellow at NYU, will be the fellow liaisons for the year. The RFS board is looking forward to working closely with the NYSSA toward the overarching goal of furthering the field of anesthesiology both academically and politically. ■

*Amreen Rahman, M.D., is an anesthesiology resident (PGY-3) at Mount Sinai.*



# Residents *and* Fellows

## Publish Your Case Report in *Sphere*

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- Are you interested in building your CV?**

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**Subject:**  
**Article for Sphere**

**Submit your case report for publication in *Sphere*.**

**All cases will be reviewed and the most interesting will be published.**

**If you have questions, email Lisa O'Neill at [lisa@nyssa-pga.org](mailto:lisa@nyssa-pga.org)**



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*Directors:* George Silvay, M.D., Ph.D., Menachem Weiner, M.D., Marc Stone, M.D.

## St. Kitts Marriott Resort, St. Kitts, West Indies January 19-24, 2020

Oral presentation of interesting & complex cases for residents, fellows and junior attendings.

For abstract information contact: Email: [menachem.weiner@mountsinai.org](mailto:menachem.weiner@mountsinai.org)  
Deadline: October 30, 2019

For information for faculty: [george.silvay@mountsinai.org](mailto:george.silvay@mountsinai.org)  
For general information: [margorie.fraticelli@mountsinai.org](mailto:margorie.fraticelli@mountsinai.org)  
Symposium website: [www.clinicalupdateinanesesthesiology.org](http://www.clinicalupdateinanesesthesiology.org)



**New or Reinstated Members  
April 1 – June 30, 2019**

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Geraldine Diaz, D.O.  
Roman Lorin, M.D.  
Ricky Zegelstein, M.D.

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Ajay Dharmappa, M.D.  
Caitlin Guo, M.D.  
Dewan Haque, M.D., M.B.B.S.  
Genewoo Hong, M.D.  
Matthew Lee, M.D.  
Christian Mabry, M.D.  
John Mendiola, M.D.  
Roni Mendonca, M.D.  
Shairko Missouri, M.D.  
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Suzette Singh, M.D.  
Katerina Tellier, M.D.

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Chitra Raghavan, M.D.  
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Jennifer Wisotsky, M.D.

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Steven Kaplan, M.D.

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Dhananjaya Kamiseti, M.D.

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Avishai Neuman, M.D., FASA

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Cecilia Leatham, M.D.  
Roman Shulkin, M.D.

**DISTRICT 2**

Samantha Lomando, M.D.  
Jayme Sack, M.D.

**DISTRICT 3**

Kristina Pavliak, D.O.

**New or Reinstated Members  
April 1 – June 30, 2019**

**Resident Members** *continued*

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John Dawson, M.D.  
Avneet Gujral, D.O.  
Nikita Hansen, M.D.  
James Lee, M.D.  
Parth Patel, D.O.

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Mohan Ramdas, M.D.

**DISTRICT 8**

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**DISTRICT 3**

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Venkata Ponakala

**DISTRICT 8**

Manuel Arias Bohorquez

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**DISTRICT 8**

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## 2019



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**Go to [www.pga.nyc](http://www.pga.nyc) and register today!**

## Participate in the Democratic Process

You have an opportunity to voice your opinions on positions and policies of the New York State Society of Anesthesiologists at the annual Reference Committee Hearing, which is open to the membership at large.

### REFERENCE COMMITTEE

Saturday, December 14, 1:45 p.m., Marquis Ballroom (9th floor)  
Reviewing: Officers and Directors reports; Bylaws & Rules; Communications; Government & Legal Affairs; Economic Affairs; Patient Safety and Quality Improvement; Pain Management; Critical Care Medicine; Judicial & Awards; Annual Sessions; Continuing Medical Education & Remediation; Academic Anesthesiology; and Retirement committee reports.

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All Officer, Director, Standing Committee, and Board of Directors' reports are subject to review by a panel of your peers and are discussed at this open forum.

Please come to listen, learn, and, if you wish, to speak. Here's your chance to have a direct impact on the decision-making processes that will steer the New York State Society of Anesthesiologists into the future.

For additional information, contact Stuart A. Hayman, executive director, at NYSSA headquarters.



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This course was developed by Medcom, Inc., in association with Elliott S. Greene, M.D., professor of anesthesiology, Department of Anesthesiology, Albany Medical College, and Richard A. Beers, M.D., professor of anesthesiology, SUNY Upstate Medical University, and the NYSSA, thanks to an unrestricted educational grant from New York state.

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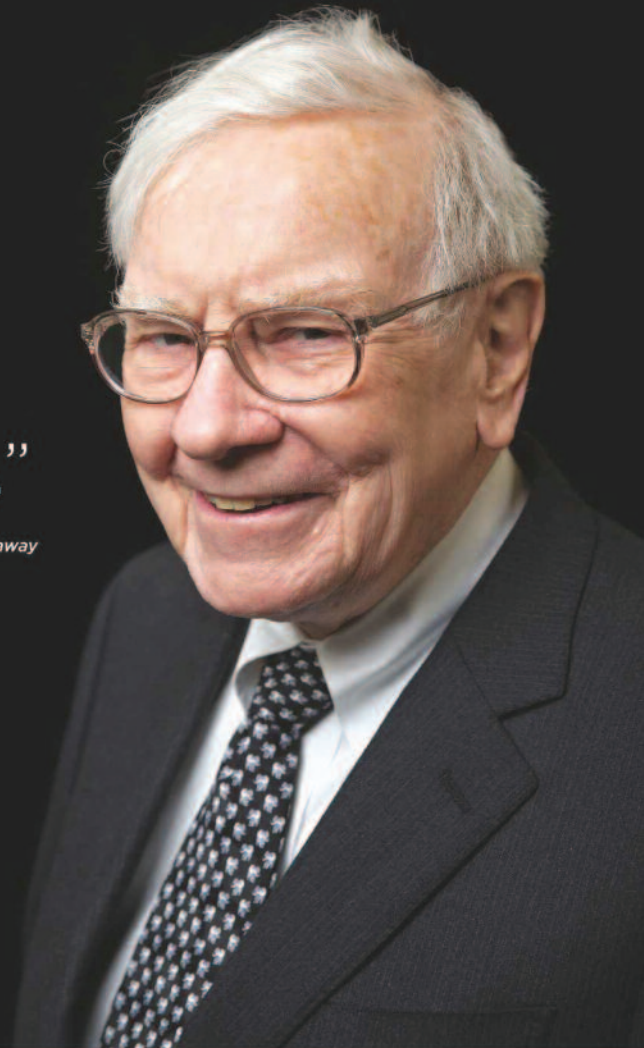
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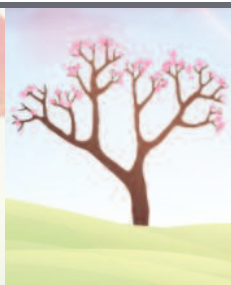


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