



IMPENDING DEATH OF HOSPITALS: WILL YOUR ANESTHESIA PRACTICE SURVIVE?

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How would *you* like to know exactly what's going to happen in the future so that you can prepare for and profit from it?

I have a crystal ball. Here, let me share it with you.

We're going to review some of the trends currently impacting, and soon to impact, hospitals that will, I predict, lead to their destruction, at least as we know them.

There is absolutely no question that these trends are going to have an impact on your anesthesia practice. Start preparing now.



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THE EVOLVING RELATIONSHIPS BETWEEN ANESTHESIOLOGISTS AND THEIR HOSPITALS AND ASCs

By the time this issue of *The Communique* is in your hands, 2015 will be a fading memory and 2016 will have begun to take shape.

One important voice sounding a warning or at least a heads-up about what is coming is that of Mark Weiss, Esq. The title of Mr. Weiss's article—*Impending Death of Hospitals: Will Your Anesthesia Practice Survive?*—which is also the title of his forthcoming book—is intentionally provocative. He lays out several of the major threats confronting hospitals, starting with health system growth, through mergers and acquisitions, acquisition of physician practices and investments in integrated delivery networks. Others have predicted that the Federal Trade Commission will place a damper on hospital merger activity in 2016, but the quest for greater scale and scope is going to continue. Anesthesiologists may want to consider the wisdom of relying on the ongoing health of just one or two hospitals. This is especially true in light of the ability of physician-owned facilities, notably ambulatory surgery centers, and new technologies (think telemedicine) to disrupt hospitals' traditional business. Mr. Weiss concludes in no uncertain terms that anesthesiologists who are not yet deeply engaged with freestanding facility care should turn in that direction.

Of course, with more than 5,600 licensed hospitals in the U.S., the need and opportunity for anesthesiologists in hospitals is not going to dissipate completely in the near future. In the Fall 2015 issue of *The Communique*, Rick Bushnell, MD, MBA explained why forming a perioperative surgical home (PSH) with the active support of the hospital was right for his group. He brings us up-to-date on the process

of agreeing upon goals, priorities and resources that has led to the formation of a true partnership in his new article *The Perioperative Surgical Home: Our Partnership with the C-Suite*.

Jerry Ippolito, MBA, MHSA reminds us all of the continuous need to attend to the well-being of one's hospital and surgeons in *The Hospital is Your Practice's Client—Understand Client Satisfaction to Retain Your Contract*. As Mr. Ippolito states, "Every business, regardless of its service offering or discipline, must continue to reinvent itself, to remain marketable, in changing times. Anesthesia is no exception."

The arrival of a new year always brings us coding changes. Kelly Dennis, MBA, who is a certified expert coder with 32 years of experience in anesthesia, reviews the changes to the CPT® system and also to the increasingly frustrating Physician Quality Reporting System (PQRS) in *2016 Coding Updates for Anesthesia*. PQRS is now in its penultimate year of existence, and we would like to think that the Merit-Based Incentive Payment System that, in 2019, will replace the various Medicare quality reporting programs bedeviling us today will be an improvement. We shall see.

Confidentiality is a topic that perennially looms large in healthcare. Improving or even maintaining health does not take place in a void; information is and must be shared in order to achieve our health-related goals both as individuals and as participants in healthcare systems. One area that engenders confusion is the extent to which personal information gathered and shared in the context of peer review may be protected from disclosure or "discovery" in legal proceedings. Every state has a statute governing the discoverability of records, reports and

conclusions. In *Confidentiality in the Peer Review Process: What Does it Mean and What is Covered? Part I*, Neda Ryan, Esq. reminds readers of the basic principles and considerations and also provides a summary of the statutes for Alabama through Iowa. Part II will appear in the Spring issue of *The Communique* and will contain summaries for the remaining states.

Just as important a legal matter, although one that comes up somewhat less frequently than confidentiality, is covered by Kathryn Hickner, Esq. in *"I'm Out Of Here!" Now What?* Physicians leaving a practice are often covered by an employment contract with the group they are leaving and also by federal and state laws regarding employer benefit plans, notification to patients, enforceability of restrictive covenants and other issues. The written agreement of course trumps verbal promises regarding termination; in case of ambiguity in the employment contract or potential claims against the other party, entering into a written separation agreement may make sense. Anesthesiologists and others should try to exit their old relationships with as much care as they enter into new ones.

We hope that 2016 will be a year of successful and satisfying relationships, old and new, for all our readers.

With best wishes,

Tony Mira
President and CEO





THE PERIOPERATIVE SURGICAL HOME: OUR PARTNERSHIP WITH THE C-SUITE

Rick Bushnell, MD, MBA

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“CMS’ pay-for-performance reimbursement changes are looming. As members of the Huntington Accountable Care Organization (ACO), anesthesia recognizes the need to improve surgical outcomes. Our collective financial future is tied to solid quality improvements that only increasingly coordinated care can deliver. We will double down on our cooperative effort with our hospital in order to improve medical outcomes, to lower costs and to improve the patient experience.” – Pacific Valley Medical Group, Pasadena, CA.

SUMMARY OF RECENT EVENTS

The Centers for Medicare & Medicaid Services (CMS) is pushing quality, the American Society of Anesthesiologists (ASA) is pushing the perioperative surgical home (PSH) and our 30-partner Pacific Valley Medical (anesthesiology) Group (PVMG) in Pasadena, CA is picking up both causes. In our commitment to a PSH clinic staffed and managed by anesthesiologists, we are fully embracing the concept of transitional care & perioperative medicine. This is our contribution to our patients and to our Huntington Memorial Hospital’s (HMH) Readmission Reduction Program.

This past summer, we made rapid progress toward putting these concepts into operation. In June, two members of our group attended the ASA conference on the PSH. In July, we recruited a few more of our partners. In August, our anesthesia group hosted a presen-



tation by Zeev Kain, MD, MBA of the Department of Anesthesia, University of California, Irvine to our administrators and surgeons. In September, several of us divided up the work (below) and in October, we presented the concept and proposed a partnership with the Huntington Memorial C-suite.

PRESENTATION TO THE C-SUITE

Our hospital administrators have long been aware of the issues of costly readmissions, looming CMS changes and marginal patient experience for some. They can be forgiven for being unaware, though, of how an engaged anesthesia group can help with those issues. Like many anesthesia groups, they were unaware of how an active, mature PSH partnership can meet their needs. In our presentation, then, we started by defining the PSH as (1) a concept, (2) a process and (3) a physical presence.

As a concept, the PSH is the idea that patients experience better surgical outcomes when anesthesiologists are fully engaged in the entire perioperative continuum. Complicated patients do especially better when physician anesthesiologists take responsibility for pre-surgical optimization, in-room anesthesia, immediate post-op care and transitional care medicine. Who better than anesthesiologists to understand the surgical challenges presented to patient physiology? Who better, then, to optimize pre-operative physiology and surveil post-operative outcomes? If not us, who? If not now, when? As an aside, anesthesia groups absolutely must understand their value to the concept of the PSH. Individual anesthesiologists must realize and exercise their superior medical management abilities relative to other care givers. The concept is the ASA’s investment.

As a process, the PSH is the engagement and coordination of anesthesia services throughout the entire continuum of surgical care. From the decision to operate to final disposition of the patient, anesthesiologists must make themselves available to patients, to their surgeon partners and to hospital administrators. In the case of Huntington’s 11,000 annual surgical cases, that seems a very tall order. In order to target resources toward those most at risk, PVMG will design systems to triage our surgical patients. We will assign 20 percent of the sickest to MD pre-op clinic

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THE PERIOPERATIVE SURGICAL HOME: OUR PARTNERSHIP WITH THE C-SUITE

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visits, MD operating room anesthesia and MD post-discharge transitional care medical management by anesthesiologists. The remainder will be seen in a pre-op clinic by mid-level providers under MD management. PVMG will invest a full time equivalent anesthesiologist to manage the clinic and to work up patients. The manpower is our practice's investment.

As a physical presence, the PSH is necessarily a location with staff and support from the hospital. It is a substantial investment of both finances and administrative effort in managing 11,000 patients more effectively. Currently, the majority of those elective patients present to the hospital and the pre-operative holding suites the morning of surgery. You can imagine the resulting cancellations and delays that result from last-minute pre-op work that could have been done weeks before the very day of surgery. This patient and information flow is no longer acceptable. It wastes resources and it exposes patients to sub-optimal outcomes. Huntington Memorial is already in process of expanding the physical capacity of this clinic to ac-

commodate all the surgical patients. This physical facility and support staff are the hospital's investment.

After thus explaining the PSH, we presented the PSH anesthesia team to the C-suite: those of us (initials below) who had coalesced into a working group, self-selecting ourselves into areas of responsibility based on our individual natural interests. There will be much other work and room for the remainder of our group, but in addition to seeing patients in clinic our initial responsibilities were divided in this manner:

AF - Goal directed therapy, regional block room, liaison to cardiothoracic section

RY - Data management, research, metrics, liaison to ObGyn section

JH - Pre- & post-operative work-up protocols, liaison to HMH quality committee

LK & AC - Pain management, liaison to orthopedic section

TC - Financial management, billing, negotiations

JM - Executive leadership, politics, liaison to general surgery section

RB - Experience in establishing pre-post-op clinic, pace, focus & vision

MM - Liaison to ambulatory surgical centers, clinic duties

MA - Scheduling, office management, clinic duties

CK - Pre- and post-discharge protocols, NICU, PICU and fetal surgery section

The proximate result of the presentation of our team was the demonstration of our interest, our motivation, our re-

search and the medical resources we were offering our Huntington C-suite administrators. We wanted them to sense an enthusiastic, well-motivated team, who offered a progressive physician partnership and a well-conceived plan.

OUR INITIAL GOALS INCLUDED

- Reducing day-of-surgery cancellations by 90 percent by the end of the 1st year
- Reducing surgical length of stay by 20 percent by the end of the 2nd year
- Reducing readmissions by 50 percent by the end of the 3rd year

To accomplish this, we specifically asked our C-suite to consider actively supporting the following program:

- Having every one of our 11,000 elective surgery patients appear in the PSH clinic,
- Triage and identify the sickest 20 percent of patients for pre-op clinic appointments with an anesthesiologist, with assignment to anesthesiologists intra-op, post-op and in post-discharge clinic,
- Improvement of pain management services with a dedicated operative suite nerve block room manned by those anesthesiologists most skilled at ultrasound regional nerve blocks, and
- Establishment of RN/NP/PA/CRNA intervention teams to improve post-op and post-discharge surveillance and intervention on the hospital floor, in the home setting, in the emergency department and in the post-discharge clinic.





In response, and to our Huntington Memorial C-suite's great credit, their explicit #1 priority was to improve the patient experience and surgical outcomes. They elaborated their faith in our PVMG anesthesia group as a worthy partner. Demonstrating intuitive understanding of the PSH, the CEO, the CFO and the VP of Quality found this project a worthy investment of their administrative energies and hospital finances. Our C-suite administrators then asked by what means they could facilitate the project.

We offered to provide the physician manpower and leadership. Our group would increase the presence of an anesthesiologist in clinic as the patient and management demands increased. We would compensate that physician ourselves (more on physician billing and reimbursement in a future article) and not request a stipend from the hospital. In return, we presented the specific wish list below that included:

- Appoint a Huntington Memorial PSH administrative champion
- Appoint an anesthesiologist physician champion

- Expand the pre-op clinic facilities and increase the nursing staff
- Establish PA/NP/RN/CRNA discharge planning, home health and ER intervention teams
- Expand the role of quality committee to include mid-level HMH administration managers
- Improved collection of patient outcome data within
- Public relations help with and leadership of the effort; HMH as our partner
- HMH must be able to follow the cost, reimbursement and profit on each surgery
- Administrative support in same day surgery for nerve block room to improve the quality of pain management
- Patient data mining and patient triage support

CONCLUSION

At the end of our presentation, PVMG and Huntington Memorial shook hands on a new partnership.

Huntington named both anesthesiologist and administrative champions. The two of us immediately established weekly standing meetings. Huntington has also offered to support our second evening PSH conference with a presentation from a world class speaker, Maxime Cannesson, MD of the Department of Anesthesia, University of California, Irvine. Sponsored by Edwards Life Sciences, Dr. Cannesson will present the concept of Goal Directed Fluid Therapy and provide updates related to both invasive and non-invasive hemodynamic monitoring.

PVMG has selected anesthesiologists who are ready to see patients in clinics. Our Huntington administrators are fully on board and engaged. Our group is committing physician leadership manpower and Huntington is committing administrative energies and financial support. Together PVMG and Huntington Memorial have forged a progressive Anesthesia/C-suite partnership.

Now more than ever, the PSH is right for our patients, our hospital and our group. 

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TREND 1: HOSPITALS ARE GETTING BIGGER AND THAT IS A WEAKNESS

Government induces physician labor

Obamacare favors the growth of hospitals with its incentives for aligning physicians. Think Accountable Care Organizations (ACOs) and other incentives to coordinate care, meaning coordination via hospitals.

Although reports lag by several years, at least 20 percent to 30 percent of all practicing physicians are currently employed by hospitals. There was a 34 percent increase in hospital employment of physicians between 2000 and 2010.

In addition, an uncertain number of physicians, very likely a significant number of them, are controlled by hospitals through alignment relationships such as ACOs and foundation model medical groups.

Hospital merger mania

As hospitals gobbled up physician practices, hospitals began gobbling each other up as well.

In 2013 there were 105 hospital mergers. In 2014 there were fewer, approximately 100. Overall, since 2010, there has been a 44 percent increase in the pace of hospital mergers.

Hospitals merge because they think that there's strength in a larger entity. In other words, they believe that it brings so-called economies of scale. If that means that two hospitals merge and become one, and then one facility closes down, perhaps that's the case. But that's not the general trend. Instead, mergers are often used to build bigger hospital systems in which there are little to no economies of scale. It's often the case that when large entities merge, administrative costs go up.

In the 1990s, there was a similar wave of hospital mergers. Most merged hospitals failed. The same argument about economies of scale was made then: that merging would cut costs. But it didn't turn out to be true.

Hospitals are losing the economic bet on employed physicians

A 2014 study by the Kentucky hospital industry revealed that the cost

to hospitals of employing physicians is increasing.

A majority of hospitals reported increasing losses per physician; on average more than \$100,000 per employee and, for some specialists, more than \$200,000 per employee.

The larger the hospital and the larger the hospital system, the larger the losses.

Hospitals are losing the bet on integrated delivery networks

And, as to quality, a large study by the National Academy of Social Insurance "found little evidence that integrated delivery networks have reduced costs or improved the quality of care."

Fragility will lead to cascading failure

In the 1990s, if a hospital failed, chances were it failed alone. In other words, the physician practices associated with that facility were independent. Certainly, office-based physicians found privileges at another facility. Hospital-based physicians were impacted disproportionately in comparison to their office-based colleagues, but at least there were other hospitals to which to expand their services.

But now, if a hospital or a merger-bloated hospital system with its employed or otherwise tightly affiliated physicians fails, all of those physicians are out of a job.

So we have merger for the cure of high costs. And we have a history from the 1990s of a similar trend that resulted in the failure to cut costs resulting in hospital failures. But as opposed to what happened in the 1990s, today many of these merged hospitals not only have traditional hospital-side expenses, they have taken on the huge expenses of





employing physicians. Note that's not just physician labor expense, but the complete expense of operating the practices, from space to equipment to supplies to billing to staff and so on.

TREND 2: PHYSICIAN-OWNED FACILITIES

The growth of physician-owned facilities is a key disruptor of the traditional hospital business, shifting cases out of hospitals.

Ambulatory Surgery Centers

Ambulatory surgery centers (ASCs) pull cases—generally the better reimbursed cases—out of the hospital O.R. They offer a significantly cheaper alternative to Medicare, private payors and patients. They also make money for their physician owners.

Currently, there are nearly 6,000 ASCs in the United States. There has been a slowdown in the net addition of ASCs during the last two years. In large part this is due to the fact that hospitals are attempting to remove the competition by purchasing ASCs in the local market, closing some and converting

others to hospital outpatient departments (HOPD).

Notwithstanding that buying spree, it's unlikely that hospitals will be able to stop the shift of cases to the ASC setting.

Procedures that only a few years ago were inpatient are now being performed on an outpatient basis. And, in some specialties, new surgical codes enable cases to be brought to ASCs, thus opening the specialty to fostering ASC development.

HOPD payment differential will backfire

Although recent federal budget legislation has reduced some of the benefit of operating an outpatient facility as a HOPD sooner or later the payment differential will play itself out to disrupt hospitals' futures. There's little justification for paying more to hospitals for the same procedure that can be performed in a hospital-free, that is, ASC, setting.

But even if the differential continues to be paid, physicians will continue to invest in and take cases to ASCs and payors will continue to want access to their more cost efficient services.

It's unlikely that hospitals will be able to garner the political support to put the same roadblocks on ASCs that they've managed to place on physician-owned hospitals.

Physician-owned hospitals

In order to protect their near monopoly, the investor-owned and non-taxpaying hospitals (many of which are busy employing and otherwise aligning physicians) have claimed that if physicians own hospitals in order to create teamwork and provide coordinated care, that is bad. But if hospitals own physicians in order to create teamwork and provide coordinated care, that is good.

This nonsensical argument will eventually lose traction.

Even if physicians are prevented from owning hospitals that qualify to treat federal healthcare program cases, they will continue to invest in smaller facilities focused on private payor cases. They will be able to avoid the low reimbursement that comes from governmental programs and the "no reimbursement" that comes from complete charity care.

TREND 3: NEW CLASSES OF COMPETITORS

New business models are disrupting the flow of patients, patients who were formerly destined to be referred into a hospital's "world."

Walk right in

These models include walk-in clinics of the type opening at retail stores such as Walgreen's, Rite Aid and CVS. In fact, CVS, until recently known as CVS Pharmacy, is now known as CVS Healthcare, which is a clear indication of where they believe healthcare is going.

Other examples are the plethora of walk-in and urgent care facilities built

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in strip centers and other ease-of-access locations. In fact, in Colorado, Texas and a number of other states, free-standing emergency rooms—often located near or at intersections close to acute care hospitals—siphon off patients headed to the hospital's OR based on their accessibility and their near zero wait times.

The point here is that these types of facilities signal a trend: non-traditional ventures are disrupting the flow of patients to physicians' offices and to hospital emergency rooms. More importantly, because this trend has an exponential impact, patients don't have the same emotional barriers to obtaining medical care outside of the physician office or hospital setting that they had 20 years ago.

In other words, if care can be obtained in a less intense, less costly, more convenient setting, it's not just insurance carriers who are going to push for it, it's patients who are going to demand it.

Updated house calls

It's 7:00 a.m. on a Wednesday morning and you feel like death warmed over. When you call your doctor's office (not open until 8:30) you know that you'll be told that they might be able to fit you in on Friday. You're lucky, because the average waiting time in the U.S. works out to more than 18 days.

But why bother, especially when a growing number of services will send a physician or nurse practitioner to see you now, at a cost that's probably one-third to one-half less than what your own physician would charge for an in-office appointment.

And, if you don't have to see a physician, or even a nurse, in person, why see one? Why not stay at home and simply



transmit the same information about your condition to a physician or another provider via telemedicine?

It's not difficult to see that both house call services and telemedicine are disruptive to traditional medical practitioners. In fact, in some states, primary care physicians are exerting pressure on state regulators to make it more difficult for telemedicine and other telehealth companies to operate. Eventually those anticompetitive efforts will fail as patients demand those services. After all, pushing for regulation is the death gasp of any profession or industry; if they can't compete on their own, they turn to the government, and especially to bureaucrats, to protect them.

It requires only slightly more foresight to realize that, in the end, those and other new classes of competitors will not only disrupt traditional office practice, they'll disrupt hospitals as well.

Patients will no longer be following the normal route of (1) go to a primary

care doctor in an office building on or near a hospital campus, (2) be referred by that physician to a specialist on staff at the same hospital for more detailed diagnosis and care and (3) receive diagnostic services and treatment at the hospital.

TREND 4: THE ROLE OF TECHNOLOGY

We're at a technological tipping point and tech is the fuel for the fire of the demise of hospitals as we know them.

For decades, the cost of technology in almost every industry *other than healthcare*, resulted in lower costs to the consumer. But in healthcare, all technology did was increase costs.

This history of technology also fed the growth of hospitals. Who, but large facilities, could afford to buy the technology? Wasn't it cheaper and more efficient to, in essence, spread the cost of that technology by locating it in a central location, the hospital, for access by those in the community, both physicians and other providers, as well as by patients?

Thus came the centralizing of technology (read that as medical equipment) from imaging to monitoring to operating rooms themselves.

But today, the cost of technology has shifted. Instead of being more expensive, it is less. In fact, in many cases it's become so much less that it is, or soon will be, affordable at the consumer level, bypassing completely the ASC and physician level.

And, importantly, the size (sometimes there is, effectively, no size at all) of new equipment has shrunk.

Technology is quickly becoming the enabler for devices and for services that permit the disruption of the centuries-old doctor-patient relationship.



Star Trek in your home

Remember the “tricorder” from Star Trek, the handheld medical diagnostic device? Now, it’s time for the real one.

The Qualcomm Tricorder XPRIZE is a \$10 million dollar prize for a tool capable of capturing key health metrics and diagnosing a set of 15 diseases. As of this writing, there are seven finalists.

Consider the OtoHOME device from Cellscope. It’s an iPhone device that allows parents to examine their child’s ears and record the result. It then connects them to a doctor for an immediate response. Dozens of other smartphone and wearable devices exist, each of which will reduce visits to traditional primary care doctors. Referrals to specialists (including all of those employed by hospitals) will be reduced, as will diagnostic procedures performed at hospitals.

Tech will also lead to less invasive surgery and to implantable devices that allay more surgery.

It’s also bound to lead to the fact that more procedures can be performed in either smaller, specialty hospitals or in outpatient settings. Hospitals will no longer need to provide everything to everyone. Procedures will move out of general hospitals into specialty ones and eventually will move out of hospitals altogether into ambulatory facilities.

THE BOTTOM LINE FOR HOSPITALS

Hospitals have expanded to become “full service” and have “bought” physicians to capture patients into the system. They claim that by closely aligning physicians they can deliver better care at a lower cost. But they are losing money on employed physicians and there’s no evidence that close alignment of physicians results in better care.

At the same time, patients are increasingly taking more control of their own diagnosis (and in some cases care) via technology.



Both technology and new classes of healthcare businesses (e.g., CVS Healthcare, Teladoc, etc.) are enabling patients to bypass traditional brick and mortar facilities (e.g., hospitals and physicians’ offices).

Patients don’t care as much as before whether they see a doctor, a nurse practitioner or some type of technician. And, for hospitals this is the big one, they don’t care as much if they obtain care from someone within the hospital’s patient acquisition funnel, or if they get surgery at an ASC or some other non-hospital site. As medicines improve (medicine as the future of surgery) and as miniaturization permits more procedures to be performed outside of the hospital, non-hospital facilities will syphon off a larger and larger percentage of hospital business.

Or perhaps patients won’t receive care at any facility—perhaps the facility will come to them: care in a “pod” inside or outside of your house?

ULTIMATE HOSPITAL BOTTOM LINE

Hospitals will shrink. They will be for the sickest people only. They might become monitoring stations for patients receiving care at home. Many will fail.

THE BOTTOM LINE FOR ANESTHESIOLOGISTS AND CRNAs

If you think that hospital employment or close alignment is safe, think again.

Anesthesia groups can’t ever be dependent upon a single hospital relationship. In the past, the concern was that that facility might terminate your contract. In the near future, the concern will be that the hospital might not survive.

Certainly, some hospitals will survive but they will be only for the sickest patients and the most complicated procedures. There will continue to be some—reduced—need for anesthesia services at those facilities.

ULTIMATE ANESTHESIA BOTTOM LINE

Freestanding facilities, even mobile ones, will be the future of the huge bulk of surgical care. If your practice isn’t already heavily focused on freestanding facility care, begin pivoting in that direction. ▲

[Author’s Note: This article is an abridged adaptation of my upcoming book *Impending Death of Hospitals: Why You Must Plan Your Medical Practice’s Survival*, due to be released in early 2016.]

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2016 CODING UPDATES FOR ANESTHESIA

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Perfect Office Solutions, Inc., Palmetto, FL

When you received your 2016 Current Procedural Terminology (CPT) and American Society of Anesthesiologists (ASA) Relative Value Guide (RVG) books or discs, you probably noticed there were no new anesthesia code additions or deletions listed for this year. Since the CPT book usually arrives before the RVG, you may not have taken a good look through your RVG or may not have ordered a 2016 RVG as there were no coding changes. However, there are a number of important updates in the RVG New/Revised RVG Coding Comments section which are not included in the Anesthesia section of the CPT. These comments may affect the way anesthesia coders assign procedure codes in the upcoming year. As this article will not include all updated comments, be sure to order your 2016 RVG. I've chosen a few that are certain to have an impact on 2016 coding for anesthesia services.

Let's start with 00218, "Anesthesia for intracranial procedures; procedures in the sitting position" with a base value of thirteen units. As you may know, base unit values increase as the difficulty of a procedure increases. The new coding comment indicates "This code may be reported for anesthesia for any intracranial procedure performed with the patient in the sitting position." For example, although the sitting position for cranial surgery is associated with a high incidence of air embolism (Schubert), a craniotomy or craniectomy for evacuation of a subdural infratentorial hematoma may be performed with a



patient in the sitting position. Rather than assigning 00210 "Anesthesia for craniotomy or craniectomy for evacuation of hematoma" with a base unit value of ten, coders will assign 00218. This code assignment also depends on the anesthesia provider clearly indicating on the anesthesia record that the patient was in the sitting position.

Coders cannot capture billable services that are not indicated on the anesthesia record, even if they are marked on an internal billing sheet. Billing sheets are not usually considered as part of the patient's medical records. There is no universal anesthesia record and a typical anesthesia billing company sees a number of different records, so coders must determine where on each record anesthesia providers document special positioning, which can be quite challenging with paper records and handwritten notes. With a paper record, the clearest way to document is a legible note in the remarks or comments section.

Electronic anesthesia records (EARs) are much easier to read and may have a field summary, which typically includes an area to document when the patient is in the sitting, or any other special position. If the EAR doesn't have a field summary, look within the body or comments section. If you are not sure where this information is documented, learn where patient positioning information is documented in your practice.

There were substantial changes to pacemaker coding comments under CPT codes 00530, 00534 and 00537 (See Table 1). The comments describe anesthesia for pacemaker services and indicate when it is acceptable to report the higher base unit values for active testing of an implantable cardioverter defibrillator (ICD) device or electrophysiologic (EP) testing. So it is important that (1) coders understand the difference, and (2) anesthesia providers are giving enough information to the coders to allow proper anesthesia code selection.

If cardioversion or defibrillator functions are not tested, coders are referred to CPT 00530, with a base value of four units. Documented testing of cardioversion or defibrillator functions increases the base value to seven units and is reported with CPT 00534. If an EP procedure is performed, CPT 00537 with a base unit value of ten is the appropriate anesthesia code. Coders should review these codes and circumstances with providers to ensure documentation supports the anesthesia code selected and reported, and be aware the Center for Medicare and Medicaid Services (CMS)



has assigned a lower unit value than the RVG for EP procedures (See Table 1). The anesthesia codes for pacemaker related services are not listed in the MLN Matters article “National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers” (Number MM9078) as requiring a -KX modifier (indicating “Requirements specified in the medical policy have been met”) for Medicare patients, although the surgeon may be required to report a -KX modifier.

Another common area of interest to anesthesia coders is related to extracorporeal shock wave lithotripsy (ESWL). When I first started in anesthesia more than 32 years ago, it was common to see treatment for lithotripsy while the patient was immersed in a water bath; however, now it may be more common to see other types of ESWL treatment. According to Dr. Grasso, “In first-generation lithotriptors (Dornier HM3), the patient was placed in a water bath. However, with second- and third-generation lithotriptors, small water-filled drums or cushions with a silicone membrane are used instead of large water baths to provide air-free contact with the patient’s skin.” The 2016 comment for CPT 00872 indicates, “Use only when patient immersed in water bath. With small water filled drums/cushions, see 00873.” As there is a base unit value difference of two units between these codes, coders should ensure they are reporting as instructed. If you are not certain whether your practice’s facilities still use water bath or not, it’s time to check!

CPT codes 36221–36626 describe non-selective and selective arterial catheter placement and diagnostic imaging of the aortic, arch, carotid and vertebral arteries. The 2016 ASA Crosswalk revises the reported anesthesia code for each of these procedures to 01916, “Anesthesia for diagnostic arteriography/venography” with a base value of five units. This is a substantial change from 2015 crosswalk codes ranging from six to ten base units.

Aside from multiple valuable comment and crosswalk code revisions, it is noteworthy that the 2016 RVG no longer includes ASA standards and guidelines relevant to coding and billing in the back of the book. The bad news is that it is no longer a matter of flipping through to the end of the RVG to access information when coders need to provide “proof” of why we do the things we do. The good news is the ASA provides all current version of their standards and guidelines on the ASA website (See Resources). While the information is not as convenient, unless you have internet access, keep in mind there is added value to having access to the most up-to-date information ASA provides.

Trying to keep up with ongoing changes to the Physician Quality Reporting System (PQRS) coding is a constant challenge for coders. There were no changes to the 2016 requirements for reporting cross-cutting measures, although a number of new cross-cutting measures have been added. However, PQRS coding is a different story.



You may have noticed in CPT Appendix B – Summary of Additions, Deletions and Revisions that there were textual changes to Category II Code 6030F (removing “cap and mask and sterile gown and sterile gloves and a large sterile sheet and 2 percent chlorhexidine” from the code description), and there were no Category II code deletions—but that doesn’t mean anesthesia coders don’t have to worry about deleted PQRS codes. Although Measure #44 (Category II Code 4115F) is still listed as a valid code, CMS removed this measure from claims-based reporting. Code 4115F is still a valid code for registry reporting along with CPT 00562. In a nutshell, effective January 1, 2016, Measure #44 is no longer reportable if your anesthesia practice is using claims-based PQRS reporting.

Similarly, although Category II Codes 4250F and 4255F (Measure #193) are both still listed in the 2016 CPT, 2015 will be the last reporting year for this measure. Measure #193 has been retired and, it too, will no longer be reportable effective January 1, 2016. These changes, announced in the final physician fee schedule rule, which was published in the Federal Register on November 16, 2015, leave claims-based reporting anesthesia groups (estimated at 80 percent) only one

CPT Code	Comments	RVG Base Unit Value	CMS Base Unit Value
00530	Includes programming and testing of lead and generator function	4	4
00534	Includes testing of cardioversion or defibrillator functions	7	7
00537	Used only for electrophysiologic procedures	10	7

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2016 CODING UPDATES FOR ANESTHESIA

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PQRS measure specific to anesthesia – Measure #76 (Category II Code 6030F). Since anesthesia providers do not have nine measures across three domains, they will automatically be subject to the Measures Applicability Validation (MAV) process (unless they make a measure applicable to themselves by reporting it even once “unsuccessfully,” e.g., by appending the -8P modifier that shows that the measure wasn’t performed and doesn’t indicate that there was a valid reason for the non-performance. Many anesthesiologists unfortunately fell into this trap, which deems them to have failed PQRS altogether, for payment year 2016 based on 2104 reporting.)

The MAV applies to both claims-based and registry-based reporting, though the methodology differs. With claims-based, as there is only one applicable anesthesia measure (#76), as long as your provider meets the 50

percent threshold and also reports at least one “cross-cutting measure” if any apply (see below), no penalty *should* be assessed. Keep in mind that a claim with an -8P modifier, which indicates the action was not performed and no reason was documented, does not count toward the 50 percent threshold—or successful performance. Surprisingly, many anesthesia providers who successfully performed and reported PQRS in 2014 received a 2016 penalty notice (based on a two year look back period) and it appears other specialties experienced the same issue. Fortunately, the American Medical Association (AMA), Medical Group Management Association (MGMA) and the ASA are aware of the problem and are working toward a potential solution.

Unfortunately, anesthesia practices that do not place Swan Ganz or Central Venous Pressure (CVP) lines have no associated claims-based PQRS measures.

According to the PQRS help desk (Quality Net communication to author), “if you are not able to report Measure #76 via claims, you are required to hire a registry for reporting the other applicable measures or a Qualified Clinical Data Registry (QCDR).” Although claims-based reporting of PQRS measures has not gone away, if you can’t report the only anesthesia PQRS measure left, registry reporting allows your anesthesia practice to report enough anesthesia specific performance measures to avoid payment penalties in 2018.

Similar to Measure #193, many of the registry-related PQRS codes include “G” codes as listed in the Healthcare Common Procedure Coding System (HCPCS) book. In 2016, there are no longer anesthesia clusters related to claims-based reporting. Cluster Number 38, Anesthesiology Care (for Registry-Based Measures), includes Measures #424, #426, #427 and #428 (See Table 2).

Also, take a few minutes to thumb through the Category II performance measure codes listed in the 2016 CPT. The ASA has been working on developing specific measures relative to quality reporting of anesthesia services (see superscript number 11 under Category II footnotes). Many of these codes appeared in the 2014 CPT and several may look familiar to anesthesia coders. Codes listed in Table 3 are Category II performance measure codes developed by the ASA, although these codes are reported only through a registry.

By 2019, coders will see PQRS segue into a new quality program called the Merit-Based Incentive Payment System (MIPS). Whether you are a seasoned coder or new to the specialty, anesthesia coding will continue to be unique, interesting and challenging! 🏔️

Measure #	Category II or HCPCS Codes	Short Description (See code for full description)	Report via
404	G9642 G9643 G9497 G9644 G9645	Anesthesiology Smoking Abstinence	Registry ONLY
424	4255F G9654 4559F	Perioperative Temperature Management (Similar to Retired Measure #193) Cluster #38, Anesthesiology Care	Registry ONLY
426	G9656 G9657 G9655 G9658	Transfer of Care to Post Anesthesia Care Unit Cluster #38, Anesthesiology Care	Registry ONLY
427	0581F 0582F* 0583F	Use of Checklist or Protocol for Transfer of Care Cluster #38, Anesthesiology Care	Registry ONLY
430	4554F 4556F 4557F* 4558F	Prevention of Post-op Nausea/Vomiting Cluster #38, Anesthesiology Care	Registry ONLY

* not listed in 2016 PQRS Individual Measures Excel spreadsheet 112715



TABLE 3		CATEGORY II PERFORMANCES MEASURE CODES
CPT Category II Code	Short Description – Superscript 11, developed by ASA (See code for full description)	
0581F	Patient transferred to Critical Care Unit	
0582F	Patient not transferred to Critical Care Unit	
0583F	Transfer of care checklist used	
0584F	Transfer of care checklist not used	
4554F	Patient received inhalational anesthetic agent	
4555F	Patient did not receive inhalational anesthetic agent	
4556F	Patient exhibits three or more risk factors for post op nausea/vomiting	
4557F	Patient does not exhibit three or more risk factors for post op nausea/vomiting	
4558F	Patient received at least two prophylactic agents of different classes	
4559F	Intraoperative warming (similar to RETIRED Measure #193)	
4560F	Anesthesia technique did not involve general or neuraxial anesthesia	
4561F	Patient has a coronary artery stent	
4562F	Patient does not have a coronary artery stent	
4563F	Patient received aspirin with 24 hours of anesthesia start time	
9006F	Symptomatic carotid stenosis (No Measure Associated)	
9007F	Other carotid stenosis (No Measure Associated)	

Resources

2016 Professional Edition CPT American Medical Association

2016 Relative Value Guide and Crosswalk, American Society of Anesthesiologist

Hyperlink Resources

American Society of Anesthesiologist (ASA), Standards and Guidelines
<http://www.asahq.org/quality-and-practice-management/standards-and-guidelines>

ASA, Physician Quality Reporting System Reporting for 2016
<http://www.asahq.org/quality-and-practice-management/quality-improvement/physician-quality-reporting-system/PQRS-2016-Notice>

CMS Anesthesiologists Center, 2014 Anesthesia Base Units by CPT Code [Zip 13KB] (latest published information, unchanged for 2016 and 2016)
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/2014-Anesthesia-BaseUnits-CPT.zip>

CMS, Final Rule containing Revisions to Payment Policies under the Physician Fee

Schedule and Other Revisions to Part B for CY 2016

<http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf>

CMS, 2016 Cross Cutting Measures List
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS-Crosscutting.pdf

CMS, 2016 PQRS Claims/Registry Measure Specifications Release Notes
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_IndivMeasures_ReleaseNotes_111715.pdf

CMS, PQRS MAV Process for Registry Based Reporting
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS_IndivMeasures_Guide_11_17_2015.pdf

CMS, PQRS Measures Codes
<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/measurescodes.html>

CMS, Qualified Clinical Data Registry Reporting
<https://www.cms.gov/Medicare/Quality->

[Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html)

Ronald Hirsch, MD, FACP, CHCQM. New Guidance on Pacemakers Come with Needless Modifier: RAC Monitor, March, 2015
<http://www.racmonitor.com/rac-eneews/1803-new-guidance-on-pacemakers-comes-with-needless-modifier.html>

Michael Grasso, III, MD. Extracorporeal Shockwave Lithotripsy, January, 2015
<http://emedicine.medscape.com/article/444554-overview>

MLN Matters Number MM9078, NCD for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers, October, 2015
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9078.pdf>

Noridian, NCD for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers - Revised
<https://med.noridianmedicare.com/web/jeb/article-detail/-/view/10542/ncd-for-single-chamber-and-dual-chamber-permanent-cardiac-pacemakers-revised>

Armin Schubert MD, MBA. Positioning Injuries in Anesthesia: An Update. Advances in Anesthesia. Volume 26, October 2008, Pages 31-65
https://www.openanesthesia.org/craniotomy-positioning_injury/

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“I’M OUT OF HERE!” NOW WHAT?

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We all know that the healthcare industry is experiencing a wave of integration. This trend has been evident for many years. Fewer physicians are willing to assume the legal, financial and other business risks associated with owning their own practices. More and more physicians, including anesthesiologists, are becoming employed by large physician groups, health systems and national providers.

This shift necessarily involves not only entry into new employment arrangements but also the termination of existing relationships. And those terminations are often governed by written employment agreements, state and federal healthcare laws and employer benefit plans and other policies and procedures.

Before pursuing their next opportunity, physicians should pause for a moment and first attend to the arrangement that they are leaving. Departing physicians need to understand their legal rights and obligations when leaving their current employment relationships in order to avoid unintended consequences and detrimental missteps along the way. Here are a few words of practical advice for physicians contemplating an exit from their current employment arrangements.

- **Ensure that the relationship is terminated in accordance with the terms of the written employment agreement.** Whether the physician is terminating the employment agreement with or without cause, the physician is facing an involuntary termination initiated by the employer or the parties are mutually agreeing to end the relationship, the parties must terminate the relationship in accordance with the timing, prior notice and other procedural requirements set forth in



the written employment agreement, when applicable. Failure to do so can result in a breach of contract claim and sometimes significant liability exposure.

- **Avoid relying on verbal promises and assurances regarding the transition.** In the event that the parties have mutually agreed to terminate an employment relationship in a manner that is contrary to the terms of the written contract, such agreement should be reduced to writing. Verbal promises and assurances provided by the other party that it will cooperate and agree to waive certain rights under the employment agreement are generally not enforceable unless reduced to writing. Relying upon verbal promises and assurances is especially dangerous when the departing physician’s primary contact is not the ultimate decision maker and lacks ultimate authority to ensure a smooth transition.
- **Understand your obligations to obtain tail coverage.** Employment agreements that permit professional liability insurance to be

maintained on a claims made basis often require the physician (at least under certain circumstances) to assume the cost of obtaining tail coverage upon termination of the relationship. Before exiting an employment relationship, the physician should assess whether such obligation is present and the associated expenses. Note that the cost of tail coverage may vary greatly depending upon the particular state. Sometimes a physician’s obligation to procure tail coverage can be addressed, upon consent of the employer through an amendment to the written employment agreement, through the maintenance of the existing policy or by obtaining nose coverage.

- **Determine your rights and obligations to provide patients with notice of your departure.** The right of a physician to inform his/her patients of the departure is often addressed in the underlying written employment agreement. Many state laws also include provisions related to patient notices upon a physician’s departure. Non-solicitation provisions set forth within employment agreements are subject to applicable state law. Further, even when employment agreements include non-solicitation provisions and the state laws are silent on patient notices, physicians are sometimes able to persuade their employers to permit appropriate notices to patients based upon applicable ethical rules, principles of patient choice and continuity of care considerations.
- **Assume that noncompetition covenants will be enforced when**



permitted under applicable state law. It is common for physicians contemplating a departure to express disbelief that their employers would actually want to enforce a restrictive covenant or that a court would compel compliance with such an obligation. But they are often surprised. Employers place non-competes in their agreements for a reason—they believe they are important. When enforceable under applicable state law, non-competition prohibitions may significantly impact a physician's post-termination career and should be taken very seriously. Physicians should review the restrictions carefully and objectively to ensure complete compliance. Applicable case law often informs how courts will interpret ambiguities within the contractual language (e.g., how the restricted geographic area would be determined). That being said, employers will sometimes grant waivers of such covenants when there is an incentive to do so.

- **Consider a separation agreement.** In the event that either party has potential claims against the other or there are ambiguities in the underlying written employment agreement regarding the terms of departure, it may be best to enter a separation agreement. Whether a separation agreement is necessary or appropriate depends upon the particular circumstances and each party's respective negotiating leverage. Separation agreements often include releases of claims and confidentiality, non-disparagement and indemnification provisions. They also often include, for example, provisions related to post-termination access to patient and billing records (for continuing care of patients, audits, litigation, etc.), non-solicitation and non-com-

petition prohibitions, obligations to obtain and pay for tail coverage, the calculation and payment of bonus compensation, payout for unused vacation or sick time, settlement amounts and buy-outs, references provided by the employer to third-parties with respect to the departing employee and reports to licensure bodies, the National Practitioner Data Bank and governmental bodies, as applicable.

- **Anticipate collateral consequences, when applicable.** Departing physicians should understand the impact that their employment termination may have on any medical staff memberships and faculty appointments. Also, those physicians who participate in or own the employing practice or related or third party physician organizations, accountable care organizations, co-management companies, ambulatory surgical centers, real estate investment entities and other ventures may need to terminate such membership or ownership interests in connection with the termination. Such termination requirements may be set forth in the employment agreement itself or in the shareholder, operating, participation or buy-sell agreements, as applicable.
- **Refrain from saying or doing something you regret.** Some employment terminations are amicable but others are more like a bitter divorce. In such cases, it is often wise for physicians to take the emotion out of all negotiations and communications with the soon to be former employer and others to the extent possible and rely upon attorneys and other advisors to negotiate the transition when helpful. Employment agreements often contain confidentiality and non-disparagement provisions that apply during and after the term. Even when

those requirements are not reduced to writing, physician employees should understand that they are generally not entitled to retain any property, passwords or confidential information of the employer after the termination. Further, even if the governing employment agreement does not include a non-disparagement provision, departing physicians should be careful not to impermissibly defame their employers or violate any applicable fiduciary duties owed to the employer on the way out as such actions can result in substantial legal exposure and financial liability.

Briefly stated, physicians should exit their existing employment relationships with care. It is advisable for physicians to take some time to review the terms of their written employment and related agreements, to understand their rights and obligations under applicable laws (including for example those pertaining to post-termination restrictive covenants, access to records and patient notices) and to understand how employer benefit plans will impact their departure. Before succumbing to the relief, hope, excitement (and perhaps even fear or anger depending upon the circumstances) regarding the termination and what lies ahead, physicians should take a moment to tie up any loose ends before moving forward. 

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CONFIDENTIALITY IN THE PEER REVIEW PROCESS: WHAT DOES IT MEAN AND WHAT IS COVERED? PART I

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Depending on one's standpoint and experience, the peer review process can bring about mixed feelings in healthcare providers. Opinions about the effectiveness of the process, those who sit on the panel and the outcome are often debated. However, what is often less debated until long after the process has taken place is whether the information reviewed during the peer review process is subject to discovery in other settings.

Generally, the peer review process is a retrospective review of an event or series of events conducted in an effort to improve quality of care. In order to encourage candid review, many states have enacted laws to limit the discoverability of the proceedings, the records reviewed and the records created during the peer review process. In other words, in a civil proceeding, the contents of the peer review meetings and the records discussed are not discoverable and are not subject to a subpoena and the participants in the meetings are not required (or, in many cases, permitted) to testify to or disclose the matters discussed by the committee or its decision. However, in light of these legal protections, many lawyers representing plaintiffs in malpractice cases seek to poke holes in the protection to obtain evidence to support their case against physicians. This unfortunate fact jeopardizes and compromises the effectiveness of the process.



In light of the litigious environment within which all physicians practice, it behooves all anesthesiologists and pain specialists to consider the following:

1. Familiarize yourself with the peer review process within your organization and the facilities in which you practice to ensure that retrospective reviews are protected by the privilege.
2. It is especially important to consider how to initiate the peer review process to ensure initial inquiries are protected.
3. Work with the administration/risk management in your group or the facilities in which you practice to improve upon the peer review process.
4. Ensure any conversations or notations about the peer review committee's review of an issue

remain within the confines of the peer review process. In other words, casual conversations with colleagues or notations in a patient's record regarding the review may be subject to discovery.

5. Familiarize yourself with the types of records that are protected under the privilege in the state in which you practice.

On the next 3 pages, you will find Part I (Alabama through Iowa) of a brief summary of what is protected by the peer review privilege in every state. Please note that the table is meant to be strictly informational and would require a more detailed review of the state's judicial interpretation of its statutes. A summary of the remaining states (Kansas through Wyoming) will appear in the next issue of *The Communique*. 

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STATE	CITATION(S)	BRIEF DESCRIPTION
Alabama	Ala. Code § 6-5-333(d)	Information, interviews, reports, statements, memoranda, findings, conclusions and recommendations furnished to a medical peer review committee are privileged. Meeting records and proceedings are confidential. Records made during the regular course of business are discoverable.
Alaska	Alaska Stat. § 08.20.185(a) Alaska Stat. § 8.20.185(c)	A member of a peer review committee who authors/submits a report in good faith is immune from civil liability. Patient records used during the proceeding that were confidential before being submitted to the committee remain confidential and are not subject to inspection. Patient records presented to a peer review committee for review under this section that were confidential before their presentation to the committee are confidential to the committee members and to the board members and are not subject to inspection or copying under AS 40.25.110 - 40.25.125. A committee member or board member to whom confidential records are presented under this subsection shall maintain the confidentiality of the records. A person who violates this subsection is guilty of a class B misdemeanor.
Arizona	Ariz. Rev. Stat § 36-445.01(A) Ariz. Rev. Stat. § 36-445.01(B)	All proceedings, records and materials relating to the reviews are confidential and not discoverable except in proceedings before the Arizona medical board or in actions by an individual health care provider against a hospital or center or its medical staff arising from the discipline of such individual health care provider or refusal, termination, suspension or limitation of the healthcare provider's privileges. No member of the committee or person furnishing information to the committee may be subpoenaed to testify.
Arkansas	Ark. Code § 20-9-503	The proceedings and records are not subject to discovery or as evidence. No person in attendance will be required to testify in any civil action. Records from original sources are not immune from discovery merely because they were presented during the meeting.
California	Cal Bus & Prof Code § 805.01(d) Cal. Evid. Code § 1157(a)	Information from a peer review body including raw data, patient information, case files or records, interviews and records of interviews, peer review proceedings analyses and conclusions are not discoverable or subject to a subpoena. The documents are not admissible as evidence in any court within the state.
Colorado	Colo. Rev. Stat. § 25-3-109	Any records, reports or other information of a licensed or certified health care facility that are part of a quality management program designed to identify, evaluate and reduce the risk of patient or resident injury associated with care or to improve the quality of patient care shall be confidential information and not subject to subpoena, discoverable or admissible as evidence. No person who participates in the reporting, collection, evaluation or use of such quality management information with regard to a specific circumstance shall be required to testify.
Connecticut	Conn. Gen. Stat. § 19a-17b	The proceedings of a medical review committee are not discoverable or eligible as evidence. No person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to the content of such proceedings.
Delaware	24 Del. Code tit. 24, § 1768	The records and proceedings of the committee meetings are confidential. A person in attendance is not required to testify as to what occurred at the meeting. A person furnishing information to the committee in good faith is not liable for damages. However, the law does not create a privilege or right to refuse to honor a subpoena issued by or on behalf of the Board of Medical Licensure and Discipline pursuant to § 1731A(d) of this title, or issued by the Attorney General pursuant to § 2504(4) of Title 29, nor may it be construed to limit access to records by rights-protection agencies whose access is authorized by federal law.
District of Columbia	D.C. Code § 44-805	The files, records, findings, opinions, recommendations, evaluations and reports of a peer review body, information provided to or obtained by a peer review body, the identity of persons providing information to a peer review body and reports or information provided pursuant to § 44-802 or federal or other District of Columbia law shall be confidential and shall be neither discoverable nor admissible into evidence in any civil, criminal, legislative or administrative proceeding. Exceptions include a criminal proceeding where a health professional is accused of a felony if the court determines the disclosure is essential to protecting the public interest.
Florida	Fla. Stat. § 766.101(5) Fla. Stat. § 395.0191(8)	The investigations, proceedings and records of a committee shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such committee, and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions or other actions of such committee or any members thereof. However, information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his or her knowledge, but the said witness cannot be asked about his or her testimony before such a committee or opinions formed by him or her as a result of said committee hearings.



CONFIDENTIALITY IN THE PEER REVIEW PROCESS: WHAT DOES IT MEAN AND WHAT IS COVERED? PART I

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STATE	CITATION(S)	BRIEF DESCRIPTION
Florida (cont)	Fla. Stat. § 766.101(5) Fla. Stat. § 395.0191(8)	<p>The investigations, proceedings and records of the board, or agent thereof with whom there is a specific written contract for the purposes of this section, as described in this section shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of matters which are the subject of evaluation and review by such board and no person who was in attendance at a meeting of such board or its agent shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such board or its agent or as to any findings, recommendations, evaluations, opinions or other actions of such board or its agent or any members thereof. However, information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such board; nor should any person who testifies before such board or who is a member of such board be prevented from testifying as to matters within his or her knowledge, but such witness cannot be asked about his or her testimony before such a board or opinions formed by him or her as a result of such board hearings.</p>
Georgia	Ga. Code § 31-7-132 Ga. Code § 31-7-133	<p>The proceedings and records of a review organization shall be held in confidence and not be subject to discovery or introduction into evidence in any civil action; and no person who was in attendance at a meeting of such organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings or activities. The confidentiality provisions also apply to any proceedings, records, actions, activities, evidence, findings, recommendations, evaluations, opinions, data or other information shared between review organizations which are performing a peer review function or disclosed to a governmental agency as required by law. However, information, documents, or records otherwise available from original sources are not immune from discovery or use in any such civil action merely because they were presented during proceedings of such organization, nor should any person who testifies before such organization or who is a member of such organization be prevented from testifying as to matters within such person's knowledge; but such witness cannot be asked about such witness's testimony before such organization or about opinions formed by such witness as a result of the organization hearings.</p>
Hawaii	Haw. Rev. Stat. § 624-25.5	<p>Neither the proceedings nor the records of peer review committees shall be subject to discovery. Information protected shall not include incident reports, occurrence reports or similar reports that state facts concerning a specific situation, or records made in the regular course of business by a hospital or other provider of health care. Original sources of information, documents or records shall not be construed as being immune from discovery or use in any civil proceeding merely because they were presented to, or prepared at the direction of, the committees. No person in attendance at a meeting of a committee or case review forum shall be required to testify as to what transpired at the meeting. The prohibition relating to discovery or testimony does not apply to the statements made by any person in attendance at the meeting who is a party to an action or proceeding the subject matter of which was reviewed at the meeting.</p> <p>Information/data relating to a medical error reporting system that is compiled and submitted by a medical provider to a healthcare review organization for the purpose of evaluating and improving the quality and efficiency of health care, when done through a peer review committee is subject to discovery. Information and data protected shall include proceedings and records of a peer review committee, recordings, transcripts, minutes, and summaries of meetings, conversations, notes, materials or reports created for, by, or at the direction of a peer review committee, when related to a medical error reporting system.</p> <p>Information and data protected from discovery shall not include incident reports, occurrence reports, statements, or similar reports that state facts concerning a specific situation and shall not include records made in the regular course of business by a hospital or other provider of healthcare, including patient medical records. Original sources are not construed immune from discovery. The prohibitions contained in this section shall apply to investigations and discovery conducted by the Hawaii medical board, unless otherwise required by statute.</p>
Idaho	Idaho Code § 39-1392b	<p>All peer review records shall be confidential and privileged, and shall not be directly or indirectly subject to subpoena or discovery proceedings or be admitted as evidence, nor shall testimony relating thereto be admitted in evidence, or in any action of any kind in any court or before any administrative body, agency or person for any purpose whatsoever. This section shall not prohibit or otherwise affect the use of documents, materials or testimony in healthcare organization proceedings, nor shall it prohibit or otherwise affect the dissemination, for medical purposes, of information contained in such documents or materials or the conclusions and findings of such healthcare organization. This section shall not affect the admissibility in evidence in any action or proceeding of the patient care records of any patient.</p>



STATE	CITATION(S)	BRIEF DESCRIPTION
Illinois	735 Ill. Comp. Stat. 5/8-2101	All information including interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a healthcare practitioner's competence shall remain privileged and strictly confidential. The information may be used for medical research, increasing organ and tissue donation, evaluation and improvement of quality care or granting, limiting or revoking staff privileges or agreements for services.
Indiana	Ind. Code § 34-30-15-1 Ind. Code § 34-30-15-2 Ind. Code 34-30-15-3	<p>All proceedings of a peer review committee are confidential. All communications to a peer review committee shall be privileged communications.</p> <p>Neither the personnel of a peer review committee nor any participant in a committee proceeding shall reveal any content of: communications to; the records of; or the determination of; a peer review committee outside of the peer review committee.</p> <p>However, the governing board of: a hospital; a professional healthcare organization; a preferred provider organization; or a health maintenance organization or a limited service health maintenance organization; may disclose the final action taken with regard to a professional health care provider without violating the provisions of this section.</p> <p>Upon approval by the health care facility's governing body, the peer review committee of a healthcare facility may submit or disclose to the agency the following for purposes of patient safety or quality of healthcare matters: communications to the peer review committee; peer review committee proceedings; peer review committee records.</p> <p>Information and materials submitted or disclosed to the agency (as defined by IC 16-40-5-1) under this subsection are confidential and privileged from use as evidence in an administrative or judicial proceeding and the agency may not release the information or material outside the agency.</p> <p>Information and materials may be submitted or disclosed to the agency under this subsection without violating this section or waiving the confidentiality and privilege attached to the communications, proceedings, records, determinations or deliberations of the peer review committee. Upon its determination, the governing body of a hospital may report, as part of the hospital's quality assessment and improvement program, a determination of a peer review committee of the hospital regarding an adverse event concerning patient care to the state department of health or another state agency without violating this section or waiving the confidentiality and privilege attached to the communications, proceedings, records, determinations or deliberations of the peer review committee.</p> <p>A person who attends a peer review committee proceeding shall not be permitted or required to disclose: any information acquired in connection with or in the course of a proceeding; any opinion, recommendation, or evaluation of the committee; or any opinion, recommendation or evaluation of any committee member.</p> <p>Information that is otherwise discoverable or admissible from original sources is not immune from discovery or use in any proceeding merely because it was presented during proceedings before a peer review committee.</p> <p>A member, an employee, an agent of a committee or other person appearing before the committee may not be prevented from testifying: as to matters within the person's knowledge; and in accordance with the other provisions of this chapter.</p> <p>However, the witness cannot be questioned about this testimony or other proceedings before the committee or about opinions formed by the witness as a result of committee hearings.</p>
Iowa	Iowa Code § 147.135	<p><i>Peer review</i> records are privileged and confidential, are not subject to <i>discovery</i>, subpoena, or other means of legal compulsion for release to a person other than an affected licensee or a <i>peer review</i> committee and are not admissible in evidence in a judicial or administrative proceeding other than a proceeding involving licensee discipline or a proceeding brought by a licensee who is the subject of a <i>peer review</i> record and whose competence is at issue. A person shall not be liable as a result of filing a report or complaint with a <i>peer review</i> committee or providing information to such a committee or for disclosure of privileged matter to a <i>peer review</i> committee. A person present at a meeting of a <i>peer review</i> committee shall not be permitted to testify as to the findings, recommendations, evaluations or opinions of the <i>peer review</i> committee in any judicial or administrative proceeding other than a proceeding involving licensee discipline or a proceeding brought by a licensee who is the subject of a <i>peer review</i> committee meeting and whose competence is at issue. Information or documents discoverable from sources other than the <i>peer review</i> committee do not become non-discoverable from the other sources merely because they are made available to or are in the possession of a <i>peer review</i> committee. However, such information relating to licensee discipline may be disclosed to an appropriate licensing authority in any jurisdiction in which the licensee is licensed or has applied for a license.</p>



THE HOSPITAL IS YOUR PRACTICE'S CLIENT—UNDERSTAND CLIENT SATISFACTION TO RETAIN YOUR CONTRACT

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The past several years have, once again, brought major changes to the anesthesia community and have greatly impacted private practice anesthesia. Whereas the early nineties were a time of “anesthesia surplus” when anesthesiologists struggled to find opportunities paying as little as \$100,000, those days were followed by a shortage of anesthesia providers. Supply and demand economics dictated that during the days of anesthesia staffing shortage, prices and compensation for anesthesia staff increased to the highest levels in history. Now, a new day is on the horizon where hospitals have many choices for anesthesia coverage. Smaller, private practice anesthesia groups struggle to sustain financial viability. Many groups are exploring mergers to achieve economies of scale and hoped-for negotiation leverage with private payers. Larger and mega-groups continue to liquidate their value and sell to publicly traded companies such as EmCare or MedNax. A growing number of large anesthesia staffing companies continue to enter the market. Daily, hospitals are approached by multiple anesthesia staffing providers in attempts to contract for a hospital’s anesthesia business; large, publicly traded companies offer hospitals the opportunity for “one-stop-shopping” for hospital-based physician services.



In summary, this means increased competition among private anesthesia groups to retain their contracts with hospitals.

With hospitals under increased financial pressures and needing to focus on the bottom line, a group’s preaching to the hospital about quality care and loyalty is insufficient to retain its contract. The fastest way to encourage a hospital to seek an alternative anesthesia provider is for the group to request an increased stipend without demonstrating commensurate financial and service value to the hospital. The hospital is the

anesthesia group’s client. Groups need to quickly understand and provide high levels of client service in order to retain their contracts.

In healthcare we speak a lot about “the customer” and providing “customer service”; many hospitals engage organizations such as Disney, Marriott and Studer to educate them about customer service. Alas, most of this customer service is of the “softer” kind and is really about “customer satisfaction” or what we typically refer to as “soft and fuzzy” and making the patient feel satisfied or valued. For anesthesia, this



element of customer service needs to be understood and provided. The service must provide quantifiable, financial value, however, in addition to the historically intangible value of clinical quality. Pay for Performance tools assist in measuring the lack of, or deficits of, clinical quality, but not necessarily levels of exceptional clinical quality. What this means for your group is that the unwritten and unspoken expectation of performance is clinical service at an exceptional level. All too often anesthesia is heard to whine, “*anesthesia gets no respect.*” To this we reflect on “The Serenity Prayer” which states in part: *Allow me to accept the things I cannot change and provide me the wisdom to change the things I can.* Anesthesia groups need to accept the existing finances of healthcare reimbursement and focus on changing their hospital’s perception of them. Groups need to earn the respect of their hospital clients by providing and demonstrating measurable, financial value, which for anesthesia, extends well beyond the practice of good medicine. For the hospital, the operating room is the single greatest producer of revenue and typically accounts for at least 65 percent of hospital revenue and profit. Anesthesia groups need to reprogram their thinking and stop focusing on “how much money anesthesia and the OR make for the hospital,” and begin focusing on ***How Anesthesia Can Assist the Hospital to Make More Money!*** This is the primary way to demonstrate your group’s value and retain your contract!

Anesthesia’s ability to demonstrate value rests in four primary buckets:

1. *Exceptional clinical outcomes* – this is an expectation that seldom gets recognition; deficient outcomes get recognized and have associated financial penalties.
2. *Development of new clinical service offerings* (chronic pain management, etc.).

3. *Assistance with improving perioperative program operational efficiencies*, which is the foremost factor in:
4. *Assistance in increasing case volume*, which is the greatest revenue producer for the hospital and best enables anesthesia to demonstrate its value.

The remainder of this discussion focuses on anesthesia’s ability to assist in increasing OR case volume and associated revenue, by developing OR programs that are surgeon service oriented and make optimal use of surgeon time.

In the operating room we regard the surgeon as the customer. The surgeon wants to be seen as a patron of the hospital; the customer maintains the option to shop elsewhere. The hospital-business will not survive without the physician (and patient) customer(s). As in the retail environment the physician-customer maintains an expectation that the vendor (hospital) delivers a quality product. However, in the hospital setting, the product is a service vs. a tangible product; physician-customers place primary emphasis on the hospital meeting their service oriented expectations. Anesthesia is a driving force in meeting surgeons’ expectations which primarily are:

1. *Quality patient care*, which is taken for granted.
2. *Experienced OR staff who can anticipate* surgeon and case requirements, and also good equipment/instruments.
3. *Sufficient OR access*, in balance with surgeons’ practice needs, by hour of day and day of week. This requires staffing by OR and anesthesia.
4. *Optimized/efficient use of surgeons’ time*. This requires a collaborative effort, by all parties, including OR, anesthesia and



the surgeon. Anesthesia needs to be the driver, or champion, of efficient perioperative services operations.

The reality is that anesthesiologists do not refer patients to hospitals. Anesthesiologists must pose a question to themselves: *Do you consider yourself a consulting specialist, and if so, then, don’t consulting specialists need to garner referrals; don’t consulting specialists need to develop and protect referral sources?* The surgeon is anesthesia’s referral base and anesthesia must assist the hospital to accommodate surgeons’ needs and expectations and to build case volume.

In general, customers’ expectations, regardless of who the customer is, will not be met unless expectations are reasonable and clearly defined. Most frequently, for anesthesia, this involves establishing how many anesthesia sites are staffed by hour of day and day of week. The number of staffed sites *can not* be a moving target if customer service is to be effectively delivered; however, anesthesia must be reasonably flexible to accommodate varying activity levels and must be service oriented. In addition to agreement on the number of staffed sites, in order for anesthesia to effectively



THE HOSPITAL IS YOUR PRACTICE'S CLIENT—UNDERSTAND CLIENT SATISFACTION TO RETAIN YOUR CONTRACT

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provide customer service, anesthesia must be able to rely on:

- An OR committee (or governance body) having developed effective scheduling policies and procedures and further, consistently enforcing them,
- Surgeons' offices effectively communicating with OR scheduling,
- Surgeons effectively communicating with anesthesia with regard to difficult cases or sick patients,
- Nursing effectively implementing preadmission screening protocols that have been developed jointly with anesthesia,
- Charts being completed on the day of surgery,
- Patients being appropriately prepared for surgery in either a pre-op unit or on the hospital floor,
- Ability to transport the patient to the OR in a timely manner in order to have on-time case starts,
- Surgeons reporting to the OR on time for on-time case starts,
- Experienced OR staff and appropriately set-up cases in order to reduce case times,
- Experienced charge nurses working with anesthesia to run the day's schedule, and
- Experienced PACU staff who can function with relative independence.

In turn, an effective anesthesia group, demonstrating value to its client hospital, will be providing services as outlined in the anesthesia contract and services agreement and will be measured and monitored on a regular basis through



use of some type of score-card. Where anesthesia stipends are in place, a portion of the stipend should be placed at risk and evaluated based on mutually agreed "risk-reward" criteria. The score-cards are used to measure anesthesia's performance, to provide anesthesia financial incentives for good performance and to penalize deficient performance against the stipend. This is how anesthesia groups come to the negotiating table as true business partners of the hospital. Anesthesia groups need to provide at least the following elements of services value to their hospitals' perioperative programs:

- Be current in state-of-the art anesthesia care with an emphasis on ambulatory anesthesia,
- Maintain reasonable flexibility with regard to agreed expectations—maintain an attitude of meeting or exceeding expectations,
- Assure consistent and reliable staffing for all anesthesia sites agreed to,

- Take ownership in developing and providing oversight for effective preadmission screening programs. Agree as a group to established guidelines and algorithms. Collaborate with nursing on the administration of the preadmission screening program and assist with nursing education,
- Screen all ASA III and above patients and visit with all inpatients prior to the day of surgery. Develop processes to administer anesthesia consults for the preadmission unit. Call patients on the evening prior to surgery. Be as familiar as possible with patients' conditions prior to the day of surgery,
- Review patient charts at least the day prior to, if not several days prior to surgery,
- Proactively work with nursing on schedule planning and management and proactively assist



nursing to enforce scheduling policies. Assign a lead charge anesthesiologist to work with the charge nurse/OR Manager on schedule planning and daily schedule administration,

- Begin reviewing the schedule with nursing several days prior to surgery,
- Facilitate getting patients into the OR for on-time case starts,
- Facilitate expediting turnaround time,
- Where appropriate, maintain an effective medical direction model where CRNA direction is based on case complexity, patient acuity and CRNA skill level,
- Be promptly available to CRNAs during on-going cases and also to CRNA cases to expedite induction and emergence,
- Develop a staffing model and service agreement model whereby anesthesia staffing requirements of remote sites does not disrupt OR staffing,
- Develop a quality improvement and education model for all anesthesiologists, CRNAs and hospital staff (RNs, RTs), where appropriate,



- Assign lead individuals to foster skills and business development in key services such as cardiac/vascular, OB, ambulatory, pain (and, potentially, neuro, trauma, pediatrics),
- Focus on delivering the highest level of patient care with respect for the patient's time and provide hospitality,
- Focus on defining expectations and then exceeding those client/customer expectations in efforts to assist the anesthesia practice to flourish,
- Depending on expectations, payor mix and OR efficiencies and case times, there may still be a need to approach hospital administration for a stipend payment to deliver on expectations,
- Play a key role in developing and sustaining *your business/your practice* by focusing on what is required to develop a marketable and financially viable surgical program with increasing case volume.

Indeed, all of the above will require a reinvented approach and mindset on the part of anesthesiologists in private practice. Providing increased value to your hospital client will require increased effort and time on the part of group members. The motivating factor must be the drive to remain in private practice as long as possible; to sustain the financial viability of your practice/business. Every business, regardless of its service offering or discipline, must continue to reinvent itself, to remain marketable, in changing times. Anesthesia is no exception. The group will incur increased expenses in providing these services to the hospital. The expense of losing your contract, however, is far greater. ▲

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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
January 25-29, 2016	California Society of Anesthesiologists 2016 Winter Anesthesia Conference	Hyatt Regency Resort and Spa Maui, Hawaii	http://www.csahq.org/up-more.php?idx=67
January 29-31, 2016	American Society of Anesthesiologists Practice Management 2016	San Diego Hilton Bayfront San Diego, CA	http://www.asahq.org/meetings/practice-management-2016
February 18-21, 2016	American Academy of Pain Medicine 32nd Annual Meeting	Palm Springs Convention Center Palm Springs, CA	http://www.asahq.org/meetings/calendar/2016/02/american-academy-of-pain-medicine-32nd-annual-meeting-(20160218)
February 19-21, 2016	Arizona Society of Anesthesiologists 42nd Annual Scientific Meeting	Hilton Scottsdale Resort & Villas Scottsdale, AZ	http://www.az-anes.org/annualmeeting/2015/exhibitorinformation.html
February 26, 2016	McDermott Will & Emery's 14th Annual ASC Symposium	JW Marriott Marquis Miami Miami, FL	http://www.mwe.com/ASC-2016/
February 27, 2016	Michigan Society of Anesthesiologists 61st Annual Scientific Session	Diamond Banquet and Conference Center Novi, MI	https://www.mymsahq.org/Events/AnnualScientificSession.aspx
February 29-March 4, 2016	Healthcare Information and Management Systems Society 2016 Conference and Exhibition	Sands Expo Las Vegas, NV	http://www.himssconference.org/
March 19, 2016	Washington State Society of Anesthesiologists Spring Scientific Meeting	Bell Harbor International Conference Center Seattle, WA	http://www.wa-anesthesiology.org/
April 14-17, 2016	California Society of Anesthesiologists 2016 Annual Anesthesia Meetings and Workshops	Hyatt Fisherman's Wharf San Francisco, CA	http://www.csahq.org/up-more.php?idx=70
April 27-30, 2016	Becker's Hospital Review 7th Annual Meeting	Hyatt Regency Chicago, IL	http://www.beckershospitalreview.com/conference/
May 5-7, 2016	Medical Group Management Association 2016 Anesthesia Conference	Gaylord National Resort & Convention Center National Harbor, MD	http://www.mgma.com/marketing-solutions/exhibit/aaa/mgma-anesthesia-conference-exhibit
May 16-18, 2016	American Society of Anesthesiologists ASA Legislative Conference 2016	Hyatt Regency Washington on Capitol Hill Washington, D.C.	http://www.asahq.org/meetings/legislative-conference-2016
June 3-5, 2016	Advanced Institute for Anesthesia Practice Management 2016	The Cosmopolitan Las Vegas, NV	http://www.aiapmconference.com/

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