The nightly news has brought us an unending litany of sad stories about the impact of the housing crisis, unemployment and the recession on the average American. As bad as CNN and the other networks would have us think things are, the fact is that the impact on the average anesthesia practice has not been all that serious. For many a practice the national news has provided a reason to do some belt-tightening, but no cause for serious concern.

In an effort to better understand the impact of the broader economic situation on anesthesia practices across the country, a review of 20 representative ABC client practices was undertaken. This analysis reveals that surgical volumes and collections have continued to grow despite the dire prognostications of the Sunday morning talk show guests. Fortunately the news is not as bad as one would have expected. What does become

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Did the title of the first article in this issue of the Communiqué, Assessing the Impact of the Recession on Anesthesia, make you think that we were reporting bad news? We are pleased to note that data from our clients show that the recession had not on average, as of 2009, had a substantial impact on their practices.

ABC Vice President Jody Locke analyzed data from 20 large, representative anesthesia practices in 20 different states for the two-year period 2008–2009 and found that the total number of surgical and obstetrical anesthesia cases had increased by nearly 4.5 percent. While growth in the number of procedures was negative (9 percent fewer cases), only 1.4 percent of overall practice revenues (down from 1.6 percent) came from elective cosmetic cases. Health plan payments in 2009 were up 3.64 percent compared to 2008 – but patient payments had dropped more than 8 percent, perhaps reflecting the cost shift from employers and health plans to employees, and individual loss of coverage.

On this last point, the subject of balance billing patients is of increasing interest. In his article Out Of Network Penalties: How Your Patients Can Help You Receive Payment In Full, Hal Nelson, ABC Director of Compliance and Client Services, discusses the potential benefits of a form letter explaining the process of appealing a claim denial sent to patients as soon the initial out-of-network penalty is assessed. Mr. Nelson also updates readers on the nuances of billing for postoperative pain management in the Compliance Corner.

As was also observed by Mr. Locke, hospitals are becoming more reluctant to support their anesthesiology departments through stipends. He concluded that trend awareness, strong negotiating talent and attentive customer service, above and beyond clinical excellence, can help make or break a practice – as has always been the case, in good economic times as well as in down markets.

Ensuring income in retirement and not just during the working years is very important to most anesthesiologists and nurse anesthetists. Josephine Ballard of ABC’s Financial Management team provides an overview of an interesting vehicle for increasing pre-tax contributions to retirement plans in Cash Balance Plans.

In the Fall 2009 issue of the Communiqué we introduced readers to the Shareable Ink® electronic anesthesia record, a system that is now being marketed as F1RST Anesthesia Record (FAR) in partnership with ABC. In Shareable Ink® – Pilot Project, written by Kathy Payne, Vice President of Operations for ABC-Western Region, three key stakeholders reveal their impressions of the technology. FAR permits anesthesiologists to document cases using a digital pen on a familiar anesthesia record. It provides an uncomplicated and inexpensive bridge to a future Electronic Medical Record (EMR) and we invite you to learn more.

The articles summarized above give you a glimpse of the range of expertise found among ABC staff. We also benefit from the lengthy anesthesia experience of a number of lawyers in private practice. Giving a nod to the increased competition and the public relations imperative that characterize anesthesia practice today, Adrienne Dresvic, Esq. and Carey Kalmowitz, Esq., identify ways to reduce the risk that marketing efforts may violate the federal Anti-Kickback and Stark self-referral laws in Healthcare Marketing – Navigating the Regulatory Landscape. Abby Pendleton, Esq. reminds us that The Anesthesia Community Must Be Prepared for Increased Audit Activity by RACS and Others.

The business environment in which anesthesiologists practice becomes more challenging every year. Most of the challenges are external to the conduct of individuals and groups. The uncertainties of health care reform can paralyze hospital systems and surgery practices. Residency programs and nurse anesthesia schools may train too few providers – or too many. An anesthesia practice may bill perfectly for perioperative visits, only reporting visits that satisfy the definition of the level of evaluation and management service selected, and then be blindsided by an investigation by a RAC that doesn’t understand Medicare payment policy.

Knowing your own practice by tracking your clinical and financial performance benchmarks both internally and across the relevant market (local or national) puts you at an immediate advantage, however. Making sure that you understand the laws and regulations that have an immediate impact on your practice is equally important. We hope that our quarterly Communiqués and weekly Alerts are helping you with both of these endeavors.

Tony Mira
President and CEO
The Anesthesia Community Must Be Prepared for Increased Audit Activity by RACs and Others

Abby Pendleton, Esq.
The Health Law Partners, P.C., Southfield, MI

Pursuant to Section 302 of the Tax Relief and Health Care Act of 2006, CMS’ Recovery Audit Contractor (RAC) Program was made permanent and was expanded nationwide. The RAC contractors are in place for all 50 states with regard to Medicare Part A and B claims. RACs are permitted to attempt to identify improper Medicare payments resulting from incorrect payments, non-covered services (including services denied as not medically necessary), incorrectly coded services, and duplicate services. RACs are prohibited from selecting claims at random to review. Instead, RACs are charged to use proprietary “data analysis techniques” to determine claims likely to contain overpayments, a process known as “targeted review.”

Although the RAC permanent program just got underway, the CMS RAC program soon may be expanding even more. In Section 6411 of H.R. 3590, the “Patient Protection and Affordable Care Act” (i.e., the health care reform bill), Congress has proposed to expand the RAC program, specifically the use of contingency-fee-based RAC contractors, to audit not only Part A and Part B Medicare claims, but also to review Medicare Advantage (Part C), Medicare Prescription Drug (Part D) and Medicaid claims. This bill is in line with a recent White House Memorandum which states President Obama’s support of the use of “high-tech bounty hunters” to help find health care fraud in government-run Medicare and Medicaid programs. It is uncertain at this point in time how a RAC expansion into Medicaid claims will impact the current Medicaid national auditing program that is underway pursuant to the Medicaid Integrity Program.

In an important development for the anesthesia community, in January of 2010, the RAC for Region D, HealthDataInsights, posted an anesthesia focus area on its website as one of the CMS approved areas for RAC review. The RAC for Region D covers 17 States and 3 territories as follows: Alaska; Arizona, California, Hawaii; Iowa; Idaho; Kansas; Missouri; Montana; North Dakota; Nebraska; Nevada; Oregon; South Dakota; Utah; Washington; Wyoming; Guam; American Samoa; and Northern Marianas. The focus area called for reviewing claims in connection with anesthesia care and evaluation and management services. In posting the issue for review, the RAC stated: “Under NCCI Edit rules, the anesthesia care package consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care. Anesthesia CPT codes 00100 to 01999 (except 01996) include Evaluation & Management (E&M) services rendered on the day before anesthesia (pre-operative day), the day of the anesthesia and all post-operative days. CPT code 01996 includes E&M services on the same

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Assessing the Impact of the Recession on Anesthesia

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Conventional wisdom suggests that a downturn in the economy would affect an anesthesia practice in at least three ways, any one of which would result in a decline in practice income. First to go are the elective cosmetic surgeries that are paid for with discretionary monies usually resulting from bonuses and windfall profits. A general contraction of the household budget might even lead to the deferring of non-essential elective surgeries. Clearly there is evidence of companies restructuring their health insurance options for employees. Theoretically such changes might even impact a practice’s payor mix. Few major companies are not trying to shift more of the burden for health care costs to their employees. Ultimately, the pundits argue, patients will be less able and less willing to pay the portion of the bill that they are responsible for. The reality is there is some truth to each of these theories, just not as much as one might have expected. It would appear that despite some minor shifts, those who need surgery still get it and those who have insurance still find a way to pay for most of it.

A comparison of surgical volume for elective cosmetic cases such as facelifts, blepharoplasties, breast reductions, augmentations and truncuoplasties does indicate that about 9% fewer patients elected to have these procedures done in 2009 than 2008 (6,075 in 2008 versus 5,588 in 2009). Revenue for such elective cosmetic procedures declined correspondingly from $4.7 Million to $4.1 Million or 14 percent. In other words not only did the number decline but also the profitability. This data notwithstanding, the overall financial impact of changes in elective cosmetic procedure activity was relatively insignificant (1.6% of cases to 1.4). This is not to say that the loss of such revenue is immaterial. At an average of $745 per case, cosmetic cases tend to be some of the most profitable services anesthesia groups provide.

Tracking trends across a large sample of practices can reveal surprising and seemingly contradictory patterns. Table 1 is a case in point. Each of the practices surveyed had a different focus with regard to cosmetic surgeries, but the three procedures listed below were performed

| TABLE 1 | Cosmetic Procedures of the Breast |
|---|---|---|---|
| | | 2008 | 2009 |
| 19318 | Reduction Mammoplasty | 1,573 | 1,523 | -3% |
| 19324 | Mammoplasty Augmentation; Without Prosthetic Implant | 813 | 716 | -12% |
| 19325 | Mammoplasty Augmentation; With Prosthetic Implant | 497 | 580 | 17% |
| Overall summary of Breast alterations | 2,883 | 2,819 | -2% |

clear, though, is that each economic and political cycle brings its own specific set of practice management challenges and the current situation is no exception. This review of practice strengths and weaknesses identifies both threats and opportunities as we all prepare for the implementation of health care reform.

Three criteria guided our selection of the practices to be used in this study. First we sought a representative mix of large and small practices providing a full range of anesthesia services. We were fortunate to be able to identify 20 clients in 20 states. We also needed clients with at least 2 full years of data so that reliable comparisons could be made between 2008 levels of activity and 2009 levels without having to annualize data. Finally, our goal was to pick practices that were large enough and diverse enough that they would be representative of their particular markets. Most cover multiple sites, including a primary hospital and at least one surgery center. Collectively, these practices provide more than 500,000 surgical and obstetrics anesthetics a year. These are typical private practices at full-service community hospitals. None is at an academic center, or at an inner-city facility dedicated to the care of Medicaid patients.
by all of them. As indicated, the overall volume of breast alterations was down slightly with the notable exception of the increase in breast augmentations with prosthetic implants. This information was not filtered for diagnosis or patients with breast cancer.

Contrary to popular belief and many an anesthesiologist’s perception, surgical volumes have remained relatively strong over the past two years. These 20 practices experienced a consistent rate of growth in total case volume of almost 4.5%. See Table 2. Billable units increased by a somewhat smaller percentage due to a slight decrease in the acuity of care, as measured in average units per case. The biggest increase was a 10% increase in billable units but five of the practices experienced more than a 5% growth in unit production. Five lost volume but the declines were nominal (1%).

Two theories may explain this stronger than expected growth in anesthetic activity. It is reasonable to assume that there is only so much surgery than can be postponed or avoided. Ultimately, it is not the economy that determines the need for surgery but the patient’s anatomy. ASA and CPT code-level trend analysis reveal relatively few significant patterns or trends with the notable exception of endoscopies, which for many practices were the one bright spot on the horizon.

Endoscopy has been the hot topic of anesthesia practice management for the past few years. The details of the discussion, the fascinating politics of anesthesia coverage for endoscopy and the long term potential will be the subject of an article in a future issue of the Communiqué. Suffice it to say that any review of performance for the past two years must identify and exclude the endoscopy numbers, because they tend to skew the picture. As indicated in Table 3, only a few of the sample practices actually saw a drop in endoscopic anesthesia business from 2008 to 2009.

Since endoscopy tends to be a diagnostic service targeting Americans in their 50s and 60s who are still working and healthy, the growth in this line of business may be masking another subtle but distinct trend in the data: a change in acuity of patients presenting for anesthesia. A classification of the overall case data by ASA physical status reveals a subtle but distinct shift in average patient physical status. As the chart in Figure 1 indicates, more than half of all patients who present for surgery and obstetric services are quite healthy. What is not quite so clear is the subtle increase in ASA physical status III, IV and V patients. ASA IV and V patient populations increased from 25,126 to 27,017, an increase of 7.5%. Given the aging of the American population this is not an unexpected development, but clearly one that could have significant implications over time.

Providing the care and getting paid for it can be two entirely different matters. Despite the political focus on the number of uninsured Americans, the number of patients without insurance who presented for surgery does not appear to have changed materially. What the data and our analysis does show are three distinct phenomena at work. The numbers of patients covered by public plans (Medicare, Medicaid, Tricare and Workers’ Compensation) continue to inch up due to an aging American population. This growth is eroding the

<table>
<thead>
<tr>
<th>TABLE 2</th>
<th>Summary of Sample Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases</td>
</tr>
<tr>
<td>2008</td>
<td>538,997</td>
</tr>
<tr>
<td>2009</td>
<td>562,815</td>
</tr>
<tr>
<td>Change</td>
<td>4.42%</td>
</tr>
</tbody>
</table>

| TABLE 3 | Endoscopy as % of Total Cases |

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Assessing the Impact of the Recession on Anesthesia

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managed care population ever so slightly. Of note, however, is that a number of these practices had historically opted out of participation with major payors in their respective areas, but in 2009, a number of them felt strong pressure to opt in. In every case such a change had a negative impact on practice revenues in the short term.

This high level summary payor mix information is based on total ASA units billed for each of the calendar years, 2008 and 2009. See Figure 2. A corresponding graph of actual payments posted would reveal that almost 72% of practice revenues come from PPO and HMO plans with which the practices participate (versus about 19% from public payors). As has been the case for the past few decades, getting paid for anesthesia continues to be a matter of getting paid by the patient’s insurance.

The single most notable finding of our analysis is that the percentage of total practice revenue that was received from patients has dropped 8.16% from 2008 to 2009, as shown in Table 4. This is not a surprising finding, but rather a new challenge that anesthesia practices must come to terms with. As expected, if companies shift more of the burden for the cost of health care to patients, then practices will have to develop new methods and strategies to get patients to pay what they owe. But this has always been a challenge and the current state of the economy only exacerbates a long-term problem.

Such insights only underscore the importance of negotiating aggressively with payors. As indicated, the majority of a practice’s “fee for service” revenue is received from patients’ insurance. What might seem ironic is that at the same time companies are pushing back on employees and asking them to pay a larger share of the cost of health care, insurance companies have not resisted renegotiating favorable contract renewals. Aggressive practices have been very focused on their contracting strategies to maintain their cash flow. So far the strategy seems to be paying off. It is not uncommon for commercial payors to exceed renewal rate increases of 3 or more percent. Given the fact that 20% of a practice’s payors typically accounts for about 80% of a practice’s revenue, a few good contracts can make or break a practice. The rewards of effective payor negotiations are not only material, they may be essential in light of the other downward pressures on practice income.

Payor mix has always been a significant barometer of financial strength for a medical practice. What the payor mix tells us is how many of the practice’s patients are “locked in”

![Figure 1: Distribution of Sample Patient Population by ASA Physical Status](image1)

![Figure 2: Payor Mix](image2)
based on governmental rates set in Washington or state capitols and how much the practice can actually negotiate. The Public Payor Percentage (PPP) is a useful measure of the degree of freedom and flexibility of a practice financially. Typically, if the PPP is greater than 50% the practice will not only realize average yields per unit billed that are below the national average but will probably find itself needing substantial support from the facility to survive. The most desirable practices will always be those with the greatest flexibility to not only negotiate with payors for a substantial portion of their income but also balance bill patients.

Perhaps the most interesting dimension of payor mix, however, is its ability to change based on a variety of factors that may have less to do with the demographics of a service area than with the nature and mix of services provided. There was a period of time when many anesthesia practices felt they could afford to departicipate with major payors and bill the patients directly. This was a reasonable strategy so long as the net impact on revenue was positive. Many of these same anesthesia groups are now reconsidering their previous strategies for both political and economic reasons. Often such shifts result in short-term income hits. Another factor is the correlation between lines of business and payor mix. A decrease in patients with commercial indemnity insurance at a practice’s outpatient surgery centers may cause the overall percentage of Medicare patients to increase dramatically even though the absolute number of seniors being treated did not increase.

It is often said that if you have seen one anesthesia practice, you have seen one anesthesia practice. So many factors determine the level of activity and the revenue potential for anesthesia services that it is misleading to draw too many assumptions from a limited study. There is a fundamental divide between what gets paid per ASA unit billed to public payors versus what gets paid by private, commercial payors. As Table 5 clearly demonstrates, all anesthesia practices need their commercial revenue to offset the impact of Medicare and Medicaid. What ultimately distinguishes the financial strength of a practice is just how much of an offset the commercial income provides. The laws of physics and economics being what they are, it is safe to assume that over time all practices will trend towards the average. Those at the high end may experience significant erosion in the revenue they receive from their best contracts. If there is any good news in all of this, it is that there does appear to be some upside for the practices at the low end of the spectrum.

Most anesthesia consultants now agree that it is essential not only to track payor mix trends for the practice as a whole but by line of business. While it is true that sometimes such information may not shed much light on new strategic or financial opportunities, it is essential to good planning. Given the dramatic developments unfolding with health care reform, few practices can afford to overlook any potential sources of additional revenue, no matter how small.

The discussion thus far has focused on revenue generated directly based on work performed and units billed but there is one more piece to this rather complicated puzzle. It is the piece that has more to do with diplomacy and finesse than hours spent caring for patients. The last decade has seen an unprecedented level of data sharing with hospitals in an effort to forge financial partnerships the likes of which would have been considered unthinkable just a few years earlier. MGMA surveys indicate that more than 75% of anesthesia practices receive some form of financial support or income guarantee from their primary facilities. While the terms and the amount of support vary considerably from hospital to hospital, the impact has been dramatic:
most practices can no longer survive on the revenue they generate through their billing operations. The economics of coverage and call, recruitment and retention have completely changed the nature and focus of anesthesia practice management. Anecdotal evidence supports the perception that hospitals are becoming ever more reluctant to subsidize anesthesia, at least at historical levels. The loss or reduction of such revenue could lead to a whole new set of challenges for many.

Historically, anesthesia practices have been primarily focused on the revenue side of their balance sheet but this is starting to change. As has been the case in other industries, the need to cut costs has led to a rethinking of basic service requirements and assumptions. Many an anesthesia practice has already started to grapple with the question, what if we did not get support from the hospital. Hospitals are looking very closely at operating room efficiency and asking if they can really afford to continue to offer such capacity. Meanwhile anesthesia practices are also having to look at their own cost structures and the configuration of the care team. There is a resurgence in interest in mergers as another possible avenue for lowering overhead and minimizing expensive manpower redundancies. Not only has customer service taken on a new significance in an era of increasing competition for scarce health care dollars, but the more creative practices are starting to take a page from the airlines to reset customer expectations in an effort to make them more attainable.

It was not the intent or scope of this review to assess the impact of health care reform on anesthesia practices, but rather to identify the issues that have been flushed up by the current state of the economy. Political developments in Washington have their own way of unfolding and complicating the economic cycles we all experience regularly. Irrespective of one’s perspective on or concerns about the potential impact of providing insurance for an additional 32 million Americans, one thing is clear: the key to survival is financial. Good care and effective customer service are essential, but the bottom line must be positive. The good news is that anesthesia has survived the nation’s recession with a minimum of permanent damage. Most anesthesia providers’ incomes actually went up each of the past two years. Most group practices still enjoy strong relationships with their hospitals and surgery centers. For most, the prospect of continued success is bright. As always, caution must be the byword. Economics is not a discipline that respects one’s wishes. Just as powerful economic and political forces are slowly changing the face of American health care, so too, are they changing the face of anesthesia. Victory will ultimately only be awarded to those which are astute and diligent enough to divine the underlying trends and make the most of them.

Mr. Locke is responsible for the scope and focus of services provided to ABC’s largest clients. He is also responsible for oversight and management of the company’s pain management billing team. He will be a key executive contact for the group should it enter into a contract for services with ABC. He may be reached at Jody.Locke@anesthesiallc.com.
day as the 01996 service only. Physicians can indicate that E&M services rendered during the anesthesia period are unrelated to the anesthesia procedure by submitting modifiers 24, 25, 57 and/or 59, depending on claim specific circumstances, on the E&M service. Only critical care E&M services are payable during the anesthesia post-operative period. The post-operative period is defined as the day immediately following the anesthesia service and any subsequent days during the same inpatient hospital admission as for the anesthesia service.”

Notably, during the week of March 22, 2010, although CMS initially approved the issue in November of 2009, CMS directed the RAC vendor to remove the anesthesia care package issue from the list of approved issues. CMS would not comment on the removal, however, anesthesia groups should continue to monitor this area for any future developments.

Although this anesthesia issue appears to be uncertain at this point in time with regard to RAC scrutiny, anesthesia and pain groups could face audits in other areas as the RAC program is further developed and as other payers increase auditing efforts. The historical data from the RAC demonstration program does not assist anesthesia or pain practices in determining any particular focus areas for RAC audit activity that could be forthcoming in the future. We do expect the RACs to study various resources such as the OIG work plan and other CMS guidance materials. For example, we know that the 2008 OIG Work Plan addressed interventional pain management procedures in connection with Section 1862(a)(1)(A) of the Social Security Act, which requires that services must be medically necessary.

The OIG noted that interventional pain management was a growing specialty and that Medicare paid almost $2 billion for interventional procedures in 2005. The review was to focus on the appropriateness of payments for the procedures. In September of 2008, the OIG issued a report on “Medicare Payments for Facet Joint Injection Services” wherein they found that 63% of facet joint injection services allowed by Medicare in 2006 did not meet Medicare program requirements, resulting in $96 million in improper payments.

Given the current audit and enforcement environment, we encourage all physician practices to strengthen their compliance programs and documentation practices. For example, we would encourage anesthesia and pain practices to pay careful attention to oversee:

a. that each provider is only capturing allowable anesthesia time for billing purposes and that appropriate documentation exists to support the recorded start and end times;

b. compliance with the medical direction requirements including improving documentation practices to demonstrate such compliance;

c. improvement in documentation practices with regard to separately payable services such as invasive monitoring lines and post-operative pain services;

d. improvement in medical necessity documentation in connection with the performance of pain management procedures; and

e. improvement of documentation practices relative to the provision of evaluation and management services.

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The Anesthesia Community Must Be Prepared for Increased Audit Activity by RACS and Others

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With regard to medical direction documentation, it will be important to re-evaluate current documentation practices. As many are aware, in 1998, CMS specifically adopted a regulation to address medical documentation in connection with conditions for payment for medically directed anesthesia services. According to 42 CFR §415.110(b):

The physician alone inclusively documents in the patient’s medical record that the conditions set forth in paragraph (a)(1) have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

Fortunately or unfortunately, depending on your perspective, CMS has yet to provide specific instruction on exactly how this documentation must be accomplished. From a practical standpoint, there are multiple ways in which medical direction could be documented. The reality is that the key to effectuating meaningful compliance with documentation requirements in your practice is to carefully select a method that will be followed and one that captures all necessary medical direction criteria. Per 42 CFR §415.110, medical direction requires that for each patient the anesthesiologist fulfill the following seven (7) specific responsibilities:

- Performs the pre–anesthetic exam and evaluation
- Prescribes the anesthesia plan
- Participates in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence
- Ensures that any procedures in the plan that he/she does not perform are performed by a qualifying individual
- Monitors the course of anesthesia at frequent intervals
- Remains physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

Absent instruction from your Medicare contractor directing a specific method, some potential documentation methods a practice may choose to consider include: individual attestation statements with a comment section; a combination of attestation statements and time line initialing; and handwritten notations with no formal attestations. Given what may be unprecedented levels of auditing, regardless of the documentation method selected, it is imperative that the documentation is robust and captures all elements to establish that medical direction was accomplished in the case. Moreover, it must accurately reflect the services rendered and accurately reflect the appropriate provider(s) who rendered the service.

For those practices that receive requests for records from a RAC or other payers, it is imperative that you timely respond to record requests and that you provide all relevant documentation to support the payment of the claim at issue. To the extent a RAC or other Medicare contractor reviews your records and denies the claim, the traditional Medicare appeals process would apply requiring you to file a redetermination request within 120 days of receipt of a denial. The Medicare appeals process has several stages including: (1) Redetermination- 120 day deadline; (2) Qualified Independent Contract Review- 180 day deadline; (3) Administrative Law Judge hearing stage- 60 day deadline; (4) Medicare Appeals Council- 60 day deadline; and (5) Federal Court.

Abby Pendleton is a partner with the health care law firm of The Health Law Partners, P.C. in Southfield, Michigan. The firm represents hospitals, physicians, and other health care providers and suppliers with respect to their health care legal needs. Pendleton specializes in a number of areas, including but not limited to: Recovery Audit Contractor (RAC), Medicare, Medicaid and other payor audit appeals, healthcare regulatory matters, compliance matters, reimbursement and contracting matters, transactional and corporate matters, and licensing, staff privilege and payor de-participation matters. She can be reached at apendleton@thehlp.com.
In the Winter 2009 Communiqué issue Jill Thompson wrote an introductory article featuring the highlights of a Cash Balance Plan. The article proposed that individuals earning $245,000 or greater may be interested in pursuing this retirement vehicle as a means for increasing their retirement funds while gaining the benefit of additional tax savings.

To determine if a Cash Balance Plan is suitable for your practice an initial understanding should be obtained of the administrative and funding differences between a Cash Balance Plan and a Traditional 401(k) plan. Table 1 illustrates the major differences between the two plans.

As discussed in the 2009 article companies with the following characteristics are good candidates for Cash Balance Plans:

- Owners who desire to contribute more than $49,000/$54,500 per year;
- Owners over 40 years of age who desire increased tax deductions or wish to increase their pension savings;
- Companies that have demonstrated consistent profit patterns; and
- Companies that are already contributing 3% or more to employees’ accounts or are at least willing to do so.

In addition to a “stand alone” Cash Balance Plan one can opt for “combo” plans. These plans allow a Cash Balance Plan to be combined with a tradition 401(k) plan in order to provide for a larger contribution amount and allows combination with a whole life policy as well. For groups or businesses that are closely held, these types of “combo” policies are very common as they allow owners to maximize their retirement plan contributions. Furthermore, for groups with owners and a few employees the group can offer the option of some of the employees being covered under the cash balance plan and another group of employees being covered under the profit sharing plan.

Table 2 shows a Case Study of a small physician group with one employee that meets the requirements for a Cash Balance Plan. Table 2a illustrates the
CASH BALANCE PLANS
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The group’s desire was to increase their pre-tax contributions to meet their retirement needs. Table 2b depicts a defined contribution plan combined with a cash balance plan at the maximum funding levels. Table 2b illustrates that the cash balance funding level for the principal’s ranges from $88,000 to $143,700 (noting that this difference is due to difference in age) for a combined contribution total ranging from $119,200 to $143,700.

The combined plans can also be layered with life insurance up to the maximum amount allowable under Treas. Reg 1.401-1(b)(1)(i) which is an amount less than 100 times the projected monthly retirement income. As interpreted under Rev. Rul. 74-307 generally, 33% of defined benefit contribution may be used for whole life insurance premium. This option (Table 2c) allows the participant to purchase life insurance with tax-deductible dollars; therefore, the tax-deductible contribution is increased.

The three tables clearly illustrate the significant contribution increases that are attainable via a Cash Balance Plan and/or “Combo” plan versus a traditional contribution plan. It also becomes apparent that these plans can be flexible to meet the needs of the individual as well as the group. It should be noted that with respect to partnerships each partner can have their own contribution amount; this amount can be determined by percentage of pay or a flat dollar amount. Tax deductions on behalf of non-partner employees are taken on the partnership return while deductions for partner contributions are taken on their personal returns. Cash Balance Plans are qualified plans that have the same tax effect of reducing ordinary income dollar for dollar. With many partners in the 45% tax bracket the saving from contributions become significant to the practice.

If your group has been looking for an alternative vehicle to maximize retirement funding, gain additional tax deductions and meet the characteristics listed above a Cash Balance Plan may be a viable option for your group.

We would like to thank Jacob, Haxton & Boord, LLC (www.jhbllc.com) for their assistance with this article.

Josephine Ballard, Financial Manager, has been with ABC for two years and is part of the division of Financial Management and Consulting Services. She is responsible for financial and strategic practice management for anesthesia clients nationwide. She has twenty years of experience in private practice management as well as serving as an Administrative Director in anesthesia / pain based ASCs. Josephine has earned a Master Degree of Science from CUNY – Queens with a concentration in health care administration.
When a patient follows their payer guidelines and has surgery by an in-network surgeon at an in-network hospital, why should they be assessed an out of network penalty if their anesthesiologist is non-contracted with the payer? The answer might surprise you — often they do not pay a penalty. United Healthcare and other managed care entities will typically pay your claim on appeal at 100% of billed charge, and getting the patient involved is the most effective way to accomplish this.

The issue of non-network penalties has been going on for years. Four specialties are the most involved — radiology, anesthesiology, pathology and emergency medicine. Patients have no advance knowledge of whether one of these specialty physicians is in network or not, even if they choose a hospital and surgeon that are in their member directory.

When a patient has services provided by a non-par anesthesiologist in this scenario, the claim payment will typically be reduced by 45% of billed charges, since the payer software recognizes that the anesthesiologist does not have a contractual relationship with the payer. This means that on the patient’s explanation of benefits (EOB), the insurance company passes the non-covered charges on to “patient responsibility”. Not only is this unfair to the patient, it may also be a violation of the contractual terms that the payer has agreed to abide by when the patient signed up for their plan.

Patients are unaware of the insurance company’s responsibility to pay the charge in full. From personal experience, when I worked for several managed care health care plans, a small percentage of patients would call and complain, and the payer customer service reps were instructed (only at that time) to adjust the claim and pay 100% of billed charges. Unfortunately, the majority of patients would ignore the EOB and eventually get sent to collection. This resulted in lost revenue for many anesthesia practices.

The key to resolving this issue is helping to educate the patient on their rights with their insurance plan. A good billing customer service staff can explain the issue to the patient in simple terms and empower the patient to lobby for full payment on their behalf. A more proactive step is for the billing department to create a form letter explaining the appeal process that is sent to the patient as soon as the initial out-of-network penalty is assessed. The amount of additional collections that are possible by employing these strategies is staggering.

One would think that in today’s hi-tech world, insurance companies would pay the claim at full charge for a non-network anesthesiologist on initial claims submission. Then again, United Healthcare didn’t make $81 billion dollars profit last year by accident. Educating your patients on this issue will not only increase your collections, it will also show good will to your patients and help them avoid being unfairly penalized by their insurance plan.

Hal Nelson, Director of Compliance and Client Services

As a nationally known expert in the field of anesthesia, Nelson brings a variety of expertise to ABC clients in helping medical practices resolve anesthesia coding, billing and compliance challenges. His experience navigating through Medicare billing regulations, anesthesia and pain coding, payer audit defense, charge ticket review, compliance plan development and physician documentation analysis ensures ABC clients have a safety net for these challenging issues. He has 20 years experience on both the payer and billing side and is one of the specialty executives in charge of supporting sales, marketing, operations, auditing and compliance initiatives.
Marketing is an integral component of any business enterprise’s efforts to maintain and expand its economic base. Many healthcare providers (including pain and anesthesia practices) likely have been strategizing about their marketing programs as they contemplate the prospects of declining reimbursement and heightened regulatory scrutiny. As practices develop their plans, they must be mindful that marketing practices which are commonly applied in most other industries potentially might implicate significant compliance risks for healthcare providers. While the healthcare regulatory framework is extensive and highly complex, this article will focus solely on the principal federal laws that govern many healthcare providers’ marketing practices with referral sources, in particular, the Medicare and Medicaid Anti-Kickback Statute (the “AKS”), and the Federal Stark Law (“Stark”).

Healthcare Marketing and the AKS

The AKS is an intent-based statute which contains both civil and criminal penalties. Any arrangement in which anything of value is exchanged between a referral source and a third party in connection with the provision of services paid for by a federal program potentially implicates the AKS. Since marketing inherently is designed to cultivate business (including health care items and services reimbursed by federal programs) through the offering of incentives, many common marketing activities potentially violate the AKS. Thus, together with evaluating the efficacy of a particular marketing activity, practices should design their marketing with a view towards mitigating the attendant compliance risks.

Healthcare providers customarily entertain and offer gifts and other items, (e.g., tickets, dinners, etc.) to physicians and other persons in a position to refer or arrange for referrals. In a progressively more competitive environment, the pressure to enhance revenue often leads practices to expand their networks of referral sources, and marketing often is viewed as the means to do so. As discussed in compliance guidance issued by the Office of the Inspector General, gifts, gratuities, and other entertainment activities trigger potential AKS risks when they involve parties in a position to refer services or influence referrals to the provider. As a result, providers should implement certain safeguards designed to reduce these risks. Below are certain procedural safeguards that practices should consider when structuring their marketing programs:

- The practice’s administration should be notified of all marketing activities with referring physicians (and other referral sources).
This will permit the practice to coordinate, monitor, track, and evaluate such activities from a compliance perspective.

- The practice should never provide referral sources with cash gifts. Any non-monetary gifts can never be tied to referrals, should be nominal in value, and be tied to educational/business sessions.
- In the event that a referring physician (or other referral source) suggests or represents that referrals or continued referrals are conditioned upon providing entertainment or gifts to such individual, the practice should immediately refrain from any marketing effort with that individual. Also, the practice must avoid making any statements to a referral source that could be construed to mean either (a) that increased referrals will translate into more lavish entertainment, or (b) conversely, that any decrease in referrals will result in a reduction of entertainment.
- The practice must not correlate its marketing expenditures to the volume or value of referrals related to the referral source.
- When entertainment takes the form of dining, the practice should spend a significant portion of time discussing business/education matters with the individual.
- The practice must be aware of the amount expended on entertainment, both in terms of any specific episode (e.g., dinner), and the aggregate expenditure on any single referral source during a year. Simply put, the likelihood of the arrangement being viewed as an inducement to refer increases in proportion to the level of entertainment expenditures.

**HEALTHCARE MARKETING AND STARK**

Stark is a broad prohibition that bans physician referrals of Medicare beneficiaries to entities with which they (or immediate family members) have a financial relationship for “designated health services” (“DHS”), which include, among others, diagnostic testing services, hospital services, and physical therapy services, unless an exception applies. For Stark purposes, a financial relationship may arise from a compensation arrangement, which includes the provision of anything of value to a referring physician. As a result, practices that provide DHS which market to physicians or physician-owned entities should be cognizant that such activities directly implicate Stark. If Stark is triggered, and an exception is not met, a provider will be subject to severe sanctions, including denial of claims for those referred services.

Stark contains an exception for “non-monetary” compensation that applies to certain marketing activities. Under this exception, a DHS provider that furnishes something of value (e.g., meals, entertainment, non-cash gifts such as tickets, etc.) to a referring physician up to an annual limit of $355 will be protected. Notably, if a DHS provider’s marketing activities do not comply with this exception, it will not be able to lawfully bill for any DHS ordered by that referring physician.

As noted above, practices should implement certain procedural safeguards when engaging in marketing activities that involve providing gifts to, and/or entertaining, physician referral sources. These should include, in particular, those principles discussed above. In the event that a DHS provider inadvertently exceeds the limit (by not more than), Stark provides that the excess can be corrected by the referring physician repaying such excess by the end of the calendar year or 180 days from the date of such payment, whichever is first.

**CONCLUSION**

Given the complex healthcare regulatory framework, practices engaging in marketing activities need to ensure that they adhere to certain procedural safeguards when marketing to referral sources. In practice, this should cover any and all activities, involving, for example, entertainment activities and the offering of any gifts to referral sources. While practices realistically cannot forego marketing, by implementing the safeguards discussed above, they can meaningfully reduce the AKS and Stark risks associated with marketing.

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**Adrienne Dresevic, Esq.** is a founding member of The Health Law Partners, P.C. Ms. Dresevic practices in all areas of healthcare law and devotes a substantial portion of her practice to providing clients with counsel and analysis regarding Stark and fraud and abuse. Ms. Dresevic can be reached at adresevic@thehlp.com.

**Carey F. Kalmowitz, Esq.** is a founding member of The Health Law Partners, P.C. Mr. Kalmowitz practices in all areas of healthcare law, with specific concentration on the corporate and financial aspects of healthcare, including structuring transactions among physician group practices and other healthcare providers, development of diagnostic imaging and other ancillary services joint ventures, physician practice, IDTF and home health provider acquisitions, certificate of need, compliance investigations, and corporate fraud and abuse/Stark analyses. Mr. Kalmowitz can be reached at ckalmowitz@thehlp.com.
In the Fall 2009 Communiqué, Dr. Vernon Huang, Founder and CMO of Shareable Ink®, first introduced readers to the Shareable Ink® digital anesthesia record. The Shareable Ink® product currently marketed as F1RST Anesthesia Record (FAR), in partnership with ABC, offers a method of capturing anesthesia events and transmitting the data directly to ABC for processing.

For most anesthesia groups, current workflow involves filling out a paper anesthesia record. Shareable Ink® provides an electronic method of capturing anesthesia events as they are recorded on the anesthesia record – without requiring any significant change in process. At the end of the day, simply connect the Shareable Ink® pen to a conveniently located docking cradle and upload your completed anesthesia records. Over a secure web site the anesthesia record information is delivered to the billing office for processing. Gone is the hassle of keeping track of paper anesthesia records and transporting them to the billing office, thus speeding up the billing process and reducing charge lag time.

Shortly after the release of the Fall 2009 Communiqué, ABC’s Western Regional office was asked to participate in a pilot project for Shareable Ink® in collaboration with Anesthesia Care Associates, a practice located in the San Francisco bay area. Three plus months into the pilot, here is what we’ve learned from the perspective of some key stakeholders:

**Joe Fenerty, M.D., President Of Anesthesia Care Associates And New User Of Shareable Ink®**

“Unlike other technology changes, using the Shareable Ink® system required minimal effort from group members. We’ve found with the built-in edit checks there is a reduction in charges returned for missing information. The speed in which the data is available for billing results in a positive impact on the revenue cycle.

“On the con side some members found the digital pen to be less ergonomically friendly and opted to not take advantage of the product and reverted back to using a standard pen.”

**Matthew Barnhart, VP, Product Development, Shareable Ink®**

“Implementation couldn’t have been better. From acceptance by the individual anesthesia providers to the OR unit clerks, by and large the experience was very easy. Ease of implementation is attributed to how closely the digitized anesthesia record workflow mirrors current day reality. Virtually, it’s a ‘no big deal’ event. In fact, we’ve seen such a success with the pilot that we are installing and plan to go live at a sister campus in the next few weeks.

“The next leap with the Pilot is interfacing the Shareable Ink® system with F1RST Anesthesia, bringing billing data directly into the billing software and thereby eliminating human intervention. In the absence of the interface records are printed from the Shareable Ink® website for processing by the billing office.

“On the horizon Shareable Ink® is building in functionality to support care team models and expanding the single point of service view to one of gluing multiple independent episodes together.”
**Karen Gehne, Manager, ABC-Western Region**

“The Shareable Ink® website is easy to access and use. New users can acquaint themselves and navigate the website in five to seven minutes. Daily we access the Shareable Ink® website and retrieve the anesthesia records for billing. One main advantage of this product from a billing and collections perspective is the clarity of the anesthesia record. Frequently what is submitted for billing is a second, third or fourth generation copy of the anesthesia record, resulting in problems with legibility of information recorded on the record. The writing on the Shareable Ink® anesthesia record is a bold, clear original that can be reprinted over and over with equal clarity.

“Another benefit is the completeness of the records; helping to speed up the billing process and reduce the number of instances a critical data element is missing. This eliminates delays in the billing process due to pending input from the provider.”

FAR is a viable and attractive alternative for practices looking for an automated anesthesia record. A minimal investment in hardware (color laser printer and a few docking cradles), together with a quick training session with users, paves the way for virtually any practice to implement and begin seeing the advantages the system offers. If you are looking to reduce administrative paperwork, eliminate pended claims while decreasing charge lag days, I would encourage you to explore FAR. While FAR is not an EMR it does provide an automated way to capture and transport anesthesia records.

To learn more about FIRSTAnesthesia Record call (800) 242-1131 ext 4113 or visit our website at www.anesthesiallc.com.

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**Kathy Payne, CPC**

Ms. Payne joined ABC in 2008 through the acquisition of Anesthesiologists Associated Inc. She has over 25 years of experience in the health care billing industry focused exclusively in anesthesia. Prior to her work with ABC, she was the Vice President of Billing and Collections for Anesthesiologists Associated Inc. responsible for leading and directing 100+ staff members, with multiple office sites across several western states. Ms. Payne has overseen growth and improvements in billing and collection processes and her leadership provides stability and ensures consistent and reliable service to clients. Prior to her time with Anesthesiologists Associated Inc., she spent seven years in billing at Deaconess Medical Center in Spokane, Washington. She studied at Spokane Community College and is accredited by the American Academy of Professional Coders as a Certified Professional Coder. Ms. Payne is a long-time member of the MGMA Anesthesia Administration Assembly.
The variety of commonly used modalities for the management of post-operative surgical pain makes it imperative that practitioners understand the specific documentation and billing requirements of each option. Listed below are the five most common approaches and their corresponding claims submission guidelines. As is always the case, reimbursement will vary by payer.

- **Intravenous Patient-Controlled Analgesia Management (IV PCA)** – Surgeons are reimbursed for routine post-operative pain management as part of their global fee. Due to this fact, Medicare does not allow anesthesiologists to bill for this service. However, many non-Medicare payers do. The physician must see the patient on a post-operative day and document a progress note to include a problem focused history and exam with straightforward medical decision making. The typical code billed for this service is “subsequent inpatient visit” code 99231 (2 units).

- **Patient-Controlled Epidural Analgesia (PCEA)** – If an epidural is placed for post-op pain and is not the primary mode of anesthesia, it can be billed separately from the anesthetic with codes 62318 (cervical/thoracic – 10 units) or 62319 (lumbar – 9 units). In addition, each calendar day of epidural catheter management is billable with code 01996 (3 units).

- **Spinals/Duramorph** – If a spinal is placed for post-op pain and is not the primary mode of anesthesia, it can be billed separately from the anesthetic with code 62311 (8 units). In addition, a follow-up visit can be billed the next calendar day, if medically necessary. The typical code billed for this service is “subsequent inpatient visit” code 99231 (2 units). Keep in mind that some payers will bundle and deny any evaluation and management service billed the day after anesthesia. For combined spinal-epidurals commonly used in OB cases, it is not appropriate to bill separately for the spinal injection, since the injection is typically performed via the epidural catheter/trocar.

- **Interscalene/Brachial Plexus Blocks**

As part of our desire to keep both clients and readers up to date, the Communiqué has been printing compliance information since its inception. In the Compliance Corner, we will now formally keep you abreast of the various compliance issues and/or pick out a topic that would be of interest to most of our readers.
– If general anesthesia is used for a shoulder case, and an interscalene block is placed for post-op pain, the block can be billed for separately with code 64415 (8 units). If a continuous interscalene block is placed instead of a single stick, then code 64416 (13 units) is billed. For continuous blocks, there is no longer a global period, meaning that you can bill for follow-up visits if you physically see the patient on a subsequent calendar day. The typical code billed for this service is “subsequent inpatient visit” code 99231 (2 units).

• Femoral and Sciatic Nerve Blocks

– If a general anesthetic is used for a knee case, and a femoral and/or sciatic nerve block is placed for post-op pain, then the block(s) can be billed for separately with codes 64447 (femoral – 7 units) and/or 64445 (sciatic – 7 units). If a continuous block is placed instead, then report either code 64448 (continuous femoral – 12 units) or 64446 (continuous sciatic – 12 units). Follow-up visits can be billed if applicable, as mentioned above with the continuous brachial plexus blocks.

In conclusion, it is imperative to indicate that your block is separate and distinct from the primary mode of anesthesia used in the case when billing for post-op pain procedures. For example, groups should not check off both “general” and “regional” as the modes of anesthesia unless they are truly intending to do a combined “general-regional” technique, which would negate the separate billing of the block. Although most payers will allow a post-op pain block to be used as an adjunct to a general anesthetic, if the block itself could have provided the entire anesthetic, then documentation of medical necessity for the “general” is recommended. Per CMS requirements, anesthesiologists should state clearly on the anesthesia record that the block is “for post-op pain per surgeon request”. Per the AMA, post-op pain blocks can be performed either pre-operatively, intra-operatively or post-operatively. However, post-op pain blocks performed prior to the induction of anesthesia are not to be included in billable anesthesia time and are billed as “flat fee” surgical procedures instead, per the ASA.

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<td>Midwest Anesthesiology Conference – Illinois Society of Anesthesiologists</td>
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