



New Communiqué Website

Anesthesia Business Consultants, LLC (ABC) is proud to announce the launch of a new Communiqué website. This website will offer features not previously available. Communiqué continues to feature articles focusing on the latest hot topics for anesthesiologists, nurse anesthetists, pain management specialists and anesthesia practice administrators. We look forward to providing you with many more years of compliance, coding and practice management news through Communiqué. Please log on to the Communiqué site at www.communiquenews.com.

GAIN YOUR FAIR SHARE: GAINSHARING MAKES A COMEBACK

By Mark F. Weiss, J.D.

Have you heard the news in connection with the “Rewarding Results” pay for performance study funded by The Robert Wood Johnson Foundation, the California HealthCare Foundation and the Commonwealth Fund?

No, it’s not that the three-year long study resulted in a finding that payment of financial incentives to physicians motivates change. Rather, it’s the fact that someone convinced these non-profits to throw money at a “study” of something so patently obvious. (If you close your eyes you might actually hear the sound of a newsboy on a corner near you shouting “Extra! Extra! People motivated by money!”) Aren’t the federal and state anti-kickback and self-referral laws based on studies which show that physicians’ practice patterns are affected by monetary gain?

All kidding aside (and, sorry if this article is a bit disjointed, as I’m simultaneously typing a \$30 million grant proposal for a proposed study on whether mammals have hair), the anesthesia community should not look a gift horse in the mouth: The pay for performance



movement (nicknamed “P4P”), supported by payors and pundits alike, together with the Department of Health and Human Services’ Office of Inspector General’s (“OIG”) 2005 advisory opinions on gainsharing, signal that the time is ripe for anesthesia groups to negotiate for a share of the upside they can create.

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MGMA/ASA ANESTHESIA COST SURVEY

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Surveys, surveys, surveys.....how can they help you and how can they hurt you? As a wise person once said, "s/he who has the data rules" so you better be one of the people who has it. And you better also do your part to make it as representative as possible. The Medical Group Management Association

(MGMA) Anesthesia Administration Assembly (AAA) and the American Society of Anesthesiologists (ASA) are committed to this mantra, which is why they have collaborated once again on the third annual 2006 *Cost Survey for Anesthesiology Practices* (based on 2005 data).

In the third version, participation has increased to 149 responses (129 usable) representing over 3400 doctors, or nearly ten percent (10%) of active ASA members. In addition, there were 64 responses (52 usable) to this year's inaugural pain management survey, representing well over 100 pain man-

ISSUES OF THE DAY

As the spring conference schedule winds down many of us find ourselves asking the same question. Some excellent speakers have made some very interesting presentations on a wide variety of practice management topics at the Conference on Practice management in Phoenix and the Anesthesia Administrators' Assembly in Seattle, but it is not quite clear what the big issues are. Or, to put it another way, it is not entirely obvious that there is, in fact, one overarching issue of the day. The national policy issues like Medicare reimbursement cuts and Pay for Performance continue to be a source of concern and discussion but one does not sense a high degree of urgency to take up the cause. While the ASA and other organizations like the Anesthesia Business Group are doing a great job of keeping us focused on realistic global strategies, it is pretty clear that most anesthesiologists and CRNAs are much more focused at a different level. Yes it is true that anesthesia practices are worried about having enough good people to meet the service requirements of their customers, but what they are really worried about is the potential impact of the surgi-center across the street or and the future of their current stipend.

Historians have suggested that the

march of civilization involves a regular swinging of the pendulum of public opinion from the general to the specific. People become inspired by the big movements, civil rights and the rise of global terrorism, but they ultimately end up acting on their specific problems and challenges. Perhaps we are just in one of those periods of transition. It is hard to stay focused on the big picture when the local view looks so turbulent. When a long-term exclusive contract at a county hospital in Bakersfield, California is given to a staffing company from upstate New York with no experience in the state, one begins to wonder what is really driving such decisions. There is so much anecdotal evidence of hospital administrations turning on their anesthesia practices is it any wonder many anesthesiologists are getting pretty anxious.

Our authors understand just how technical and specific the issues affecting our clients' practices have become. They represent a diversity of regional perspectives, historical areas of focus and distinct vantage points. Marc Weiss gives us a western legal perspective on the concept of gain-sharing, a notion that many of us find so intriguing but which attorneys have tried to tell us is so problematic given the Stark guidelines. Needless to say, Marc's ideas

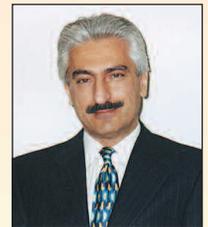
provide some very thought-provoking options. Shena Scott writes to us from the deep south on a topic of key interest to anyone who has had to ask for financial support: what is the value of national survey information and how can we all help make it more relevant. Our internal staff share some of their insights as we all get ready for the implementation of a new set of diagnosis codes. We also have some thoughts for you to ponder with regard to the potential of ultrasound to guide your nerve blocks.

As always, we hope you find our articles relevant and timely as you sort out the critical issues for your particular practice, wherever it may be. Our only goal is to provide you with reliable and valuable options. If there are issues that you would like our panel of experts to address please let us know. We always love to hear from you and to know what matters in your next of the woods.

Sincerely,



Tony Mira, CEO



agement physicians. As participation has grown, information has been broken down into more tables. New in 2006 were both a separate set of academic tables within the anesthesiology section and a completely separate section of pain tables. Participation is key to not only ensuring the representation of the data but also in having sufficient responses to “slice and dice” it in enough ways to make it meaningful for respondents and others who would use it. With increased participation in the future, we hope to improve the number of columns within existing anesthesia tables, to add sections and tables in response to member needs, and to “grow” the pain management section.

The anesthesiology survey is divided into eleven different table groupings for each of seven different “sections” of anesthesiology practices. Within each section, tables are then broken into sub-sections (represented by columns within the table) for relevant break-points within that sub-section. MGMA has a policy that it will not report any statistic with less than ten (10) responses, which is why you will see some asterisks (*) populating some fields, indicating that there were insufficient responses in this sub-category to report this statistic (supporting the argument as to why increased participation allows the data to be “sliced and diced” more ways). The first number in a table indicates the “section” it represents and the numbers following the period represent the table number. Thus the data points you find in Table 1.4a should be the same data points you find in Table 5.4a (assuming there were sufficient responses to populate 5.4a), except that the group being represented in 1.4a is “all practices” responding and the group being represented in 5.4a is divided into columns based upon the staffing model of the practice.

The sections in the 2006 anesthesia cost survey book are as follows:

1. All Practices
2. 10 or Less FTE Physicians (small practices)
3. 11 to 30 FTE Physicians (medium practices)
4. 31 or more FTE Physicians (large practices)
5. By Staffing Model — physician only, < 1 CRNA per FTE Physician (physician heavy care teams), and >1

- CRNA per FTE Physician (anesthetist heavy care teams)
6. By Government Payer Mix (30% or less, 31 to 49%, 50% or greater)
7. By Number of Trauma Centers
8. Academic Only Practices

Within each section are several table groupings. Some of the important statistics you will *on a per FTE physician basis* are:

- ASA units
- Procedures
- Charges
- Revenue
- Total operating cost, with and without non-physician practitioner (NPP) cost
- NPP cost
- Physician compensation cost
- Physician benefit cost



You will also find many of the same statistics listed above *as a percent of total medical, per anesthetizing location, per procedure type (e.g. surgical cases, labor epidurals, C-sections, other flat fees, etc.) and per ASA unit.*

There is also a section revealing the number of groups who are receiving compensation from hospitals for the services they provide (often called a “stipend”) and the amount of compensation typically received. While numbers such as these can only be used as background, it is interesting to note the high percentage (57%) of groups who must now rely on such compensation in order to be able to recruit and retain providers in a marketplace that is unable to provide such compensation from more traditional sources, such as patients and third party payers. The median amount these groups report receiving from hospitals is over \$1.2 MM, a fairly significant jump from the 2005 report.

In the new pain management section, you will find many of the same types of statistics broken down on a *per physician* and *per procedure* basis. From the report you will be able to discern a typical reimbursement for specific procedure types such as: new patient consults/visits; established patient visits; all other E&M visits; single shot epidurals; transforaminals; sympathetic blocks; facet joint nerve blocks; trigger point injections; nerve stimulators/vertebranstomy, and all other chronic pain procedures. You will also be able to understand the typical mix of consults versus procedures, staffing ratios, patients seen per day, and more.

In short, there is a wealth of information contained within these reports. Hospitals use it, managed care companies use it, and the government uses it. MGMA and ASA recognize this fact and have partnered together in an effort to provide the most comprehensive and representative sample they can for, and in representation of, anesthesiology and pain management practices. The validity of the data, and the ability to break it down into usable formats, depends on participation from all types of groups and practice styles across the country. In an effort to enhance participation, we will be moving to an “every other year” format after this year. MGMA is trying to encourage online submission in an effort to achieve a variety of goals, including: enhancing accuracy of data with built in edits, improving turnaround time, creating the ability to integrate data from this survey with data from other surveys (such as the Physician Compensation and Production Survey) down the road, and enhancing the ability to provide trending information to individual practices. Participants receive a free copy of the survey. Meanwhile, those who did not participate last year can purchase a copy of the 2006 version at a special affiliate price for ASA members by calling 1-877-ASK-MGMA or by visiting either www.mgma.com or the practice management section of the ASA website (www.asahq.org). ▲

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What is Gainsharing?

Gainsharing is a pay for performance model particularly applicable to the anesthesia-hospital relationship. Let's take a step back and look at what gainsharing is, and isn't, on a larger scale.

First, gainsharing is not a healthcare industry-specific notion. In fact, it is a tool that has had general application across industry lines for many years. Roughly speaking, gainsharing is a compensation system that aims to involve workers in improving performance and that, by way of measurement, shares between labor and management the financial gains made.

Gainsharing is not a new concept either. One of the earliest cited examples in the United States is a system designed in the 1930's by a union official named Joseph Scanlon in order to save steel workers' jobs. The "Scanlon Plan" encouraged workers to adopt more efficient production methods by giving them half of the savings generated.

What differentiates gainsharing from other motivational type programs, such as quality circles, six sigma programs and total quality management is that those tools are not linked directly to compensation, while gainsharing is.

Gainsharing is not profit sharing; the system need not have anything to do with profitability, and is generally keyed to lowering costs. But, it can be linked to any number of factors, including quicker performance, exceeding quality baselines and the like. Finally, gainsharing is not individual-specific; rather, it is applied to groups of workers, the aim being to modify overall behavior, and therefore output, however measured.

Although there is no one single type of gainsharing in healthcare, in general, the term has been used to describe programs to align physician incentives with those of hospitals by offering physicians a share of the hospital's variable cost savings. Of course, gainsharing can also include payment for



measured quality improvement and for quicker case turnaround times, as well as for other cost savings or improvements.

Gainsharing and the OIG

The normally independent reimbursement mechanisms applied to hospitals, on the one hand, and physicians, on the other hand, are a hotbed for potential gainsharing arrangements. From the perspective of Medicare, hospitals are paid on the basis of DRGs (Diagnosis Related Groupings); in other words, a fixed fee not tied to the actual cost of providing care, while physicians are paid on a fee for service basis. Under this system, in the absence of gainsharing, physicians are not affected by the actual cost of hospital services, supplies and devices, and therefore, have no incentive to economize or standardize. Gainsharing conforms, to a certain extent, the otherwise differing incentives.

In the early 1990's, I designed what were then novel programs for anesthesia group clients, contracting with hospitals for a significant share of the savings resulting from changes in anesthesiologists' practice patterns. But by the end of the decade, the regulatory winds changed.

In July 1999, the Office of Inspector

General ("OIG") of the Department of Health and Human Services released a Special Advisory Bulletin entitled "Gainsharing Arrangements and CMPs ["civil monetary penalties"] for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries." Special Advisory Bulletins are designed to warn of practices that potentially implicate the fraud and abuse laws subject to enforcement by the OIG.

The Bulletin focused on the Social Security Act's provisions that permit the government to impose a civil monetary penalty, that is, a fine that can be levied administratively, if a hospital makes payment to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's care. CMPs can be tremendous: \$2,000 per affected patient plus \$50,000 per act plus up to three times the amount of the payment offered or made to the physicians as an inducement. Although the OIG conceded in the Bulletin that gainsharing may result in benefits without impacting the care received by Medicare or Medicaid patients, it held fast to the position that, nonetheless, gainsharing violated the CMP provision as the inducement itself violated the law. The OIG's position was that a change in the law was required in order for an

exception to be made permitting gainsharing. Furthermore, the OIG stated that it would not issue advisory opinions (that is, give sanction to a specific deal) regarding gainsharing programs.

Although focused on presenting the issues under the Social Security Act's civil monetary penalty provisions, the Bulletin mentioned that gainsharing also raises concerns under the federal antikickback statute, a statute that is also enforced by the OIG. The antikickback statute prohibits remuneration if at least one purpose of the remuneration is to induce referrals of items or services reimbursable under a federal healthcare program. It's easy to see that if the physician group receiving gainsharing payments also refers patients to the paying facility, there is a potential kickback.

A False Start?

Despite its 1999 position, in January 2001, the OIG issued Advisory Opinion No. 01-01 to address a situation in which a hospital proposed to share with a group of cardiac surgeons a percentage of the hospital's cost savings arising from the surgeons' use of specific supplies and medications during designated cardiac surgery procedures. Advisory opinions, although binding only on the parties to the specific transactions, give a useful glimpse into the considerations the government takes into account; that information helps guide the design of transactions.

Although the OIG concluded that the proposed arrangement violated both the CMP law and the antikickback law, it determined that it would not impose sanctions – this is the language of a favorable opinion.

The cardiac surgery group in the deal was the dominant such group practicing from the hospital. The hospital expected to include the other cardiac surgeons practicing at the hospital in similar gainsharing programs. The hospital engaged a third party to administer the gainsharing program. The program administrator conducted a study and identified nineteen specific cost saving opportunities, which were reviewed for medical appropriateness. The nineteen opportunities were broken down into three categories: (1) opening packaged items only

as needed during a procedure; (2) the substitution, in whole or in part, of less costly items for the items currently being used by the surgeons; and (3) the use of a certain preoperative (should this be: pre-operative? peri-operative?) medication only in respect of high-risk patients.

The program included safeguards intended to protect against inappropriate reductions in services, including the use of historic practice patterns to establish floors below which no cost savings would be shared and the adoption of clinical indicators that had to be followed to assure that services and items would not inappropriately curtailed in an attempt to share in the gains.

The program tracked the savings on each of the nineteen categories and split the savings equally between the surgery group and the hospital. Patients would be given prior written notice of the gainsharing program.

Following the 2001 opinion, the OIG remained silent in terms of advisory opinions on gainsharing for four years. Despite the fact that Advisory Opinion 01-01 gave a green light to the specific deal, most hospitals remained concerned that the general scope of the 1999 Bulletin continued to reflect the government's disapproval of gainsharing arrangements and, therefore, shied away from entering into such deals.

Change in the Tide: 2005

In January and February, 2005, the OIG broke its four year silence and issued six consecutive Advisory Opinions, numbered 05-01 through 05-06, on gainsharing arrangements, finding that all six were structured so as not to warrant either the imposition of Civil Monetary Penalties or prosecution for violation of the antikickback law.

Advisory Opinion No. 05-01 involved an agreement between a hospital and a cardiac surgery group. The hospital engaged an independent third party to study potential cost savings and to administer, the gainsharing program for a fixed monthly fee. The surgeons were to share up to fifty percent of the hospital's savings resulting from the adoption of a number of recommendations to curb the inappropriate use or waste of medical supplies. The recommendations were grouped into four categories: (1) opening certain packaged items only as needed; (2) performing blood cross-matching only as needed; (3) substitution, in whole or in part, of less costly items for items currently being used; and (4) product standardization of certain cardiac devices where medically appropriate.

The OIG stated that the proposed arrangement contains safeguards intended to protect against inappropriate reductions in



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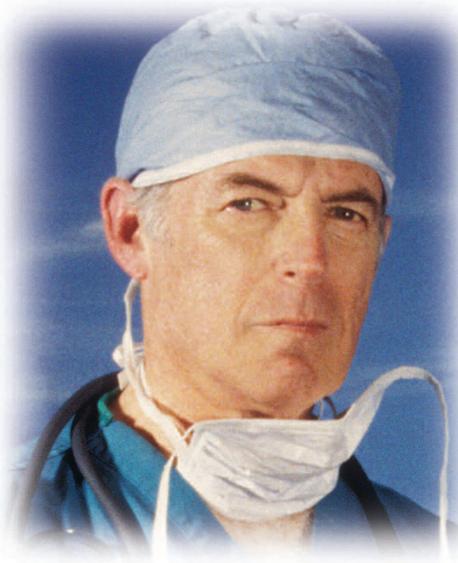
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services, including the use of floors below which no savings would accrue to the surgical group, as well as the continued availability of the same selection of devices as before the gainsharing arrangements were implemented.

Advisory Opinion No. 05-02 involved an agreement between a hospital and five independent cardiology groups. The hospital engaged an independent third party to collect data and analyze and manage the gainsharing program in return for a fixed monthly fee. Under the program, the hospital will pay each group a share of the first year cost savings directly attributable to specific changes in the group's cardiac catheterization laboratory practices to curb inappropriate use or waste of medical supplies.

The eighteen recommendations developed by the third party program manager can be grouped into two categories: The first, standardization of the types of cardiac catheterization devices (stents, balloons, interventional guidewires and catheters, vascular closure devices, diagnostic devices, pacemakers, and defibrillators) used by the group, was to be safeguarded by a process in which the individual cardiologists will make a patient-by-patient determination of the most appropriate device; the full range of devices will continue to be available. The second, limiting the use of certain vascular closure devices to an "as needed" basis for inpatient coronary interventional procedures and diagnostic procedures, was to be safeguarded through the use of objective historical and clinical measures reasonably related to the practices and the patient population at the hospital to establish a "floor" beyond which no savings would accrue to the groups.

Advisory Opinion No. 05-03 involved an agreement between a hospital and a cardiac surgery group. Again, this would be a fifty-fifty split of the first year savings from the adoption of cost saving recommendations described as fitting within four categories, (1) open items as needed, including the disposable components of the cell-saver unit; (2) performing blood cross-matching only as needed; (3) substitution of less costly products with no appreciable clinical significance; and



(4) product standardization of heart valves.

A floor beneath which no benefit would accrue to the surgical group was to apply in the case of the cell-saver and blood cross-matching recommendations. With respect to the product standardization recommendations for cardiac devices, the surgical group certified that the individual surgeons will make a patient-by-patient determination of the most appropriate device and that the full range of cardiac devices will continue to be available. The OIG found no appreciable clinical significance (and, therefore, no potential for violation of the CMP law) in the proposed open as needed policy for items other than the cell saver disposables and in the substitution of less costly items.

Advisory Opinion No. 05-04 involved a series of similar agreements between a hospital and a number of cardiology groups whereby each group would receive a share of the first year cost savings directly attributable to specific changes in the specific group's cardiac catheterization laboratory practices. The program administrator, to be paid a flat monthly fee, identified cost saving opportunities for each group after studying their practice patterns. In general, the recommendations involved changing practices to curb inappropriate use or waste of medical supplies. Specifically, there would be (1) standardization of cardiac catheterization

devices (stents, balloons, interventional guidewires and catheters, vascular closure, diagnostic devices, pacemakers, and defibrillators), where medically appropriate; (2) limitation on the use of certain vascular closure devices to an "as needed" basis, with the devices being readily available in the procedure room (which the groups certified will not adversely affect patient care); and (3) the substitution of less costly contrast agents.

With respect to the "as needed" use of vascular closure devices and the products substitution recommendations, the gainsharing deal would utilize objective historical and clinical measures to establish a "floor" beyond which no savings would accrue to any of the cardiology groups. With respect to the proposed product substitution recommendations, the administrator identified national averages and historic patterns of use and established quality thresholds beyond which no cost savings will be credited. In addition, the physicians would continue to have available the full range of products and will make a determination of substitution on a patient by patient basis.

Advisory Opinion No. 05-05 involved an arrangement between a hospital and a cardiology group whereby the group would receive a percentage of the first year cost savings resulting from adopting the recommendations developed by a program administrator engaged by the hospital for a fixed fee. As in *Opinion No. 05-04*, the subject is reducing cost in the cardiac catheterization lab.

Divided into two categories, the first category consists of product standardization where medically appropriate. The second consists of limiting the use of vascular closure devices to an "as needed" basis for inpatient coronary interventional procedures and diagnostic procedures.

The OIG found there were multiple safeguards in place, including the fact that the vascular closure devices subject to limitation would remain readily available and that the reduction in use will not adversely affect patient care; and the fact that, with respect to the product standardization recommenda-

tion, the individual cardiologists will make a patient-by-patient determination of the most appropriate device and the availability of the full range of devices will not be compromised by the product standardization. Additionally, the OIG was satisfied with the fact that the proposed arrangement would utilize objective historical and clinical measures reasonably to establish a “floor” beyond which no savings would accrue to the cardiology group.

Advisory Opinion No. 05-06 involved a hospital’s proposal to share with a group of cardiac surgeons the first year cost savings to result from the implementation of cost reduction measures. The program administrator engaged by the hospital to implement and oversee the gainsharing program studied historical practices and identified twenty seven recommendations to curb inappropriate and wasteful use of medical supplies. Grouped into four categories, recommendations concerned (1) adopting an open as needed policy for packaged items; (2) limiting the use of certain supplies to those cases for which they are needed; (3) substituting less costly items; and (4) product standardization of certain cardiac devices and supplies where medically appropriate.

In respect of the open as needed policy, the OIG found that the insubstantial time it takes to open a package of supplies is not a perceptible reduction or limitation in the provision of items or services to patients sufficient to trigger the CMP. With respect to the specific product substitution recommendations, the OIG determined that the substitutions will have no appreciable clinical significance and therefore do not constitute a perceptible reduction or limitation in the provision of items or services to patients sufficient to trigger the CMP.

Even though the remaining recommendations involving limitations on use of certain surgical supplies and product standardization would trigger the CMP, the OIG concluded that it would not seek to impose sanctions, as the proposed arrangement protects against inappropriate reductions in services by ensuring that individual physicians will still have available the same selection of cardiac devices.

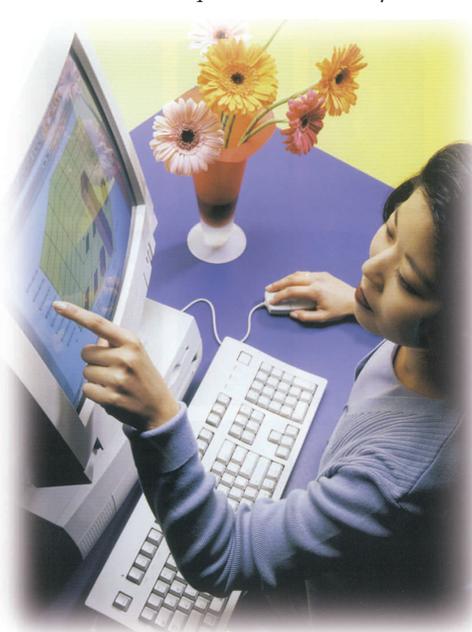
A Stark Contrast?

On the basis of the six gainsharing OIG opinions, it’s obvious that a gainsharing program can be legally structured – at least as concerns the statutes within the OIG’s purview. The problem, of course, is that “Stark,” the federal “self-referral” prohibition, is *outside* of the OIG’s range of authority.

For Stark to be triggered, a physician must make a referral, in respect of a Medicare beneficiary, for certain designated health services. The referral must be to an entity in which the physician, or certain family members, has a direct or indirect financial relationship.

For many physician groups, notably the cardiology and cardiac surgery groups which received the favorable OIG opinions discussed above, Stark is a significant problem, as those physicians clearly refer patients to the gainsharing-paying hospitals.

On the other hand, for anesthesia groups that provide perioperative services only, the chance of a Stark issue is slight, as it is unlikely that the group’s physicians will make referrals – a necessary element of a Stark violation. However, for groups providing, whether alone or in addition to perioperative services, chronic pain management services that refer patients to the gainsharing facility, the Stark issue requires detailed analysis.



It should also be noted that state law may contain similar, or different, antikickback and self-referral prohibitions. If so, solving the Stark and federal antikickback/CMP issues is only part of the compliance analysis that must be performed before any deal is implemented.

What Gain to Share?

Assuming that the relationship between the anesthesia group and the hospital does not present unsolvable compliance issues, possible subjects for gainsharing are very much tied to facts of your specific hospital or surgery center and warrant serious thought and investigation.

For example, possible gainsharing deals might focus on drug cost savings, procedures to split bottles of drugs, or increased O.R. productivity based on case turn-around times. In fact, let me turn this around on you, the reader: Send me your suggestions on other possible gainsharing “targets” for a follow up article and, if you’re the first to make a specific suggestion, I’ll send you a copy of my book on anesthesia employment agreements.

It’s clear that both the regulatory trends and the willingness of payors to adopt performance-linked payment make this the right time to consider possible gainsharing deals. As with most other economic arrangements with facilities, one of the key factors in negotiating a successful gainsharing program is to implement a long term strategy to make the facility well aware of the benefits that the group provides, as well as of the potential additional value that it can help create.

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DIVINING THE FINANCIAL POTENTIAL OF ULTRASOUND

By Jody Locke, CPC



Technological developments in medicine tend to fall into two categories: dramatically new breakthroughs and the clever application of existing technology to new applications. Despite the enthusiasm of practitioners involved with the introduction of a new technique or approach to an age-old problem, reimbursement tends to favor incremental advances over quantum leaps. The insurance industry has a frustrating tendency to view any new clinical solution with skepticism until the evidence has been carefully considered and validated, a process that may involve numerous changes of position over time.

The development of the fluoroscope, while based on radiological concepts, represented a quantum leap in the ability to visualize the anatomy on a real-time basis. Its value to the pain management physician has now been clearly demonstrated through empirical assessment. Based on this evidence insurance plans, for the most part, have acknowledged the additional costs of the fluoroscope in allowing separate reimbursement when fluoroscopy is used for needle guidance for most nerve block procedures. But such was not always the case. For years pain management physicians complained persistently as the pendulum of reimbursement swung from one extreme to the other before finally resulting in its current position. Before this would happen, though, new CPT codes specifically defining the nature of the service to be reimbursed would have to be created and accepted by payors as an integral part of their fee schedules. Some may argue that codes 77002 (formerly 76003)

and 77003 (formerly 76005) still do not adequately compensate the practitioner but at least the uncertainty has been resolved.

Now ultrasound is being used with increasing frequency for the same or a very similar application: the visualization of needle placement for nerve blocks in the pain clinic. For all the enthusiasm of its promoters, age old questions are being asked in an effort to determine whether the time and effort necessary to master the application will bear similar results. On the one hand, the convenience of the technology holds great promise, while at the same time suspicion clouds the value of the investment and its potential for financial return. It is a familiar story; we just don't know how it will end.

The arcane process that leads from the introduction of a new medical technique or procedure to consistent and appropriate reimbursement is neither linear nor predictable. It is, instead, a curious interplay of a variety of clinical, political and economic factors, the slightest change in the relative proportion of which can dramatically affect the outcome. Who proposes a solution and who disposes of its value can be key factors in the outcome. As in so many things, timing is everything.

The clinical value of new technologies must be proven on its own merits long before the editors of the CPT (Current Procedural Terminology) will consider its inclusion. As in so many things, a credible champion can move this process along fairly expeditiously. The problem is that many techniques have attained the status of numerical codification in CPT without ever becoming incorporated into payor fee schedules. It is an important first step.



Consider the fate of two distinct approaches to endotracheal intubation. The use of a fiberoptics for resolution of difficult intubations was never recognized as a separately reimbursable service, its use in the performance of a bronchoscopy notwithstanding, while the insertion and placement of double lumen tubes did form the basis for new codes specifically reimbursing anesthesiologists for one lung techniques. Today ASA codes 00529 (11 units), 00541 (15 units) and 00626 (15 units) ensure a positive reimbursement differential when the use of one lung anesthesia is clearly documented.

Anesthesiologists should make a special note that while the ASA Relative Value Guide was accepted by Medicare in the 1980s, subsequent updates must all be evaluated on their own merits. To wit, the

ASA attempted to address payor policy issues concerning reimbursement for TEE (Trans-esophageal Echocardiography) with the introduction of a TEE monitoring code (93318), but the inclusion of the code accomplished little and has yet to be recognized by a major insurance plan. The message here is that while it is essential to have an appropriate code, a code does not ensure reimbursement.

The good news for the pain practitioner eager to apply ultrasound guidance to needle guidance for nerve blocks is that ultrasound is already recognized by CPT. The anesthesiologist hoping to use fluoroscopic guidance in the routine performance of a block for a regional anesthetic or for purposes of post-operative pain management cannot hope to see any additional reimbursement for the use of ultrasound. What remains to be proven is whether the historical CPT description fits the new application. Code 76942 can be found in the radiology section. As such a few caveats must be noted. Radiology services have two components, a technical and a professional component. As a general rule of thumb, the technical component is worth significantly more than the professional component. A place of service differential can also result in some very curious disparities between the facility fee, so named because the facility gets a separate payment, and the non-facility fee. Claims for reimbursement must be clearly identified by use of an appropriate modifier and place of service indicator. The impact of all these factors on reimbursement for the Detroit metropolitan area for 2007 is indicated in the table shown.

Lest the reader be left with the wrong impression here, the typical provider is only entitled to the lowest rate indicated. Very specific criteria must be met for the individual practitioner or practice to be entitled to either the technical component or the facility fee itself. These are intended to reimburse the facility for both the technician and the overhead.

Code on claim	Component	Facility Allowable	Non-Facility Allowable
76942-TC	Technical		\$138.70
76942-26	Professional	\$35.45	\$35.45
76942	Global		\$174.15

As if all these distinctions are not confusing enough, anesthesiologists often get distracted by the inclusion of these same services in their own ASA Relative Value Guide. ASA Relative Value units have nothing to do with reimbursement potential of services paid based on a fee schedule basis. A recent MGMA list serve discussion of the value of ultrasound focused on strategies to obtain a two unit reimbursement. Unfortunately, such a focus misses the point. A reimbursement consultant with a national billing company wrote that “many of my providers are using ultrasound guidance for regional blocks and I am seeing exactly that (extra 2 units) being reimbursed for this technique.” None of us dispute his claim that ultrasound may well replace fluoroscopy as a more practical and convenient way to accurately target pain-inducing anatomy; the question is whether the reimbursement community will assess the convenience of the tool and its potential to be a standard of care and determine that it is a bundled service and not worth separate reimbursement.

What we must also not forget is that reimbursement is the product of some very simple but fundamental economic principles. Average fee schedule allowances for epidural steroid injections have gone down over time in inverse proportion to their frequency of administration. The law of supply and demand suggests that the more a particular service is performed the less payors need to pay for it. In other words, the payor view is that they obviously do not need to provide a financial inducement to physicians to perform it. It is the dramatic growth in claims for CPT Code 62311 (the

best code for spinal injections) that has also prompted most Medicare intermediaries to implement LCDs (Local Coverage Determinations) to warn practitioners of the potential for abuse.

There is a tendency to look at current reimbursement data for a particular service and draw conclusions about the future of reimbursement. Pain management reimbursement consultants are all too familiar with the three phases of reimbursement for a new service. Many claims for valid codes get paid without question until the payors start to understand what the claims are for. Anyone who was involved with getting paid for IV PCA a decade ago understands how misleading reimbursement data can be. Once claims



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DIVINING THE FINANCIAL POTENTIAL OF ULTRASOUND

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adjudicators begin to identify a pattern they start questioning the medical necessity of the service. For many services, like IV PCA, this is the kiss of death. Others, such as TEE survive after considerable debate, policy clarification and the implementation of specific reimbursement guidelines. (TEE is now reimbursable by most Medicare intermediaries if the anesthesiologist completes a report documenting his or her assessment of valvular function and hemodynamic efficiency.) To achieve permanent status on payor fee schedules (the third phase of the process) a number of specific criteria have to be met.

First, the service or technique must have a clear and obvious clinical value. There must be evidence that additional reimbursement is necessary to induce providers to perform the service. This may pertain to the cost of the technology or the skill and training of the practitioner to perform the service reliably. There must also be a compelling argument to unbundle the reimbursement. Payors are especially suspect of every attempt to unbundle a particular service and would rather increase reimbursement for an existing service if the standard of care has changed than allow extra reimbursement under a second code. There is no better example of this phenomenon than Aetna's approach to reimbursement for fluoroscopy a couple of years ago. Seemingly out of the blue and without warning Aetna started denying claims for fluoroscopy claiming that since it had become a standard of care for the administration of nerve blocks the reimbursement should be tied to the block code and not the separate fluoroscopy code. Because CMS had already addressed the issue and come to a different conclusion Aetna policy eventually changed to conform to an industry norm. The problem for proponents of ultrasound guidance for nerve blocks is that there is no such Medicare precedent.

Even when reimbursement guidelines appear to have been resolved they are often subject to capricious revision. Any number of factors can trigger a post-payment review of a particular service. A routine audit of claims for single shot and continuous femoral and axillary blocks by Blue Shield of Louisiana led its executives to conclude that nerve block techniques performed as an adjunct to an anesthetic, even a general anesthetic, should not merit separate reimbursement and that, moreover, all monies paid out over the course of the past year for such services were paid in error and must be refunded. Unfortunately, this is a not uncommon occurrence in the world of reimbursement. Despite our desire to assume that being paid for a service constitutes legitimate reimbursement, this is not always the case and nothing is more frustrating than to have to pay back monies to which we thought we were entitled.

Clearly, the value of a medical service

should not be assessed only in terms of reimbursement potential. Such thinking demeans the specialist and only feeds payor cynicism with regard to physician motives. If a service is valuable and truly justifies separate reimbursement, its costs, risks and benefits should be argued with reliable and empirical data. Just as we should not be too quick to accept current reimbursement patterns as a prediction of future revenue potential, neither should we be deterred by the political and strategic challenges to a reasonable fee schedule payment. Wanting to get paid for a particular service and believing it has value is not enough. Demonstrating the value, however, and getting those who hold the purse strings to accept it is an entirely different matter and a goal worthy of persistent commitment. If there is one thing the experience of the past few decades has taught us, it is never easy to predict how reimbursement decisions will ultimately get resolved. ▲



Coding Corner

THE FUTURE OF CODING – ICD-10-CM AND ICD-10-PCS

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and The International Classification of Diseases, Tenth Revision, Procedure Classification System (ICD-10-PCS).

Currently 138 countries have implemented ICD-10-CM for mortality reporting and 99 countries have implemented it for morbidity reporting, with the United States still using the ICD-9-CM system it is difficult to compare our health data with international data. Although, the United States implementation of either one of these systems has not been announced, draft legislation contains a provision to implement ICD-10. Implementation will be based on the process for adoption of standards under the Health Insurance Portability and Accountability Act (HIPAA). There will be a two-year implementation window once the final notice to implement has been published in the *Federal Register*.

If passed, HR 4157, The Health Information Technology Promotion Act, would require the Secretary to implement ICD-10-CM and ICD-10-PCS on October, 1, 2009.

Benefits

- ❖ Improvements to the quality of care and patient safety.
- ❖ Fewer rejected or questionable reimbursement claims.
- ❖ Improved information for disease management.
- ❖ More accurate reimbursement rates for emerging technologies.
- ❖ Better understanding of the value of new procedures.

Major changes in the ICD-10-CM include:

- ❖ 21 chapters (ICD-9 has 17).
- ❖ The E-codes and the V-codes are

incorporated within the new system rather than the current supplementary classifications.

- ❖ Identification of trimesters to obstetrical codes.
- ❖ Expanded diabetes, injury, alcohol/substance abuse, and post-operative complications.
- ❖ Ability to report laterality (to specify whether a medical condition occurred on the right or left side).
- ❖ Standard definitions for “excludes” notes.
- ❖ Combination diagnosis/symptoms codes.
- ❖ Identification of initial encounter, subsequent encounter, and sequelae of injuries.
- ❖ Expanded external causes of injuries.
- ❖ Improved clinical detail.
- ❖ Addition of a sixth character.
- ❖ Addition of a seventh character extension in some chapters. (ICD-9, max 5).

The ICD-10-CM is published by the World Health Organization (WHO) you may find the guidelines for the use of this classification in the *Official Coding and Reporting Guidelines* of ICD-10-CM (www.cdc.gov/nchs/icd9.htm).

Major changes in the ICD-10-PCS include:

- ❖ 15 sections in the ICD-10-PCS with almost eighty eight thousand codes compared to the maximum of ten thousand codes of our present system.
- ❖ Consists of alphanumeric codes rather than all numeric codes. The current system contains a maximum of four numbers with a decimal point, the new system has a maximum of seven characters with no

decimal point.

- ❖ The includes and excludes notes are not included in the new system.
- ❖ All codes have a unique definition
- ❖ Ability to aggregate codes across all essential components of a procedure.
- ❖ Extensive flexibility.
- ❖ New procedures and technologies are easily incorporated.
- ❖ Code expansions do not disrupt systematic structure.
- ❖ Limited use of NOS and NEC categories.
- ❖ Terminology is precisely defined and used consistently across all codes.
- ❖ No diagnostic information is included in the code.
- ❖ Increases accuracy and efficiency by being able to recognize and report the procedures performed.

For detailed information on the development of ICD-10-PCS visit the CMS Web site: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.asp

As our world grows smaller the need for accurate health data will benefit us all.



PROFESSIONAL EVENTS

DATE	EVENT	PLACE	CONTACT INFO
Aug. 4-8, 2007	American Association of Nurse Anesthetist Annual Meeting	Denver Convention Center, Denver, CO	www.aana.com
Sep. 27-30, 2007	New England Society of Anesthesiologists Fall Annual Conference	The Mount Washington Hotel, Bretton Woods, NH	www.nesa.net
Sep. 14-16, 2007	Ohio Society of Anesthesiologists Annual Meeting	Cincinnati Westin Hotel, Cincinnati, OH	www.osainc.org
Oct. 12, 2007	American Society of Critical Care Anesthesiologists Annual Meeting	Grand Hyatt, San Francisco, CA	www.ascca.org
Oct. 12, 2007	Society for Ambulatory Anesthesia Mid-Year Meeting	San Francisco Hilton, San Francisco, CA	www.sambahq.org
Oct. 12, 2007	Society for Pediatric Anesthesia Annual meeting	Hilton San Francisco, San Francisco, CA	www.pedsanesthesia.org
Oct. 12, 2007	Society of Neurosurgical Anesthesia & Critical Care Annual Meeting	San Francisco, CA	www.snacc.org
Oct. 13-17, 2007	ASA Annual Meeting	Mascone Center, San Francisco, CA	www.asahq.org
Oct. 13, 2007	American Association of Clinical Directors Annual Meeting	San Francisco, CA	www.aacdhq.org
Oct. 28-31, 2007	MGMA Annual Conference	Pennsylvania Convention Center, Philadelphia, PA	www.mgma.com
Nov. 2-4 2007	Association of Anesthesiology Program Directors/Society of Academic Anesthesiology Chairs Annual Meeting	Mandarin Oriental, Washington, D.C.	www.aapd-saac.org
Nov. 12, 2007	Minnesota Society of Anesthesiology Fall Meeting	Crowne Plaza Northstar, Minneapolis, MN	http://www.mmaonline.net/SpecialtySocieties/msa.cfm
Dec. 7-11, 2007	New York State Society of Anesthesiologists Postgraduate Assembly in Anesthesiology	New York Marriott Marquis, New York, NY	www.nyssa-pga.org
Jan. 25-27, 2008	ASA Conference on Practice Management	Tampa Marriott Waterside Hotel, Tampa, FL	www.asahq.org
Apr. 30-May 4, 2008	Society of Obstetric Anesthesia and Perinatology Annual Meeting	Renaissance Chicago Hotel, Chicago, IL	www.soap.org
Jun. 18-22, 2008	Society of Cardiovascular Anesthesiologists Annual Meeting	Vancouver Convention Center, Vancouver, BC, Canada	www.scahq.org
May 17-18, 2008	MGMA Pain Management Preconference	Philadelphia Marriott Downtown, Philadelphia, PA	www.mgma.com
May 18-21, 2008	MGMA AAA Annual Conference	Philadelphia Marriott Downtown, Philadelphia, PA	www.mgma.com



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