

WHAT DOES THE QZ MODIFIER REALLY MEAN?

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HEALTHCARE POLICY AND ITS UNINTENDED CONSEQUENCES

American medicine has many quirky aspects. Those who claim they can fix it have no clue what they are up against. Perhaps the most bizarre is the relationship between payer policies and clinical behavior. The law of supply and demand may apply to many disciplines, but not medicine, at least not consistently. Public and private payers are always trying to adjust the supply of medical services by raising or lowering rates or implementing rules to limit utilization of services. Normally this process of utilization review and policy revision kicks in when billing patterns change. An increase in the number of epidural steroid injections billed ultimately resulted in lower payment per injection and rules that limited how many injections could be billed in a six-month period. The same



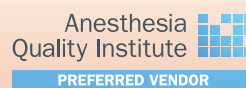
can be said in anesthesia for screening endoscopy: a dramatic increase in billings resulted in new codes and lower base values. Sometimes, though, it is just not that simple. And so we come to the story of the payment policy for anesthesia. The implications of the anesthesia care team take us to a whole new level of economic complexity.

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THE CHALLENGE OF CHANGE

Today's healthcare market is in a very dynamic stage. On the one hand, there are so many exciting medical developments; clinicians are truly conquering some of the world's most serious challenges. Cancer and AIDS are probably our two most dramatic success stories. In anesthesia the use of targeted nerve blocks may allow us to beat back the opioid crisis. What used to be a death sentence is now just an inconvenience.

Unfortunately, the flip side of the coin is the cost of healthcare. Despite all the rhetoric, there does not appear to be a good solution. As a result, every healthcare organization must now focus on ways to reduce the cost of diagnosis and treatment. This affects hospitals and, especially, their review of stipend requests from anesthesia departments. This affects anesthesia practices in a very significant manner as they struggle to recruit and retain sufficient providers to meet every expanding hospital expectations.

To this end, our lead article discusses the current trends in CRNA care and the potential of new models of team management. What was introduced as an arcane Medicare billing modifier has become one of hottest topics in the specialty. Howard Greenfield, MD and ABC's own Jody Locke, MA, vice president of anesthesia and pain practice management services have compiled a very thorough review.

Attorney Mark F. Weiss, JD, of the Mark F. Weiss Law Firm, always has some interesting insights to guide us through the myriad challenges on negotiating a fair contract. Increasingly it is our negotiating skills that determine our success or failure in medicine and not the quality of service provided.

Another attorney, Kathryn Hickner, Esq., of Kohrman, Jackson & Krantz, LLP, then delves into the every intriguing issue of practice mergers and acquisitions. How big is big enough? Her observa-



tions are especially salient to the current environment.

First time *Communique* author Nirav Kamdar, MD, MPP, with the Department of Anesthesiology and Perioperative Medicine at UCLA, then takes us into the fascinating realm of telemedicine. Some very exciting things are happening at UCLA. We are always interested in looking into the future of anesthesia. In today's competitive healthcare arena innovation may well differentiate winners from losers.

Finally, our always reliable anesthesia consultant, Kelly D. Dennis, MBA, of Perfect Office Solutions, Inc., brings us back to reality with a very careful and exhaustive review of today's anesthesia documentation requirements. If ever you were wondering how complicated anesthesia billing has become, this is a worthy explanation. It should be mandatory reading for all providers.

There is never a shortage of hot topics in anesthesia. We are constantly seeking useful and reliable solutions to today's

most pressing problems. I hope you find our ideas timely and relevant. Please let us know how they may be helpful to you and what challenges you are currently facing.

We look forward to seeing many of you at ANESTHESIOLOGY® 2019 in Orlando.

With best wishes,



Tony Mira
President and CEO



THE GOOD, THE BAD AND THE UGLY: WHY SOME NEGOTIATIONS SUCCEED

Mark F. Weiss, JD

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It was a Tuesday. 3:27 pm to be exact. I was in the conference room. That's when the negotiation walked in.

Negotiations are not events. Metaphorically speaking, they are living, breathing *things*. They may be relationships, but at a minimum, they are processes. There are no *exact* rules for negotiation no matter what I or the authors of the over 20,000 books on the subject available from Amazon might tell you, no more than reading 20,000 diet books alone will actually make you lose weight.

There are, however, some core principles, some art and some psychology that I've observed, collected and utilized over the course of the past 30+ years in negotiating deals with opposites as diverse as nuns in black habits to executives from multibillion-dollar public companies in pinstripe suits. I'll share a few of them with you. As they say, take my comments "for checking."

A few more things before you dig in.

This is not an article on specific negotiation tactics. Neither is it an article on a specific type of negotiation, say for an exclusive contract with a six-hospital system, or for the sale of your anesthesia group, or for flipping on its head the company model arrangement those gastroenterologists are imposing on you if you want to extend your relationship with their ASC.

Instead, it's an article on a few of the overriding *principles* for you to take into account in connection with *any* negotiation. And, it's written from the perspective of helping you understand why some negotiations succeed, but others fail.

Let's get started.



PRINCIPLE NO. 1 — THE GOOD, THE BAD AND THE UGLY

No baseball player bats "a thousand" (1,000) in baseball parlance. In fact, the player with the highest career batting average, Ty Cobb, batted .366 over a 24-season career. In other words, he didn't get a hit 2/3 of the time.

In similar fashion, over time, no anesthesia group successfully closes every deal they approach.

The cold hard fact is that in some negotiations, "the good" succeed, others, "the bad" fail for reasons that may or may not have been preventable, and others, "the ugly" were set up so that they were never going to be permitted to succeed.

For some readers, this may appear to be a strange place to start. But, if you think about it, it's the only place to start because it drives home a point that is essential for your overall success: although the good and the bad start off the same

and take time to understand, the ugly are easier to spot, that is, if you keep your eyes and ears open, and perhaps, also, your nose.

The poster child for the ugly is the hospital administrator who drags out discussions of the renewal of an exclusive contract, perhaps mentioning an RFP, perhaps telling you that administration needs more time to think about it, but all the while dragging you out. Other plans are likely being made, plans that don't include you.

Does the process itself smell bad, even before any terms are discussed? If so, you have a very short time period in which to use whatever leverage you have. Which, obviously, means being able to realistically threaten that you will walk, *now*.

Understand that sometimes things are set up so that you will fail.

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WHAT DOES THE QZ MODIFIER REALLY MEAN?

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It all started with a simple question: what is the best way to allocate the allowable payment of an anesthetic case when there is an anesthesiologist *and* a CRNA involved in providing the care? Once upon a time, when an anesthesiologist and a CRNA managed a case together, the practice would generate one bill for each, which obviously made medical direction look very expensive. In the early 1980s, the Healthcare Finance Administration (HCFA) started tinkering with various payment methodologies. It was a most interesting period to be in the anesthesia billing business because each year the formula changed until the current Medicare methodology was finally adopted as a compromise to achieve three objectives.

The first was to establish **standard rules for the billing of cases involving anesthesiologists and CRNAs**. The second was to **provide consistent guidelines for the calculation of the allowable value of a case**. And, lastly, it was intended to **recognize the value of the CRNA's service**, a fact that would also be memorialized in CRNAs being given Medicare provider numbers.

One piece of this puzzle was the creation of a series of claim modifiers that would inform the payer what the relationship was between the providers involved in the care of the patient. In the early days these "Q" codes, as they were often called, were only known to coders and billers. Physicians and CRNAs did not concern themselves with the mechanics of claim submission, nor with the arcane process of payment verification. What was first intended as a way of flagging a payer how to pay for an anesthetic case soon became

one of the hottest topics in anesthesia practice management. Now it is the rare provider who has *not* heard of the QZ modifier and who does *not* have an opinion as to its significance in practice management.

HOW IT ALL BEGAN

A table in the Medicare Carriers Manual was disseminated to all Medicare intermediaries and then to all anesthesia practices. (See Table 1).

HCFA established seven criteria that must be met for payment of the medical direction portion of the allowable. They are listed in Chart 1 on page 5 with the acceptable exceptions. They define the documentation requirements for QK claims. While the necessary details are not submitted with each claim, the assumption is that if the claim were audited, the necessary detail could be provided to the auditor. Many practices have established an attestation statement on their anesthesia record that meets the compliance requirements.

When these medical direction modifiers were first implemented they only applied to Medicare and Managed Medicare plans.

Table 2 represents the current state of these modifiers for a practice in New

TABLE 1

Medicare Medical Direction Modifiers

Modifier	Criteria	Impact on Payment
AA	Physician-only care	100% of allowable
QK	Physician medically directing two to four CRNAs or two residents	50% of allowable
AD	Physician medically directing more than four CRNAs	Maximum of four units per case
QX	CRNA medically directed by a physician	50% of allowable
QZ	Unsupervised CRNA	100% of allowable

CHART 1

Healthcare Finance Administration Anesthesiologist/CRNA Billing Criteria and Exceptions

The Seven Rules for Billing Anesthesia Medical Direction

The Criteria:

1



Performs a pre-anesthetic examination and evaluation;

2



Prescribes the anesthesia plan;

3



Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

4



Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

5



Monitors the course of anesthesia administration at frequent intervals;

6



Remains physically present and available for immediate diagnosis and treatment of emergencies; and

7



Provides indicated-post-anesthesia care.

The Exceptions:

- Addressing an emergency of short duration in the immediate area
- Administering an epidural or caudal anesthetic to ease labor pain
- Periodically (rather than continuously) monitoring an obstetrical patient
- Receiving patients entering the operating suite for surgery
- Checking on or discharging patients in the recovery room
- Handling scheduling matters

Jersey. These are the contractual claim requirements. Clearly, the concept has caught on. Plans that expect one claim per medically directed case are now the exception rather than the rule.

The result was a conversation across the specialty about the significance between billing for CRNA care as medically directed or non-medically directed. As is so often the case, there are different perspectives.

Three sets of distinct stakeholders approach this issue with *very different* perspectives. They are anesthesiologists, CRNAs and hospital administrations.

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TABLE 2 Payer Billing Requirements for Medical Direction

Insurance Plan	Case Count	% Claims (Jan'19 - Jun'19)	Claim requirements
Medicare NJ	4,809	30%	QK and QX billed separately
Horizon BCBS HMO	3,098	19%	QK and QX billed separately
Medicaid HMO	1,789	11%	QK and QX billed separately
Horizon BCBS	1,697	11%	QK and QX billed separately
Medicare HMO	1,651	10%	QK and QX billed separately
Aetna PPO	512	3%	QK and QX billed separately
Amerihealth	417	3%	QK and QX billed together
Work Comp NJ	357	2%	QK and QX billed separately
Medicaid NJ	247	2%	QK and QX billed separately
United Healthcare	208	1%	QK and QX billed separately
Blue Shield MR	141	1%	QK and QX billed together
Total	16,099	100%	

What is so interesting about these medical direction modifiers is that they have gone from being arcane claim indicators to the identification of very specific and distinct models of practice. While it used to be that only billing staff worried about AA vs QZ modifiers, now it is one of the hot topics of the specialty.

Billing For Anesthesiologists and CRNAs and How It Affects Hospital Administrators

Chart 2 provides a breakdown of cases performed between January 2019 and June 30 by all Anesthesia Business Consultants' (ABC) clients across the country for Medicare patients. The data was pulled based on the Medicare concurrency modifier used for billing. Based on this sample, 72 percent of all cases billed by ABC to Medicare involved care by a CRNA.

THE ANESTHESIOLOGIST PERSPECTIVE

Anesthesiologists have typically viewed the Medicare documentation

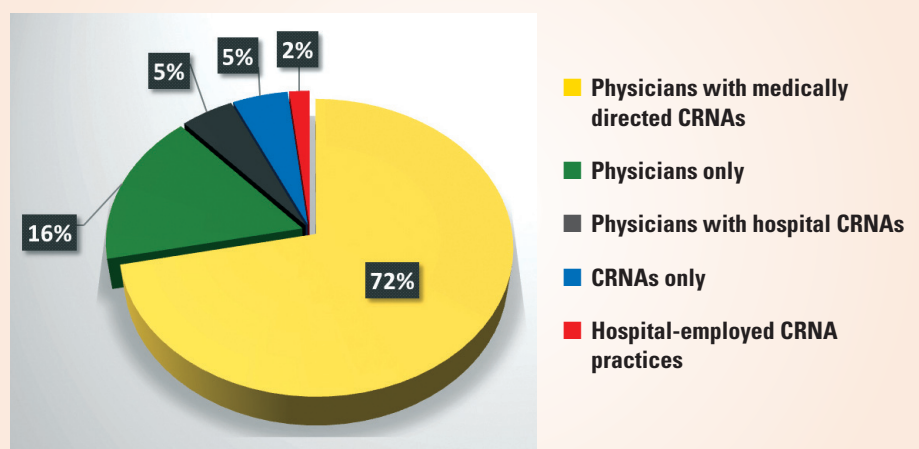
requirements for medical direction as yet another burdensome documentation requirement. An anesthesiologist sees four current practice models: those that consist of only anesthesiologists, practices that employ CRNAs, those that work with hospital-employed CRNAs and those that consist of CRNAs and no physicians. In addition, it should be noted that some CRNAs are employed by a hospital and these are typically medically directed to a

private anesthesia group. Physicians that medically direct hospital-employed CRNAs want to make sure they get their medical direction payment so they have a compelling motivation to comply. Those that employ their CRNAs have been most preoccupied with the QZ versus medical direction question.

Because the distinction, in most cases, is revenue neutral, a growing number of ABC clients that employ CRNAs bill CRNA claims with the QZ modifier knowing that, technically, this means that the CRNA cases are non-medically directed, which may or may not actually be the case. The reality is that many such practices have what is best referred to as an oversight or zone model. Typically, this means that there is an anesthesiologist available to assist and intervene in cases where the CRNA needs help. From a revenue perspective, however, this means there is no medical direction payment to the overseeing physician. The only revenue opportunity exists when he or she performs a specific procedure that is paid separately from a fee schedule such as invasive monitoring, or ultrasonic guided nerve block.

There is considerable confusion about the use of the term "supervision." From a Medicare perspective supervision

CHART 2 Total Medicare Cases by Practice Type



THE CRNA PERSPECTIVE

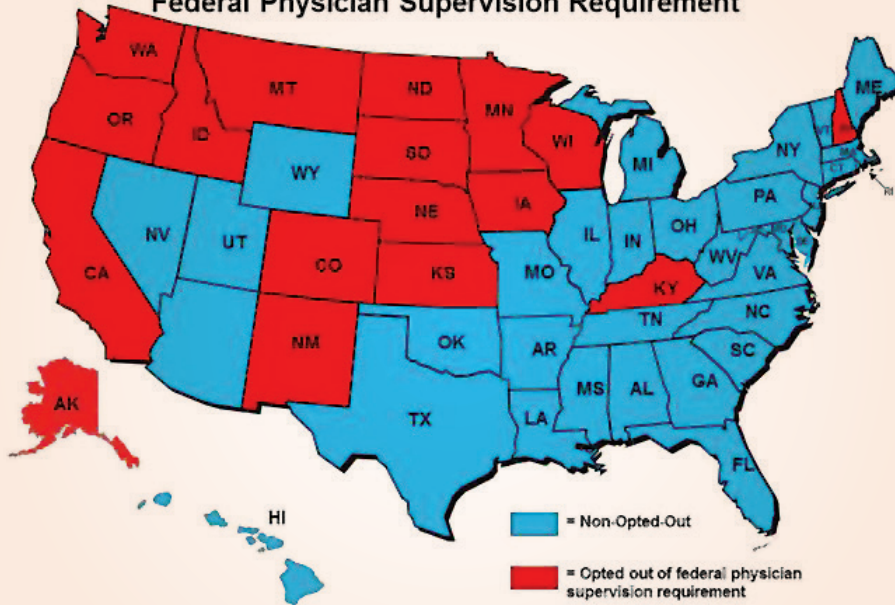
From the CRNA perspective, QZ represents a significant state of recognition, independence and autonomy. HCFA experimented with various payment options for team care through the early 1980s. For a period of time the payment formula changed almost every year, with different percentages of the allowable going to the physician and the CRNA. And then, finally, the issue was resolved: 50 percent of the allowable to the physician and 50 percent to the CRNA. This established a mechanism to allocate the allowable, but the American Association of Nurse Anesthetists (AANA) wanted full recognition for CRNAs as independent providers. When this finally happened in the late 1970s, and all CRNAs got Medicare provider numbers, they could start competing with physicians for the right to provide anesthesia care. The final step in this process was achieved when 17 states agreed to become “opt-out states,” meaning that there was no requirement for a physician to oversee or medically direct a CRNA.

AANA marketing focuses on the cost savings associated with CRNA care. Much of it is based on a claim that there is no difference between the care provided by physician anesthesiologists and CRNAs. This approach has even spawned its own vocabulary: some CRNAs refer to anesthesiologists as MDAs as an analogous comparison to CRNAs, MDAs vs CRNAs. While it is true that the average total compensation package for anesthesiologists is higher than that for CRNAs, the gap is slowly closing. Where there is a subsidy from the facility, the inclusion of CRNAs may reduce the total cost of anesthesia care under some circumstances, but the cost savings is most dramatic when most of the CRNA care is QZ care.

This trend towards more QZ care raises some interesting questions about

CHART 3

States That Have Opted Out of the Federal Physician Supervision Requirement



To date, 17 states have opted out of the federal physician supervision requirement, including: Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana, South Dakota, Wisconsin, California, Colorado and Kentucky, Aug 8, 2019.

refers to a scenario in which the criteria for medical direction are not met, which means that the physician is only allowed a maximum of four units per case, three base units and one time unit for induction. While the term oversight is not part of the Medicare vocabulary, we believe it best describes these scenarios.

In short, the concept of QZ billing is gaining popularity because it is simple to implement and revenue neutral. As is true of so many things that appear to be a simple solution, there may be more to this discussion than meets the eye. It is always worth exploring the other dimensions of any practice management option.





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the quality of care. Anesthesiologists will argue that the inclusion of physician anesthesiologists is essential for the effective management of complex cases and clinical complications.

THE HOSPITAL PERSPECTIVE

Hospital administrations often find themselves caught on the horns of a dilemma. On the one hand they want to reduce the cost of anesthesia care, especially when they must pay a significant subsidy, while on the other they want their patients to get the best quality care. It is the rare administrator who does not agree that physician anesthesiologists must be part of the service solution. Ironically many of the practices that have migrated to a QZ model work in facilities that have specific oversight requirements, many of which mirror the Medicare medical direction rules.

Historically the anesthesia model was defined by the local culture and norm. Consider the state of Pennsylvania. The state has the highest number of CRNAs in absolute terms and may still reflect the history of the specialty and the

fact that nurse anesthesia preceded physician anesthesia. There are virtually no physician-only practices and a disproportionate number of practices that medically direct hospital-employed CRNAs. California, by contrast, has been a state where virtually all anesthesia groups consisted only of anesthesiologists. Texas and Nevada even had a number of what are referred to as “surgeon request practices.” In other words, the anesthesiologists affiliated themselves with surgeons such that they became circuit riders following their client surgeons. Each model seemed to fit the unique needs of the local market and appeared to be acceptable so long as no financial support for anesthesia was required from the hospital.

Subsidy contracts for anesthesia services changed everything. Once anesthesia was no longer a free service, hospital administrators started to pay much closer attention to what they were paying and what value they were getting. Many a California hospital administrator, for example, who found himself having to pay a substantial subsidy to a physician-only group suddenly started suggesting

the need to include CRNAs in the mix. In fact, the CRNA option has become a popular focus of many a California hospital administrator.

The experience of the past five or so years clearly indicates that the quality-versus-cost balance is tipping increasingly towards cost. Objectively, one can argue this may have been inevitable. All anesthesia care has become incredibly safe thanks to modern pharmacology and the technology of anesthesia monitoring. Patients are often told that they are at greater risk driving to the hospital than undergoing general anesthesia. The current state of the specialty in terms of patient safety appears to have somewhat undermined its value proposition.

While it used to be that the hospital administrator was given a certain anesthesia delivery model, now he or she plays a much more active role in determining the model. There is considerable fluidity and flux in the configuration of anesthesia departments these days. The form of an anesthesia practice is now much more a function of the venue and the types of cases being performed. One model may work in the main OR, while another may be more appropriate to the endoscopy suite.





The concept of opt-out states for the Federal Physician Supervision Requirement is changing customer expectations. While the alternative to physician-only anesthesia care used to be medical direction, now unsupervised CRNA care, the QZ model is gaining popularity. In fact, new models of delivery such as the zone model are being developed to restrike the traditional relationship between doctor and nurse. The zone model assumes that a physician oversees, not medically directs, a squad of CRNAs.


Curiously, these alternative delivery models do not always reduce the need for financial support. The configuration of the anesthesia team, and the respective compensation packages of anesthesiologists and CRNAs, may actually not be the real determinant of the need for a subsidy, which is ultimately determined by the relationship between the coverage requirements of the facility and the revenue potential of the cases performed.

FINAL THOUGHTS

How often do we hear anesthesia practice managers say that the only constant in medicine is change? It has

become the refrain to a long ballad of frustrating economic, social and political challenges. The mantra used to be “if it ain’t broke don’t mess with it,” but today’s mantra suggests that if you don’t see the problem you are not looking closely enough. Medicine is a business. Business is about competition. Only the fittest survive. And so it is with the specialty of anesthesia. Never have anesthesia providers felt so unsure that their current practice situation would survive. The market for anesthesia services is undergoing a dramatic state of reinvention. Whatever your model of delivery today; it is likely to be different tomorrow or next year.

QZ was once a technical statement of billing policy; it is now a philosophical question. It was once a proposal of parity; now it is a question of value. It was once a guarantee of access to payment; now it is a window of opportunity to capture market share. As private payers review and revise their fee schedules, CRNAs appear to be losing ground financially. Ironically, payers may be accepting the AANA argument that nurse anesthesia represents a more cost-effective option. A number of plans now pay less for QX and QZ than they do

for AA and QK cases. QZ has become the emblem and beacon of an alternative model of care. None of us knows for sure where this will end up, but one thing is now very clear—there is no going back. QZ has become yet another layer of complexity in an already complex set of anesthesia management challenges. 

Howard Greenfield, MD, is a board-certified anesthesiologist and graduate of Temple University School of Medicine with anesthesia training at Jackson Memorial/University of Miami. He is an experienced clinician, and has served as Chief of Anesthesia at Memorial Regional Hospital.



He became one of the original founding partners of Sheridan Healthcare. Greenfield later went on to found Enhance Healthcare with Dr. Robert Stiefel. Together, they have extensive national experience helping hospitals and anesthesia groups structure and negotiate anesthesia service agreements, optimize the revenue cycle, and implement operating room improvement initiatives. Enhance Healthcare partners are actively involved in the anesthesia merger and acquisition space. They have advised a number of anesthesia practices on strategic alternatives, and have worked with investment banking and private equity to help complete a number of group transactions. Dr. Greenfield can be reached at hgreenfield@enhancehc.com.

Jody Locke, MA, serves as Vice President of Anesthesia and Pain Practice Management Services for Anesthesia Business Consultants. Mr. Locke is responsible for the scope and focus of services



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THE GOOD, THE BAD AND THE UGLY: WHY SOME NEGOTIATIONS SUCCEED

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PRINCIPLE NO. 2 — ALWAYS HAVE AN ALTERNATIVE

If your contracting opposite knows that you need, *really need* the deal, you have ceded power. Sure, you might close the deal, but on what terms?

Think, for example, of the situation in which an anesthesia group contracts with one hospital only. When the contract comes up for renewal, the hospital administrator knows that your group's very existence turns on the renewal of the contract. Many CEOs will use that to the hospital's advantage. Few anesthesia group leaders are willing to call their bluff.

Spread your wings. No matter what you are negotiating, always have alternatives, not just because it's a good thing to do on its own, but because it will give you negotiating strength. As in the story of the chicken and the pig who plan what to make for breakfast and decide on ham and eggs, you want to be like the chicken, that is, *involved* in the process, and not like the pig, who's forced to be fully *committed*, to its detriment.

Yes, it might take time to develop alternatives. If you didn't start three years ago or three weeks ago, start now. You will

be behind, but waiting until three years from now will only make things worse.

PRINCIPLE NO. 3 — BEGIN EARLY AND DON'T FOOL YOURSELF

Start strategizing early, way before any formal negotiation takes place.

As the physicist Richard Feynman quipped, "the first principle is that you must not fool yourself—and you are the easiest person to fool."

So, begin with telling the truth. The truth of your situation. The truth of your strengths. The truth of your weaknesses. The truth of your alternatives. The truth of *everything*. Then fix what you can and understand that the rest might be used against you and be ready for it.

Just don't fool yourself.

PRINCIPLE NO. 4 — KNOW WHAT CLASS OF DEAL ARE YOU NEGOTIATING

Deals often go a-foul as a result of misunderstanding what class of deal is being negotiated.

I divide contracts into two major classes, Transactional Contracts™ and Relationship Contracts™.

Transactional Contracts™ are ones in which the parties negotiate for a deal which, essentially, terminates as of the closing. For example, think about the purchase of a car or the purchase of a house. The parties trade consideration and part ways.

But many of the deals that anesthesia groups negotiate are Relationship Contracts™, situations in which the closing of the deal is the *start*, not the end, of the relationship.

Each class of agreement requires a different strategy. Know what you are negotiating.

PRINCIPLE NO. 5 — UNDERSTAND WHAT NEGOTIATION IS

It's easiest to understand this point in the context of negotiation for the renewal of an exclusive contract.

Physicians inexperienced in business often mistakenly regard hospital negotiation as a formal process separate from day-to-day activities at the facility. When at the facility, they are on their way to render patient care or are headed back to the department office or out the door. Hallways are not negotiation tables. For many physicians, location is a factor in negotiation—the physical *context* controls the question of whether or not there is intended *content*.

To a hospital administrator, someone who regularly negotiates as a part of his or her job, all discussions with contracting parties, whenever and wherever, are part of the negotiation process. The administrator's office, the board room, the washroom or the hallway, even the check-out line at the local market, are all simply locations—and to him or her, location is not important; it is *content*, not physical *context*, that controls.

Because you can count on the fact that hospital administrators are not going to change their perception of the





immateriality of physical location to negotiation, it's incumbent on physicians to learn this lesson and learn it well.

Any communication with, or within earshot of, an administrator is a part of the negotiation process. Plan what you and any member of your group is going to do and say, not just reactively, but proactively, as well.

Stick to the plan. Everywhere.

PRINCIPLE NO. 6 — BE DETACHED

Negotiation requires detachment from the outcome. It is next to impossible for you to be detached from your own deal. Bring in experts to conduct the negotiation.

If you are not detached, fear of losing the deal and the ease of confusing the deal with an attack on your own ego often destroy the ability to come to terms. That's the case whether it's your own fear and your own ego or that of other members of the group.

I'm not telling you not to be involved as part of the team in a combined effort, but you should not be the face of your own negotiation.

PRINCIPLE NO. 7 — UNDERSTAND YOURSELF

What do you actually want?

In other words, what is the specific goal of the negotiation? Why?

How realistic are those goals? What are your alternatives, both in terms of

satisfying your actual needs and in terms of less satisfactory but still acceptable outcomes? What is your fallback position and what is your bottom line? What is the market? How well do you understand it?

In addition to addressing this issue from the 50,000-foot level, that is, in connection with the entire negotiation, you need to do similar thinking in connection with each meeting and conversation with the other side.

Lack of understanding of what you want and why you want it cut off potential routes for solving impasses, can lead to selling yourself short, and to bad and blown deals. You have complete control over this aspect of negotiation. Use it to your advantage.

PRINCIPLE NO. 8 — UNDERSTAND THE OTHER SIDE

What does the other side want? And, even more so, why do they want it? And, as to "why," remember that there's the reason...and then there's the *real* reason. The more you work on this, the more likely you are to see other opportunities and strategies to bridge impasses.

Understanding the other side plays out on multiple levels. There's the level of the entity that's involved on the other side of the negotiation, the hospital, for example. And, there's the level of the individuals representing that other side, such as the hospital CEO.

Build deep profiles of both levels. Embarrassingly deep. To be fully prepared, you need to spend hours and hours, sometimes even weeks, to ferret out the details that underlie the incentives that drive both the opposite party and the people negotiating for it.

And remember that the incentives of the people on the other side often differ from that of their employer or principal.

Incentives are often at the root of what appears to be wacky positions and wacky decisions. It explains why a CEO will scuttle a favorable deal for her

employer when it's at odds with the metrics behind her bonus. It explains deals based on a short-term world view versus a long-term one. It explains borderline (and over-the-borderline) illegal behavior.

PRINCIPLE NO. 9 — BE PREPARED. THEN PREPARE SOME MORE.

Let's revisit baseball and batting champ Ty Cobb, mentioned above.

In baseball, there's spring training, and there's also practice, practice and more practice in between, and prior to, games. How many thousands of hours of practice does a star batter devote to his handful of minutes at bat each game? It makes all the difference in his career.

Why do you think that negotiating a deal for your anesthesia group is any different? It's not.

There are hours, days, weeks and even months or years of preparation that go into negotiating a successful deal.

Even if you don't spend the time, the chances are high that the other side will. So, how do you think things are going to work out for you?

Never wing it. You can't just show up at bat, swing and hit a home run. No one can.

Not even Ty Cobb was that lucky. ▲

Mark F. Weiss, JD, is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He is also the co-founder of a healthcare mergers and acquisitions advisory firm, Steering Advisors. He can be reached by email at markweiss@advisorylawgroup.com or at markweiss@steeringadvisors.com.



WHAT IF EVERYONE IS DOING IT BUT YOU DON'T WANT TO: RESISTING ACQUISITION BY A LARGER ANESTHESIA GROUP

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The healthcare industry has been experiencing a wave of integration for years. On a daily basis, we hear about health systems and large independent national and regional practices acquiring smaller practices. This is especially true in the anesthesia space. Just because consolidation is trendy does not mean that it is necessarily the most desirable course of action for your group.

FACTORS DRIVING PRACTICES TO SELL OR NOT SELL

There are several reasons why independent anesthesia groups sell to larger practices. One driving factor is the constant increase in operating costs. Small practices are especially burdened by the increasing cost of employee health insurance and other benefits as well as the cost of technology that is needed to comply with federal regulations and maintain competitiveness in the industry. They are challenged by demands from physicians and mid-level providers for greater work/life balance and schedule accommodations that are more difficult to coordinate when the pool of providers is relatively small. Another driving factor is the desire to have more negotiating leverage with payers. Some small practices also desire to merge with multi-specialty groups to seek a greater market share in ancillary service lines. Perhaps most commonly, practices realize that they will need to align with others in order to thrive under the changing reimbursement landscape that increasingly focuses on value-based payments. To summarize, larger groups



often have advantages when it comes to economies of scale, generous staffing and technology resources, greater bargaining power and the ability to better coordinate care and implement quality and efficiency initiatives.

In addition to the economic reasons described above, some hospital-based groups, such as anesthesiology practices, face political pressure to integrate with larger groups. For example, health systems sometimes prefer that their various hospitals be staffed by a consistent provider with which the system has had a positive experience. Larger groups are sometimes viewed as more sophisticated and trustworthy from a financial and compliance perspective. They are also sometimes viewed as better strategic partners for dealing with a challenging and changing healthcare reimbursement and delivery environment.

There are also compelling reasons for remaining independent. Although there are advantages to being part of a larger organization, many physicians, especially those who are more entrepreneurial, strongly value autonomy. To some, it is the presence of this factor that makes them feel most secure. They appreciate having control over their careers and the day-to-day operations of their practices. Further, physicians in smaller groups often enjoy just as much, if not more, compensation than they would with a larger group. This is true for younger anesthesiologists who often receive less compensation as employed anesthesiologists of larger national groups than they would if they were physician owners of a smaller practice. Others oppose acquisition by a larger group because they are simply resistant to (or very cautious of) change.

EVALUATING AND NEGOTIATING A POTENTIAL ACQUISITION

Because of the tensions created through the various competing interests just described, smaller groups that are considering a potential integration transaction need to be thoughtful. In order to conduct the proper cost/benefit analysis, groups need to consider the factors driving them towards a potential acquisition, factors weighing against the transaction and the relative importance of those considerations. Whether to integrate with a larger group needs to be the group's decision based upon its unique circumstances.

The first step for any practice that is considering being acquired by a larger practice is to define the goals and underlying purpose of the transaction. The group should understand what it wants, what it can compromise on, and what it can't give up.

The factors driving a group towards an acquisition may sometimes be addressed without selling the entire practice to a larger firm. There are many ways for physician practices to align with other providers without selling their business in its entirety. For example, some groups will address staffing insufficiencies by entering services or staffing relationships with other groups or by garnering the support of hospitals through physician recruitment arrangements. Some groups will address rising expenses by leveraging greater economies of scale through relationships with group purchasing organizations or management companies. Some align themselves with physician organizations, physician hospital organizations, accountable care organizations and clinically integrated networks to better thrive under new a reimbursement regime that focus more on paying for quality and efficiency than it ever has before.

When evaluating a potential acquisition or other integration, it's imperative to



carefully consider the key terms of the deal. For example, will assets, contracts, leases and provider numbers be transferred and, if so, how? Will clinical or non-clinical personnel be terminated? What will be the post-closing or post-integration compensation, governance and management structure? Will pre-existing liabilities be addressed through escrow funds or another mechanism? How will pre-closing accounts receivables be treated? Are there non-competes, non-solicitation provisions or other restrictive covenants to consider? How will the pension and other benefit plans be impacted? Do the parties share a similar culture and trust each other? Can the parties unwind the acquisition or integration if they have difficulty working together?

Once a potential acquisition or other integration transaction is identified as potentially desirable, it's important to involve legal advisors and consultants early in the process. Healthcare attorneys can advise clients on how to mitigate risk through financial, legal, regulatory and reputational diligence and various legal structures. Attorneys can also assist the group to better understand what is, and what is not, permissible in this space.

Financial relationships that are permissible in any other industry are often not permissible in the healthcare industry. The state and federal healthcare laws govern the manner in which each acquisition and integration relationship described above may be structured. The regulations at issue include federal and state anti-kickback laws, state fee-splitting laws, the federal Stark law and parallel state self-referral laws, civil monetary penalty laws, state corporate practice of medicine doctrines, federal and state patient privacy laws, tax exempt laws, federal anti-trust laws, state and federal securities laws, state licensure requirements, state certificate of need laws, state insurance laws, reimbursement laws and regulations and contractual requirements, and many more. As an aside, it is interesting to note that the federal government is currently reviewing ways in which the federal Stark and anti-kickback regulations may be modified to afford even more flexibility to parties that desire to align with each other to embrace various value-based initiatives.

Once a physician group has identified the desired business terms and confirmed

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WHAT IF EVERYONE IS DOING IT BUT YOU DON'T WANT TO: RESISTING ACQUISITION BY A LARGER ANESTHESIA GROUP

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that they are defensible from a regulatory perspective, healthcare attorneys are also crucial in protecting the group during discussions with the other party. The first step is often to enter an agreement to protect the confidentiality of the information shared with the other party. The next step is often to enter a letter of intent or memorandum of understanding setting forth the proposed business terms. Although these agreements are typically non-binding (except for confidentiality and no-shop provisions), they promote efficiency by ensuring that the parties are on the same page from a business perspective before time and money is spent draft and negotiating transaction documents. Healthcare attorneys can also assist in navigating sensitive issues, for example, whether the group's agreement with the hospital requires the hospital to consent to the arrangement and selecting a valuation consultant who will

determine whether the proposed agreement is within the range of fair market value as required by the federal healthcare regulations.

Each physician group contemplating an acquisition or other integration transaction should have a strong negotiating team that has the support of the group's leadership. Because acquisitions require the approval of a majority or super majority of the practice's equity holders, it's important that those leading negotiations understand the position of, and communicate with, the practice's equity holders. It is unfortunate when a subset of practice leadership pursues a potential transaction after heavy negotiation but then does not garner the corporate approvals necessary for it to move forward.

When the physicians within a group disagree whether it is advisable to proceed with an acquisition or another type of alignment, it's important for the group

leadership to ensure that it is complying with the group's governing documents in such regard. The group's Articles of Incorporation, Bylaws, Operating Agreements, Shareholder Agreements, Buy-Sell Agreements and similar documents often address what needs to occur. If the governing documents are sparse, the manner in which the group proceeds may be dictated by the underlying governing corporate law set forth in statutes and case law.

The current healthcare reimbursement and delivery environment is challenging for small physician groups. Now is a great time for practices to carefully consider how they will position themselves for success in the future. They should thoughtfully consider their own unique circumstances and various factors weighing for and against an acquisition or other integration options. Many practices are realizing that it is not necessary to take the dramatic step of selling to larger practice in order to survive. Sometimes bolstering integration in a less extreme manner through one of the options outlined above is the best way to go. 

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PERIOPERATIVE TELEHEALTH: SHOULD YOUR PRACTICE MAKE THE DIGITAL LEAP?

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Is telehealth use among anesthesiologists something new? No. Anesthesiology has had over a decade of experience with telehealth in the perioperative environment and an even longer experience using the technology in the intensive care units. But as telecommunication technology has drastically improved in the last decade, and mobile phone adoption has reached near ubiquity in the United States, there has been a newfound interest with telehealth adoption among anesthesia practices. As anesthesiologists are compelled to practice more often in the perioperative space, this technological tool is ripe for adoption and use among anesthesiologists and other perioperative physicians.

THE ECONOMICS AROUND TELEHEALTH ADOPTION

Across the United States, we see heavy consolidation of healthcare practices—anesthesia is no exception. Larger corporate groups are purchasing anesthesia practices to reap the benefits of economies of scale. Healthcare systems are purchasing hospitals to increase their geographic footprint and maintain their reimbursement revenues in the face of consolidating payer entities. There is a phenomenon of regionalization and geographic specialization happening within these larger healthcare systems. Hence, patients will come to each healthcare location for consultation from farther distances.

The younger demographic of soon-to-be surgical patients (18-35) grew up with smartphone technology and



[universally own a mobile device](#). They are accustomed to ordering and receiving goods and services immediately from their phones: they order an Uber or Lyft for their immediate transportation, Doordash for their food delivery, Amazon for their market and grocery runs...they even order their medications for delivery over the internet and directly from their pharmacy. This demographic has the same expectations of “just-in-time” delivery of goods and services for daily shopping as they do for healthcare. They are flocking to technology savvy healthcare startups for their primary care including One Medical and Forward. [To attract and stay relevant to this demographic](#), who are currently the low-risk healthcare cohort, healthcare practices must understand that telehealth will be a staple digital interface for the modern patient.

THE STARTUP COSTS

Most practice managers may be reluctant to invest in telehealth due to sunk capital costs and daily operating costs. As conferencing technology advanced away from desktop computers to mobile phone technology, the sunk costs involved diminished and now are largely organizational. At UCLA, it was very practical and cost-permissive to pilot our telehealth endeavor using Zoom Telecommunications. This third-party software platform has longstanding experience with video digital conferencing and their end-to-end user interfaces are simple, logical and practical. Zoom’s platform is also HIPAA compliant when contracting with healthcare practices, which protects the practice from patient privacy concerns. Consumer and

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business telecommunication technologies have a downside in that they require administrative support to maintain the patient schedule and send out a Zoom-generated internet link by email to both provider and patient. Patients need to download a computer or cell phone app to launch the Zoom platform and there continues to be technical glitches on particular internet browsers for launching the platform. Overall, commercial telecommunication platforms can serve as a practical first step for smaller healthcare practices who want to pilot telehealth consults with patients.

After a year of our program, our UCLA Department migrated from Zoom to an electronic medical record (EMR) embedded telehealth portal provided by EPIC called MyChart Video in which the technological platform was designed and implemented by Vidy. This simplified our administrative workflow as all the perioperative clinic scheduling for telehealth consultations were coordinated within the EMR, and both patients and providers could launch the telehealth portal from within the EPIC EMR or on their mobile device. This facilitated access to the patient's chart during the patient interview and gave legitimacy of the interaction for the patient as they were accessing their patient-facing EMR portal to open the telehealth encounter. I am confident that in the future, the majority of commercial EMR platforms will offer a refined telehealth portal for their healthcare customers and bundle this feature into their product.

THE PROVIDER BENEFIT

Anesthesiologists face a clinician brand problem in modern healthcare. Often, our presence is elusive and we are apparitions behind the ether screen



keeping our patients stable, safe and alive during major invasive procedures. Some clinicians argue that if we are doing our jobs right, patients shouldn't remember us at all. However, I would argue that it is of prime importance for anesthesiologists to establish and maintain patient rapport prior to the day of surgery. Telehealth offers this digital interface venue between anesthesiologist and patient. The convenience of telehealth promotes on-time patient encounters since patients can link into the telehealth visit from virtually anywhere that has a cellular phone or internet connection. At UCLA, we have had patients enter an anesthesia consult from the passenger seat of a driving car, from their work office, from their living room, and even just out of bed while still wearing pajamas! Using telehealth encounters, we get a small glimpse into the patient's home environment where we often see their partner, spouse, children or parents during the encounter and get a sense of their post-procedure support network. More specifically, we can evaluate their airway and even capture a still image of their airway and embed it

into our chart or note to assist the airway assessment on behalf of an anesthesia colleague who will eventually care for the patient. The digital interview vastly improves a general phone-based assessment from the anesthesiologist to determine if this patient is "sick or not sick" far in advance of the surgical procedure date. In the literature, the [telehealth consultations did not result in an increase of case cancellations or delays compared to those seen in-person](#). Overall, this digital interfacing opportunity for the anesthesiologist demystifies our role in the care process and ultimately advances the brand of our specialty as physicians.

THE PATIENT BENEFIT

Patients derive the main benefits from telehealth encounters. The interaction with the anesthesiologist prior to their case is highly valued to many patients. Albert Schweitzer accurately said, "pain is a more terrible lord of mankind than even death itself." Today, patients continue to have anxiety of the pain during surgery and even rare instances of awareness under surgery. They appreciate the opportunity to reveal those fears of anesthesia directly to a provider. At UCLA, we found that patients who have tried a telehealth encounter for pre-operative evaluation prefer doing their consultation again using the platform and the majority of them are very satisfied with the experience, particularly for its time-saving benefit in urban Los Angeles traffic conditions. According to market research reports, the benefits that drive telehealth adoption are the convenience of the platform, the costs saved for the patient (both direct and time saved), and the reliability of avoiding an in-person visit. [According to an Advisory Board survey](#), 40 percent of telehealth

respondents would want to use telehealth for a pre-surgery appointment. Of those surveyed, the platform, tends to attract users that are young, live in urban environments, have higher incomes, and are privately insured.

THE DISADVANTAGES

While digital patient interfaces are convenient and augment the patient-anesthesiologist relationship, there are challenges to acknowledge. First, the demographics indicate that this platform is more consistent with a younger demographic and those who are comfortable adopting new technology. It may limit capturing the older, frailer population for which pre-operative evaluation is most important. If a healthcare practice has a patient population with a co-morbidity burden, telehealth may serve as a supplement rather than a replacement of a physical pre-operative evaluation clinic.

Financially, there are important considerations to evaluate the return on investment. Any clinical consult takes time away from general operating room activities. It requires a clinician or advanced practice nurse to spend non-OR time interfacing with the patient. This

detracts from revenue generating activities. Unfortunately, current reimbursement for telehealth encounters from Medicaid and Medicare are poor or even non-existent. [Medicaid reimbursement stipulations vary from state to state](#) and must be investigated by each individual practice to establish reimbursement. Medicare gives limited telehealth reimbursement, except for rural locations, but recent announcements within CMS show that these stipulations could be changing in the future. Already, Medicare offers telehealth modifying codes for particular fee-for-service and remote monitoring billing codes (i.e., 99212-99215 and 99091, respectively). Medicare also offers telehealth waivers for bundled payment programs such as complete joint replacement to aid telehealth adoption within bundled payment programs. I would argue that telehealth-based perioperative consultation is currently not revenue generating, but rather a brand building activity.

WHO SHOULD ADOPT THE TECHNOLOGY?

Perioperative telehealth programs are not advantageous for every healthcare

practice. Large healthcare systems with patients with great geographic reach should invest in the technology, both to attract a younger, healthier, demographic into their system, as well as to add convenience to the surgical process for their patients who are accessing their system from more remote geographic locations. Telehealth visits make clinical sense in practices where patients have multiple co-morbidities where the practice would contemplate in-person pre-operative consultation. Since early literature shows no increase in case cancellations with ASA physical status I, II and III patients, telehealth offers an alternative to save on the sunk and operating costs involved in establishing a brick-and-mortar perioperative clinic. Finally, groups that wish to bundle more value into their surgical care package and experience should aim to invest into telehealth platforms to advance a competitive advantage and attract the tech-savvy, young, demographic that will be the future utilizers of modern healthcare and balance the financial risk pool for the healthcare system.

AREAS OF GROWTH

Within anesthesia, large areas of growth for telehealth use is predicted. I believe that anesthesiologists are the leaders of applied physiology in the hospital due to our mastery of monitoring real-time physiology with high-fidelity monitoring devices. In the future, I believe that reputation should transition to mastery of applied physiology outside the hospital using telehealth and remote monitoring technology. We already see large interest from private industry and big-technology companies around remote patient monitoring and wearables. Recently, Apple and Stanford University published their first study using Apple smartwatches to monitor and diagnose new onset atrial fibrillation



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in a general population among those using wearable sensors. Many expect the application of machine learning and deep learning methods to remote monitoring data will grow at a very high velocity in the next decade. Recently, [the FDA cleared the first home remote monitoring wearable technology platform for patients](#) and I expect we will see more remote monitoring devices to emerge in the digital health space. I would argue that this is a very ripe area where anesthesiologists should interact and co-develop with the industry to maintain our niche as applied physiology experts in a modern, cloud-computing, world.

Additionally, as patients adopt and use healthcare sensors within the home, we will see a growth in “patient-entered outcome data.” This is data that is pushed from a patient’s Bluetooth-enabled healthcare device to their phone, and eventually to the EMR for remote monitoring. I imagine such tools will help anesthesiologists redefine clinical assessment issues such as functional capacity

and pre-operative optimization. Already at UCLA, we use Bluetooth-enabled weight scales to monitor our heart failure patients and track their dry weights so that we can schedule elective procedures when they are optimized. We can extend “patient-centered outcome data” to follow patients who aim to lose weight prior to surgery, or patients who need improved glucose control prior to elective cases, or even patients who have chronic pain and require an opioid reduction plan prior to coming back to the operating room. I picture a surgical future [where rehabilitation has an active telehealth and remote monitoring component](#). [Amazon already announced](#) that they plan to deploy Alexa voice activation to decipher healthcare related information and push that information directly to clinicians via an electronic medical portal. In fact, telehealth opens up an entire new role where the anesthesiologist leads the 7-14 day transitions of care back to the outpatient world after an acute intervention—an activity that is highly valued by both CMS and healthcare systems to prevent unnecessary hospital readmissions.

Telehealth Implementation Tips:

For those anesthesiology practices that wish to make the digital leap by implementing a perioperative telehealth program, I offer the following advice:

1. **Pilot the endeavor using commercially available video conferencing tools** and survey the experience with both patients and clinicians early in the process.
2. **Expect technical hiccups when you first launch the program.** The learning curve is small, but it is still present for both patient and provider.
3. **Start telehealth encounters ON TIME.** Patients who conduct their business activities via their mobile phones expect on-demand services.
4. **Explain the limitations of a telehealth visit during the consent process** including the lack of a full physical exam or the need for a clinic visit to their primary care physician or specialist prior to their case if their history calls for a physical visit.
5. **Set the expectations of the visit early in the conversation.**
6. **Look at the camera lens when speaking to your patient**—not the window that displays the patient. Remember, the digital camera is above your computer or laptop screen.
7. **Conduct your telehealth visit in a professional environment.** Although these visits can technically be done from your own home, patients have a traditional expectation in their minds about visits with physicians. 

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DOCUMENTING ANESTHESIA SERVICES

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I'm often asked what kind of documentation is necessary to support anesthesia services. Answers will vary, based on the anesthesia practices' unique characteristics. For example, an anesthesia practice that uses a "care team" approach—employing medically directing anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) and Anesthesia Assistants (AAs)—will have different requirements than a practice where anesthesiologists personally perform all procedures. Additionally, documentation requirements in a teaching facility are more comprehensive than those in a private anesthesia practice.

Let's start with basic documentation requirements, and move to alternative examples as we go.

BASIC DOCUMENTATION REQUIREMENTS

The National Committee for Quality Assurance (NCQA) publishes 21 elements in its Guidelines for Medical Record Documentation, with six listed as core components; however, not all of the requirements pertain to anesthesia providers (who do not usually have a patient relationship beyond and unrelated to anesthesia services provided for surgical procedures). From this list, basic documentation principals applicable to anesthesia services are as follows:

- Each page in the record contains the patient's name or identification (ID) number;
- All entries in the medical record contain the authors ID. Author ID may be a handwritten signature, unique electronic ID or initials; (Note: If anesthesia practices are still using paper records, a staff log



is recommended for all signatures and initials)

- The record is legible to someone other than the writer.

The American Association of Nurse Anesthetists (AANA) publishes comprehensive documentation guidelines on its website. The American Society of Anesthesiologists (ASA) does not publish documentation guidelines, although guidelines for Basic Standards for Pre-Anesthesia Care, Basic Anesthesia Monitoring, and Post-Anesthesia Care are available to both members and non-members. Solo CRNA practices may choose to follow AANA guidelines, as referenced in the resources. The information provided in this article is based on ASA information.

PRE-ANESTHESIA CARE

In accordance with the ASA Guidelines, "An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care." The Center for

Medicare & Medicaid Services (CMS) requires that a medically directing anesthesiologist sign the pre-anesthesia documentation. All of the following guidelines pertain to pre-anesthesia care, with the exception of documented medical emergencies:

- Reviewing the available medical record;
- Interviewing and performing a focused examination of the patient to:
 - Discuss medical history, including previous anesthetic experiences and medical therapy;
 - Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management;
 - Order and review pertinent available tests and consultations as necessary for the delivery of anesthesia care;

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- Order appropriate preoperative medications;
- Ensure that consent has been obtained for the anesthesia care; AND
- Documenting in the chart that the above has been performed.

INTRA-OPERATIVE ANESTHESIA CARE

The ASA developed Standards for Basic Anesthesia Monitoring in 1986, which were last updated October 28, 2015. Although emergency circumstances and life-saving measures take precedence, the following broad standards apply, with defined methods:

- Standard I – Qualified anesthesia personnel shall be present in the room throughout the conduct of all general and regional anesthetics and monitored anesthesia care (MAC).
- Standard II – During all anesthetics, the patient's oxygenation, ventilation, circulation and temperature shall be continually evaluated.

POST-OPERATIVE ANESTHESIA CARE

Standards for Post Anesthesia Care were last updated by the ASA on October 15, 2014. They apply to General, Regional or MAC provided at any location. The standards require all patients, unless specifically ordered otherwise by the anesthesia provider, to be admitted to a Post Anesthesia Care Unit (PACU) or equivalent area. The anesthesia provider is responsible for the patient, including support appropriate to the patient's condition, until patient care is transferred to a PACU nurse.

REVIEWING DOCUMENTATION

Anesthesia record auditors check anesthesia graphs, available on both paper and electronic records, to ensure continuous monitoring by the anesthesia provider, and can confirm the reported anesthesia time several ways.

One method is to review both the documented time along the top of the anesthesia graph and counts the "tick" or monitoring checks as a five-minute increment, based on ASA's guidelines of monitoring and evaluating the patient's arterial blood

pressure and heart rate at least every five minutes. These monitoring checks should begin shortly after the reported anesthesia start time, and end in proximity to the reported anesthesia stop time, unless documentation supports a delay or complication. Another method compares reported anesthesia times to the operating room (OR) circulator and PACU notes. Although these times typically will not match *exactly*, they should be close to the reported anesthesia times. Time checks are the same for any type of anesthesia practice.

Documentation in the medical record should support specific anesthesia modifiers reported. Anesthesia modifiers were listed on the Office of Inspector General (OIG) Work Plan under "Anesthesia Services – Payments for Personally Performed Services" from 2013 through 2018. Although the report number was removed from the Work Plan last year, it is still important to have an understanding of what each of the modifiers mean in relation to the documentation.

Medical direction modifiers (See Table 1) indicate to CMS and other insurers that certain steps have been followed by a medically directing anesthesiologist, as defined in the Medicare Claims Processing Manual (MCPM), under Chapter 12, Section 50, Payment for Anesthesiology Services. Anesthesia practices using the care team approach and reporting medical modifiers "QY" or "QK" and "QX" will look for documentation to support the reported modifiers. According to CMS, "Medical direction occurs if the physician medically directs qualified individuals in two, three or four concurrent cases and the physician performs the following activities." These are also known as the "seven steps" of medical direction.

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;

Table 1 – Anesthesia Modifiers

AA – Anesthesia services performed personally by the anesthesiologist;

AD – Medical supervision by a physician; more than four concurrent anesthesia procedures;

G8 – Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures;

G9 – Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition;

QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;

QS – Monitored anesthesia care service;

QX – CRNA service; with medical direction by a physician;

QY – Medical direction of one certified registered nurse anesthetist by an anesthesiologist;

QZ – CRNA service: without medical direction by a physician; and

GC – these services have been performed by a resident under the direction of a teaching physician. (The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in §100.1.2. One of the payment modifiers must be used in conjunction with the GC modifier.)

3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;

6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

CMS allows six exceptions in the on-line manual that some carriers consider to be illustrative, rather than exhaustive, such as:

1. Addressing an emergency of short duration in the immediate area;
2. Administering an epidural or caudal anesthetic to ease labor pain;
3. Periodic, rather than continuous, monitoring of an obstetrical patient;
4. Receiving patients entering the operating suite for the next surgery;
5. Checking or discharging patients in the recovery room; and
6. Handling scheduling matters.

“Frequently Asked Questions (FAQs)” were on several Medicare Administrative Contractor websites that indicated:

“As long as the medically directing anesthesiologist ‘remains physically present and available for immediate diagnosis and treatment of emergencies’ (rule number “vi” of the CMS “seven requirements”), we agree that the following procedures would be an illustrative but not exclusive list of allowed interventions:

- Placement of a Swan-Ganz catheter, central line or arterial line
- Placement of an epidural catheter for post-operative analgesia or in preparation for subsequent surgery (for a ‘to follow case’)
- Placement of other peripheral nerve blocks prior to subsequent surgery, to include brachial plexus blocks, ankle blocks, femoral nerve blocks, etc.”

However, one is hard pressed to find these answers online now, as many of the FAQs have disappeared over the years. Novitas has published, removed and published again a variation of FAQs, which currently indicates as follows:

“An anesthesiologist may perform and, if otherwise eligible, seek reimbursement for procedures (such as arterial line insertions, central venous catheter insertions, pulmonary artery catheter insertions, and epidural, spinal, and peripheral nerve blocks) performed in an area immediately available to the operating room when performance of such services does not prevent him/her from being immediately available to respond to the needs of surgical patients.”

This information was last modified July 15, 2019. When you find this kind of information published, keep a copy on your hard

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DOCUMENTING ANESTHESIA SERVICES

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drive or print it out to include with your compliance information. As mentioned, when these are no longer available you will have support for following the guidelines.

Any anesthesia practice working with “qualified individuals,” including residents, fellows, CRNAs, AAs and Student Registered Nurse Anesthetists (SRNAs), should be aware of CMS’s medical direction requirements and exceptions. Many private payer policies have also adopted these guidelines.

Anesthesia practices involved in teaching have additional rules to follow. Information regarding teaching documentation requirements is available in the MCPM under Section 100, Teaching Physician Services. A teaching physician is defined as “A physician (other than another resident) who involves residents in the care of his or her patients.” Anesthesia services furnished in teaching settings are paid under the physician fee schedule if the services are:

- Personally furnished by a physician who is not a resident;
- Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service.

If an “AA” modifier or “AA GC” modifiers are reported, documentation must support either personal performance or documented teaching of one or two residents. In my personal experience, electronic anesthesia records (EARs) are helping to improve teaching documentation as EARs clearly identify who was in the room, who provided which service, and typically include legible attestations from the teaching anesthesiologist.

If more than one teaching anesthesiologist worked with the resident, Medicare requires the claim to be filed under the teaching anesthesiologist who started the case, with the GC modifier appended

to indicate which services were performed by the resident. CMS does not require a GC modifier for SRNA services because the modifier description pertains only to residents or fellows, depending on the circumstances.

CMS allows a teaching CRNA to report full base and anesthesia time (QZ modifier), under the teaching CRNAs provider number, for two concurrent cases, provided that the teaching CRNA is not medically directed by an anesthesiologist, and the CRNA is present with the SRNA during the pre- and post-anesthesia care for each case. The CRNA must document her or his involvement with each of the two cases.

Conversely, CMS allows a teaching anesthesiologist to report either personal performance (AA modifier) if she or he is continuously involved in a single case with an SRNA or medical direction (QK modifiers) for two concurrent cases, provided that the steps for medical direction have been followed. In effect, a teaching CRNA may receive full payment for teaching two SRNAs, whereas a teaching anesthesiologist only receives partial payment for their

medical direction. No payment is made under Part B for services provided by a SRNA. This is important to keep in mind if a SRNA solely places an arterial line, for example, without the teaching CRNA or anesthesiologist’s involvement.

Depending on your compliance plan or policy, anesthesia practices conduct either internal or external reviews (or a combination of both) to spot-check documentation, as compared to the information sent to CMS or other insurance companies. There are additional areas of documentation concern, some general and some specific to anesthesia. The medical record should support all information provided on an anesthesia claim form, with examples indicated below:

- Provider of medical service or services.
- Diagnosis and procedure codes.
- Anesthesia times, including documented discontinuous anesthesia time and any case relief or transfer of patient care—this is particularly important if your state Medicaid






has a face-to-face policy for reporting labor epidural services.

- General, Regional or Monitored Anesthesia (MAC): CMS and other insurance companies may have medical necessity policy and/or require a QS, G8 or G9 modifier when MAC is provided.
- Indication of physician or teaching CRNA presence at induction, emergence and other “demanding” procedures: note that induction and emergence are not applicable to regional or MAC, although documentation of presence during initiation or placement may apply.
- Procedure notes for invasive monitoring lines and/or other “surgical” procedures, including who provided the service and when time notations allow coders to determine when blocks or catheters are placed and whether discontinuous time is applicable. Keep in mind that these “surgical” procedures (such as an arterial line) are not “medically directed or supervised”, which only pertains to anesthesia services.

- Surgeon’s request for post-operative pain management, when applicable.
- Qualifying circumstances, such as an emergency*.
- Physical status, such as a patient with a severe systemic disease*.

*Although CMS does not allow the reporting of physical status modifiers or qualifying circumstances procedure codes, other insurances may recognize and pay for these difficult anesthesia situations.

Documentation compliance is more than just an expectation—it is a necessity. Regardless of whether your anesthesia practice has a formal compliance plan, under the Federal Register Publication of the OIG Compliance Program Guidance for Third-Party Medical Billing Companies, the OIG believes that all healthcare providers should be using internal controls to “more efficiently monitor adherence to applicable statutes, regulations and program requirements.” It is vital providers of anesthesia services understand what information is billed on their behalf and whether they conform to these readily available guidelines. 

Resources

American Association of Nurse Anesthetists (AANA), Documenting Anesthesia Care, © Copyright 2016

[https://cms.aana.com/docs/default-source/practice-aana-com-web-documents-\(all\)/documenting-anesthesia-care.pdf?sfvrsn=ac0049b1_4](https://cms.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/documenting-anesthesia-care.pdf?sfvrsn=ac0049b1_4)

American Society of Anesthesiologists (ASA), Standards and Guidelines

<https://www.asahq.org/standards-and-guidelines>

Center for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 12 – Physicians/Non-Physician Practitioners

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

National Committee for Quality Assurance (NCQA), Guidelines for Medical Record Documentation http://www.ncqa.org/portals/0/policyupdates/supplemental/guidelines_medical_record_review.pdf

Office of Inspector General, Work Plan

<https://oig.hhs.gov/reports-and-publications/work-plan/index.asp>

Novitas Solutions (July, 2015) Anesthesia

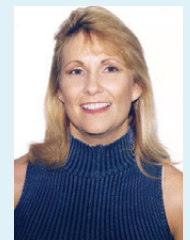
<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00173915>

Office of Inspector General, Compliance Guidance, Federal Register / Vol. 63, No. 243 / Friday, December 18, 1998 / Notices

<https://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf>

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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
October 13-16, 2019	Medical Group Management Association 2019 Annual Conference	New Orleans Ernest N. Morial Convention Center New Orleans, LA	https://www.mgma.com/events/the-annual-conference
October 18, 2019	American Society of Anesthesiologists International Forum on Perioperative Safety & Quality	Hyatt Regency Orlando Orlando, FL	https://www.asahq.org/ifpsq/asa
October 19-23, 2019	American Society of Anesthesiologists ANESTHESIOLOGY® 2019 Annual Meeting	Orange County Convention Center Orlando, FL	https://www.asahq.org/annualmeeting/?utm_source=asahq&utm_medium=landing-page&utm_campaign=Annual-Meeting
October 24-26, 2019	Becker's ASC Review 26th Annual Meeting: The Business and Operations of ASCs	Swissôtel Chicago, IL	http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/
October 31- November 2, 2019	MEDNAX Anesthesia Leadership Conference	JW Marriott Turnberry Aventura, FL	http://www.mednax.com/
November 4-8, 2019	California Society of Anesthesiologists 2019 Fall Anesthesia Conference	Fairmont Orchid Big Island, HI	http://www.csahq.org/events/details/2019/11/04/cme-events/2019-fall-anesthesia-seminar
November 16-17, 2019	American Society of Anesthesiologists Anesthesia Quality Meeting™ 2019	ASA Headquarters Schaumburg, IL	http://asahq.org/meetings/asa-quality-meeting
December 13-17, 2019	The New York State Society of Anesthesiologists, Inc. 73rd Annual PostGraduate Assembly in Anesthesiology	New York Marriott Marquis New York, NY	http://pganyc.weebly.com/

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