Background of the Authors:
National anesthesia management companies increase revenue for acquired groups....or do they? This article presents pros and cons for both viewpoints with discussion by two leaders in the field of anesthesia practice management, Michael R. Hicks, MD, MBA, MHCM, FACHE, a physician executive from Dallas, TX and Joe Laden, a practice manager based in Louisville, KY.

Mr. Laden
Over the past several years, anesthesiologists have been increasingly willing to sell their practices to acquiring firms. In a typical transaction, the anesthesiologist practice owners agree to reduce their incomes in return for the purchase of their stock in their practice. The stock payment is usually several times the annual salary reduction. The anesthesiologists benefit by receiving

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Dear Readers,

We are entering the new year determined to enhance our engagement with you. Many of you have provided us with comments and questions on articles in past issues, opening the door to new topics and new contributors and at the very least to different perspectives.

If you have read previous issues of the Communiqué, you know that more and more of our content reflects reciprocal and often iterative learning. It is time to open up this process. We want to hear from you. Beginning with the Spring issue, we will add a “Letters to the Editor” section and we hope that you will write to us (editor.communique@anesthesiallc.com) with your observations on any item that has caught your interest. We will forward comments or queries, and we will do our best to supplement the authors’ responses in future “Letters to the Editor” pages wherever our own replies are likely to contribute to a useful discussion. Publication of your letters in the Communiqué will remain subject to our discretion, as we’re sure you will understand.

You may have noticed an increasingly conversational format in recent articles. The give-and-take between experts such as Michael Hicks, MD, MBA, and Joe Laden in their article Point-Counterpoint: Do National Anesthesia Management Companies Increase Revenues for Acquired Groups? is a stellar example of the genre. This discussion began in an electronic list serv on the website of the Medical Group Management Association-Anesthesia Administration Assembly, of which both Dr. Hicks and Mr. Laden are members. When they began exchanging views on the relative benefits of exchanging cash flow today for an equity stake or other potential for wealth creation in the future, it was not at all clear that the conversation would turn to the role and value of salary surveys, as it did in their article. There is a strong disincentive for financially successful practices to participate in such surveys—which by their nature show averages below the levels achieved by the leaders—when the surveys are used for prospective salary-setting. As Dr. Hicks says, “the provision of anesthesia services is now a regional and national business and there are many valid business and legal reasons for not sharing revenue and expense information even in the aggregate even though this information has previously been willingly provided.” Thus the dialogue between Dr. Hicks and Mr. Laden has ended up introducing an important topic that has not been touched on previously in the Communiqué—the inherent limitations of compensation surveys in a consolidating marketplace.

Richard Dutton, MD, MBA and Matthew Popovich, PhD also use a conversational approach in their article on the ASA-Anesthesia Quality Institute’s Quality Clinical Data Registry, QCDR Made Simple—Ha! The conversation here, however, is between an unseen interlocutor who asks the questions so many of you are raising about the QCDR, and the QCDR’s designers/managers, for example, “What are my options?” and “What measures can I report on?” It is a format that should make it easier for readers to assess whether and how to participate in reporting to the QCDR, even as the registry and its requirements continue to develop.

In Phoenix Project: Reconstructing a Local Group from the Ashes of its Predecessor, Mark Weiss, JD uses his own hallmark conversational style, notable for its direct challenges to readers (“Even if the hospital hasn’t expressed a preference, you know who shouldn’t remain at the facility, so why fool yourself at the cost of your own future?”) as well as its upbeat conclusions (“the death of an anesthesia group can be leveraged into the birth of a new one.”)

Some of the most useful material presented in our publications comes from the pragmatic conversations that our writers have with our readers and other members of the anesthesiology community that morph into ideas for more generalized education. Understanding the Impact of Individual Exchange Plans on Anesthesia Practices by ABC’s own Jody Locke is one such article. Mr. Locke walks readers through the mechanics of estimating the dollar impact of participating in one or more of the Obamacare Exchanges. The higher patient cost-sharing responsibilities under these health plans drive not just accounts receivable management but also contracting strategies and even prepayment policies.

Still more information that you can use in your practice throughout the year are staff articles on Current Procedural Terminology® (CPT) code changes for 2015, on ICD-10 coding and on the National Practitioner Data Bank.

Please do send us your ideas on additional topics you would like to see addressed—or to address yourself—as well as your comments on any of the information, suggestions or conclusions contained in this issue. We are looking forward to the next stage in our ongoing conversation with you.

With best wishes,

Tony Mira
President and CEO
The fact is, folks, that the Qualified Clinical Data Registry (QCDR)—and pay for performance reporting in general—is ridiculously complex. And the rules are changing every year. This article will lay out some of the basics, using simple lists and bullets, in the hope of making the options more intuitive. We wish to acknowledge also the editorial assistance of Karin Bierstein, herself an expert, who will correct any inadvertent misstatements we might make. Between the three of us we should be able to lift the fog a little bit.

Let’s begin with some Q&A:

Do I have to participate in performance reporting?

Leaving aside the local advantages of an effective quality management program, external performance reporting is already required for hospital and ambulatory surgery center accreditation. Performance reporting at the federal level is also required for every “eligible professional” (EP)—physician, certified registered nurse anesthetist (CRNA) and anesthesiologist assistant (AA)—paid by Medicare, or else payments will be docked. The penalties at this moment are small, but the government is committed to increasing them to as much as 10 percent of total payments over the next five years. Many anesthesiologists have already received letters from Medicare noting their failure to participate in performance reporting in 2013, and informing them that their payments will be decreased in 2015.

When?

Sooner than you think. For practices with minimal Medicare billing, the financial penalties for not reporting will be small at first. But Medicaid will soon follow, and private insurers likely after that. One way or another, every practice will need to measure and report on quality if it wants to stay in business for the next decade.

What are my options?

Sixty-one percent of anesthesiologists in 2012 reported quality measures to the Physician Quality Reporting System (PQRS). Most anesthesiologists report via the claims-based reporting option. This requires appending a code to each case billed to Medicare, saying that the antibiotics were given on time, that you washed your hands before placing the central line, or that the patient was normothermic when they hit the Post-Anesthesia Care Unit (PACU). (These were three of the five measures most commonly reported by anesthesiologists in 2012.) In 2014 reporting these measures successfully yielded a 0.5 percent (half of one percent!) incentive from Medicare, but beginning in reporting year 2015, satisfactorily reporting will only prevent a -2.0 percent penalty. Worse still, the number of measures that must be reported has increased from the current three up to nine, with required inclusion of at least one cross-cutting measure for claims-based and “traditional” qualified registry reporting. And yes, the average anesthesia provider currently has only a few measures to choose from when using these mechanisms and no outcome measures or cross-cutting measures. More on this below.

There are alternatives to the individual claim reporting mechanism, as Medicare attempts to phase it out. One is the Group Practice Reporting Option (GPRO), which allows groups to present their data through an aggregation service. Often involving the same measures but through a different mechanism, it allows for EPs to receive the 0.5 percent incentive in 2014 while attempting to avoid penalties in the future. Another alternative is to be part of an Accountable Care Organization—a consortium of physicians and facilities accepting a risk- and/or savings-sharing payment from Medicare—in which case you are probably a salaried employee of an HMO like Kaiser or a large university system, and can safely stop reading now—you’re most likely covered.

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The final, and newest, alternative is the Qualified Clinical Data Registry (QCDR), intended to give eligible providers credit for participation in external benchmarking for quality improvement. While the reporting mechanism is similar to other reporting mechanisms described above, the set of measures that can be reported is much broader. Medicare has given these approved registries in each specialty the autonomy to define their own important quality metrics, in exchange for doing the data capture, analysis and reporting that Medicare used to have to do itself. We can expect Medicare to continue to promote registries in order to offload the data management burden onto private entities.

I'm already lost—Help!

OK, let's look at a glossary. Here is a handy list of the critical acronyms:

**CMS**—The Centers for Medicare and Medicaid Services. In round numbers about 1/3 of all healthcare payments in the US are from Medicare, with another 1/6 through Medicaid. So about 50 percent of all healthcare is bought by the federal or state government. It's a little less than that for anesthesia, but this is still a big hunk of our business.

**P4P**—Pay for Performance. What the government intends to do, instead of paying for quantity or service or time. The burden of demonstrating performance is on us.

**PQRS**—The Physician Quality Reporting System. The first steps toward P4P—in reality, Pay For Reporting and not for Performance in the sense of “outcomes” for practitioners by CMS. Now about eight years old, the program began as a scheme of incentive payments to eligible providers who reported either performing or not performing one or more approved quality improvement measures.

**EP**—Eligible Professional. Any individual who bills CMS for their professional clinical services to a patient. This includes anesthesiologists, CRNAs, AAs and others.

**NQF**—The National Quality Forum. A not-for-profit, membership-based organization created to endorse measures for use by CMS and others for quality reporting. Highly bureaucratic—approval of a measure through NQF can take years of effort and costs hundreds of thousands of dollars. CMS-approved measures often form a subset of all NQF-approved measures.

**VM**—The Value-Based Payment Modifier. The CMS companion program to PQRS, just getting started. Uses the same set of measures and combines PQRS and QCDR measures with outcome and cost measures. EPs not satisfactorily reporting PQRS will be penalized under the VM program cumulatively; this money will fund an incentive pool for those who meet all of the requirements. The VM system is already active in 2014, with results to be applied in 2016.

**MAV**—The Measure Applicability Validation process. Groups and providers using the claims-based or “traditional” qualified registry reporting mechanisms who cannot find enough applicable measures to report are subject to the MAV test, which assesses whether more measures would have been available. Assuming CMS agrees that there were none, the EP will not be penalized under PQRS.

**QCDR**—The Qualified Clinical Data Registry. A new mechanism for practices to report PQRS and that will, in the future, impact their VM. QCDRs are developed and maintained by medical specialty societies, and must seek to improve quality within that specialty by means of data aggregation and periodic feedback to participants (benchmarking). The QCDR can use both approved PQRS measures and its own non-PQRS measures. In 2015, the QCDR will be authorized to include up to 30 of these non-PQRS, specialty-specific measures, thus allowing any participant in a QCDR that takes advantage of this authorization to find the minimum nine that must be reported.

**GPRO**—The Group Practice Reporting Option. Practices can send their data to CMS as a group (all providers using one Tax Identification Number for their business). This is different from the QCDR, as the GPRO only allows reporting the existing PQRS measures and requires different minimums.

OK, I get it. I have to report performance on quality measures to CMS. What next?

Talk to your office manager and your practice management company. This is complicated material and everyone should get professional advice. Then consider your exposure—the percent of cases your eligible professionals bill to CMS. Then decide what your practice posture will be. Do you want to do everything possible to earn VM incentives? Or are you satisfied
with avoiding penalties? Do you have an existing system to capture clinical data, or are you starting from scratch? Once you’ve answered these basic questions, you should check out the following publicly available resources:

- CMS—The definitive source, but not always easy to understand! http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
- The AQI website—Information on the QCDR. http://www.aqihq.org/PQRSOverview.aspx
- ABC weekly e-Alerts on PQRS, VM and QCDR topics—http://www.anesthesiallc.com/publications/anesthesia-industry-ealerts

What measures can I report on?

The following currently approved PQRS measures apply to most anesthesiologists. These measures can be reported through any mechanism: claims-made, group-reporting or through the QCDR. When reviewing the measures, EPs should pay attention to the CPT Codes in the denominator of the measures. If the specified denominator codes for a measure are not included on the patient’s claim (for the same date of service) as submitted by the individual eligible professional, then the patient does not fall into the denominator population, and the PQRS measure does not apply to the patient.

- #30—Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics (this measure has been ‘retired’ by CMS, and can no longer be reported to PQRS in 2015)
- #44—Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- #130—Documentation of Current Medications in the Medical Record (the denominator codes do not include anesthesia codes)
- #193—Perioperative Temperature Management—For General anesthetics > 60 minutes, the percentage of patients reaching the PACU at greater than 36 degrees, or in whom active warming devices were used
- #226—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (non-anesthesia codes)
- #342—Pain Brought Under Control within 48 Hours of admission to palliative care (non-anesthesia codes)
- #358—Patient-Centered Surgical Risk Assessment and Communication: The Percent of Patients who Underwent Non-Emergency Major Surgery Who Received Preoperative Risk Assessment for Procedure-Specific Postoperative Complications using a Data-Based, Patient-Specific Risk Calculator, and who also Received a Personal Discussion of Risks with the Surgeon (non-anesthesia codes)

How do I report?

This is the question you should ask your practice managers. The short version is that someone (possibly including the provider at the point of care) indicates in the medical record that the patient is eligible and the measure has been met. Someone else abstracts this information from the medical record or the billing documentation and turns it into a code. That code is reported directly to CMS with the bill for the case (under claims made) or to the GPRO or QCDR. Performance on the measure is calculated at the end of the year, based on the rate of successful reporting over all eligible cases.

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QCDR Made Simple — HA!

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What’s different about the QCDR?

EPs participating in the QCDR report their performance on a case-by-case basis just as they would to CMS under claims made. The QCDR then analyzes performance and reports on the EP’s behalf to CMS. The difference is that the QCDR may measure other elements than those reported to CMS (it’s a real registry, not just a billing mechanism). The QCDR will provide regular feedback to the provider throughout the year. And—most important—the QCDR can provide reporting credit for non-PQRS measures.

Aha! That’s how I can find nine measures to report!

Exactly! Here are the 11 non-PQRS measures available in the ASA-QCDR (the National Anesthesia Clinical Outcomes Registry, or ”NACOR”) for 2014. Even more will be added in 2015.

• Post-Anesthetic Transfer of Care: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU)
• Prevention of Post-Operative Nausea and Vomiting (PONV)—Combination Therapy (Adults)
• Prevention of Post-Operative Vomiting (POV)—Combination Therapy (Pediatrics)
• Composite Anesthesia Safety—The percentage of all patients who complete a scheduled procedure without a major complication
• Immediate Perioperative Cardiac Arrest Rate
• Immediate Perioperative Mortality Rate
• PACU Reintubation Rate
• Short-term Pain Management
• Composite Procedural Safety for Central Line Placement
• Composite Patient Experience

OK, I know this is important, and I have to do it. How much is it going to cost me to prevent penalties or earn incentives?

Costs will depend on the current sophistication of your practice information technology and on your billing or quality capture vendor. Talk with them first! Participation in NACOR is open to any anesthesia practice in America and is free to ASA members. The ASA-QCDR service is also free to ASA members participating in NACOR. Non-member EPs (i.e. your nurse anesthetists and AAs) can use the ASA-QCDR service for $295 per EP per year, with discounts available for large groups. This is likely a fraction of the penalty and incentive money at risk, but each group will need to make this assessment on their own.

Can I still participate in 2015?

Yes, although you need to get moving. CMS has threshold levels of reporting required under each mechanism, so you will need to have your data flowing soon. For the QCDR, EPs using the QCDR option will need to report at least nine measures covering at least three National Quality Strategy domains for at least 50 percent of their patients seen during 2015.

If you’re reading this at the ASA Conference on Practice Management or the Tulane-ABC-Medical Business Solutions Advanced Institute for Anesthesia Practice Management (AIAPM), please stop by the AQI, ASA or ABC exhibits to learn more. There will be presentations at each meeting on the topic of PQRS reporting and the QCDR.

The AQI is here to help you manage federal performance reporting in our brave new world of healthcare quality. Complicated, yes. But you can do it! ▶

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funds now rather than in the future, and this money is taxed at the capital gains rate rather than at the much higher W-2 income rate.

A question has arisen as to whether the voluntary reduction in anesthesiologist salaries through these types of acquisitions will depress the overall “fair market value” of anesthesiologist salaries in a locale, a region or even nationally. This is important to independent anesthesiologists who rely on fair market anesthesiologist compensation rates when negotiating with facilities for financial support. There is an assumption that anesthesiologist salary surveys incorporate the reported before and after W-2 wages of anesthesiologists involved in these practice sales. An additional assumption is that the salaries of anesthesiologists who sell their practice in this manner remain at their agreed to lower level for the foreseeable future.

There are a number of published national physician compensation surveys from entities such as the Medical Group Management Association, American Medical Group Association, Merritt Hawkins and Medscape. However, none of these surveys are scientific and some data are self-reported by medical groups. Hence, it is not known if anesthesia groups that are acquired have participated in surveys or whether their salary data will be reported after acquisition.

Dr. Hicks

There are a number of factors that can lead an anesthesiology group to consider merging or selling its practice. These include the opportunity to trade future income potential for a cash payout today, a desire to take an equity stake in an entity with a perceived greater ability to provide income and wealth creation in the future, or on a more pessimistic level, the sense that the market for anesthesia services is peaking and that the current group’s situation—be it structure, leadership or environment—does not permit it to make the necessary changes to be successful in the future.

Regardless of the motivation, however, the owners of large sophisticated practices that do sell/merge/affiliate are replacing one form of economic gain (practice revenue distributed generally in the form of W-2 income) for other types of economic gain such as a share of the sales price in a pure cash buyout, cash and equity in the new practice, and possibly different tax treatment of funds, as Mr. Laden points out.

However, I think there are some other but less frequently discussed considerations that are important as well. First, many of the acquired platform groups, through better strategy and management, command higher commercial insurance rates than most other groups even within their home geographies. As a result, when they take a “discount” off of their pre-transaction income the end result is that their future salary stream is reset to the true prevailing market rate for their area excluding their practice. In other words, post-transaction these physicians will earn what their colleagues in other local practices earn and consider as “market” rates. I know this is almost unbelievable by many who work in smaller practices but I am certain that no sophisticated purchaser, whether in private equity or a strategic acquirer like the large physician practice management companies, is going to enter into a high dollar acquisition and create an artificially low labor expense to get a deal done. This would be a significant financial misstep and sophisticated acquirers generally don’t make those kinds of mistakes. This doesn’t mean that these companies are not sometimes overpaying for acquisitions but purchase prices depend on a number of factors and labor expense is only one of them. This is a topic for another time, though.

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Point-Counterpoint: Do National Anesthesia Management Companies Increase Revenues for Acquired Groups?

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Secondly, some acquired practices, even the sophisticated ones, immediately begin to be the beneficiaries of even better expertise, scale and technology and as a result begin to “repair” their "discounted" incomes. In other words, the decrease in income resulting from the acquisition really becomes much smaller as a result of improved contracts, scheduling efficiencies and overhead reduction while the benefits provided in terms of equity and tax treatment continue to accrue to the sellers.

Unfortunately, consolidation in anesthesia is frequently portrayed in terms of “selling out” or acting out of fear. I am sure for some practices, possibly smaller ones, that may be true. However, I am certain—from multiple personal experiences—that for larger, more sophisticated groups these transactions occur not as a result of fear or even greed but as a result of sound strategic planning and sophisticated capital structure decisions. Medical practices of all types, not just anesthesia, require—now and in the future—assets that allow their leaders the opportunities to make executable decisions based on sound knowledge and strategy. These transactions in anesthesia are a path, but not necessarily the only path, toward that goal.

Mr. Laden

Dr. Hicks has made an excellent point that anesthesiologists who merge into or are acquired by a group with better commercial payer rates can benefit from the higher rates. For example, from the ASA Commercial Fees Paid survey in the Southern section the managed care rate for all payers at the 25th percentile is $58 and at the 75th percentile is $75, a 29.4 percent difference. Theoretically, if a group at the 25th percentile level in the Southern Section joined a group in that section at the 75th percentile and had 40 percent of its patient revenue with contracted managed care payers, patient revenue would increase by 11 percent overall after joining the group with higher rates.

If the patient revenue per owner anesthesiologist were $1,000,000 (see MGMA 2014 Physician Compensation Survey and MGMA 2014 Cost Survey for representative data) for example, after joining the group with higher rates the anesthesiologist’s patient revenue would increase by $110,000 annually in our example, replacing much of the anesthesiologist’s income that was monetized in the form of capital gain proceeds.

Whether or not physician income can be increased after an acquisition may depend on the type of organization the doctor joins. Doctors who sell must examine their employment contracts carefully and determine if salary increases and/or performance bonuses are possible and probable. For example, will the new practice owners take additional practice income for themselves or is there a mechanism for additional revenue to be shared with the anesthesiologists? It may be better to sell to an organization that has true physician representation in its management structure.

There can be many paths to increasing income after acquisition. The most immediate will occur if the acquiring organization has higher payer rates. However, the doctors need to find out if the acquiring organization actually has higher fees with their major payers. For example, a dominant local Blue Shield may not care that the acquirer has great Blue Shield contracts in other states. On the other hand, the acquiring organization may have a favorable national contract with a nationwide payer.

The acquiring organization may have plans to expand the acquired practice to nearby locations or to add a free-standing pain clinic. Depending on the deal, expansion revenue and profits may or may not be shared with the anesthesiologists who sold their practice.

Dr. Hicks

Our ideas are not dissimilar—for any group merger/acquisition/partnership the devil is in the details. My view has long been that anesthesia practices need active strategy creation and decision-making with a view of creating additional value not only for their customers but also for their own members. In the case of the intrinsic value to the practice’s members this value can be in the form of increased W-2 income, or exchange of one form of equity for another or enhanced job security. What doesn’t work, as many in the business unfortunately know all too well, is just sitting around and waiting/ignoring/hoping that nothing changes. One thing that can be said concerning income is that when a group’s anesthesia contract is acquired in a competitive
bidding process by some other entity it is nearly certain that physician incomes are not going up or even likely to remain the same.

That being said, however, there are other salary related issues in any proposed transaction. As Mr. Laden suggests, income after a transaction—now and in the future—does depend on the type of organization the physician joins. In this regard, there are several different models.

Traditionally most anesthesia acquisitions were straight cash transactions—the seller gets cash and the buyer gets the equity interest and control of the practice. The profit stream that the buyer is acquiring comes from a reduction in income to the physicians since the overwhelming majority of practices distributed all monies after meeting overhead expenses to the physician partners. The physician sellers’ logic, as alluded to previously, is that they are trading future earnings (and uncertainty) for cash in the bank today that can be used however they see fit (investment, retirement, new boat or house, etc.). All of the large strategic acquirers only did this type of transaction and it remains the most common form.

Lately this has changed somewhat, however, with the advent of a “partnership” model wherein an equity position in the acquiring company comes with the cash. In this case the physicians are now trading future patient service earnings for cash and possible capital appreciation in the acquirer’s stock. These transactions still require the creation of a profit stream and this largely comes from the reduction in income of the physicians (but not below market rates as mentioned above). However, it creates opportunities that other relationships may not. Not surprisingly, it is always in the interest of the acquirer to enhance the revenue of any practice it acquires (for obvious reasons). However, in partnership models it is in both the acquirer’s and the physicians’ interest to enhance profitability since both parties stand to gain as owners of the company. Part of this gain can be provided in the form of W-2 income (“income repair”) while the enhanced profitability leads to capital appreciation of the company’s stock. This is proving to be a very attractive option in the anesthesia M&A marketplace because if the salaries are able to be brought back near or at their level prior to the acquisition then the physicians have no decrease in real income and also the benefit of an equity position that is likely to increase faster and more appreciably than their relatively illiquid ownership position prior to selling.

Of course, this is an example of a major deal point and not a devilish detail and is indicative of some of the creativity that can be exercised in creating a transaction. As is always the case, physicians, whether they are selling their practices or not, must examine all of the transaction documents including their employment contracts carefully and determine if salary increases and/or performance bonuses are even possible or probable.

Mr. Laden

Based on the complexity of the transactions that Dr. Hicks has described, it would be wise for anesthesiologists considering an acquisition or partnering deal to bring in experienced advisors who can help navigate a pathway to a favorable conclusion. While it may seem straightforward to simply take cash-in-hand, the anesthesiologist should be completely aware of his or her clinical and financial path over the next 5-10 years. If the doctor takes stock in the acquiring organization, the future plans of the organization should be thoroughly vetted by the doctor and the doctor’s financial advisors.

Dr. Hicks

A key aspect of any substantial transaction is the rigor applied to the due diligence process. Key deal points, and importantly the underlying assumptions on which they are based, demand examination as to whether they are sustainable post transaction. Some key assumptions involve whether existing relationships that the buyer and
seller have prior to the transaction will continue and under what terms after the transaction is consummated. Examples pertaining to anesthesia transactions include the stability of service contracts with facilities, employment terms of the clinical staff and whether financial terms of existing relationships will remain in place or extend to newly acquired clinicians or sites of services. Relative to rate comparisons with payers, this can be problematic for several reasons, not the least of which include legal and regulatory barriers to sharing this type of information prior to a transaction. In my experience this is difficult if not impossible at the individual contract level but can be reasonably approximated at the aggregate level using third party organizations to make comparisons and then blinding the potential buyer and seller to actual payer specific contract rates.

In general, most payer contracts remain at the regional or state level but recently a few major payers with national footprints have been agreeable to national anesthesia rates. These appear to be a mixed benefit with some parts of the now larger practice getting minimal or no increase in rates but other parts being beneficiaries of significant positive contributions. At a corporate level there are ways to distribute this benefit to make such a contract appealing to the entire practice, however.

As Mr. Laden points out, some groups do not have the benefit of significant commercial rates contracts. These groups are potentially in a difficult position as they are the most likely to require significant financial support and are also less likely to be attractive merger or acquisition targets. They are also the most likely to depend on having valid compensation data during negotiations.

Mr. Laden

If there are secrecy provisions in acquisitions deals, wouldn’t this prevent the doctor and/or his group from reporting to Medical Group Management Association (MGMA) and other surveying organizations after the acquisition?

Dr. Hicks

Obviously, proprietary information should always be protected and treated as the valuable asset that it is. That being said, there are no “secrecy” provisions outside those that are found in all other competitive business environments. What may be different, however, is that the provision of anesthesia services is now a regional and national business and there are many valid business and legal reasons for not sharing revenue and expense information even in the aggregate even though this information has previously been willingly provided.

For example, to whose benefit is it for a large anesthesia practice to openly report to the world its compensation or that it has superior reimbursement rates? Will doing so help those who have managed their practice so as to achieve superior rates or will it lead to a tougher negotiation environment during the next round of negotiations after groups with lower rates have used the data to improve their own rate structure? In my experience the quality of information reported to MGMA and other organizations is a mixed bag. Some practices that have better financial performance choose not to participate as there is little to be gained by releasing that their rates are superior to others and in fact are only providing competitors a rate target for their own negotiations. In this context it can be argued that smaller groups desiring better rates can either join one of the larger sophisticated groups, create their own version of the same or develop the expertise to get better rates on their dime and their time.

That being said, I understand the value of surveys in general. However, their utility was greater and their need more acceptable in a prior era when groups were small, local and minimally managed. In this era of national competition their use may indeed be problematic. For example, the payer rate issue does indirectly come up in Request For Proposal responses as hospitals and health systems want to understand why there may be differences in subsidy requests among competitors for a service contract. In fact, I have been asked several times if I really had the correct subsidy numbers in submitted pro forma budgets as our submitted subsidy proposal was so different (lower or higher) than those of other bidders.

Mr. Laden

As anesthesia groups consolidate through acquisition or merger, it appears
that salary surveys may become less useful than in the past. Anesthesiologists may need to find other methods to validate their compensation in situations such as arranging financial support from healthcare facilities. Perhaps the true test of fair compensation is the amount it takes to attract quality anesthesia providers to a particular geographic location. This will vary with the desirability of the geographic area, the current scarcity of anesthesia providers and job specifics.

Dr. Hicks

This is an example of the nature of the changing competitive landscape. Many anesthesiologists and practice leaders are troubled by this and with some justification. However, it is a Catch-22 situation. Many of the groups with high-income clinicians are loathe to report this data for the very reason that they are above the reported averages and it is to their benefit to have the world believe that they make less than they really do. As a result I believe the national surveys can be fairly inaccurate and this includes the data produced by the ASA.

Unfortunately, in my opinion hospitals as well as practice leadership frequently frame the discussion incorrectly. It is even more perversely framed by outside consultants who blur the compensation requirement to hire an incremental or additional clinician (the clinician at the margin from an economic perspective) with the cost of an entire clinical staff. I have even observed national consultants attempt to (mis)use MGMA and other data to justify grossly underweighting the services of anesthesiology subspecialists that are few in number and high in demand. Similarly, the data are also used to benefit some groups when they request subsidy increases in order to add additional clinicians who can be and are added for substantially less than the amount of the requested subsidy increase.

In fact, it may be helpful for the group to let the hospital believe that anesthesiologist incomes are actually lower than they really are. In some cases, excluding academic anesthesiologists, few if any anesthesiologists make as little as some surveys suggest. In summary, I have certainly encountered hospital leaders who try to use those data in the way Mr. Laden describes. My response has been to suggest to them that we both do a recruiting search and see how many clinicians express an interest in their proposed compensation rates. Sometimes it works and sometimes it doesn’t. I will say that it is more difficult for the anesthesia group to fight this off when they have no other options for work.

Mr. Laden

It appears that anesthesiologist salary adjustments after practice sales will not be reflected in national physician compensation surveys because:

1. Compensation reporting to the national surveys is inconsistent or inaccurate, and
2. Anesthesiologist salaries may not be reduced for long after practice acquisition due to shared revenue expansion initiated by the acquiring organization.

The current trend toward fewer small independent anesthesia groups will most likely continue, especially if there is increasing downward pressure on hospital financial support for these groups. Surgery should continue its increase due to the aging population and technical innovation. I believe the future is bright for anesthesiologists even though many may experience changes in their financial and organizational structures.

However, even if all anesthesiologists are eventually employed by hospitals, practice management companies or mega-groups, I believe there will always be a need for anesthesiologist salary surveys just as there is in most major industries.

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Joe Laden has worked for independent anesthesiologists as a business practice manager for over 30 years. He is a well-known member of the Medical Group Management Association (MGMA) and of the MGMA’s Anesthesiology Administration Assembly. He can be reached at www.linkedin.com/in/joeladen.
If you have not spent much time thinking about the impact of the Exchange plans now being offered under Obamacare, you are not alone. For many anesthesia providers and their administrative staff, the specific implications of the Patient Protection and Affordable Care Act (ACA) passed in March 2010 are more or less a black box. As is true of so many issues in healthcare, the devil is in the details; unfortunately this is just one more complicated issue that merits special management focus.

So what are Exchange plans and how do they work? It is important to understand that Exchange plan options are offered in every state. These insurance options are available through the Health Insurance Marketplace at Healthcare.gov. Essentially this provides options for those who are not covered through their employer. In each state where they are offered, private, commercial insurers have contracted to provide coverage at discounted rates. For example, Blue Cross of California continues to offer its traditional PPO coverage, as does Blue Shield, but both now offer an Individual Exchange option.

As of January 1, 2014 all eligible Americans must be covered by insurance for their medical care. They will either be covered by their employer or through an Exchange plan. While many patients have signed up, thus far there is a very real concern that these numbers will increase as we move into 2015 as more Americans look to avoid the penalty associated with being uninsured. Depending upon the state where the person lives they will either choose their coverage through a state Health Insurance Exchange or through the Federal Exchange. The ACA introduced some very significant features that had not previously existed: the mandate that every American have health insurance coverage, the fact that patients cannot be denied coverage for pre-existing conditions and subsidies for those that cannot afford to pay their premiums. The law identifies four levels of coverage that must be offered.

- **Bronze**—has the lowest monthly premium and the highest out of pocket cost and a $5,000 deductible where the maximum out-of-pocket per individual is $6,350
- **Silver**—has the second lowest premium with a deductible of $2,000 where the maximum out-of-pocket per individual is $6,350
- **Gold**—has the second highest premium but no deductible
- **Platinum**—provides the best benefits for the highest premium with no deductible and a maximum out-of-pocket expense of $4,000

The principal vehicle for communicating the details of plan options is www.healthcare.gov, which is where people are expected to review the details of each plan and make an application for coverage. In addition to the federal Exchange, quite a number of states like...
California and Oregon offer their own Exchange options. For practice managers interested in the plans offered in a given location there is a wealth of specific market data available online. Figure 1 is an example of the coverage patterns for Los Angeles.

Ultimately, the questions every practice must answer are whether to contract with the Healthcare Exchange plans and what rate to accept and that’s if they can even participate in the given insurance Exchange Networks. Some insurance plans have closed networks, meaning they will not take new providers. For example, Blue Cross of California will not readily contract with a group at a Tier 2 hospital.

When the Exchange plans were first being rolled out, many of the major insurers were offering significantly discounted rates for Exchange plans. Most practices declined these offers, preferring to wait to see how significant the impact would be. Not surprisingly, as the number of patients covered through Exchange options has increased, the major plans are now more eager to contract with providers, and the terms they are offering are improving dramatically. In many cases it is now possible to get the same rate for an exchange plan as for the corresponding PPO plan.

Every practice situation is different, though, and contracting decisions should be made based on solid analysis of reliable data. There are a number of aspects of this Exchange issue that merit close review but three are essential:

1. The number and percentage of patients covered by each Exchange plan,
2. The effective yield per unit, and
3. The impact of deductibles and co-payments

Any analysis of the impact of a new payer option must begin with a careful assessment of the number of patients covered. Plans with a nominal impact on the practice’s cash flow may not merit the same level of aggressive contracting as smaller plans. You may also not have the leverage to significantly affect contract rates. Traditionally, practice managers assess the impact in two ways: by tracking the number of patients treated each month and by calculating their percentage. Two examples are shown in the tables on the next page. Note that
Understanding the Impact of Individual Exchange Plans on Anesthesia Practices

Continued from page 13

the impact of Blue Shield patients was far more significant than the impact of Blue Cross's option in Table 1. (In the state of California Blue Shield and Blue Cross are competitors, both selling coverage for physician services.) Of particular significance to the practice in issue is the fact that the increase in Blue Shield Exchange patients actually represented a net increase in overall practice volume.

Each practice must assess the financial, strategic and political implications of these trends but clearly the impact is significant. A meaningful discount in either case could have a material impact on the practice's collections and cash flow. This is why the next analysis is so important: identifying the actual average impact as measured in terms of effective yield per ASA unit billed (Table 2). Because of the idiosyncrasies of anesthesia billing most practices will find it more useful to isolate time-based units billed and the collected payments specifically applied to these units; in other words, charges and payments for flat fee services (invasive monitoring, nerve blocks, intubations, etc.) should be excluded. Many also prefer to use a calculation methodology that only includes cases that have been paid in full.

A quick review of the data presented in these tables reveals a curious inconsistency. Why is there such a discrepancy between the Blue Cross PPO rate and the Blue Cross Exchange rate? The answer is simple. The practice decided to wait and see what the impact of the Exchange would be on Blue Cross. The result soon became obvious: out-of-network providers are paid at a much lower rate, the checks go to the patients and then the provider must attempt to collect their usual and customary charge, all of which can not only result in lower yields but bad publicity. In the case of the practice shown here, upon review of the impact of these factors management recently changed its approach and decided to enter into a contractual relationship. Blue Cross has now agreed to a rate that matches the PPO rate, which will change the effective yield shown in Table 2 over time.

### TABLE 1

<table>
<thead>
<tr>
<th>Blue Cross</th>
<th>% of Exchange Patients</th>
<th>Blue Shield</th>
<th>% of Exchange Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>Exchange</td>
<td>25</td>
<td>106</td>
</tr>
<tr>
<td>363</td>
<td>6.4%</td>
<td>16</td>
<td>87</td>
</tr>
<tr>
<td>297</td>
<td>5.1%</td>
<td>17</td>
<td>97</td>
</tr>
<tr>
<td>335</td>
<td>4.8%</td>
<td>11</td>
<td>106</td>
</tr>
<tr>
<td>360</td>
<td>3.0%</td>
<td>14</td>
<td>110</td>
</tr>
<tr>
<td>365</td>
<td>3.7%</td>
<td>19</td>
<td>134</td>
</tr>
<tr>
<td>354</td>
<td>5.1%</td>
<td>17</td>
<td>149</td>
</tr>
<tr>
<td>402</td>
<td>4.1%</td>
<td>29</td>
<td>128</td>
</tr>
<tr>
<td>358</td>
<td>7.5%</td>
<td>18</td>
<td>116</td>
</tr>
<tr>
<td>389</td>
<td>4.4%</td>
<td>21</td>
<td>141</td>
</tr>
<tr>
<td>331</td>
<td>6.0%</td>
<td>14</td>
<td>117</td>
</tr>
<tr>
<td>296</td>
<td>4.5%</td>
<td>201</td>
<td>1,291</td>
</tr>
<tr>
<td>3,850</td>
<td>5.0%</td>
<td></td>
<td>1,291</td>
</tr>
</tbody>
</table>

### TABLE 2

<table>
<thead>
<tr>
<th>Yield Per ASA Unit</th>
<th>Contract Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross PPO</td>
<td>$55.40</td>
</tr>
<tr>
<td>Effective Yield Per Unit</td>
<td>$40.92</td>
</tr>
<tr>
<td>Blue Cross Exchange</td>
<td>$57.10</td>
</tr>
<tr>
<td>Blue Shield PPO</td>
<td>$52.89</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$54.48</td>
</tr>
</tbody>
</table>
The other issue highlighted by this data is the distinction between the contracted rate and the actual yield posted. One of the distinct challenges of medical billing is the mechanics of payment. Historically, most PPO plans have followed the Medicare model and pay the provider 80 percent of the allowable minus the balance due for the deductible and/or copayment. Any billing person will be happy to confirm that it is much easier to get money from the insurance than the patient. This is a particular challenge for Exchange plans where patients may have a significant responsibility based of the level of the plan they selected. It should also be noted that the out-of-network benefits are drastically less for these Exchange plans, sometimes non-existent, and as such the patient ends up having to pay a larger portion of the bill, often times 100 percent of the charge.

Ideally, the payment posting process captures not only the amount of the actual payment but the allowable, deductible and co-insurance amounts. This data allows for the following calculations which involve dividing both the deductible amount and the co-insurance responsibility by the allowed. While we tend to assume that deductibles are a much bigger issue early in the year, as Table 3 indicates, the impact of deductible and co-insurance can vary significantly from patient to patient and month to month.

Why does this information matter? It affects both contracting strategy and accounts receivable management. A very significant patient responsibility may result in consistently lower yields per unit even with similar contract rates. Whether this information can be used to advantage in payer negotiations is not always clear, but it should always be considered.

Higher patient responsibility and the challenge of collecting money from patients after the service has been provided may lead to a discussion of pre-payments or other strategies designed to create a higher sense of responsibility on the part of patients. Some practices are now starting to experiment with pre-payment programs, especially in ambulatory settings.

It is also worth noting that greater patient responsibility will inevitably have an impact on accounts receivable metrics such as days in accounts receivable, the percentage of the total accounts receivable over 120 days and bad debt write-off percentages. Those who manage and monitor their billing staff based on such performance metrics may need to reset expectations if the impact of these plans is significant. There could also be potential implications in cases of exclusive service agreements that involve financial support based on a disparity between the cost of providing the care and actual collections.

So based on what we know so far what can we conclude about the impact of healthcare Exchange plans? It is probably not as significant as some providers might have feared, but it is still significant. The point is, though, you won’t know the impact unless you examine it, carefully monitor the impact of these individual Exchange plans and monitor the data on a regular basis. Like so many aspects of anesthesia practice management, the more you know, the more leverage and options you have.

There are a variety of methods that may be employed in the calculation of a yield per case. One method divides date of entry collections for a given period of time by the Date of service units billed. The problem with this approach is that there is no correlation between the payments and the units. Another approach relies on a date of service approach, in which payments are applied back to the date of service they are intended to pay. This approach can yield useful results but must be viewed with a lag of at least three to four months. A third approach uses date of service data filtered for only paid cases. This approach is not a perfect solution but can be used to obtain more current metrics because it compensates for the lag.

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Table 3 indicates, the impact of deductible and co-insurance can vary significantly from patient to patient and month to month.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Deductible &amp; Co-insurance</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4 (Up to Nov’14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross PPO</td>
<td>Ded %</td>
<td>4.7%</td>
<td>2.5%</td>
<td>2.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>9.9%</td>
<td>8.4%</td>
<td>7.4%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Blue Cross Exchange</td>
<td>Ded %</td>
<td>30.5%</td>
<td>19.1%</td>
<td>65.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>9.6%</td>
<td>3.9%</td>
<td>9.0%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Blue Shield PPO</td>
<td>Ded %</td>
<td>4.7%</td>
<td>2.5%</td>
<td>1.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>9.9%</td>
<td>7.7%</td>
<td>7.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Blue Shield Exchange</td>
<td>Ded %</td>
<td>32.8%</td>
<td>7.0%</td>
<td>7.7%</td>
<td>13.5%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>18.5%</td>
<td>15.6%</td>
<td>10.6%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

### TABLE 3: Impact of Deductible and Co-Insurance

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Deductible &amp; Co-insurance</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4 (Up to Nov’14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross PPO</td>
<td>Ded %</td>
<td>4.7%</td>
<td>2.5%</td>
<td>2.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>9.9%</td>
<td>8.4%</td>
<td>7.4%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Blue Cross Exchange</td>
<td>Ded %</td>
<td>30.5%</td>
<td>19.1%</td>
<td>65.0%</td>
<td>87.2%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>9.6%</td>
<td>3.9%</td>
<td>9.0%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Blue Shield PPO</td>
<td>Ded %</td>
<td>4.7%</td>
<td>2.5%</td>
<td>1.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>9.9%</td>
<td>7.7%</td>
<td>7.6%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Blue Shield Exchange</td>
<td>Ded %</td>
<td>32.8%</td>
<td>7.0%</td>
<td>7.7%</td>
<td>13.5%</td>
</tr>
<tr>
<td></td>
<td>Co-Ins %</td>
<td>18.5%</td>
<td>15.6%</td>
<td>10.6%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

Jody Locke, MA serves as Vice President of Pain and Anesthesia 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. He can be reached at Jody.Locke@AnesthesiaLLC.com.
Phoenix Project: Reconstructing a Local Group from the Ashes of its Predecessor

Mark F. Weiss, J.D.
The Mark F. Weiss Law Firm, a Professional Corporation, Dallas, TX

Dateline Phoenix

Phoenix. No, not the city in Arizona, but the mythical bird. The one that springs to life from the ashes of its predecessor.

Anesthesia groups, like birds, have a life cycle. Birth to death. Formation to failure.

The group’s founders hatch the concept and bring it into existence. The group obtains business traction in its infancy and grows until it reaches maturity.

But, sooner or later and as inevitable as the sunset, the group begins to decline: the loss of contractual relationships. The unfastening of the bonds that bind the group together. Its eventual dissolution isn’t far off. The flames of death engulf the group.

But unlike natural birds, many dying anesthesia groups have within them the kernel of rebirth. Enter the phoenix.

Death and Praxis

In today’s anesthesia market, we’re seeing two slightly different patterns of anesthesia group decline and death: the failed site of a national or regional anesthesia group and the failed independent group.

Most see those groups as unsalvageable. Yet, under the right conditions, with the right leadership, both types of groups might be made to rise from the ashes.

Consider the following two generic examples:

Community-Odessa Medical Center

For the past several years, a national anesthesia group, through a controlled forty-seven provider subsidiary, Community-Odessa Anesthesia (Com-Od), has held the exclusive contract at Community-Odessa Medical Center, a 402 bed hospital.

Marketing materials aside, Com-Od has never been able to gain traction at the facility. It’s become the poster child for the Promise-Delivery Gap™: It promised the stars but delivered sand.

Since obtaining the contract, Com-Od has seen many providers come and go. The national parent organization has changed local leadership, to no avail.

The hospital has informed Com-Od and its national parent organization that it won’t renew its exclusive contract when it expires in six months.

Localville Hospital

Localville Anesthesia Group (LAG), a twenty-three physician group, was formed in 1987 to obtain the contract at Localville Hospital. Other than some work at a close by surgeon owned ambulatory surgery center, LAG is dependent upon its relationship with the 209 bed hospital for its business existence.

Although it performed well for its first few decades, LAG, which has been run in a club-like fashion—a supermajority of its thirteen shareholders is required for any action—has begun faltering. It can’t respond quickly enough to the hospital’s demands for changing service lines.
There's not sufficient will among its members to take action. Some are near retirement and fear change; others are stuck in the notion that things that have always worked will continue to work. As a result, those members block any action that would disrupt the status quo, especially those that call for an expenditure because it would reduce the amount of dollars available to be distributed currently.

The hospital has informed LAG that if the group doesn't become responsive to its needs, it will seek other coverage when the current contract expires.

The Default Course

In the default, or natural, course of things, both Com-Od and LAG are headed to anesthesia group heaven, or, more probably, anesthesia group hell.

In Com-Od's case, its corporate parent will pull the plug on Com-Od at the end of the exclusive contract term.

In LAG's case, it's highly unlikely, given the existing structure, that it will be able to pull up out of the death spiral that it's in, especially because many of the group's members don't understand their true position relative to the ground.

In both cases, unless group members take action, they will soon either be unemployed, looking for jobs at some distant location, or working as commodity level providers for the new contract holder—for how long and at what compensation no one can know but few will likely find attractive.

The Phoenix Strategy™

The alternative, the Phoenix Strategy™, is to birth a new group out of the ashes of the old.

While it's absolutely true that in each of our examples, Com-Od and LAG, the groups are dying and will soon be dead, the trick is to first see beyond the rot to the kernel of business opportunity that exists within.

In each situation, despite the problems that have caused the group's downfall, there are significant assets that can be leveraged into a new group and a new contract with the hospital.

Leadership

Without someone or some few individuals willing to champion the creation of a new group, a Phoenix group, from the remains of the old and then lead it moving forward, it's impossible for any dying group to rise from its ashes. The default position is that the dead stay dead.

But it's possible for a true leader or core leadership group to spark the start of new life into a Phoenix group. Although the hospital itself might foster those efforts, a topic of a different sort touched on briefly, below, suffice it to say that without strong leadership, it's impossible to successfully implement the strategy.

That home grown leadership can be supplemented. You don't have to go it alone. For example, leaders can, and should, seek advice from outside experts and assistance from the billing service that will perform the new group's collections.

Labor Force

One clear advantage for those reconstituting a group is that there's a partial labor force already in place. Partial because it's likely that some of the existing group members shouldn't make the cut in connection with the group's rebirth.

When an outside group "wins" an RFP, there are generally three buckets into which the facility places the existing group members: Those that must be recruited by the new group, those that can either stay or go and those that the new group can't ever engage.

Why make the mistake of doing any different in creating a new group from an old one? Even if the hospital hasn't expressed a preference, you know who shouldn't remain at the facility, so why fool yourself at the cost of your own future?

Localness

Perhaps the greatest advantage that a Phoenix group has is that its leaders know the influencers at the facility and those influencers know you.

Of course, depending on what triggered the downfall of the existing

Continued on page 18
group, it may be that that familiarity is what bred contempt. The solution is to amputate from membership in the new group those who caused the contempt, and to then work hard to rehabilitate the budding Phoenix group’s image.

But localness alone isn’t sufficient in and of itself. Instead, it has to be nurtured and leveraged into support for the group that both counts (the right people and the right message) and that cannot easily be reversed or withdrawn.

**Funding**

There’s no free lunch: Implementing the Phoenix Strategy requires an investment by the moving parties, an investment in themselves.

This isn’t a game for amateurs. Quite unfortunately, the unwillingness to invest in their own future is what got many anesthesiologists into the Com-Od and LAG situations to begin with.

In addition to contributing capital for equity interests in the new practice entity, making loans to the entity and borrowing from traditional lenders, groups have other sources of funding, some from outside the group and some from inside. Of course, outside funding includes stipend support from the hospital.

And, in connection with inside financial support, a Phoenix group’s members often agree to defer the flow of compensation from the group, tying their compensation to available funds. For example, methodologies include an extended lag time between month of service and month of payment and a floating compensation unit value.

**Sponsorship**

In addition to providing financial support, the hospital is a natural sponsor for the rebirth of a Phoenix group.

It needs coverage. It’s sick and tired of the existing group. It could turn to an RFP and attract a national group (or a replacement national group) or some other regional player, but an RFP is increasingly being seen as a fool’s choice: in many cases it’s what created the problem with the existing group in the first place.

This is especially true in connection with the rebirth of a group that was once a part of a large national or regional group. The hospital has been burned once and is likely to be more amenable to an active financial and political role in fostering the creation of a truly local group that is likely to be highly responsive to the hospital’s needs.

**Conclusion**

Unlike natural death, the death of an anesthesia group can be leveraged into the birth of a new one.

Someone is going to take over the provision of anesthesia services at the facility. Will you be offered a job with the new master? Will you pack up and leave on your own volition for a job somewhere else? Or will you attempt to master your own fate at the facility?

Under the right circumstances, with the right leadership and support, the transgressions of the past can be surmounted and the advantages of localness can be leveraged into a new beginning.
The National Practitioner Data Bank: What You Need to Know

Neda M. Ryan, Esq.
Corporate Compliance Attorney, ABC

The National Practitioner Data Bank (NPDB) was established under Title IV of the Health Care Quality Improvement Act of 1986 and has been operational since September of 1990. The NPDB impacts both anesthesiologists and certified registered nurse anesthetists (CRNAs) as certain entities are required to report adverse actions taken against their licenses, clinical privileges and professional society memberships. The issue of the NPDB most commonly arises under scenarios involving medical malpractice claims as, often, any and all payments made—regardless of whether those payments are made to dispose of a claim or to satisfy a judgment—must be reported to the NPDB.

The Data Bank

According to the NPDB Guidebook, the intent of [the NPDB] is to improve the quality of health care by encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from State to State without disclosure of discovery of previous medical malpractice payment and adverse action history.

The NPDB allows for reporting and querying of physicians, dentists and other healthcare practitioners (e.g., nurses). State licensing boards, hospitals, healthcare entities and professional societies must submit reports to the NPDB of certain adverse actions taken against physicians and nurses under their jurisdiction. Likewise, malpractice insurers must report payments made to plaintiffs on behalf of all licensed practitioners. The NPDB is a tool for hiring entities in their due diligence process. The NPDB repeatedly states that the NPDB is an alert or flagging system.

Reporting to the NPDB

Actions reportable to the NPDB include the following:

• Medical Malpractice Payments—Entities, including insurance companies, making settlement payments or other payments of a claim or judgment (in whole or in part), under an insurance policy, self-insurance, or otherwise, for the benefit of a physician or nurse for medical malpractice.

• Licensure Actions by Boards of Medical Examiners—Each Board of Medical Examiners must report any action based on reasons relating to professional competence or professional conduct (e.g., denial or withdrawal of an application for license renewal).

• State and Federal Licensure Actions—Each state and federal licensing and certification agency must report adverse actions taken as a result of a formal proceeding (e.g., revocation or suspension of license or certification agreement or contract for participation in Medicare and Medicaid, reprimands, censures or probation); dismissals or closure of the formal proceeding by the licensee resulting in surrendering the licenses or certification agreement or contract for participation in Medicare and Medicaid, or leaving the state or jurisdiction; any other loss of license or loss of the certification agreement or contract for participation in Medicare and Medicaid, or the right to apply for or renew, a license or certification agreement or contract for the healthcare provider; and/or any negative action or finding by a state authority or federal agency, organization, or entity regarding the physician or nurse.

• Peer Review and Private Accreditation Actions—Peer review organizations and private accreditation entities must report negative actions or findings taken against a physician or nurse.

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THE NATIONAL PRACTITIONER DATA BANK: WHAT YOU NEED TO KNOW

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- Actions Taken Against Clinical Privileges—A healthcare entity must report (i) professional review actions adversely affecting a physician or nurse’s clinical privileges that span longer than thirty (30) days; (ii) when it accepts the surrender of clinical privileges or any restriction of such privileges by a physician or nurse; or (iii) when a professional review action is taken concerning a physician or nurse.

- Federal or State Criminal Convictions Related to Healthcare—Federal and state attorneys related to the delivery, payment, or provision of healthcare items or services related to the delivery, payment, or provision of healthcare items or services (regardless of whether an appeal is pending).

- Civil Judgments Related to Healthcare—Federal and state attorneys and health plans must report civil judgments against healthcare practitioners related to the delivery of a healthcare item or service (regardless of whether an appeal is pending).

- Exclusions from State or Federal Healthcare Programs—Federal government agencies (e.g., HHS or OIG) and state law and fraud enforcement agencies must report those who are excluded from participating in Federal or State healthcare programs.

- Other Reportable Actions—State and Federal agencies must report other adjudicated actions related to the delivery, payment, or provision of a healthcare item or service against physicians or nurses (regardless of whether an appeal is pending).

Shortly after the NPDB was in place, the Office of the Inspector General (OIG) conducted a study and published a report, National Practitioner Data Bank: Malpractice Reporting Requirements. One of the purposes of the report was to ascertain whether a reporting floor should be imposed upon reports of malpractice payments. In conducting a survey of malpractice insurers, the OIG determined that while imposing a reporting floor would encourage settlement of smaller claims and would significantly reduce the number of reports forwarded to the NPDB, potentially meaningful reports would not be made when cases are settled for amounts below the floor, sometimes deliberately to avoid reporting. Accordingly, the OIG determined that the benefits to reporting do not outweigh the potential drawbacks of diminished reporting.

QUERYING THE NPDB

Hospitals, state licensing boards, other health care facilities, professional societies and plaintiffs’ attorneys all have authority to query the NPDB under certain circumstances. Additionally, individuals may query their own records at any time. Hospitals are the only entities that must query the NPDB. Hospitals must query with respect to those who apply for a position on the medical staff or to obtain clinical privileges at the hospital. Queries must also be made every two years thereafter. Other healthcare entities may query the NPDB when they seek to have an employment or other affiliation relationship with an individual. Moreover, state licensing boards may query the NPDB at any time. Plaintiffs’ attorneys may only query the NPDB in certain circumstances, but medical malpractice payers may not query the NPDB at any time. NPDB records are not accessible to the general public and are only released to authorized persons and entities.

DISPUTING NPDB INFORMATION

When an adverse action is submitted to the NPDB, a copy of the report is sent to the subject of the report. It can be extremely difficult for a physician or a nurse to change a report made to the NPDB. Although subjects may not submit changes to the report directly, subjects may request the reporting entity to file corrections if they believe there to be inaccuracies. The NPDB itself may not modify information within the report.

At times, the reporting entity will amend the report and notify all the entities to whom reports have been sent that the original report has been revised. However, in other instances, the reporting agency will refuse to amend the original report. In such instances, the subject of the report may escalate the issue through a formal dispute process and/or add a statement to the report.

When an entity refuses to amend the report, the physician may escalate the issue to the Secretary of Health and Human Services (Secretary) who will only review the report for factual accuracy and not the appropriateness of the action or the merits of the claim. Importantly, according to the NPDB Guidebook, “[t]he dispute process is not an avenue to protest a payment or to appeal the underlying reasons of an adverse action affecting the subject’s license, clinical privileges, or
professional society membership. Neither the merits of a medical malpractice claim nor the appropriateness of, or basis for, an adverse action may be disputed.” Formal disputes may only be beneficial to the subject, therefore, if the facts reported are inaccurate. The subject of the report may, in addition to escalating the dispute to the Secretary, submit a statement that will be permanently attached to the report.

**Hiring an Attorney**

Anesthesiologists and CRNAs may find it worthwhile to obtain the assistance of an attorney when faced with reportable adverse actions. Some reports to the NPDB are required and can occur without proof of an anesthesiologist’s or CRNA’s wrongdoing. For example, if a medical malpractice claim is settled (with no admission of wrongdoing), a report may be made to the NPDB because money was paid in connection with a medical malpractice claim. Moreover, anesthesiologists and CRNAs may also find it prudent to hire attorneys to represent them in licensure or staff privilege issues to avoid reporting to the NPDB. If a report must be made to the NPDB in such instances, the physician or nurse may utilize the assistance of an attorney in agreeing to the language that is being submitted to the NPDB; such a strategy may assist in averting future issues associated with NPDB queries. Finally, if an NPDB report has been filed, an anesthesiologist or a CRNA may use the assistance of an attorney to draft the statement to be attached to the report.

**Conclusion**

Reports to the NPDB can have a significant impact on an anesthesiologist’s or CRNA’s prospective employment. Anesthesiologists and CRNAs should be aware of which types of adverse actions will be reported to the NPDB and should take care to mitigate any potential future impact by seeking the assistance of qualified counsel. Although some reports may not be avoided, the content of the report may be negotiated so as to be acceptable to all parties.

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**Advanced Institute for Anesthesia Practice Management**

Securing the Future for Anesthesia Practices

Las Vegas – April 17-19, 2015

Sixteen experts in the business of anesthesia and pain medicine will be presenting at the second Advanced Institute for Anesthesia Practice Management (AIAPM) next April. The conference, which is jointly sponsored by Tulane University Health Sciences Center, Anesthesia Business Consultants, LLC and Medical Business Solutions, LLC, will again take place at the Cosmopolitan Hotel in Las Vegas.

Consolidation among of anesthesia and pain medicine practices—acquisitions, mergers and hospital employment—is the single biggest change that continues to confront us all. Leaders of large national anesthesia management companies will talk about maintaining independent hospital relationships and navigating through the acquisition process. There will be presentations on technology, on coding and billing. Participants will learn about compliance issues in structuring business deals and in acquiring and using technology and social media.

More than 300 people attended the first AIAPM in April 2014. More than 32 exhibitors ringed a large hall that was exceptionally conducive to the networking and informal information exchanges that are such an important part of professional conferences. The numbers are expected to grow this year, given comments received such as “I always learn new things to bring back and share with our group. I think the speakers do a great job in covering a lot of information in a short time, and are always willing to answer questions during the meeting and after. Thank you.”

For the conference agenda, registration and hotel information, please contact info@aiapmconference.com or visit www.aiapmconference.com.
The American Medical Association 2015 CPT® Codebook is now available. It contains 9,951 total Current Procedural Terminology (CPT) codes and more than 500 code changes: 266 new, 147 deleted and 129 revised codes. The good news for anesthesia providers and coders is that the only change to the anesthesia code section (00100-01999) is the deletion of three codes, all due to low utilization. The deleted codes are:

- 00452 Anesthesia for procedures on clavicle and scapula; radical surgery
- 00622 Anesthesia for procedures on thoracic spine and cord; thoraco-lumbar sympathectomy
- 00634 Anesthesia for procedures in lumbar region; chemonucleolysis

The bulk of the coding changes for 2015 fall within the surgical section and the impact, if any, regarding most of these changes will become apparent upon the release of the American Society of Anesthesiologists (ASA) 2015 A Guide for Surgery/Anesthesia CPT® Codes 2015 Crosswalk (not available at press time). Since many of these surgical coding changes involve changes to the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) for 2015, due to bundling of services, or revisions of the relative value units (RVUs), anesthesiologists will see some new and revised crosswalks in 2015.

The RUC review of specific procedures is based on fifteen different screening criteria. Examples of screening criteria are Medicare's High Volume Growth Screen, where Medicare utilization for a specific code increased by at least 100 percent from 2006 to 2011, and when two CPT codes are reported together on the same day of service by the same provider of service more than 75 percent of the time. The RUC revaluation of codes may directly or indirectly impact physicians’ reimbursement.

One new CPT code of potential interest to anesthesiologists who are qualified to perform interventional Transesophageal Echocardiography (TEE) is CPT code 93355. The code description reads:

**Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g., TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intraprocedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D.**

Code 93355 is reported once per intervention and only by an individual who is not performing the interventional procedure. Note that code 93355 includes the work of:

- Passing the endoscopic ultrasound transducer through the mouth into the esophagus, when performed by the individual doing the TEE;
- Diagnostic TEE and ongoing manipulation of the transducer to guide sizing and/or placement of implants, determination of adequacy of the intervention, and assessment for potential complications; and
- Real-time image acquisition, measurements and interpretation of $39 billion in Medicare spending. To date, the RUC has recommended reductions in work RVUs and code deletions for 945 services, allowing for the redistribution of more than $3.5 billion. Another 218 procedures are still under review. The RUC review of specific procedures is based on fifteen different screening criteria. Examples of screening criteria are Medicare’s High Volume Growth Screen, where Medicare utilization for a specific code increased by at least 100 percent from 2006 to 2011, and when two CPT codes are reported together on the same day of service by the same provider of service more than 75 percent of the time. The RUC revaluation of codes may directly or indirectly impact physicians’ reimbursement.
image(s), documentation of completion of the intervention and final written report.

Code 93355 cannot be reported in conjunction with any other TEE, Doppler, color flow or 3-D image reconstruction codes. In the final rule, CPT 93355 was assigned 6.38 RVUs which yields a national MPFS amount of $228.41.

**Waiver of Co-insurance for Anesthesia Provided for Screening Colonoscopies**

Another reporting and payment change of interest to anesthesiologists is the waiver of the patient co-insurance and deductible when anesthesia is provided for screening colonoscopies.

Effective January 1, 2015, the separately payable anesthesia service done in conjunction with a colorectal cancer screening test should be billed with modifier 33 on the same claim line as the anesthesia service. If the test began as a colorectal cancer screening test but resulted in unplanned tissue removal, e.g., a colonoscopy with polyp removal, etc., the anesthesia professional should report a PT modifier on the claim line rather than the 33 modifier. In order to report the services correctly, anesthesiologists providing anesthesia for colonoscopies will need to adequately document whether the service was a colorectal cancer screening test or a colorectal cancer screening test that was converted to a diagnostic or therapeutic procedure. Anesthesiologists may want to verify with the gastroenterologist the final CPT code used for all colonoscopies that they provide anesthesia services.

Medicare has two Healthcare Common Procedure Coding System (HCPCS)/CPT codes for colon cancer screening colonoscopies to distinguish whether the patient is at high risk or not. A patient is considered to be at high risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polypl;
- A family history of adenomatous polyposis;
- A family history of hereditary non-polyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer;
- A personal history of inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis.

For the colorectal screening cancer test, the gastroenterologist has the choice of two G codes for Medicare patients and, as indicated in Table 1, both G codes would require the use of modifier 33 with the ASA code 00810 in order to have Medicare waive the co-insurance and deductible amounts. If modifier 33 is not reported, Medicare will reimburse the claim at 80 percent of the fee and the anesthesia provider will be required to bill the secondary insurer, or patient, as applicable, for the co-insurance.

When a screening colon cancer colonoscopy is performed and the physician finds a problem (e.g., polyps, foreign object, bleeding, etc.), the procedure is no longer considered “screening.” In place of using the screening G codes, the GI procedure should be reported with the CPT code for a diagnostic or therapeutic colonoscopy (CPT 45378-45398) with modifier PT. When modifier PT is used the deductible is still waived but the co-insurance is not. Table 1 shows the coding rules applicable to the Medicare regulation.

In the discussion accompanying the Final Rule on the MPFS for 2015, CMS stated that the change regarding the waiver of the co-insurance for screening colorectal cancer testing is a national policy and takes precedence over any local coverage policy that limits Medicare coverage for anesthesia services furnished during a screening colonoscopy by an anesthesia professional. However, if the screening colonoscopy is converted to a diagnostic or therapeutic colon procedure, all Medicare medical necessity guidelines will remain unaffected.

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**TABLE 1**

<table>
<thead>
<tr>
<th>GI HCPCS Code</th>
<th>GI HCPCS Code Descriptor</th>
<th>Anesthesia ASA Coding</th>
<th>Anesthesia Modifiers</th>
<th>Co-insurance Waived</th>
<th>Deductible Waived</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0105*</td>
<td>Colon cancer screening; colonoscopy on individual at high risk</td>
<td>00810</td>
<td>33</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>G0121</td>
<td>Colon cancer screening; colonoscopy for individuals NOT meeting criteria for high risk</td>
<td>00810</td>
<td>33</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>G0105 or G0121 converted to a CPT code as listed below</td>
<td>When a screening colonoscopy is converted to a diagnostic or therapeutic procedure the screening G code is not billed and a CPT code is reported, however since the deductible is waived modifier PT needs to be appended</td>
<td>00810</td>
<td>PT**</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>45378 - 45389</td>
<td>Colonoscopy, flexible; ………</td>
<td>00810</td>
<td>None</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

* When billing for the “high risk” beneficiary, the screening diagnosis code on the claim must reflect at least one of the high risk conditions listed above.
** When a screening colon for a Medicare patient is converted to a diagnostic or therapeutic colon procedure (e, removal of polyps, biopsy, etc,), the service is reported with modifier PT.

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Finally, in regards to colonoscopies, it is important for anesthesiologists to know that many of the lower gastrointestinal (GI) CPT codes reported by the gastroenterologist have been revised by the AMA in 2015. In addition, several new lower GI CPT codes have been added (e.g., Colonoscopy through stoma and Ileoscopy through stoma). For the 2015 reporting year, CMS has established G codes to mirror the 2014 CPT codes that were deleted in 2015. As a result, if the patient has Medicare (Fee for Service or Medicare Advantage), gastroenterologists have a complicated billing situation. That is to say:

- If the code has not changed from 2014 to 2015 or is new in 2015, physicians report the CPT code
- If the code has changed from 2014 to 2015, physicians report the G code for Medicare patient
- If the facility (ASC, hospital outpatient, etc.) is billing Medicare, the 2015 CPT code is used regardless of whether the code is new or has not changed

Of course, if it is a commercial, Medicaid, Exchange, or other payer, the physician should report the 2015 CPT code unless the payer advises them otherwise. While lower GI endoscopic billing is complicated for the GI physician in 2015, the anesthesiologist services would all fall under the ASA/CPT code 00810. The only additional information required is specific to the colorectal cancer screening codes and the use of modifier 33 or PT as discussed above.

**POTENTIAL SUSTAINABLE GROWTH RATE IMPACT**

The last CMS MPFS issue of concern to anesthesiologists is the payment rate effective for services furnished on or after January 1, 2015 and on or after March 1, 2015. Current law requires that physician payments be reduced by 21.2 percent from the 2014 rates. In prior years, Congress has taken action to avert a large reduction in the MPFS rates before they went into effect. The Protecting Access to Medicare Act of 2014 established a zero percent change in payment rates from the 2014 rates. In prior years, the proposed reduction will not be implemented prior to March 1, 2015. Therefore, the proposed reduction will not be implemented prior to March 1, 2015, allowing Congress time to address the proposed payment rate and consider a permanent change to the Sustainable Growth Rate (SGR) methodology. The Final Rule also addresses changes to malpractice RVUs and Geographic Practice Cost Indices (GPCIs), both of which may impact physician reimbursements.

**Epidural Steroid Injection Reimbursement**

Of particular interest to pain medicine physicians are changes to the payment for ESI. Payments for ESIs were significantly reduced in the 2014 MPFS, provoking an outcry from the pain medicine community. As a result, CMS will raise payments for 2015 using prior resource inputs pending further review and recommendations from the AMA RUC. CMS will not, however, pay separately for image guidance in 2015. It is our understanding that pain medicine organizations have already begun looking at potential CPT code and other changes to ESI services and will work with the AMA RUC to provide additional feedback to CMS. Table 2 compares the MPFS national reimbursement for epidurals in 2013, 2014 and 2015.

**TABLE 2** Medicare National Reimbursement for Epidurals in 2013, 2014 and 2015

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
<th>2013(^a)</th>
<th>2014(^b)</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>62310</td>
<td>Inject spine cerv/ Thoracic</td>
<td>$253.13 ($349.07)</td>
<td>$110.89 ($201.68)</td>
<td>$244.52</td>
</tr>
<tr>
<td>62311</td>
<td>Inject spine lumbar/Sacral</td>
<td>$213.32 ($309.28)</td>
<td>$108.90 ($199.89)</td>
<td>$225.19</td>
</tr>
<tr>
<td>62318</td>
<td>Inject spine w/cath crv/thrc</td>
<td>$244.63 ($340.57)</td>
<td>$111.41 ($202.40)</td>
<td>$233.42</td>
</tr>
<tr>
<td>62319</td>
<td>Inject spine w/cath lmb/scrl</td>
<td>$175.90 ($271.84)</td>
<td>$79.84</td>
<td></td>
</tr>
<tr>
<td>62320</td>
<td>Inject spine lumbar/ Sacral</td>
<td>$111.41 ($202.40)</td>
<td>$60.86</td>
<td>$122.51</td>
</tr>
</tbody>
</table>

\(a\) The amount in parentheses shows the payment plus fluoroscopic guidance - $95.94

\(b\) The amount in parentheses shows the payment plus fluoroscopic guidance - $90.99

**TABLE 3** Medicare Reimbursement for Joint Injections with Ultrasound Bundled in 2015

<table>
<thead>
<tr>
<th>Joint Injection Coding &amp; Payment-2014</th>
<th>Joint Injection Coding &amp; Payment-2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>20600 - Drain/lnj joint/bursa w/o us</td>
<td>20600 - Drain/lnj joint/bursa w/o us</td>
</tr>
<tr>
<td>$48.36</td>
<td>$48.33</td>
</tr>
<tr>
<td>20600+76942 - Drain/lnj joint/bursa w/us</td>
<td>20604 - Drain/lnj joint/bursa w/us</td>
</tr>
<tr>
<td>$122.51</td>
<td>$72.32</td>
</tr>
<tr>
<td>20605 - Drain/lnj joint/bursa w/o us</td>
<td>20605 - Drain/lnj joint/bursa w/o us</td>
</tr>
<tr>
<td>$50.51</td>
<td>$50.84</td>
</tr>
<tr>
<td>20605+76942 - Drain/lnj joint/bursa w/us</td>
<td>20606 - Drain/lnj joint/bursa w/us</td>
</tr>
<tr>
<td>$124.66</td>
<td>$79.84</td>
</tr>
<tr>
<td>20610 - Drain/lnj joint/bursa w/o us</td>
<td>20610 - Drain/lnj joint/bursa w/o us</td>
</tr>
<tr>
<td>$60.90</td>
<td>$60.86</td>
</tr>
<tr>
<td>20610+76942 - Drain/lnj joint/bursa w/us</td>
<td>20611 - Drain/lnj joint/bursa w/us</td>
</tr>
<tr>
<td>$135.05</td>
<td>$91.29</td>
</tr>
</tbody>
</table>
### 2015 TAP Blocks Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>64486</td>
<td>Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)</td>
</tr>
<tr>
<td>64487</td>
<td>Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)</td>
</tr>
<tr>
<td>64488</td>
<td>Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)</td>
</tr>
<tr>
<td>64489</td>
<td>Transversus abdominis plane (tap) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)</td>
</tr>
</tbody>
</table>

### Bundling of Ultrasound with Joint Injections

In addition to the CPT codes above, pain medicine providers may be interested in the bundling of ultrasound with the following procedures in 2015 (as listed in Table 3). Again, the payment amounts reflect MPFS national reimbursement levels.

### New Codes for Transversus Abdominis Plane Blocks

New codes for post-op pain blocks are on the way. Starting in 2015, anesthesia providers will report transversus abdominis plane (TAP) blocks with one of four codes depending on whether the service is performed by injection or continuous infusion and unilaterally or bilaterally. The codes and their descriptors are listed in Table 4.

### Total Rewrite of Drug Screening Codes and Guidelines

The CPT 2015 manual revamped the entire code set for drug screens and issued new guidelines and definitions. Instead of differentiating testing procedures based on qualitative or quantitative methodology, the new reporting mechanism differentiates procedures according to whether they are:

1. Presumptive (used to identify possible use or non-use of a drug or drug class);
2. Definitive (qualitative or quantitative methods that identified possible drug use or non-use and identify the specific drugs and associated metabolites); or
3. Therapeutic Drug Assays (quantitative procedures performed to monitor clinical response to a known, prescribed medication).

The updated reporting mechanism has been designed to address the following:

1. Ability to be easily modified for future changes and technological advances;
2. Identification of updated clinical settings, and
3. Identification of “sources” for specimen(s).

The Presumptive Drug Class Screening section includes Guidelines for the Presumptive Drug Class Screening section, Drug Class List A (which itemizes commonly assayed drugs within the listing) and Drug Class List B (which itemizes assays that require more resources than Class A). This section also includes guidelines that explain the intended use for the listing and the codes. Five new codes have been developed to identify presumptive testing with introductory guidelines explaining the intent for use of these codes.

Definitive Drug Testing includes fifty-nine new definitive drug testing codes. The codes are arranged by drug classes. Refer to the Definitive Drug Classes Listing table for drugs and metabolites included in each definitive drug class.

Based on the latest information from Medicare, next year pain management physicians may be required to use the entirely new sets of CPT codes for commercial payers and Medicare G codes to report qualitative and quantitative drug screens. At the AMA-CPT 2015 Symposium held in November 2014, CMS officials presented numerous G codes that were created for 2015. CMS’ overall position is that when the timing of a CPT code creation precludes adequate timeframe for CMS consideration of comments and RUC valuation, they will implement or default to the use of G code(s). In the 2015 MPFS Final Rule, CMS indicated they would also create a G code if the revisions and or deletions to AMA-CPT may affect the code RVU value. In addition, they would add G code(s) when AMA-CPT separated a CPT code into two CPT codes.

In the Final Medicare Rule for 2015, CMS said, “These codes represent various drug screening codes, many of which are specific to individual drug testing. While we appreciate the recommendations for these tests, we are concerned about the potential for overpayment when billing for each individual drug test rather than a single code that pays the same regardless of the number of drugs that are being tested for. Therefore, it is our recommendation to delay pricing for these codes at this time, until further information and education is obtained.”

As of press time, CMS had not yet released the clinical lab fee schedule for 2015. Stay tuned for additional updates as we learn more on how Medicare and other payers plan to respond to these extensive changes.
TEN QUESTIONS ABOUT ICD-10

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Vice President of Provider Education and Training, ABC

Even though there has been a substantial amount of information published regarding the implementation of ICD-10 over the last ten years, there are many misconceptions that continue to plague the physician community. Rumors run rampant; some are valid while others are completely unfounded. Frequently we hear the need for change in healthcare, yet resistance to change continues to stifle our ability to move forward. The unknown is a scary place. It is more comfortable to work with an established system that is flawed rather than implement a new, technologically advanced system. Reflecting back several years ago with the implementation of the 5010 HIPAA electronic transactions standard, many organizations were negatively affected because they were not prepared, yet after some adjustments, 5010 is successfully operating behind the scenes with little to no effort. Let’s review ten questions concerning ICD-10 in an attempt to dispel the myths.

Who developed ICD-10?

The World Health Organization (WHO) developed the ICD-10 Clinical Modification (CM) diagnosis coding system. The Centers for Disease Control and Prevention’s (CDC) National Center for Health Statistics (NCHS) develops and maintains the US version of ICD-10 CM. All modifications to ICD-10 are required to conform to WHO conventions. The physician community and healthcare industry had extensive input in the development of ICD-10 CM; in fact, much of the clinical detail was a result of the input received from physicians. So why all the resistance if the physicians gave much of the input?

What is the ICD-10 compliance date?

The looming question is “will there be another delay and if so when?” Currently, federal regulations require that ICD-10 codes be utilized for dates of service beginning October 1, 2015; thus, ICD-9 will expire on September 30, 2015. Once again, there has been much discussion regarding a delay of the implementation date. Last year’s delay was a political maneuver that was slipped in at the last minute to appease physicians because of the recurring Sustainable Growth Rate (SGR) issues. The delay surprised the Centers for Medicare and Medicaid Services (CMS), the American Academy of Professional Coders (AAPC), the American Health Information Management Association (AHIMA) and the entire healthcare community. Due to the multiple delays, it is understandable that the healthcare community has lost its confidence in the implementation taking place. As of the time this article is being written, it appears that legislation drafted by Representative Pete Sessions (R-TX) will include a two-year delay of ICD-10 for consideration by Congress.

Why don’t we wait for ICD-11?

The projected date for the release of ICD-11 is 2017. The US version would then take another two years of revisions prior to release and implementation in 2019 at the earliest. In addition, ICD-11 builds on the concepts of ICD-10; therefore, it would be prudent to implement ICD-10 and become familiar with the new concepts and guidelines before upgrading to ICD-11. Greater diagnosis specificity is going to be necessary prior to 2019.

What is the impact on CPT codes?

The Current Procedural Terminology (CPT) codes will be unaffected by the implementation of ICD-10-CM.

How is ICD-10 implementation related to the Affordable Care Act (ACA)?

The implementation of ICD-10 is not part of the Patient Protection and ACA of 2009. ICD-10 is governed by HIPAA; therefore, it is not related.

Why should we change to ICD-10?

ICD-9-CM is obsolete and no longer able to reflect the many changes in healthcare, i.e., clinical knowledge and medical terminology advancements over the last 40 years. Today’s need for data is very different than it was 40 years ago. ICD-10 includes greater detail that will lead to better justification of medical necessity. Many interested parties anticipate that it will lead to fewer coding errors with fewer rejected claims because the system is more understandable and specified.
codes and check for consistency between diagnosis and procedure codes to identify illogical combinations of diagnoses and reduce opportunities for fraud. Hopefully there will be fewer gray areas.

What are the benefits of ICD-10 CM adoption?

Many physicians view the implementation of ICD-10 as onerous and expensive; there are many benefits that will offset this cost.

- Improvements in patient outcomes and patient safety through better data for analysis and research
- Improved ability to manage chronic diseases by better capturing patient populations
- More accurate reflection of clinical complexity and severity illness in patients
- Improved ability to identify high-risk patients who require more intensive resources
- Improved ability to manage population health
- Improved information sharing, which can enhance treatment accuracy and improve care coordination
- Enhanced public health surveillance and improvement strategies
- Improved ability to assess effectiveness and safety of new medical technology
- Improved administrative efficiencies and lowered costs (e.g., fewer rejected and improper reimbursement claims, decreased demand for submission of medical record documentation)
- Justification of medical necessity
- More accurate and fair reimbursement
- More accurate representation of physician performance
- Increased patient engagement (as a result of access to better data)
- Validation for reported evaluation and management codes
- Less misinterpretation by auditors, attorneys and other third parties

Can we just use the crosswalk from ICD-9 to ICD-10?

General Equivalence Maps (GEMs) to convert ICD-9 to ICD-10 should only be used as a guide for coding and not for the actual coding of claims. The code should be confirmed based on the clinical documentation presented. Many physicians find the volume of codes intimidating and the use of a crosswalk may seem to alleviate the stress of learning the whole new code set. Remember, 78 percent of the codes have a 1:1 relationship. This should dispel the fear about the number of ICD-10 CM codes. Laterality (right vs left) also accounts for almost 50 percent of the increase. The remaining 22 percent of codes will have a “one to many” relationship. These are the codes for which the crosswalk may not be applicable because they will need more clinical documentation in order to identify the appropriate ICD-10 CM code.

What about using external cause codes, signs/symptoms and unspecified codes?

As in ICD-9, the reporting of external cause codes has no mandatory requirement for reporting in ICD-10. It is only applicable under certain circumstances. Signs and symptoms, as well as unspecified codes, are also only reported under certain circumstances. It is important to report the code that represents the level of certainty known for that procedure or encounter. If the information is not known or available, then it is acceptable to report the appropriate unspecified code or the signs/symptoms. However, it is inappropriate to code unspecified or signs/symptoms if the information is available to the physician.

Where do we start ICD-10 training for our physicians?

According to AHIMA, the amount of training individual physicians will need is based upon the role they play within their practice. It is recommended that each practice perform an assessment to determine how their current documentation will compare to the documentation necessary to code ICD-10. Once this assessment is complete, the appropriate training for the organization can be determined. For instance, if a physician is doing their own coding, more extensive training will be required than for a physician who is documenting only and using the services of a coder. This assessment may alleviate the anxieties related to the implementation.

The key to a successful ICD-10 implementation is preparation. The time is now. Delaying practice assessment and training in hopes of a delay could potentially affect your cash flow for several months. It is better to be safe than sorry.

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Professional Events

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<td>April 30-May 2, 2015</td>
<td>Medical Group Management Association 2015 Anesthesia Administration Assembly</td>
<td>The Palmer House Hilton Chicago, IL</td>
<td><a href="http://www.mgma.com/mgma-anesthesia-(aaa)-conference">http://www.mgma.com/mgma-anesthesia-(aaa)-conference</a></td>
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<tr>
<td>May 15-17, 2015</td>
<td>Arizona Society of Anesthesiologists 41st Annual Scientific Meeting</td>
<td>Scottsdale, AZ</td>
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