



MAKING MEANINGFUL USE MORE MEANINGFUL

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Using a cloud-based Meaningful Use Electronic Health Record (EHR) like FIRSTUse enables anesthesiologists to participate in either the Medicare or Medicaid EHR Incentive Programs. For those of us who have been doing this for the last few years, the incentive payments have been quite substantial. While data entry does require some time and commitment, the process is straightforward and provides additional non-financial rewards to the physician and patient. As physicians, we have the ability to document patient encounters, review patient records, generate patient lists and securely message our patients. In addition, there is now technology to securely message the growing number of other healthcare providers in the Direct Protocol messaging trust bundle.

Historically, anesthesiologists have been the unseen doctors behind the mask. Patients may be grateful for good care, but they may not remember much about



the experience due to the amnestic effects of our medications and the fact that much of their attention is on their surgical outcome. However, it is not that unusual for patients to have particular questions or concerns about their anesthesia care. Here are some of the common patient concerns:

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THE CHALLENGES ARE GREAT—AND SO IS THE EXPERTISE IN OUR SPECIALTY

No fewer than four experts in anesthesia practice management have contributed articles to the *Communiqué* for the first time in this issue. We are struck—not for the first time—at both the vast knowledge reservoir in our community and the generosity of so many professionals who go the extra mile to share their expertise. Let us take this opportunity to thank our regular authors and especially newcomers Danielle Reicher, MD; Steve Boggs, MD; Pat Everett, CPA, CMPE and Ron Booker, JD, CPA.

Anesthesiologists have been seeking out the best electronic health record systems (EHRs) to improve data collection for both clinical and administrative purposes, not to mention for purposes of qualifying for the Medicare Meaningful Use payment incentives. Dr. Reicher describes a specific and very important application of EHR technology in *Making Meaningful Use More Meaningful*: communicating with patients. Have you thought about the value to the patient of documenting the medications and doses given and any unusual reactions or airway difficulties, particularly if the patient has concerns about anesthesia? In one of her examples, Dr. Reicher notes that anesthesiologists may sometimes “observe hives or anaphylaxis after giving a combination of medications. We know that the most common allergic reactions are due to antibiotics or muscle relaxants. ... We may need to refer the patient to an allergist and we certainly want them to be aware of all the medications they received. All of this information can be recorded in the electronic record after a thorough discussion with the patient.” Does this not suggest an excellent way of affirming the role of the anesthesiologist in the management of the entire perioperative episode? And as Dr. Reicher, who has been recording her patients’ care through *FIRSTUse* for several years, makes clear, EHRs are an excellent way to “become more engaged with our patients and the health-care system in general.”

One of Dr. Boggs’s areas of particular interest is GI sedation—an interest that is sadly timely, with the September 4 death of comedienne Joan Rivers a week after undergoing an endoscopic procedure during which she suffered a cardiac arrest. For the past several years, Dr. Boggs has been working closely with endoscopists at Mount Sinai in New York and elsewhere, evaluating turnover time and safety metrics. He will be presenting both at a Point-Counterpoint session and on a panel at the ASA Annual Meeting in New Orleans in October, and he gives us a detailed preview of

his arguments in *Computer-Assisted Personalized Sedation (CAPS): Will It Change the Way Moderate Sedation is Administered?* We were pleased to have the opportunity to provide Dr. Boggs with claims data showing that the cost of anesthesia and anesthesia providers may be quite competitive with cost of CAPS.

Pat Everett’s name is very familiar in the anesthesia community. In his article *Anesthesia Practice Attributes Your Hospital Leadership Teams Value Most*, Mr. Everett distills an extraordinary amount of hands-on experience with both anesthesia providers and hospitals into a list of the top five attributes of highly successful anesthesia groups with whom he has worked. The list starts with “strong leadership.” The idea that leaders should be strong is familiar enough—but does everyone realize that the kind of strong leadership that really matters to hospitals entails the ability to make decisions quickly, without the “need to take this back to my group first?” Another attribute of a great group is consistent application of clinical standards and protocols to patients across all the anesthesiologists in the group. Read Mr. Everett’s article and take very seriously his conclusion that what hospital leaders want most is “a group of anesthesia professionals who ‘fly under the radar’ and about whom they rarely hear complaints.”

Look closely, too, at *The Value of a Quality Practice Administrator*, written by another extremely experienced anesthesia practice administrator, Ron Booker. There is more—much more—to the business side of anesthesia than revenue cycle management; anesthesiologist, CRNA and AA recruitment and retention, and managed care and hospital contracting. Mr. Booker uses carefully chosen examples of typical and atypical practice challenges to show the value of a high-quality administrator who possesses sound skills in four essential domains: decision-making, problem-solving, communication and relationships.

Laura Dyrda’s is another new name in the *Communiqué*—but Ms. Dyrda is in fact well known and much appreciated under her previous byline, Laura Miller. Ms. Miller serves as the Editor-in-Chief of *Becker’s ASC Review* and *Spine Review*. An ever-growing majority of anesthesiologists, CRNAs and AAs provide services at ambulatory centers and certainly need to be sensitive to the specific pressures weighing on the facilities with which they partner—or hope to partner. Ms. Dyrda’s summary *10 Concerns Facing ASCs Heading Into 2015* highlights concerns that may not be immediately apparent

to clinicians, such as the lack of any government incentives to begin using EMRs like those offered to hospitals and physicians, patient familiarity with outpatient surgery and competition with hospitals to recruit physicians.

We welcome returning contributor Rick Dutton, MD, MBA who brings us up to date on a vitally important new mechanism for anesthesia professionals to report performance data to Medicare: *The Qualified Clinical Data Registry (QCDR)*. Going forward into 2015 and beyond, physicians must report such data to Medicare in order to avoid payment penalties under both the Physician Quality Reporting System (PQRS) and the Value-Based Modifier program. The claims-based method of reporting that most anesthesiologists have used to date is being phased out in favor of registries. At the same time, the number of quality measures that physicians must report in order to avoid penalties is increasing. The National Anesthesia Clinical Outcomes Registry (NACOR) run by the Anesthesia Quality Institute (AQI), which is headed by Dr. Dutton, solves both problems by having obtained QCDR certification. Dr. Dutton will be presenting at the ASA Annual Meeting and we encourage you to hear him as well as to read his article.

Within ABC, we have a wealth of knowledge that it is also our privilege to share in these pages. Darlene Helmer, Vice President of Provider Education and Training covers *Medicare’s Modifier 59 Expansion* in this issue’s Compliance Corner. Joette Derricks, Vice President of Regulatory Affairs and Research, alerts readers to *Potential Revenue Losses with Health Insurance Exchange Patients Due to Premium Payment Default*. Both article titles are mercifully self-explanatory!

Let me once again express our deep gratitude to the anesthesiologists, administrators, journalists and compliance and regulatory experts who have given us the content for this issue of the *Communiqué*. The sophistication and energy of all these individuals benefits and inspires us all.

With best wishes,



Tony Mira
President and CEO



THE QUALIFIED CLINICAL DATA REGISTRY (QCDR)

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By now, many readers of the *ABC Communiqué* will have heard about the Qualified Clinical Data Registry (QCDR) and will be wondering (or dreading) what this means for them and their practice. This article will lay out the basic definitions and requirements.

The QCDR is a new mechanism for eligible professionals (EPs) to report data on their performance to the Centers for Medicare and Medicaid Services (CMS). CMS currently reimburses about one-third of anesthesia care in the United States, and almost every practice derives a portion of its income from CMS. As a federal agency, CMS has been at the forefront of responding to public demand for transparent reporting of healthcare quality from both hospitals and providers. This has led to a steadily escalating requirement for performance reporting.

Under the QCDR, EPs contributing data to a clinical registry can get credit for meeting the requirements of the Physician Quality Reporting System (PQRS) and the Value Modifier (VM) program.

Technically, a QCDR is designated by CMS under the provisions of the 'Final Fee Schedule Rule' published in November, 2013. Registries could nominate themselves for this designation during January 2014, and were then required to meet more than 30 requirements before certification. Among the requirements, the registry must have been in existence for a while, must represent a specific specialty or discipline of medicine, must collect data from multiple sites and healthcare systems, must maintain a public list



of performance measures and definitions, must provide regular feedback to contributors and must be able to collect, analyze and transmit data to CMS in an approved format.

As noted above, the QCDR is a new vehicle for providers and practices to report performance data to CMS, under the existing Pay for Performance (P4P) systems. The original PQRS program, now more than five years old, was created to encourage individuals to publicly report performance on one or more established quality measures. Through 2014, CMS offered small incentives to do so—for example, providers reporting successful performance on at least three measures in 2014 will receive a bonus payment from CMS equal to 0.5 percent of their Medicare billing for the year. Beginning in 2015, however, this carrot becomes a stick. The PQRS bonus changes to a 'payment adjustment' of negative two percent

of reimbursements for those who are *not* reporting successfully, with increasing penalties in the years ahead.

The VM system is a new program, which overlaps and expands on PQRS. In 2016, CMS will assess physician performance data from 2014. EPs not reporting their performance will be penalized; those who do report successfully will be eligible for incentive payments under a complex formula designed to redistribute money from worse performers to better ones. Successful VM reporting requires nine measures, from three different domains of the national quality strategy, and must include at least one outcome measure.

The original method for reporting PQRS performance to CMS was the 'claims-made' mechanism. This is still used by the large majority of practitioners who participate in PQRS (61 percent of all anesthesiologists participated in 2013; about the same percentage of nurse anesthetists), including many through ABC. This mechanism requires the billing company to append a code to each eligible case indicating compliance with a given measure. For example, the code for 'anesthesia for upper abdominal laparoscopic surgery' would be accompanied by an additional code indicating 'prophylactic antibiotics were given at the correct time.' CMS then conducts an annual audit of all cases for every provider to determine which cases were eligible for each measure, whether performance was met and

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THE QUALIFIED CLINICAL DATA REGISTRY (QCDR)

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whether the provider is eligible for an incentive payment based on their results.

A newer mechanism for reporting performance under both PQRS and VM is the group reporting option, whereby aggregate performance for the year for an entire practice group is sent to CMS as a single file by a certified vendor. This moves some of the burden for scoring performance from CMS to the vendor, without changing other aspects of the program. In 2014 group reporting became mandatory for groups of 100 or more providers, and in 2015 this requirement will be extended to all groups of 10 or more, as CMS seeks to de-emphasize the claims-made approach.

PQRS and VM use the same set of CMS-approved measures. Most of these are derived from a larger set of measures collected and endorsed by the National Quality Forum (NQF), set up as a public-private partnership a decade ago specifically for this purpose. The process of creating a measure, validating it, and achieving NQF endorsement and CMS inclusion can take years of work. In theory, any EP can report on any of the 300+ approved measures, but in practice this is hard to do because eligibility for a given measure is usually determined by a billing code (e.g., the Current Procedural Terminology™ or CPT code for anesthesia providers). If the EP is not billing that code, then they are not eligible for that measure. For example, an anesthesia provider might feel that they have some involvement in the measure developed by the Society for Thoracic Surgeons to encourage early extubation after coronary artery bypass surgery. But because this measure is specific to the CPT codes for the surgery (not the anesthesia care) this measure is not actually available to our specialty. Most medical disciplines—including anesthesia—do not have enough measures approved by CMS for the aver-



age clinician to meet the new nine-measure requirement of the VM system.

Performance reporting to CMS through a QCDR is similar to group reporting through a certified system—the registry will send a single report to CMS summarizing the provider's performance on a given measure for the entire year. Unlike PQRS and VM, however, a QCDR can use specialty-specific measures drawn from outside the existing pool approved by CMS. These 'non-PQRS measures' can be from any credible source, and must be clearly defined, publicly transparent and valid for the stated purpose.

Plans for the future of P4P programs can be glimpsed in existing regulations, in comments by officials and in legislation being debated in Congress. First, it is clear that P4P will not go away. A steadily increasing percentage of every provider's reimbursement from the federal government will be linked to documentation of compliance with performance measures, and will be publicly reported. In 2015 this is a two-percent risk—or \$2000-\$5000 per year for most anesthesia practitioners—but the planned evolution of

PQRS and VM will bring the total at risk to about ten percent by 2020, or tens of thousands of dollars per EP. Further, it is likely that where CMS leads, the entire fee-for-service universe will follow; PQRS requirements have already been extended to some state Medicaid programs and private insurers are likely to follow suit. It is clear that registry-based reporting is the most favored mechanism going forward. Federal officials believe that physician participation in clinical registries, with regular public benchmarking, is an important tool to achieve the triple aim of improved outcomes, improved efficiency and improved patient experience. Strategies to enhance registry reporting can be seen in the evolution of the Meaningful Use program, in proposals and demonstrations for alternative payment models and in Congressional efforts such as the proposal to reform the Sustainable Growth Rate formula. More cynically, the QCDR approach also relieves CMS of much of the burden of collecting, cleaning and scoring performance data from individual providers.

QCDR AND THE ANESTHESIA PRACTITIONER

The American Society of Anesthesiologists (ASA) recognized in 2008 the value of a specialty-specific clinical registry, including the ability to meet regulatory requirements. The ASA has invested millions of dollars in development of the Anesthesia Quality Institute (AQI) and its product, the National Anesthesia Clinical Outcomes Registry (NACOR), to which many ABC practices contribute. NACOR was certified for group reporting of PQRS measures in 2012, and earlier in 2014 became one of the first QCDRs approved by CMS. In doing so, AQI scoured the existing NQF and CMS measure lists, then combined this with years of work

by the Committee on Performance and Outcome Measures to propose a list of measures comprehensive enough that almost any clinical anesthesia provider will be able to find the minimum nine measures required to earn future incentives. The 19 measures approved for submission through NACOR include eight PQRS measures and 11 non-PQRS measures, and are briefly listed in Table 1. Specifics are available on the AQI website at <http://www.aqihq.org/PQRSOverview.aspx>. In this pilot year of the QCDR, both CMS and the AQI will be assessing the value and reportability of these measures, with anticipation of adjustments in future years. The 2015 proposed final rulemaking will allow up to 30 non-PQRS measures for inclusion in the QCDR; this will enable AQI to include subspecialty measures for pain, obstetrics, pediatrics and cardiac practitioners.

QCDR submission of performance data to CMS is available to any eligible professional in a practice that is contributing data to NACOR. Participation in NACOR is on a per-group basis at a fee of \$1000 per attending physician anesthesiologist or independently-practicing nurse anesthetist. This fee is discounted to \$0 for ASA members; most practices in the care team model thus participate in NACOR at no cost, as a benefit of ASA membership. QCDR reporting to CMS will be available at no additional charge to ASA members and for \$295 per year to non-member EPs, with discounts available to large groups. To meet PQRS and VM requirements through the QCDR, practices must self-nominate to CMS, must complete waivers and submit National Provider Identifier (NPI) numbers for each EP to AQI, must collect and code the primary measure information in their electronic systems (either billing or medical record) and must transmit this information to NACOR as part of their regular data contribution. ABC is positioned to facilitate this activity on behalf of their client practices.

TABLE 1 Measures included in the National Anesthesia Clinical Outcomes Registry (NACOR) Qualified Clinical Data Registry measure set.

Detailed definitions, including instructions for coding, are at <http://www.aqihq.org/PQRSOverview.aspx>.

Existing PQRS Measures:

#30:	Timely administration of prophylactic antibiotics
#44:	Continued administration of beta blockers to cardiac surgery patients
#76:	Observation of a bundle of sterile precautions when placing a central venous catheter
#130:	Documentation of current medications
#193:	Normothermia on arrival to the Post-Anesthesia Care Unit
#226:	Tobacco use screening and cessation counseling
#342:	Pain brought under control within 48 hours
#358:	Preoperative patient risk assessment using a validated tool

Non-PQRS Measures:

1. Use of a checklist for post-anesthesia transfer of care, OR to ICU
2. Use of a checklist for post-anesthesia transfer of care, OR to PACU
3. Prophylaxis against postoperative nausea and vomiting, adults
4. Prophylaxis against postoperative nausea and vomiting, children
5. Composite anesthesia safety rate (outcome)
6. Perioperative cardiac arrest rate (outcome)
7. Perioperative mortality (outcome)
8. Rate of reintubation in the postanesthesia care unit (outcome)
9. Management of postoperative pain
10. Safety rate for central venous access (outcome)
11. Composite anesthesia patient satisfaction (outcome)

While QCDR reporting appears to be the favored approach to P4P in the next decade, the claims-made and group reporting options for PQRS are still a reasonable approach to avoid negative payment adjustments. The lack of sufficient measures for anesthesiologists in these systems will make it difficult to qualify for incentives in the years to come, however. At present, NACOR is the only QCDR available to anesthesia practitioners, but in time practices may have several alternative QCDRs to choose from, using the same or similar measure sets. Which one is most appropriate for a given group will likely depend on other aspects of the registry, such as its interaction with the electronic medical record and its utility for quality improvement activities, clinical research or other regulatory reporting.

As has been the case over each year in the past decade, specific requirements

for P4P will continue to change going forward. The AQI follows this evolving landscape closely, and recognizes that facilitating performance reporting for anesthesia providers is an important mission of the registry. In this way, we hope to continue to serve our participants and advance the quality of anesthesia care. ▲

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1. History of unusual sensitivity or resistance to anesthetic agents
2. Severe postoperative nausea in the past
3. History of difficult airway
4. Unusual reaction to a medication in the past
5. Fear of anesthesia
6. Desire to know what anesthetic agents are given

Using a Meaningful Use product like FIRSTUse, we can efficiently respond to any of the concerns by communicating with our patients through the “visit notes” or similar feature. If my patients have an unremarkable anesthetic and do not seem particularly interested in extra details, I may leave this blank or simply thank them for the privilege of being their anesthesiologist that day. On the other hand, I can respond to any of the concerns above in a concise and accurate fashion. I can state which medications and doses they received if the concern is about their sensitivity to agents. If indeed there was increased or decreased sensitivity, I

can document this. I can tell them what antiemetics they were given. I can tell them about their airway management, emergence pattern or unusual medication reactions. All of this information can be accessed on the patient side via [Health Companion®](#), a secure free personal health record. *[Note: the author is a cofounder of Health Companion.]*

If the patient does not have any specific questions preoperatively, it is not unusual for the anesthesiologist to have particular concerns after giving an anesthetic. Here are some examples:

1. Difficult airway
2. Adverse medication reaction
3. Unusual sensitivity or resistance to anesthetic agents
4. Previously undiagnosed hypertension
5. Wheezing or secretions in patient who denied pulmonary symptoms preoperatively
6. Difficult intravenous access
7. Emergence delirium
8. Electrocardiographic abnormality not previously noted

In the past, these issues might be noted in a progress note or explained verbally to the patient or family member, or even provided in writing to the patient. However, communicating this information in a secure way and ensuring a permanent electronic record allows the patient and physician a more reliable method of transmitting valuable information. The patients will be able to access this information anytime, anywhere in the future or share it with future caregivers. This is not to say that I would not explain any of this to patient and family in person. I will always make every effort to convey useful and important information face to face. But so often, when patients leave a healthcare facility, these conversations are not well remembered.

I recently had a patient who cautioned me that she was a real “lightweight” when it comes to anesthesia. She was extremely concerned about this. I administered sedation for her colonoscopy and she required a very average dose of midazolam and propofol. She awakened immediately after the procedure. I was able to tell her that she responded quite typically to the medications and she was very relieved to hear this. I also put this information in her visit notes and included the doses. She was very pleased when I told her I would include that information so she could have it for future reference.

If I have a patient with a known difficult airway who safely undergoes anesthesia with a laryngeal mask airway (LMA), I am able to explain in the visit notes that the case went well. I can further explain that the airway device used often works well even with patients who have a difficult airway and that this does not guarantee future success.

When considering adverse medication reactions, anesthesiologists





may observe hives or anaphylaxis after giving a combination of medications. We know that the most common allergic reactions are due to antibiotics or muscle relaxants. We also know that other medications can be responsible. We may need to refer the patient to an allergist and we certainly want them to be aware of all the medications they received. All of this information can be recorded in the electronic record after a thorough discussion with the patient.

Some may be skeptical of the added time required to document this. However, the incidence of adverse events is not that high and having the electronic record is actually more efficient and timesaving than trying to scribble out an unofficial note for patients to take home.

Improved patient communication is not only advocated by the federal government, but it is also supported by our professional societies. The ASA [Practice Guidelines for Management of the Difficult Airway](#) published in *Anesthesiology* 2013: 118: 251-270 state that anesthesiologists should:

“inform the patient (or responsible person) of the airway difficulty that was encountered. The intent of this communication is to provide the patient (or responsible person) with a role in guiding and facilitating the delivery of future care. The information conveyed may include (but is not limited to) the presence of a difficult airway, the apparent reasons for difficulty, how the intubation was accomplished, and the implications for future care. Notification systems, such as a written report or letter to the patient, a written report in the medical chart, communication with the patient’s surgeon or primary caregiver, a notification bracelet or equivalent identification device, or chart flags, may be considered.”

Specific templates have been recommended for documentation and are available online at http://www.apsf.org/newsletters/html/2010/summer/06_diffairway.htm. This data can all be incorporated into the visit notes of the F1RSTUse EHR.

Unfortunately, the position that anesthesiologists may be exempt from future Meaningful Use penalties has reinforced the belief that anesthesiologists play a limited role in patient care and need not participate in such programs. We should not abandon this excellent opportunity to become more engaged with our patients and the healthcare system in general. While we may not be a daily fixture in the medical lives of our patients, our role is critical and the information we gather can be extremely vital to the electronic medical record. Let’s make Meaningful Use even more meaningful! ▲

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COMPUTER-ASSISTED PERSONALIZED SEDATION (CAPS): WILL IT CHANGE THE WAY MODERATE SEDATION IS ADMINISTERED?

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I. BACKGROUND

The medical specialty of anesthesiology is recognized for being in the forefront of adopting technology to enhance patient safety. The rapid dissemination of pulse oximetry and capnography in anesthetic practice are two classic examples of early adoption of technology by the medical community to make our practice safer. The creation of the Anesthesia Patient Safety Foundation (APSF) further exemplifies our specialty's commitment to both patient welfare and technological progress.

Over the past few decades, a new factor has prominently inserted itself into the equation, influencing the introduction of new technology. That is cost-effectiveness. In evaluating a new product, whether it provides ideal patient care or cost-effective care may give different answers.

The professional cost of anesthesia services is only a small percentage of total physician services (\approx three percent of Medicare spending in 2010). Yet, the increase in spending on monitored anesthesia care (MAC) for esophagogastroduodenoscopy (EGD) and for colonoscopy has grown significantly over the past decade. A 2012 RAND study found that from 2003 to 2009, the number of colonoscopies and



upper gastroenterology (GI) procedures increased 26 percent. In this same period, payments to anesthesia providers tripled among Medicare beneficiaries and quadrupled among commercially insured patients.

Striking regional variation exists. An anesthesia provider (2012) is most likely to be involved in a GI procedure in the Northeast (48 percent), followed by the South (38 percent), the Midwest (26 percent) and the West (14 percent). This RAND study concluded that \$1.1 billion per year was spent on payments to anesthesia providers for care in what this study deemed to be low-risk patients.

Several questions come to mind. Why has there been such a significant increase in anesthesia involvement in

EGD and colonoscopy? Studies suggest that both GI physician preference (clinical and financial) and patient preference for propofol versus traditional methods of GI sedation (midazolam and narcotic) are the primary drivers. For GI physicians, sedation of any type increases the rate at which cecal intubation is achieved and polyp detection rates are also increased. Moreover, with propofol, patient flow through the GI unit is quicker, patients are discharged sooner without lingering effects and more cases can be performed per day. For patients, they can truly “not remember anything,” and still emerge without nausea or lingering effects to be discharged promptly from the GI unit.

While there is regional variation in the payment model for MAC anesthesia for GI procedures, some vindication may be seen for anesthesia providers who have argued for our involvement in these procedures in the recent Centers for Medicare and Medicaid Services (CMS) Proposed Rule for the 2015 Medicare Fee Schedule. CMS has gone on record acknowledging that the prevailing standard of care for endoscopies in general and screening colonoscopies in particular is undergoing a transition and that anesthesia separately provided by an anesthesia professional is becoming “the prevalent practice” (Proposed Rule pp. 186-187). Therefore, CMS is revising the

definition of “screening colonoscopy” to bring anesthesia furnished in conjunction with the service within the scope of the provision that Medicare Part B waives beneficiaries’ deductible and coinsurance and pays 100 percent of the Fee Schedule amount established for certain colorectal cancer screening tests.

By proposing to pay 100 percent of the fee for an anesthetic for a screening colonoscopy under the regulation to be revised (42 C.F.R. §410.160(b)(7)) and by waiving the patient’s share in every instance, CMS has admitted that anesthesia provided by an anesthesia professional is at least as “medically necessary” as the sedation that is currently bundled into the gastroenterologist’s fee. It would be anticipated that Medicare would pay the anesthesiologist. However, there are a number of Local Coverage Decisions (LCDs) in which various Medicare contractors have predetermined that anesthesia for routine screening colonoscopies is not medically necessary. LCDs may need to be modified accordingly.

II. COMPUTER-ASSISTED PERSONALIZED SEDATION

In the US, if an anesthesia provider is not available to provide sedation, the alternative has been for the patient to receive either traditional sedation administered under the supervision of the GI physician (midazolam/narcotic) or no sedation. Because of this, Ethicon, a subsidiary of Johnson & Johnson, became interested in the concept of a device that would permit the administration of propofol for moderate sedation. Per FDA labeling, propofol had previously only been permitted to be administered by an



anesthesia provider or to a patient in an ICU setting.

The approval process was quite lengthy, with the Sedasys® system not receiving approval initially. However, in May, 2013 the Sedasys system received premarket approval (PMA) from the FDA¹. Sedasys is presently the only FDA-approved computer-assisted personalized sedation (CAPS) device on the market. Function of the system is outside the scope of this article, but information can be found on the company website (<http://www.sedasys.com>).

Ethicon specifically states that Sedasys is not intended to replace an anesthesia provider, but rather to permit the administration of mild-to-moderate sedation to patients who would otherwise not be able to receive propofol. Sedasys is approved for use for the following:

- Initiation and maintenance of minimal-to-moderate sedation
- American Society of Anesthesiologists (ASA) physical status I and II patients \geq 18 years old
- Colonoscopy or (EGD)

Sedasys is not indicated in the following patient populations:

- Patients <18 years old.
- ASA physical status IV and V.
- Patients using a fentanyl patch.
- Patients with abnormal airway or diagnosed sleep apnea.
- Patients with gastroparesis.
- Patients with Body Mass Index \geq 35.
- Patients undergoing both colonoscopy and esophagogastroduodenoscopy during the same procedure visit.
- Patients undergoing emergent colonoscopy or esophagogastroduodenoscopy.

Sedasys is contraindicated in the following patients:

- Patients with a known hypersensitivity to propofol injectable emulsion or its components.
- Patients with allergies to eggs, egg products, soybeans or soy products.
- Patients with a known hypersensitivity to fentanyl.
- Pregnant or lactating women.
- Delivery of any drug other than propofol emulsion.
- Patients with a full stomach.

Notably, Sedasys is not approved for use in ASA III patients, but it is also not contraindicated in this patient population. One thing must be made clear. Repeatedly in the Sedasys literature, “the pivotal study”² is cited by the manufacturer. It must be kept in mind that Sedasys administration of propofol was compared against “traditional” sedation with midazolam and narcotic, not against propofol administered by an anesthesia provider. Secondly, the numbers of patients over the age of 70 and in ASA class III were extremely limited. Out

¹ Birnbach DJ (Chair) USA, DHHS, Center for Devices and Radiological Health, Medical Devices Advisory Committee, Anesthesiology and Respiratory Therapy Devices Panel. May 28, 2009. Transcripts from Free State Reporting, Inc. 1378 Cape Saint Claire Road, Annapolis, MD 21409

² Pambianco DJ, Vargo JJ, Pruitt RE, et al. Computer-assisted personalized sedation for upper endoscopy and colonoscopy: a comparative, multicenter randomized study. *Gastrointest Endosc.* 2011;73(4):765-772.

COMPUTER-ASSISTED PERSONALIZED SEDATION (CAPS): WILL IT CHANGE THE WAY MODERATE SEDATION IS ADMINISTERED?

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of 1000 study subjects, 28 were ASA III patients and “there were very few patients over 70 years of age.” With 1,000 subjects in the study, it can also be argued that this study was significantly underpowered to reach the conclusions that the authors made.

For anesthesia providers, perhaps the most concerning aspect of the Sedasys system is the inability of the system to prevent or manage loss of consciousness. The manufacturers have addressed this concern two ways. First, they have developed a clinical training program that is endorsed by the International Society for Anesthetic Pharmacology and is provided by an independent, qualified third party with expertise in airway management. Clinical training consists of online knowledge-based training (approximately 4 hours) and simulation-based training (approximately 6 hours). This training (from their website) provides clinicians with the:

- Knowledge base underpinning moderate sedation practice
- Skill set necessary to rescue patients from deeper-than-intended sedation states
- Additional knowledge and skills required when propofol is used to provide sedation

A further safety measure for Sedasys is the requirement that, “an anesthesia provider must be immediately available.” What “immediately available” means is left to the discretion of each facility.

III. CRITIQUE:

I have been informed that the Sedasys system has been placed into practice in one location, so Ethicon is just starting to market the device. In discussion with industry representatives,

the ideal pattern would be for its use in a high-turnover GI suite. In this circumstance, appropriately selected patients would be managed with Sedasys, with non-candidates being managed by anesthesia personnel. However, once the device is utilized clinically, there will be strong cost pressures to widen the indications for its use.

Airway training may appear to be a simple skill, but it could be reasonably argued that the skill set required to rescue a patient from a deep anesthesia or general anesthesia cannot be taught in 10 hours.

Gastroenterologists, indeed many specialists, may look on airway management quite differently than anesthesiologists. In the Sedasys FDA application, one gastroenterologist said, “I’ll say another word about airway management for gastroenterologists. I have performed over 10,000 endoscopies. I have seen more larynxes and backs of the throats than probably most anesthesiologists. So, a gastroenterologist’s familiarity with the anatomy of the throat and the vocal cords and the esophagus is probably more than most anesthesiologists and I think there is a

disservice done to gastroenterologists to think that we don’t know how to manage an airway because we don’t intubate patients regularly. Remember, we do intubate patients regularly. We just intubate their esophagus regularly. We don’t intubate their bronchus.” The point here is precisely that anesthesiologists are focused on intubating the trachea to preserve the airway, not the esophagus for diagnosis. That constitutes a significant difference.

Five percent of the population is known to have a difficult airway. Identification of these patients poses problems for anesthesia providers who deal with this issue daily, let alone for the provider whose background is not in airway management.

The risk of MAC anesthesia has been demonstrated to be roughly equivalent to that of general anesthesia, in large part because of airway events. Airway events are also the most common cause of closed claims against anesthesiologists, especially in GI endoscopy. Furthermore, mild to moderate anesthesia can heighten the problems with the management of a reactive airway. Therefore, while the pharmacologic studies to date have



revealed that patients will start breathing with the redistribution of propofol, a finite risk to the patient remains.

Simulation training is an excellent technique for training coordinated teamwork and a systems approach to managing critical issues. However, few would argue that current simulation models are effective in actually training airway management. The approximation of the best simulation models to human tissue and various morphologies is poor. Consequently, utilizing simulation training to teach GI and nursing providers airway rescue skills is an unproven proposition.

Scheduling in the GI suite has the potential to become problematic. What will occur when an ASA III patient is assigned to the Sedasys room? Who will make the ultimate determination of the ASA physical class? There will be pressure to downgrade the ASA physical class, changing the ASA class from ASA IV to III or from III to II. What will prevent this change? Or, if downgrading does not occur, will the patient be rescheduled for another suite, perhaps having to wait for the availability of an anesthesia provider?

Cost savings is also controversial. A 2009 RAND³ study sponsored by Ethicon Endo-Surgery made the following observations:

The potential demand for CAPS is huge, being 98 million procedures in 2005 and a projected 106 million in 2015. In 2005, the overall size of the sedation market delivered by anesthesia providers was approximately \$5 billion. Approximately 40 percent of this market, or \$2 billion, was considered by the study's authors as suitable for moderate sedation and therefore redistribution to CAPS. Specialties for which CAPS could be used include Gastroenterology (fastest growth rate),

FIGURE 1

1 Set of Capital Equipment:	\$220,000
1 Set of Multiple Patient Use Components	\$4,586 *
Price for Single Patient Use Components required:	
for each colonoscopy procedure:	\$110
for each EGD procedure:	\$120
* Approximately 3 sets of multiple patient use components are required per set of capital equipment.	

FIGURE 2

CODE	Site	Number of Cases	Average Total Charges	Average Total Payment
00740	Upper GI	8,705	\$1,275	\$446
00810	Lower GI	15,156	\$1,299	\$468

Cardiology, Ophthalmology, General Surgery, ENT and OB/Gyn.

Proceduralists would be affected by CAPS in two ways, first by additional payments for use of the technology and second, by shifting procedure settings away from hospitals. For GI specialties, the study considers that nearly 45 percent of total expenditures on anesthesia would be available for reallocation. However, the study authors note that, “not all of these changes will fully materialize, because presumably payers will compensate (providers) for the use of the CAPS technology in lieu of anesthesia providers.”

CAPS is expected to save insurers significant money, with most saving coming from reduced facility revenue and anesthesia professional fees. For a total of 38 million procedures, the average cost reduction would be \$11.35 per procedure (\$431 million).

In June 2014, the Agency for Healthcare Research and Quality (AHRQ) released its Healthcare Horizon Scanning System – Potential High-Impact Interventions Report on Cross-Cutting Interventions and Programs⁴. The key

expert comment was that “Sedasys[®] has significant potential to disrupt the current methods of delivering propofol-mediated sedation.” However, the authors were unsure “whether the potential benefits of wider access to propofol-mediated sedation were significant enough to offset safety concerns about potential over sedation of patients in a setting without an anesthesiologist present.”

In discussion with representatives from Ethicon, tentative costs figures for the Sedasys system are as shown in Figure 1.

It should also be noted that the Sedasys system requires that a nurse specifically monitor the patient and have no other duties during the procedure. This—in addition to the cost of the machine and disposables—significantly adds to the cost model for Sedasys.

To compare projected Sedasys costs with cost data from actual claims submitted for anesthesia providers, a representative national sample of claims submitted for Anesthesia Business Consultants’ clients from October 2013 through March 2014 and excluding self-pay, government payers and pending claims was analyzed. The results appear in Figure 2.

³ Dick A, Mattke S, Yu, H. Assessing the Budget Impact of the Computer-Assisted Personalized Sedation Technology for Key Stakeholders. RAND Health, 2009.

⁴ <http://effectivehealthcare.ahrq.gov/ehc/assets/File/Crosscutting-Horizon-Scan-High-Impact-1406.pdf>

COMPUTER-ASSISTED PERSONALIZED SEDATION (CAPS): WILL IT CHANGE THE WAY MODERATE SEDATION IS ADMINISTERED?

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These values include payments for anesthesiologists providing care, nurse anesthetists providing care alone and to anesthesiologists and nurse anesthetists (care team model) together. The numbers are consistent with the Rand study⁽³⁾ which found that the average payment of Medicare patients was \$150 and for commercially-insured patients was \$500.

Measuring ASA Physical Status for 155,139 upper GI procedures, 51 percent of the patients were ASA I and II, 39 percent were ASA III and 8.5 percent were IV, V or VI. For upper GI procedures in patients over 18 years of age, out of 141,259 patients, 61 percent were between the ages of 18 and 65, while 38 percent were over the age of 65. Twenty-one percent of these patients were over the age of 75.

It can be seen that payments to anesthesia providers at these rates may be competitive with the cost of Sedasys, the disposables and the required nurse. Moreover, a large percentage of patients in this population who received care from an anesthesia provider did have a high ASA class and advanced age.

It is not entirely clear that CAPS will save the money that is alleged. It may be more effective at redistribution of revenue away from anesthesia providers and toward insurance companies and proceduralists. Also, GI nurses have voiced concerns about their responsibilities in administering a medication which is specifically labeled to be “administered by an anesthesia provider.” For the proceduralists, the savings may not be as dramatic as heralded, because with a nurse focused exclusively on monitoring the patient, the cost of the entire model is significantly increased.

IV. CONCLUSION

Anesthesiology has a proud history of continually providing better and safer care to patients. Now, as a specialty, we have to recognize an additional commitment, to provide cost-effective care for our patients. The seal of our society has a lighthouse on it with the word, *Vigilance* emblazoned above it. Anesthesia providers have always taken

this to mean personal vigilance in the care of their patients. However, new models of providing care for our patients will continue to emerge and will challenge this interpretation of our motto.

CAPS is an interesting development and anesthesiologists have typically been “early adopters” of technology. Sedasys may find a place in large GI units, where an anesthesiologist is always available, where patients assigned the wrong ASA class can be moved to a room with an anesthesia provider and where the volume of patients permits amortization of Sedasys costs across a large pool of patients.

Conversely, the Sedasys model as presently is not likely to be useful in small GI offices, in smaller units where an anesthesia provider is not available and where the number of cases is not sufficient to recoup the substantial expenditure required for the system and its components. ▲

Steve Boggs, MD, MBA is the Director of the Operating Room and Chief of the Anesthesia Service at the James J. Peters VA Medical Center in the Bronx, NY. He is also Associate Professor of Anesthesiology at the Icahn School of Medicine in Manhattan, NY. Dr. Boggs has been involved in the administration of anesthesia departments for over a decade. For the past several years, he has been working closely with endoscopists at Mount Sinai and elsewhere, evaluating turnover time and safety metrics and is involved in developing a curriculum for GI sedation for low-and-middle income countries and in evaluating new methods of training providers in bag/valve/mask ventilation. He can be reached at stevendaleboggs@gmail.com.



PRESENTATIONS on MAC and CAPS at the ASA Annual Meeting

Dr. Boggs will be speaking on the topics addressed in this article at two sessions:

POINT-COUNTERPOINT (PC11)

Computer-Assisted Personalized Sedation (CAPS) – Is the Coming Technology of CAPS a Friend or Foe?
Mon, Oct 13, 1:00 – 2:30 PM

PANEL (PN30)

Computer-Assisted Personalized Sedation (CAPS) – the Future of Moderate Sedation
Tue, Oct 14, 1:00 – 3:00 PM

ANESTHESIA PRACTICE ATTRIBUTES YOUR HOSPITAL LEADERSHIP TEAMS VALUE MOST

Patrick C. Everett, CPA, CMPE

Founder and President, ProSTAT Anesthesia Advisors, Alpharetta, GA

Since establishing ProSTAT in 1995, I have had the pleasure of working for more than 325 hospitals/health systems, physician-owned and Certified Registered Nurse Anesthetist (CRNA)-owned anesthesia practices, academic medical centers and related anesthesia businesses in 46 states and the District of Columbia.

My consulting business has evolved over the years from an exclusive focus on anesthesia group practice to one that now include hospitals and health systems (just over 150 at last count). That evolution has helped me better understand the viewpoints and value structure of hospital leaders as I spend time in their offices now discussing anesthesia challenges, solutions and strategies for the future with their perspective in mind. It is the substance of those detailed discussions that I hope to share with you in this article.

Five to ten years ago, I feel safe in saying, many (though not all) anesthesia practices didn't place a top priority on what hospital leaders (and surgeons, for that matter) wanted from their anesthesia provider. Patient care and safety and practice management topics filled the agendas of most anesthesia group meetings I attended. If you were an anesthesia stakeholder prior to 2007, you probably recall when it was a constant struggle to both recruit and retain anesthesiologists and anesthetists. Many wise hospital leaders at the time, understanding the great value of a strong anesthesia department, were very hesitant to push their group



toward service improvements because those informed leaders knew there were better paying or better lifestyle anesthesia jobs available, often just down the street at a competing hospital or surgery center.

But viewing the anesthesia specialty through the lens of today's much changed patient care, service and business environment, the facility-contracting leverage enjoyed by even small private practices has been deeply eroded, although certainly not eliminated. With anesthesia residents, CRNAs and Anesthesiologist Assistants (AAs) being trained in greater numbers, combined with a much slower hiring trend since 2009 and a growing number of anesthesia management companies (AMCs) and expansion-

mind private practices offering their services to hospitals, the picture looks very different.

Despite the greater range of options in the market, I find that the overwhelming majority of hospital/health system leaders I encounter are not actively seeking a replacement for their incumbent anesthesia group. Instead, they are looking for ways to better partner with their anesthesiologists and anesthetists to achieve the overarching goal of better care at a more affordable price, albeit on more aggressive terms than in the past.

The secret to keeping those hospital leaders in a "partner," not "adversary,"

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ANESTHESIA PRACTICE ATTRIBUTES YOUR HOSPITAL LEADERSHIP TEAMS VALUE MOST

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frame of mind is to develop an anesthesia service that not only provides topnotch clinical care, but that is viewed by your stakeholders as one that is indispensable to the institution. In fact, your goal as it relates to these stakeholders—hospital administrators, OR nursing staff and your surgeons—is to create uncertainty and perhaps even a level of anxiety about the prospect that your group might not be there tomorrow. In my many one-on-one interviews with hospital/health system leaders, I always make it a point to ask what anesthesia-related concern keeps them up at night. Those who have a high regard for their anesthesia team often cite the possible loss of their group when I pose that question.

Following is a discussion of the **Top 5** attributes of these very highly regarded groups who have greatly, though not totally, insulated themselves from the external market forces that exist today.

1. **Strong leadership** in terms of a single voice speaking for the group with the proven ability to effect change and ensure buy-in by all group members. Any anesthesia group president, chairman or clinical chief who has served as the primary

liaison with hospital leaders has experienced the incredible pressure *to respond to allegations* about the group's and individual member's flaws and/or transgressions, *and promise immediate action to rectify the problem*. Each time an anesthesia group leader listens to this kind of criticism but responds, "I need to take this back to my group first," her personal credibility and the value of her group in the eyes of the hospital leadership undoubtedly suffers to some degree. A hospital client of mine in the Midwest went through that back-and-forth constantly with the president of the contracted group. He expressed to me his frustration that the group president either took weeks and sometimes months to get back with a solution to the problem, or the matter was more often than not simply forgotten. As of this writing, that private practice group is being viewed as a strong candidate for health system employment, and there are plans to hire an anesthesiologist from the outside to be the new department head.

A hospital in the Northeast hired my firm about two years ago to evaluate their contracted anesthesia care team group and help that group develop a cost saving strategy to slowly reduce the annual support payment. The plan I developed was presented to both the hospital and anesthesia group leadership teams, and both initially agreed to support the plan, with the hospital committing to further support the group financially if the plan's implementation resulted in significant attrition of clinicians (it didn't). But after six months the anesthesiologists had not implemented any suggestions

because of an inability to make decisions, coupled with threats by some members of the Board of Directors to quit if certain suggested measures were initiated. When the hospital contacted four national staffing companies to obtain bids for the contract, however, the majority of the anesthesia group shareholders were jarred enough to vote to replace their Board and empower the newly-elected members to "act in the best long term survival interest of the group" without having to obtain the previously necessary 100 percent of group membership support. As a result of a series of wise decisions by that new Board, the contract was renewed for three years with far less damaging financial ramifications for the group than were initially envisioned.

2. **An ability to police/discipline bad actors proactively.** When groups are quick to recognize physician or anesthetist clinical practices or behavior that are detrimental to the practice's reputation and credibility, *and to initiate corrective action before* the hospital leaders bring up the concern, they are viewed in a far more positive light than those groups who visibly resist terminating bad actors because "they are a good doctor" or "they are a good anesthetist." Dr. Alan Rosenstein's 2011 research with medical professionals (published in the American Journal of Medical Quality) found a very strong correlation between disruptive behavior and medical errors (resulting in compromised patient safety—51 percent, adverse events—67 percent, compromised quality—71 percent). So while strong clinical skills are highly

coveted attributes, the environment in which those skills are deployed cannot be toxic, or the patients, hospital personnel and ultimately the institution itself is at risk.

3. An accommodating philosophy toward surgeons and their desires to work at *their* (reasonable) convenience.

In nearly every institution I visit today, I hear varying levels of frustration voiced by anesthesiologists (and often hospital leaders) about the inefficiencies for anesthesia and nursing personnel created from a far greater emphasis on providing surgeons with easy access to operating rooms at times convenient to them. Granted, more hospitals today are coming to understand that *over-accommodating* surgeons is not always good business for their organization or the anesthesia group, but offering an inviting environment to surgeons is critical to their market share growth objectives, and that is an unmistakable priority for every hospital leadership team. The best barometer I can think of that alerts you that the anesthesia accommodation level is below where it ought to be is when *the reasonable and rational surgeons* on your medical staff begin lodging frequent complaints with you or the hospital about the anesthesia availability or service.

4. A willingness by the anesthesia practice to apply clinical standards and protocols to patients consistently as a single group, not as individual clinicians.

The confusion and frustration that arises among nurses and surgeons when anesthesiologists and anesthesiologists in the same group diverge widely on their assessment of a patient or their approach to care is one of the more common complaints I hear in my consulting engagements. Of course, the clinician's perspective is

frequently that one's clinical judgment in a patient's plan of care is sacrosanct and cannot be compromised under any circumstances. While reasonable hospital leadership understands this perspective, most will still want to explore areas for compromise. Unfortunately, some anesthesia groups make the mistake of pointing out that "surgeons don't have to always follow standardization in the way they operate." I am told that these kinds of comments undermine the professional stature of the anesthesia group in the eyes of hospital leadership, and astute anesthesia groups (and astute surgeons) already understand that the day is coming in the not-too-distant future when surgeons will have fewer and fewer preferences they can request if they veer outside the standard without adding value commensurate with cost.

5. A priority for all members of an anesthesia group to act as positive ambassadors, not only for their group and medical staff, but for the facility where they practice.

Most hospitals consider their anesthesia team as one of many strategic advantages they reference when recruiting surgeons and marketing their facility to patients, employers and community leaders. When hospital administrators find themselves too frequently apologizing for the negative acts, omissions or behaviors of the anesthesia organization, the whole group ceases to be viewed as an asset and instead can be very quickly viewed as a liability that requires fixing through some concrete action (RFPs, employment, stipend reductions, etc.). I saw this "positive ambassadorship" expectation fully tested some years ago when the lead anesthesiologist, when confronted, readily admitted she had told members of her church and country club to drive the extra 60 minutes to a larger hospital up the

Interstate for their elective surgery because the care at the local hospital where her group held the contract was "unsafe."

In addition to these five, there are a number of desirable characteristics of anesthesia groups that may get less press, but that are still very important:

- Transparency/good faith when contractual fair market value and financial support is determined
- Compensation systems that allow the hospital and anesthesia group to align incentives
- Active involvement and leadership on important hospital committees
- An open mind to technology solutions for care delivery challenges
- Staffing models that make care delivery and economic sense in today's environment
- A group that contracts with all major governmental and commercial payers

But more than anything, incisive hospital leaders I know want a group of anesthesia professionals who "fly under the radar" and about whom they rarely hear complaints, so when they sign that monthly or quarterly financial support check they are smiling, not cursing. 

Patrick C. Everett, CPA, CMPE is a nationally-recognized independent consultant who focuses exclusively on all business aspects of the anesthesiology specialty. After careers with an international accounting firm and a practice administrator position with a large care team private anesthesia group in Atlanta, he founded ProSTAT Anesthesia Advisors, celebrating the firm's 20th year in business in 2015. He can be reached by email at pateverett@anesthesiaadvisors.com.



10 CONCERNS FACING ASCs HEADING INTO 2015

Laura Dyrda

Editor-in-Chief, Becker's ASC Review & Becker's Spine Review, Chicago, IL

Healthcare is always changing and ambulatory surgery centers (ASCs) are in a great position to take advantage of the new care philosophy: providing the best quality for the lowest cost.

However, that's only if they can overcome some of the bigger market challenges facing ASCs today:

1. Transitioning to value-based care. ASCs traditionally depended on volume to drive their bottom line, but healthcare is moving more toward pay-for-performance instead of fee-for-service. Bundled payments, accountable care organizations (ACOs) and shared savings programs all promote outcomes over volume and require healthcare providers to take on risk.

"As payers increasingly sell health plans tied to ACOs, ASCs will progressively feel compelled to participate in ACOs as well," says Adam C. Powell, PhD, president of Payer+Provider Syndicate. "This is likely to be particularly pronounced in high-density areas in which ACOs have a strong presence. Many ASCs will have to take a serious look at how they position themselves in this changing environment."

There are some ASCs preparing to participate in ACO contracts independently while hospitals are acquiring others before participation.

2. EMR implementation. The U.S. government provided incentives for hospitals and physicians to begin using electronic medical records, but not for ASCs. As a result, many ASCs haven't implemented Electronic Medical Records



(EMRs) and are now behind in data collection.

"Another reason ASCs lag behind in EMR implementation is they offer a certain value—doing procedures more efficiently than hospitals—and EMRs could slow the pace," says Steven Gayer, MD, MBA, chair of the American Society of Anesthesiologists' Committee on Ambulatory Surgical Care and an anesthesiologist with Bascom Palmer Eye Institute in Miami. "The challenge is to find an EMR built around the ASC's efficiency. At the hospital, you might have time to click through many screens while waiting for the operating room to open up, but at ASCs when you're doing multiple procedures in a row, there isn't time to fill in every field. We need a specialized EMR and that's been slow in coming."

However, the data gathering potential is significant for ASCs. They can find inefficiencies or negative trends and fix them quickly before a bigger issue arises.

3. Data collection and optimization. Gathering single-center data is great for identifying and fixing issues at the center, but outside data is necessary for benchmarking and additional improvement. The Ambulatory Surgery Center Association offers a benchmarking program collecting data from a large number of ASCs across the country with the potential to offer both broad benchmarks as well as very specific numbers for certain types of centers. Clinical organizations—including the Society for Ambulatory Anesthesiology (SAMBA)—also have outcomes registry data available.

The SAMBA registry is a web-based database that aligns with some EMR records. “Gathering data is not sufficient on its own. You have to gather data and then do something with it,” says Dr. Gayer. “Anesthesia leaders are looking for what the data says about quality of care and how they do things at their facility. We’re looking to make things more efficient, safer and improve patient satisfaction postoperatively.”

4. Promoting ASC benefits. There is strong data showing ASCs generally have higher quality and lower costs than hospitals because of their smaller size and often focused expertise. Patient satisfaction is also high at surgery centers, but in many communities people still go wherever their surgeons recommend and aren’t aware of ASCs.

“As a result of their smaller size, ASCs often lack the brand recognition of local health systems,” says Mr. Powell. “Furthermore, some patients may be hesitant to receive care outside the walls of a hospital. Quality fears can be mitigated by sharing literature on the positive relationship between volume and quality, as well as applicable performance scorecards.”

Prices published online will help patients make comparisons with other healthcare facilities and determine the best value. A few ASCs across the country are already publishing prices online, a trend expected to grow.

5. Physician recruitment. Hospitals are purchasing physician practices and offering employment contracts to new and veteran surgeons across the country. Independent physicians are also finding it harder to maintain their business with new regulations and expenses, making the hospital contracts seem even more attractive. However, hospital-employed surgeons are often unable to perform cases at ASCs.

Rural ASCs are especially hit hard, as surgeons often train in urban areas and decide to begin practicing in the urban environment.

“According to a survey conducted by the Colorado Health Institute, the top three factors that rural doctors rated as very important were the availability of recreational and leisure activities, the sustainability of the environment for raising children and the degree of professional independence available to them,” says Mr. Powell. “Emphasizing these benefits during the recruitment process may be helpful.”

6. Patient experience with higher acuity cases. Higher acuity cases once relegated to hospital settings are coming into surgery centers. These include orthopedic joint replacements, spine surgeries and older patients with more comorbidities. Technology allows surgeons to perform these cases with less invasive procedures and anesthesiologists to better control pain.

Surgeries involving catheters were once hospital-only procedures, but now anesthesiologists working in ambulatory centers can thread the catheter and inject

the catheter before the surgery is over to maintain the block. Pain pumps gradually infuse the local anesthetic mixture for the patient so they can go home with the pump still intact.

“The patient can either come back to the center for us to remove it, or remove it at home on their own. In that case, we would conduct a follow-up call to make sure all went well,” says Dr. Gayer. “This helps us minimize postoperative narcotic use and allows patients to resume their typical activities of daily living earlier. We’re extending the physician anesthesiologist’s presence from the preoperative evaluation, the intraoperative experience, the postoperative recovery room stay and finally into patients’ homes as well.”

There is great patient satisfaction associated with continuous catheters and pain pumps, says Dr. Gayer, and more ASCs are implementing them. “It takes a leader to come in and say we can do this and we should do this.”

7. Case cancellations. Cancelling cases—especially the day of surgery—has a significant impact on patient satisfaction and the ASC’s bottom line. The surgery center has staff ready and waiting for the patient, and sometimes they even begin the preoperative process. If the case is cancelled, it wastes time, and prevents another patient from filling that slot.

In some cases, cancellations are preventable—such as when the patient doesn’t follow preparation protocol or history isn’t taken beforehand. The patient history can identify red flags that would prevent them from having surgery at the center, such as sleep apnea, high BMI or ASA score.

“The ambulatory surgical center may not be the appropriate venue for some patients,” says Dr. Gayer. “A good quality database allows benchmarking with similar facilities to compare the percentage of cancelled and postponed



10 CONCERNS FACING ASCs HEADING INTO 2015

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cases and find trends. If the cancellations were preventable, new protocols may be instituted. Smart ASC leaders are diving into the analysis of big data and I think that's meaningful for the future."

8. Drug shortages. Facilities struggle to obtain drugs which may have temporary limited availability, which means vials from different manufacturers may be of different sizes and have different labels. The variation puts staff members at risk of making mistakes.

"We are dealing with processes that occur millions of times, so the risk of mixing up drugs is now higher," says Dr. Gayer. "Another issue is single-use only vials. If you have a shortage of a critical drug and only use 5 ccs of a 10 cc vial on a patient, you're required to throw away the balance. Somewhere down the line another patient might be denied that drug due to lack of availability."

ASCs can combat these challenges by compounding drugs, but that's an expensive and time consuming process. "The expense is significant, but it may

be the right thing to do in the time of shortages," says Dr. Gayer. "However, you are also introducing another variable, the risk of infection through contamination."

9. High deductible insurance plans/patient collections. More patients are covered by high-deductible health plans, which can impact ASCs in several ways. It takes longer for patients to meet their deductible with these plans, and elective procedures are often put off until the deductible is met. ASCs might experience a slower start to their year than in the past.

These plans also require patients to pay more out-of-pocket. Some centers require patients to pay upfront while others have payment plans. Experts suggest sending bills earlier and more frequently to patients with payment plans. When centers aren't able to collect, they can turn those claims over to debt collectors, but that strategy is less than ideal.

Staff members are also undergoing training to communicate about payment with patients. It takes extreme sensitivity

and compassion to work with patients on payment plans, especially when the patient is in pain. But collections are important to keep the ASC running.

10. Leadership under healthcare reform. Business can't go on as usual with the new healthcare reform regulations maturing. Leaders must be flexible and responsive to new legislation and market changes. Many physician leaders are pursuing MBA programs.

"We are using the new skills and philosophy to help lead and satisfy our organization's mission," says Dr. Gayer. "The first priority is patient safety and providing a good experience for the patient, but we also want to run the facility in a manner that sustains the organization."

Surgery centers are small businesses and require strong relationships between staff and management to run efficiently. "Anesthesiologists working in ASCs can provide leadership—their base of operations is the ASC," says Dr. Gayer. "Anesthesiologists will play a vital role in the development of the surgical home. I think that's where we're going in the future." ▲

Laura Dyrda is Editor-in-Chief of Becker's ASC Review and Becker's Spine Review, online and print publications of Becker's Healthcare. She joined Becker's Healthcare in 2010



and has previous experience as a journalist and freelance writer for various online and print publications. Ms. Dyrda graduated from Knox College with a degree in Creative Writing. She is located in Chicago and can be reached at ldyrda@becker-shealthcare.com or 312-253-9170.

THE VALUE OF A QUALITY PRACTICE ADMINISTRATOR

Ronald Booker, JD, CPA

Houston, TX

Compensation packages for senior practice administrators in large, private anesthesia groups can be well into six figures. That's a lot of money, but are they really worth it? During this time of turmoil in the healthcare market where there is tremendous pressure on all healthcare providers, including doctors, to do more for less, does it make sense to pay one individual so much money? Each anesthesia practice must decide who they want to help run their business and how much they should be paid. However, the following issues should be a part of the equation.

The business side of anesthesia is very complicated. Anesthesiologist, CRNA and AA recruiting and retention. Scheduling. Retirement plans and health insurance benefits. Employee policies and enforcement. Managed care and hospital contracting. Revenue cycle management (billing and collections). Coding. Compliance. Accounting. Payroll. Risk management (lawsuits) and insurance. Continuous quality improvement. Computer and communication systems. Strategic planning and implementation. Hospital administration relationships. Surgeon and patient satisfaction.

Can any one person be an expert in all of these areas? Not likely. So why not hire lower cost experts to handle all of these issues and save the expense of a high priced administrator? There are at least four essential skills that a quality administrator brings to an anesthesia practice that more than justify his or her compensation: decision-making, problem-solving, communication and relationships.



DECISION-MAKING

Just as a conductor of an orchestra contributes not a single note to a beautiful piece of music but is indispensable to the performance, a practice administrator brings together the right team and helps them blend their skills to create a high-functioning organization that makes good decisions. Here are a couple of examples.

A well-meaning partner of a large anesthesia group and the new HR director decided to hire an independent broker to evaluate the practice's health, dental, vision, disability and life insurance plans. As expected, following his evaluation, the broker presented complicated and colorful charts and graphs showing that the practice was being too generous in offering "above market" insurance

to its employees and recommended a significant reduction in benefits and increase in employee contributions that would save the partners a significant amount of money. The well-meaning partner, anxious to look good to his partners, was ready to make an elegant presentation to the board that he was confident would result in the unanimous approval of the new plan.

The experienced administrator helped him avoid what might have been a disaster by asking the following questions: how much residual financial liability would the group incur by changing from a self-funded plan to a full indemnity plan, and where would the money come from? How long would the

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THE VALUE OF A QUALITY PRACTICE ADMINISTRATOR

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savings be guaranteed? Was the current insurance provider given a chance to modify coverage and reduce costs? How would this new plan affect recruiting and retention of new providers? Would the change breach any employment contract provisions? How would a change in network affect partner and employee access to their current family doctors and hospitals? Changing employee insurance benefits may be the right thing to do, but the decision involves much more than just reducing insurance costs, and a quality administrator will help identify and answer these issues to allow the partners to make a good decision.

In the second example, the group's finance committee and CFO read an article stating that patient deductibles and financial responsibilities are increasing significantly as employees pass more costs to their employees. In response, the committee decided to 1) hold filing all claims to non-government payers for 45 days so that the hospital and surgeons

will get hit with the patient deductibles, and 2) start collecting deposits from patients prior to surgery. It sounded like a no-brainer until the administrator spoke up, asking, "How many deductibles is the practice being hit with currently? What effect will holding claims have on the practice's cash flow? How will the billing department handle holding only non-governmental claims? How will the group collect from patients pre-surgery and how much will it cost? How will the new policy affect the group's relationship with hospitals and surgeons?" By focusing on the forest instead of just one tree, a quality administrator can help identify the impact of decisions on the entire practice to avoid unintended consequences.

PROBLEM-SOLVING

There is an old adage: "you don't know what you don't know." This is a difficult concept for very intelligent and successful people to accept, but it is as true in an anesthesia practice as it is in any

other endeavor. A quality administrator has access to personal experience, colleagues, conferences, professional journals and other resources to help them identify new ways to deal with traditional problems. In addition, they often know that they don't know the answer and that it is time to bring in someone who does.

Take the example of a six-anesthesiologist practice where a partner is nearing retirement. The group's historical and successful strategy has been to interview young anesthesiologists near completion of their residency and to offer the best candidate a full-time job with a one year partnership track. This structure was primarily driven by the shortage of anesthesiologists and the need to keep the call burden reasonable for all of the partners.

However, in many markets, things have changed. There is a ready supply of qualified anesthesiologists looking for stable jobs in a flexible environment. Maybe the group can hire a young anesthesiologist on a three-year partnership track or as a full-time permanent employee. Maybe the group can hire a less expensive CRNA to replace the anesthesiologist during the day and hire a stay-at-home parent or a semi-retired baby boomer anesthesiologist to cover some calls. A quality administrator recognizes and honors what has worked in the past but is always looking for creative solutions that take advantage of current circumstances and isn't afraid to ask for help from colleagues and consultants.

COMMUNICATION

By far, the number one problem in every anesthesia practice is poor communication. In small groups, the partners are so busy providing clinical services that they don't take the time to stay informed about non-clinical issues. In larger groups, it is not uncommon for

long-term partners to barely know each other, much less to know about what is going on in numerous committees. The key to good decision-making and problem-solving is knowing and understanding the truth. A quality administrator's ability to understand the important issues and clearly communicate them to each partner is essential to the success of the practice.

The relatively young twelve-member board of a very large anesthesia practice decided to consider partnering with or selling to a national practice. They decided to retain a consultant for \$20,000 to help them evaluate their options. Before the meeting had even ended, the buzz was spreading among the other partners that the board had decided to sell the practice, that each board member had been promised a \$20,000 bonus from a potential buyer, and that they intended to fire all of the older partners so that they would not benefit from the sale. This may sound like an exaggeration, but it isn't. Lack of truth breeds rumors and gossip that can destroy the best laid plans. A quality administrator is in a unique position to listen to partners' concerns, communicate the facts and dispel misinformation. Even in situations such as lawsuits where confidentiality is required, a quality administrator can be invaluable in helping partners feel inside the loop.

TRUST

At the end of the day, the most valuable asset that a quality administrator brings to an anesthesia practice is trust. It takes time to develop and does not usually happen without planning and hard work. However, having an administrator who the partners know, because of experience and their relationship, will be honest, reliable, and effective is a valuable asset to the practice. It is important to know that the administrator is truly committed



to the success and best interest of the partners. While good decision-making, problem-solving, and communication are essential to the success of any practice, there are many times when a partner just needs to hear from someone they trust that things are OK.

An experienced administrator was recently asked by his 25-member anesthesiology group to try and quantify his value to the practice. After considerable thought, the administrator produced a spreadsheet showing how just a few successes regarding managed care contracting, staffing; and adding new facility contracts had resulted in an additional eight million dollars for the partners over a three-year period. I don't know how much the administrator was being paid, but I'm guessing that this was a pretty good return on investment for the anesthesiologists. The administrator then asked each anesthesiologist to anonymously describe the administrator's value to

them. While many commented about their increase in compensation, most commented about bad decisions that were avoided, problems that were solved without most partners even knowing about it, or keeping peace in the family.

A quality administrator is worth his or her weight in gold. Hire carefully, evaluate constantly and reward appropriately. Your group will be better for it. 

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COMPLIANCE CORNER: MEDICARE'S MODIFIER 59 EXPANSION

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The Centers for Medicare & Medicaid Services (CMS) began the National Correct Coding Initiative (CCI) edits as an initiative to promote correct coding by providers and to prevent Medicare payment for improperly reported services. The CCI program consists of automated edits that are part of the claims processing systems deployed by the Medicare Administrative Contractors (MACs). Specifically, the CCI edits contain pairs of Healthcare Common Procedure Coding System (HCPCS) codes (i.e., code pairs) that generally should not be billed together by a provider for a patient on the same date of service. All code pairs are arranged in two columns. Column 1 contains the primary code and column 2 the secondary code or service format. The column 2 code is generally not payable with the column 1 code.

Under certain circumstances, a provider may bill the column 2 service in a CCI code pair by including a modifier on the claim that would bypass the edit and allow both services to be paid. A modifier is a two-digit code that further describes the service performed. While the CCI edits contain 35 different modifiers that may be used to bypass the CCI edits, modifier 59 is the most frequently reported.

Modifier 59 is used to indicate that a provider performed a distinct procedure



or service for a patient on the same day as another procedure or service. It is attached to the secondary, additional, or lesser service in the code pair.¹ Pursuant to the Medicare Claims Processing Manual and the 2014 Current Procedural Manual, modifier 59 may represent a:

- Different session,
- Different procedure or surgery,
- Different anatomical site or organ system,
- Separate incision or excision,
- Separate lesion, or a
- Separate injury (or area of injury in extensive injuries).²

When modifier 59 is used, pursuant to the Medicare Claims Processing Manual, the provider's documentation must demonstrate that the service was distinct

from other services performed that day.³ Section 1833(e) of the Social Security Act requires that providers furnish "such information as may be necessary in order to determine the amounts due" in order to receive Medicare payment.

For example, the family of HCPCS codes 22520-22522 describes percutaneous vertebroplasty. Current Procedural Terminology (CPT®) code 22520 identifies percutaneous vertebroplasty of a single thoracic vertebral body. CPT code 22521 describes percutaneous vertebroplasty of a single lumbar vertebral body. CPT code 22522 is an add-on code for percutaneous vertebroplasty of each additional thoracic or lumbar vertebral body. If a physician performs percutaneous vertebroplasty on contiguous vertebral bodies such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body should be reported with CPT code 22522. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22520 and 22521.⁴ Currently modifier 59 would be used to indicate the second procedure is distinct since it was performed on a separate organ/structure. As of January 1, 2015 modifier XS (separate structure) would also be correct. In both cases, the physician's documentation must clearly indicate that the procedures were on different distinct structures.

The Office of the Inspector General (OIG) and CMS have longstanding concerns about potential fraud and abuse related to the use of modifier 59. As a

¹ "Medicare Claims Processing Manual," Chapter 23, section 20.9, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf>

² Ibid.

³ Medicare Claims Processing Manual," Chapter 12, section 30, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

⁴ "National Correct Coding Policy Manual for Medicare Part B Carriers," Chapter IV Surgery: Musculoskeletal System CPT Codes 20000-29999, January 1, 2014, <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

result, CMS released on August 15, 2014 four new modifiers for coders and billers to choose from starting January 1, 2015 when reporting services to Medicare that would have previously been reported with modifier 59. The new modifiers and their descriptors are shown in Table 1.

Although the new modifiers will take effect, January 1, 2015, CMS stated in the Transmittal that modifier 59 will remain active. However, the agency may “selectively require” use of one of the new modifiers for certain codes that have a higher risk of incorrect billing.⁵

Table 2 sets forth a few additional scenarios in which the new modifiers might add clarity to why both services/procedures were performed.

Modifier 59 (distinct procedural service) has never been well understood by physicians, coders or billers. Often it is used by a coder or a biller as a default modifier to get a previously denied service reimbursed. In its announcement regarding the new HCPCS modifiers, CMS cites high rates of misuse as a

TABLE 2

59 EXPANSION MODIFIER	CODING EXAMPLE
XS	A physician sees a Medicare patient and treats the patient for pain in the upper back with a transforaminal epidural performed with fluoroscopy. The primary-column 1 HCPCS code is (64479). During the same encounter the physician treats the patient’s pain in their knee and reports the HCPCS code (20610 – a column 2 code) for arthrocentesis, aspiration and/or injection major joint or bursa HCPCS. Before January 1, 2015, modifier 59 would be reported with the arthrocentesis procedure. Effective January 1, the new expansion modifier XS (separate structure) would be used.
XU	An anesthesiologist, certified in Transesophageal Echocardiography (TEE), is requested by the surgeon to carry out TEE service during the intraoperative period in which the anesthesiologist is also providing the anesthesia service for a procedure on the heart. The TEE is in accordance with all Medicare regulations. The anesthesia HCPCS code (00560) would be submitted as usual based on the surgical procedure and the TEE HCPCS code 93312-26-XU (unusual non-overlapping service) would be submitted. (Note: the 26 modifier indicates the professional service for the probe placement, interpretation and written report and archiving of the TEE images.)

factor for the change, noting that the 2013 Comprehensive Error Rate Testing (CERT) program report projected \$770 million in improper payments involving modifier 59. A November 2005 OIG report had previously found that forty percent of code pairs billed with modifier 59 in FY 2003 did not meet program requirements, resulting in \$59 million in improper payments.⁶

Opinions on whether the new 59 modifier expansion effort to clarify distinct procedural services will reduce or increase denials are about 50-50. Many industry experts are waiting for additional clarification from CMS or the MACs about exactly how to use the new subset modifiers. Surprisingly, CMS stated in the transmittal that either 59 or a subset modifier may be payable on a claim line, though it goes on to say that “a rapid migration of providers to the more *selective* modifiers is encouraged.”⁷ In addition, as of yet private payers have not indicated what, if anything, they will implement or accept regarding the four expansion modifiers.

Each January, CMS releases corresponding CCI guidance specific to each range of HCPCS codes. Many experts believe that the 2015 guidance manual will require a major rewrite to correspond to CMS statement that particular code pairs in CCI may be identified as payable only with one of the new X modifiers. Currently, CCI edits state only that a modifier is or is not allowed with the edit without guidance on specific modifiers. Providers, coders and billers should stay alert to additional guidance from CMS or their MAC as the effective date grows closer. ▲

TABLE 1

MODIFIER	DESCRIPTION
XE	Separate Encounter — A service that is distinct because it occurred during a separate encounter
XS	Separate Structure — A service that is distinct because it was performed on a separate organ/structure
XP	Separate Practitioner — A service that is distinct because it was performed by a different practitioner
XU	Unusual Non-Overlapping Service — The use of a service that is distinct because it does not overlap usual components of the main service

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⁵ “CMS Manual System, Pub 100-02 One-Time Notification, Transmittal 1422, August 15, 2014, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf>

⁶ Office of Inspector General, “Use Of Modifier 59 To Bypass Medicare’s National Correct Coding Initiative Edits” November 2005, OEI-03-02-00771, <http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf>

⁷ “CMS Manual System, Pub 100-02 One-Time Notification, Transmittal 1422, August 15, 2014, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf>

POTENTIAL REVENUE LOSSES WITH HEALTH INSURANCE EXCHANGE PATIENTS DUE TO PREMIUM PAYMENT DEFAULT

Joette Derricks, CPC, CHC, CMPE, CSSGB

Vice President of Regulatory Affairs & Research, ABC

The Affordable Care Act (ACA) was passed four years ago and there have been plenty of ups and downs regarding its rollout. Now that it appears to be here to stay, healthcare providers need to change their focus on the impact the new health insurance exchanges may have on their financial bottom line.

Individuals who buy coverage on the Marketplace and fall below certain income levels can qualify for advance payments of a premium tax credit (APTC) to help pay their premiums. As long as these individuals pay their share of the first month of premium, insurers cannot later terminate their coverage without first giving a three-month (90-day) grace period to pay. The Obama Administration saw this rule as a means to further the continuity of care for those who cannot afford premiums for certain months due to job loss or other financial constraints. Many healthcare experts see the grace period as an unacceptable loophole.

Any time these subsidized members become delinquent on their monthly premium payments, health insurers must follow certain federal rules before terminating their coverage.¹ Providers need to understand these rules, as they will directly affect your payments for services and may affect how you operate your practice. This is especially true



for smaller physician groups that may not have the charity care funds or other options, such as paying the patient's premium to help offset the potential financial loss.

Insurers have to pay claims for services rendered during the first month of the grace period. Insurers may pend claims for services rendered in the second and third months, but must continue to treat the member as eligible. If the member never pays the premium, the insurer can terminate the member's coverage, retroactive to day 31 of the grace

period. Because the member defaulted on the premium payment, any claims for services rendered in the second and third months (days 31 through 90) will be denied.

So what does this mean? Patients with unpaid claims face a tax penalty but are not charged with a rate increase, issued a repayment order or even banned from participating in another exchange. In essence, enrollees can jump from one exchange plan to the next every four months—and still receive full health coverage.

Brett Johnson, JD, MPH, MS wrote an article in an American Bar Association Newsletter that provides a table clearly illustrating the course of this grace period.² (See Table 1 on following page).

Some insurers are releasing detailed procedures on how they plan to implement the grace period. For example, Blue Cross Blue Shield of Arizona (BCBSAZ), in their January 2014 Volume 4 Issue 1 newsletter regarding network updates, offered the following summary:³

- *The three-month grace period applies only to individuals who are:*
 - *Enrolled in a Qualified Health Plan through the Marketplace;*
 - *Are receiving a federal subsidy-APTC; AND*
 - *Have paid their share of the first month of premium.*
- *If a member meets the criteria above, BCBSAZ must give the member a*

¹ 45 C.F.R. § 156.270(d)

² http://www.americanbar.org/content/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1308_johnson.html

³ <http://bluesletteronline.com/volume4-issue1/network-updates/aca-three-month-grace-period-for-delinquent-premiums/>

TABLE 1 **The Exchanges' Three-Month Grace Period for Non-payment of Premiums by Subsidized Enrollees**

First month of delinquency	Second and Third months of delinquency	Terminated after three months of delinquency
<ul style="list-style-type: none"> • Normal payment of claims. • Plan effectively treats this month as paid even if enrollee is eventually terminated for non-payment. • No-provider notification of the patient's delinquency. 	<ul style="list-style-type: none"> • Plan has the option to pend claims for services performed until the enrollee pays the outstanding premium balance. • Providers submitting claims during these two months are notified of the potential for a denied claim. • If enrollee pays off the premium balance, providers' claims are paid at that time. 	<ul style="list-style-type: none"> • Plan has the option to deny all claims for services performed in the second and third months of delinquency. • Providers may seek payment for denied claims from the patient. • Patient may then enroll in a different exchange plan during the next open enrollment period regardless of whether they pay off premium balances with previous insurers.

Source: Johnson B. Health Benefit Exchange Contracting – Providers Could Be Left Holding the Bag for Two Months of Claims on Subsidized Exchange Patients. ABA Health eSource (August 2013).

three-month grace period to cure any default in premium payments.

- *During the grace period, BCBSAZ cannot terminate coverage for non-payment of premium. The member will show as “eligible” for electronic and phone inquiries about eligibility. BCBSAZ will, however, send notification letters to providers who submit claims for*

services for individuals who are in the second and third months of the grace period.

- *BCBSAZ will process precertification requests in normal timelines, but will notify providers, as described above, when members are in their grace period.*
- *BCBSAZ will pay all appropriate claims for services rendered to a*

member during the first month of the grace period.

- *BCBSAZ will pend all non-pharmacy claims for services rendered to a member in the second and third months of the grace period.*
- *BCBSAZ is allowed to, and will, deny pharmacy claims during the second and third months of the grace period.*
- *BCBSAZ will send notification letters to providers submitting claims for services to individuals who are in the second and third months of the grace period. The notification letter will indicate:*
- *The claim has been pended because the subsidized member is in the second or third month of the 90-day grace period; and*
- *Claim(s) may be denied if the subsidized member exhausts the 90-day grace period without paying all outstanding premiums.*
- *If the member cures the premium default, BCBSAZ will process the claims in accordance with the member's benefit plan and all normal claims-handling procedures.*
- *If the member does not cure the default by the end of the grace period, BCBSAZ will terminate the member's coverage retroactive to day 31 of the grace period and deny all claims for services rendered in the second and third months.*
- *BCBSAZ will process grievances and appeals as required by law. This may result in BCBSAZ asking for medical records for cases for members who ultimately are not eligible. BCBSAZ will work with providers to try to minimize unnecessary work and records requests.*



POTENTIAL REVENUE LOSSES WITH HEALTH INSURANCE EXCHANGE PATIENTS DUE TO PREMIUM PAYMENT DEFAULT

Continued from page 25



The grace period loophole could take a serious toll on provider collections. Physicians may be left with payment for a patient's treatment during months two and three of the grace period not covered and effectively not collectible.

How much will this impact physician practice finances? Early numbers indicate between 15 and 30 percent of enrollees may default on their premium payments.

"This thing is working," President Obama said on April 17, 2014, at the White House, where he announced that more than eight million Americans had signed up for enrollment.⁴ The potential impact of the grace period loophole became apparent last month when Aetna reported that out of 720,000 sign-ups, only about 580,000 were paid up by May 20—a payment rate of only 80.6 percent.⁵

That would leave Aetna's paid enrollment down as much as 30 percent from that May sign-up tally.

It is not clear how representative Aetna's experience is of broader exchange trends, or whether its projection may be too conservative. Other major insurers were still gathering the data. Some states, such as Washington, indicated about a \$10,000 drop in premiums in a two month period.⁶

An estimate released by the Blue Cross Blue Shield Association, reflecting enrollment activity among 35 Blue Cross Blue Shield plans in 47 of the 50 states, including plans sold by WellPoint Inc., from October 2013 through February 2014, showed that premium payments were received from 80 to 85 percent of its new Obamacare health insurance enrollees.⁷

The gap between the sign-ups and the number of current premium-paying customers reflects both those who never sent in a first payment and those who stopped paying for any number of reasons. Finances may have been stretched too far, and some may have gotten fed up with high deductibles, while others could have switched plans so they wouldn't have to switch doctors. Still others may have found a job that came with health benefits, or others lost income and qualified for Medicaid.

In support of adequate notification to health care providers, the American Medical Association's (AMA) House of Delegates adopted a new policy calling upon insurers to inform physicians when their patients enter the grace period. Insurers that do not notify physicians would face a binding eligibility determination that would make them responsible for claims made during the grace period. The AMA noted that insurers are already capable of giving doctors real-time verification of eligibility, co-payments, deductible information and claims processing status.



⁴ <http://www.whitehouse.gov/blog/2014/04/17/president-obama-8-million-people-have-signed-private-health-coverage>

⁵ <http://acasignups.net/14/07/09/which-investors-business-daily-completely-mangles-my-data>

⁶ <http://www.insurance.wa.gov/about-oic/news-media/news-releases/2014/6-12-2014.html>



The American Hospital Association (AHA) is also researching strategies for dealing with the grace period loophole. Because plans offered on the new health insurance exchanges are not federal healthcare programs, the Anti-Kickback Statute (AKS) and other federal enforcement statutes do not apply, according to a legal advisory issued by the American Hospital Association.

In an Oct. 30, 2013 letter to Rep. Jim McDermott (D-Wash.), United States Department of Health and Human Services (HHS) Secretary Kathleen Sebelius confirmed plans purchased on the exchanges established by the ACA are not federal healthcare programs and therefore are not covered by the Anti-Kickback Statute. Additionally, the ACA allows a third party to pay the premium on an exchange plan.

This should mean hospitals and health systems can supplement the

insurance premiums for patients as they see fit. However, in a Nov. 4, 2013 Q&A, HHS expressed concerns these payments could create an uneven playing field in the market and declared that the Department “discourages this practice and encourages issuers to reject such third party payments.” Additionally, HHS “intends to monitor this practice and to take appropriate action, if necessary.”⁸

According to the AHA brief, HHS cannot currently take legal action against payments of this nature without rulemaking, as it has already declared ACA plans to be separate from federal healthcare programs and not subject to the Anti-Kickback Statute or similar laws. The brief states: “While it undoubtedly was intended to have a chilling effect on the willingness of hospitals to provide insurance subsidies for individuals in need, the Q&A appears to have no legal force or effect on hospitals (or insurers)

and to be unenforceable.”⁹ Even if HHS decided to pursue rulemaking, AHA doubts HHS has the authority to enforce a ban on healthcare providers helping their patients afford ACA premiums.

In short, hospitals and some physician groups may see it as a viable option to pay the patient’s premium for a few months in order to recoup a significantly larger reimbursement for the care rendered. Like many other provisions of the ACA, the final decision on whether healthcare providers will be able to make the patient’s payments may rest with the court system. ▲

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⁷ <http://www.reuters.com/article/2014/04/02/usa-healthcare-payments-idUSL1N0MU1YP20140402>

⁸ <https://www.federalregister.gov/articles/2014/03/19/2014-06031/patient-protection-and-affordable-care-act-third-party-payment-of-qualified-health-plan-premiums>

⁹ http://www.ahanews.com/ahanews/jsp/display.jsp?dcrpath=AHANews/AHANewsNowArticle/data/ann_081513_graceperiod



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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
October 9-10, 2014	Society of Anesthesia and Sleep Medicine 4th Annual Meeting	Hotel Monteleone New Orleans, LA	http://www.sasmhq.org/
October 10, 2014	International Society for Anaesthetic Pharmacology 23rd Annual Meeting	W New Orleans Hotel New Orleans, LA	http://www.isaponline.org/
October 11-15, 2014	American Society of Anesthesiologists Anesthesia 2014 Annual Meeting	Ernest N. Morial Convention Center New Orleans, LA	http://www.asahq.org/Annual-Meeting.aspx
October 23-25, 2014	Ambulatory Surgery Centers 21st Annual Conference	Swissotel Chicago, IL	http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/
November 7-8, 2014	Society of Academic Anesthesiology Associations Annual Meeting	The Palmer House Hilton Chicago, IL	http://www.SAAAhq.org
November 8-9, 2014	ASA Quality Meeting 2014	ASA Headquarters Schaumburg, IL	http://education.asahq.org/aqm
December 12-16, 2014	PostGraduate Assembly in Anesthesiology 68th Annual Exhibit	New York Marriott Marquis New York, NY	http://www.nyssa-pga.org/pga-meeting
January 12-16, 2015	California Society of Anesthesiologists 2015 Winter Conference	The Fairmont Kea Lani Maui, Hawaii	http://www.csaahq.org/up-more.php?id=59
January 14-17, 2015	University of California, San Diego, Department of Anesthesiology Update 2015	Kona Kai San Diego San Diego, CA	http://anes-som.ucsd.edu/2015_update/
January 23-25, 2015	ASA Conference on Practice Management	Atlanta Marriot Marquis Atlanta, GA	http://www.asahq.org/For-Members/Practice-Management/Conference-on-Practice-Management.aspx

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