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Why Utilization and Productivity Metrics Matter

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You cannot manage what you cannot measure. This is today's business mantra and no aspect of any serious business is exempt, from productivity of operations to quality of customer service. The goal is to use objective metrics to drive down cost and improve quality. Is it any wonder that the tools that are driving the management of business should be applied to medical and service specialties like anesthesia? Much as anesthesiologists and CRNAs may resist efforts to quantify their productivity and objectively assess the quality of care provided, this is becoming the new reality in medicine. To resist is to demonstrate one's inflexibility and to invite alternative solutions. The largest and most aggressive players in the specialty are investing millions in

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Anesthesia Practices Are Not Islands

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main" begins John Donne's famous poem. Anesthesiologists have come to realize that not only are they "a piece of the continent" that is their group, but that they are interdependent on their hospital or health system. The anesthesiologist's and the group's well-being is bound up with that of their institution, and perhaps with the health and welfare of other entities as well.

The hospital "continent" is under enormous pressure to improve quality and to hold down costs, and so, therefore, is the "country" that is the anesthesia department. If the incumbent anesthesia groups are not properly managing their costs and quality, the chances are that their hospitals are looking for alternatives. ABC Vice President Jody Locke's latest article for the Communiqué, *Why Utilization and Productivity Metrics Matter*, walks readers through the variety of metrics available to practices that want to measure and demonstrate their value to their hospital partners. The immediate goals are to develop data that lead to more efficient coverage models in terms of both staff and operating room utilization and to identification of best practices—including productivity—among the providers. As Mr. Locke writes, "Those who have come to understand the importance of being lean and effective are gaining market share while those that refuse to accept the inevitable are losing ground and losing their franchises. Effectiveness and efficiency are the new keys to success." The overarching goal is to produce the lean, cost-effective and high-quality anesthesia service demanded of the hospital's anesthesia partners.

Groups can form bigger islands, or even continents of their own, by growing. Mergers and acquisitions are the more popular and certainly the more immediate strategy, but organic growth is often feasible as well, as Mark Weiss, Esq. writes in *Anesthesia Group Mergers, Acquisitions and (Importantly) Alternatives*—and it entails becoming a more valuable component of the hospital continent or family. Cement your current facility relationships, explore opportunities to expand the practice to additional facilities and tighten up the group's internal operations. Other alternatives to being acquired by a larger entity include acquiring another group, creating a cooperative arrangement with other practices or launching a Management Services Organization (MSO), or even offering a practice management or locums service.

"Even if you're committed to seeking a buyer," states Mr. Weiss, "you can't stop or even slow your efforts to develop your business while you're searching." Bill Britton of Cross Keys Capital elaborates on this point in *How an Investment Banker Can Make an Anesthesia Practice That Wants to Sell Become a More Attractive Acquisition Partner.* As we know, some groups are solving the dilemma of small size and limited resources by seeking out venture capital. In his article, Mr. Britton identifies seven areas that buyers of anesthesia practices focus on, starting, not surprisingly, with corporate governance and leadership. The characteristics that make a group an attractive target are also the characteristics that make it successful. The investment banker's perspective is one that everyone should consider.

Did you miss the death story of the Medicare Sustainable Growth Rate (SGR) formula? Attorneys Serene Zeni, Gregory Moore and Alexandra Hall explain its history and the legislation that killed the SGR, as well as what comes next, in *The SGR "Fix" in the Context of Anesthesia Practice*.

As health plan co-insurance and deductible amounts continue to grow, so do the challenges of collecting. "Self-pay" used to refer primarily to uninsured patients. As Neda Ryan, Esq. and Christopher Ryan, Esq. explain in *Getting Paid by the Self-Pay Patient*, the term now applies, too, to patients with high deductibles. Obtaining compensation from these individuals often depends on having in place the necessary policies and protocols, which are summarized in the article.

Has Someone Gotten in Trouble for Doing That? asks Vicky Mykowiac, Esq. Yes, someone has, and Ms. Mykowiac explains various problematic activities that gave rise to civil and criminal fraud actions with *Lessons for Anesthesia Groups from Real* Cases and lessons learned. One specific area of interest on the part of the federal government is physician compensation that may implicate the anti-kickback statute. ABC Vice President Joette Derricks reviews recent fraud alerts in *Is the Office of the Inspector General Turning its Attention to Physician Issues*?

We are well into the second half of 2015 and it seems that the anesthesia practice management news cycle is running faster than ever. Groups continue to morph and consolidate, as do health systems and, more recently, even large health plans. We hope that our publications continue to provide a useful service in helping our readers navigate these many changes.

With best wishes,

Tony Mira
President and CEO

Anesthesia Group Mergers, Acquisitions and (Importantly) Alternatives

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It's come to the point that a good part of my work with anesthesia groups involves *surgery*: removing an earworm—a catchy tune that continually runs through the group's mind.

In fact, it's always the same tune, part of The Clash's *Should I Stay or Should I Go Now*:

> Should I stay or should I go now?
> Should I stay or should I go now?
> If I go, there will be trouble,
> and if I stay it will be double.
> So come on and let me know.
> This indecision's bugging me.

Stay, as in should our group remain independent?

Go, as in should we sell out to someone, maybe anyone, who'll buy us?

But as is generally the case in life, the decision is not purely either/or, black or white, yes or no. There are many alternatives. And that's what we "operate on" as part of what I call the Future Finder™ process.

Some Background

As you're certainly more than familiar, there's a storm of uncertainty resulting from the rapidity of market change in healthcare in general and in anesthesiology in particular.

Hospitals seek to employ or otherwise "align" physicians. They seek to control specialty referrals through employment models, accountable care organizations and other hospital-centric networks.

For independent anesthesia groups there's mounting competitive pressure from large regional and national groups. And for all anesthesia providers, from the individual to the immense group, there's the looming impact of technology.

Many believe that they will find shelter from this uncertainty through a sale to a large regional or national group, or to a private equity backed venture. Yet others are forging new routes, alone or in alliance with other practitioners, and creating their own futures.

What route is best for you?

Acquisitions

It's important to understand the basic economic structure of an anesthesia group acquisition.

As opposed to the sale of, for example, a manufacturing business that includes inventory, machinery, raw materials and real estate, all of which can be valued and sold, the only thing that most anesthesia groups have to sell is their future cash flow.

Accordingly, the usual anesthesia practice acquisition is essentially a valuation, at a multiple, of the group's reconstructed earnings; reconstructed because most groups don't have significant, or any, earnings in the technical sense due to the fact that they annually distribute all of their available cash to their physician owners.

To illustrate, if the group is normally distributing $100x to the physicians when the amount of compensation required to recruit and retain is a lesser $70x, then a purchaser would, conceivably, value the group based on a multiple of the difference, that is, on a multiple of $30x.

As a part of the sale, the group's physician owners would receive an employment contract for, in our simplified example, $70x per year, often for a guaranteed number of years.

The astute reader might realize that, all things being equal, the group has financed the purchase price by forgoing the collection of the additional $30x. That's correct.

However, those physicians nearing the end of their active careers may be more than happy to obtain five, or six, or

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Anesthesia Group Mergers, Acquisitions and (Importantly) Alternatives

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more times that $30x up front because they have no intention of working for more than one or two additional years.

Even those physicians who foresee many years of continued practice often favor an acquisition because it results in a shifting of risks, for example, the risks that the hospital contract might be terminated, or that collections will plummet one year into the term of a multiple year employment guarantee.

While certain risks can be shifted, sellers do assume other risks, such as the fact that continued practice, without a sale, might be more remunerative or that the lump sum purchase price received might not actually deliver a higher return than would a continued investment in their own careers.

How long the hot acquisition market will last is anyone's guess. Certainly large groups in *key* markets, key being different for each potential acquirer, tend to drive higher valuations. But that's not to say that a smaller group in a particular buyer's viewpoint wouldn't make a prime candidate to fill in perceived gaps in their footprint.

Alternatives

Just because the acquisition market is hot doesn't mean that you should be interested in a sale or, even if you are, that it's the right option for you or that any buyer would actually purchase your group.

And, for the many who seek to control their own future, no sale can deliver that ability. By definition, you will have sold off your ability to control your professional future, at least within the confines of the acquired group and maybe, depending on the scope and enforceability of covenants not to compete, within a significant geographic area. Maybe that trade-off is worth it to you. Maybe it's not.

And, for those who believe that larger is smarter or that larger is safer, consider the example of General Motors' bankruptcy.

There are multiple alternatives to a sale, some mutually exclusive and others additive. Let's explore some of them.

1. Become a Much Better Competitor

Reminiscent of Garrison Keillor's imaginary Lake Wobegon, "where all the women are strong, all the men are good-looking, and all the children are above average," I've yet to meet an anesthesia group that doesn't claim that it provides wonderful care and fantastic service and that it has a great relationship with the hospital's administration.

But, as 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.

Immediately start to take steps to cement your relationship with the facilities at which your group currently provides services. Correct service deficiencies. Correct personnel deficiencies. Create an Experience Monopoly™ in regard to the level of service that your group provides to its "customers": hospitals, referring physicians and patients. If you receive a coverage stipend, seek ways to reduce it, knowing that that is how competitors often gain a foothold.

Explore opportunities to expand your practice to encompass additional facilities. This must include additional hospitals and, very importantly, outpatient facilities. Expansion outside of acute care hospitals is essential in order to hedge against a future that will likely not be hospital-oriented.

At the same time, tighten up your group's internal operations. Get your governance structure in order to enable your group to make quick decisions. Review your compensation plan to

make certain that it creates the proper incentives and motivators. And begin to bank capital to enable the group to expand on multiple fronts.

2. Do Your Own M&A

Instead of simply thinking of mergers and acquisitions (M&A) from the perspective of a target, consider that your group can become an acquirer.

Although you might actually consider buying another local group that is engaging in a true acquisition, there's no reason why you need to restrain your thinking to paying cash.

Your group can combine with other groups through merger to form your own larger entity. Although size itself doesn't secure success, it can enable your group to establish a wider geographic presence, achieve some economies of scale and potentially create stronger payer contracting power. It also serves to create leverage in connection with facility contract negotiations.

There is a plethora of ways to structure mergers, from those in which your group essentially makes itself larger by subsuming other groups into its fold, to structures in which your group and another create a new entity.

3. Alignment Models

Within bounds permitted between competitors (although the truly entrepreneurial reader will realize that there's no need to deal only with competitors), there's little limit on the types of non-traditional or hybrid ventures that can be constructed.

For example, it's possible to construct co-op type ventures in which groups across geographic bounds align for purposes of reducing costs (e.g., malpractice insurance) and of amassing data that can be analyzed and used to improve their practices (e.g., through the design of protocols) as well as to

demonstrate value to hospitals and health systems.

Or, as another example, it's possible to construct management services organization (MSO) structures in which multiple groups link to centralize various management functions. There's a mention of MSOs below, from a slightly different angle.

Note that these ventures do not have to be limited to arrangements with other anesthesia groups. Depending on the specifics, they can be cross-specialty (e.g., anesthesiology and radiology) and cross-profession (e.g., MD and CRNA).

4. Profit From Existing Capabilities and Intellectual Capital

If your group has an internal business operation with a dedicated practice manager, consider expanding that function into a separate spun off business entity that provides MSO type services to other groups as well as to your own.

For example, you can sell your manager's and your group's leaders' business expertise, and you can operate a locums service with your own group's physicians or with third parties.

Importantly, your MSO structure can be a vehicle to create initial relationships that might later be expanded to make the client a merger or acquisition target.

Conclusion

There are always more options than you've considered to date. There are always alternative structures to a sale and alternative strategies for the success of your practice.

Even if you're committed to seeking a buyer, you can't stop or even slow your efforts to develop your business while you're searching. There might not be a buyer. If there is, you may not like the price. You might realize that you don't want to sell. You might actually want to buy.

In closing, remember that the best strategy formulation is not a straight-line process. It's not an on-off/sell-or-don't-sell/merge-or-don't-merge situation. Rather, it's a fluid, circular process, keeping options open even as you explore a primary one, continuing to build as you continue to search for the right structure, the right deal, for *you*.

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Why Utilization and Productivity Metrics Matter

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the tools and technology of productivity and quality measurement. Whether this is ultimately good for the specialty is another question for another day.

From OR Utilization to Provider Productivity

The concept of productivity management in anesthesia is undergoing a significant evolution. Many practices have implemented tools to monitor operating room (OR) utilization, which is an essential first step. Operating room productivity metrics define the opportunity for production in a given facility. They measure the appropriateness of scheduling patterns. An OR that consistently generates six hours of billable anesthesia time in an eight-hour day is inherently more desirable than one that only generates an average of four billable hours. In many institutions the disparity between optimum utilization and actual utilization serves as the basis for the calculation of hospital subsidies or revenue guarantees.

Once some basic calculations have been mastered, the resulting utilization metrics may prove useful in identifying opportunities for more effective operating room utilization. We all know that the typical anesthesia billing system has more

and better data about what happens in the OR suite than can be found for any other single source; the question is how best to use the data? While many anesthesia practices still consider themselves captive to surgeon preferences and OR scheduling practices, others are definitely making considerable headway in demonstrating to their respective administrations that the economics of anesthesia is very similar to that of the facility. An anesthetizing location that does not generate enough revenue to support the cost of the anesthesia staff to cover it is most likely a loss leader for the hospital as well.

Practices that are serious about trying to close the gap between coverage requirements and revenue potential are starting to further fine-tune their analytical tools to assess individual provider productivity, a concept that is considered controversial in most practices. Many practices where physicians are paid based on a productivity-based compensation system, i.e., one where provider compensation is based on hours or units billed, delude themselves into thinking that such systems encourage provider productivity. In fact, such systems tend to encourage differential levels of production. Essentially they simply reward the hardest workers, but do little or nothing to encourage greater provider productivity except among providers who are already predisposed to generating more income. It is the rare anesthesiologist or CRNA, however, who cannot be made more productive and efficient with appropriate monitoring and incentives.

Those practices that are serious about remaining competitive in the current environment are also using their data to assess staffing models. Physician-only practices are re-assessing the assumption that they provide better care without CRNAs. While an Anesthesia Care Team (ACT) model is not always the cheaper solution, practices that are unwilling to seriously consider alternatives to having anesthesiologists do their cases alone are quickly being dismissed as old school. It is the nature of today's businesses that they have to anticipate change and be able to reinvent themselves quickly to survive. Why should it be any different in the specialty of anesthesia?

All of this speaks to an inevitable paradigm shift within the specialty. It used to be that a good practice was defined by busy operating rooms and a favorable payer mix. The anesthesia group's destiny was ultimately in the hands of the surgeons and administration. Why should this be? Why should practices not use their experience and data to suggest practical solutions for process improvement? This is exactly what is happening as anesthesia providers climb up the medical food chain to take more control of their own destiny.

Operating Room Utilization

As is true of so many common analytical challenges, the data that is most useful to the goal at hand is probably not immediately available to the practitioners. Establishing useful operating room productivity metrics requires some forethought, consistent quality control and a very flexible toolset. There are many confounding factors. Knowing what data points to include and to exclude is essential. Business intelligence must always result in actionable indicators.

While it is possible to generate some primitive utilization metrics without actually capturing the anesthetizing location, these will have only limited utility in the long run. If you truly want to measure what is happening in each operating room and be able to use this information to modify hospital behavior, the room

TABLE 1

Room Utilization - 1st Quarter of 2015

Operating Room	# of Days	Total Hours	Hours per Day	Utilization
OR01	60	329	5.5	69%
OR02	62	332	5.3	67%
OR03	62	339	5.5	68%
OR04	63	304	4.8	60%
OR05	40	194	4.8	60%
Overall	**287**	**1,497**	**5.2**	**65%**

Room Utilization - 4th Quarter of 2014

Operating Room	# of Days	Total Hours	Hours per Day	Utilization
OR01	62	338	5.5	68%
OR02	64	352	5.5	69%
OR03	62	336	5.4	68%
OR04	63	290	4.6	58%
OR05	33	157	4.8	60%
Overall	**284**	**1,474**	**5.2**	**65%**

number must be captured by the billing system, which in many cases is a challenge in and of itself. Consistently capturing the room number requires a clear list of locations, a place on the anesthesia record for the location to be captured and consistent collection by the billing staff. Without rigorous quality control for this process, most practices will miss 10 to 15 percent of the cases in their utilization calculations.

The next step is to define reasonable and realistic subsets of the practice. Including and averaging too large a sample of data may invalidate the value of the metrics produced. Special consideration must always be given to the needs of specific service lines, especially in larger facilities. Obstetric activity is usually the first carve-out. Cesarean sections may be included to the extent that they are scheduled in operating rooms as surgical cases. Specific facility requirements must be identified and delineated but of much greater significance is the ability to identify lines of business for purposes of benchmarking and comparison. The following is a typical hierarchy of lines of business:

- Inpatient operating room
- Outpatient operating room
- Endoscopy
- Cardiovascular (heart room)
- NORA (non-operating room anesthesia)

At issue here is the need to assess performance on a "same-store" basis. Comparing utilization in an endoscopy center to a heart room, for example, would be of little relevance or utility. Some of the factors that make comparisons useful include type of cases performed, coverage and call requirements and staffing options. Table 1 demonstrates how the overall results may appear unchanging, while significant differences for a single OR may surface from one quarter to the next.

Defining Useful Metrics

Knowing what metrics to calculate can be a little daunting as there are many options. The key, though, is to use normalized data. Typical production data is divided by clinical day. In other words, we are interested in cases, units, hours or collections per day. If there are five operating rooms, some of which are used five days a week and some of which are only used infrequently, we only want to tally days of actual use for purposes of calculating metrics. It is also useful to limit the timeframe being evaluated. Since 75 percent of all activity typically takes place between 7 AM and 3 PM, the most reliable data only includes activity for week days during this time frame. Typically cases that start before 7 AM or run later than 3 PM are truncated for purposes of calculating the hours applicable.

The following are some general considerations to guide the selection of an appropriate metric or metrics.

- **Cases** are easy to tally and provide a clear reference to the schedule. The problem is that since there is such variability in acuity of care and case times it is difficult to draw any meaningful conclusions about utilization from normalized case tallies per day.
- **Billed ASA units** may provide a very useful metric in that they reflect both time spent and acuity of care. Units are also the primary determinant of financial performance potential. The only challenge here is that if the intent is to share this data with administration, hospital folks tend not to understand how anesthesia charges are calculated.
- **Hours per location day** may not reflect the acuity of care but they do equalize the actual time spent

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in a billable or production mode, and, as such, can be very useful in assessing both OR utilization and provider productivity.

- Ideally, one would like to be able to assess the **financial yield per location day**, but this is actually more challenging than might appear. The problem lies in determining when the cases performed are paid in full. Lagging collections performance is one approach but then one may not be measuring current performance levels.

A key issue in the development of performance metrics is the critical distinction between OR utilization metrics and provider productivity. The two are often related, but each must be assessed independently. Anesthetizing location utilization focuses on average and normalized metrics by venue. Let us suppose that a given hospital with ten main ORs consistently produces 5.6 hours of billable anesthesia time per day shift. This value allows us to compare the utilization of this suite of ORs to other practices and benchmark data. If the numerator is eight hours then this represents 70 percent utilization (5.6 divided by 8 hours). Generally, the target for a well-managed OR is 80 percent. With this number we can assume there is some upside potential for improved utilization. Where is the opportunity, though? Comparing individual operating rooms might shed some light on the question, especially if one or more of the rooms are consistently underutilized. It might also be useful to compare activity by hour of the day. Maybe there are holes in the schedule that could be better managed. These are all utilization options which assume that anesthesia is just one of a number of stakeholders in determining utilization.

The ultimate goal here is to identify lines of business and anesthetizing locations that are efficient and profitable. One could also say the goal is to categorize each location as sustainable or unsustainable. Typically, the goal is to identify underperforming venues that require financial subsidy. Truly useful metrics should support and justify closing rooms or modifying coverage requirements. Truly useful provider productivity metrics should allow for the identification of best practices and inefficient providers. When used appropriately and judiciously, utilization and productivity metrics can greatly reduce the need for financial support and enhance the independence of an anesthesia practice.

Educating Administration

Most anesthesia groups make a common mistake in assuming that their hospital administration understands the economics of anesthesia; most have no clue about what makes for a profitable anesthesia practice. As in any activity intended to modify behavior, the key to success is to educate stakeholders. They must come to understand and appreciate the anesthesia perspective. This does not happen overnight and it does not happen without a commitment to serious communication. Those practices that only sit down with administration every couple of years to renegotiate the terms of the exclusive contract are at a serious disadvantage. If an anesthesia practice wants to be seen as part of the solution and not as part of the problem it must be creative and proactive in its interactions with hospital staff.

The chair of one of our clients was feeling particularly besieged by regular requests to add anesthetizing locations that he knew would not generate additional revenue consistent with what the staff required. He had a report designed that tracked actual hours of billable anesthesia time against coverage hours by anesthetizing location by month. In other words the report showed how many hours he was expected to staff and then what the resulting billable anesthesia hours might be. In doing so the chairman created his own productivity metrics that, basically, measured the effect of scheduling on anesthesia profitability. Utilization percentages varied by lines of business; it was a large practice that was expected to cover more than 30 locations a day. It took a while for administration to buy into the methodology but month after month the chairman would simply drop the report on the COOs desk. Eventually the administration saw the wisdom of the approach and over time took the information into consideration as it made strategic planning decisions affecting the operating rooms. The administration started to accept and understand the chairman's position that he would not staff any location that would not generate 45 base and time units per location day.

Educating hospital administration requires finding a common language and vocabulary. Take a simple example. Hospitals tend to tally cases and hours of OR time. Anesthesia providers tend to track units and minutes billed. In anesthesia revenue potential is a function of units billed, but most hospital administrators have no idea what base and time units are and would be suspicious of any metrics based on them. While anesthesiologists tend to default to dollars generated, this is not such a good starting point because most administrators believe that anesthesia is overpaid. The challenge, then, is to find a common frame of reference that has meaning and relevance to both parties. Once this is established the hospital staff has to have time to get comfortable with the data and validate its accuracy. This can

be a very frustrating process for providers used to making life and death decisions in ten to fifteen seconds in the operating room.

Once a dialogue is established then it is important to focus the discussion. Service providers gain the trust and confidence of administration by starting small. Identify problems for which solutions can be suggested. Demonstrate the value of the assistance. Small wins lay the groundwork for bigger changes. There is a saying in sales that "each yes gets one step closer to the big yes." So it is in working with administration.

Too often anesthesia practices fail to see their staffing and coverage challenges from the administration's perspective. This can be a huge obstacle to behavior modification. As Steven Covey writes in *Seven Habits of Highly Effective People*, "seek first to understand." In business, the best solutions are always the ones in which all parties benefit. Collaborative problem-solving is always more effective than unilateral demands for support.

Here is a typical example. An anesthesia group went to administration with a request for a $1.5 million subsidy. The group was starting to fall apart. Poor management had resulted in a very unstable practice. Given that there had been no meaningful dialogue with the practice, nor any indication as to just how much the practice was struggling, the CEO called in a consultant to verify the calculations and make recommendations. The consultant confirmed that it would take at least $1.5 million to cover the costs for providing care based on the current coverage requirements. The real value of the consultant's report, however, was a discussion of hospital coverage requirements. Ultimately, the necessary subsidy was greatly reduced when the hospital reduced its coverage requirements. Had the anesthesia practice started with this or had they been providing the hospital regular reports showing their utilization metrics, the consultant would not have been necessary. Basically, all the consultant did was bridge the communication gap.

Today's successful anesthesia practices are built on partnerships with administration: the more communication, the better; the more sharing of data, the better and the more collaborative problem-solving, the better. Knowing what to share and how to share it is not always easy, but it is an essential survival skill that must be mastered in the current environment. Most hospital administrators do not want to change anesthesia solutions, nor do they want to have to bring anesthesia in-house, but many simply come to the conclusion that they have no choice. This is the new reality that all groups must come to terms with.

A Leaner and More Efficient Anesthesia Practice

The real problem in anesthesia is that staffing models tend to be defined based on historical and cultural models that may not fit the current requirements. There is a great divide in the United States between physician-only practices and ACT practices. Western anesthesia practices tend to be physician-only practices and so this model has become the norm. Why a practice in Philadelphia believes that the anesthesia care team is the best way to deliver care while a similar practice in Pasadena has never seriously considered using nurses is one of the great mysteries of the specialty.

Another curious and defining factor for an anesthesia practice tends to be its lack of business focus. Most consultants and observers would agree that the typical anesthesia group is more of a medical professional fraternity than a clearly focused business entity. One of the most obvious results is that physicians are vetted and then hired to become members of the fraternity. They are assumed to be competent and productive until found to be otherwise. Most have no clear mechanism for monitoring and evaluating shareholders and partners. And the biggest and most divisive challenge any practice faces is the need to discharge a member.

It is these factors that make the concept of monitoring provider productivity so challenging and even controversial. It is the rare anesthesiologist who accepts the notion that he or she needs to be monitored and measured. Nevertheless, it is a basic principle of sociology that social control requires identification of the actors. One cannot improve provider performance and effectiveness if one cannot objectively evaluate and compare providers for the same types of work. Herein lies the challenge and the opportunity for the practice that has just received word that there is no additional money in the hospital budget for a larger stipend and that the hospital actually wants to reduce it.

Can the monitoring and measurement of provider productivity make a difference? It has actually been the key to success for most businesses. Good business is about creating maximum value. Since payroll is an anesthesia practice's greatest expense it is the area where the greatest gains can be achieved. It is clearly the belief of the nation's largest anesthesia groups that the goal to long-term viability lies in driving down the cost of care, which must inevitably mean more leveraging of physicians through the use

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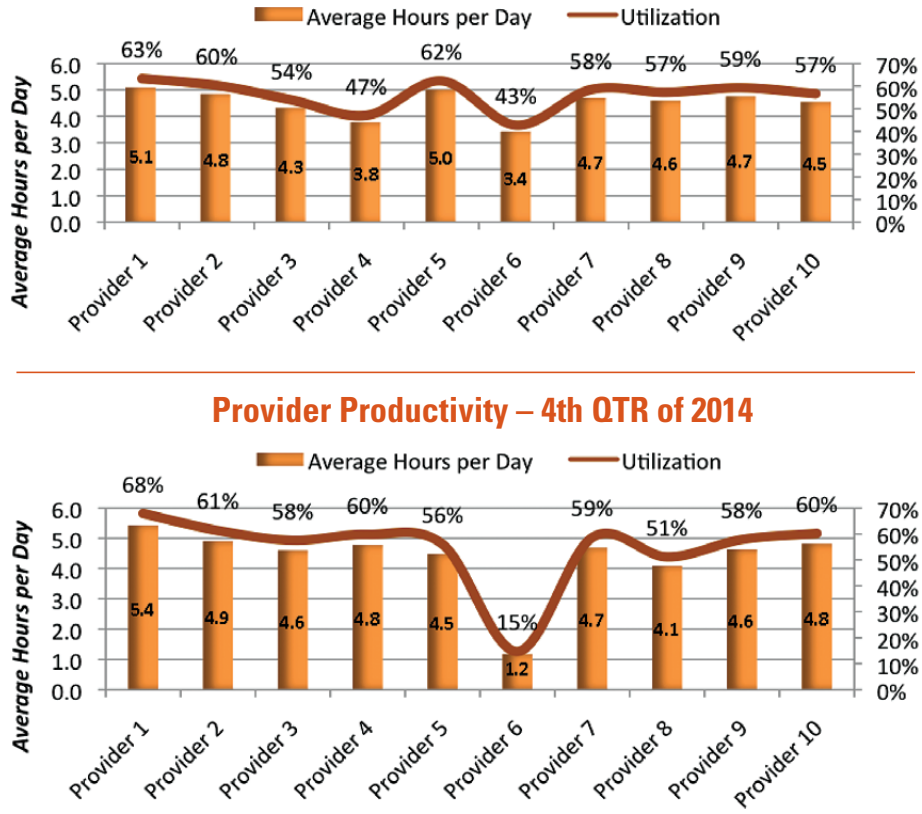
FIGURE 1



of CRNAs and more closely monitoring individual physician productivity and quality metrics. See Figure 1 for an example of the results of measuring individual provider productivity by both average hours per day and utilization.

Managing Change

The specialty of anesthesia has evolved through three phases. For most of its history, anesthesiologists were generally busy enough and the payer mix favorable enough that there was no need for financial support from the hospital. As the environment for the hospitals became more competitive and anesthesia practices were being asked to provide more coverage and services, many groups were able to negotiate stipends or revenue guarantees. Currently more than 75 percent of all anesthesia practices receive some form of financial support from the facilities they serve. Now this is changing. The number one line item most hospital administrations and hospital systems want to reduce is the amount paid for anesthesia.

It used to be that a successful practice was defined by its gross receipts. Enough money solved all problems. Through most of their history anesthesia practices have focused on generating revenue. They did this through payer contracting, their management of billing offices or outside billing vendors and the negotiation of hospital subsidies. By most estimates all three options hold only limited potential to support practice balance sheets. Now the focus is starting to shift to the expense side of the ledger. Those who have come to understand the importance of being lean and effective are gaining market share while those that refuse to accept the inevitable are losing ground and losing their franchises. Effectiveness and efficiency are the new keys to success.

Strategic planners love to remind us that more often than not the beliefs and strategies that have gotten us to where we are today will not get us to where we need to be tomorrow. It would appear that anesthesiologists would be well advised to give this some serious consideration. As anesthesia becomes more and more of a commodity, its monetary value diminishes. Understanding this and finding ways to offset the decline are why metrics matter.

If you are not currently monitoring your own operating utilization metrics and measuring provider productivity and you are an ABC client, feel free to request a free analysis from your account manager. If you are not an ABC client and are curious how your metrics compare please contact our consulting team for a proposal and analysis. ABC has a vast repository of benchmark data for OR utilization and provider productivity for you to benchmark your practice.

Jody Locke, MA serves as Vice President of Anesthesia and Pain Practice Management for ABC. Mr. Locke is responsible for the scope and focus of services provided to ABC's largest clients. He is also responsible for oversight and management of the company's pain management billing team. He will be a key executive contact for the group should it enter into a contract for services with ABC. Mr. Locke can be reached at Jody.Locke@AnesthesiaLLC.com.

How an Investment Banker Can Make an Anesthesia Practice That Wants to Sell Become a More Attractive Acquisition Partner

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There are a number of factors that impact both the relative and absolute attractiveness of a practice to a potential partner/buyer. First off, it is assumed that all anesthesiologists provide high-quality clinical care, but there is much more that needs to be considered when gauging whether or not a practice is attractive. Based on Cross Keys Capital's extensive transactional experience as the most active investment banking firm representing physicians, and more specifically anesthesiologists, on the sale of their practice, we have identified seven high-level areas of focus that buyers use to evaluate the overall attractiveness of a practice.

1. **Corporate Governance/Leadership.** The board of directors needs to be comprised of high-quality, well-respected physicians, medical directors and executives who have leadership experience in operating and guiding their group. This is a critical component when dealing with prospective buyers as a lack of leadership and structure could potentially be perceived as being disorganized, raising concerns to buyers on their ability to execute a transaction. Also, a formal board and executive roles within a practice need to be clearly defined, as well as identifying physicians who have taken on leadership or board positions within the hospital.

2. **Size of Practice.** Factors that determine size are evaluated individually and collectively in order to assess the overall attractiveness of a practice by potential buyers. Typically, these are bucketed into two categories: (i) operational (e.g., revenue, EBITDA, case volume, unit volume, etc.) and (ii) organizational (e.g., number of partner and non-partner physicians, CRNAs, number of facilities, number of anesthetizing locations, etc.) metrics that are then analyzed from both a historical and projected basis to assess the financial trends.

3. **Strength of Hospital Relationships**. Existing hospital relationships are a key value driver for anesthesiology practices, as well as the terms and length of existing contracts. Another critical component is how long the practice has been serving the hospital and the strength of the relationships with the hospital administration and senior leaders. Obviously, tenure with a longer duration is typically perceived as a "stickier" relationship, although hospital systems have been sending their services through an RFP

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process placing that relationship at risk. Also, relationships with surgeons and other specialists are critical.

4. **Managed Care Providers and Payer Mix.** Practices' managed care providers and payer mix will play a significant role when evaluating attractiveness. Practices' geographic location, diversity of managed care providers, payer rates and payer mix are critical during the evaluation.
5. **Profitability of the Practice.** This is a key area of focus by buyers as it dictates whether the target group is a 'business' or a 'practice.' The major profitability drivers to a practice are: (i) types of payers (e.g., government, managed care, par vs. non-par, etc.), (ii) financial support (e.g., stipends, subsidies, revenue guarantee, etc.), (iii) patient population and demographics, (iv) staffing model (e.g., care team, physician only, follow the doctor, etc.), (v) billing and coding (e.g., internal billing vs. outsourced), (vi) back office/ administrative support and (vii) data capture. All of these drivers can increase or decrease attractiveness depending on where the practices strengths and weaknesses are.
6. **Clinical Quality.** HIGH QUALITY is a given.
7. **Growth Initiatives.** Practices' growth initiatives are where buyers evaluate the practices' ability to scale and integrate as a business. Practices need to ask themselves: Has our practice demonstrated growth? How have we gone about it? What future opportunities do we see?

In order to be an attractive practice, our recommendation would be to focus on strengthening and improving leadership roles, implementing the proper governance for your group, solidifying facilities' contracts, building a cohesive culture within the group, establishing an internal audit of coding and compliance and evaluating the merits of partnership-track vs. employed physicians. We believe maintaining excellent control over these critical components will not only streamline your practice and operate more efficiently but actually will elevate it to a true business.

In conclusion, because investment bankers possess intimate knowledge of the triggers for all active buyers of anesthesiology practices, hiring a banker can help you understand and identify who is the best potential buyer for your group while maximizing and protecting the value of your practice.

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The SGR "Fix" in the Context of Anesthesia Practice

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It is not by chance that the discussions leading to the SGR "fix," the Medicare Access and CHIP Reauthorization Act of 2015 (H.R.2), signed into law on April 16, 2015, began with an anesthesiologist, Republican Congressman Andy Harris, MD. The manner in which the Sustainable Growth Rate (SGR) would be fixed was particularly relevant to anesthesiologists who get roughly 31 percent of commercial payment when they bill Medicare, according to Jane Fitch, MD, chair of anesthesiology at the University of Oklahoma Health Sciences Center in Oklahoma City, in an interview with *Anesthesiology News*. Understanding H.R.2, therefore, is necessary to understand how anesthesia practices will be reimbursed in the future.

To understand the rationale underlying H.R.2, it is necessary to start with the basic assumption that providers need to shift away from the fee-for-service model and that there is not already a focus on quality by the practitioner without forcing the issue through reimbursement. It will then appear that H.R.2 guides the payment system in the right direction. While the underlying concepts of quality seem simple to integrate into reimbursement, H.R.2 ignores the cost and complexity involved in instituting its measures on a provider level. Even after a provider invests in the cost of compliance, H.R.2 is broad enough that a provider can miss the mark on what it takes to qualify for an incentive or higher reimbursement.

I. The Immediate Fix

Before Senate approval of H.R.2 on April 14, 2015, Medicare payments for physician services were annually adjusted upward or downward by a conversion factor determined by the SGR. The SGR intended to ensure the expense per Medicare beneficiary did not surpass the gross domestic product (GDP). However, due to the slow growth of the economy, SGR would have cut reimbursement for physician services by 21.2 percent by April 1, 2015.

H.R.2 avoids this massive decline by freezing the current conversion factor to zero percent through June 2015, which means physicians will maintain their current compensation for services provided. The conversion factor will increase to .5 percent as of July 1, 2015, and continue at .5 percent every year through 2019, which will gradually increase physician reimbursement every year rates are recalculated. From 2020 to 2025, the conversion rate will return to zero percent, leveling reimbursement during that period.

II. Not Catchy Enough For The Headlines

Where providers may get lost is in the actual details of reimbursement after the SGR fix is implemented. The complex reimbursement model achieved by H.R.2 did not make the headlines when the public was pressuring the Senate to sign the bill into law.

As of 2026, H.R.2 incentivizes providers towards "quality" as opposed to volume consistent with the overall trend in health care. For this purpose, H.R.2 requires use of two conversion factors, which will apply to practitioners (including physicians, physician assistants, nurse practitioners and clinical nurse specialists and certain other qualifying professionals) depending on whether they are reimbursed under a "qualifying" alternative payment model (APM). A provider qualifies by furnishing a particular threshold (depending on the year, starting in 2019) of his or her services under an APM or an entity participating in an APM that falls under one of these payment systems as defined under the Social Security Act: (1) innovative payment models; (2) the shared savings program; (3) a demonstration; or (4) any demonstration project required by federal law.

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The reward for "qualifying" is reimbursement with a year upward conversion factor of .75 percent. The caveat is that he or she must also use certified electronic health record (EHR) technology and specific quality measures and either bear financial risk for participation or be a patient-centered medical home. A conversion factor of .25 percent will apply to professionals participating in non-qualifying APMs, leaving the fee-for-service model available, but, theoretically, less attractive.

H.R.2 sunsets payment incentives under the physician quality reporting, value-based payment modifier, and meaningful use programs by 2018. H.R.2 establishes in its place the Merit-based Incentive Payment System (MIPS) in 2019, merging all three programs into one. MIPS is structured to evaluate overall provider performance by scoring performance in various categories and giving each category a proportion: "quality" (30 percent), "resource use" (30 percent), "clinical practice improvement activities" (15 percent), and "meaningful use of electronic health records" (25 percent). Each measure is largely dependent on provider reporting and studies with an additional incentive for "exceptional performance." The provider's MIPS score will factor into her reimbursement rate.

III. Just When You Thought You Understood "Meaningful Use"

H.R.2 reestablishes the current standards for data sharing. H.R.2 mandates and permits data sharing (even selling) in multiple contexts. Of course, H.R.2 continues to promote data privacy and security while expanding access to unidentifiable patient information.

The extent of data sharing encouraged by H.R.2 increases the data security risks already prevalent in the healthcare industry. For example, H.R.2 sets a goal of achieving interoperability of EHR systems by December 31, 2018, and prohibits deliberate blocking of information sharing between EHRs from different vendors by redefining meaningful use. This requirement may pose a challenge to providers given the Secretary's power to adjust meaningful use penalties and decertify EHRs if not achieved.

The data sharing provisions of H.R.2 will generate further complications for professionals already struggling to comply with HIPAA and HITECH.

IV. The Provider Fix

Regardless of one's perspective on H.R.2, the practitioner must nonetheless prepare for its impact. Even if a provider chooses not to participate in Medicare, third-party payers are more than likely to follow suit and the precedent established by H.R.2 will be inescapable.

The unpredictability of the value add or decline of H.R.2 is creeping into different contexts of provider arrangements. For example, recently drafted employment contracts accommodate the contingency of a decline in reimbursement by shifting the burden of such decline from the employer to the employee.

Anesthesiologists will need to reevaluate their current efforts to comply with quality measurements, data protection and value performance. They will need to look at current and potential relationships with other providers and ensure such relationships account for the potential decline in reimbursement in the long term. H.R.2 did not simply solve the SGR problem. Rather, it created numerous long-term challenges that providers will need to truly understand to protect their bottom line and determine their professional success. It also perpetuated the many challenges already experienced by anesthesiologists in other payment reform contexts, such as failing to answer how quality is measured in the context of anesthesia practices. Despite the law starting with a conversation in the presence of anesthesiologists, the law only temporarily favors anesthesiologists and only creates more ambiguity in the long term.

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Getting Paid by the Self-Pay Patient

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The number of self-pay patients continues to rise. The term "self-pay" used to apply primarily to the population of individuals who are uninsured; now, the term continues to expand to also represent the insured population with high deductible plans. Some in the community call self-pay "no pay" because collecting payment from these individuals can be extremely difficult. Unfortunately for healthcare providers, medical debts do not rise to the top of many consumers' priority lists, especially if money is tight. They often fall behind items like mortgages, car payments and credit card bills. To address this situation there are two options: either eliminate self-pay patients from a practice altogether (which is not feasible for most anesthesiologists), or take the right steps early on to increase a practice's likelihood of being paid. This article will focus on the latter option and review some helpful steps in assisting anesthesiologists in getting paid by self-pay patients.

1. **Communication with Patients and Facilities**
   Communicating with patients about their financial responsibilities clearly, early and often can avoid confusion and ambiguity in a patient's payment obligations. It also assists in quicker payment for services rendered. Communication with the patient regarding payment can, and should, begin prior to the procedure, should continue through the patient's experience, and, whenever possible, should be in writing. During appointment reminder calls, the patient's insurance can be confirmed

and any outstanding balances with the practice can be discussed. Moreover, for patients who are not new to the facility, insurance information can be validated and updated. When an individual arrives for his/her appointment, the patient's information should be confirmed, including his/her insurance and any outstanding balances can be paid. Finally, following the procedure, a request can be made for the patient's credit card information so it can be billed when the charge is determined.

Unfortunately, for our anesthesia readers, this type of communication is left to the facility and the group has little to no control over patient communication prior to the patient presenting for surgery. However, the facility's and the anesthesiologists' interests are somewhat aligned in this regard. Facilities should be open to a discussion with their anesthesia groups about improving this process and maximizing opportunities to obtain payment from patients. Some anesthesiologists may also find it helpful to craft an anesthesia-specific informational flyer to be handed to patients upon admission. This flyer may explain to patients what to expect and whom to contact if they have questions about anesthesia coverage for their procedures.

2. **Incentivizing Prompt Payment**
   The group or the practice may find it useful to give discounts to patients for prompt payment of their balances. Often, groups or facilities find prompt pay discounts beneficial to save on the costs associated with collecting the payment from the patient. While beneficial, however, implementing a prompt pay discount must be done with caution as it may implicate the Federal Anti-Kickback Statute (AKS).

   The AKS generally prohibits remuneration in exchange for the generation of healthcare business. The AKS has a safe harbor for the waiver of inpatient beneficiary coinsurance and deductible amounts (42 CFR §1001.952(k)) (Inpatient Safe Harbor). When instituting a prompt pay discount, care must be taken to ensure, among other things, that (a) the cost cannot be shifted to the Medicare or Medicaid programs, other payers, or individuals; (b) the discount must be given without regard to the reason for the patient's admission, his/her length of stay, or diagnosis related group; and (c) the waiver may not be part of a price reduction with the third party payer.

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In a favorable Advisory Opinion issued in 2008, the Office of Inspector General (OIG), analyzing a prompt pay discount arrangement by a health system for outpatient services, stated that while the arrangement did not fit squarely within a safe harbor, the health system took steps and various commitments to ensure that the discount was not a disguise for payment for referrals. In addition to following the elements of the Inpatient Safe Harbor, which, of course, did not apply directly, the OIG noted the additional steps the health system took, such as (i) not advertising the discount opportunity, (ii) only informing patients and/or their representatives of the discount during the course of the actual billing process, (iii) notifying third-party payers of the discount policy, (iv) the health system bearing the costs of the arrangement, and (v) having the amount of the discount bear a reasonable relationship to the amount of avoided collection costs. In giving its support for the arrangement, the OIG stated, "[w]e believe that these features reduce the likelihood that the Proposed Arrangement would be used as a means to draw additional patient referrals to the Health System and is consistent with the characterization of the Proposed Arrangement as a prompt payment discount implemented for the purpose of more successful bill collection." If you are considering this type of arrangement, your group should have the proposal analyzed by a healthcare attorney to ensure compliance.

3. **Establishing Payment Plans**
   It is important that patients be given every opportunity to pay. Not only should they have multiple avenues through which to pay—cash, check, credit card, etc.—but they should be given opportunities to pay over time in the event that full immediate payment is impractical or impossible. Groups should establish payment plans with their billing companies and/or billing personnel that are reasonable and viable both for the patient and for the group.

   Importantly, sometimes when payment plans are established, the payment owed by the patient reflects a lesser amount than what was originally billed. As mentioned in the previous section, offering discounts must be done with care and with regard to applicable State and Federal laws. Discounts should not be a regular occurrence and should be given only after an individual determination of the person's ability to pay. The amount of the discount must not be shifted to payers.

4. **Collection Agencies**
   The landscape surrounding collections from patients can be tumultuous and as time progresses, the likelihood a practice will be able to collect patient payments diminishes dramatically. That being said, payment is not impossible and practices should not give up on the money they have earned. Many practices find it helpful to review their aged accounts (*e.g.*, those accounts that are more than 90 or 120 days overdue) and select which accounts to send to a collection agency.

5. **Self-Pay Policies**
   The above may all be incorporated into a self-pay policy. Having a clear plan for how to address self-pay patients is instrumental in smooth and efficient payment. It is important for the policies to be fluid enough to apply to most all patients without an additional burden on the practice. Finally, policies should be reviewed by qualified counsel to ensure compliance with applicable laws and regulations.

Payment by self-pay patients can be difficult, but practices can put steps and procedures in place to minimize administrative burden while maximizing revenue. Working in conjunction with facilities, billing personnel, and, when necessary, collection agencies, can also assist in streamlining the process.

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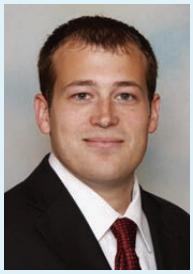

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Has Someone Gotten In Trouble For Doing That? Lessons for Anesthesia Groups from Real Cases

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Anesthesia billing is complex and riddled with a minefield of potential compliance issues. Thoughtful anesthesia groups have effective compliance programs in place, designed to minimize the risk of government allegations of fraud and abuse. When crafting and maintaining an effective billing compliance program it is helpful to understand which areas of anesthesia billing have been the subject of legal action. Moreover, like it or not, when a compliance officer is able to point to specific instances in which anesthesia providers have been subject to criminal or civil penalties, s/he is more able to obtain the highest level of compliance from otherwise recalcitrant providers. This article will provide information on where to find details on legal cases impacting anesthesia providers and discuss strategies for implementing the lessons that can be learned from a thorough understanding of the cases.

How to Find the Cases

The government understands the value of publicizing the cases it brings against providers and uses a number of venues to report on its successful legal actions. Anesthesia providers can also learn about cases of interest from their specialty societies and the media.

The Office of Inspector General

The Office of Inspector General for the Department of Health and Human Services (OIG) was established in 1976 to fight waste, fraud and abuse in Medicare, Medicaid and more than 100 other HHS programs. Currently there are approximately 1,600 OIG employees dedicating a majority of their time to oversight of Medicare and Medicaid through a nationwide network of audits, investigations and evaluations to assist in the development of cases for criminal, civil and administrative enforcement. See http://oig.hhs.gov/about-oig/about-us/index.asp.

The OIG has an easily navigable website (http://oig.hhs.gov/) that contains information on OIG focus areas and legal actions against providers including:

- *Criminal and civil enforcement actions*: The OIG posts information on its criminal and civil enforcement actions often related to its work as part of the Medicare Fraud Strike Force and the Health Care Fraud Prevention and Enforcement Action Team. In addition to information on current actions there is an archive going back to 2003. See http://oig.hhs.gov/fraud/enforcement/criminal/index.asp.
- *State enforcement actions*: The OIG posts information on cases handled by state Medicaid Fraud

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Control Units that operate in 49 States and the District of Columbia. In addition to information on current actions there is an archive going back to 2010. See http://oig.hhs.gov/fraud/enforcement/state/index.asp.

- *Civil monetary penalties and affirmative exclusions*: The OIG posts information about providers who resolved cases in which the OIG sought civil monetary penalties, assessments and/or exclusions based on allegations of fraud and abuse. Please note that these cases are generally resolved through a settlement agreement with the provider denying liability. In addition to information on current cases there is an archive going back to 2003. See http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp.
- *Semiannual Report to Congress*: The OIG issues a semiannual report to Congress keeping it informed of the OIG's activities, significant findings and recommendations. The Semiannual Report often contains information on significant fraud and abuse cases and initiatives. In addition to the current Semiannual Report there is an archive going back to 1996. See http://oig.hhs.gov/reports-and-publications/archives/semiannual/index.asp.

In addition, the OIG publishes a Work Plan every year. Although this Work Plan does not contain specific cases, it does set forth some of the focus areas for the OIG for the current and upcoming years. Since 2013, the Work Plan has included the following anesthesia issue:

> Anesthesia services—Payments for personally performed services
>
> We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesia services reported on a claim with the "AA" service code modifier met Medicare requirements. Physicians report the appropriate anesthesia modifier code to denote whether the service was personally performed or medically directed. (CMS, Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 50) Reporting an incorrect service code modifier on the claim as if services were personally performed by an anesthesiologist when they were not will result in Medicare's paying a higher amount. The service code "AA" modifier is used for anesthesia services personally performed by an anesthesiologist, whereas the "QK" modifier limits payment to 50 percent of the Medicare-allowed amount for personally performed services claimed with the "AA" modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due.

See http://oig.hhs.gov/reports-and-publications/workplan/index.asp. With anesthesia in the OIG's spotlight, it behooves practices to keep abreast of current OIG enforcement actions.

The United States Department of Justice

The Department of Justice (DOJ) is tasked with enforcing all of the laws of the United States, including everything from bank robbery to drug trafficking to terrorism. Within the mix, and as a one of its top priorities, the DOJ enforces the laws surrounding healthcare fraud and abuse. The civil and criminal prosecutions for the DOJ are handled in branch offices located in each state, with some states having multiple branch offices. See "Find Your United States Attorney" at http://www.justice.gov/usao/find-your-united-states-attorney. Importantly, each branch office has its own website, most issuing press releases (and holding press conferences) on indictments, settlements and convictions. Savvy compliance officers recognize that careful monitoring of the website for the United States Attorney's office in their jurisdiction can lead to valuable information on those areas in healthcare under the most vigorous investigation where their practice is located.

Specialty Societies

Both the American Society of Anesthesiologists (www.asahq.org) and the American Medical Association (www.ama-assn.org) publish information on cases involving healthcare fraud and abuse. Anesthesiologists can also visit the websites for their state societies for information specific to the states in which they practice.

Media and Social Media

As mentioned above, the DOJ issues press releases on its cases and resolutions. These press releases often lead to more in-depth reporting in traditional local and national media outlets. Not surprisingly, social media has gotten into the fray with information on healthcare fraud cases in on-line publications, blogs and even on YouTube. See, e.g., https://www.youtube.com/watch?v=WeAVD0oMoHA.

Cases and Lessons Learned

The following cases give anesthesia providers a glimpse into the areas of interest to federal and state prosecutors (both civil and criminal) relating to anesthesia practices. Each set of cases is followed by the lessons that can be learned from the cases.

ANESTHESIA TIME

Endoscopy Center of Southern Nevada – Tonya Rushing and Dr. Dipak Desai

Ms. Rushing was the CEO of the now defunct Endoscopy Center of Southern Nevada and owned the billing company that submitted claims for the Endoscopy Center. The government alleged that Ms. Rushing instructed the anesthetists employed by the Endoscopy Center to overstate their time on the anesthesia records and then she instructed the billing company staff to rely on the false anesthesia times when submitting claims. The billing company received nine percent of net collections on the fraudulently billed time for services rendered. Ms. Rushing pled guilty to conspiracy to commit healthcare fraud and was sentenced to one year and a day in prison, two years of supervised release, 150 hours community service, a $10,000 fine and $50,000 in restitution.

Dr. Dipak Desai owned the Endoscopy Center. The government alleged that Dr. Desai had the CRNAs use left-over anesthesia drugs in previously opened vials and that he used the same colonoscopy scopes and bite plates from patient to patient. More than 50,000 patients were warned to be tested for hepatitis and HIV, nine patients contracted incurable hepatitis C, and at least two patients died from the illness. Dr. Desai was found guilty of second degree murder and insurance fraud and was sentenced to life in prison with possible parole after 18 years.

The CRNAs that provided the anesthesia services and knew about the reuse of the scopes and bite plates were also charged criminally. Anesthetist Ronald Lakeman was convicted of insurance fraud and criminal neglect and sentenced to eight to 21 years in prison. Anesthetist Keith Mathahs pled to criminal neglect of patients resulting in death, insurance fraud and racketeering but was sentenced to only 28–72 months in prison because he cooperated with prosecutors and testified against the other defendants. See https://www.fbi.gov/lasvegas/press-releases/2015/endoscopy-center-ceo-sentenced-in-billing-fraud-scheme, http://www.reviewjournal.com/news/nurse-anesthetist-sentenced-prison-hepatitis-c-outbreak, http://www.reviewjournal.com/news/desai-sentenced-life-prison-possibility-parole-hepatitis-outbreak.

US v. Cabrera and Arbona

The government brought a civil case against an anesthesiologist and his billing clerk alleging overbilling of anesthesia time. Interestingly, the government investigators substantiated the allegations by comparing the billed time to the operating reports, anesthesia records and nursing notes. The defendants were found joint and severally liable for $1.3 million dollars. See http://www.leagle.com/decision/2000340106FSupp2d234_1307.xml/U.S.%20v.%20CABRERA-DIAZ.

Lessons Learned

Anesthesia time is an integral part of anesthesia billing and will always be a considered a compliance risk area. An effective compliance program should include education of providers and billing staff regarding the definition and documentation of anesthesia time along with regular audits of records with a special emphasis on comparing the anesthesia record to the facility records to ensure the accuracy of the documented anesthesia time. Groups should also consider billing directly from the anesthesia record so that the billing staff can compare the anesthesia time to the monitoring grid to confirm congruence. Finally, cases that involve poor quality of care often lead to increased interest in prosecution and enhanced penalties.

MEDICAL DIRECTION

Vanderbilt University Medical Center

This case was filed as a whistleblower lawsuit by a former anesthesiologist with the group. The allegations are that

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the group submitted claims for medical direction without meeting the seven steps (e.g., the anesthesiologist was in a separate building and therefore not immediately available) and that the electronic medical record provided anesthesiologists with only one choice for describing the level of treatment, "medically directed," even though treatment of patients almost never met the necessary criteria. See https://www.nashvillepost.com/news/2013/9/11/whistleblowing_docs_allege_vast_vumc_medicare_billing_deception. This case remains pending.

Dr. Richard Toussaint

Dr. Toussaint was indicted in May 2015 on 17 counts of healthcare fraud against Blue Cross Blue Shield, UnitedHealthcare and the Federal Employees Health Benefits Program. The charges against Dr. Toussaint, an anesthesiologist and founder of a chain of upscale hospitals in Texas, are for claiming that he was present and personally participating in the anesthesia services when in fact he was under anesthesia himself or on a private jet or in another state. The indictment states that Dr. Toussaint would:

- Hand-write his initials in both the top and bottom right sections of the medical record in the 'Pre-Anesthesia Consultation & Plan' and 'Anesthesia & Surgical Vents' sections and then leave the hospital;
- Hand-write on the chart 'Present for induction and emergence' along with his initials—knowing he would not be present for these events; and,
- Order nurses and other caregivers to falsely claim he was present when he was not.

If convicted, Dr. Toussaint faces ten years in prison for each count of healthcare fraud and a $250,000 fine in addition to forfeiture of several luxury cars allegedly purchased with the fraudulently acquired money including a 2016 Bentley, a 2012 Rolls-Royce Ghost and a 2015 McLaren 650S Spider. See http://www.dallasnews.com/news/crime/headlines/20150520-dallas-anesthesiologist-to-plead-not-guilty-to-17-counts-of-health-care-fraud.ece, http://healthcare.dmagazine.com/2015/05/20/feds-indict-founding-physician-of-forest-park-medical-center-on-17-counts-of-healthcare-fraud/

Lessons Learned

With the medical direction modifiers included in the OIG Work Plan and the filing of cases involving the seven steps of medical direction, thoughtful compliance officers understand the need for effective training of anesthesiologists and billing staff on medical direction criteria and exceptions. Groups should consider billing directly from the anesthesia record (rather than a charge document) so that the billing staff can append the correct medical direction modifier based on the actual documentation in the record.

Moreover, compliance officers should conduct regular compliance auditing of records to ensure that the correct modifier is being billed. For anesthesia groups that are using an EMR, the compliance program should include a review of the EMR to ensure that anesthesiologists have the ability to bill all level of services and are not forced to select medical direction in those instances in which the seven steps were not met.

An effective compliance program should include policies requiring providers and other employees to report any potential fraudulent conduct to the compliance officer/compliance committee so that the group can take the necessary corrective action. Failure to correct potentially fraudulent conduct can lead to a whistleblower lawsuit.

Finally, under federal law the DOJ can prosecute cases for alleged fraud involving commercial insurance companies. An effective compliance program must include substantive and procedural policies applying to commercial insurance companies including a careful review of contracts with the insurance companies and relevant state laws.

PRE-DOCUMENTING CASES

University of California – Irvine

This case was filed as a whistleblower lawsuit by a former professor/anesthesiologist and was settled for $1.2 million. As in the Vanderbilt case, the whistleblower alleged that the anesthesiologists were not meeting the seven steps of medical direction as the physicians would be in a different building at the time they claimed to be medically directing. What distinguished this case was the fact that the government conducted an unannounced site visit and reviewed anesthesia records in which the

anesthesiologist had pre-documented cases to make it appear that s/he was present including cases where the anesthesiologist had filled out the record before the case started, and cases where the record was fully documented through emergence despite the fact that the patient was still in the middle of surgery. See http://articles.latimes.com/2013/mar/28/local/la-me-uci-medical-20130328, http://articles.latimes.com/2008/sep/26/local/me-ucirvine26,

Lessons Learned

Both the Toussaint case and the UC Irvine case focus on providers documenting anesthesia records before services were provided, which the government considers a quality of care issue as well as a potential fraud issue. Documentation of services should be done contemporaneously with the service rendered, or after the fact in an accurate and open amendment, but should never be done prior to the service rendered. Anesthesia groups should, if necessary, educate providers to ensure that they understand that records should not be pre-documented. In those instances where pre-documentation has occurred, groups should take corrective action, including disciplinary action, against the offending provider.

Moreover, compliance officers should understand and educate providers regarding the appropriate way to amend a medical record. Medicare provides guidance on this issue at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1237.pdf.

HEALTHCARE FRAUD AND FALSIFYING RECORDS

Dr. Paul Madison and Jeanette Shin

Dr. Paul Madison and Jeanette Shin were indicted in 2012 for alleged healthcare fraud against private insurance companies and the federal workers compensation program. If convicted, Dr. Madison faces ten years in prison and a $1.5 million fine and Ms. Shin faces six years in prison and a $750,000 fine. The allegations against Dr. Madison were that he: (1) claimed to provide anesthesia services to patients undergoing chiropractic manipulation under anesthesia (MUA) that were not performed; (2) disguised fraudulent billings by creating false medical and billing records; (3) directed billing staff, nurses, chiropractors to create false records; and (4) directed staff to lie to investigators. The allegations against Ms. Shin are that she falsified her nurse's reports by claiming the chiropractors performed MUAs under anesthesia when she knew it was not true. This case is not yet resolved. See http://www.justice.gov/usao/iln/pr/chicago/2012/pr1221_01a.pdf

Lessons Learned:

As with the Toussaint case, the government charges included alleged fraud against commercial insurance companies. Savvy compliance officers include policies regarding accurate documentation and billing to commercial insurance companies as an integral part of their compliance program. Compliance education and monitoring should also include close attention to commercial payers.

The government will seek redress against not only the provider that benefitted financially from the fraud, but also against office staff who did not benefit directly; it is the act of fraud and not the money directly received from the fraud that dictates government action.

DISTRACTED ANESTHESIA PROVIDERS

Milne v. Medical City Dallas, Rinkenberger (surgeon) and Spillers (anesthesiologist)

Drs. Rinkenberger and Spillers were sued for malpractice after a patient died 10 hours after an AV node ablation. Allegations in the complaint against Dr. Spillers included "distracted doctoring." Dr. Rinkenberger testified at his deposition that Dr. Spillers failed to notice dangerously low blood oxygen levels until 15 or 20 minutes after the patient turned blue and that he saw Dr. Spillers on a cell phone and an iPad when he should have been closely monitoring the patient. Dr. Spillers admitted that he goes on to the internet while personally providing anesthesia stating:

> "I have logged on to the Internet before especially if—specifically if I have a question about the patient's

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Has Someone Gotten In Trouble For Doing That? Lessons for Anesthesia Groups from Real Cases

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medications, about the procedure, yes, we'll often, you know, do a search and find out information pertaining to the case. I will occasionally check e-mail. I will occasionally check scheduling for the office. But in general, no, I—the time spent on the Internet during a case is, you know, very brief, a couple, three minutes."

Dr. Spillers denied that he posted on Facebook during cases when, in fact, the plaintiff's attorney had obtained the following postings from Dr. Spiller's Facebook page:

- "After enduring the shittiest Friday I've had in a while I just found out my next patient has lice. Freakin lice. I didn't even know they still made those. Help."
- A picture of an anesthesia monitor with the post, "Just sitting here—sitting here watching the tube on Christmas morning. Ho ho ho."

See http://blogs.dallasobserver.com/unfairpark/2014/04/dallas_anesthesiologist_cops_t.php and https://stanfordhealthcare.org/health-care-professionals/medical-staff/medstaff-update/2013-february/201302-distracted-doctoring-and-patient-safety.html. As of the writing of this article there has been no final disposition of this malpractice action.

Lessons Learned

Aside from the fact that plaintiff attorneys are increasingly including distracted provider allegations in malpractice litigation, the use of electronics and social media while providing anesthesia has implications for the relationship between the anesthesia group, surgeons and hospital administration. Anesthesia groups are increasingly evaluated on "customer service" and the use of electronics and social media during patient care looms large as a major concern to facilities and surgeons. Prudent anesthesia groups should have a policy on the use of electronics and social media including the circumstances in which electronics can be used and the consequences for failure to comply with the policy.

Conclusion

An effective compliance program is the key to ensuring that all services are accurately and adequately documented and that all submitted claims and payments are correct. Thoughtful compliance officers review government and commercial payer resources regularly to ensure that their groups remain current on the state of the law and the claims policies of both governmental and commercial insurance programs. They also educate and monitor claims on a regular basis to assess provider compliance and take corrective action as needed to safeguard the group from fraud and abuse.

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Is the Office of Inspector General Turning its Attention to Physician Issues?

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A review of recent activity by the Health and Human Services Office of Inspector General (OIG) indicates that it may be physicians' turn for a higher level of scrutiny. Over the past few years, the OIG has released three Special Fraud Alerts focusing on physicians' arrangements. In 2013, the OIG issued a fraud alert about physician-owned device distributorships, and in 2014 it issued a fraud alert about lab payments to physicians. The third alert, issued June 9, 2015, addresses physician compensation arrangements that may result in significant liability under the federal Anti-Kickback Statute (AKS).

One purpose of the AKS is to protect patients from inappropriate medical referrals or recommendations by healthcare professionals who may be unduly influenced by financial incentives. Section 1128B(b) of the Social Security Act (the Act) makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce, or in return for, referrals of items or services reimbursable by a Federal healthcare program. When remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal healthcare program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. Conviction will also lead to exclusion from Federal healthcare programs, including Medicare and Medicaid. The OIG may also initiate administrative (non-criminal) proceedings to exclude persons from the Federal healthcare programs or to impose civil money penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.[1]

Potential AKS violations may be pursued under the federal False Claims Act (FCA), which prohibits the knowing submission of false claims to the government.[2] The Affordable Care Act (ACA) amended the AKS in that claims submitted to the government for federal healthcare programs may be "false" if they were the product of illegal kickbacks in violation of the AKS.[3] Penalties under the FCA greatly increase the potential financial harm of an AKS violation, with penalties of up to $11,000 per false claim and treble the amount of damages to the government.[4]

1. Physician Owned Distributorships (PODs)

The March 26, 2013 Special Fraud Alert: Physician-Owned Entities calls out PODs as "inherently suspect" under the

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[1] 42 U.S.C. § 1302a-7b(b).
[2] 31 U.S.C. § 3729-3733.
[3] 42 U.S.C. § 1320a-7b(g)
[4] 31 U.S.C. § 3729(a).

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AKS. This Special Fraud Alert addresses physician-owned entities that derive revenue from selling, or arranging for the sale of, implantable medical devices ordered by their physician-owners for use in procedures the physician-owners perform on their own patients at hospitals or ambulatory surgical centers (ASCs).

The OIG has repeatedly expressed concerns about arrangements that exhibit questionable features with regard to the selection and retention of investors, the solicitation of capital contributions and the distribution of profits. Such questionable features may include, but are not limited to:

(1) selecting investors because they are in a position to generate substantial business for the entity,

(2) requiring investors who cease practicing in the service area to divest their ownership interests, and

(3) distributing extraordinary returns on investment compared to the level of risk involved.

PODs that exhibit any of these or other questionable features potentially raise four major concerns typically associated with kickbacks—corruption of medical judgment, overutilization, increased costs to the Federal healthcare programs and beneficiaries and unfair competition. This is because the financial incentives PODs offer to their physician-owners may induce the physicians both to perform more procedures (or more extensive procedures) than are medically necessary and to use the devices the PODs sell in lieu of other, potentially more clinically appropriate, devices. The OIG is particularly concerned about the presence of such financial incentives in the implantable medical device context because such devices typically are "physician preference items," meaning that both the choice of brand and the type of device may be made or strongly influenced by the physician, rather than being controlled by the hospital or ASC where the procedure is performed.

2. Laboratory Payments to Referring Physicians

This June 25, 2014 Special Fraud Alert addresses compensation paid by laboratories to referring physicians and physician group practices for blood specimen collection, processing and packaging and for submitting patient data to a registry or database. The OIG has repeatedly emphasized that providing free or below-market goods or services to a physician who is a source of referrals, or paying such a physician more than fair market value (FMV) for his or her services, could constitute illegal remuneration under the anti-kickback statute. Recently there has been an influx of laboratory AKS or FCA settlements in which both the laboratory and the physician or physician group have reached settlements with the OIG regarding allegations that the laboratory paid a physician more than fair market value for the physician's services or for services the laboratory does not actually need or for which the physician is otherwise compensated. Such payments are suspect under the AKS because of the implication that one purpose of the payments is to induce the physician's Federal healthcare program referrals. The OIG also historically has been concerned with arrangements in which the amounts paid to a referral source take into account the volume or value of business generated by the referral source.

Specimen processing arrangements typically involve payments from laboratories to physicians for certain specified duties, which may include collecting the blood specimens, centrifuging the specimens, maintaining the specimens at a particular temperature and packaging the specimens so that they are not damaged in transport. Payments under specimen processing arrangements

typically are made on a per-specimen or per-patient-encounter basis and often are associated with expensive or specialized tests.

Medicare allows the person who collects a specimen to bill Medicare for a nominal specimen collection fee in certain circumstances, including times when the person draws a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacuum tube to draw the specimen). Medicare allows such billing only when: (1) it is the accepted and prevailing practice among physicians in the locality to make separate charges for drawing or collecting a specimen, and (2) it is the customary practice of the physician performing such services to bill separate charges for drawing or collecting the specimen. Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn.[5] Physicians who satisfy the specimen collection fee criteria and choose to bill Medicare for the specimen collection must use Current Procedural Terminology (CPT) Code 36415, "Routine venipuncture – Collection of venous blood by venipuncture."[6]

Characteristics of a specimen processing arrangement that may be evidence of such unlawful purpose include, but are not limited to, the following:

- Payment exceeds fair market value for services actually rendered by the party receiving the payment.
- Payment is for services for which payment is also made by a third party, such as Medicare.

- Payment is made directly to the ordering physician rather than to the ordering physician's group practice, which may bear the cost of collecting and processing the specimen.
- Payment is made on a per-specimen basis for more than one specimen collected during a single patient encounter or on a per-test, per-patient or other basis that takes into account the volume or value of referrals.
- Payment is offered on the condition that the physician order either a specified volume or type of tests or test panel, especially if the panel includes duplicative tests (e.g., two or more tests performed using different methodologies that are intended to provide the same clinical information) or tests that otherwise are not reasonable and necessary or reimbursable.
- Payment is made to the physician or the physician's group practice, despite the fact that the specimen processing is actually being performed by a phlebotomist placed in the physician's office by the laboratory or a third party.

The OIG is also concerned about arrangements under which clinical laboratories are establishing, coordinating or maintaining databases, either directly or through an agent, purportedly to collect data on the demographics, presentation, diagnosis, treatment, outcomes or other attributes of patients who have undergone, or who may undergo, certain tests performed by the offering laboratories. Typically these are specialized and expensive tests paid for by Federal healthcare programs. This Special Fraud Alert addresses such "registries" or "registry arrangements," whether they are referred to as "registries" or "observational outcomes databases" or by other terminology. Many times the

[5] Section 1833(h)(3) of the Act; Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 16, section 60.1.

[6] The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2015 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this document should refer to the most current version of the Current Procedural Terminology available from AMA.

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laboratories that participate in registry arrangements assert that they are intended to advance clinical research to promote treatment, to provide physicians with valuable clinical knowledge for patients with similar disease profiles and to provide other benefits to physicians or the healthcare industry generally.

Registry arrangements may take various forms; however, they typically involve payments from laboratories to physicians for certain specified duties, including, by way of example only, submitting patient data to be incorporated into the registry, answering patient questions about the registry and reviewing registry reports.

With the growing interest in genetic testing some laboratories have been approaching physicians to solicit their patients through a registry arrangement. Components that may implicate the AKS in such arrangements include but are not limited to:

- The laboratory collects comparative data for the registry from, and bills for, multiple tests that may be duplicative (e.g., two or more tests performed using different methodologies that are intended to provide the same clinical information) or that otherwise are not reasonable and necessary.
- Compensation paid to physicians pursuant to registry arrangements is on a per-patient or other basis that takes into account the value or volume of referrals.
- Compensation paid to physicians pursuant to registry arrangements is not fair market value for the physicians' efforts in collecting and reporting patient data.
- Compensation paid to physicians pursuant to registry arrangements is not supported by documentation, submitted by the physicians in a timely manner, memorializing the physicians' efforts.
- The laboratory offers registry arrangements only for tests (or disease states associated with tests) for which it has obtained patents or that it exclusively performs.

3. Physician Compensation Arrangements That May Result in Significant Liability

The OIG advised in a June 9, 2015, Special Fraud Alert, that physicians who enter into compensation arrangements such as medical directorships must ensure that those arrangements reflect FMV for *bona fide* services the physicians actually provide. Although many compensation arrangements are legitimate, a compensation arrangement may violate the anti-kickback statute if even one purpose of the arrangement is to compensate a physician for his or her past or future referrals of Federal healthcare program business. OIG encourages physicians to carefully consider the terms

and conditions of medical directorships and other compensation arrangements before entering into them.

Prior to the release of the Special Alert, the OIG had reached settlements with 12 individual physicians who entered into questionable medical directorship and office staff arrangements. The OIG alleged that the compensation paid to these physicians under the medical directorship arrangements constituted improper remuneration under the anti-kickback statute for a number of reasons, including that:

- The payments took into account the physicians' volume or value of referrals;
- The payments did not reflect FMV for the services to be performed; and
- The physicians did not actually provide the services called for under the agreements.

OIG also alleged that some of the 12 physicians had entered into arrangements under which an affiliated healthcare entity paid the salaries of the physicians' front office staff. Because these arrangements relieved the physicians of a financial burden they otherwise would have incurred, OIG alleged that the salaries paid under these arrangements constituted improper remuneration to the physicians. OIG determined that the physicians were an integral part of the scheme and subject to liability under the Civil Monetary Penalties Law.[7]

Conclusion

Given the OIG's focus on these physician issues, physicians must ensure that any medical director agreement includes appropriate compensation for the services provided. OIG directs physicians

to its guidance on the topic, including its Roadmap for New Physicians. The Roadmap states that physicians accepting a medical directorship must assume substantial professional responsibility for the care at the facility by actively overseeing clinical care at the facility, leading the medical staff to meet the standard of care, ensuring proper training and education and identifying and addressing quality problems. The Roadmap discusses situations in which physicians signed improper medical director agreements that improperly paid for referrals and resulted in settlements of hundreds of thousands of dollars paid to the government.

Similarly, OIG's concerns regarding specimen processing arrangements and PODs are not abated when those arrangements apply only to specimens collected, or devices placed from patients enrolled in a non-Federal healthcare program. Arrangements that "carve out" Federal healthcare program beneficiaries or business from otherwise questionable arrangements implicate the AKS and may violate it by disguising remuneration for Federal healthcare program business through the payment of amounts purportedly related to non-Federal health care program business. Because physicians typically wish to minimize the number of laboratories or other vendors to which they refer or order services or items for reasons of convenience and administrative efficiency, arrangements that carve out Federal healthcare program business may nevertheless be intended to influence physicians' referrals of Federal healthcare program business to the offering laboratories or device manufacturer.

Notwithstanding the extremely high enforcement priority on this subject, most compliance officers fail to include this area in serious ongoing monitoring and auditing as called for by the OIG in their various compliance guidance documents. The reason for this reluctance arises out of the fact that arrangements with physicians generally involve either inside or outside legal counsel and compliance officers become convinced that since that is the case, the arrangements must be allowable. This is definitely not the case as is evidenced by the number of enforcement actions taken against such arrangements.

A closer look at these Alerts is warranted by all physicians in conjunction with legal counsel with expertise in the AKS and the physician's Chief Compliance Officer.

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[7] http://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf

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Professional Events

Date	Event	Location	Contact Info
September 10-13, 2015	Texas Society of Anesthesiologists 2015 Annual Meeting	The Westin La Cantera Resort San Antonio, TX	http://www.tsa.org/professional/meetings.php
September 12, 2015	Washington State Society of Anesthesiologists 76th Annual Meeting	Bell Harbor International Conference Center Seattle, WA	https://wassa.memberclicks.net/fall-and-winter-scientific-meetings
September 17-20, 2015	The American Academy of Pain Management 26th Annual Meeting	Gaylord National Resort & Convention Center National Harbor, MD	http://www.aapainmanage.org/annual-clinical-meeting/
September 26-27, 2015	The Ohio Society of Anesthesiologists 76th Annual Meeting	Hilton Easton Columbus, OH	http://osainc.org/index.php?option=com_content&view=article&id=9&Itemid=7
September 17-20, 2015	New England Society of Anesthesiologists 58th Annual Meeting	Ocean Edge Resort Brewster (Cape Cod), MA	http://nesa.net/NESA/AnnualMeeting%20Pages/AnnMtg2015prov.html
September 26-30, 2015	American Health Information Management Association 2015 Convention and Exhibit	Ernst N. Morial Convention Center New Orleans, LA	http://www.ahima.org/convention/geninfo
October 24-28, 2015	American Society of Anesthesiologists Anesthesiology 2015	San Diego Convention Center San Diego, CA	https://www.asahq.org/Annual%20Meeting/Go%20ANESTHESIOLOGY%202015
October 22-24, 2015	Becker's ASC 22nd Annual Meeting	Swissotel Chicago, IL	http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/
November 6-7, 2015	Society of Academic Anesthesiology Associations 2015 Annual Meeting	Renaissance Baltimore Harborplace Baltimore, MD	http://saaahq.org/meetings.htm
November 21-22, 2015	American Society of Anesthesiologists Quality Meeting 2015	Loews Chicago O'Hare Hotel Rosemont, IL	http://asahq.org/meetings/asa-quality-meeting
December 11-15, 2015	The New York State Society of Anesthesiologists 68th Annual PostGraduate Assembly in Anesthesiology	New York Marriott Marquis New York, NY	http://www.nyssa-pga.org/pga-meeting

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