

# THE SMART ANESTHESIA GROUP'S GUIDE TO DEFENDING A PAYER AUDIT

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Anesthesia groups currently find themselves in the uncomfortable position of being a target of the Office of Inspector General (OIG) of the Department of Health and Human Services, the largest inspector general's office in the federal government, with approximately 1,600 people dedicated to combating fraud, waste and abuse in government programs, including Medicare. The OIG's duties are carried out through a nationwide network of audits, investigations and inspections.<sup>1</sup> The current OIG Work Plan includes two ongoing anesthesia issues:



1. **Anesthesia Modifiers:** "Physicians must report the appropriate anesthesia modifier code to denote whether the service was personally performed or medically directed (Centers for Medicare and Medicaid Services, Medical Claims Processing Manual, Pub. No. 10004, Ch. 12, § 50). Reporting an incorrect

service code modifier on the claim as if services were personally performed by an anesthesiologist when they were not will result in Medicare paying a higher amount. The service code "AA" modifier is used for anesthesia services personally performed by an anesthesiologist, whereas the "QK" modifier limits

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# ANESTHESIA IN AN ERA OF SCRUTINY: LEARN, PLAN AND PREPARE TO APPEAL

That healthcare has been—and remains—in an extended period of heightened scrutiny is not news to anyone in the sector as a whole or anesthesia in particular. While Health and Human Services Secretary Tom Price, MD, has attempted to lighten physicians' regulatory burdens by making participation in some bundled payment programs voluntary rather than mandatory, proposing to raise the exclusion threshold for MACRA's Merit-Based Incentive Payment System to \$90,000 in annual Medicare billings, and other actions, another form of scrutiny—government audits of providers' use of federal healthcare dollars—has not waned. As this issue of *Communique* is about to be published, even Dr. Price himself is the focus of an Office of Inspector General (OIG) review to determine whether his use of private charter planes complies with federal travel requirements.<sup>1</sup>

Anesthesia care providers and pain specialists are the focus of auditors' attention in several areas. OIG has declared ferreting out fraud and abuse in opioid prescribing practices as a leading priority. Although the majority of painkillers are prescribed by primary care physicians, pain specialists are sure to be on the agency's radar.

Similarly, this past June, the Centers for Medicare and Medicaid Services (CMS) directed data mining company eGlobal Tech to issue a comparative billing report (CBR) related to anesthesia services for lower endoscopic procedures. CBRs are educational tools that show an individual practitioner how their billing pattern on a given procedure compares with that of their peers at the state and national levels. But the reports are not merely educational. CMS uses CBRs as a strategy to ensure compliance and coding accuracy, and they could potentially make a group eligible for a CMS audit.

As Vicki Myckowiak, Esq., notes in her lead article for this issue, the government's efforts to identify fraud and abuse are at an all-time high. OIG's 2017 Work Plan includes two areas specific to anesthesia. In addition to providing an overview of this and other major types of audits of which anesthesia practices could find themselves a focus, she offers advice on how to minimize the impact of an audit, should it occur, and how to appeal should the outcome be unfavorable.

Also in this issue:

- Will Latham, MBA, of Latham Consulting Group explores the nuances of being an anesthesia leader—not an easy thing to do, considering that many physicians are, by nature, leaders themselves. How do you win the support—the “consent”—of a high-talent herd whose members do not view themselves as followers?
- Mark F. Weiss, JD, presents the metaphorical tale of the flea that killed the medical center CEO, the flea being a small but outspoken group whose relative power brought one senior executive's reign quickly to an end. For anesthesia groups, “change within the organization, as well as change within a domain in which the organization interacts, can occur as a result of agitation by a vocal minority,” Mr. Weiss cautions. “Forget silo-like thinking and the world-view that results are directly proportional to efforts. Leverage, properly and forcefully applied at the right points, can move your world.”
- Robert Johnson, MBA, and Robert Stiefel, MD, of Enhance Healthcare Consulting, Inc., return with their

second article on responding to a request for proposal (RFP). Once a formality that rarely led to an actual change in anesthesia providers, the RFP now demands an anesthesia group's serious and concentrated attention. The ideal situation is to maintain a strong enough relationship with your facility to prevent an RFP from being issued, but if it happens—and that likelihood is increasing—there are steps to take and practices to follow that can maximize your group's chances of preserving the relationship.

- Jody Locke, MA, ABC's vice president of anesthesia and pain practice management, notes that while many anesthesia practices now include outpatient venues such as ambulatory surgery centers and endoscopy centers in the mix of environments in which they deliver services, not all outpatient settings are necessarily advantageous. Taking a closer look is in an anesthesia group's best interest. Mr. Locke presents data and a case example.

We look forward to seeing many of you at ANESTHESIOLOGY® 2017 in Boston, October 21-25 at Booth #1735.

With best wishes,

Tony Mira  
President and CEO



<sup>1</sup>Stevens, Matt. “Tom Price Says He'll Stop Use of Private Jets Until After Review,” *New York Times*, September 23, 2017.



# LEADING LEADERS: BUILDING INFLUENCE IN A HIGH-TALENT GROUP

**Will Latham, MBA**

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*In despair at the way its programs were organized, the business school at one university recruited as the director of programs a successful businessman, who had made a modest fortune in his own business and wanted to move on to a new career. "I will soon put some order in this place," he thought and said. He wrote memorandum to the academics laying down new procedures. No one read the memorandum. He called a meeting. No one came. In frustration, he asked for an explanation.*

*"These are independent individuals," he was told. "You cannot command them to come to a meeting at your convenience; you have to negotiate a time and a place convenient to them all; you had better send around a list with possible alternatives." He did and they came, or most of them did. He explained the new procedures, which, he said, would be introduced the next month. At that point, one of the older faculty members said, gently, "Bill, in this kind of institution, you cannot tell us to do anything; you can only ask us and try to persuade us to agree."*

*"Well then," Bill said, "let me ask you what you think we should do to put some sense into this place."*

*"No, Bill," the elder replied, "that's what we hired you for, to come up with those sort of ideas. But they will only work if we agree with them. If we don't, why then you will have to persuade us or come up with some better ideas. This is, you see, an organization of consent, not of command."*

– Charles Handy, *The Age of Unreason*

Many leaders of anesthesia groups face challenges similar to the ones that Bill faced. Their organizations:

1. Are often in need of significant change because of the rapid and



severe evolution of the healthcare industry.

2. Are high-talent entities composed of individuals who are smart, talented and powerful (at least in terms of their organization). Such high-talent individuals have many employment options, and, therefore, have a strong sense of independence from both the organization and its leader. They often require leadership of the "consent and not command" type.

## HIGH-TALENT ORGANIZATIONS

In his important book, *Leading Leaders*, Jeswald W. Salacuse notes that high-talent organizations (such as anesthesia groups) are composed of "elites"—individuals who, because of their "education, talents, wealth or power, are able to exert significant, usually disproportionate influence within their organization."

One of the key characteristics of high-talent organizations is that the persons designated as leaders have limited authority over the people they are supposed to lead. "Authority," in this instance, is defined as the right, by virtue of one's

position, to direct the activities of another person—in short, to tell them what to do. Most anesthesia group leaders don't have that level of authority. They can't say "just do it."

In addition, these elites often:

- Have had a role in choosing the leader, and consequently feel the leader is beholden to them, not the other way around.
- Don't see themselves as followers, and, therefore, are quick to challenge or belittle anything that suggests they are being led.

## HOW TO LEAD LEADERS

So how do you herd these cats?

Over the years, many authors have sought to explain leadership. Some feel that it is a skill honed through practice and study. Others believe it is a rare natural talent, like artistic ability, that a person is born with. For others, it is situational—an effective leader in some situations might be a disaster in others.

But any successful leader of a *high-talent* organization relies on two key elements:

1. A focus on the *relationship* between the leader and the person being led. It's that relationship that causes a person to act in ways the leader wants them to.
2. An in-depth understanding of the *interests and goals* of each elite follower, and the ability to effectively communicate that the elite follower can achieve their goals through the organization.

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payment to 50 percent of the Medicare allowed amount for personally performed services claimed with the AA modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due (SSA § 1833(e)). We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesia services reported on a claim with the AA service code modifier met Medicare requirements.”

2. **Medical Necessity:** “Medicare Part B covers anesthesia services provided by a hospital for an outpatient or by a freestanding ambulatory surgical center for a patient. We will review Medicare Part B claims for anesthesia services to determine whether they were supported in accordance with

Medicare requirements. Specifically, we will review anesthesia services to determine whether the beneficiary had a related Medicare service.”

With the government’s fraud and abuse detection efforts at an all-time high, anesthesia groups must fully understand: 1) the ways in which CMS conducts audits; 2) practical steps to minimize the impact of an audit; and 3) the appeals process available to them in the event of an unfavorable audit.

## TYPES OF MEDICARE AUDITS

CMS uses different types of audits to detect perceived provider fraud and abuse. These audits may differ in scope and may be conducted by different entities on behalf of Medicare, but each type of audit can result in a demand by CMS to refund payments. The following list is not exhaustive of current CMS audit and monitoring programs.

- **Comprehensive Error Rate Testing**

CMS established the Comprehensive Error Rate Testing (CERT) program to monitor the accuracy of Medicare fee-for-service payments. The CERT process

begins with the Medicare program identifying procedure codes that statistically appear to be the subject of potentially incorrect billings and/or payments. Once the procedure codes are identified, the CERT contractor randomly selects claims made with the procedure code for a probe audit and sends the identified provider a letter requesting copies of relevant medical records. Generally, Medicare does not pay the claims requested in a CERT audit until the review substantiates the appropriateness of payment.

Upon receipt of the medical records, the CERT contractor reviews the records to determine whether the claims and records comply with Medicare coverage, documentation and coding and billing rules. When performing these reviews, the CERT contractor must follow Medicare regulations, billing instructions, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals and Local Coverage Determinations (LCDs) made by the applicable Medicare claims processing contractor. The CERT contractor does not develop or apply any coverage, payment or billing policies of its own.

If the CERT contractor determines that the records and claims do not substantiate payment, it sends the provider a



<sup>1</sup> <http://oig.hhs.gov/organization.asp>

letter denying the reviewed claims. Moreover, negative findings from a probe audit often lead to a more extensive post-payment audit and subsequent repayment demands for “erroneous” claims.

- **The Contractor Medical Review Program**

As the name suggests, Contractor Medical Review Program Audits (MR Audits) are conducted by the Medicare Contractors under Part B of the Medicare program and are designed to uncover erroneous documentation, billing and/or Medicare payments.

Providers are selected for an MR Audit for a variety of reasons, including atypical billing patterns, specific identified billing issues, anonymous complaints and/or volume of services provided. Often providers are singled out for an MR Audit if their utilization for a given service exceeds that of their peers.

Most MR Audits are conducted on a post-payment basis and begin with a probe review where the Contractor reviews a sample of claims to determine whether services were medically reasonable and necessary and correctly paid. Some MR Audits are automated, and denials can be generated based on statistical and/or coding information.

In other cases, the provider receives a letter requesting documentation for certain patients on specific dates of service. The Contractor reviews and analyzes the documentation sent in by the provider to determine whether the services were fully and completely documented, medically necessary and correctly billed.

Upon conclusion of the probe review, the Contractor can take any of the following steps:

1. Refrain from action based on appropriateness of documentation and services.
2. Provide notification and education.
3. Make a demand for repayment.
4. Place a provider on pre-payment



utilization review, which consists of medical review of claims prior to payment.

5. Conduct an expanded post-payment audit. Contractors are authorized to review a relatively small number of claims and then to use statistical sampling to extrapolate any denials to an entire universe of claims for a designated period of time.
6. Refer the case to the OIG for further investigation for potential fraud and abuse.

- **Recovery Audit Contractor**

Recovery Audit Contractor (RAC) audits are provided by independent companies whose payment for the audit services provided is based on a percentage of the money recovered for the Medicare program. RACs are tasked with identifying and correcting improper payment for Medicare services. RACs are supposed to identify both overpayments and underpayments, collect the overpayments and facilitate repayment of the underpayments, but, not surprisingly, the number of overpayments dwarfs the number of underpayments.

Like CERT contractors, RACs are bound by statutes, regulations, CMS national coverage, payment and billing policies, and LCDs. RACs do not develop or apply their own coverage, payment or billing policies.

RACs use proprietary software to identify claims that may have received improper payment. If the payment can be determined to be incorrect based solely on computer data available to the RAC (e.g., in contravention of the Correct Coding Initiative) the RAC will make an overpayment demand and request a refund from the provider. In most cases, however, the RAC requests the medical records from the provider, reviews the claims and medical records, and then makes a determination as to whether the claim contains an overpayment, underpayment or correct payment.

The use of RACs is not without controversy. Providers find the RAC system burdensome because it takes significant resources to respond to the voluminous record requests and to defend denied claims. Additionally, there is a concern that paying the RACs on a contingency basis incentivizes RACs to deny claims

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for issues such as documentation or medical necessity, areas which are highly subjective and often disputed by providers.

## STRATEGIES FOR PREVENTING ADVERSE AUDIT FINDINGS

The primary objective when faced with a Medicare audit is to effectively input the audit process to achieve a positive audit result. If the audit result is not positive, the anesthesia group's objective should be to preserve all appeal rights and, eventually, to win the case during the appeals process. There are a number of steps groups can take to meet these objectives.

### • Before the Audit

Groups can take proactive measures to minimize the potential negative effect of an audit. The implementation and maintenance of an effective compliance program can help ensure that the group's providers are fully and completely documenting the anesthesia record and that

the anesthesia record is driving the correct coding and billing of the services. A discussion of the elements of an effective compliance program is beyond the scope of this article. However, a good starting point for any anesthesia group is the "[OIG Compliance Program for Individual and Small Group Physician Practices](#)."

Anesthesia groups should also educate their staff regarding Medicare audits and responses *before* an audit occurs. For example, all staff should understand the protocol to follow if an auditor shows up at the billing office or if the group receives an audit letter.

The protocol should include: 1) the designation of a point person to handle the audit; 2) the requirement that all audit requests be immediately given to that point person; 3) an understanding that the staff does not have to speak with the auditors and should refrain from signing any documents provided by the auditors; and 4) a method for documenting and confirming the records and other documents provided to the auditor.

### • During the Audit

Most audits begin with a request for records, which is usually sent to the billing address. If the group's address is associated with a billing company or facility, the group should implement a policy ensuring that the billing company/facility notify it immediately if an audit record request is received. Groups often make the mistake of sending in the requested records without first conducting a review of the records. However, the audit submission may vary depending on the documentation and/or billing issues, if any, raised in the records.

Anesthesia groups should work with qualified legal counsel and consultants well-versed in issues related to anesthesia practices to carefully review requested records and to consider the following steps and strategies:

1. Ensure that all deadlines are met. If it appears that the group will need more time to compile the audit documents, its representative should contact the auditor for an extension and keep written confirmation that the extension was granted.
2. Review the record request to determine any connections between the records. Identifying connections will give the anesthesia group an idea of the issues surrounding the audit request. For example, do all the records involve monitored anesthesia care? Are all the records for billing with the AA modifier?
3. Compile the following documents for review by the group's legal counsel and qualified consultant:
  - a. The audit letter.
  - b. Copies of the entire perioperative record for each patient



whose records are part of the audit. The group should also include the surgeon's report, the circulating nurse's report, and documentation for lines and postoperative pain procedures.

- c. Information on any previous audits or correspondence that may impact the current audit. For example, if the group was the subject of a previous audit for the same types of services, and the Medicare Contractor determined that the services were appropriate in the previous audit, the group may consider providing that helpful information to the current auditor.
- d. Relevant internal reports such as total Medicare payments for all codes in the requested records. For example, if Medicare paid a total of \$300,000.00 for all services provided during the audit period, and the auditor makes an overpayment demand of \$350,000.00 based on a statistical sample, the group may want to retain a

statistician to review the statistical extrapolation.

4. If the records are illegible, the Medicare auditor is more likely to deny the services. Groups can counteract this problem by submitting not only the illegible records but also a word-for-word dictation of the records.
5. Work with legal counsel to review all Medicare authorities, such as LCDs and contractor policies, to determine if the records meet the Medicare documentation and medical necessity requirements.
6. Work with the consultant to determine whether the anesthesia records support the services billed.

Groups should be certain to keep copies of all submitted documents and to provide the documents to the auditor in a way that provides proof of submission (e.g., certified mail, return receipt requested). Once the records are submitted, the anesthesia group must wait for the results of the audit. If the audit results are unfavorable, then the group should consider an appeal.



## THE APPEAL PROCESS

Whether the audit determination comes from a CERT audit, an MR audit or a RAC audit, the appeal process is the same. The first step is the receipt of an adverse initial determination. The next steps are as follows:

- **Level 1: Redetermination**

A redetermination is a request that the Contractor take another look at the audit findings. Redetermination is an independent on-the-record review of the initial determination. The Contractor is supposed to have the claims reviewed by auditors who did not take part in the original adverse determination. The request for redetermination must be submitted within 120 calendar days from receipt of notice of the initial determination.

- **Level 2: Reconsideration**

If the redetermination is unfavorable, then the next step is to appeal to a Qualified Independent Contractor (QIC). Providers must submit their request for reconsideration in writing within 180 calendar days from receipt of notice of the redetermination. It is important to note that the provider must submit all evidence at this stage of the appeal process. Failure to submit evidence at this stage could preclude subsequent consideration of the evidence.



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Providers should also ensure that their legal counsel is raising some common legal defenses to the audit, including: 1) waiver of liability; 2) provider without fault; and 3) the treating physician rule.

## • Level 3: Administrative Law Judge Hearing

Unfavorable reconsideration decisions can be appealed to an Administrative Law Judge (ALJ). The ALJ level is independent of the RAC contractor. The provider must file the request for an ALJ hearing within 60 days of receipt of the reconsideration decision.

Unlike the lower levels of appeal, the ALJ hearing provides an opportunity to provide evidence via witnesses such as the provider, coding experts and medical experts. In most instances, the hearings are held via conference call or video-teleconference. In-person hearings may be granted if good cause is shown, but in-person hearings are not the norm. Anesthesia groups should be prepared to be present and testify at the hearing. The group's testimony will be the strongest

weapon in the arsenal, but it may also be prudent to produce expert witnesses at the hearing to support the appropriateness of the documentation and coding of the services.

## • Level 4: Medicare Appeals Board


Groups can file appeals to the Medicare Appeals Board within 60 days of receipt of the decision of the ALJ. Importantly, CMS or the Medicare Contractor can also request an appeal from the ALJ determination, and the Appeals Board can decide to hear an appeal of its own accord. The Appeals Board review is on the record, so in-person testimony is not allowed.

## • Level 5: Federal District Court

The final step in the appeals process is to the Federal District Court. This appeal must be filed in writing within 60 days of the Appeals Board decision.

## CONCLUSION

Although anesthesia groups should be concerned about the probability of a Medicare audit, there are proactive steps

to take to minimize the risk of an adverse outcome. Compliance with Medicare rules, regulations and policies is the best defense to an audit. A thorough familiarity with the types of Medicare audits is essential to successfully navigate the ins and outs of the audit. Finally, a comprehensive approach to the audit and, if necessary, to an appeal of the audit determination, can lead to a positive outcome for the anesthesia providers. 

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ing anesthesia and chronic pain practices on issues including compliance programs, reimbursement, third-party payer coverage issues, Medicare audits, commercial payer audits, fraud and abuse defense, contracting, chronic pain informed consent and HIPAA. Ms. Myckowiak has helped implement and maintain compliance programs for dozens of anesthesia and chronic pain practices across the country. She also works extensively with third-party billing companies. A graduate of Franklin and Marshall College and The National Law Center at George Washington University, Ms. Myckowiak is a member of the American Bar Association, the American Health Lawyers Association, the Health Care Compliance Association and the Michigan Society of Healthcare Attorneys. Ms. Myckowiak frequently writes and speaks nationally on trends in healthcare law, including contracting, fraud and abuse, government enforcement efforts and regulatory initiatives, and compliance programs. She can be reached at [vicki.mycklaw@gmail.com](mailto:vicki.mycklaw@gmail.com).





# LEADING LEADERS: BUILDING INFLUENCE IN A HIGH-TALENT GROUP

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## BUILDING RELATIONSHIPS

Let's look first at relationships. Relationships are based on a perceived connection between leaders and followers, and successful leaders work very hard to create that connection because they know that effective leadership depends on it.

Different leaders use different methods to create relationships. Some rely on their personal dynamism and charisma, using their special ability to articulate visions, grand designs or glowing futures in which their followers would share. Others use quiet methods of reason and logic. The common thread among successful leaders is their ability to communicate. Communication is fundamental to relationship-building, and, therefore, to leadership.

That said, communication with the "masses" differs from communication with elite followers.

The most effective way to influence elite followers is to build the necessary relationships with them—not in crowds, but one-on-one. Smart, talented, powerful people require one-on-one, tailor-made leadership, delivered up close and personal. That doesn't mean that it always has to be face-to-face. It could be a phone call, an email exchange, a memo, a letter, a handwritten note. These vehicles will suit different situations. However, the communication must be delivered on a one-on-one basis.

Communication is only one piece of the puzzle. Even if you communicate well, you will only be able to lead if you understand and accommodate your elite followers' interests and goals. You must remember that people don't follow you because you claim to be leader, because others have designated you as leader, or because you have charisma or charm. People usually follow you because they believe *it is in their best interest to do so*. Effective leaders understand this and seek to engage other leaders, understand their interests, listen

to their objections and concerns, and look for means to accommodate their interests while pursuing their own overriding goal of building a coalition to move the group forward.

## WHAT IF ALL DON'T AGREE?

Groups often find that, even with effective leadership, not all group members will agree on a unified goal for the future. Some groups are stymied by the fact that all don't agree, while others have developed a culture in which:


- All physicians are offered the chance to have input on an issue (either directly or through their leaders).
- If all don't or won't agree on a specific plan, the group votes and *all agree in advance to support the group decision, whether they like the decision or not*.

You can help your group make an important leap to the next level of performance by discussing and answering the following three questions:

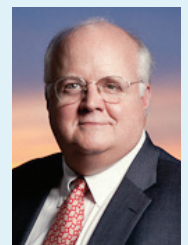
1. **How will we make decisions as a group?** In our experience, the best decision-making approach tends to be "seek consensus first, but if it cannot be reached, vote."
2. **What is expected of each physician once the group has made a decision?** The answer to this question is crucial. An unstated thought of many physicians is, "If I didn't vote for it, I don't have to support it." Groups can't function with this mindset. The group should agree that once a decision has been made by the agreed-upon decision-making method, all physicians (whether they agree with the decision or not) will support it. That means they will do what has been agreed to, not sabotage it, and continue to follow the agreement unless they

can change the decision by working through the proper channels.

3. **What do we do if someone doesn't meet the agreed-upon expectations?** Here is where the rubber meets the road. At a minimum, the group can remind outliers that they all have agreed to support group decisions. We also recommend that groups set up a formal process to deal with those who don't live up to their commitments.

A few years ago, I worked with a group that had this discussion at the beginning of its planning retreat. One of the physicians said, "So, if we make a decision, we are really going to do it?" I responded in the affirmative, to which he replied, "Well, I guess I will have to pay attention at this meeting!" 

**Will Latham, MBA**, is President of Latham Consulting Group, Inc., which helps medical group physicians make decisions, resolve conflict and move forward. For more than 25 years



Mr. Latham has assisted medical groups in the areas of strategy and planning, governance and organizational effectiveness, and mergers, alliances and networks. During this time he has facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; helped over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of over 120 medical practices representing over 1,200 physicians. Mr. Latham has an MBA from the University of North Carolina in Charlotte. He is a frequent speaker at local, state, national and specialty-specific healthcare conferences. Mr. Latham can be reached at (704) 365-8889 or [wllatham@lathamconsulting.com](mailto:wllatham@lathamconsulting.com).



# THE FLEA THAT KILLED THE MEDICAL CENTER CEO: A CAUTIONARY TALE

Mark F. Weiss, JD

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Earlier this year, a flea bit and killed the CEO of one of the top-ranked academic medical centers in the nation. Metaphorically speaking, of course. And the lessons of this sad (?) story cut both ways for you and your anesthesia group.

In his book, *The War of The Flea*, the seminal work on guerrilla warfare, Robert Taber wrote about how a small band of guerrilla fighters could emerge victorious in a conflict with a larger, well-organized enemy: “Analogically, the guerrilla fights the war of the flea, and his military enemy suffers the dog’s disadvantages: too much to defend; too small, ubiquitous, and agile an enemy to come to grips with.”

## THE DOG

In 2014, Ohio State University concluded a national search for the new leader of its Wexner Medical Center. It selected, and then hired, Sheldon Retchin, MD, as its CEO. His salary? Close to \$1 million per year.

## THE FLEA

In May 2017, *just three letters* signed by a handful of the 1,200 physicians that Wexner employs triggered Dr. Retchin’s resignation.

The first letter, dated May 1, 2017, *signed by only 25 physicians*, raised complaints about Dr. Retchin’s management style. According to a report in *The Lantern*, the Ohio State school newspaper, the complaining physicians wrote they had “no confidence” in Dr. Retchin’s leadership. The signers claimed that more than 100 other doctors supported their position, but were afraid to join in the letter.

The second and third letters were *signed by just six physicians each*.

Even assuming no crossover in the signatories, 37 physicians (yes, some in positions of authority) out of 1,200—*that’s only three percent*—were able to unseat the king.

Dr. Retchin, the frontman for a high and mighty organization, and, one can argue, the organization itself, became the latest victims in the war of the flea.

## WHY THIS MATTERS TO YOU

What does this mean for your anesthesia group and for you, personally?

From the organizational perspective, as in a guerrilla war, change within the organization, as well as within a domain in which the organization interacts, can occur as a result of agitation by a vocal minority. Just as no vote was required for a dictator like Castro to take over Cuba, no medical staff vote, no survey by Press Ganey, no long and drawn out process among “stakeholders,” is required to topple the status quo.

What you think is permanent is only temporary. Just *how* temporary is the question.

From the dog’s perspective, what you do, and how you do it, within your group, and how you project it to essential third parties, is all-important in maintaining relationships, contracts and even existence. It’s complex work carried out over multiple disciplines but it cannot be ignored or dispensed with. That’s the flea prevention. It’s required.

And, just the same, from the perspective of the individual, the small, the “out group,” the “flea”—a steadfast, vocal

and somewhat intransigent minority—can kill the dog.

Your individual or group leader can attack much larger prey. Just how depends on the situation. But, suffice it to say, it takes time and effort and a combined arms approach.

Another group, large or small, can be made irrelevant. The hospital CEO can be forced out. The small organization can ingest the larger.

Forget silo-like thinking and the world-view that results are directly proportional to efforts: Leverage, properly and forcefully applied at the right points, can move your world.

And, yes, the dog bites back. No win is guaranteed.

Many say that the world is a tough place. Maybe it is, because it’s not just dog-eat-dog. In Dr. Retchin and Wexner’s world, it’s flea-kills-dog as well.

Whether you’re the metaphorical dog or the metaphorical flea, the same applies to you. ▲

Mark F. Weiss, JD, is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, TX and Los Angeles and Santa Barbara, CA, representing clients across the country. He can be reached by email at [markweiss@advisorylawgroup.com](mailto:markweiss@advisorylawgroup.com).





# YOUR HOSPITAL ISSUES AN RFP FOR ANESTHESIA SERVICES: NOW WHAT? (PART 2)

**Robert Johnson, MBA**

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**Robert Stiefel, MD**

*Co-Founder and Principal, Enhance Healthcare Consulting, Aventura, FL*

In the last issue of *Communiqué*, we discussed the various reasons hospitals may want to replace their existing anesthesia service with an alternative. We cited evidence that hospitals currently are showing more interest in replacing their anesthesia groups and are going to greater lengths to employ formal processes such as the request for proposal (RFP) to help them make the decision. In addition, we reviewed survey data illustrating the reasons hospitals are increasingly looking at other provider groups: 1) inadequate service levels (45.5 percent), 2) subsidy levels (38.2 percent) and 3) issues with group leadership (16.4 percent). A reason not addressed in our previous article that an anesthesia group may receive an RFP is as an alternative for the hospital to obtaining a Fair Market Valuation (FMV). Some hospitals have concluded that FMV firms use published market surveys that



are not relevant to their circumstances, and instead rely on the actual market information from an RFP.

In our experience, incumbent anesthesia groups often contribute to the hospital's decision to look elsewhere because they have become complacent about the level and quality of their services and are unaware that hospital senior leaders are

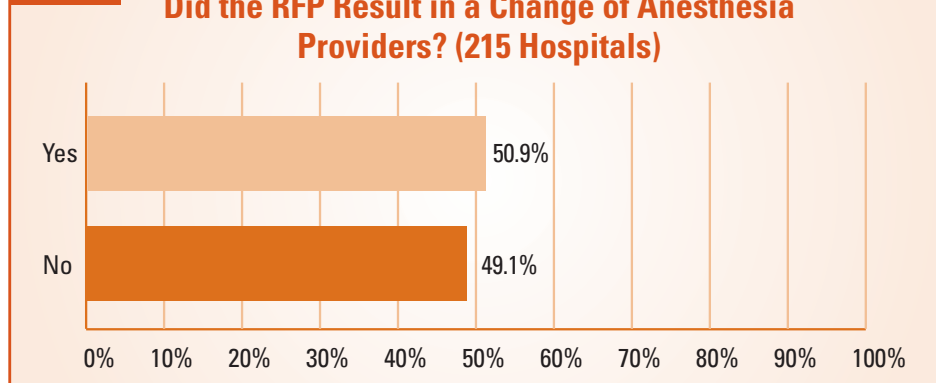
more willing today to risk the uncertainty of contracting with a new anesthesia group in order to gain improved service at a lower subsidy.

In this article we will focus on what you should expect once you receive an RFP, whether you should respond and how best to respond should you decide to do so. Historically, RFPs were used to “scare” incumbent groups into providing expanded services or accepting lower subsidies, and a change to a new group as a result of an RFP was rare.

This is not the situation today. In order to understand how often RFPs were being used by hospitals to change their provider group, Enhance Healthcare Consulting (EHC) surveyed 215 hospitals. The results (Figure 1) show a statistical tie between the hospitals that changed groups (50.9 percent) and those that did not (49.1 percent). It should be disturbing to an incumbent group that it has an approximately 50/50 chance of being replaced as a result of an anesthesia services RFP.

**FIGURE 1**

## Did the RFP Result in a Change of Anesthesia Providers? (215 Hospitals)



### AN OUNCE OF PREVENTION

For this reason alone, an incumbent group's best strategy to deal with an anesthesia RFP is to not get one in the first place. As discussed in our previous article, groups should make sure they are doing everything possible to avoid placing the hospital in a position in which an RFP is considered.

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## YOUR HOSPITAL ISSUES AN RFP FOR ANESTHESIA SERVICES: NOW WHAT? (PART 2)

*Continued from page 11*

When a group receives or knows that it is about to receive an RFP, a frequent question is: “Can we stop it, or is it too late?” In rare circumstances, there may be an opportunity to stop or reverse an RFP. If the hospital hasn’t put out the RFP but your group has good reason to expect it soon, you may be able to stop it if, and only if, you can show the hospital CEO that they are acting out of haste or have been misinformed, and that you can provide a more accurate picture of the situation. You may also be able to stop the process if it is poorly planned and creating disruption among the medical staff.

If the conditions are right for a reversal, then the next question is how to take advantage of these circumstances. First, look for the telltale sign of lack of planning, i.e., when leadership is acting from emotion or misinformation and skipping the basics required for an effective RFP. Second, if you think your group can convincingly demonstrate significant issues with the RFP, take your case directly to the CEO.

Otherwise, continue under the assumption that the process will not be reversed and your group will have to decide whether to respond to the RFP. This question is usually raised by senior members of the group who are angry at the hospital and/or overly confident that their group cannot be replaced. In our experience, groups that choose not to participate and not to respond to the invitation to bid will be replaced. Always respond. The time and effort that your group invests in the response is small compared to the potential consequences of not responding and losing the relationship with the hospital.

Take the opportunity to do some self-reflection and examine how your group’s actions have led to the RFP. If your group is to learn from this experience, it

must reject the belief that other groups are not capable of replacing it or are not willing to work under the conditions the hospital has imposed. These are dangerous attitudes to take into a competitive process. If your group feels insulated from the competition, then it is likely to fail to adequately defend its position and may lose the contract to another group.

It is important to find out as much as you can about other groups you will be competing against. If it is limited to a few groups such as other small local providers, then you probably already have some knowledge of who you are competing against and can expect a reasonably even playing field. If the list includes mainly large multispecialty vendors, then the hospital may intend to include your radiology, emergency department (ED) and hospitalist groups in a multispecialty RFP (discussed below).

In a formal, well-organized RFP, the hospital will have adopted rules for how the process will be conducted and the participants will remain confidential. However, you may discover some of the groups that have been invited to bid if they start contacting the hospital for information regarding your group. A well-organized RFP process will have rules

that include warning bidders that they will be disqualified if they contact the current anesthesia group or others at the hospital.

### THE COMPETITION

Most hospitals will send RFPs to four to seven groups or vendors, including two or three national (single or multispecialty) vendors, one or two regional groups and one or two local groups, including the incumbent.

The quality of responses will range from fair to outstanding. In general, the larger the organization, the higher the quality of the response. Larger groups often have the resources to devote to responding to RFPs. Large national multispecialty vendors have full-time business development teams that respond to RFPs and use expensive production techniques to display relevant information.

Small, local incumbent groups do not have these resources. However, with a small outlay, a group can produce a professional document. If you believe your hospital will be issuing an RFP, we recommend utilizing the expertise of those with experience in responding to anesthesia RFPs. Professional presentation formats are available to help give your response a look and feel like that of the larger vendors.

Groups often ask about the importance of the quality of the RFP document. Give the RFP the attention it deserves with a thoughtful, well-organized, error-free response and professional-looking graphics.

### MULTISPECIALTY RFPs

A new development in the hospital-based physician services industry that includes anesthesia is the multispecialty





RFP, in which the hospital issues an RFP for two or more services. These could include: anesthesia, radiology, ED services, hospital medicine and ICU services. The principal motivation is to reduce the hospital's expenditure on physician services, i.e., subsidies.

A simple example would be one in which the RFP combines the ED (staffed by a local group) that is profitable with anesthesia services that require a subsidy. The hospital issues an RFP for a single vendor that would provide both services. The hospital is looking for a provider to combine both services into one operation and would use the profits of the ED to make up for the loss incurred in staffing the anesthesia program. If your group is included in an RFP of this type you will need to consult with experts who have experience with these arrangements.

### THE RFP PROCESS

In a formal, well-organized RFP process, the hospital will have adopted rules for how the process will be conducted. Those rules will be articulated in the RFP document.

Keep the following in mind throughout the process:

- Maintain a sense of professionalism and an appropriate sense of decorum at all times. Regardless of your existing relationship with the hospital, this is a formal process and should be treated as such. Acting out in the ORs, making disparaging comments about the RFP, and displaying anger in any form should not be permitted by any group member.
- Hold a group meeting immediately to develop a plan to address the RFP.
- If you don't have an administrator, appoint one or two group members to review the RFP and determine what may be required.



- Start an action calendar based on the RFP timetable.
- Plan a series of regular group meetings to review progress on the response.
- Meet with your hospital CEO. Even if you met with the CEO earlier when the RFP was announced, request another meeting. Include your group president and one other well-respected, even-keeled, articulate group member in that meeting. Wear business attire, have questions ready and take notes. If there is any chance of reversing the RFP decision this meeting will be your opportunity to explore this possibility. *If and only if your group is prepared to follow through*, indicate your group's willingness and desire to meet the hospital's terms now in exchange for their rescinding the RFP. Try to engage the CEO and hospital leadership in a discussion of the RFP to assess their confidence in moving forward with it.
- Determine who your allies are and assess the level of support they can offer. Typically, groups believe the surgeons are in their corner. We

have found that to be generally true, but don't assume that the support will be there unsolicited; you might have to ask for it. Approach surgeons off premises or by phone rather than in the operating room. It is appropriate to ask them to write letters of support, and ask them to copy the Board on these letters.

- Do not approach hospital staff about the RFP or any related issues. Even if they indicate support, they are employees of the CEO. You can assume that everything you say to them will be related to the administration.

The RFP document is typically a five- to 10-page document laid out in multiple sections. It typically begins with a statement defining the RFP's goals and objectives. This statement usually addresses quality and service. For example:

*The goal of this solicitation is to obtain quality anesthesia services for the facilities that make up this RFP and is focused on achieving a specific anesthesia services solution that recognizes the*

## YOUR HOSPITAL ISSUES AN RFP FOR ANESTHESIA SERVICES: NOW WHAT? (PART 2)

*Continued from page 13*



*value of synergies, best practices, clinical leadership expertise and performance expectations, including initial and ongoing management and minimization of cost of anesthesia services while maximizing care of our patients, meaningful and action oriented quality and management information reporting, and compliance with all Centers for Medicare and Medicaid Services (CMS) and regulatory requirements associated with provision of anesthesia services.*

RFPs vary in the manner in which they relay information about the hospital and the information they are seeking from your group. Whether they are structured in a question-and-answer format or as open-ended statements, the information needed will be the same. A typical RFP will include a timetable with deadlines (see Figure 2).

Other topics addressed in the RFP might include a waiver of confidentiality; respondent group communication and contact during the RFP and selection process; rejection of proposal; and award criteria. The group may want to have an attorney review these, but the hospital will rarely change them.

### GROUP RESPONSE TO RFP QUESTIONS AND STATEMENTS

The hospital will expect the respondents to answer to every question or explain why it cannot. The hospital will prefer the responses to be presented in the same order as the questions. Use the same format (unless an attachment is indicated) for each response regardless of whether the same information is provided in other parts of the RFP response.

Hospitals will seek to minimize the disruption that might result from multiple vendors calling the administration or OR asking for information to help them answer the RFP questions and validate the data. For this reason, the RFP will require that questions be asked in an organized manner, such as by requiring questions to be submitted in writing by a certain date. The hospital should provide the answers to any questions to all of the candidates in this process, including the incumbent.

**Group profile information:** When and where did your group begin providing anesthesia services? Provide your group organizational chart. Describe the size of the organization even if you are the incumbent and the hospital knows your group information. You may have difficulty with questions about your group's revenue and compensation. You will need to decide what may be gained or lost by failing to provide the requested information versus with transparency.

**Anesthesia quality metrics:** The single most frequent deficiency in an

**FIGURE 2**

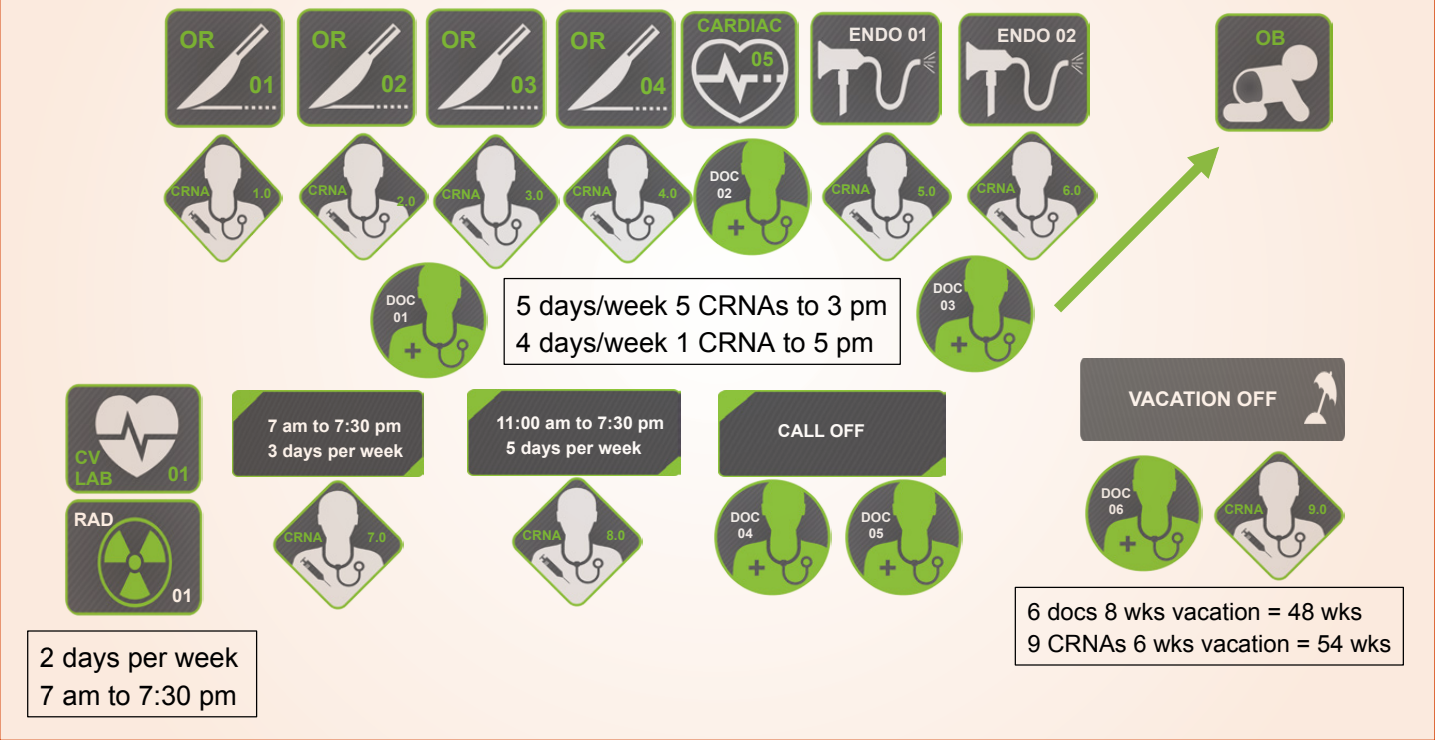
### Sample RFP Timetable with Deadlines

Activity	Due Date
RFP distribution to vendors	5/16/2015
Questions submitted from vendors	6/16/2015
Hospital responses to questions	6/28/2015
Response due to hospital	7/16/2015
Proposal conference call with hospital	7/23/2015
Tentative vendor presentation(s)	8/23/2015
RFP award notice	9/1/2015
Tentative start date	2/1/2016

FIGURE 3

### Proposed Staffing Model

Coverage: 7.2 sites plus OB  
6 Physicians/9 CRNAs



incumbent group’s response is the lack of a defined quality and performance metrics program. If this is true of your group, start a quality and performance metrics program immediately and

communicate your plans for doing so to the hospital. Describe the metrics that will be instituted. If you are unfamiliar with current acceptable metrics and the thresholds used to measure them, seek

the advice of experts in this area. Will the providers be incentivized to meet these metrics or other standards? If so, describe the monetary amount(s).

**Operating room management:** If your group wishes to improve its chances of retaining the contract and is not currently participating in OR management, describe how you will do so in the future, including such areas as OR scheduling, daily huddles and “board running,” with an emphasis on maximizing efficiency and focusing on patient needs. While some members of your group may resist making some of these changes, they should be aware that the competition will be offering to provide these services and more.

**Staffing/coverage requirements:** The group should be very specific regard-



## YOUR HOSPITAL ISSUES AN RFP FOR ANESTHESIA SERVICES: NOW WHAT? (PART 2)

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ing the proposed staffing. For example, state that the staffing model will cover (if it doesn't already) all call and allocated provider vacation. Your model should include the full complement of community-based anesthesia providers you are providing as the incumbent group, and demonstrate exactly how your group provides 24/7 anesthesia services, preoperative and postoperative evaluation and postoperative acute pain management. Do not assume the hospital understands how you provide anesthesia coverage. Provide an illustration (see Figure 3).

**Financial information and consideration:** Carefully and completely explain the group's proposed financial arrangement. Many groups are reluctant to share their financial information. However, full transparency will improve your chances of keeping the contract. If you are asking for a subsidy, the hospital will be much more comfortable if it understands why you are requesting one. Most subsidies result from poor provider


utilization. In the most respectful manner you can muster, show the hospital the expense involved in staffing sites that aren't efficiently utilized.

### **Proposal evaluation and award:**

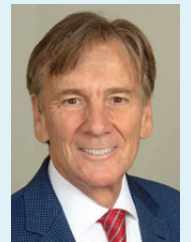
The RFP usually describes the criteria used to evaluate the respondents. This could be valuable to the incumbent group regardless of its use in the RFP process. Use it as a scorecard to measure your group and anticipate what other groups will provide in their responses.

### **CONCLUSION**

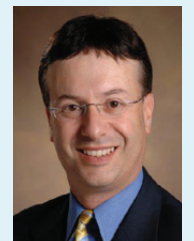
Receiving an RFP from a hospital for whom your group has provided anesthesia services for many years is a difficult experience. Your group has not had to prove its worth in an impartial business environment that considers your services a commodity. The competition you will encounter in this process is serious and will test your group's resilience. However, we have seen incumbent groups, even small local

groups, prevail in this process and retain their contracts with a thorough and professional response to an RFP. 

**Robert Johnson, MBA,** Principal at Enhance Healthcare Consulting, is a healthcare executive with broad experience in multiple healthcare environments. He started at Johns Hopkins Hospital as a perfusionist in the cardiac operating rooms and eventually became administrator of the anesthesiology department. He has also served as senior associate chief operating officer at Duke Hospital and held positions with Baylor College of Medicine, the University of Pittsburgh and Sheridan Healthcare. As a vice president for HCA, he played a critical role in leading negotiations with hospital-based physician practices. He joined EHC as a principal in 2014. He can be reached at [bob.johnson@enhancehc.com](mailto:bob.johnson@enhancehc.com) or (404) 905-7014.



**Robert Stiefel, MD,** Co-founder and Principal of Enhance Healthcare Consulting, is a board certified anesthesiologist who has worked with many of the nation's largest health systems to deliver sustainable improvement in their ORs. As co-founder of L&S Medical Management, Dr. Stiefel helped grow that organization to 140 clinical providers over eight years. Since 2006 he has been a consultant for hospitals and health systems, advising on anesthesia and operating room performance improvement. With EHC, he has been a lead consultant with many institutions on financial performance and operational improvement. He received his training at Tufts University School of Medicine and University of Massachusetts Medical Center. He can be reached at [rstiefel@enhancehc.com](mailto:rstiefel@enhancehc.com) or (863) 610-2085.





# EXPANDING INTO NON-HOSPITAL VENUES: THE TRUE MEASURES OF SUCCESS

Jody Locke, MA

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Anesthesia Business Consultants, LLC, Jackson, MI*

The typical anesthesia practice now includes a combination of traditional hospital facilities and ambulatory surgery centers (ASCs), endoscopy centers and other outpatient venues such as doctors' offices. With the continued migration of surgical cases from inpatient to outpatient place of service, a variety of service locations is considered essential to survival.

While the payer mix at hospitals may be eroding due to an increase in Medicare and Medicaid patients, the ASC often attracts a more favorable mix of patients, thus helping the practice maintain an overall average net yield per ASA unit billed that comes closer to supporting the practice's financial needs. Rarely do these ambulatory venues require a financial subsidy. Since their call coverage requirements are limited to day-time activity, the inclusion of an ASC makes it easier for the practice to manage the manpower needs of the practice as a whole.

Ideally, the addition of ASCs enhances the practice's overall financial picture, but not all ASCs are the same. Any student of economics knows that as you push out the supply curve, you experience diminishing marginal productivity. Those who pursue practice expansion must understand this principle and appreciate its significance for the practice's future. Blind pursuit of all surgical venues in a given geography may not be the best strategy.



A summary of 30 ABC client practices throughout the U.S., that covers both inpatient and outpatient venues, highlights the potential advantages and disadvantages of such expansion (see Figure 1). We have focused on trends over a five-year period, from January 2012 to December 2016. All data has been compiled by date of service so that payments correspond to the charges to which they are applied.

In general, this has been a period of expansion for most of these practices; surgical volumes have increased year over year for both inpatient and outpatient locations. Generally, payer mixes have remained consistent, and despite the

potential impact of Obamacare, most practices experienced slight increases in net yield per ASA unit billed.

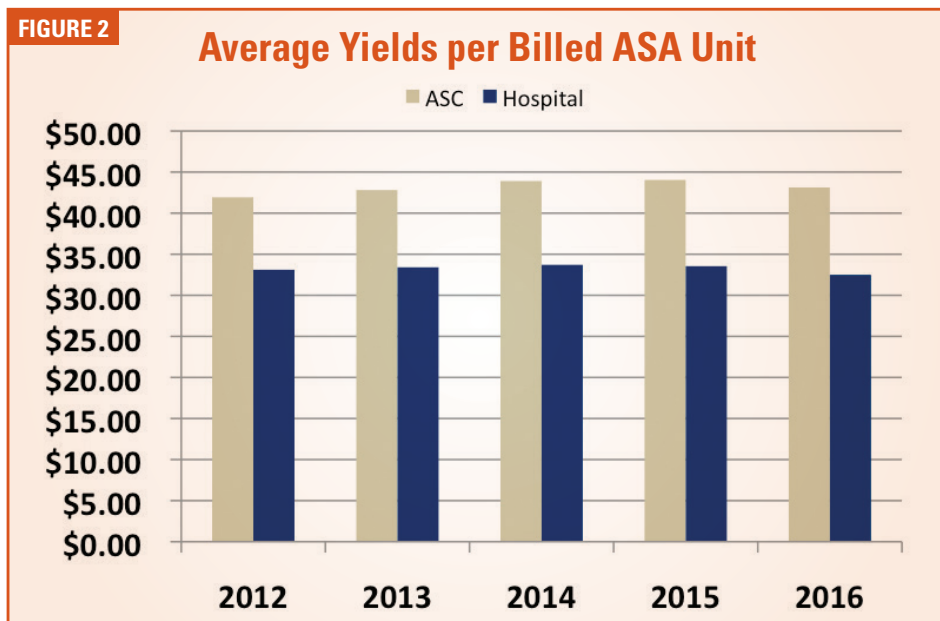
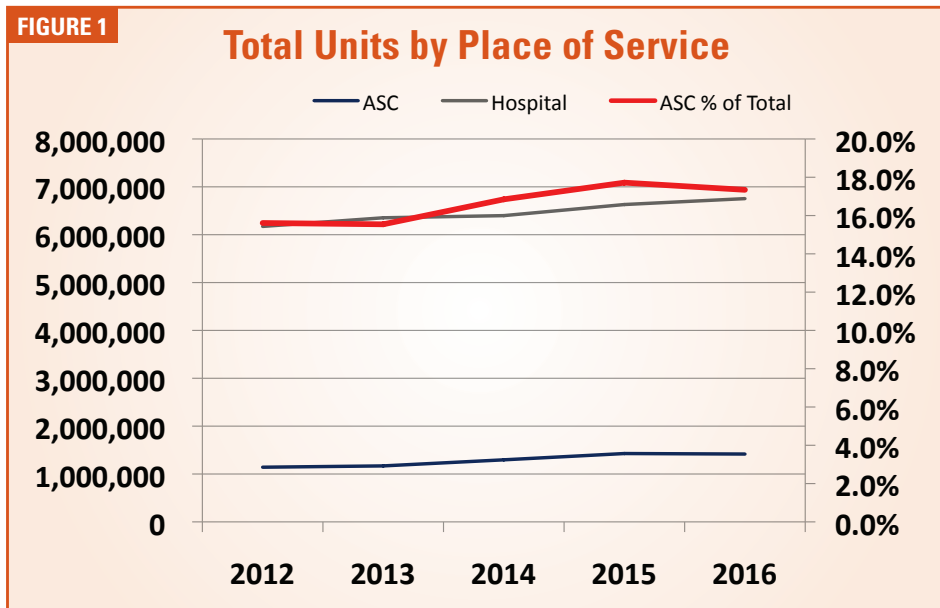
For the purposes of this study, all activity was categorized as either hospital or outpatient, based on place of service. Thus, some outpatient activity is included under the category of hospital. The ambulatory data also includes endoscopy centers when they are performed outside the hospital. While some practices cover more outpatient venues than others, overall, non-hospital unit production represented about 15 percent of total unit production in 2012 and has increased slightly, but not dramatically, over time.

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## EXPANDING INTO NON-HOSPITAL VENUES: THE TRUE MEASURES OF SUCCESS

Continued from page 17



Collections for these non-hospital services outstripped production levels. For the entire sample, non-hospital collections went from 19 percent of total practice collections to just under 22 percent.

What most practices focus on is the significant differential in the net yield per unit billed, which is an obvious

reflection of differences in payer mix and which, as indicated in Figure 2, can be significant. Often, more inpatients are covered by Medicare and Medicaid than patients in the non-hospital venues, although this is not always the case; sometimes the actual yield at the outpatient facilities can be quite

disappointing. Net yield per unit is only one part of the equation, and other metrics are far more relevant to the overall assessment of each venue's value to the practice.

### THE VALUE OF AN ANESTHESIA PRACTICE

The value of an anesthesia practice can be defined by three variables: the average number of surgical or obstetric cases performed; the average acuity of cases as defined in terms of average units per case; and the effective net yield per unit. Most practices track cases performed by month. Many also track the total ASA units billed each month. While these are important pieces of information to track, *it is the ratio between the two that can be most significant.* Average units per case should be tracked by line of business. The typical community hospital bills about 13 units per case for inpatient procedures, while the value for outpatient and ambulatory cases may be between eight and 10. The average endoscopy case only results in seven units per case, and this may drop if the proposed revaluation of the endoscopy codes goes into effect next year. (The proposal is to drop the base value of a colonoscopy from five units to four units.)

Unit production reflects the work associated with the line of business, but it is the net yield per unit billed that actually determines the payment. Given an average Medicaid rate of \$15 per unit, an average Medicare payment of \$21 per unit and an average PPO rate of \$65 per unit, obviously, the more Medicare and Medicaid patients seen, the greater the limit on fee-for-service collections and the greater the need for financial support from the facility. Herein lies the challenge. Ideally, each new venue or line of business should contribute positively to the practice's bottom line.

FIGURE 3

### A Typical Practice Scenario

	Units per day	Yield per unit	Yield per day
Hospital 1	41.2	\$38.97	\$1,605.31
Hospital 2	27.4	\$39.60	\$1,086.03
ASC 1	36.1	\$40.12	\$1,449.06
ASC 2	40.0	\$48.68	\$1,946.10
ASC 3	35.8	\$48.68	\$1,742.79
Endo Center	51.9	\$23.27	\$1,207.71
Overall Average	38.7	\$39.89	\$1,545.05

This is not always the case. In fact, if practices were to implement a serious cost-accounting model, they might find that they should exit certain venues.

#### STRATEGY GONE AWRY

One practice covered the primary hospital in a local market. As new surgery centers opened, the practice felt it was important to contract with all of them, until they realized they could not afford to compete in the local labor market. The problem was that their manpower was being deployed to unproductive centers. Once they cancelled a few contracts, their financial situation improved dramatically.

Figure 3 offers an example of this phenomenon. The practice represented

here covers two hospitals, three surgery centers and one endoscopy center. The table provides normalized data for the first quarter of 2017. Production data is divided by anesthetizing location days. All data was limited to day shift activity, 7 am to 3 pm, so that hospital values could be compared to non-hospital values. It should be noted that if the practice relies on a physician-only model, the average actual cost per location day can be as high as \$2,100. Medical direction of CRNAs tends to reduce this cost, but the results can vary significantly, from \$1,500 to \$1,800 per location day.

In this example it is clear that neither hospital generates enough revenue to completely cover the cost of care, thus

necessitating financial support from the facility. The point is, though, that with two possible exceptions, the other locations are not generating sufficient revenue to completely cover the cost of care.

This is a very common phenomenon. There may be many valid and important strategic considerations to justify the contracts with the less productive venues, but it may also be that the practice has never carefully examined the profitability of its various lines of business. A snapshot perspective such as this does not tell the whole story. One or more of these venues may be in “ramp up mode,” i.e., expected to increase profitability over time. But what if this is not the case? Failure to track these subtle metrics could be seriously problematic over time.

There is a common saying in business that you cannot manage what you do not measure. As medicine becomes increasingly more competitive, it is essential for practices to judiciously manage their balance sheets. In the past, optimizing collections was the key to an anesthesia practice’s success, but now that success hinges much more on effective management of clinical resources and productivity. ABC clients: if you do not know or have access to the datapoints and values discussed above, feel free to reach out to your account manager for assistance in benchmarking your practice. ▲

**Jody Locke, MA,** serves as Vice President of Anesthesia and Pain Practice Management Services for Anesthesia Business Consultants. Mr. Locke is responsible for the scope and focus of services provided to ABC’s largest clients. He is also responsible for oversight and management of the company’s pain management billing team. He is a key executive contact for groups that enter into contracts with ABC. Mr. Locke can be reached at [Jody.Locke@AnesthesiaLLC.com](mailto:Jody.Locke@AnesthesiaLLC.com).





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## What You Don't Know Can Hurt You.... Understand and Meet the QPP Requirements

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) marked the end of Medicare payment's fee-for-service model and the beginning of a performance-based payment system, the Quality Payment Program (QPP). The QPP offers the choice of two tracks: the Advanced Alternative Payment Models (APMs) or the Merit-Based Incentive Payment System (MIPS). Most anesthesia practitioners participating in the QPP in 2017 will utilize MIPS.

As CMS transitions to a pay-for-performance methodology, it is easy to get lost in the acronyms and the policy. The co-sourced **MACRA MadeEasy** certified Qualified Clinical Data Registry (QCDR) platform guides clients through these changes and provides a structured and practice-specific

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## PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
October 20, 2017	American Society of Anesthesiologists International Forum on Perioperative Safety & Quality	Seaport Hotel Boston, MA	<a href="https://www.asahq.org/ifpsq">https://www.asahq.org/ifpsq</a>
October 21-25, 2017	American Society of Anesthesiologists ANESTHESIOLOGY® 2017 Annual Meeting	Boston Convention & Exhibition Center Boston, MA	<a href="https://www.asahq.org/annualmeeting/?utm_source=asahq&amp;utm_medium=landing-page&amp;utm_campaign=Annual-Meeting">https://www.asahq.org/annualmeeting/?utm_source=asahq&amp;utm_medium=landing-page&amp;utm_campaign=Annual-Meeting</a>
October 26, 2017	Texas Tech University Health Sciences Center™ 34th Annual Pain Symposium for Health Care Professionals	Texas Institute of Medical Education Plano, TX	<a href="http://dailydose.ttuhs.edu/2017/august/lub-pain-management.aspx">http://dailydose.ttuhs.edu/2017/august/lub-pain-management.aspx</a>
October 26-28, 2017	Becker's ASC Review 24th Annual Meeting: The Business and Operations of ASCs	Swissôtel Chicago, IL	<a href="http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/">http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/</a>
October 27-29, 2017	UC Davis Health 28th Annual Anesthesiology Update	Monterey Plaza Hotel & Spa Monterey, CA	<a href="http://www.ucdmc.ucdavis.edu/anesthesiology/calendar/AnnualUpdate.html">http://www.ucdmc.ucdavis.edu/anesthesiology/calendar/AnnualUpdate.html</a>
November 3-4, 2017	Society of Academic Associations of Anesthesiology & Perioperative Medicine 2017 Annual Meeting	Swissôtel Chicago, IL	<a href="http://www.saaahq.org/meetings/2017-annual-meeting">http://www.saaahq.org/meetings/2017-annual-meeting</a>
November 9-11, 2017	MEDNAX Services, Inc.* 2017 Anesthesia Leadership Conference	Loews Portofino Bay at Universal Orlando Resort™ Orlando, FL	<a href="http://www.mednax.com/">http://www.mednax.com/</a>
November 18-19, 2017	American Society of Anesthesiologists Anesthesia Quality Meeting™ 2017	ASA Headquarters Schaumburg, IL	<a href="http://asahq.org/meetings/asa-quality-meeting">http://asahq.org/meetings/asa-quality-meeting</a>
December 3-7, 2017	American Society of Health-System Pharmacists Midyear Clinical Meeting & Exhibition 2017	Orange County Convention Center Orlando, FL	<a href="http://events.jspargo.com/Midyear17/public/enter.aspx">http://events.jspargo.com/Midyear17/public/enter.aspx</a>
December 8-12, 2017	The New York State Society of Anesthesiologists, Inc. 71st Annual PostGraduate Assembly in Anesthesiology	New York Marriott Marquis New York, NY	<a href="http://pganyc.weebly.com/">http://pganyc.weebly.com/</a>

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