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# WHY THE COST OF ANESTHESIA CARE MATTERS

by Jody Locke

*Vice President of Anesthesia and Pain Management*

Have you heard about or seen the Hospital Corporation of America (HCA) white paper, 'How to control the rising cost of anesthesia care'? Having spent over \$96 Million in anesthesia subsidies last year alone, HCA has gone on the offensive by arming its legions of hospital CEOs with not only a logical framework for cost management but a team of anesthesia contract specialists whose job it is to carefully assess the economics of every anesthesia contract before it is renewed. The primary focus of the team is to assess the reasonableness of each private group's request for support and the compensation they believe they are entitled to. Almost as important is the analysis of the hospital's coverage requirements. More often



than not, the review process results in resetting expectations for both anesthesia

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# ANESTHESIOLOGY'S ROLE IN EFFECTIVE OR GOVERNANCE

By Jerry Ippolito, President

*OR Efficiencies, LLC*



**Jerry Ippolito**

Last year the publishers of the *Communiqué* asked me to comment on whether anesthesiology should have a role in OR schedule planning and administration. I feel so adamantly about this matter that I titled the article "Who's Really Running

Your Business" – I chose that title because if anesthesiology does not participate in schedule planning and administration, then anesthesiology can only react to the decisions of others. The same holds true with regard to OR program governance. When anesthesiology does not take a proactive role in fostering and enforcing effective governance, then anesthesiology will remain in a reactive mode and will

not be able to optimize satisfaction levels of its customers (surgeons, administration, nursing, and last but not least the patient).

Too frequently we hear of anesthesia referred to by nursing and administration as "A Necessary Evil". In my experience anesthesiology typically has a sound grasp on what is necessary to run an efficient and marketable OR program.

## EBB AND FLOW

August is here. For most of us this is the time of year when we strive to enjoy family, the weather, and hopefully a little extra time away from the rat race. Ever since I was a kid, the big event of the season was the family vacation. Some, of course, were more memorable than others. There was always a certain sense of adventure about the entire enterprise. It was not uncommon for us to have as much fun planning the trip as executing it. I always liked the contemplation of options and the exploration of possibilities in my mind. Somehow just the idea of a change in routine seemed to have a very restorative effect on all of us.

The other thing I have noticed about this time of year is that you hope you can sneak away without anything going wrong or unraveling while you are on vacation. I must confess I was rather nervous that Congress would not act in time to avoid a cut in the Medicare rate. Having given anesthesiologists a most favorable increase in the conversion factor in January it seemed like we were slipping into an all too familiar pattern. Now I know I can relax a little, not that there aren't other reimbursement issues looming on the

horizon, but they can wait till fall as far as I am concerned.

Whatever your plans for the next couple of months, I hope you find a comfortable retreat far from the madding crowds to read and ponder the various perspectives we have compiled in this issue of *Communiqué*. As always, we have striven to find authors who will help you explore and better understand the ever-changing face of anesthesia practice management. You will note we cover the spectrum with some insightful pieces on basic business issues such as the importance of managing the cost of anesthesia care and your role in O.R. management. We thought you might be interested in one physician's opinion on Aquavan. There is also a most relevant and practical discussion of the Roth 401(k). Whether you agree with our authors or not does not matter. Our goal is to bring you new perspectives on topics of the day so that you can gain some perspective on your own practice situation.

If there is one thing I have learned over the nearly 30 years I have been in this business, it is that healthcare is subject to incredible ebb and flow. This year's threat of a Medicare rate cut only reminds

us that anesthesia practice management is a lot like financial planning; you can never really celebrate your successes nor feel too bad about your setbacks, because sometimes they are two sides of the same coin. You just have to hope that you have a reasonable and appropriate long-term strategy so that you continue to have some degree of control of your own destiny versus having it imposed on you by others.

Let us hope that your practice situation is secure and that you have the luxury of contemplating some of the ideas presented in the following pages. May your time with family and friends be pleasant and a source of happy memories. We always welcome and appreciate feedback and comments on our authors' ideas. Maybe you will even be sufficiently inspired to share some of your own. After all, if it weren't for you and this challenging business we wouldn't be here.

Sincerely,

Tony Mira, founder and CEO



Maintaining program efficiencies and garnering new business is even more important to anesthesiology than to the hospital as an anesthesiology group does not have the same level of financial reserves as a hospital. Unfortunately however, rather than being a “Champion” for program reform by promoting program development, anesthesiology typically points fingers at administration and nursing. Due to the perception of anesthesiology being a “necessary evil” or “having an agenda of its own”, regardless of how sound recommendations may be, nursing and administration seldom listen to anesthesiology.

A lot is written in the literature these days as to whether or not anesthesiology should be running the OR. Running the OR and fostering development of effective governance are two different issues. I was recently interviewed by the publication *OR Manager*, and asked whether anesthesiology or nursing should run the OR. My response was that if effective governance is in place, then it does not matter which constituency of the four-legged stool (anesthesiology, nursing, surgeons, or administration) runs the OR on a daily basis. Running the OR is the implementation, execution, and enforcement of the policies and procedures developed by the governance body. Some feel that anesthesiology should run the OR because in order to maintain an effective OR program physicians must be positioned to police physicians. Others feel anesthesiology should run the OR as OR Directors come and go from institutions and anesthesiology is generally a more stable entity. Lastly, there is a school of thought that anesthesiology should run the OR because anesthesia is “ever-present” in the OR.

I don't totally disagree with any of this thinking, but I must indicate that making anesthesiology the “policeman” of the OR without holding other

constituencies accountable will only result in fostering the reputation of that “necessary evil”. About seven years ago I was engaged by a major mid-Atlantic university hospital to assist in improving operating room efficiencies. To this day I use this case study as an example of what happens when effective governance is lacking. In this instance the Chairman of the Department of Anesthesiology was sponsoring the engagement for the hospital. The anesthesiology chair had been directed by the Dean of the university and hospital CEO to “fix the OR”. The OR was totally dysfunctional; surgeons did whatever they wanted whenever they wanted; the environment was total chaos. The Chair continues to be a highly regarded individual and has a sound grasp of what is required to maintain an effective OR program. The Chair proposed sound strategies for change and promoted sound policies and procedures. Needless to say the Chair remained very frustrated as progress was not being made and it was alleged to be the fault of anesthesiology. Progress was not being made as only one

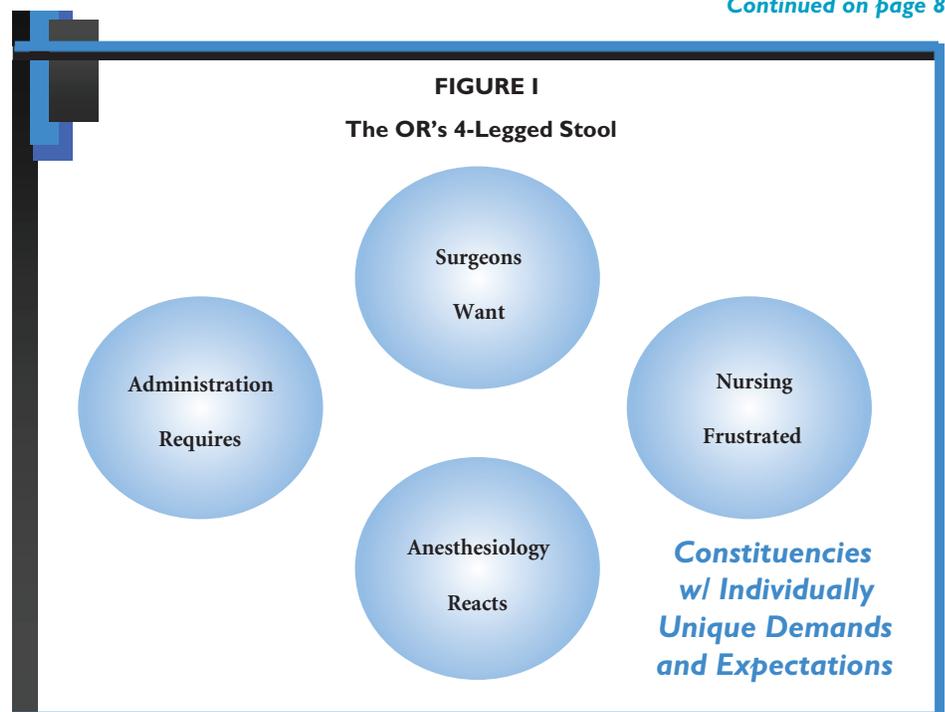
constituency of the four legged stool was being held accountable: anesthesiology. I was simultaneously engaged at a university on the opposite side of the city where effective governance was developed and each of the constituencies was held accountable. Anesthesiology championed the process through its “ever-presence in the OR” and there was tremendous progress.

Generally when there is a lack of effective governance silos develop among the four constituencies and it is difficult to have effective program management and optimized satisfaction levels among the constituency members. Indeed each of the constituencies does have an agenda (see Figure 1 below).

### THE OR'S 4-LEGGED STOOL

Typically in siloed environments constituency members maintain an expectation that their wants and needs will be fulfilled, by others, to a 100 percent level, 100 percent of the time. In this environment constituency members do

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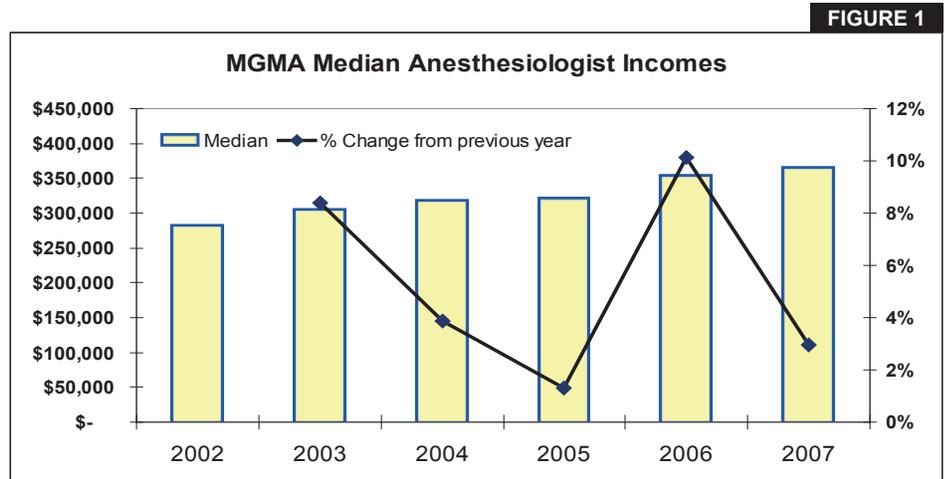


## WHY THE COST OF ANESTHESIA CARE MATTERS

*Continued from page 1*

provider compensation and the CEO's expectations of unrealistic staffing and call. It is unclear exactly how the other hospital networks will follow suit, but one thing is absolutely certain; renegotiating an anesthesia service contract is no longer what it once was. Maintaining the financial viability of the practice is not a simple matter of drawing a line in the sand any more.

There is no question that the most significant factor in the cost calculation is compensation. Every request for financial support starts with an estimate of what the providers should be paid for the services they provide. Ever since the publication of the Abt Report in 1994 anesthesia compensation requirements have tended to be based on national perceptions of comparability. Given a national manpower shortage,



most anesthesiologists and CRNAs believed they were entitled to the same compensation they could get elsewhere. The result was a substantial increase in overall compensation levels across the country. According to MGMA surveys the average physician compensation

increased by 10% from 2005 to 2006 alone (based on 2004 and 2005 survey data). It stands to reason that the source of this additional compensation was primarily the result of hospital subsidies and not better contract rates with payors or a wholesale improvement in collection performance by billing companies and private anesthesia office staff.

It should not surprise any reasonable observer of the anesthesia marketplace that a sharp spike in income and income expectations will trigger a reaction. Since anesthesiology groups are using the MGMA survey data as the basis of their requests for more support, hospital CFOs are starting to question the numbers with ever more care. Inevitably the survey data is proving to be as much of an obstacle as an argument for anesthesia requests for subsidies. The reason is simple; the tide has turned. With an increase in the supply of qualified providers, hospitals are beginning to look more at their own bottom line than the possibility of losing their anesthesia groups. To some this shift is perceived as counter-intuitive. In an effort to control costs long-term, a growing number of hospital CEOs are revealing that they are willing to pay considerably more in the short term to



change anesthesia groups even if it means relying on locums for a period of time. The message seems to be that hospitals are growing restive and considerably less willing to give in to requests for financial support that will continue to increase anesthesia provider compensation in the face of declining overall hospital profits. They must be on to something, because anesthesia practices seem to be backing down and accepting what they are being offered with increasing frequency. The evidence of this change in attitudes is both empirical and statistical. The most recent MGMA compensation survey shows only a nominal increase (3%) in median compensation from the previous year (see Figure 1).

There is a lesson in this for the specialty as a whole. Just as businesses must constantly find ways to manage their cost of doing business to remain profitable, so must anesthesia group managers and administrators find ways of maintaining their own competitive advantage in an increasingly competitive market. While it is true that some businesses have more options than others – banks did away with tellers and airlines did away with food – no business or specialty is immune from the need to be as efficient and effective in the delivery of services as possible. The days of supplier-induced demand have long since disappeared. Every anesthesia group that gets financial support from its hospital today would do well to develop alternative strategies in anticipation of the elimination of that support.

Unfortunately, traditional cost management strategies only go so far in the delivery of anesthesia services. A group practice can increase its deductible for healthcare, shop around for cheaper malpractice or renegotiate its contract for billing services, but none of these

ultimately has as significant an impact on the cost of service as the number of staff required to provide the service.

Fortunately, anesthesiology has some strategic options not as readily available to other medical specialties. The most obvious of these is the potential to leverage more expensive physician time with less expensive CRNA time. Just as high-priced lawyers rely on junior lawyers and paralegal assistants to perform the less demanding aspects of their job, so too have anesthesiologists in most parts of the country, except the far west, perfected the medical direction model. The fact is that it is virtually impossible for a physician-only practice to compete on price with a careteam practice without lowering the compensation expectations of the anesthesiologists. In addition, we all know that the best possible situation for an anesthesiologist is to work with hospital-employed CRNAs. To a large extent this explains deltas in average compensation between the west and the rest of the country.

There is no question that a careteam approach to the administration of anesthesia services will maximize the income of the physicians so long as there is a reasonable differential in the total compensation package between the anesthesiologist and the nurse. Conventional wisdom suggests that if the total physician compensation package is 2.5 times that of the CRNA there will be a slight cost advantage at an average medical direction ratio of 1 physician to 2 nurses and a material cost advantage at an average medical direction of 1:3. In other words, there is no question that the more leveraged a practice is, the more cost effective the delivery of service. As we all know, though, cost is not the only factor in determining the configuration

TABLE 1

The Impact of Staffing and Productivity on the Cost of Anesthesia per Location Day

Practice #	Anesthesia Physicians	FTE Employed CRNAs	Cost per Anesthetizing Location per Day
1	15.2	50.2	\$1,381
2	3.4	9.2	\$1,511
3	5.2	12.8	\$1,582
4	38.0	91.4	\$1,601
5	20.0	42.8	\$1,701
6	8.4	14.2	\$1,943
7	9.4		\$1,946
8	15.8		\$1,946
9	13.4		\$1,946
10	21.6		\$1,946
11	11.4		\$1,946
12	6.0		\$1,946
13	7.0		\$1,946
14	13.6		\$1,946
15	27.4		\$1,946
16	3.0		\$1,946
17	16.6		\$1,946
18	34.4		\$1,946
19	7		\$1,946
20	20.0		\$1,946
21	9.6		\$1,946
22	8.0		\$1,946
23	6.8		\$1,946
24	21.0		\$1,946
25	28.4	2	\$2,001
26	18.8	5.2	\$2,165
27	18.0	5	\$2,166
28	24.0	10.4	\$2,289
29	14.4	6.6	\$2,309
30	19.2	24.6	\$2,310
31	19.2	9.8	\$2,350
32	14.8	7.6	\$2,352
33	19.0	11	\$2,404
34	10	12	\$2,413
35	17.4	20.4	\$2,451
36	14.2	10.2	\$2,514
37	26.4	19.2	\$2,522
38	9.0	6.6	\$2,526
39	13.0	10.4	\$2,579
40	11.6	10.2	\$2,642

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# WHY THE COST OF ANESTHESIA CARE MATTERS

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of the careteam. More often than not, historical, philosophical, and practical considerations involving the availability and cost of CRNAs will also play a significant role in any consideration of modification to an existing model.

The data in Table 1 on page 5 were developed to objectively assess the impact of staffing models and provider productivity on the overall cost of anesthesia care. The data are based on a sampling of ABC client data for 40 practices, carefully reviewed and compiled for this purpose. These are all private anesthesia practices, which have been with the company for at least year. They represent clients all across the country with consistent books of business, i.e. none is in a ramp-up mode for any of its main facilities. FTE staffing levels were based on a standard metric of days worked and assumed that an FTE physician or CRNA would take 6 weeks of vacation. The significant disparity in the cost per day of coverage for an anesthetizing location is the result of both productivity and coverage requirements, which will be discussed in more detail below.

On the one hand, the data raise a very interesting question: how can the cost of

**TABLE 2**

	Feb-06			Mar-06			Apr-06			May-06		
	Average Hours per Location Day	Average Hours per Day Shift	% of Hours performed during day	Average Hours per Location Day	Average Hours per Day Shift	% of Hours performed during day	Average Hours per Location Day	Average Hours per Day Shift	% of Hours performed during day	Average Hours per Location Day	Average Hours per Day Shift	% of Hours performed during day
N1	4.9	4.3	87.4%	4.8	3.8	78.2%	3.8	3.4	88.5%	4.5	3.8	83.8%
N2	4.9	4.1	84.0%	5.8	5.0	84.9%	4.2	3.6	84.9%	4.7	4.0	85.1%
N3	4.5	3.5	78.3%	6.0	4.6	76.9%	5.0	4.0	80.9%	5.6	4.1	72.6%
N4+N5	5.7	4.0	69.8%	5.9	4.5	76.6%	4.9	3.7	74.2%	5.6	4.2	75.6%
CYSTO	2.1	1.4	67.7%	2.7	1.7	64.5%	2.9	1.6	54.9%	3.1	1.8	58.8%
M1	6.5	4.3	66.6%	6.7	4.5	66.8%	6.1	4.4	72.0%	6.8	5.0	72.6%
M2	6.0	4.0	66.1%	7.3	4.7	63.9%	5.4	3.1	57.1%	6.4	3.9	60.8%
M3	6.4	4.2	66.5%	6.9	4.6	66.6%	5.7	3.7	63.7%	5.9	3.7	63.1%
M4	6.1	4.6	74.5%	6.6	4.2	62.8%	5.1	3.4	66.0%	6.5	4.3	66.6%
M5	5.1	4.2	81.6%	6.0	4.4	72.5%	4.9	3.8	76.9%	6.3	4.3	67.2%
M6	5.6	4.7	83.2%	6.7	5.2	76.9%	4.9	3.5	71.5%	5.4	4.4	82.6%
M7	5.6	2.8	50.5%	5.9	3.1	52.2%	5.0	3.2	63.6%	4.9	3.0	61.0%
M8	5.1	4.0	77.9%	6.6	4.5	68.5%	4.3	3.2	74.9%	5.6	4.3	76.4%
M9	6.7	4.3	64.8%	8.4	5.0	59.0%	7.0	4.2	60.0%	7.2	4.5	62.5%
M10	6.3	3.9	62.7%	7.8	4.6	58.6%	6.5	4.0	61.7%	7.7	4.6	59.6%
M11	6.9	3.7	53.9%	8.0	4.7	58.7%	7.8	4.1	53.7%	9.0	4.2	47.0%
M12	6.1	2.1	34.5%	6.6	2.6	39.3%	6.2	2.1	34.1%	6.6	2.8	42.1%
M14	6.3	4.6	73.3%	5.8	4.5	76.9%	7.3	4.2	57.5%	6.4	4.7	73.7%
M15	6.5	3.8	59.4%	6.4	4.3	66.7%	6.1	4.2	69.6%	6.4	4.0	62.5%
M16	6.7	4.3	63.9%	8.6	4.6	53.1%	7.5	4.6	62.1%	7.3	4.7	64.5%
3E#5	6.2	5.1	81.7%	7.5	5.2	69.2%	6.9	5.1	73.9%	6.0	5.1	84.5%
3E#6	6.0	3.3	54.2%	6.3	4.0	62.9%	5.1	3.5	70.2%	5.7	3.0	53.1%
4E#1	6.9	5.1	74.0%	6.4	5.2	80.7%	6.9	4.9	70.4%	7.0	5.0	72.4%
4E#2	6.3	5.1	80.8%	7.0	5.6	80.2%	5.4	4.0	74.5%	6.9	5.7	82.1%
4E#3	5.9	4.4	74.4%	6.9	4.9	70.8%	5.7	3.7	65.5%	6.6	3.9	59.5%
4E#4	6.1	4.5	72.7%	7.0	5.1	73.4%	5.8	4.5	77.9%	6.7	4.9	72.1%
Robot	7.7	3.4	43.5%	6.9	3.0	43.3%	6.4	3.1	48.0%	7.5	3.2	42.9%
Unknown	1.4	1.0	72.2%	1.1	0.6	58.2%	0.9	0.7	77.7%	2.0	1.6	79.0%
Average per Day	159	104	65.5%	178	115	64.6%	153	98	64.0%	169	108	64.1%
Average per Room Day	5.9	4.0	68.1%	6.6	4.4	67.1%	5.7	3.8	66.4%	6.2	4.2	66.6%

covering one anesthetizing location for a day be so much higher in one location than another? The short answer is because it can be. In other words, there is sufficient revenue, either from fee-for-service collections or from a combination of fee-for-service collections and hospital support to justify such a cost structure. On the other hand, the data clearly indicate just how much the cost can be reduced if it must. Ironically, what the data also demonstrate is that the careteam does not always result in lower costs if the nurses are not managed in an economically advantageous or significantly leveraged mode.

It is worth noting here that it is not uncommon for subsidy discussions to focus on an average cost per location day of \$1,950, which is the cost of a physician providing coverage alone. This is approximately what results if the total

cost of an anesthesiologist is \$430,000 (W2 income, benefits, malpractice and overhead) and is divided by 221 days (365 days minus 108 weekend days, 6 holidays and 30 days of vacation).

Clearly the careteam is no panacea, nor a guarantee of above average physician compensation. For all the advantages of economic leverage, if the practice does not generate adequate revenue from professional service collections it doesn't matter how carefully the pie is divided. There can also be significant offsetting considerations to the careteam model including decreased provider productivity, management costs, and provider availability and turnover in staff. There is a prevailing belief in the Western states that the inclusion of CRNAs in the delivery model is not a desirable option. The more a practice

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# UNDERSTANDING THE ROTH 401(k)

Jill E. Thompson

Vice President of Financial/Consulting Services

As the name suggests, a Roth 401(k) combines features of the traditional 401(k) with those of the Roth IRA. It's offered by employers like a regular 401(k) plan, but as with a Roth IRA, contributions are made with after-tax dollars. While you don't get an upfront tax-deduction, the account grows tax-free, and withdrawals taken during retirement aren't subject to income tax, provided you're at least 59 1/2 and you've held the account for five years or more.

The Roth 401(k) concept was introduced with the Economic Growth and Tax Relief Reconciliation Act of 2001, which stipulated that employers could start offering these plans on Jan. 1, 2006. So far, 12% of all employers offer a Roth 401(k), according to Hewitt Associates, an employee benefits consulting firm, and 32% have indicated that they are likely to do so this year.

The Roth 401(k) can offer advantages to high-income individuals who haven't been able to contribute to a Roth IRA because of the income restrictions. (Roth IRA eligibility for 2008 phases out between \$101,000 and \$116,000 for single filers and \$159,000 to \$169,000 for those who are married and file jointly). There are no income stipulations for Roth 401(k)s.

In addition, Roth 401(k) accounts are subject to the contribution limits of regular 401(k)s — \$15,500 for 2008, or \$20,500 for those 50 or older by the end of the year — allowing individuals to put away thousands of dollars more in tax-free retirement income than they would through a Roth IRA. (In 2008, Roth IRA contributions are limited to \$5,000 a year, or \$6,000 for those 50 or older.)

The hitch: Those limits apply to contributions to *both* types of 401(k) plans, so you can't save \$15,500 in a regular 401(k) and another \$15,500 in a Roth 401(k). There's no new opportunity to



save here, but there's an opportunity to save with a different kind of tax treatment.

Employees who are offered this option face a choice. Making a sound decision hinges on your estimation of the taxes you think you'll pay in retirement. If you expect your tax rate to be the same or higher in retirement than it is now, you might be better off with a Roth 401(k). If you're in your peak earning years, on the other hand, and you figure your tax bracket will be lower in retirement, you'll benefit from continuing with traditional 401(k) contributions.

In reality, of course, things are much more complicated. For one, no one can predict with certainty what tax rates will be in the future, though the general consensus is that they're likely to rise to help the government offset growing budget deficits and pay for Social Security and Medicare. That's one reason why employees in the top tax brackets have indicated their preference for the Roth 401(k)—they are ready to pay the regular tax now, whatever it is, because the certainty that they won't have to pay taxes in the future offsets the value of the tax deferral.

Still have questions about the Roth 401(k)? We've gone ahead and answered the most important ones.

1. **Who is eligible for a Roth 401(k)?**  
Anyone whose employer offers it. This is where it gets tricky: Among the

major concerns for employers are the costs associated with managing the plan, and educating their employees about this investment option. Employers are much more likely to offer a Roth 401(k) if their employees indicate that they intend to participate. So if you want a Roth 401(k) option to be added to your plan, make sure to let your employer know.

2. **What happens to the employer match?**  
Employer matches are made with pretax dollars, and the match accumulates in a separate account that is taxed as ordinary income at withdrawal.
3. **What are the early withdrawal rules?**  
Early Roth 401(k) withdrawal rules are subject to the same requirements as the traditional 401(k).
4. **What happens if I leave my current employer?**  
The Roth 401(k) balance can be rolled over into a Roth IRA.
5. **What happens if I plan to pass it on?**  
With a traditional 401(k), the heir must pay taxes as he or she withdraws the money. However, an heir may be able to receive tax-free distributions of the money left through a Roth 401(k) if the account is at least five years old.
6. **Is the Roth 401(k) option here to stay?**  
Yes. At one time, the Roth 401(k) option was set to expire after 2010, but it was made permanent by 2006 legislation.

**Notes:** We recommend that you consult an independent legal or financial advisor for specific advice about your individual situation. 

## ANESTHESIOLOGY'S ROLE IN EFFECTIVE OR GOVERNANCE

Continued from page 3

not take responsibility for their actions and are unwilling to police themselves, much less each other. The Director of Surgical Services and Anesthesiology remain in a “NO-WIN” situation until both anesthesiologists and surgeons recognize that they must be accountable for their actions, be responsible for development of solutions, not maintain expectations that their needs will be fulfilled by others, be champions of program change and prosperity as opposed to complainers.

Effective surgical program governance is best achieved by considering the OR as a business corporation. The OR is the “Financial Engine of a Hospital” and should be governed as such. Corporations have boards of directors and CEOs. CEOs do not make unilateral decisions; CEOs brief boards of ongoing situations and changes in the environment, provide data and information, and guide decision making after having analyzed facts and circumstances. Boards develop strategic and tactical plans and develop policies and procedures. CEOs and management teams implement and enforce decisions of the board. In this regard, what we typically refer to as the hospital's OR Committee acts as the board; the Director of Surgical Services, in partnership with Anesthesiology acts as the CEO. To this point you may say to yourself, “Our hospital has an OR Committee, but the OR is still dysfunctional and chaotic. In my experiences most hospitals' OR Committees are dysfunctional, lack value and clout for the reasons listed in **Table 1**.

Generally the OR Committee lacks clout because it has not been formally constituted and given a specific hospital operations charge by the hospital's CEO (differing from the Department of Surgery, which is a medical staff body). Similarly, if the CEO does not bestow formal authority on the OR Committee and support Committee decisions, disgruntled

**TABLE 1**

<b>TYPICAL OR COMMITTEE CHALLENGES</b>	
<b>TYPICAL SITUATION</b>	<b>RESULT</b>
Composed of large numbers of surgeons	Unable to reach decisions; becomes a complaint forum
Inadequate representation from other key groups (e.g. anesthesiology, OR management, administration)	Discussions become slanted, personal and political in nature
Lacks factual information, data and absence of authority / clout	Reliance on anecdotal information and absence of authority does not result in change
Meets infrequently	Cannot engage in pressing issues
Poor attendance, tardiness	No quorums for decisions, lack of vested interest by membership, results in downward spiral

individuals (usually surgeons) make “end-runs” to the hospital's CEO around the Committee. In these instances the CEO typically intercedes, makes decisions based on the anecdotal evidence provided by the complaining party and undermines the Committee's authority and effectiveness. Committee members lose interest and are unwilling to invest their personal time; a negative spiral develops.

The foundation of effective surgical services program governance is based on the composition, authority, mission, charge, and enforcement of the OR Committee. The foundation of effective OR governance is the development of a *culture* so that programs are developed and governed by that culture and not by one or several individuals. Some key activities and attributes of an effective OR Committee follow:

- Fulfills its charge of fostering development of and maintaining a quality oriented, effective, efficient, and marketable surgical services program through the development

and enforcement of effective policies and procedures;

- Is charged and supported by the hospital's board and CEO as a hospital operations committee; decisions of the Committee are not overruled by hospital administration, the Board, or departments of the medical staff. The OR Committee is not subordinate to medical staff bodies (e.g. Department of Surgery or medical staff as a whole) and does not require their approval of its decisions.
- Maintains a philosophy that the OR is a shared and common work place, is no one person's or constituency's domain: a place where compromise and consensus is paramount
- Is of a manageable size – typically of 11 to fifteen members
- Maintains representation of key and high volume surgical specialties as well as of anesthesiology;
- Assures that physician committee members (particularly surgeons)

have a vested interest in the hospital and in the Committee's decisions because those decisions affect them directly. Thus the surgeons on the OR Committee should be effective formal and informal leaders and:

- operate frequently at the hospital and use the hospital as their primary place of surgery;
  - have an interest in developing their practices;
  - have willingness to foster program change and success for the greater community;
  - have the ability and willingness to approach their colleagues about issues or problems;
  - have the qualifications appropriate for OR Committee service even if they are chiefs of their own services; and
  - have an ability and willingness to enforce policies and procedures even against physician friends and business associates.
- Includes at least one anesthesiologist with good interpersonal, commu-

nicative, organizational and data interpretation skills, an anesthesiologist who takes a lead role — or *the* lead role — in the planning and administration of the schedule on a daily basis (this may not necessarily be the chief of anesthesiology);

- Includes representation of OR management (Director of Surgical Service, OR Manager) and Administration (VP over surgery, CNO, but not CEO)
- Meets on a monthly basis and has a planned agenda
- Is guided by data and factual information presented by Anesthesiology together with the Director of Surgical Services ;
- Charges the Director of Surgical Services and anesthesiology to implement and enforce policies and procedures developed by the OR Committee

Where this structure is in place Anesthesiology is positioned to assist in championing program development

and success but is not regarded as a “policeman or necessary evil”. Where this structure is developed each of the rationales for Anesthesiology's running the OR referenced earlier in this article, physician-to-physician leadership, stability and omnipresence, takes shape in a formal and organized manner:

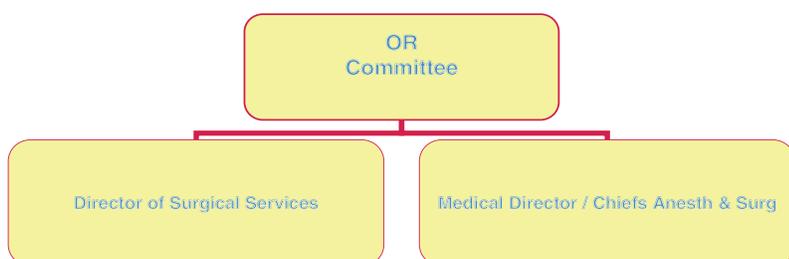
- Anesthesiology participates in enforcing policies and procedures among anesthesiologists and surgeons (physician to physician communication);
- Anesthesiology maintains a constant presence in the OR
- Directors of Surgical Services come and go, but a “culture” sustains program success.

When this governance structure is developed, it does not matter whether “anesthesia” or nursing runs the OR – neither does, as illustrated in Figure 2. Anesthesiology works in partnership with the surgeons and with nursing to guide the OR Committee in its decisions and to implement policies and procedures developed by the OR Committee. ▲

Additional articles by Jerry Ippolito and complimentary learning tools can be obtained by visiting [www.ORefficiencies.com](http://www.ORefficiencies.com)

FIGURE 2

## Governance Organization - Example



**DSS and Dept Chiefs execute and enforce the policies and procedures approved and implemented by OR Committee (i.e. A relationship of governance, not an administrative reporting relationship)**



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# GETTING A POLITICAL RETURN ON INVESTMENT

By Cindy Roehr, CPA

Legislative Liaison, MGMA Anesthesia Administration Assembly  
Cedar Rapids, IA

To most, the phrase “return on investment” means the profit from your savings or retirement plan. After all, an investment is an asset that you put to work with the idea that it will grow and provide income in the future. Even conventional accounting practices recognize this, which is why some expenditures are considered assets, while others are considered expenses.

But as practicing physicians, you should consider two other expenditures as investments, even if they show up on your profit-and-loss statement as expenses: 1) your state and national professional association dues, and 2) your practice executive (manager or administrator). Both will pay you back through political involvement, also known as public advocacy or government affairs.

## ASSOCIATIONS LITERALLY ADD VALUE

During medical school and residency, you probably didn't get a chance to come up for air long enough to see what your state and national medical and specialty societies were doing for you. At that point in your career, you were investing in yourself. Now that you've entered the world of professional practice, consider becoming more fully engaged in two of the critical functions that state and national associations generally perform: ongoing clinical education and political advocacy.

Advocacy at the state level is increasing in importance. Scope of practice, managed care, insurance law, tort reform, and medical assistance payments are all issues anesthesiologists are encountering at the



state level. Your national association, the American Society of Anesthesiologists (ASA) ([www.asahq.org](http://www.asahq.org)), monitors all of these issues (and more), and has staff and resources dedicated to sharing solutions and tactics through its Washington D.C.-based Office of Government and Legal Affairs. The Medical Group Management Association (MGMA) also has a government affairs office that works in concert with ASA Government Affairs to advance the interests of physicians in general and anesthesiologists in particular.

In addition, although national payment issues have dominated recent discussions, state initiatives have become a focal point of the annual ASA Legislative Conference. This exceptional conference, usually held in May, provides valuable information and training. The speakers provide examples of challenges that have been fought and successful tactics that have been employed.

On that front, this article was written during the summer debate on reversing the impending Medicare payment cuts, and the final outcome of that battle was unknown. But lost in the weeds of today's

heated debate is the substantial increase in the anesthesia payment rate that took effect at the beginning of 2008, a political “overnight success” that was years in the making.

The ASA took a multifaceted approach to securing the 32% increase in the conversion factor work value. Their hard work and persistence cannot be overlooked. Your ASA dues were part of the investment in this, but they were not the only investment. Your contributions to – and your investment in – the ASA Political Action Committee (PAC) and state society PACs were, and continue to be, just as important! The power wielded by any PAC is proportionate to its size.

## MONEY CHANGES EVERYTHING?

Many science professionals take a jaundiced eye toward investing hard-earned money in a PAC or making a direct political contribution. But neither deserves the bad rap.

Do PAC and political contributions buy success? No. So, do they matter? Yes. Politics is not a science but an art – the art of the possible, some say – and because money is the fuel of the political message process, the answer is, “Absolutely yes!”

PAC contributions allow for an investment in those lawmakers (in both parties) who support anesthesiology and medical issues on “The Hill” and in your state capital. It is exciting to now have a Maryland anesthesiologist, Andy Harris, MD, running for Congress. If he wins, he will be a beacon to lead the House on health-care-related issues during the next, possibly dynamic, session of Congress.

While a Maryland State Senator, Harris once presented this stark picture: The typical trial attorney gives \$1,000 to his PAC, and 90% of his peers give something. The typical anesthesiologist gives \$100 to his PAC, and 10% of his peers give something. Simple math explains the tort reform story:  $\$1,000 \times 90\% = \$900$ .  $\$100 \times 10\% = \$10$  – a 90:1 advantage for trial lawyers! Tort reform is only one area of legislation – similar statistics can be given regarding the American Association of Nurse Anesthetists (AANA).

Issues regarding scope of practice continue to increase throughout the nation. We all know that money talks – and the more there is, the louder it speaks.

Here is another math equation that may help. Let's say you perform a mere 800 cases/year with an average of 10 units per case. Let's presume that 40% are Medicare, paid in the first half of 2008 at an average conversion factor of \$20.03 — a nice \$3.87 increase from the 2006 payment rate -- and that your practice operates at a fairly typical 10% overhead rate. Quick calculations show that ASA's investment in the political process put more than \$5,000 in your pocket during the first six months alone! How much of that have you thought about investing back into the ASA or your state or local PAC?

The bottom line in this investment: If you don't give, you don't care.

### THE PRACTICE EXECUTIVE: OVERHEAD OR INVESTMENT?

Trust us when we write this – many practice executives face the unrealistic expectation of paying for themselves annually, either through cost reductions or revenue increases. Viewed as an expense, it's no wonder this pressure exists to pay for their existence. View practice administrators as an investment, however, and you begin to see how it can pay dividends for you and your practice, particularly in the political arena.

If a practice executive does not have

public advocacy and political involvement in his or her job description, then it is time to rewrite it. As the medical practice business leader is given key responsibilities for revenues and expenses, politics and community involvement is part of the job. Your practice executive can help your community understand the impact that inadequate Medicare and Medicaid payments have on your practice and the community. They can educate others about how Medicare fees are NOT physician profits but are instead “patient care payments” that fund the entire medical system.

On the revenue side, there are key regulations dealing with health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other insurance products to understand. Medical assistance fee schedules are state-focused, and Medicare fee schedules are part of the national political scene. The ability to use anesthesiologist assistants (AAs) to meet expanding demand requires state licensing. Efforts to streamline credentialing take place on both the state and national levels. MGMA has been a leader on the national level to simplify credentialing and other administrative requirements with regard to both public and private payers. Providing support to your administrator's MGMA membership also provides support to these important initiatives. Compliance with billing policies and regulations, and changing them when necessary, requires political savvy.

On the expense side, there are payroll and employment laws, pension and benefits administration rules, and even facility and safety regulations to follow. Plus, there is tort reform, often an area where substantial overhead reductions can be made.

Political affairs affect all elements of the medical practice executive's job, and the elements of the job make the practice better for you and your patients. Your practice executive can help you:

- Draft communications;
- Arrange visits with state and federal lawmakers;
- Create a regional PAC;
- Serve as your “rapid response team;”
- Create your talking points;
- Make appointments with legislators and accompany you on them;
- Connect the dots – your patients are your legislator's constituents, and by growing your billing office you create jobs again affecting potential voters!
- Provide advocacy training to you and other physicians;
- Serve as the sentinel for the group, monitoring what happens outside the hospital walls; and
- Serve on advisory committees created by associations and politicians.

While you provide patient care, your practice executive is available during the business day (and sometimes the evening) to deliver your message to the legislature and to the members of Congress. He or she can become a “go-to” resource for legislative staff, providing facts and education to those who help form policies and laws.

Government and political relationships are like other investments. To maximize their benefits, they take time, energy, and money. If you already invest in your association and your practice manager, congratulations! If you don't, it's not too late to start! ▲

The ASA advocates 1:1:1 – contribute the funds from one case to the ASA PAC, contribute the time from one day to lobbying at your state capitol (or working in place of one of your peers so he or she can), and work to develop a relationship with one politician. For more information, visit the ASA PAC section of the American Society of Anesthesiologists Web site. Be sure to have your membership number handy to access this members-only site!

# Compliance Corner

*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.*

## HOW TO REPORT ANESTHESIA FOR COSMETIC SURGERIES

**Steve Berman**

*Vice President of Compliance*

One of the many items that our coders and others deal with on a regular basis is how to address surgeries that have a cosmetic component. When the entire case is cosmetic there is very little difficulty in knowing how to bill. Most insurance carriers will not pay for cosmetic procedures without prior authorization. In such cases, the patient will be billed directly for the procedure unless he or she has pre-paid.

Some cases appear to be cosmetic based on the procedure that was done, and yet the anesthesiologist (or the patient!) requests that the insurance company be billed. If the insurance company is one that pays for cosmetic procedures then it is expected that there should be a pre-authorization number in the file. If the demographic sheet says that the procedure is cosmetic, it should be billed as such.

When the case includes both a covered service and a cosmetic service it is important to provide all the information needed to bill. Ideally, the anesthesia record and/or charge ticket should show the distinct start and stop times of the covered service and of the cosmetic service respectively. The total anesthesia time billed must be split accordingly



between the patient and the insurance company. In some cases the covered and cosmetic surgery does not have clearly delineated times. If that occurs, the documentation should reflect the total time for the case, including indication on the anesthesia record of how much time the cosmetic procedure took. Then the base and time of the covered service would be billed to the insurance company and any additional base plus time units would be billed directly to the patient.

It is important that the anesthesia provider not try to bill a cosmetic

procedure as a covered service when s/he knows that the service is cosmetic. This is important not just because of potential fraud issues, but also because when the insurance company gets the cosmetic bill, it will deny the entire claim and delay the billing of the patient. If the insurer does pay on the basis of misleading coding, and if the practice is audited after the payment, there could be restitution and penalties. The best way to handle cosmetic surgery cases is to obtain payment from the patient in advance, which is the procedure used by many anesthesia groups. 

## WHY THE COST OF ANESTHESIA CARE MATTERS

*Continued from page 6*

limits its options, the more it becomes an effect of, rather than in control of its circumstances.

Given all these issues, considerations, and limitations how can a practice stay competitive and remain financially viable without increased financial support from the hospital? Some might suggest the solution requires thinking outside the box regarding historical perceptions of the role of the anesthesia department in the management of the operating room. In short, if the anesthesia practice cannot increase its revenue through more effective collections or reduce its costs materially then it must look at ways to manage the number of staff necessary to provide the service. The most cost effective practice represented in Table 1 is also the practice that has been most effective in two areas of practice management: maximizing the leverage of the careteam and minimizing the impact of scope creep in hospital coverage requirements.

As the head of the group would be quick to add, though, the pressure to add locations and give in to scope creep is never ending. His approach is simple. Armed with monthly updates of actual O.R. utilization he is constantly educating administration and pushing back on requests for new venues. His own private benchmark is 45 ASA units per location day (see Table 2 on page 6); if he cannot see this as a reasonable average level of productivity he will not accede to expanding coverage.

Obviously this is an approach that requires considerable focus and discipline, but it is clearly one that has paid off handsomely for the group. Not only does the practice get no financial support from the hospital, but physician compensation levels are above average.



It is hard to argue that this is not one of those best practices that could benefit most other anesthesia groups across the country.

Every anesthesia practices' situation is unique. It would be naïve to think that a given strategy or plan that works well in one hospital in one part of the country would have the same results elsewhere. This is not the point. Every practice must assess and address the unique factors that determine provider costs, and be willing to analyze and address them. More often than not the result will be a difference of degree rather than of kind, but sometimes it is that 10% extra that will make the difference between success and failure, between the ability to recruit and retain the best providers and an inability to do so, between the perception that the anesthesia practice is part of the solution versus part of the problem, and, ultimately, between the ability to demonstrate to the administration that the group can manage itself effectively versus needing to be taken over by the hospital or some other entity.

In the ever changing dynamic of anesthesia relations with hospital administrators there is a lot at stake. Many victories are Pyrrhic. The value of success does not always seem to justify the cost of the battle. There is a tendency to give in or, worse yet, give up in the face of today's changing economic realities. Just as there is almost always a solution to an inscrutable clinical challenge, so too, there is virtually always a solution to a seemingly intractable economic problem so long as there is sufficient commitment to a positive outcome and a persistent willingness to creativity and innovation. What anesthesiologists and CRNAs should always remember is that every hospital needs anesthesia services to run its operating rooms. There is always a way to make the numbers work. The choice is simple: be part of the problem or part of the solution. The necessary tools and resources are more available to the typical anesthesia practice than most anesthesiologists are willing to admit. The question is when and how they want to take advantage of them. ▲

# THE LOGICAL FALLACY INHERENT IN THE MARKETING OF AQUAVAN

By Stuart Roth, MD

President, Hunt Valley Anesthesia  
Baltimore, MD

Aquavan is the trade name of the drug fospropofol. A prodrug is one which is modified by the body into an active form; in this case, the familiar drug, propofol. As its name suggests, Aquavan is water soluble. It is being marketed as a sedative agent for a variety of procedures including endoscopies. The selling point is that it is safe for nonanesthesiologists to use for sedation.

The reason that is proposed for its potential safety is its slower onset. Since it must be converted by the body into its active form, it takes longer for it to reach its peak sedating effects. In addition, its effects last for a longer time until it is inactivated by the body. In my view, these points contain a whopping logical fallacy and will not stand up to scrutiny.

The nature of sedation is such that the amount of drug or drugs necessary to achieve a given level of sedation is highly variable from person to person. The typical induction of sedation is to give a bit and see how the patient reacts. One continues to administer the drug or drugs until the patient is in a proper state for the procedure in question. This is titration to effect. It constitutes part of the art of anesthesia.

The logical fallacy is that a drug with a slower onset is somehow safer for a nonanesthesiologist to administer. I believe that the opposite is true; it is more dangerous to administer. The reason that it is more dangerous is that as one gives the drug and observes the effect, one tends to give more sooner to get the patient to the proper level of sedation as efficiently as possible. The danger lies in the fact that the drug effect is delayed by its slower onset. This means that the drug effect will peak after the desired level of



sedation is reached.

The consequence of the delayed peak is the potential for sedation to become general anesthesia. Should the patient slip into this deeper state, the implications are serious. The patient may need airway interventions of some kind to prevent airway obstruction or even bag and mask ventilation should he or she become apneic. The need for this sort of airway intervention is the reason that so many gastroenterologists prefer that an anesthesiologist or nurse-anesthetist be present to provide sedation and monitoring during endoscopies.

Unfortunately, conscious sedation can quickly become deep sedation or general anesthesia even in the most skillful of hands. However, the most skillful of hands can deal easily with airway issues whereas others without the requisite training and experience can get into serious trouble. A drug with a slower onset and a slower peak of effect will cause exactly these problems in greater abundance.

There is another less compelling problem with a longer-acting drug. The recovery time is longer. Those endoscopy centers used to the efficient turnover of limited recovery space will need longer to recover their patients. Given the present climate in outpatient medical

services, longer recovery times represent lost revenue.

In conclusion, there is nothing inherently wrong with fospropofol but there is a significant problem with its marketing. The fallacy that this drug will allow for safe, efficient sedation without the need for skilled anesthesia personnel will, I'm afraid, not be borne out in the reality of everyday practice. The need for practitioners skilled in managing airways will only be heightened by this drug for the reasons I discussed. 

*Note: Dr. Roth's opinion piece on fospropofol, like all third-party articles published in the Communiqué, represents the views of the author alone. While we welcome contributions to the Communiqué from friends and clients, ABC, LLC does not have any opinion on the clinical merits or issues relating to fospropofol or any other anesthesia drug.*

*In May, ABC notified subscribers to our e-mail list that the Anesthetic and Life Support Drugs Advisory Committee of the Food and Drug Administration (FDA) had recommended approval of Aquavan (fospropofol bisodium) on May 7, 2007. We also saluted the Advisory Committee for voting 9-1 against the use of fospropofol by nonanesthesiologists, following testimony by the American Society of Anesthesiologists (ASA). The ASA presented live testimony at the FDA's open hearing on May 7 through Thomas K. Henthorn, M.D., Chair of the Department of Anesthesiology at the University of Colorado – Denver. A copy of the ASA letter, which sets forth the scientific foundation and references for the arguments made by Dr. Roth above, is available for download at <http://www.asahq.org/Washington/ASAfospropofolcomments4-23-08.pdf>.*

# ADDITIONAL REVENUE LIES IN THE ACCURATE DOCUMENTATION OF THE PROCEDURE

By Devona Slater

*Auditing for Compliance and Education, Inc.*  
Leawood, KS

In today's environment, anesthesia providers may improve their reimbursement just by being more specific regarding the procedures that they perform. Many times in providing audits and reimbursement reviews, we find that the anesthesiologist does not give specific information for a coder to accurately code from the anesthesia record. This can result in a loss of revenue. An example is a general anesthetic given for which the procedure description was hydrocelectomy, inguinal hernia repair w/ mesh. Based on the information on the anesthesia record, we would only be able to choose from the hydrocele repair (CPT 55040/00920 (3)) or the hernia repair (CPT 49505/00830 (4)). A review of the surgeon's record indicates the hydrocele involved the spermatic cord which would allow the coder to assign CPT code 55500/00860 (6). The accurate code assignment of this procedure would allow the group to bill an additional two units.

Another example is a thoraco-abdominal repair for a congenital diaphragmatic hernia. With this information, a coder would assign CPT code 39503 and cross walk it to ASA 00756 with seven base units. But in reading the surgeon's report, the procedure was not done by a transabdominal approach but instead by a thoracotomy approach, which would allow the coder to use the alternate ASA code of 00540 which is a base unit value of twelve units. This means an additional five units that could be captured if the anesthesia provider had been more specific on the procedure description and noted the approach.

Another common mistake is that of an inguinal hernia repair. Anesthesia groups



may be losing two units if the procedure was performed by the surgeon using laparoscopy. Again, simply documenting how the procedure was performed would allow the coder to easily assign the correct CPT code (49650/00840 Base 6) instead of the general code for inguinal hernia repair, CPT code 49505/00830 with a base of four.

A final example is one we see many times auditing and it is the description given as "cysto." With this description the coder would only be allowed to assign CPT code 52000/00910 with base units of three. But if

the surgeon manipulates the stone the coder would assign CPT code 52353/00918 with five base units. If in fact in reading the report the coder could determine that the calculus was in the kidney or upper 1/3 ureter, then the alternative code for 52352 or 52353, 00862 with seven base units, may be more appropriate to report. Again, the physician's documentation is crucial in these instances to ensure we are getting the highest payment possible.

In today's reimbursement environment one cannot afford to leave money on the table. It is important for anesthesiologists to realize that coding personnel are limited as to the description given or what is readily available. It is not possible for a coder to pull the surgeon's dictation on every procedure. Physicians should be thorough and conscientious in describing the procedures that they perform so that coders can obtain the appropriate reimbursement for the services. ▲

## NWAAG Invite

Anesthesia Business Consultants (ABC) and Associated Anesthesiologists Incorporated (AAI) would like to invite you to attend the second meeting of the Northwest Anesthesia Administrative Group (NWAAG) on Thursday, October 2, 2008. The initial meeting was held on June 4, 2008 in the Seattle area and was attended by 15 Anesthesiologists and Anesthesia Administrators. The consensus of the attendees was that this type of organization would be very useful and informative for anesthesia practices in the Northwest.

If you are involved in managing the business of your anesthesia practice, this new regional network will provide you with valuable up-to-date information on

anesthesia issues that directly affect your practice. Please join us in making this new network a success.

- Big vs. small anesthesia group
- How to retain and hire anesthesiologists
- How to approach the hospital for help in recruitment and stipends
- PQRI update

**\*\*RSVP required via email at [RSVP@anesthesiallc.com](mailto:RSVP@anesthesiallc.com) by Monday September 15th. Confirmation and site directions will be sent to you upon your RSVP.\*\***

We look forward to seeing you!

## PROFESSIONAL EVENTS

DATE	EVENT	LOCATION	CONTACT INFO
Aug. 9-13, 2008	American Association of Nurse Anesthetists Annual Meeting	Minneapolis Convention Center, Minneapolis, MN	<a href="http://www.aana.com">www.aana.com</a>
Sep. 11-14, 2008	New England Society of Anesthesiologists Annual Meeting	Marriott Hotel on the Wharf, Newport, RI	<a href="http://www.nesa.net">www.nesa.net</a>
Sep. 12-14, 2008	Ohio Society of Anesthesiologists Annual Meeting	The InterContinental Hotel, Cleveland, OH	<a href="http://www.osainc.org">www.osainc.org</a>
Oct. 17, 2008	Society for Ambulatory Anesthesiology	Orlando, FL	<a href="http://www.sambahq.org">www.sambahq.org</a>
Oct. 17, 2008	American Society of Critical Care Anesthesiologists Annual Meeting	Orlando, FL	<a href="http://www.ascca.org">www.ascca.org</a>
Oct. 17, 2008	Society for Pediatric Anesthesia Annual Meeting	Orlando, FL	<a href="http://www.pedsanesthesia.org">www.pedsanesthesia.org</a>
Oct. 17, 2008	Society of Neurosurgical Anesthesia & Critical Care Annual Meeting	Orlando, FL	<a href="http://www.snacc.org">www.snacc.org</a>
Oct. 18-22, 2008	ASA Annual Meeting	Orange County Convention Center, Orlando, FL	<a href="http://www.asahq.org">www.asahq.org</a>
Oct. 19-22, 2008	MGMA Annual Conference	San Diego Convention Center, San Diego, CA	<a href="http://www.mgma.com">www.mgma.com</a>
Oct. 27-31, 2008	CSA Hawaiian Seminar	Mauna Lani Hotel, Island of Hawaii	<a href="http://www.csahq.org">www.csahq.org</a>
Oct. 31–Nov. 2, 2008	Association of Anesthesiology Program Directors/Society of Academic Anesthesiology Chairs Annual Meeting	Hyatt Regency San Antonio, San Antonio, TX	<a href="http://www.aapd-saac.org">www.aapd-saac.org</a>
Dec. 12-16, 2008	New York State Society of Anesthesiologists Postgraduate Assembly in Anesthesiology	New York Marriott Marquis, New York, NY	<a href="http://www.nyssa-pga.org">www.nyssa-pga.org</a>
Jan. 23-25, 2009	ASA Conference on Practice Management	Arizona Grand Resort, Phoenix, AZ	<a href="http://www.asahq.org">www.asahq.org</a>



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