

THE PERIOPERATIVE SURGICAL HOME: “RIGHT FOR OUR GROUP?”

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Our Pacific Valley Medical Group (PVMG) in Pasadena, California consists of 29 partners. We’re an independent, single specialty group primarily serving Huntington Memorial Hospital and Shriners Hospital for Children, Los Angeles. We love our practice, our hospitals and our community, and as a group we think we do a great job.

As is true for most anesthesia practices, the delivery of our standard, elective anesthetic involves meeting a patient three minutes ahead of time, delivering anesthesia in the OR, landing that person in recovery and moving on to the next; “wash, rinse and repeat.” We delegate pre-operative management and post-discharge care to others. But



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THE FUTURE AIN'T WHAT IT USED TO BE

The late great Yogi Berra was famous for his humorous and wise observations. It is true that “the future ain’t what it used to be.” Until a few years ago, the future did not encompass the perioperative surgical home (PSH), but the potential impact of the PSH model cannot be doubted now. It is hard, if not impossible, to argue with the relevance of the model as value-based purchasing takes hold within the governmental and private payer markets.

The lead article in this issue, *The Perioperative Surgical Home: “Right for our Group?”* by Rick Bushnell, MD, MBA, a private practice anesthesiologist in Southern California, is a shining example of the response that the proponents of the PSH hoped to bring about. The PSH is emphatically “right” for Dr. Bushnell’s group—a single specialty private practice, which, like many others, has been successful at providing traditional surgical anesthesia care but is wondering not just how to survive, but rather whether “this is the best we can do.” This is such a refreshing perspective: the PSH seen as an opportunity “to elevate our own practice of anesthesia” and as something much more than a defensive strategy. Because the three-minute pre-op interview often shortchanges the patient and the patient-anesthesiologist relationship, Dr. Bushnell’s group plans to place a physician in the clinic to see patients both pre-operatively and following discharge. The group has recognized that anesthesiologists must expand their skill sets in order to be effective in providing pre-op and post-op care. By the time you read this, Dr. Bushnell’s group will have participated in a PSH strategy meeting hosted by one of their hospitals. We look forward to keeping you posted on the progress of the venture in a series of follow-up articles.

The future not being what it used to be, but being, in fact, much more challenging, anesthesia practices must have leadership that is performing well. Readers who serve on their groups’ Boards of Directors will probably recognize some of the behaviors that can undermine performance in the newest article by Will Latham, MBA, CPA,

of Latham Consulting Group: *Improving Board Performance*. They will also benefit from seeing to it that present and potential Board members understand their role and responsibilities, which Mr. Latham lays out succinctly while also explaining when and how to remove dysfunctional Board members.

Many anesthesia group Boards will at one time or another contemplate a practice-related financial relationship that implicates the federal Stark law. Over the last 25 years, an impressive mythology has grown up over what is, and what is not, a Stark violation. Understanding the basic principles of this complicated law is important, if only to avoid wasting time worrying about how it might apply when it actually is not in issue, and the 10-point primer offered here by Kathryn Hickner, JD of Ulmer & Berne, LLP (*Stark 101 for Anesthesiologists*) will help groups focus on what they need to know.

A less familiar legal risk for anesthesia groups that offer retirement programs including 401(k) plans is the responsibility of the plan fiduciary. The fiduciary may be a member of the group, or the group may engage an investment firm or professional. Patrick Runyen, CPA, CFP of Independence Advisors sets out some of the liabilities to which anesthesia groups, as plan sponsors, may be exposed in *Managing the “L” Word in Your Practice’s Retirement Plan (Liability, That Is)*.

The future is not what it used to be in the realm of anesthesia practice management, either, ABC Vice President Jody Locke reminds us in *Anesthesia Informatics: The Future is Upon Us*. Whether we like it or not, “while a pen, an anesthesia record and a good billing agent used to be the essential keys to financial success, a whole new set of high-tech tools is becoming necessary”—specifically with the requirements of PQRS and QCDR reporting, the meaningful use program and ICD-10 coding. Those new tools will also be called for participating in alternative payment models forthcoming from Medicare. Although few anesthesiologists are participating in the early versions of these models, which ABC

Vice President Joette Derricks summarizes in *A Basic Primer on the Bundled Payments for Care Improvement Initiative*, reviewing the fundamentals of the BPCI Initiative will help to prepare readers for the further efforts CMS is going to undertake to meet its goal of having 50 percent of Medicare payments in alternative payment models by 2018.

One cannot help but ask the question raised by Mr. Locke: “At what point does the provision of care become less relevant than the documentation of the care?” The question is, of course, rhetorical at this point. Anesthesia practices simply must make the necessary investments in information technology and accept their responsibility for seeking to make healthcare accountable and more cost-effective. Jessica Kovash, CHTS-PW, of Koratek Perioperative Consulting, LLC takes a pragmatic look at anesthesia information management systems in her article *Ensuring the Hospital’s AIMS Produces the Business Information Your Practice Needs*. Whether your hospital is looking at a new AIMS implementation or already has an AIMS in place, there are steps you can take to make sure it turns the data captured by the system into the business information your practice needs.

Changing healthcare delivery models and payment systems, and the information technologies that are ever more integral to the new models, present us with enormous opportunities as well as challenges. We take comfort in the conclusion that most anesthesiologists, like the public, know that healthcare can be much better. I, for one, believe that we are getting there.

With best wishes,

Tony Mira
President and CEO





IMPROVING BOARD PERFORMANCE

Will Latham, MBA, CPA

President, Latham Consulting Group, Inc., Chattanooga, TN

The Scene: Monthly Board Meeting

Gotham Anesthesia Associates is a 45-physician anesthesiology group providing services to patients in and around Gotham, New Jersey. Several years ago the group agreed that it was too large to have all members of the group involved in every issue the group considers. At the time they developed a five-physician “Board” that was to guide the day-to-day, week-to-week operations of the group.

The group settled on five members to allow for representation of each of the major service locations and/or sub-specialty area.

The Board meets once a month at 6:15 PM. Unfortunately, typically only Dr. Jones (the group’s President) and the Administrator are present at 6:15 PM. Other physicians join the meeting at various points and business typically gets started by 6:45 PM. Dr. Peters never arrives before 6:45 PM because, he says, “we never start until then anyway.”

The group’s agenda is sent out three days in advance of the meeting, with back-up information. Drs. Jones, Peters and Thompson always review this information thoroughly before coming to the meeting. Dr. Smith typically looks over just the agenda. Dr. Roberts gets his agenda and information from the Administrator when he arrives at the meeting.

At the beginning of the meeting each physician receives an updated agenda and supporting information. The physicians then discuss the issues presented, with each physician promoting the needs of their own service location or sub-specialty area. The topics are often vigorously discussed and long-fought, with each Board member doing a great job of representing their constituents. The President frequently



reminds the attendees to consider the group perspective, but this rarely appears to happen. Although the group has a mission and vision statement, they are rarely referred to in the meeting. All physicians participate in the discussion, with the exception of Dr. Smith who rarely expresses an opinion.

Frequently the physicians discuss issues related to spending money. There is always much discussion about how the expenditure will affect each Board member.

Around 9:00 pm, individual Board members start receiving pages and, one by one, start leaving the meeting. The meeting usually ends by 10:00 pm when there is no longer a quorum.

At last week’s meeting, the group discussed the need to open a new service location in a nearby community that is growing rapidly. When it became apparent that the Board could not reach consensus, the Board voted with the final outcome being four to one for the proposal. Dr. Peters, who voted against

the proposal, protested loudly. He stated to the members present that, “there is no way in blue blazes that I’m going to go to that location.” On the way home from the meeting, he called a couple of the non-Board members on his cell phone to tell them what happened, who had voted for the satellite and that he was against the decision. The next morning, Dr. Jones (the President) received several telephone calls from non-Board members expressing their displeasure and indicating that this issue must be discussed at an emergency shareholder meeting.

Sound familiar?

Before we look at ways to improve the performance of Gotham’s Board, let’s look at the things this group does right:

- The group has decided on a subset of individuals to govern the group.
- Meeting agendas are sent out in advance with back-up information.

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IMPROVING BOARD PERFORMANCE

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- Gotham has mission and vision statements. They have given some thought as to what they would like to be.
- The President encourages the Board members to consider the needs of the entire group.

However, in Gotham’s case, the Board’s effectiveness is limited by how well the individual members understand their role and conduct themselves.

ROLE AND RESPONSIBILITIES OF THE BOARD

No matter what size the group is, every anesthesia group Board has seven key responsibilities:

1. Setting Mission and Vision
2. Moving Group Towards Strategic Goals
3. Conducting Oversight
4. Dealing with Disruptive Physicians
5. Evaluating Management
6. Evaluating Board Performance
7. Over-Communicating with Constituents

As they serve in this role, it is essential that Board members focus on



TABLE 1 Expectations of Group Board Members

	Effective Boards	Ineffective Boards
Participation	Show up, show up on time, show up prepared.	Sporadic attendance, come late, leave early, unprepared.
Focus	Needs of the group.	Needs of the individual.
Confidentiality	Decision-making process is confidential.	Limited or no confidentiality.
Individual Members Support of Decisions	Members support the decisions or resign (the best Boards present decisions as unanimous).	Members only support decisions they agree with.

the needs of the *entire organization*, not just their own needs or the needs of the people they feel they represent. In fact, as Board members, each of them has a legal fiduciary responsibility to make decisions that take into account the needs and expectations of the entire group.

EXPECTATIONS OF BOARD MEMBERS

The best Boards have the expectations for their members set forth in Table 1 above.

To encourage these behaviors effective Boards periodically evaluate their own performance. Table 2 shows a form that can be used to support this effort.

SUPPORT OF GROUP DECISIONS

There will be times when all Board members do not agree with a Board decision. This is to be expected. The question is: what is expected of a Board member when a decision is not the one they wanted?

TABLE 2 Typical Performance Criteria for Board Members

Scale: 3 = Usually 2 = Sometimes 1 = Rarely	
Performance Criteria	Score
Good attendance habits (at most meetings, arrives on time).	
Comes to meetings well prepared, having reviewed agenda and materials.	
Actively participates in meetings.	
Follows meeting ground rules and does not attempt to dominate discussions.	
Expresses his/her opinions, votes his/her own mind.	
Supports the organization’s mission/vision.	
Actively supports Board decisions and does not sabotage Board efforts.	
Keeps decision-making confidential.	
Has a group (rather than representational) orientation.	
Total	



In our experience effective Board members speak in support of Board decisions, even if it is difficult.

Mature Board members understand the difference between *supporting* a decision and *agreeing* with it. Board members should be able to *support* a Board decision if the decision:

- Was voted on after a range of views were explored;
- Is based on the best available knowledge; and
- Is consistent with the group's stated mission and vision.



The Board should set aside time to discuss how it will handle disagreements. We recommend that all Board members agree to communicate Board decisions as follows:

1. "We thoroughly discussed the issue..."
2. "The Board agreed that this was the right thing to do..."
3. "I plan to support the decision..."
4. **"And you should too."**

REMOVING DYSFUNCTIONAL BOARD MEMBER

There are times when the Board faces the tough decision of what to do with or to a dysfunctional Board member.

Disagreements on the Board are to be expected, but there is a difference between a "devil's advocate" (challenger) and someone dysfunctional.

It is likely your group's bylaws address steps to remove a Board member.

Because meeting attendance is so important, some groups have included an automatic process to remove Board members who are often absent. The language might be "Any member absent from three meetings in succession or

four meetings in any 12-month period is automatically terminated. If such a member seeks reinstatement within two months, the Board may grant this, but not more than once per term."

If you are having trouble with a dysfunctional member, we suggest the following:

1. Conduct a peer evaluation using the form in Table 2.
2. Have the individual member counseled by the President or Chairman.
3. Vote to replace the individual. We know this is tough. However Board meeting time is too precious to allow dysfunctional Board members to squander.

CLOSING

Oh—and who is paging the Board members at 9:00 pm in the above case study? Their spouses, of course, who have been told to page them so they can slip away from the meeting... 

Will Latham, MBA, CPA, President, Latham Consulting Group, Inc. Latham Consulting Group helps medical group physicians make decisions, resolve conflict and move forward. For more than 25 years Mr. Latham has as-



sisted 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; assisted 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. Latham has an MBA from the University of North Carolina in Charlotte and is a Certified Public Accountant. 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.



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many of us are now asking “Is this the best we can do? Is this our best effort?” Many think not. Patients, payers, administrators and our partner surgeons are beginning to expect more from our practice in this pending era of ‘pay for performance.’

The healthcare funding debate is now over. The Centers for Medicare and Medicaid Services (CMS) and private payers will be reducing their costs by coupling reimbursements to quality and patient outcomes. Anesthesiologists will be held directly economically accountable for transfusions, length of stay and a growing number of other cost and quality metrics. As anesthesiologists, we want to participate in perioperative medical care in order to prevent the cancellations, to optimize the acute phase and to reduce readmissions. We are moving now to improve our quality of care in direct response to the demands of many. We understand that agencies, administrators and patients alike will rate our professional practice relative to our peers.



In addition to CMS reductions, economic pressure on MD anesthesiologists continues to grow from mid-level, non-physician, lower cost providers. When the outcomes are much the same, how then will anesthesiologists continue to justify their presence as a physician specialty? If we expect to bill at higher rates than mid-levels then we must provide additional value, proving our relevance. We must be willing to assume more responsibility by providing the critical pre-operative and post-discharge management that only anesthesiologists can deliver.

As individual anesthesiologists, we also know that we can improve the patient experience. Patients intuitively understand that anesthesia is a big deal, and commonly anesthesia is their biggest concern. They are frequently disheartened by having such a hugely important part of their medical care seemingly taken so lightly. As anesthesiologists, self-relegating our own importance to a three minute pre-op interview is to diminish, in the perception of many, the importance of our specialty. We can do better for our patients and our specialty.

As a group, we understand that our hospitals are struggling with their own CMS challenges, and they are hungry for physician leadership. All hospitals and Accountable Care Organizations (ACOs) need solid physician partners to creatively drive and participate in quality improvements. PVMG intends to be that partner for Huntington and Shriners. We intend to be the specialty group that coordinates the perioperative push for improved surgical outcomes. We intend to be those physicians that most understand the entire continuum of anesthesia care. We intend to do more than magically appear, spin the Sevo dial and walk out anonymously at the end of

the day. We’ll place an MD in clinic to see our patients both pre-operatively and post-discharge.

More fundamentally, though, we want to elevate our own practice of anesthesia. As physicians we know that meeting medically complicated patients three minutes before surgery is sub-optimal. Can we get them through surgery? In most cases, yes, but we know we can do better. Who better to optimize surgical patients than anesthesiologists? We are that physician specialty that knows best the surgical challenges presented to patient physiology. Delegating pre-op and post-discharge care solely to others is no longer good enough, and PVMG intends to more actively manage complicated patients. It’s fundamentally outstandingly good medicine to have anesthesiologists more involved.

The American Society of Anesthesiologists (ASA) is advancing the concept of the perioperative surgical home (PSH) in order to increase physician anesthesiologist involvement in the entire surgical process. We recognize the PSH as the ASA’s central strategy for increasing the relevance of our specialty. PVMG will pick up that cause by partnering with our hospitals to establish a perioperative surgical home in Pasadena in the form of pre-op and post-discharge clinics.

At Shriners Hospital for Children, Los Angeles, we’ve stationed a physician anesthesiologist to evaluate every child in the ambulatory clinic days to weeks before surgery. The same anesthesiologist admits and discharges each patient on the day of surgery and follows them up in post-discharge clinic during their first follow-up visit with their surgeon. At Shriners Hospital, Los Angeles, the continuum of anesthesia care encompasses the entire perioperative continuum; from the decision to operate to final dispensation.



Our clinic model for both pre-operative and post-discharge evaluation by the same physician is based on increased patient satisfaction and a high priority placed on the continuum of patient management. We also recognize clinic processes as separate learning curves and skill sets apart from OR skill sets. Clinic physicians must necessarily be familiar with national guidelines for pre-op evaluation and optimization protocols. They also must develop additional clinical intuition and interventional strategies for post-discharge patients who are about to fail: those at highest risk of readmission. The combination of seeing patients both pre-operatively and post-discharge is a major advantage in preventing the readmissions so costly to our organizations. The continuity also serves physicians well in that seeing post-discharge patients is an excellent education that immediately raises physician pre-op evaluation skill sets.

This model, the popularity and the results of this clinic are self-evident in the near-zero cancellation rate, the zero readmission rate and in patient satisfaction surveys. Because of this success and the encouragement of the ASA,

PVMG will now bringing this model to Huntington Memorial. Huntington's 11,000 surgical cases pose a different challenge, though. The large adult population presents entirely different medical demographics and the sheer volume forces us to concentrate on those patients at highest risk.

Our most immediate goal for the Huntington Memorial clinic will be for our MDs to concentrate on the most complicated 20 percent of patients. We'll also be recruiting the help of our surgeon partners in our effort to triage this population. The range of surgeries is likewise diverse, even including labor and delivery patients. In this triage effort, we also know that we'll need the help of a data management vendor.

To introduce this effort, in August we held our own first annual perioperative surgical home conference. We are grateful to Zeev Kain, MD, the face of the ASA's PSH, for his wonderful introduction of this concept to our gathering. In attendance that evening was the majority of the C-suite, a healthy selection of surgeons, mid-level hospital administrators and PVMG anesthesiologists. The result: our Huntington Memorial

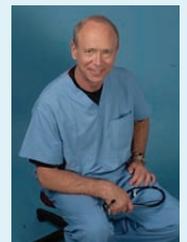
CEO is hosting a mid-September strategy meeting. We're all taking this effort seriously and we're determined to form a strong, productive Huntington-PVMG partnership.

Our group recognizes the perioperative surgical home and anesthesia clinics as great public relations, excellent physician leadership and fundamentally good medicine. As important, though, if our specialty is to maintain its relevance, then as anesthesiologists we must assume more responsibility. We must extend and improve our management to include the complete perioperative process, a continuum from the moment of decision to operate to the completion of recovery.

Relevance in the future will be defined by cost, quality and patient experience. Our Pacific Valley Medical Group in Pasadena is determined to elevate the specialty of anesthesia and deliver better outcomes to our patients, our hospital and our payers.

Yes, the perioperative surgical home is indeed "right for our group." 

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STARK 101 FOR ANESTHESIOLOGISTS

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Sometimes those of us in the healthcare industry become so immersed in the multitude of applicable regulations, and their evolution and ambiguities, that we need to take a step back and be reminded of the basics. So for a few moments, let's push aside the status of healthcare reform, the future of independent anesthesiology practices, the abstract and sometimes conflicting guidance governing anesthesia joint ventures and the nuances of ICD-10. Let's refresh our recollection regarding a federal law that has been with us in various forms for about 25 years and that continues to impact us each day. This is a broad overview of the federal Stark law¹ in 10 quick bullet points.



1. It's important to understand what Stark is and what it is not. It is relatively common for healthcare attorneys to receive calls from clients requesting a Stark review of a relationship when the Stark law is not even at issue. For example, many services relationships between anesthesiologists and ambulatory surgical centers and the joint ventures between anesthesiologists and gastroenterology groups avoid implicating Stark but involve risk under applicable federal or state anti-kickback laws and state fee-splitting laws. These laws are not all the same. In order to analyze an arrangement and ensure legal compliance, it is crucial to understand which laws are truly applicable and which laws are not.

2. The federal Stark law is a technical statute that requires a technical analysis. In order for a relationship to implicate Stark, five basic elements must be present: (1) a *physician* must make (2) a *referral* for the furnishing of (3) *designated health services* payable by Medicare (4) to an *entity* (5) with which he/she (or an immediate family member) has a *financial relationship*.² When the Stark law is implicated, only the physician may make such a referral, and only the entity may present (or cause to be presented) claims for such referred services, if a Stark exception applies to protect the applicable financial relationship. Each arrangement

must be analyzed on a case-by-case basis with close attention to the underlying circumstances.

3. In the Stark context, intent (whether bad or good) doesn't matter. Unlike the federal Anti-Kickback Law,³ which is a criminal law prohibition focused on impermissible intent, Stark is a strict liability civil statute. In other words, an honest good faith mistake can result in a Stark violation. And yes, this does mean that an inadvertent missing signature on a services agreement or an attorney's failure to ensure that an agreement has a term of at least one year may alone prevent reliance on an available Stark

¹ For purposes of this article, "Stark" refers to 42 U.S.C. §1395nn, and the regulations and guidance promulgated thereunder.

² A discussion of Stark's application to Medicaid claims is beyond the scope of this broad overview.

³ See 42 U.S.C. §1320a-7b(b) and the regulations and guidance promulgated thereunder.



exception and could, depending upon the circumstances, result in a relationship constituting a Stark violation that results in millions of dollars of overpayments.

4. Understanding the applicable definitions is the key to any Stark analysis.

Each element of the Stark law relies upon specific statutory and regulatory definitions that are clarified by regulatory preamble, case law and other federal guidance. For purposes of this brief article, we note that the term “physician” includes anesthesiologists (MDs and DOs); “designated health services” (or DHS) include without limitation certain inpatient and outpatient hospital services;⁴ and financial relationships may be direct or indirect and may include not only ownership and compensation relationships but also other relationships involving non-monetary remuneration exchanged between the parties.⁵

5. Some (but not all) anesthesia arrangements implicate Stark.

For example, in order for an arrangement to violate Stark, there must be a referral of DHS involved.⁶ It is common for anesthesiologists with pain medicine practices to order DHS in connection with their pain management services.

Also note that the Centers for Medicare and Medicaid Services (CMS) has indicated that anesthesiologists (unlike other specialties such as hospital-based pathologists, radiologists, or radiation oncologists under certain circumstances) may be considered to have made referrals of DHS when they order the technical component of DHS performed by someone other than the physician.⁷ But also note that the Stark definitions of “inpatient hospital services” and “outpatient services” do not include “professional services performed by physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists and qualified psychologists, if Medicare reimburses the services independently and not as part of the inpatient or outpatient hospital service (even if they are billed by a hospital under an assignment or reassignment).”⁸

6. Every element of a Stark exception must be satisfied in order for the exception to be helpful. There are numerous exceptions but reliance upon an exception requires that each and every element be satisfied. One common exception relied upon by anesthesiologists is, for

example, the personal services arrangement exception.⁹ Broadly summarized, the personal services exception requires that (a) each arrangement is set out in writing, is signed by the parties, and specifies the services covered by the arrangement; (b) the arrangement covers all of the services to be furnished by the physician (or an immediate family member of the physician) to the entity; (c) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement; (d) the term of each arrangement is for at least one year; (e) the compensation to be paid over the term of each arrangement is set in advance, does not exceed fair market value, and, except in the case of certain physician incentive plans, is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and (f) the services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law.

7. In the Stark context, fair market value becomes not only a business term but also a legal term. As referenced above, demonstrating fair market value is often essential to ensuring that proposed arrangements are compliant with Stark.¹⁰ The definition of fair market value in the healthcare regulatory context is different than in other contexts. Although it is sometimes acceptable for the

⁴ “Designated health services” include clinical laboratory services, physical therapy services, occupational therapy services, outpatient speech-language pathology services, radiology and certain other imaging services, radiation therapy services and supplies, durable medical equipment and supplies, parenteral and enteral nutrients, equipment, and supplies, prosthetics, orthotics, and prosthetic devices and supplies, home health services, outpatient prescription drugs and inpatient and outpatient hospital services.

⁵ See 42 CFR §411.354. In the anesthesia context, financial relationships can involve, depending upon the circumstances, exclusive agreements with stipends or other compensation, ownership interests in ambulatory surgical centers and the receipt of other items of value such as space and equipment. See *U.S. ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88 (3d Cir. 2009).

⁶ For example, see discussion in Advisory Opinion No. 98-001 (1998) (regarding a proposed ambulatory surgical treatment center).

⁷ See Stark Phase III Final Rule preamble, 72 FR 51012, 51021 (2007).

⁸ See 42 CFR §411.351.

⁹ See 42 CFR §411.357.



STARK 101 FOR ANESTHESIOLOGISTS

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parties to make a good faith reasonable determination of fair market value and document such determination in their files, the best approach is to obtain a third party valuation from a qualified and experienced healthcare valuation consultant.

8. Stark violations can have devastating consequences.

As described above, when the Stark referral prohibition is violated (because Stark is implicated and there is no available exception), Medicare reimbursement is not available for the DHS services provided as a result of the prohibited referral. This can result in denials of payment or mandatory refunds of payment. Providers are required to report and return any resulting overpayment no later than 60 days after the date on which the overpayment was identified or the date on which any

corresponding cost report is due, if applicable.¹¹ Stark law violations can also serve as the basis for civil monetary penalties, False Claims Act liability (which may result in a *qui tam* suit and *treble* damages) and potentially exclusion from the governmental health care programs.¹²

9. CMS has a protocol that providers may use to self-disclose a Stark violation.

Note that CMS has adopted a Medicare self-referral disclosure protocol to enable providers to self-disclose actual or potential Stark violations. Despite the guidance and discretion available to CMS to mitigate the impact of a Stark violation, the self-disclosure process remains a very intimidating process for the health care community.¹³

10. Stark calls upon anesthesiologists to act prudently.

For anesthesiologists, it is crucial to seek legal guidance when there is any potential healthcare regulatory concern.¹⁴ Experienced health care attorneys will be able to assist in determining the actual legal issues and to advise whether a proposed relationship is defensible from a legal perspective. Relationships between anesthesiologists and hospitals or other facilities should always be documented in writing to reflect the entire relationship, be updated overtime as appropriate, be reviewed to confirm commercial reasonableness and be scrutinized to ensure that compensation is within the range of fair market value. When in doubt about whether the Stark prohibition is applicable to a proposed relationship, the parties should certainly err on the side of caution and satisfy each and every element of an available Stark exception or refrain from implementing the arrangement. Even when Stark is clearly not implicated, satisfaction of a Stark exception is typically advisable as a best practice and regulatory safeguard. ▲

¹⁰ For example, for purposes of the Federal Stark law, “fair market value” means: “the value in arms’ length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.” 42 U.S.C. §1395nn. The regulations promulgated pursuant to the Federal Stark law go on to state, “general market value” means: “...the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.” 42 C.F.R. §411.351 (emphasis added). For a discussion of fair market value principles as they relate to hospital exclusive contracts, see for example the Stark Phase II Interim Final Rule, 69 FR 16054 (2004).

¹¹ ACA §6402.

¹² See 42 U.S.C. §1395nn, 42 CFR §411.353 and 42 CFR §1003.100. See also for example *In U.S. ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88 (3d Cir. 2009) and the Covenant Medical Center 2009 False Claims Act Settlement (<http://www.justice.gov/opa/pr/covenant-medical-center-pay-us-45-million-resolve-false-claims-act-allegations>).

¹³ ACA §6409. See also https://www.cms.gov/medicare/fraud-and-abuse/physiciansselfreferral/self_referral_disclosure_protocol.html.

¹⁴ An excellent resource for new or experienced physicians attempting to understand Stark and the federal fraud and abuse laws is “A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse,” which is available at <http://oig.hhs.gov/compliance/physician-education/index.asp>.

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ANESTHESIA INFORMATICS: THE FUTURE IS UPON US

Jody Locke, MA

Vice President of Anesthesia and Pain Management Services, ABC, Jackson, MI

Anesthesia practice management used to be relatively simple. Bill correctly, collect aggressively, and everyone is happy. It is true that Medicare and managed care made getting paid a little more challenging, but a good day's work in most facilities generally resulted in enough revenue to cover the cost of the providers, and when it didn't most hospitals have been willing to make up the difference with some level of stipend or revenue guarantee.

Most anesthesia providers would argue that for all the payment challenges created by diverse payer rules, fee for service medicine is still the preferred system. They like the fact that you get paid to provide services. What they don't like are the increasing layers of complexity being imposed by efforts to measure quality and appropriateness of care. Especially concerning is the perception that what started as a trickle of inconvenient reporting requirements is gaining momentum to form a river of change that threatens to wash away any vestige of the once familiar mode of practice. Many older doctors are glad their time as anesthesiologists is almost up. They understand that it will be up to the next generation to find opportunity in what appears to be an irreconcilable sea of constraints and regulations.

THE GOOD OLD DAYS

Remember the days of 4-by-6-inch charge books that fit in the pocket of hospital greens? Anesthesia providers got quite good at documenting what



they could bill to patients and their insurance. There was never a doubt about the surgical procedure, the start and end times of cases or any of those unusual patient or operative factors that might apply. Their charge tickets even included little check boxes for the other services they might be able to include such as invasive monitoring, transesophageal echocardiography, the administration of nerve blocks for post-operative pain management and ultrasonic guidance. There was a certain freedom that was consistent with the history and culture of the specialty. Each provider developed his or her own protocols and approaches and billed accordingly. Anesthesia has always prided itself on its autonomy. Such notions as peer review, provider profiling or performance assessment were just not a major part of the culture of the specialty. I can remember asking an anesthesiologist if anesthesia were art or science and he said yes!

For years anesthesia has operated in the shadows, an arcane world whose

true value was really only understood by its practitioners. "Who is that masked man?" was the title of a *Newsday* feature article about Dr. Peter Walker, a Long Island anesthesiologist, in 1982. Those were the days when anesthesia was a free good for hospitals, meaning it did not cost the hospital anything to contract with a group for professional services. Then everything started to change. Payers started to question the cost of anesthesia care and hospitals started to get insistent requests for financial support from their contracted anesthesia providers. As the economics of care started to change customers and payers started asking questions. Ultimately the specialty ended up under the magnifying glass.

The evidence of this change has been both general and specific. In general terms the overall cost of American healthcare has become a topic of public debate and anesthesia is no exception. The impact of this transition has been especially evident in payer contract negotiations. But specifically with regard to the specialty, as each individual anesthesia practice made its case for some level of financial support to hospital administration more questions were being raised about what they were getting for what they were paying. This has proved to be a rude awakening for many anesthesia practices. The specialty was crossing over from a world in which providers got paid for what they billed to one in which they got paid for what they negotiated.

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ANESTHESIA INFORMATICS: THE FUTURE IS UPON US

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PQRS

So what? Was anything really changing in the life of the typical anesthesia provider? Yes and no. The first incursion was the Centers for Medicare and Medicaid Services (CMS') Physician Quality Reporting System (PQRS). What a curious phenomenon! The intent was to implement some quality measures specific to anesthesia, yet the result was a set of process measures:

- Administration of antibiotic within an hour before incision
- Use of sterile technique for central venous catheter placements
- Use of active temperature management for cases 60 minutes or longer

The original list of PQRS official measures started to grow and morph. Anesthesia providers did too well with the documentation of antibiotics so the administration of beta-blockers was added to the list and ultimately antibiotic

prophylaxis came off. Each year there was a new iteration. What started as a small bonus evolved, as planned, into a potential penalty for non-compliance.

One might argue that the most curious of these is the recent PQRS “cross-cutting” measure #47, which will probably be short-lived. Anesthesia providers who round on patients with continuous catheters—like doctors performing primary care visits in their offices—are expected to ask the patients if they have an advance care directive. They don't have to look at it or know what is included. They simply need to document that they asked about it and what the answer was. While there is actually some quite compelling literature, justifying how such a measure applies to anesthesia is a little mystifying. Fortunately, most anesthesiologists will not be affected, but even so this is a preview of coming attractions.

MEANINGFUL USE

Meaningful use was another curious experiment in physician behavior modification. Providers started receiving

bonus payments to capture information that potentially could be used to populate a patient healthcare portal. Many of us wondered about such rich incentives for a program that appeared to have such limited potential benefits. Now the incentives to implement electronic medical records are considerably more complex.

Little by little, though, a pattern is emerging here. It is not hard to see where this is taking American medicine. The simple mechanics of fee-for-service medicine are giving way to an entirely new era of healthcare informatics. While a pen, an anesthesia record and a good billing agent used to be the essential keys to financial success, a whole new set of high-tech tools is becoming necessary to keep abreast of the rapidly changing face of healthcare informatics.

ICD-10

What should we make of the transition from ICD-9-CM to ICD-10-CM diagnosis coding, which must be completed by October 1, 2015? Is it the big deal that many practices are worried about, or will it prove to be another of those transitions where the advanced hype outstripped the reality of implementation?

It is a big deal and its implementation will further justify the argument for a perioperative surgical home.

Essentially, an inconspicuous formalistic element of the claim process that never had anything to do with the justification of the anesthetic will become a critical piece of information for payment of the anesthesia claim. This is no small thing. Not only are the logic and structure of ICD-10 codes considerably more complex and intricate than the previous coding sequence, but now there is an expectation that everyone in the



operating room who participates in the care of the patient should know why this patient is having this procedure at this point in time. Payers will actually have the ability to use the information on the anesthesia claim to validate the surgical claim, the consequences of which could dramatically impact denials and cash flow.

Figure 1 is a typical ICD-10 decision tree for colonoscopy services. It highlights the logic of the new sequence. While the typical anesthesia diagnosis for a polypectomy might have been limited to “polyp(s),” such a shorthand summary will not be sufficient after October 1st for a qualified ICD-10 coder to determine an appropriate and valid ICD-10 code, the absence of which would surely increase the risk that the claim would be denied by the payer. In order to avoid significant increases in denials and the resulting impact on cash flow, anesthesia providers are having to step up to the plate to master a new language and change how they document the diagnostic justification for the surgical procedure performed.

TABLE 1

Coding Options for a Colonoscopy

ICD-10-CM	DESCRIPTION
C19	Malignant Neoplasm of Rectosigmoid Junction
C20	Malignant Neoplasm of the Rectum
K52.89	Other Specified Noninfective Gastroenteritis and Colitis
K57.30	Diverticulosis of Large Intestine Without Perforation or Abscess Without Bleeding
K57.32	Diverticulitis of Large Intestine Without Perforation or Abscess Without Bleeding
K57.90	Diverticulosis of Intestine, Part Unspecified, Without Perforation or Abscess Without Bleeding
K62.0	Anal Polyp
K62.1	Rectal Polyp
K62.4	Stenosis of Anus and Rectum
K62.5	Hemorrhage of Anus and Rectum
K62.89	Other Specified Diseases of Anus and Rectum
K63.5	Polyp of Colon
K92.2	Gastrointestinal Hemorrhage, Unspecified
Z12.11	Encounter For Screening For Malignant Neoplasm of Colon
Z86.010	Personal History of Colonic Polyps

Table 1 presents a list of valid coding options for a typical colonoscopy. The anesthesia provider must provide sufficient detail in the diagnosis so that a qualified ICD-10 coder can make an appropriate determination. The real question, of

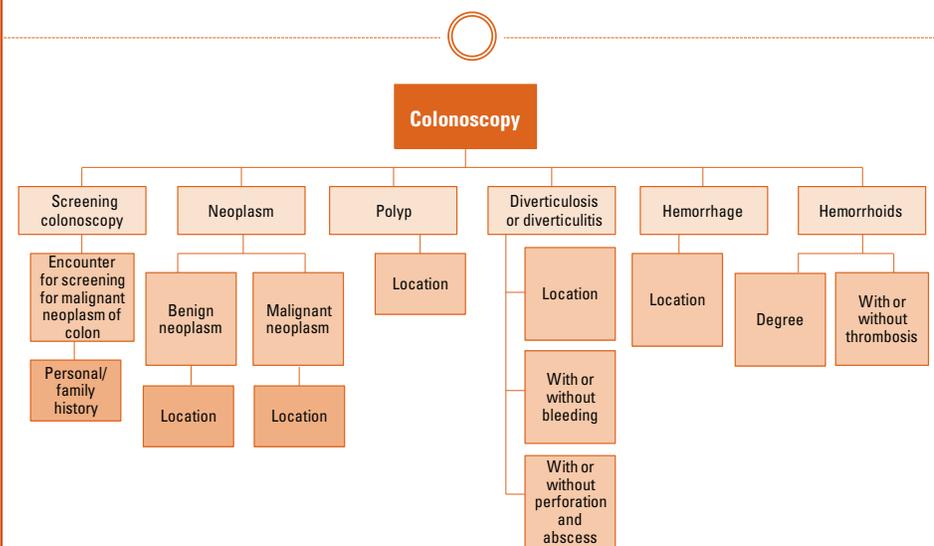
course, is whether the endoscopist can make the determination.

Anyone who thinks the transition will go smoothly has not taken the time to look into the details. The logic and the level of detail required vary greatly from one surgical procedure to another. The good news is that about 25 common procedures account for 60 percent of all surgical cases so the list of frequently performed procedures with which anesthesiologists must become familiar is fairly short.

There is a curious irony at work here. If the intent of ICD-10 is to give the payer a means of validating the surgeon’s diagnosis, then it is a very imperfect method. How do payers think the anesthesia provider will confirm the details of the post-operative diagnosis if not by means of a post-operative time out? Actually, it is starting to appear as if many anesthesia providers are better prepared than their surgical colleagues, thanks in no small measure to the full court press put on by ABC to educate all its clients.

FIGURE 1

Colonoscopy CPT 45378 and 45385



ANESTHESIA INFORMATICS: THE FUTURE IS UPON US

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What could possibly justify such a disruption? Proponents such as the American Healthcare Information Management Association (AHIMA) argue the new codes could greatly improve our ability to:

- Modernize and expand capacity to keep pace with changes in medical practice and healthcare delivery by providing higher quality information for measuring service quality, outcomes, safety and efficiency;
- Enable better patient care through better understanding of the value of new procedures, improved disease management, and improved ability to study and understand patient outcomes;
- Improve data capture and analytics of public health surveillance and reporting, national quality reporting, research, and data analysis, and provide detailed data to inform healthcare delivery and health policy decisions.

Like it or not, one of the greatest shortcomings of the current healthcare delivery system is its lack of coordination among providers, which is one of the underlying motivations for the implementation of electronic medical records (EMRs). Individual providers, and this is especially true of most anesthesia practices, tend to operate independently and in a vacuum. Such atomistic behavior and isolated charting practices are certainly not conducive to a detailed analysis of patterns of care that could result in process improvement.

The point is there is no turning back. Academicians, clinical researchers and politicians are insisting on answers to complex and detailed questions about the nature of healthcare utilization and

cost. There is a broad-based commitment to finding ways to better manage quality and cost. Anesthesia providers have no choice but to embrace the logic of ICD-10 and find ways to collaborate with their surgical colleagues in the post-operative determination of appropriate diagnoses.

While the implementation of ICD-10 will preoccupy most providers for the balance of 2015 and into 2016, there is yet another challenge looming ahead of us. CMS is committed to move from the cumbersome claims-based reporting of PQRS indicators to registry reporting. Again this is one of these ideas that make sense if you take a long-lens view, but it is being perceived as just one more complicating factor in the delivery of compassionate and quality healthcare.

Where and how will it all end? At what point does the provision of care become less relevant than the documentation of the care? It is almost Kafkaesque especially when we consider what is being contemplated as the next step in the unfolding saga of clinical documentation requirements: the Qualified Clinical Data Registry (QCDR) (and the Anesthesia Quality Institute's [AQI] QCDR is arguably the most important such registry for anesthesia).



QCDR

If you want a simple way of thinking about the QCDR try this: Make a list of all the various aspects of anesthesia care that could be measured and which might tell us something about the quality of the care provided. Put them all together and you have a rough approximation of the basic vision for the QCDR. The AQI's proposed list for its QCDR currently includes 41 measures.

The proposed plan is that each practice will pick nine measures to report. The measures are grouped into the following domains of which three must be represented by the measures selected.

1. Person and Caregiver-Centered Experience
2. Patient Safety
3. Communication and Care Coordination
4. Community and Population Health
5. Effective Clinical Care

The measures are further grouped into process and outcomes measures. "Measure #6: PACU Transfer of care: use of checklist" would represent a process measure. "Measure #11: Immediate perioperative cardiac arrest rate" would be considered an outcomes measure. Each practice must report at least two outcomes measures.

The good news is that the proposed plan allows for considerable flexibility in choosing measures that appear reasonable and relevant to the practice. The challenges will be the practical considerations associated with data capture and reporting. Those with EMRs will find such data capture relatively easy while those still using paper forms will have to modify their forms or add a new form.

The other aspect of QCDR reporting that cannot be overlooked is that this



will represent a change in submission methodology. Currently PQRS measures are included on Medicare claims as CPT codes. The plan is to migrate to a registry-based reporting system whereby the measures are sent to CMS. This will impose yet another layer of connectivity on each practice. There are various registry options open to anesthesia practice but most will probably choose the AQI QCDR. It is too early to tell what the full impact of this transition will be but this project will no doubt occupy most practices next year.

CHALLENGE AND OPPORTUNITY

It has always been one of the great ironies of anesthesia that despite the dazzling array of space-aged technology used in the operating room to manage patients safely through all manner of clinical obstacles and complications, anesthesia record-keeping still tends to be rather byzantine. Clearly, this is changing rapidly. The historical reporting tools simply cannot support the data requirements of tomorrow's medicine.

In her book *Confidence: How Winning Streaks and Losing Streaks Begin and End*, Harvard Business School professor Rosabeth Moss Kanter identifies three qualities that consistently distinguish organizations that evoke

confidence in their customers and employees. They are:

- Accountability
- Collaboration
- Innovation

It is becoming quite clear that these are the very qualities that the American public is seeking in our current healthcare system. While the various developments described above may appear to physicians as part of a vast conspiracy arraying itself against organized medicine these are simply attempts, imperfect and inchoate as they are, to bring some order to the chaos and inconsistency of the present system. There needs to be a realignment of incentives such that the system works more as a whole rather than as a collection of individual practices.

So where, you may be wondering, is there any opportunity to profit or gain from such a complicated overlay of reporting requirements? Sometimes one player's advantage comes at the expense of another's failure. It is true that the focus of all these developments is analytics, but the ultimate objective is far more significant. Either your practice is making the necessary investment in adopting the necessary technology or it is not. Most would predict that those that are not will soon be left behind. This is one reason why we are seeing such consolidation of anesthesia practices; only those with access to significant capital resources can make the necessary investment in IT.

Maybe this is the wrong question. There is a paradigm shift taking place in medicine. We joke about the fact that physicians are not business people but the fact is this is not true: they tend to be true entrepreneurs focused on the success of their own little cottage industries. For far too long the consumer paid a premium for what economists

refer to as supplier-induced demand. Only the doctor knew what was wrong with you and what it would take to make you better. This approach has resulted in the most expensive system on the planet with the least impressive results. Society wants consistent and predictable results for a reasonable cost. It wants a system that provides more accountability for outcomes in which specialists collaborate in the management of a patient's care and to see evidence that all the impressive technology serves to make the system more effective and efficient, not just more expensive. It is a tall order, to be true, but it is what drives public policy which is where all these new regulations keep coming from.

Until providers start focusing on ways to make the entire system more cost-effective instead of on their share of the healthcare pie, they will find themselves swimming upstream in increasingly perilous waters. Fee for service medicine is destined to be replaced by a far more complicated system of risk-sharing. What we have seen thus far is just a preview of coming attractions. The public knows healthcare can be much better, and, frankly, most anesthesiologists believe that too. Those who find ways to make it so will be the real heroes of the next generation. 

Jody Locke, MA serves as Vice President of Anesthesia and Pain Practice Management for ABC. 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 will be a key executive contact for the group should it enter into a contract for services with ABC. Mr. Locke can be reached at Jody.Locke@AnesthesiaLLC.com.



ENSURING THE HOSPITAL'S AIMS PRODUCES THE BUSINESS INFORMATION YOUR PRACTICE NEEDS

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Historically anesthesia information management system (AIMS) adoption has lagged significantly behind overall hospital electronic health record (EHR) adoption. However, in more recent years, the pace of AIMS adoption has accelerated with the implementation of meaningful use and with the increasingly apparent “gap” that a lack of electronic anesthesia encounter information leaves in a patient’s electronic clinical record.

“In 2014, about 70 percent of hospitals in the U.S. had some form of electronic medical record and 45 percent of anesthesia practices utilized electronic anesthesia records, otherwise known as anesthesia information management systems (AIMS).”

Unfortunately as hospitals increasingly adopt AIMS solutions, anesthesia providers (let alone anesthesia

practice management teams) have had little input in the selection, build and implementation of the AIMS. However, input from anesthesia providers and practice managers is essential in order to get optimal use and benefits out of a system, regardless of the organization’s stage of adoption.

For *new AIMS implementations/conversions*, even if your practice has little input in the selection, we encourage you to have a say in the selection, build and implementation; for *existing AIMS systems*, we encourage you to get to know the system and seek opportunities to gather the business information your practice needs (and not settle for what you are given).

RECOMMENDATIONS FOR NEW AIMS IMPLEMENTATIONS

1. Be Involved
2. Optimize System Functionality
3. Ensure Long-Term Success

Be Involved

Having the right team members and representation is a critical first step to a successful implementation—regardless of the system selected. Most hospitals (and even anesthesia providers) neglect to consider the valuable contributions that anesthesia business professionals (practice managers, HIM professionals, quality analysts, end users) can make during the build, planning and adoption of a system.



When the business professionals are present in the process they are able to provide valuable insight into data needs and assess opportunities to capture key information that benefits not only the practice but the hospital as well. Following the ideal EHR state of “capture once, use multiple times,” key information that can (and should) be captured once and used multiple times includes:

- Clinical practice data points that have an economic impact downstream (e.g., medical direction, type of anesthesia, anesthetic agents, postoperative management of pain and nausea/vomiting).
- Operational practice data for benchmarking, performance improvement initiatives, hospital contracts.





- Quality performance data for reporting and compliance (e.g., PQRS, meaningful use, and incentives).

How can you get involved? Attend training sessions and/or seek out training materials and ask questions of the vendor regarding integration/reporting capabilities. Knowledge *is* power.

Knowing and understanding system functionality and capabilities upfront—along with limitations—enable group practices to better utilize and leverage the data available in the system and, backing up a step, adeptly support the anesthesia providers in the accurate capture of required data elements. We also recommend that you get to know the hospital's internal technical expert—the person who is or will be trained to know where the data elements exist and how to export data from the database should it be required for reporting and/or ad hoc report development.

Optimize System Functionality

There are several opportunities to be involved in a system implementation/conversion and help ensure a smooth and optimal implementation for the anesthesia practice.

1. *System Build:* Get involved early on in the project, during the system build. Getting involved early on provides greater assurance that the data collected is “useable” data by both the practice and the hospital.

During the build, keep the following build “best practices” in mind:

- Establish clear data definitions and terminology that are universally understood (encourage the OR and anesthesia to work off the same data dictionary).
- Use standardized terms to allow for accurate analysis

down the road (i.e., for quality measurement and improvement, ensuring data comparisons are “apples to apples”); don't use multiple terms that describe the same thing.

- Minimize free text fields; use codified entries and lists to generate cleaner data which allows for smoother integration and data extraction.
 - Minimize number of fields; don't create different fields that capture the same information.
2. *Testing:* Participate in system and process testing prior to implementation go-live. Ensuring that the hospital's AIMS will get you the business information your practice needs *requires* system and process testing prior to going-live. During testing:
 - Obtain a written testing plan from the vendor and/or enlist the help of your consultants for development of a plan.
 - Test and validate record, data and billing service access prior to go-live.
 - Have providers document real case scenarios and transmit the data to the anesthesia business office, business intelligence software and billing services and then have the billing office and business professionals evaluate the data received.
 - Identify and resolve issues/gaps before go-live to prevent lost revenue and claim denials.
 3. *Policies and Procedures:* Assist in the development of policies and procedures for minimally required and/or best practice data entry and data capture; for amending records; for acceptable



time frames for post-case modifications such as Late Entry, Addendum and Corrections; and for down-time processes (when users are forced to revert back to paper documentation due to technical problems). Not having a clear and concise processes for such situations can result in significant gaps in quality/reporting data and potential for missed charges and lost revenue.

4. *Interfaces/Integration:* Work with the IT department and vendor representative to build a bridge for data transmission from the hospital AIMS to the practice management and billing companies for facilitating the transfer of key data for billing, compliance reporting and quality reporting. AIMS integration with billing (done the right way) eliminates:
 - Duplicate data entry
 - Manual tasks
 - Inconsistent data

If integration is not possible, look at opportunities to develop auto-generated reports that are electronically

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ENSURING THE HOSPITAL'S AIMS PRODUCES THE BUSINESS INFORMATION YOUR PRACTICE NEEDS

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transmitted to the billing department in a useable format and/or work with outside services to develop the reports needed. Lastly, investigate available reporting capabilities and/or supplemental business intelligence software integration and dashboard data display for near real-time analysis of practice performance.

5. *Implementation:* During a go-live, hospitals and IT departments should recruit a support team of super users to assist the healthcare providers with questions, problems and support as they adjust to this new clinical documentation process. Having a robust support team with adequate coverage ratios is crucial to the success of the go-live. The support team needs to be available as soon as providers experience problems. Otherwise, key teaching moments will pass and obstacles will trigger work-arounds and end-user frustration with the system.

Equally important are resources during go-live to audit the anesthesia documentation (as near to real-time as possible) for accuracy and completeness and to assist users with timely corrections to ensure accurate quality data correction and billing, preventing delays and denials. The auditors need to pay particular attention to fast-paced cases such as endoscopy and procedures performed outside the operating room such as interventional radiology, cath lab and MRI.

Establishing a clear communication process to relay issues and findings to anesthesia providers and partnering



with the anesthesia providers and IT resources to establish processes or to minimize these issues (e.g., alerts, prompts, mandatory fields, other tools to promote efficiency and compliance) will help mitigate the impact on data accuracy and availability. Developing a simple, organized issues list to capture, detail, troubleshoot and track issues will aid in the communication.

With a new documentation process moving from a narrative-free text type documentation to codified choice selection, anesthesia providers can feel anxious, rushed and overwhelmed, easily overlooking key elements such as times, procedure notes, relief personnel, quality indicators, all of which can significantly impact claims submissions.

Ensure Long Term Success

Once your group's AIMS is live (and the dust settles) it is important to establish a regularly scheduled process for auditing the data capture. Insight into and recommendations for auditing to ensure the AIMS data you are receiving on a go-forward basis is accurate, timely and useful are discussed in the next section of this article.

Continue to seek opportunities to be actively involved in upgrades and enhancements and to utilize the data being captured by the system (refer to

the subsequent section of this article on "realizing the clinical and operational data value."

RECOMMENDATIONS FOR EXISTING AIMS SYSTEMS

1. Assess Functionality
2. Audit Data Capture
3. Optimize Functionality and/or Data Captured
4. Realize Clinical and Operational Data Value through use of Business Intelligence (BI) Tools

Assess Functionality

Learn what the AIMS is capable of capturing. We would encourage you to seek out AIMS training materials and opportunities and observe the data capture flow from preop through PACU (it would be good to conduct observations on more than one provider—including a super user as, although we'd like to think there is standard documentation practice... that isn't always the case).

Additional opportunities to learn more about the system include reaching out to other groups who use the system for AIMS functionality tips and tricks (that can then be shared with your providers) and joining online user group forums.

Audit Data Capture

Once you have an understanding of the functionality and capability of the system, we recommend establishing an ongoing process for auditing data capture completeness and accuracy. Similar to work performed during the implementation phase, the audits help ensure that data is being captured accurately and timely on time for billing, compliance and quality reporting use.



Look for opportunities to improve billing efficiencies and decrease time bills remain in accounts receivable. Monitor and correct processes that result in services that are unbillable due to inaccurate or missing documentation.

Areas in which to be mindful of risks include:

- Supporting documentation (additional lines/blocks; medical direction)
- Missing documentation (procedure notes, ultrasound images)
- Accurate times (relief)
- Inconsistent documentation from one provider to the next

Optimize Functionality and/or Data Captured

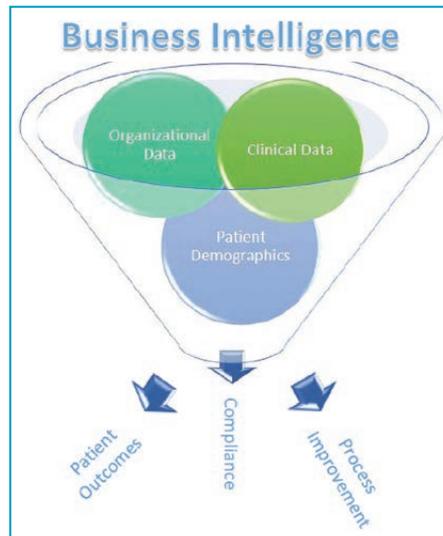
Based on the results of your functionality review and data capture audit, you will be able to identify gaps in what is or could be available vs. what is coming across to the practice in a useable format.

Look for opportunities to take the next steps in optimizing and automating the anesthesia services processes. Even with the implementation of AIMS systems few practices incorporate use of the anesthesia professional coding tools, electronically capture professional fees or electronically transmit billing information to their billing services departments.

We recommend working with the anesthesia providers, AIMS system IT resources, vendors, report experts and AIMS consultants to address gaps and ensure that the system is being optimally utilized.

Realize Clinical and Operational Data Value through use of Business Intelligence (BI) tools

Most commercial AIMS systems, particularly enterprise-wide systems,



fall short when it comes to reporting and collective data gathering for clinical and operational analysis. Getting the meaningful data out of your AIMS System and transforming it into actionable information requires the use of BI tools; analytics software, integration technology and data warehouses that can collect the data and create useable data dashboards, performance scorecards, data mining and interactive, customizable reporting. Investigate what BI tools your healthcare organization has available and explore opportunities to utilize that data for tracking patient outcomes, compliance and process improvements through evidence-based decision making. BI tools also provide predictive analytics, the ability to forecast and monitor trends which can assist in cost saving operational budgeting and strategic planning.

Using BI tools can be a little intimidating and takes an investment of time to become educated on how to use these tools and to create dashboards and reports specific to the needs of anesthesia services. Investigate what resources (business analysts) are available through your healthcare organization to assist with getting the right data out of your AIMS System. Utilize industry experts

to develop a practice management program that includes the dashboards, scorecards and custom reports needed to optimize use of the AIMS data. This expert team will validate the data for accuracy and educate your clinicians and business professionals in not only the BI tool functionality but also help to build trust in the data so that this data can be used with confidence.

CONCLUSION

An AIMS system is far more than an EHR. It is an accumulation of electronic data that can be explored and analyzed to improve patient outcomes, establish evidence-based criteria for process improvements and enhance decision-making at an organizational level. Whether it is a hospital purchased or anesthesia practice owned system, enlist the services of the anesthesia business professionals (practice managers, HIM professionals, quality analysts) to provide valuable insight into data needs and assess opportunities to capture key information ensuring the AIMS System produces the business information your practice needs. 

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MANAGING THE “L” WORD IN YOUR PRACTICE’S RETIREMENT PLAN (LIABILITY, THAT IS)

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Independence Advisors LLC, Wayne, PA

Would you consider yourself an investment professional in your spare time? I didn’t think so. But many doctors who run their own practice are unknowingly held to that standard as fiduciaries to their 401(k) plan. If you’re playing that role, in part or whole, you’ve opened yourself up to personal liability if you (or those to whom you’ve delegated the decisions) fail to make the best choices for your plan’s investment line-up.

This situation may sound far-fetched—not unlike asking your receptionist to perform medical procedures between phone calls—but I’ve seen it happen time and time again. Many small medical practices have their own retirement savings plans, typically a 401(k) or the very similar 403(b). You may start your plan with the best intentions: to give yourself and your employees the ability to build tax-deferred retirement savings. But someone has to decide what investments will be offered in the plan. Someone also must accept fiduciary duty for the decisions made. And lastly, someone must provide investment education to employees to help them effectively manage their funds.

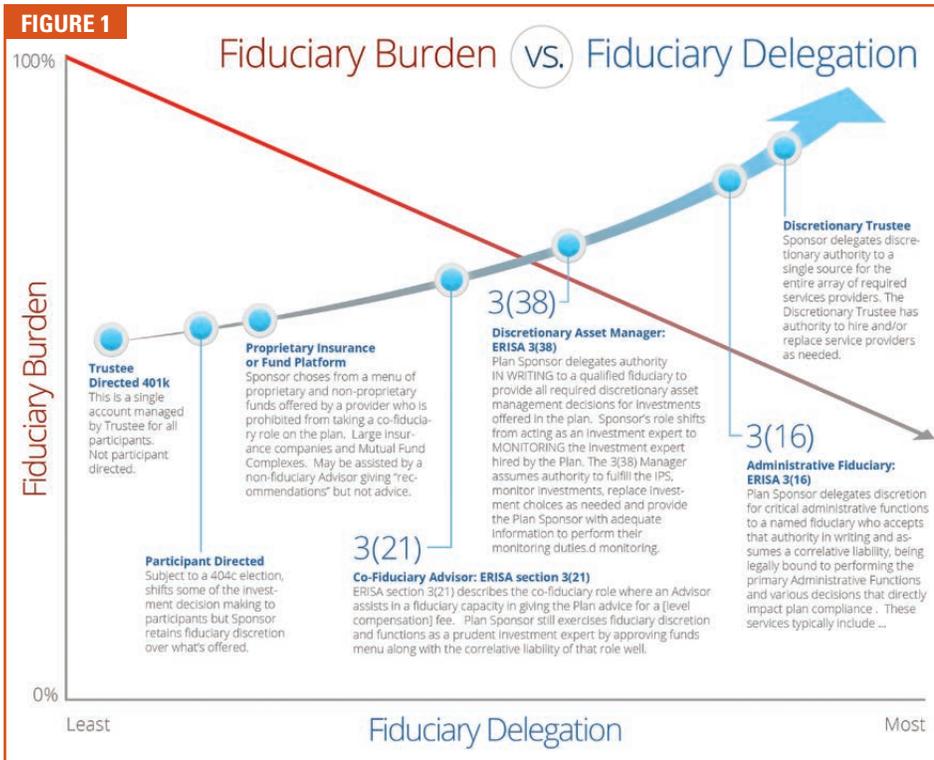
As an unpleasant surprise to many medical professionals, the investment-selection decision-maker may NOT be the one at fiduciary risk. The fiduciary risk might well remain with you, the employer, who is also referred to as the plan sponsor. That means that if the investments are ever deemed inappropriate or mismanaged, you or whoever in your practice is the named plan sponsor could be held personally responsible to restore any plan losses and/or profits improperly acquired through this breach of fiduciary duty.

[According to the US Department of Labor](#), those named as a 401(k) plan fiduciary “must act prudently and solely in the interest of the plan’s participants and beneficiaries.” This seems fairly logical. It’s important to know, however, that many of the brokerage and insurance companies currently administering these plans are either choosing not to take on the fiduciary responsibility, or are unable to act in that capacity.

If the investment companies aren’t responsible for ensuring that their investment choices and fees are appropriate, then who is? It defaults to the decision maker (the plan sponsor) at the company or medical practice. That means if an employee sues because of an inappropriate investment choice or because investment fees are higher than others available in the market, your personal assets could be at risk.

This may seem far-fetched. You’d like to believe your employees would never sue you over the 401(k) benefit you have provided them. But read some of these recent examples at large companies:

- [In August 2015](#), Boeing, with the second largest 401(k) plan in the country, reached a settlement in a class-action lawsuit that alleged the company mishandled its 401(k) plan by including investments with excessive fees.
 - [As of August 2015](#), Edison International is being sued by its employees, who are accusing the large utility company of favoring higher-cost mutual funds in its 401(k) plan.
- Even if your practice is graced by an abundance of satisfied employees, all it takes is one current or former disgruntled staff member to set the lawsuit ball in motion. So how do you protect yourself and your company? Here are three key questions you can ask to determine where you stand, and what additional actions may be warranted:
- ## 1. Who are the Fiduciaries?
- A retirement plan must have at least one fiduciary named in its written plan. If no third party is named, it’s highly likely that you or someone in your medical practice is fully liable for any fiduciary breaches that may occur. Fortunately, there are ways to pass portions of your fiduciary liability to a third party. Specifically, you can pass on the fiduciary duty associated with prudent investment management to an investment professional. Only certain types of financial institutions, such as Registered Investment Advisor (RIA) firms, are currently held to a fiduciary standard. As such, only these types of firms can accept this fiduciary duty. (That said, there are recent rumblings out of the Department of Labor that they
- [In November 2014](#), MassMutual agreed to pay \$9.745 million to retirement plan participants, to settle a suit that claimed they breached their fiduciary responsibility by receiving revenue-sharing payments from investment advisors and mutual fund companies.
 - [In December 2014](#), Nationwide settled for \$140 million, for similar revenue-sharing payments.
 - [In February 2015](#), Lockheed Martin settled for \$62 million, over a lawsuit claiming the company offered investment options with excessive fees in its retirement plan.



may require brokers and other companies to be held to the same standard, so stay tuned.)

Even if you hire an RIA firm to take on the fiduciary investment management role, you still retain a fiduciary duty to select a worthy manager to begin with. But by selecting an appropriate ally, you can effectively pass at least the investment-management buck on to the experts.

2. What Type of Fiduciary Are They?

Not all fiduciaries are created equal. There are different levels as discussed below. We suggest hiring a 3(38) fiduciary, also called a Discretionary Asset Manager. Named after the ERISA regulation that guides plan management, a 3(38) fiduciary can take on all investment-related decisions within the plan as well as the fiduciary responsibility for the decisions made, which removes the risks of related liabilities from your shoulders.

Do be sure that the firm accepts the role of 3(38) advisor in clear, unambiguous writing. What we see instead are brokerage

houses and insurance companies providing no fiduciary relief to the company, or providing a lower level of delegation, such as a 3(21) co-fiduciary or an even hazier "fiduciary warranty," which warrants very little. See Figure 1, Fiduciary Burden vs. Fiduciary Delegation. In short, when looking for someone to work with, protect yourself by ensuring you are receiving full 3(38) fiduciary protection, in writing. Fuzzy, feel-good phrases are not the same thing.

3. What Fees are You Paying?

Among the most common misperceptions we hear when speaking with medical practices is the erroneous assumption that their 401(k) plan is "free," since they never have to cut a check to pay for its management. This is a classic bait-and-switch trick, preying on those who forget that if something sounds too good to be true, it very likely is. You may not be paying the fund company directly, but you and/or your plan participants are still paying, typically through excessively priced investment options within the plan.

In most cases this is worse than paying transparent fees, since the individuals in the plan are paying them rather than the business. And those employees with the highest plan balances (typically the business owners themselves) are the ones paying the lion's share!

For your own and your employees' retirement savings, it's critical to understand the fees you are paying—all of them. Because dollars spent on expenses are dollars lost to your tax-deferred wealth accumulation, it's vital to keep your costs as low as possible. In most cases, a fund's expense ratio should not exceed one percent. In fact, depending on the asset class being targeted, many good selections are available for considerably less than that.

Those in the medical profession are all too familiar with the "L" word (i.e., liability). The word itself can cause anxiety, just seeing it in print. Fortunately, as an anesthesiologist, you already know of ways you can greatly reduce your medical practice liability risks. For example, you know it's important to be an expert at what you do. You know how to delegate other areas of expertise to trusted allies. You know it's important to always read the fine print, and to follow carefully documented procedures every step of the way. Apply these same insights to your retirement plan's fiduciary liabilities, and you and your employees alike should be able to breathe easier about your retirement savings.

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A BASIC PRIMER ON THE BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE

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The Centers for Medicare and Medicaid Services (CMS) [Bundled Payments for Care Improvement \(BPCI\)](#) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. The intent is for these models to lead to higher quality and more coordinated care at a lower cost to Medicare.

Traditional Medicare reimburses physicians on a fee-for-service (FFS) system, through Part B, and hospitals under an inpatient prospective payment system (IPPS) through Part A. Both systems are triggered by individual services being provided to beneficiaries for a discrete illness or course of treatment. Various studies have demonstrated that this approach can result in fragmented care with minimal coordination across providers and healthcare settings. As we have heard many times, the payment systems are geared to reward the quantity of services offered by providers rather than the quality of care furnished.

The Affordable Care Act (ACA) established an Innovation Center within CMS to test alternative payment and service delivery models that have the potential to reduce health care expenditures while preserving or enhancing the quality of care. The BPCI initiative is one of a dozen

initiatives that the Innovation Center is currently testing. BPCI is composed of four broadly defined care models, which bundle payments for multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for an entire episode. Table 1 shows the four models that a participating organization may use to develop their program.

In Model 1 in the table, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare pays the hospital a discounted amount based on the payment rates established under the IPPS used in the original Medicare program. Medicare continues to pay physicians separately for their services under the FFS. Model 1 began in April 2013.

Models 2 and Model 3 involve a retrospective bundled payment

arrangement where actual expenditures are reconciled against a target price for an episode of care. In Model 2, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. In Model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. Under these retrospective payment models, Medicare continues to make FFS payments; the total expenditures for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS. A payment or recoupment amount is then made by Medicare reflecting the aggregate expenditures compared to the target price.

TABLE 1 Bundled Payment for Care Improvement Models

	Model 1	Model 2	Model 3	Model 4
Episode	All DRGs; all acute patients	Selected DRGs; hospital plus post-acute period	Selected DRGs; post-acute period only	Selected DRGs; hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective



In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment. Models 2, 3 and 4 began in October 2013.

CMS has developed some unique definitions for the BPCI initiative. They are:

- *Awardees* are entities that assume financial liability for the clinical episode spending and have signed an Agreement with CMS.
- *Episode Initiators* are healthcare providers that trigger BPCI episodes of care; they do not bear risk directly (unless they also serve as an Awardee), but participate in the model through an agreement with a BPCI Awardee.
- *Conveners* are entities that bring together multiple health care providers. These conveners can participate as either Awardees that enter into Agreements with CMS and bear risk or Facilitator Conveners that do not enter into an Agreement with CMS and do not bear risk.

Over the course of the initiative, CMS will work with the Awardees to assess whether the models being tested result in improved patient care and lower Medicare costs. Awardee Agreements may also include proposals for gainsharing among provider partners. A potential downside



to the Awardee’s ability to control cost is due to beneficiaries retaining full freedom of choice to choose services and providers, including care from providers not participating in the BPCI initiative. Additionally, BPCI participants and their partnering providers are required to provide beneficiaries with written notification that explains the existence and purpose of BPCI, the beneficiary’s right of access to medically necessary services, and the beneficiary’s right to choose any provider or supplier of items or services.¹

In August 2015, CMS announced that 360 organizations have entered into agreements to participate in the BPCI initiative and an additional 1,755 providers have partnered with those organizations. In addition, CMS announced a new Medicare Part A and B payment model, the Comprehensive Care for Joint Replacement Model (CCJR). (See ABC Alert [A Role for Anesthesiologists in CMS’s New Comprehensive Care for Joint Replacement Payment Program](#), August 24, 2015.) Although the Comprehensive Care for Joint Replacement Model is distinct from the Bundled Payments for Care Improvement

initiative, both initiatives are part of the innovative framework established by the ACA to move the healthcare system toward one that rewards providers based on the quality, not quantity, of care they deliver to patients.²

Although CMS is within their mandate to establish or expand payment initiatives, BPCI results are far from conclusive. In a May 12, 2015 letter to CMS, the Healthcare Financial Management Association (HFMA) commented that BPCI models still have significant design and operational issues that should be resolved prior to any mandatory expansion.³ Also, based on CMS data, Model 2 is the only model that has seen acceptable participation. CMS’ announcement of the CCJR model is easily understood based on an examination of CMS data as of April 2015 that showed the most prevalent episode included in BPCI Models 2-4 is major joint replacement of the lower extremity.⁴

The data to date does not suggest what type of bundled payment model CMS may endorse or mandate in the future. The timing of such a decision is likewise unknown. CMS’ aggressive goal to have 30 percent of Medicare payments in alternative payment models such as accountable care organizations and bundled payments by the end of 2016 and 50 percent in by the end of 2018,⁵ however, means that bundled payment initiatives and other innovation programs are here to stay in one form or another. ▲

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¹ <http://innovation.cms.gov/initiatives/bundled-payments/>

² <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-13.html>

³ “HFMA Comments on Bundled Payments for Care Improvement Initiative,” May 12, 2015. <http://www.hfma.org/Content.aspx?id=31072>

⁴ CMS Innovation June 22, 2015 presentation to HFMA Patient Care Models Group.

⁵ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>



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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
October 22-23, 2015	Society of Anesthesia and Sleep Medicine 5th Annual Meeting 2015	San Diego, CA	http://sasmhq.org/2015-call-for-abstracts/
October 22-24, 2015	Becker's ASC 22nd Annual Meeting	Swissotel Chicago, IL	http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/
October 23, 2015	International Society of Anaesthetic Pharmacology 24th Annual Meeting 2015	Hilton San Diego Bayfront San Diego, CA	http://www.isaponline.org/events/annual-meeting/corporate-exhibit-opportunities/
October 23, 2015	Society for Ambulatory Anesthesia and American Society for Dentist Anesthesiologists Mid-Year Meeting	Westin San Diego Gaslamp Quarter San Diego, CA	http://www.sambahq.org/p/cm/ld/fid=96
October 24-28, 2015	American Society of Anesthesiologists Anesthesiology 2015	San Diego Convention Center San Diego, CA	http://www.asahq.org/meetings/calendar/2015/10/anesthesiology2015
November 6-7, 2015	Society of Academic Anesthesiology Associations 2015 Annual Meeting	Renaissance Baltimore Harborplace Baltimore, MD	http://saaahq.org/meetings.htm
November 21-22, 2015	American Society of Anesthesiologists Quality Meeting 2015	Loews Chicago O'Hare Hotel Rosemont, IL	http://asahq.org/meetings/asa-quality-meeting
December 11-15, 2015	The New York State Society of Anesthesiologists 68th Annual PostGraduate Assembly in Anesthesiology	New York Marriott Marquis New York, NY	http://www.nyssa-pga.org/pga-meeting
January 13-16, 2016	University of California, San Diego, Department of Anesthesiology Update 2016	Kona Kai Resort and Spa San Diego, CA	http://anesthesia.ucsd.edu/about/courses-and-conferences/anesthesia-update/Pages/default.aspx
January 25-29, 2016	California Society of Anesthesiologists 2016 Winter Conference	Hyatt Regency Resort and Spa Maui, Hawaii	http://www.csahq.org/up-more.php?idx=67
January 29-31, 2016	American Society of Anesthesiologist 2016 Conference on Practice Management	San Diego Hilton Bayfront San Diego, CA	http://www.asahq.org/meetings/practice-management-2016

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