Press releases following a recent publication in the British Medical Journal (BMJ) hysterically echoed the article’s headline: “Medical error—the third leading cause of death in the U.S.” The authors used a variety of published sources on the incidence, lethality and preventability of medical errors to produce an estimate of 251,000 deaths per year attributable to medical error, out of a total of about 2.6 million. As a cause of death this would rank behind only heart disease (611,000) and cancer (585,000). While the purpose of the authors was to advocate for improved coding of the cause of death in vital statistics, the purpose of the commentary was to alarm the public regarding the current state of healthcare. Should we panic?

I think not. Here’s why:

First, understand that I’m not a criminal or even an apologist. I hate medical errors and I have devoted my career to their eradication. We should strive every day to make healthcare as predictable and safe as humanly possible, and we should embed continuous quality improvement in everything we do. So looking at errors is important. But we have to recognize their place in any complicated human system.

It’s possible that errors are increasing because of increased reporting. This would be a good thing—we can’t fix what we don’t measure, to paraphrase...

Continued on page 7
The Importance of Communication in Peri-Anesthesia Matters

If you have begun to see the names of some of The Communique's authors over and over again, there is a good reason. Rick Dutton, MD and Rick Bushnell, MD, and Mark Weiss, JD, to name several, are constantly thinking about the dynamic world of anesthesia practice and they always have something interesting to tell us. Their contributions to this Summer issue are proof.

A study published in The BMJ (BMJ 2016; 353 doi: http://dx.doi.org/10.1136/bmj.i2139) on May 3, 2016, by researchers at Johns Hopkins urged the Centers for Disease Control (CDC) to list medical error as the third most common cause of death in the U.S. after heart disease and cancer. The study showed that the number of annual U.S. deaths attributable to medical error is approximately 251,454—more than three times higher than the 98,000 preventable deaths cited by the Institute of Medicine in its famous 1999 study To Err is Human.

Dr. Dutton, who led the Anesthesia Quality Institute (AQI) until he joined U.S. Anesthesia Partners and moved his practice to Dallas, asks, in Thinking about Medical Errors, whether the seemingly high volume of preventable deaths is cause for alarm. He gives three cogent reasons for a “no” answer:

1. The volume of reporting, rather than the numbers of actual deaths, may be increasing, due to various causes including changes in the definition of medical error;
2. Improvements in healthcare have led to longer lives and a greater number of older and sicker patients undergoing surgery, or, as Jimi Hendrix said, “No one here gets out alive,” and
3. Medicine is complex and errors do occur, frequently and inevitably.

Thus an increasing volume of preventable deaths is not quite as fearsome as the popular press made it out to be when the article first appeared. Read Dr. Dutton’s article, with its interesting clinical examples, and see why it is, rather, a reason to celebrate the advances of healthcare.

In his latest article, Mr. Weiss lets us in on OIG Advisory Opinion Secrets and Strategies. Most of us have a passing familiarity with the concept of OIG Advisory Opinions. A number of anesthesiologists have thought about seeking an Advisory Opinion when asked to give something of value to their hospital or ASC in exchange for continued “referrals” of surgical patients. The process is expensive and time-consuming but it can be worth a lot to the “Requestor” in the right circumstances. Those circumstances include marshalling the facts not as a history—which is how physicians are trained to organize clinical events, symptoms and connections between them—but as an advocacy piece. As Mr. Weiss notes in his inimitably direct fashion,

I often see a strategic mistake about to be made by requestors and their counsel: they approach the process as a mere presentation of the facts and then plan to sit waiting for the opinion.

That’s as far from the correct approach as penguins are from the North Pole.

Conducted properly, a request for an OIG Advisory Opinion is an argument designed strategically and psychologically to bring the OIG toward your conclusion.

In fact, if you want to analogize to a contest, it’s more like one of those cooking challenge shows on the Food Network where the contestants battle to tell the most politically correct story of what they’ll do with the money if they win.

This is an excellent illustration of how lawyers think and how physicians might most efficiently communicate with them. Lawyers, in our experience, like to start by defining the issue in terms of how to achieve a given outcome. “Did the hospital administrator intend to receive an illegal kickback when he told the group that they would no longer receive a stipend?” In contrast, physicians tend to deliver a chronological narrative: “The hospital had paid us a stipend for years. We worked hard and provided excellent care and had a solid relationship with Administration. We tried to optimize the OR scheduling but we were forced to staff empty rooms, a lot. We needed the stipend to do that. Three weeks ago the CEO, with whom I had played golf that weekend, asked us to meet with him in his office and we agreed on a time last Wednesday. He told us that the hospital was losing money because of more Medicare and uninsured patients, because of the new ASC that the orthopods had opened, and because of the cost of the MRI scanners and the daVinci robot. And [name a favorite national anesthesia management company] was interested in coming in. So we would have to give up our stipend....”

Doctors and lawyers have different ways of approaching a problem, each suited to the task at and neither one better than the other. Once again, so much comes down to communication. Consider the role that communication plays in each of the other articles in this issue of The Communique.

Dr. Bushnell notes, in The Perioperative Surgical Future, the three minutes before surgery and five minutes in recovery that is all that traditional practice has allotted to the interaction between an awake or awakening patient and his anesthesiologist. Eight minutes is not enough to foster much of an impression of the anesthesiologist among either patients or colleagues, and certainly not enough to allow the anesthesiologist to take charge of the patient’s entire perioperative surgical experience.

What is the patient-experience feedback loop discussed by Bob Vosburgh in Beyond CAHPS—Measuring the Patient Experience Digitally and Why It Matters if not a testament to the importance of clear bi-directional communication?

Three fundamental elements of a system as laid out by ABC VP Arne Pedersen’s article Collecting Dilemma of Anesthesia in 2016 is again communication, i.e., both finding out exactly what the patient’s insurance will cover and letting the patient know what his payment responsibility will be ahead of time.

We hope that we and our valiant contributors have met our own communication goals in providing you with food for thought, strategic tips and answers to some questions.

With best wishes,

Tony Mira
President and CEO
BEYOND CAHPS®—MEASURING THE PATIENT EXPERIENCE DIGITALLY AND WHY IT MATTERS

Bob Vosburgh
President, SurveyVitals®, Springtown, TX

WHY TRACK THE PATIENT EXPERIENCE?

For every patient who expresses dissatisfaction or voices concern, there are nine or ten more who keep quiet.¹ However, dissatisfied patients are often some of the most vocal. They are likely to tell at least 20 people about their experiences or go to an online review site.

Why does this matter? Aside from the potential impact on a provider’s reputation, patients who rate practitioners’ bedside manner the worst are far more likely to bring a malpractice suit. In fact, providers whose patient satisfaction scores fall within the bottom third are 110 percent more likely to be sued when compared to their top performing peers.² Patient satisfaction is consistently at the root of these claims. Multiple studies have found that it’s poor communication or patients feeling like their doctor simply didn’t care, not negligence, that is the primary driver of malpractice lawsuits.²

Satisfied patients also equate to satisfied providers. It has been shown that practices with loyal patients have lower rates of physician turnover.¹ With the average cost to replace a physician clocking in at more than $300,000 per practice, physician retention is more important than ever.²

These all-too-common scenarios can be avoided, or at least significantly reduced. When patient satisfaction is up, so is your bottom line. A recent report indicated that U.S. hospitals with top patient satisfaction scores gained net margins that were 50 percent higher than those that provided an average-to-poor patient experience.³ Additionally, patient satisfaction has been linked to better patient adherence to recommended treatment plans, which can improve health outcomes.³ Driving real-time patient feedback and improvement opportunities to administrators and providers is key to continual improvement and success in today’s rapidly changing healthcare market.

THE PROBLEM WITH CAHPS® AND DELAYED REPORTING

While most providers were blue ribbon students in school, used to being “the best,” most have never received real performance feedback. When asked about their experiences with federally-mandated CAHPS® surveys, 90 percent surveyed reported that they had never received any feedback. Of the ten percent who had, more than half said CAHPS survey results weren’t useful.

Not only are practitioners not seeing results data, but CAHPS surveys are costly, slow and yield poor patient response rates. Regulations placed upon survey vendors to administer CAHPS surveys require outdated staffing, function and administration, which in turn translates to higher costs for healthcare organizations and patients. The Centers for Medicare and Medicaid Services (CMS) still require patients to be surveyed using mailed paper surveys or live


Continued on page 4
BEYOND CAHPS®—MEASURING THE PATIENT EXPERIENCE DIGITALLY AND WHY IT MATTERS

Continued from page 3

telephone interviews. Modern modalities such as SMS (text message) and email are prohibited for most CAHPS® surveys, despite a proven track record.

Data is also inadequate. Hospitals have to return just 300 patient surveys to CMS annually to satisfy HCAHPS® requirements, even if the hospital sees hundreds of thousands of patients. So few returned surveys is a red flag concerning statistical validity. CAHPS results may very well not be a representative snapshot of the patient experience and should be utilized with caution when drawing conclusions about individual physicians or the organization as a whole.

On top of that, CAHPS results are delayed. Many organizations simply run the surveys to “fill the square,” but aren’t seeing results until months later, and, therefore, not improving. To illustrate this, a hospital-owned outpatient group conducted a trial, electing to run CG-CAHPS surveys digitally over a 48-week period. The organization examined patients’ perceptions of care—whether or not running the surveys resulted in improved scores. Nearly 10,000 patient surveys were completed during the observation period. The outcome? Other than accelerating global warming, the results regressed to a mean, less than 3 on a 5 scale, and stayed there. The positive slope was infinitesimal. No improvement occurred. Simply running surveys does not necessarily improve patients’ perceptions of care.

BEYOND CAHPS: THE VALUE OF REAL-TIME FEEDBACK

Alternatively, when valid, timely feedback is easily accessible and driven to those closest to the problem or opportunity—in this case providers—patients’ perceptions of care are improved.

FIGURE 1

Real-Time Patient Feedback Leads to Improved Scores

![Graph showing improvement in patient feedback over time](image-url)


A case study (See Figure 1) was conducted by a group of eight anesthesiologists who wrote a white paper in conjunction with the American Society of Anesthesiologists. More than 150,000 patients from six private anesthesiology practices were surveyed electronically about their experiences using a 19-question instrument. The survey incorporated elements recommended by the specialists’ Committee on Performance and Outcome Measures. Automated contact via email followed, if necessary, by text message and phone calls with interactive voice response yielded a 25 percent response rate. On average, responses were received four days from receipt of contact information. Results and comments were continuously made available through portals accessible at the organization, division and practitioner levels. Patients were given the opportunity to provide additional feedback directly to the practice. Low scores (Likert 1 or 2) generated immediate alerts to both administrators and physicians.

Within six months, the 1,127 anesthesia providers in six practices improved patient satisfaction scores by an average of 43 percent, or by two deciles, from the 47th to the 67th percentile. More impressive, practitioners from the lowest decile—those most at risk for liability suits—raised their patient satisfaction scores from the 3rd to the 40th percentile over the same six-month time frame. Most of that improvement occurred during the first 60 days—with no coaching, simply running the surveys and driving alerts to providers and administrators. The study suggests that if the feedback is sent, anesthesiologists and anesthetists will, indeed, engage in self-help and improve.

The Move to Digital: Overcoming Pushback and Best Practices

Resistance to change is not uncommon, and organizations that implement a digital patient experience of care solution may face some initial pushback. However, education of your hospital clients, internal administrators and practitioners is key to overcoming this resistance. All of these parties want to know why you are implementing a new solution. Sharing that real-time feedback leads to actionable improvement, increased awareness from practitioners and administration, and higher levels of communication should answer many of their questions. Carving out time to walk providers and administrators through navigating the solution and answering any questions they have will increase buy-in and go a long way in starting off on a positive note.

You may still encounter some pushback, typically from lower performers when compared to their peers. Realize that most practitioners have never had direct patient feedback, let alone had feedback sent to them in real-time or been compared to other high performers. Those who complain are a very small minority, well under one percent. Consistently, these individuals will find reasons they shouldn’t be receiving feedback. Reasons like, “patients are complaining about survey saturation” or “it must be some other practitioner they were rating.” It is important to demonstrate to the team that individual improvement is expected when these types of complaints are encountered. A physician lead once shared that a practitioner commented the email alerts were “annoying” and it would be the thing that pushed them “over the edge.” In this instance, the physician lead handled the situation correctly by reiterating the purpose of the solution and suggesting the physician focus on improvement to lower the alert frequency.

By trial and error, some survey practices have been found to hurt the process more than others. Providing survey “count” incentives to management, keeping results from practitioners

Beyond CAHPS®—Measuring the Patient Experience Digitally and Why It Matters

Continued from page 5

Positive Leadership

To truly effect change and reinvent, or to ensure you sustain as a top performing organization, you need to understand and apply fundamentals of effective leadership. A three-part leadership model looking at Self, Team and Atmosphere has found success among many organizations.

Self is about you as an individual, working toward excellence in all you do, having and being an effective mentor, and maintaining a healthy balance.

Team success requires proper communication, having the right people and being willing to hold team members accountable for their performance.

Atmosphere, oftentimes what people think about when they hear leadership, is something to implement after “self” and “team” are already in place. Creating the right environment, recognizing those deserving, maintaining enthusiasm and properly caring for the team round it out.

Our firm, SurveyVitals®, was founded upon, and has presented, a continuous improvement model for over a decade: Preparing, Performing and Perfecting.

- Prepare with positive expectations. If it is worth doing, it is worth doing well.
- Perform with the understanding you may be knocked down. Winners get back up and pursue relentlessly!
- Perfect your craft. Accept feedback, review your science and make needed adjustments. “Rinse and Repeat.”

As additional reporting requirements continue to take shape, it is important to note that the CAHPS model may not be enough. Like it or not, digital solutions using 21st century communication tools (email and SMS) are the way of the future and administrators should look to adopt early. Truly monitoring the health of your organization and working toward improving your patient experience can have big monetary rewards—all too important in the face of shrinking budgets. Ultimately, committing to continual improvement and bettering patients’ perceptions of care is simply doing the right thing by patients. However, reducing liability exposure, improving reimbursement, and increasing physician satisfaction and your bottom line are not too shabby side effects.

Robert Vosburgh, founder and CEO of SurveyVitals, has personally coached over 1,500 medical providers and administrators. He founded SurveyVitals following a lengthy career in the United States Air Force as a top gun fighter pilot and educator and as CEO of an online brokerage firm before moving to the healthcare sector. Out of his passion for teaching, speaking and helping organizations improve was the company created. SurveyVitals is currently the largest anesthesia-specific patient satisfaction solution in the United States. Interested parties can email info@surveyvitals.com, call (972) 442-1484 or visit www.surveyvitals.com/start/products/anesthesia.
Thinking About Medical Errors

Continued from page 1

Deming—so maybe the increase reflects increased recognition of something that’s been going on all along.

It’s possible that errors are increasing because we are providing more complex care, with more opportunities to make mistakes. This is an unintended consequence of medical practice, and can be viewed as a cost of doing business, with the increased rate of errors balanced by the benefits of the new procedure. We can expect the rate of unintended consequences to go up during our learning curve and then back down as we figure things out. Corneal abrasions associated with robotic prostatectomy are a good example of this phenomenon, and one that has been seen to wax and wane as these operations have gone from long and experimental to short and routine. Since robotic prostatectomies are ultimately beneficial, the increase in errors is also a good thing. It shows we are appropriately pushing the envelope.

Finally, it is possible that errors are increasing because our definition of what constitutes an error is continuing to evolve. Failure to treat h. pylori in a patient with a stomach ulcer today would be considered a significant error—whereas 30 years ago this therapy was not even considered. Ten years ago all of our patients were nothing by mouth (NPO) for eight hours, whereas today we are handing them oral electrolytes in the preoperative holding area. Today the failure to swab the IV port before injecting a medication is a mild deviation; a year or two from now it will be considered a major error.

Second, it is important to recognize that every patient we care for is going to die. Benjamin Franklin noted: “In this world nothing can be said to be certain, except death and taxes.” Jimi Hendrix put it another way: “No one here gets out alive.” Or if you’re a fan of Game of Thrones, try “Valar Morghulis” (“all men must die”). As those responsible for the battle against the inevitable, physicians have long studied the causes of death and attempted to categorize them. This activity, in turn, has led to scientific and governmental attention to the leading causes, which in turn has led to significant improvements in care. And we continue to push this envelope today: just ask any provider how the coronary artery bypass graft (CABG) patient of today compares to the CABG patient of 20 years ago. Today’s patient is vastly sicker, because all the easy patients either never get coronary disease in the first place (statins) or get fixed in the cath lab (angioplasties). So the patient that makes it through to the OR is older and sicker. Similar advances have occurred in cancer, AIDS, COPD and other leading causes of death, not to mention that many scourges of the developing world—infectious diseases—have been eradicated in the U.S.

So what do our patients die from? Getting old, mostly. As we eliminate preventable causes, our population gets older and frailer, balanced on the edge of a progressively narrower knife blade until reaching a point where the slightest gust of wind will blow them to their demise.

Many of these breezes, of course, can be associated with a medical error of some kind.

Which brings me to the third and final point, that medical errors are ubiquitous in medical care. I’ve delivered tens of thousands of anesthetics in my career and I can honestly say that I have never done a perfect case. In retrospect there is always something I would have done differently—one mg less of some medication, increasing or decreasing the volatile agent one minute sooner, giving just a little more or little less fluid, etc. Healthcare is complicated, and the odds of delivering the perfect anesthetic are far, far lower than the odds of filling out a perfect NCAA bracket. Don’t believe me? Open the medical record of the next inpatient you take care of and look to see if they’ve gotten every prescribed medication at the prescribed time. Invariably there will be both omissions and delays. Depending on how you’re keeping score, every one of these events would count as a medical error. Errors occur in the care of every patient!

Now put these thoughts together: death is inevitable, medical error is inevitable, and thus death due to medical error is an inescapable conclusion. When we have eliminated every named disease, accidental death will be all we have left. So maybe what the BMJ article is really documenting is an improvement, not a cause for alarm. My glass is half full!

Richard P. Dutton, MD, MBA is Chief Quality Officer of U.S. Anesthesia Partners and a practicing anesthesiologist at Baylor University Medical Center in Dallas. He can be reached at richard.dutton@usap.com.
When most practice administrators started in anesthesia billing operations, collecting for services was markedly different than it is today, even if you are relatively new to the specialty. There are a variety of factors including government regulations, The Patient Protection and Affordable Care Act of 2009 (ACA), bundled payments, high deductible health plans, out-of-network payers and new plan designs, to name a few.

**The Patient Protection and Affordable Care Act**

**“THE GREAT RACE TO THE BOTTOM”**

The Patient Protection and Affordable Care Act (ACA), or the ‘Great Race to the Bottom’ as some have coined it, brought massive change to the insurance market. Since the signing of this 2,000-page law in March of 2010, thousands of pages of regulations have been written and implemented. Moreover, additional regulations are on the way as the law gave the Secretary of the Department of Health and Human Services vast latitude to implement the law.

What the law did to the insurance distribution channel has changed the job of the insurance agents. Prior to the ACA even being introduced, agents were already using online tools to shop group insurance. The ACA forced all plan designs to include birth control as an example. These types of additions do not take into account the various needs of the American consumer at large. The law forced coverage, meaning that you have to pay a penalty if you do not buy insurance. The insurance companies needed ‘forced coverage’ in order to spread the risk. In other words, younger, healthier people pay premiums to offset the risk of older, sicker people.

The ACA married preferred-provider organization (PPO) and health maintenance organization (HMO) features into one type of insurance with various levels of patient responsibility. The outcomes for many previously-covered American consumers are higher premiums, higher deductibles, higher co-insurance—especially for out-of-network services; limited options, and narrow networks. The provider community is beginning to feel the effects of lower reimbursements for the health exchange plans. Providers are also experiencing more bureaucracy, especially with frequent changes to quality programs and more procedures being denied for payment.

While the concept of all having health insurance is noble, the execution of the concept via the ACA is not working well for all parties.

**Advance Beneficiary Notice of Non-Coverage**

Your practice may discover you have provided services in which the procedure is not covered. For these situations, it is important to implement a program of Advance Beneficiary Notice of Non-Coverage (ABN). Medicare has identified specific steps along with a form on the CMS website to ensure you can collect for these services.

In terms of practical application of ABN, it is important for your practice to work with the facility (hospital or ASC) to have preregistering patients contact the anesthesia office. This is not just for Medicare patients but also for private insurance carriers as well. Another tip is to monitor procedures or codes for which you would expect denial and concentrate on collecting ABNs for these.

Of the key points in the ABN form, three are important to address.

1. The first is that the patient will have some options and will need to select which option they wish your practice to pursue.
2. Secondly, if the patient wants you to file an appeal with the carrier due to payment denial, your practice must submit a claim. If not, you cannot file an appeal.
3. Finally, it is important to ensure that the patient and family member(s) have read, understood and completed the ABN form.

One example of the use of an ABN form is for denial of anesthesia for pain,
Current Procedural Terminology (CPT®) codes 01991 and 01992. On the private insurer side, the intent is that patients will complain about it not being covered and ultimately, influence their specific private insurer to cover it. Handled correctly, the practice will be in position to get paid by the patient for these procedures.

The following is directly from the Medicare website:

“If you have Original Medicare and your doctor, other health care provider, or supplier thinks Medicare probably (or certainly) won’t pay for items or services, they may give you a written notice called an “Advance Beneficiary Notice of Non-coverage” (ABN).

The ABN lists the items or services that Medicare isn’t expected to pay for, an estimate of the costs for the items and services, and the reasons why Medicare may not pay.

The ABN gives you information to make an informed choice about whether or not to get items or services, understanding that you may have to accept responsibility for payment.

You’ll be asked to choose an option box and sign the notice to say that you read and understood it. You must choose one of these options. You must choose one of these options:

Option 1: You want the items or services that may not be paid for by Medicare. Your provider or supplier may ask you to pay for them now, but you also want them to submit a claim to Medicare for the items or services. If Medicare denies payment, you’re responsible for paying, but, since a claim was submitted, you can appeal to Medicare.

Option 2: You want the items or services that may not be paid for by Medicare, but you don’t want your provider or supplier to bill Medicare. You may be asked to pay for the items or services now, but because you request your provider or supplier not to submit a claim to Medicare, you can’t file an appeal.

Option 3: You don’t want the items or services that may not be paid for by Medicare, and you aren’t responsible for any payments. A claim isn’t submitted to Medicare, and you can’t file an appeal.

An ABN isn’t an official denial of coverage by Medicare. You have the right to file an appeal if payment is denied when a claim is submitted.”

Figure 1 shows ABN form samples covering both Medicare and commercial insurance. The Medicare form can be found on the aforementioned website. For the commercial side, there are sample forms on the internet similar to the sample shown below. Ultimately, it is recommended to have an attorney familiar with ABN’s, evaluate and make recommendations to the practice.

**Employee Retirement Income Security Act of 1974**

**ERISA Plans**

As it relates to health plans, Employee Retirement Income Security Act of 1974 (ERISA) plans are required by law to follow the plan document. Approximately 80 percent of plans in the market are employer-sponsored and are covered by ERISA unless they are exempt. Exemptions include government or religious organization plans. The balance of the plans are governed by state insurance laws.

The following is an excerpt from the ERISA website that covers the definition of ERISA in short order and then provides information on two important and familiar amendments.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

Two important amendments expanding the protections available to health benefit plan participants and beneficiaries include:

(COBRA) Provides some workers and their families with the right to

Continued on page 10
Collecting Dilemma of Anesthesia in 2016

Continued from page 9

...continue their health coverage for a limited time after certain events, such as the loss of a job.

(HIPAA) Provides important new protections for working Americans and their families who have preexisting medical conditions or might otherwise suffer discrimination in health coverage based on factors that relate to an individual’s health.

State insurance laws vary widely, but most states have prompt payment laws designed to require insurance carriers to pay claims in a timely manner. Some states even have statutory interest assigned to insurance companies for failure to pay within the time limit. Furthermore, states may also address balance billing in their regulations as well as surprise billing, which can be taken care of with an appropriate ABN form or an assignment of benefits form, depending upon the situation. As it relates to surprise billing, a number of other states have laws limiting balance billing by out-of-network providers in certain circumstances. Some of these laws apply only to certain types of health plans (HMO vs. PPO) or only to certain types of providers or services (for example, for ambulance providers or emergency care services). It is important to know state-specific laws and be prepared to address their requirements for your practice. For the author, being a Hoosier, it was natural to review the Indiana code regarding insurance, in particular, the prompt payment law. In it, the provider is required to submit a clean claim. The insurance carrier determines the definition of a clean claim. Therefore, it is important to know not only the state insurance laws, but also to understand the implications for your practice.

Knowledge of plan documents is important especially with regard to limits on filing times, appeal times, appeal levels, etc. Maintaining a spreadsheet grid with an outline of procedures and the rules of each insurance carrier (payer) contract may provide a tool to manage the payment challenges. Documenting and time-stamping communication with the insurance carriers (payers) is also helpful. In general, ERISA allows 30 days for the insurance carrier to respond with very specific details about how/why a claim is denied. While it is easy to make a general statement about insurance carriers violating ERISA, it is important to note the specific details for each case/claim and the rules of the road. In some cases, insurance carriers blatantly violate ERISA. In these cases there are options for action and details that can be explored by an ERISA attorney. Additional information on ERISA plans may be found at: https://www.dol.gov/general/topic/health-plans/erisa.

Out-of-Network

As a strategy, is it a good idea for an anesthesia group to be out-of-network (OON)? It is a strategic discussion worth having. There are a few points to remember as the practice considers going OON with a payer.

Facilities (hospitals and ASCs) want all of their physician groups in network and usually have a requirement to that effect in writing. If a group is not in network, that group could feel political pressure from the facility. In this case, the group may be cashing in political chips that could be used for other negotiations.

Insurers view it differently. Some insurers truly do not care due to re-pricers in the market place, such as Multiplan. Some insurers utilize the re-pricer network to process claims, which has the potential to drive down reimbursement for the anesthesia practice.

For chronic pain, you may not have a choice. There are saturated markets in which the chronic pain practices are so prevalent the insurers may not offer a group a contract to come in network, whether a chronic pain-only practice or a chronic pain practice as part of an overall anesthesia practice.
Being OON is a double-edged sword. On the one hand, it can be very profitable to a group to go OON with a major payer. Anecdotally, my experience has taught me that this is true in certain situations. As an example, a large payer was not willing to negotiate and the practice decided to go out of network. We laid the groundwork politically with each of the facilities and surgeons prior to going out of network. The result was an increase in yield per unit since we had no contract with that payer. That remained in effect until our health system put pressure on the practice to get in network. In this case, it worked out well for the practice. That is not always the case. Conversely, an insurer may decide to pay you their version of the “market rate” leaving you to balance bill the patient and collect from them. In these cases, it is important to know the state laws regarding balance billing. As noted above, balance billing laws vary by state and may be onerous.

As for Blue Cross Blue Shield (the Blues) plans, and perhaps other large payers, the patient will receive the reimbursement check and the practice has to run it down, resulting in additional time and money expense. Again, anecdotally, my experience has taught me to never go out-of-network with the Blues. Terminating the contract with the Blues to negotiate is plausible. However, actually going OON with the Blues is detrimental. There have been situations when groups have been successful in going OON with the Blues and other payers. In these cases, the groups established a strategy and a plan to collect the monies from the patient or responsible party prior to terminating the contract as well as the political work with the facilities and surgeons.

Another consideration concerns co-insurance rules. Typically, OON providers have patients with higher co-insurance amounts. Moreover, the OON provider is now the more expensive provider with the exchange plans. As alluded to earlier, these plans have much higher OON co-insurance amounts. In some cases, the patient owns 100 percent of the responsibility unless it is an emergency. A great example of that comes from Aetna (emphasis added):

“Some plans do not offer any out-of-network benefits. For those plans, out-of-network care is covered only in an emergency. Otherwise, you are responsible for the full cost of any care you receive out of network.”

Two final considerations for an OON strategy concern policies. The first policy is the prompt payment policy. A group may offer a discount (while still billing the full amount) if paid prior to surgery or within the 30 days of the dates of service. State laws vary on this, and it is important to check with a healthcare attorney.

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**FIGURE 2**

Sample AOB Form

Sample AOB Form

Assignment of Benefits, Assignment of Rights to Pursue ERISA and Other Legal and Administrative Claims Associated with My Health Insurance and/or Health Benefit Plan (Including Breach of Fiduciary Duty) and Designation of Authorized Representative

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or a attorney in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above-named health care provider any legal or administrative claim or chose an action arising under any known health plan, employee benefit plan, health insurance or tort liability insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chosen an action). This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal/administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by: (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements,出具 facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action and right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring it against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider’s expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (Health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

---

Patient Signature

Date
COLLECTING DILEMMA OF ANESTHESIA IN 2016

Continued from page 11

If AOB is not permitted, the medical provider will not receive payment from the insurance company. In terms of specific language to include in the anesthesia group’s AOB, a healthcare attorney can help to craft the proper terms.

A sample AOB form is shown in Figure 2 on page 11.

UNDERPAYMENTS

Underpayments can become an issue as well. Bundled payments and Medicare Local Coverage Determinations (LCDs) are two types of which to be wary.

There are times when an insurer claims a bundled payment for certain combination of procedures. An example might be when the insurer does not pay for fluoroscopic guidance because they state that the payment went to the facility. It is important to have good relationships with the facilities and understanding of any contracts they have that might impact the practice. Of course, tracking and documenting each instance by insurer will be helpful.

Another type of underpayment can come from a LCD or a private payer policy. These typically come out on a regular basis and describe procedures that will be denied outright or denied without certain documentation. These are typically done on a state basis. With the procedures that are denied without certain documentation, it is important to note what the details of the denial is and what steps need to be taken to get reimbursed. As a practical matter, keeping track of these in a spreadsheet is quite useful.

CONCLUSION

In conclusion, group administrators have much to be on the lookout for when it comes to collections in 2016. The good news is that a strong billing operation and good tracking and monitoring processes can assist. With an engaged team of billing operations and practice administration the obstacles will be predictable and can be managed.

 Assignment of Benefits

An Assignment of Benefits (AOB) is a document that a patient signs upon intake or admission. The precise language within the assignment of benefits form becomes critical when a non-participating provider files suit against the insurance company in a reimbursement dispute.

According to U.S. Legal, the definition of an AOB is, “Assignment of benefits in the context of health care refers to an agreement or arrangement between a beneficiary and an insurance company, by which a beneficiary requests the insurance company to pay the health benefit payment directly to the physician or medical provider. The patient or guardian signs the assignment of benefits form so that reimbursement checks will be sent directly to the doctor or medical provider.”

The other policy is the “payment plan policy” which establishes a process for patients to pay anesthesia bills in an established, periodic manner. The group determines the length of the payment plan, the amount required monthly and the penalty for failure to remain current. Depending on the total amount owed, the length of the payout may run from six months to a year. Again, state laws vary and it is important to check with a healthcare attorney.

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Conclusion

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https://www.dol.gov/general/topic/health-plans/erisa
http://kff.org/private-insurance/issue-brief/surprise-medical-bills/
http://definitions.uslegal.com/a/assignment-of-benefits-health-care/

Arne Pedersen, MBA, FACCME, serves as Vice President of Practice Management for Anesthesia Business Consultants. He works in the client and consulting services and is a Practice Executive. Mr. Pedersen is also a Fellow with the American College of Medical Practice Executives (FACMPE), a distinction among peers in the Medical Group Management Association. Previous experience includes a variety of roles including strategic sourcing, eBusiness, and new product development including teams that developed and rolled out the HRA and HSA products. Prior to joining ABC, Mr. Pedersen was a highly decorated commissioned officer in the United States Army and is a Desert Storm Veteran who earned a Bronze Star Medal. Mr. Pedersen earned his Bachelor of Arts degree from Indiana University earning distinguished military graduate honors and his Master of Business Administration, cum laude, from the University of Notre Dame. Mr. Pedersen can be reached at Arne.Pedersen@AnesthesiaLLC.com.
OIG ADVISORY OPINION SECRETS AND STRATEGIES

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[Author’s Note: This article is based on my presentation at the 2016 Advanced Institute for Anesthesia Practice Management.]

The OIG Advisory Opinion (Advisory Opinion) process allows parties of actual or proposed transactions to obtain the opinion of the Office of Inspector General (OIG) of the U.S. Department of Health & Human Services as to whether that transaction violates the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) (AKS).

There’s an official process for obtaining an OIG Advisory Opinion. Then there’s the actual way that the process works. And, then there are the secrets and strategies that can be used in connection with opinions.

For decades, I considered Advisory Opinions as a set of guideposts as to how the OIG, as the primary agency charged with enforcing the federal AKS, thinks as to the application of that statute. But then I realized that there was a very different way to think of them, use them, and obtain them, which led to my work as the attorney for the Requestor of Advisory Opinion 13-15 and on many projects advising on the Advisory Opinion process and the AKS since then.

I’m going to share some of that information with you.

BACKGROUND

In order for you to grasp the dynamics of the OIG Advisory Opinion process, you first need to understand the basic elements of the AKS and its history.

In summary form, the AKS prohibits the knowing and willful solicitation, offer, payment or acceptance of any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind: (1) for referring an individual for a service or item covered by a federal healthcare program, or (2) for purchasing, leasing, ordering, or arranging for or recommending the purchase, lease, or order of any good, facility, service or item reimbursable under a federal healthcare program.

A violation is punishable as a felony: up to five years in jail, plus up to $25,000 in fines. It can also lead to exclusion from participation in federal healthcare programs.

The AKS language is extremely broad. But what did Congress really intend to prohibit?

The AKS statute was altered by Congress many times since it was first signed into law in 1972. Its scope has been changed. And, it hasn’t always made violation a felony.

Initially, the statute was aimed at criminalizing the sort of “fee splitting” that medical ethics long prohibited. The original 1972 statutory language made violation a misdemeanor. And, it was aimed solely at Medicare and Medicaid patients, not the current, broad scope of all federal healthcare program patients. It prohibited the solicitation, offer or receipt of “any kickback or bribe in connection with” furnishing Medicare or Medicaid services or referring a patient to a provider of those services.

Over the ensuing years, there were multiple amendments as a result of industry complaints that the statute picked up more than “bad” conduct—that it criminalized behavior long considered appropriate, such as paying physicians to serve as medical directors.

Continued on page 14
Somewhat strangely, Congress both broadened the language and, over time, enacted statutory exceptions, delegated authority to the OIG to adopt safe harbors (i.e., regulatory exceptions) and, finally, gave the OIG the power to issue Advisory Opinions.

**The Advisory Opinion Process**

The OIG is permitted to issue an Advisory Opinion upon the request of a person or organization involved in an existing arrangement or in an anticipated transaction in which the requestor in good faith plans to undertake what may be subject to AKS.

Note that the requestor's good faith in respect of an anticipated transaction may be contingent upon receiving a favorable Advisory Opinion. Distinguish this from a hypothetical query and from a general question as to interpretation, neither of which are permissible as the basis of an Advisory Opinion request.

It's also important to understand that an OIG Advisory Opinion has no application to any individual or entity that does not join in the request for the opinion, and that no individual or entity other than the requestor(s) may legally relay it.

Both the regulations pertaining to Advisory Opinions and the checklists provided by the OIG outline the information required to be provided to the OIG and the costs of an opinion. For purposes of this article, be aware that the request has to be in writing and that among the information that must be provided is:

**What I call the “who” information:**

1. The name and addresses of the requestor and all other actual and potential parties to the extent known to the requestor.
2. The name, title, address and daytime telephone number of a contact person.
3. Each requesting party’s Taxpayer Identification Number.
4. Full and complete information as to the identity of each entity owned or controlled by the individual, and of each person with an ownership or control interest in the entity.

**What I call the “what” information:**

1. A complete and specific description of all relevant information bearing on the arrangement and on the circumstances of the conduct.
2. All relevant background information.
3. Complete copies of all operative documents, if applicable, or narrative descriptions of those documents. For existing arrangements, that means complete copies of all operative documents. For proposed arrangements, complete copies of all operative documents, if possible, and otherwise descriptions of proposed terms, drafts or models of documents sufficient to permit the OIG to render an informed opinion.
4. Detailed statements of all collateral or oral understandings (if any).

**And, then there’s the certification:**

The request must include a signed certification that all of the information provided is true and correct and that it constitutes a complete description of the facts regarding which the Advisory Opinion is sought.

**Timeline**

Once the OIG accepts the request and assigns the file to an attorney in their office, the OIG has 60 days to issue an opinion.

However, the acceptance process and the OIG’s right to request additional information from the requestor can result in significant delay in the 60-day countdown.

In general terms, the OIG has the right to request additional information both before and after a request is accepted. The time between a request and the receipt of the response stops the clock. Additionally, the delivery of additional information to the OIG prior to the date of acceptance re-starts the entire process in terms of timing.

It’s not uncommon for the process to play out over the course of many, many months.

**Ways Advisory Opinions Can Be Used Strategically**

Now that you have some background information, let’s shift gears and address a few of the ways that Advisory Opinions can be used strategically, as well as some of the strategies and tactics used in the opinion process.
Warning!

In consulting in connection with Advisory Opinions, I often see a strategic mistake about to be made by requestors and their counsel: they approach the process as a mere presentation of the facts and then plan to sit waiting for the opinion.

That’s as far from the correct approach as penguins are from the North Pole.

Conducted properly, a request for an OIG Advisory Opinion is an argument designed strategically and psychologically to bring the OIG toward your conclusion. Its prosecution requires skill, strategy and diplomacy; absent any, you are creating an outsized risk.

As mentioned above, the Advisory Opinion process allows for significant follow-up and ongoing contact. Sure, you could just lay low and perhaps hide or just hope the conclusion is going to come out as you want it. But there’s a process that allows you to have continuing input, and you should use it to your advantage, taking every opportunity to trigger additional conversations with the assigned OIG attorney.

But this leads to a more basic question: why are you requesting an Advisory Opinion? What’s the reason?

Why?

My guess is that most requestors are seeking an actual opinion to which they want a “yes” response, that is, a positive Advisory Opinion. I believe that that is what Congress imagined—that people would seek a positive opinion. I call this a “may I” or a “should I have?” request.

May I?/Should I have?

For example, a requestor might seek an opinion on the propriety of the use of a “preferred hospital” network as part of Medigap policy, whereby the Requestors, which offer Medigap policies, would contract with hospitals for discounts on the otherwise-applicable Medicare inpatient deductibles for their policyholders and, in turn, would provide a premium credit of $100 to policyholders who use a network hospital for an inpatient stay. Those are the facts in Advisory Opinion 16-01.

Or we can translate this into an anesthesia example. A hospital might approach your group with the proposition that, upon renewal of its exclusive contract, the group will take on much more intense administrative duties, while at the same time suffering a cut in the administrative stipend received from the hospital.

Please tell me I shouldn’t have . . .

There’s a second category that I call “please tell me I shouldn’t have” and this is neither as obvious nor as straightforward. You use it to attempt to unwind a deal you were forced into.

For example, your group has been providing services at a surgery center for several years and has been paying the facility rent for office space within to complete the anesthesia record and for sitting between breaks in cases. The ASC administrator assures you it’s legal and says that it wouldn’t alter the relationship if it’s not. So you turn to the OIG for an opinion. You hope that it’s negative in order to bow out of the relationship gracefully or to restructure it.

Other Categories

There are other, more sophisticated categories as well, including blocking tactics, leverage tactics and triangulation tactics, each of which is beyond the scope of this article, but each of which should be considered in connection with your compliance efforts, and even more importantly, in connection with your offensive as well as defensive competitive efforts.

Bottom Line

You should now have an appreciation for how the process should be used as a part of advocacy. Requests are NOT the equivalent of an essay contest in which the judge takes a look at each submission and makes a yes or no decision.

In fact, if you want to analogize to a contest, it’s more like one of those cooking challenge shows on the Food Network where the contestants battle to tell the most politically correct story of what they’ll do with the money if they win.

That story impacts taste, just like your story may very well impact the outcome of a request for an Advisory Opinion. Tell a good story and use every opportunity to drive the point home.

Mark F. Weiss, J.D.

is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at markweiss@advisorylawgroup.com.
"I look upon ourselves as partners in all of this, and that each of us contributes and does what he can do best. We can create ourselves and our future." – Jonas Salk, 1985

Presented with this opportunity by Dr. Salk, how will each of our anesthesia groups create its own future? How will you as a physician maintain your professional relevance? Will you continue to commit yourself to fading traditional practice patterns and reimbursement models? Or will you take advantage of the paradigm shifts in medicine that are already upon us? Payers are demanding better results, hospital administrators are in need of help, patients are in the middle without access and the specialty of anesthesia needs a tune-up. The perioperative surgical home promises to address it all.

Led by the Centers for Medicare and Medicaid Services (CMS), payers are mandating coordinated care and improved quality through pay-for-performance reimbursement models. CMS will soon pay up to a four percent bonus for high self-reported performance scores and impose similar-sized penalties on relatively less successful providers. In 2018 the difference between maximum positive and negative scores will be eight percent and by 2022 the difference will be 18 percent…every single year. Private payers will follow suit, but this 18 percent CMS incentive alone is strong enough incentive that anesthesiologists should fully embrace quality metrics and coordinated care. Those metrics and coordinated care are best embodied by anesthesiologist presence and leadership in the perioperative surgical home preoperative clinic.

Surgeons and hospital administrators need anesthesiologists more than ever. Both are facing their own demands for increased quality metrics and reducing length of stay. Both are subject to their own system of CMS penalties, caps and bundled payments.

Both are severely in need of quality anesthesia leadership and partnership. If they haven’t yet realized the value of your perioperative skill set, then it’s time for you to offer your assistance. You may not personally know it, but your management and vision are in demand outside the operating room. Your new management target is the 20 percent of sickest patients presenting for surgery. In an era where the emphasis is to reduce length-of-stay and readmissions, your anesthesia preoperative surgical involvement is your opportunity for medical, logistical and administrative leadership.

Patients don’t have reasonable access to anesthesiologists. Anesthesiologists do not have reasonable access to patients. We are both subject to a marginal default anesthesia care model that confines access to three minutes before surgery and five minutes afterward. This is the standard of care, but whom does it serve? Whose ‘standard’ is this? How does this model constitute access? Our patients are frequently old, medically complex, pediatric, pregnant or otherwise facing critical moments in life. How is it that we, as a specialty, pretend to serve these people well by spending only the most minimal amount of time with them immediately preoperatively? Are we as anesthesiologists really that good than in the three minutes before surgery we can assess these complex patients, give them optimal care, a quality experience and our best effort? Is this really our best effort? Both patients and anesthesiologists would be much better served by establishing perioperative surgical clinics. Anesthesiologists must make themselves available.

As a specialty, anesthesia has lost a lot of access in the last 25 years. Our patients used to be admitted the night before and then stayed days after surgery. We had a chance to round on them before surgery, write orders, optimize or cancel. We rounded on them after surgery and had an opportunity to learn by observing the results of our work. Now our OR practice too often amounts to mindless assembly-line work; meeting patients three minutes ahead of time, five minutes in recovery, turn over the room in 20 minutes. “Wash, rinse and repeat.” This process makes for a timely, efficient anesthesia practice but what of quality, patient experience and the perception of our specialty? What of anesthesia medical management and leadership? We have abdicated our responsibilities by delegating the preoperative and post-discharge work to others. The perioperative surgical home offers anesthesia a platform. This is the means by which we reclaim ownership of the entire process and credibility with patients, surgeons and administrators.
The best minds in the American Society of Anesthesiologists (ASA) are pointing the way to the perioperative surgical home (PSH); anesthesiologist-staffed surgical clinics are seeing complicated patients days to weeks ahead of surgery. For the ASA, this is the moral and medical core of the future of our specialty. Medically, who better than anesthesiologists to understand the physical challenges posed to patient physiology by surgeries? Logistically, who better to coordinate the preoperative work-up, the acute intraoperative care and the post-discharge medical management? At Pacific Valley Medical Group (PVMG) in Pasadena, California, we understand that cause.

In the last year, PVMG has worked in partnership to lay the foundations for our own joint perioperative surgical anesthesia clinic. Last June we attended the ASA PSH conference. In September we presented to the Huntington Memorial Hospital C-suite. In October we shook hands on a deal with Huntington appointing one of our partners as a physician champion. We’ve held two briefing conferences for our surgeon partners and weekly meetings for the coordination of administrative staff. Huntington has additionally hired a Six-Sigma Master Black Belt PSH coordinator and elevated one of our MD, MBA physicians to Vice President of IT and Quality. I have also personally met with Dan Cole, MD, President of the ASA and Karen Siebert, MD of the California Society of Anesthesiologists seeking their guidance.

Three of our anesthesia group members are seeing patients in a well ordered clinic. Cerner software is being rewritten to accommodate and document perioperative appointments in anticipation of billing CMS. Having presented to you in previous Communiqué issues the math for reimbursement, getting paid is going to be tough, though. There are CMS billing codes, but the rates are low and private payers are holding back waiting for performance data. The PSH fee-for-service income potential for a full-time equivalent (FTE) anesthesiologist cannot yet compete with the income potential of operating rooms. Other potential income streams to support an FTE anesthesiologist in clinic include stipends from the hospital or the anesthesia group itself. At the moment, the PSH is a financial loss-leader.

Profit or loss, though, establishing an anesthesia perioperative surgical home clinic is *exactly* the right investment for the future. Having an FTE anesthesiologist available in a preoperative clinic to meet with patients days to weeks before surgery offers huge benefits. Anesthesia clearance decreases day-of-surgery cancellations and our presence dramatically improves the patient experience. Many sub-populations of patients (old, sick, parents giving up their children, pregnant) absolutely love the access they have to anesthesiologists. Our Huntington hospital administrators are thrilled to have our anesthesia group take more responsibility for surgical outcome, and the greater cooperation of care has improved our standing with our surgeons. There is every possible good thing about an FTE anesthesiologist and our leadership in pre-op clinic. Additionally, we will open up those clinics for post-discharge and pain management appointments.

As an anesthesiologist, the OR is a wonderful place to make a medical contribution. No one can spot trouble like we can and no one can intervene acutely like an MD anesthesiologist. There is no runner-up. Too often, though, we self-limit that skill set to the narrow paradigm of the OR. You can actually practice that same medical skill set well ahead of time in the preoperative clinic to optimize, precondition, triage and manage your patients to the greater benefit of all. As an anesthesiologist, think of how valuable *your* clearance of medically complicated patients would be to your anesthesia colleagues, to your patients and to your surgeons. For the 20 percent of those most in need of your attention, it is better than gold. For some, it is life itself.

Consider your *anesthesia* presence in the PSH clinic your best investment in your future. The distribution of bundled payments through ACOs is looming. Soon every specialty group will present their case to the ACO board to request a percentage of finite capped payments. Increasing your responsibility for the perioperative surgical continuum by your presence in a PSH is guaranteed to provide you with justification for a larger percentage of capped payments. Anesthesiologists must own more if they are to justify a larger request.

Like all great quests, the key to your future isn’t ‘out there.’ Your future lies within. The key to your future lies in how you as an anesthesiologist perceive your own value, your medical skills and the medical contributions only you can make. The key to your future is in stepping up to assume more responsibility. You must lead this effort yourself and make your own case by placing yourself in clinic. You must recognize the new paradigm that only you can lead.

This is the time and place for medical leadership. The perioperative surgical home is your future.
Stress is a part of life for all of us, and anesthesiologists have more than their share in a practice environment where rules seem to shift from day-to-day as the burden of paperwork and performance measurement increases and financial rewards are diminishing or put at risk. Add this to the already daunting pressures associated with long hours in the surgical suites and on-call responsibilities, and it is no wonder that patience wears thin from time-to-time.

I have been impressed throughout my career with the manner in which the vast majority of anesthesiologists handle this pressure, but have also seen a few situations where the pressures resulted in behavior that was detrimental to patient satisfaction and/or the reputation of the group. All of us have had times where stress in our personal or professional life has caused us to act or react in a way that we later find regrettable, but for those on the front lines of the medical profession, a continuous pattern of negative reaction that is disrespectful, unprofessional and toxic to the workplace (often called “disruptive”) can have an impact on the group’s business relationships, and in some cases directly affect patient care.

Although this may occur infrequently, every practice should have policies in place to identify and deal with situations involving disruptive physicians. In addition to having direct responsibility for patient safety and satisfaction, the group is a business entity with business relationships and a reputation to protect. Any behavior that has the potential to negatively affect the group’s reputation and relationships with hospital administration and staff also has the potential to undermine practice stability and value. The ability of the group to retain hospital contracts and attract new business is directly related not only to their ability to deliver clinical quality, but also the ability of all group members to work harmoniously with the entire care team to achieve the highest level of patient care and satisfaction.

A 2011 study conducted by QuantiaMD surveyed 523 physician leaders and 321 staff physicians in a variety of healthcare settings regarding disruptive behaviors. Seventy-one percent of responding physicians reported that they had witnessed disruptive behavior within the previous month, and 26 percent of those surveyed reportedly had been disruptive at one time in their career. Disruptive incidents were of higher frequency in surgery, anesthesia and obstetrics and gynecology. To the point of contract retention and business relationships, in this same study, 60 percent of physicians said their organizations have received written complaints from patients or their families relating to disruptive behavior, and 50 percent have seen patients change physicians or leave a practice due to such behavior.
Professional Association Guidance

The American Society of Anesthesiologists (ASA) Guidelines for the Ethical Practice of Anesthesiology declare that “Anesthesiologists should promote a cooperative and respectful relationship with their colleagues...[as well as] other care providers including physicians, medical students, nurses, technicians and assistants.”

Joint Commission standards require the establishment of a code of conduct that defines abusive and disruptive behaviors as well as the creation and implementation of a process for their management.

According to the American Medical Association (AMA) Council on Ethical and Judicial Affairs, disruptive behavior “generally refers to a style of interaction by physicians with others, including hospital personnel, patients and family members, that interferes with patient care or adversely affects the healthcare team’s ability to work effectively. It encompasses behavior that adversely affects morale, focus and concentration, collaboration, and communication and information transfer, all of which can lead to substandard patient care.” The AMA’s Code of Medical Ethics specifically recognizes the importance of civility and respect as a non-negotiable professional mandate.

Establishing Policies and Procedures

A group’s policy relating to disruptive physicians should start with a written Code of Conduct that establishes the general framework for all group members relating to professional conduct and procedural compliance. This Code will typically have one section that covers matters relating directly to patient care, and another covering physician professionalism.

Patient care responsibilities may require group members to:

1. Be familiar with and follow protocols relating to patient care established by the group and all contracted facilities.
2. Provide services to patients in accordance with the patient’s medical needs and physical condition, not on the basis of ethnic or racial background, gender or age.

3. Maintain the confidentiality of all patients’ healthcare information in accordance with federal and state laws, and group’s policies and procedures;
4. To respond promptly and courteously to patient inquiries or requests; and,
5. To disclose adverse events according to the appropriate process.

The physician professionalism section may include requirements to:

1. Respect all group contractual obligations;
2. Not pay for referrals or offer or accept kickbacks and avoid conflicts of interest in accordance with group policies and procedures;
3. Maintain all professional licenses, certifications or other accreditations required by law, the group bylaws, the group physician’s respective employment agreement and group contracted facilities;
4. Fulfill their obligations to carry out duties in compliance with state and federal laws and regulations, group’s policies and procedures and any facility rules and regulations;
5. Participate in mandatory compliance and other educational training provided by group;
6. Contribute to a workplace environment that is free from violence, harassment, intimidation, and is conducive to maintaining the highest professional and ethical standards;
7. Consult with or seek advice from a group board member or a management/billing company

Continued on page 20
representative, when the proper course of action is unknown;

8. Commit to be alert and ready to perform job responsibilities while on duty, including not being under the influence of alcohol or any illegal or controlled substance;

9. Not engage in criminal conduct including, but not limited to, the inappropriate use, sale, possession, transfer, manufacture, distribution, dispensation or purchase of non-medically prescribed controlled substances;

10. Refrain from any behavior that is deemed to be intimidating or harassing, including but not limited to, unwanted touching, sexually-oriented or degrading jokes or comments, obscene gestures, or making inappropriate comments about other physicians, allied health professionals, facility staff or patients;

11. Treat patients, family members, visitors, members of the health-care team and facility employees in a respectful and dignified manner at all times.

12. Work with other members of the healthcare team to resolve conflicts or address lapses of decorum when they arise;

13. Avoid the use of language that is profane, vulgar, sexually suggestive or explicit, intimidating, degrading or racially/ethnically/religiously slurring in any professional setting; and

14. Report concerns about another group physician's conduct to those authorized to receive such information and address the issue.

The Disruptive Physician Policy should clearly state the objectives and expectations with direct reference to the group's Code of Conduct, and in terms that ensure high standards of patient care and promote a professional practice environment. The recitals section should also define and describe the behavior or types of behavior that will prompt intervention.

The policy should then cover the process to be followed if disruptive behavior is encountered. This process should:

- Provide a channel through which disruptive behavior can be reported and appropriately recorded.
- Establish a process to review or verify reports of disruptive behavior.
- Establish a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report.
- Describe remedial action to be taken, being specific regarding responsibilities, timing and progressive disciplinary action.
- Include means of monitoring whether a physician’s disruptive conduct improves after intervention.
- Provide for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation.
- Identify which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
- Describe the appeal process and provide clear guidelines for confidentiality.

Situations perceived as a threat to patient safety should be specifically and separately addressed in the policy.

Recognizing that not all physicians will have the skills necessary to address these situations effectively on behalf of the group, some groups have appointed an administrative liaison that acts as in-house counselor with respect to physician
members’ ethics and behavioral practices. This position reports directly to the board, serving as a consultant to the board and committee chairs on matters requiring historical perspective. Qualifications include exceptional interpersonal communication skills and knowledge of group history, philosophy and policies. This position is typically held by a senior member of the group and former board member. He or she is available to physician members to discuss issues and problems related to their practice within the group including, but not limited to career advice, clinical practice issues not directly affecting patient care, conflict resolution, interpersonal relationships and patient complaints.

Many practices take the time and effort to develop behavior standards, but do not take the extra step to make the policies an integral part of the recruiting process, new physician orientation programs and employment agreements.

The recruiting process is the first line of defense, as it is obvious that recruiting to the established Code of Conduct and policies will go a long way towards avoiding future problems. Many groups handle this function through a recruiting or “manpower” committee where the interview process standards can be discussed to ensure they are designed to highlight the potential for disruptive behavior and are applied consistently. Multiple group members should be involved in the interview process, and references should be checked using a set of questions designed by group leadership.

Group employment agreements should include a section where the employee acknowledges review of all group policies and the Code of Conduct, and agrees to abide by them. To the extent permitted by state laws relating to employment and shareholder status, this section should also give the board the power to enforce the policies if a physician is acting contrary to them in a way that is detrimental to the group’s best interest (in the sole discretion of the board). The following is a sample of such a provision that could be included in an employment agreement:

**Professionalism** in the performance of his/her duties under this agreement, employee will conduct himself/herself at all times in a professional and collegial manner, and in a manner that reflects favorably upon the professionalism and reputation of employer. Without limiting the foregoing, employee will use all reasonable efforts to maintain harmonious and professional working relationships with other employees or representatives of employer, patients, physicians, nursing staff and representatives of facilities at which employer provides services. Employee also agrees to act consistently with federal, state and local laws governing discrimination in employment and to refrain from any action that could reasonably be construed to violate those laws. Employee hereby confirms that he/she has reviewed the group’s Code of Conduct (attached as Exhibit ___) and understands that full compliance is essential to protect the business interests of the group. Employee also hereby acknowledges the authority of the group’s Board of Directors (or Executive Committee as applicable) to enforce this Code, and all other group policies, and obligation to enforce them by all means necessary to protect the group’s reputation, business interests and patient safety.

As with all other significant components of employment agreements, this paragraph should be reviewed by legal counsel for consistency with state and federal employment and contract law.

**Responding to Reported Incidents**

So now that you have policies in place, what exactly should be done when a complaint is received?
Your first step should be to assure the individual filing the complaint that you take it seriously, that you will investigate the concerns and, if appropriate, will see that remedial measures are taken to prevent recurrence of the conduct. All complaints should be requested in writing, and initial discussions with the party making the complaint (taking place either by phone or in person) should be well documented with comprehensive factual notes regarding the complaints. Offer to keep the complaint as confidential as possible, provide assurance that there will be no retaliation for reporting the incidents, and request that the employee advise you immediately if he or she believes there have been retaliatory actions by the physician involved or anyone else.

Your second step is to determine the most effective way to confront the physician about his or her behavior. If the board has appointed a physician liaison as described above, he or she will become involved immediately and will arrange to meet with both the individual filing the complaint and with the physician who is the subject of the complaint, separately. If you have established policies, all of the next steps are outlined in that policy as described above. If you do not have a liaison or established policies, you will need to partner with at least one other influential physician in the group who shares your concerns and is willing to support your efforts to confront the issue and act as a liaison between the accused physician and the group. In order to maintain objectivity, both in appearance and in fact, the individual chosen to take the lead in the investigation should not be a personal friend of the physician involved, and should also not be an individual perceived by as an adversary by the physician being investigated.

Especially disruptive behavior involves threats, violence or sexual harassment, the practice must act promptly to remedy the problem. In all other types of situations, where a process will be carried out starting with a meeting with the physician under investigation, following are suggestions for conducting those meetings:

- Empower your board liaison or other designated individual to speak on behalf of the practice. When the meeting is scheduled, it should be clear that the liaison has the authority to speak on behalf of the practice.
- Prepare an outline of points you want to cover. Stick to a script so you avoid getting pulled into an argument. To the extent they exist, have copies of your code of conduct and any written policies and rules that apply to the situation.
- Conduct the meeting in a private, comfortable, professional setting. Reduce the tension as much as possible to encourage a positive dialogue. Do everything possible to make this a constructive problem-solving experience.
- Explain the problem behavior in factual terms. Describe the sequence of events and discuss the effect the physicians’ behavior had on staff, and the potential adverse effects his actions had on his professional reputation and the reputation of the group.
- Refrain from using emotional terms such as bad behavior, tirade or childish tantrum to describe the conduct. These terms might describe the conduct but can polarize the situation and create defensiveness.
- Give the accused physician the opportunity to explain the situation in his own words. Chances are he will not take responsibility for his behavior or might blame staff incompetence for an outburst. He
may attempt to change the subject and begin listing the ways the group is at fault for mistreating him. Don't take the bait. Insist those grievances be taken up at a different time and remind the physician that the purpose of the meeting is to address his conduct on specific dates.

- Ask for the physicians input on how past situations could have been handled differently to avoid the incidents that gave rise to complaints. Make it clear that there is never a valid reason for treating staff members disrespectfully.

- When discussing conduct, consider whether the outbursts may be a result of a drug or alcohol problem or whether his conduct could be the result of mental illness, such as depression. If there is some indication that the conduct is a result of one of these issues, it might be appropriate to refrain from taking any action until you consult with the executive committee and act in accordance with your substance abuse policy.

- Advise the physician that you will be drafting a performance improvement plan that will require him to make immediate, permanent changes in his behavior. Make it clear that failure to comply with the terms may result in discipline, up to and including termination. The plan should include objective, measurable and achievable goals designed to prevent disruptive behavior in the future.

- Make it very clear to the physician that no retaliation of any kind will be tolerated. If you have a written retaliation policy, be prepared to provide a copy at the end of the meeting.

- Carefully document what occurred and what was discussed during the meeting.

- Follow through. If you put the physician on an improvement plan, monitor his behavior and respond quickly and appropriately if requirements are not met.

**Summary**

Medical group and healthcare facility leadership share responsibility for creating a work environment that contributes to achieving the highest level of patient care and satisfaction by minimizing stress and maximizing professional fulfillment in that environment for the entire healthcare delivery team.

In the workplace, recurring behavioral issues interfere with the normal process of collegiality, cooperation and communication within a healthcare service team, and, in extreme cases, can undermine the institutional culture of safety and quality of care. Healthcare facility governing bodies and leadership should ensure that policies and systems are in place that foster collegiality, mentoring, respectful dialogue, promoting the belief that all physicians within the institution are important.

At the group level, addressing this issue is a matter of protecting reputation and other business interests, as well as ensuring a healthy and fulfilling work environment for all group members. A priority of group leadership must therefore be to recognize the detrimental effects on culture, reputation and stability that can result from recurring behavior problems, and have policies in place to address behavioral situations before they occur.

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**Gregory R. Zinser,**
**Vice President** at Anesthesia Business Consultants, has a broad range of experience in healthcare finance and administration. Mr. Zinser's recent experience includes four years as CEO of one of the nation's largest anesthesia billing and practice management companies, and CEO of the management company for one of the nation's largest anesthesia groups. With experience in all facets of anesthesia practice management, Zinser adds additional strength and depth to an ABC management team that has become the industry standard in terms of both responsiveness and quality of resources. He is a licensed CPA with an undergraduate degree in accounting with honors from the Ohio State University. Mr. Zinser can be reached at Greg.Zinser@AnesthesiaLLC.com.
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Professional Events

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<td>American Society of Anesthesiologists ANESTHESIOLOGY 2016 Annual Meeting</td>
<td>McCormick Place Convention Center Chicago, IL</td>
<td><a href="https://www.asahq.org/meetings/calendars/2016/10/copy%20of%20anesthesiology2016">https://www.asahq.org/meetings/calendars/2016/10/copy%20of%20anesthesiology2016</a></td>
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<td>Swisstel Chicago, IL</td>
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<td>November 19-20, 2016</td>
<td>American Society of Anesthesiologists Quality Meeting 2016</td>
<td>ASAs Headquarters in Schaumburg Schaumburg, IL</td>
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