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Who Really Owns Your Anesthesia Group?

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Walmart is famous for its slogan "Save Money. Live Better."

It's no surprise that the slogan is aimed at the customer.

But have you ever wondered about the supplier?

There is a tremendous analogy here for medical groups of all stripes and for anesthesiology groups in particular.

Lower Prices. Every Day.

From the inception of its business, Walmart employed a low-price strategy. And, it's certainly no trade secret that the way Walmart *sells* at low prices is to *buy* at even lower prices—in fact, at the lowest prices.

To get those lowest prices, Walmart is willing, and quite able, to buy in very large quantities. And, therein lies the twist, the twist tie, if you will, for its suppliers, and, by analogy, you will see, for you.

Manufacturers, as they began selling to Walmart, craved the large distribution the chain offered. They'd assess how much Walmart would buy, and look at how many stores Walmart would put their product in. In order to get access to the Walmart business and the tremendous distribution, the manufacturers would then sell to Walmart at reduced prices—in fact, at their lowest prices.

As a result of capturing Walmart's business, many suppliers thought they

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➤ INSIDE THIS ISSUE:

Coronavirus: A Game-Changing Event

Just when we thought we had seen it all and successfully managed innumerable practice management challenges, along comes a virus so insidious and so contagious that every aspect of the economy will be affected. Americans have been laid off in record numbers. Surgical case volumes have dropped precipitously. Once well-managed anesthesia practices are scrambling to cobble together a strategy for survival. As your business partners, we are exploring all options and will be updating you with our research and insights. This collection of articles is just a small sample of the wisdom of our eminently qualified industry experts.

Kate Hickner, Esq. discusses one of the most interesting policy developments to come out of this crisis: new guidelines for telemedicine. While it is not entirely clear how this will impact anesthesia providers, these new guidelines are sure to be a preview of coming developments. Clearly, treatment paradigms are going to change.

Will Latham draws our attention to the importance of group governance in a very interesting discussion of some of the most common governance problems groups face. He shares the insights of his years of experience managing all manner of practices. His piece consists of many very practical suggestions for today's practices.

Mark Weiss, JD poses a very intriguing question: who really owns your anesthesia group? However valuable your contract at a given facility, he submits that, in many ways, groups have sold out to the facilities they serve. Is it any wonder that so many practices have decided to sell their practices? It is a very thought-provoking piece.

One of our ever-loyal contributors, Kelly Dennis, presents some interesting thoughts with regard to the potential of an audit and the specific requirements of medical direction. It is hard to imagine that payers will be turning to audits in the current environment and yet audits tend to peak when money is short. This is a timely reminder.

ABC's own Kendall Lutz sheds some light on one of the most fundamental questions in anesthesia: is it better to be a generalist or a specialist? His piece on boutique anesthesia practices raises some interesting questions about the value of focusing on a niche or boutique market.

Michael Bronson, MD of Mission Viejo Anesthesia Consultants and our own Jody Locke provide a fascinating profile of a ketamine clinic in southern California. This is a line of business that many practices are considering but few, as yet, are pursuing. We believe this is a very timely and relevant case study for your review.

Who knows how long the current crisis will last and what its lasting impact will be on the specialty of anesthesia. The rate of infection continues to rise and, despite government intervention, it is entirely unclear how most practices will survive the economic implications of the current environment. Just know that we are all in this together. Your success is our success.

With best wishes,

Tony Mira
President and CEO

Internal Audits: Process and Frequency

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Many practices are too busy with day-to-day work to keep track of how often they should conduct internal audits. However, if your practice has a compliance plan, it generally outlines the required audit frequency. Do you know what your compliance plan requires?

If your anesthesiology practice is still using the compliance plan outline published in September 1997 by the American Society of Anesthesiologists™ in *Compliance With Medicare and Other Payor Billing Requirements,* your practice is required to review pre-submissions (claims reviewed *before* filing to the insurance carrier) on a quarterly basis, and post-submission (claims reviewed *after* filing to the insurance carrier) at regular intervals, such as semi-annually. You may also want to consider updating your compliance plan to ensure it meets current standards.

How to Prepare for Audit

Having anesthesia records available as you start your internal audit will make the review process easier. If anesthesia records are not available, you should obtain them from the hospital's medical records department.

An internal audit is simply an objective review of the anesthesia services billed to monitor the accuracy and suitability of claims. It should be performed by a qualified employee—such as the office administrator, manager, a certified coder (*other* than the employee who coded the services), the compliance officer, a physician or a combination of staff members.

Each practice determines the number of charges or percentage of claims to be reviewed for each provider. It also

determines how to make appropriate corrections and, depending on the internal audit results and compliance plan requirements (when applicable), whether to contact legal counsel. Although the standard compliance plan requires the practice to discuss all claims monitoring with legal counsel, the practice may modify the plan to require legal counsel consultation only during *external* audits.

A simple pre-submission review should compare the codes and modifiers billed with the documentation on file. Because the auditor reviews this information before submitting the claim, corrections are made during the review process, and corrective actions are taken and conveyed to staff. For example, a review determined the coder mistook "TKA" for a total knee arthroscopy (01400, base value - 4), rather than a total knee arthroplasty (01402, base value - 7). The practice must take several corrective steps:

1. Change code, if applicable. Make certain what procedure was performed as different clinical staff may be using different acronyms;
2. Ensure acronyms in your practice are clearly defined; and
3. Request a report of 01400 and 01402 claims filed to verify accuracy. Choose your time frame based on payer policy and timely filing requirements, such as one year or 90 days.

A post-submission review is more complex and should include a review from the time the claim is entered all the way through resolution. Choose a date within the past six months; and, in addition to checking codes and modifiers used, review payment processes to ensure correct payments were received and appropriate adjustments were taken. Each practice should know exactly what payment to expect from each payer. Medicare pays by location and the amount is standard; other payers may be contracted using various amounts and time calculation techniques, so a matrix of expected reimbursement is helpful. At the very least, a form listing annual expected amounts is necessary.

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Who Really Owns Your Anesthesia Group?

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had reached the promised land. Their sales shot up. Sure, margins on those sales were slim, but the quantities were stupendous. But that was just the start.

Once Walmart became a bigger and bigger and even biggest part of a supplier's business, Walmart continued putting the pressure on. They knew that the supplier was so dependent upon Walmart for their huge volume and reach, that they could push *even harder* for *really* low prices, and then for *really* lower prices, and then for *really* lowest prices.

In a very real sense, far beyond the colloquial, many manufacturers became "owned" by Walmart. The twist ties that bound them to Walmart got tighter and tighter. Their margins were on a starvation diet, but quantities were super-sized. And, if they lost the giant chain's distribution, the shock of the resulting excess capacity might pull them under.

Are You a Metaphorical Walmart Supplier?

If you're the leader of an anesthesia group, it's often much the same story. That is, if you've allowed your business to become dependent upon a single hospital or even a single system of hospitals.

If that's the case, then who really owns your group? Is it really you and your partners? Or, in essence, does the hospital or the system "own" your group in the same way that Walmart "owns" the suppliers who've become dependent upon their business?

At the extreme end of the continuum, if the hospital or system administrator were to tell you that they've decided that it's in their best interest that, as of a month from next Tuesday, all anesthesia services will be provided by Best PowerPoint Anesthesia Group or through the anesthesia department of Nearby Giant University, so you'd better go cut employment deals, what other viable alternative would you have? Likely, none.

Short of that doomsday event (but one that happens more often than you might imagine), the same dynamic plays out whenever a hospital makes a demand on a dependent group. From "we're cutting your stipend" to "we want you to expand coverage," what choice do you have other than to say "yes"? The alternative, of course, whether spoken or understood, is that you'll soon be an "ex-vendor."

Should you attempt to sell your group, if you've become that dependent on one large source of business, what sort of a discount will the buyer demand due to your huge, "baked in" fragility?

The real question is, have you, in essence, given away the ownership of your practice entity by falling into the "Walmart" trap?

Do you and your fellow physician "owners" really own what you think you own?

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Internal Audits: Process and Frequency

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TABLE 1

The Seven Steps of Medical Direction

The Criteria:

1. *Performs a pre-anesthetic examination and evaluation;*
2. *Prescribes the anesthesia plan;*
3. *Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;*
4. *Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;*
5. *Monitors the course of anesthesia administration at frequent intervals;*
6. *Remains physically present and available for immediate diagnosis and treatment of emergencies; and*
7. *Provides indicated-post-anesthesia care.*

Payment will be made at the medically directed rate if the physician medically directs qualified individuals (all of whom could be CRNAs, anesthesiologists' assistants, interns, residents or combinations of these individuals) in two, three, or four concurrent cases and the physician performs the following activities.

The physician must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring and were present during the most demanding procedures in the anesthesia plan, including induction and emergence, where indicated. (Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

An important area to review is concurrency and documentation of medical direction criteria. (See Tables 1 and 2). Depending on the software concurrency reporting capabilities, it may be necessary to review an entire day of concurrency if your practice includes residents, certified registered nurse anesthetists, anesthesia assistants or student registered nurse anesthetists. It is important to understand that concurrency calculations must include all patients, regardless of type of insurance. While some carriers allow a combination of up to four concurrent cases, graduate medical rules differ and allow up to two cases when residents or SRNAs are involved.

A physician who is concurrently furnishing services that meet the requirements for payment at the medically directed rate cannot ordinarily be involved in furnishing additional services to other patients. Nevertheless, engaging in activities described in Table 2 do not substantially diminish the scope of control exercised by the physician and do not constitute a separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met.(Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

Whether conducting a pre- or post-submission review, keep documentation of all steps taken in a compliance file. Even if your practice only reviews once a year, make certain the time frame agrees with the written compliance plan, when applicable. The adage, "It is better not to have a compliance plan, than to have one and not follow it," is particularly true for anesthesia practices, as anesthesia billing rules are often vague and ambiguous.

TABLE 2

The Exceptions as Outlined by CMS

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

Note: Novitas and other Medicare Administrative Contractors may allow additional exceptions. For example, Novitas indicates "An anesthesiologist may perform and, if otherwise eligible, seek reimbursement for procedures (such as arterial line insertions, central venous catheter insertions, pulmonary artery catheter insertions, and epidural, spinal, and peripheral nerve blocks) performed in an area immediately available to the operating room when performance of such services does not prevent him/her from being immediately available to respond to the needs of surgical patients."

Kelly D. Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I has over 36 years of experience in anesthesia coding and billing and speaks about anesthesia issues nationally. She has a Masters Degree in Business Administration, is a certified coder and instructor through the American Academy of Professional Coders. Kelly is an Advanced Coding Specialist through the Board of Medical Specialty Coding and served as lead advisor for their anesthesia board. She is also a certified healthcare auditor and has owned her own consulting company, Perfect Office Solutions, Inc., since November 2001. She can be reached at kellyddennis@attglobal.net.

Governance Traps and Tricks

Will Latham, MBA
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In today's challenging times, effective group governance takes on even greater importance. If a group cannot develop plans, make decisions and implement its plans, someone else will choose the course of the group.

Following are some governance challenges that clients have approached us with over the last year.

Speed Bump

The Problem:

"Our group revisits issues over and over again. We have members of the group who, if they do not get their way in the first vote, raise the issue over and over again to either torture the group into changing the decision, or to paralyze the group."

The Solution:

One way to reduce the use of this "torture" technique is to implement a "speed bump" for items to return to the agenda for discussion.

For example, the group could implement a policy that requires 30 percent of the shareholders to sign a document asking to bring an item back to the floor for re-discussion once a decision has been made (it is important that they sign a document, rather than someone say "I had 30 percent of the people say they'd like to re-discuss this issue").

This policy doesn't close the door to re-discussing an issue (if more than 30 percent want to re-discuss an issue, the group probably should). However, it will typically reduce the number of times this "torture" technique is used.

Reduce Disruptive Behavior

The Problem:

"Our group has several disruptive physicians and we have not been able to deal with or even confront them. This job falls to the group leadership, and it's the last thing they want to deal with. Even if they take on the disruptive physician, it is often an argument over who should decide what appropriate behavior should be."

The Solution:

One way to address this situation is for the group to develop a "Code of Conduct."

A Code of Conduct indicates the agreed upon standards of behavior expected of a member of the group. It sets out, in general terms, the standards and duties which are reasonable to expect a member of the group to observe.

Properly developed, this document can be used to effectively reign in problematic physician behavior. Everyone has fair warning about what the agreed upon expectations are. Toleration for outliers is reduced. Group leadership can act because an intervention is no longer seen as one person's opinion versus another's.

We believe that the group should set expectations in a number of areas, to include:

1. Relations/interactions between group physicians.
2. Relations/interactions with group employees.
3. Relations/interactions with those outside the group.
4. Patients and patient care.
5. Participation in practice management responsibilities.
6. Confidentiality of practice information.
7. Support of group decisions, established goals and policies.

For each area the group should answer the following questions:

1. What behaviors do we expect of each other? What is acceptable to us?
2. What is inappropriate?

3. What are some of the "unwritten rules" that guide our behavior?
4. What are the rights and responsibilities of each physician?

An example Code of Conduct can be found in Exhibit 1.

Use Committees to Share the Load

The Problem:

"Our Board is overloaded. Most of the shareholders are uninvolved, except to veto items or complain. We have committees, but they don't function well."

The Solution:

We have found that the best medical group Boards use their committees to process information prior to the Board addressing an item. When an item is raised at the Board level, their first step is often to send it to a committee to:

- Define the scope of the issue.
- Gather needed data.
- Analyze the data.
- Recommend a solution.

Once the committee has developed a solution or recommendation, this information should be presented to the Board. However, the Board must be extremely careful to not redo the work of the committee. If the Board feels the committee has not completed the assignment, it should be sent back to the committee for further work.

In addition, the Board should make every effort to accept the committee's recommendation. Why? If the Board always rejects the committees' recommendations or re-does the work, the committees will reach the conclusion that their thoughts are not being considered and stop doing the work.

Conflict Avoidance and Voting

The Problem:

"Our meetings go on and on forever. Some group members keep talking and talking, while others sit in silence. And when we vote, people seem reluctant to raise their hand and express their true opinion."

The Solution:

In our experience physicians tend to be conflict avoiders when it comes to

their peers. Sometimes discussions go on and on because people don't want to raise their hands to vote and possibly enter into conflict with those that don't agree with them. This can make meetings last much longer than they need to.

To deal with conflict avoidance, we are seeing more and more groups move to using "secret ballots" for their voting process. Most groups use secret ballots for electing their Board and officers, but some groups use them when they need to vote on controversial issues, or in some cases, all issues.

Why are secret ballots useful?

- They allow the individuals to "vote their conscience" with less fear of retribution.
- They avoid one physician "bullying" another physician into changing their vote.
- They often speed up a meeting because people don't delay voting to put off conflict.

There are several ways to implement secret ballots—here are two:

1. Use 3 x 5 cards as the secret ballots.
2. I have observed some groups starting to use "audience response

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Governance Traps and Tricks

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EXHIBIT 1

Example Code of Conduct

Preamble

Our dealings as a group are guided by our Code of Ethics. We are committed to promoting and encouraging individuality and the strengths of each member, as long as they are consistent with high-quality patient service and the larger goals of the group.

Relationship Among XYZ GROUP's Physicians

- If an XYZ GROUP physician has a problem, conflict or issue with another physician in XYZ GROUP:
  - The XYZ GROUP physician will not complain about the situation with others inside or outside of the group, or make condescending remarks about group members to others inside or outside of the group.
  - The XYZ GROUP physician will address the issue with the other physician privately.
  - If the issue is not able to be resolved, the XYZ GROUP physician will use the Professional Practice Committee and associated process to work through the issue.
- XYZ GROUP physicians will support other physicians in the group and will not "back-stab" each other.

Relationship With Patients

- XYZ GROUP physicians will treat patients with respect at all times. This will include:
  - Involving patients in decision-making.
  - Not acting condescending or demeaning towards the patient.
  - Treating the patient as a customer.
  - Respecting the patient's privacy and confidentiality.
- XYZ GROUP physicians will present a "united front" to the patients.
- XYZ GROUP physicians will not "put down" other XYZ GROUP physicians or their plans to patients or others.
- XYZ GROUP physicians will support one another for patients. If an XYZ GROUP physician disagrees with another physician's approach, they will take the issue to the physician privately.

Relationship with Other Physicians

- XYZ GROUP physicians will treat other physicians as a customer.
- XYZ GROUP physicians will focus on the needs of patients.
- XYZ GROUP physicians will be diplomatic when a physician does not understand the XYZ GROUP physician's point of view.
- XYZ GROUP physicians will keep physicians abreast and informed of clinical or medical issues.
- XYZ GROUP physicians will support all other XYZ GROUP physicians in their relationships with their physician colleagues. If an XYZ GROUP physician disagrees with another physician's approach, they will take the issue to the physician privately.
- XYZ GROUP physicians are responsible for the decision-making in the rooms they cover. It is up to that XYZ GROUP physician to make the final decision on the patient. In turn, other XYZ GROUP physicians will support the decision.

Relationship with Hospital Administration

- XYZ GROUP physicians will support the policies of the hospital or seek to change them as a group.
- Official communication with the hospital will go through XYZ GROUP's President.

Relationship with Hospital Staff

- XYZ GROUP physicians will treat hospital staff with respect at all times.
- XYZ GROUP physicians will follow the hospital's chain of command when dealing with issues and problems.
- XYZ GROUP physicians will not make condescending remarks about hospital staff in public.

Relationship with XYZ GROUP Employees

- XYZ GROUP physicians will treat XYZ GROUP employees with respect at all times.
- XYZ GROUP physicians will provide XYZ GROUP employees with a chain of command, and will operate through that chain of command.

Relationships with All

- XYZ GROUP physicians will not verbally or physically assault anyone.
- If an XYZ GROUP physician is approached by those outside the group with a problem:
  - They will support the group to the outsider.
  - They will bring the issue back to the group for discussion.

Patient Care

- Once a patient care policy has been adopted by XYZ GROUP, all XYZ GROUP physicians will implement that policy.

Practice Management

- All XYZ GROUP physicians are expected to participate in practice management activities when asked.
- The group will find a job for everyone.

Work Effort

- If an XYZ GROUP physician is needed, they will make themselves available to work.
- If an XYZ GROUP physician is in a position of responsibility, they will make themselves easy to be found.

XYZ GROUP physicians will respond to pages in a timely fashion.

systems." Some of these are apps on smartphones while others utilize dedicated voting devices.

A group we worked with recently moved to using such a voting system for all issues. They found that this has cut 25 - 50 percent off the time of every meeting by using secret ballot.

Authority

The Problem:

"We have created an Executive Committee of three physicians and given them significant authority. However, they will not make decisions within the bounds of their authority because they are afraid of second guessing by the other physicians. What can we do?"

The Solution:

There's no doubt about it, serving as a leader in a physician group is a tough job. Decisions will be second-guessed, and some people will not like any decision that is made. Here are several suggestions:

1. First, the leadership must recognize that criticism comes with the job—if they can't take it or expect it not to exist, they should avoid serving as a leader.
2. The leadership must help each other develop the mindset that it is their job to make these tough decisions, and then stick up for each other in front of the larger group.
3. If the larger group continually second guesses the authority of the leadership, the group at large should re-discuss what level of authority they are truly willing to give the leadership.
4. In some cases, leaders are afraid to make decisions because any decision can be recalled to the larger group for another vote by the members at large. Naturally, this defeats the purpose of a governance structure. For group's with this problem, they should consider a provision that requires a two-thirds majority of the shareholders to even bring up for discussion an issue decided within the authority of the leadership.

Critical Time

These are unprecedented times for anesthesiology groups. The challenges are greater than ever, as is the need for effective group governance.

If your group suffers from any of the problems mentioned in this article, we suggest you seriously consider implementing the solutions offered. The anesthesiology groups that have implemented these ideas have found their ability to make decisions and move forward to be greatly strengthened.

For more than 25 years, **Will Latham, MBA** has worked with medical groups to help them make decisions, resolve conflict and move forward. During this time he has facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; helped over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of more than 135 medical practices representing over 1,300 physicians. Mr. Latham has an MBA from the University of North Carolina in Charlotte. He is a frequent speaker at local, state, national and specialty healthcare conferences. He can be reached at WLatham@LathamConsulting.com.

Profile of an Anesthesia Ketamine Clinic

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Ketamine as a Treatment Modality for Depression

Ketamine has been well known to anesthesia providers for years. As an anesthetic agent it has been used mainly for starting and maintaining anesthesia. It induces a trance-like state while providing pain relief, sedation and memory loss. The active ingredient is similar to that in LSD. More recently its value is coming to be appreciated as an effective treatment for depression.

While the treatment of depression has traditionally been the purview of psychiatry, the use of ketamine as a treatment modality has now attracted the attention of anesthesia providers who have become quite familiar with its pharmacological properties. The administration of drug infusions is a standard practice in the treatment of surgical patients. Given anesthesia provider experience in the administration of such powerful agents, the migration from the operating room to the clinic is a slight difference of degree, but not of kind.

The typical ketamine clinic patient receives an initial 60-minute infusion. They are placed into comfortable reclining chairs and may be given headphones and an eye mask. Vital signs are monitored as they would be for a surgical patient. About 15 minutes into the infusion, patients start to experience euphoria-heightened perceptions and a floating or dream-like state. Usually these symptoms resolve within 15 minutes after the completion of the infusion.

After a second session the patient should be experiencing significant mood elevation and pain relief. If the patient reports improvement, up to four subsequent sessions will be scheduled. If they are not responding, then they are considered a "non-responder," and they are referred back to the referring physician.

Following a successful treatment series of up to six sessions, they may return in two to four month intervals for a booster infusion. The advantages of ketamine infusion in the treatment of depression and mood disorders can be significant. Ketamine does not lead to addiction and most patients report positive results. A range of 70 to 80 percent of patients report significant improvement.

Should an Anesthesia Practice Consider a Ketamine Clinic?

The history of the Ketamine Wellness Clinic of Orange County (www.ketamineoc.com) provides an interesting and relevant case study. As is true in evaluating any new business ventures, there are many considerations. One thing is clear though: any new venture requires a champion with a clear vision and a supportive team of stakeholders. Mission Viejo Anesthesia Consultants in Mission Viejo, California has consistently distinguished itself as an organization open to exploring business options that are consistent with the mission and values of the practice.

The clinic was founded in 2016 after a thorough review of current scientific and clinical studies. During the 1990s, clinical research clearly suggested a role for N-methyl-D-aspartate receptor (NMDA) antagonists in the treatment of depression. In the early 2000s, the first double-blinded, placebo-controlled studies that gave patients ketamine and followed their results showed rapid and significant improvement in symptomology after a single dose of ketamine. Subsequent studies reproduced the same results and demonstrated that multiple infusions of ketamine lead to more long-term results. As the investigation of ketamine expanded, it was found to be an effective treatment for other mood disorders and chronic pain.

An initial team of group members carefully reviewed the research available to develop the basic elements necessary to start the clinic: flow charts, clinical protocols, clinic notes, consents referral forms and a website. The clinic remains a work in progress and all aspects of the operation are constantly being refined to optimize the patient experience and the consistency of positive outcomes. Since 2016, the clinic has provided services to over 500 patients who have received thousands of infusions. The current team of providers consists of anesthesiologists, behavioral health nurses and various support staff.

Initially the clinic was set up in a large room at the hospital with only a curtain to provide privacy to patients. That initial venue was staffed by a single physician and nurse. Since 2016, the clinic has grown significantly. The current location is a six-room office-based facility that is not affiliated with the hospital. This has required some investment on the part of shareholders, but this has allowed the clinic to realize its market potential.

How the Clinic Works

All patients must be referred by a treating physician to come to the Ketamine Wellness Clinic of Orange County. The referring physician provides comments on prior medications and/or interventions to ensure ketamine is an appropriate next step in therapy. The clinic also use this interaction to establish a relationship with the referring provider, as they consider themselves one part of a collaborative team to treat each patient. All potential patients are then screened by an anesthesiologist for medical appropriateness and any contraindications to ketamine therapy. Contraindications to ketamine therapy include uncontrolled blood pressure, unstable heart disease, intracranial mass or acute psychotic hallucinations.

Patients are given a scale to fill out prior to initiation of ketamine therapy to establish an objective baseline. They then complete the same scale at the end of the series to gauge response to treatment. Most patients are able to realize a 50 percent reduction in their baseline scale by the end of the treatment. These results are also communicated to their referring physician to "close the loop." At this point, some patients are then able to work with their treating physician to decrease or eliminate some of the chronic medications they were taking before the ketamine therapy. The clinic also tracks these scales with a database which is used to run statistics to help fine-tune protocols. It is typical to fluctuate between a 70-80 percent response rate to infusions.

The Economics of a Ketamine Clinic

While the management of an office-based practice providing infusion therapy is similar to the management of an anesthesia practice, in some ways it is quite different. In both cases the volume of services provided and the ability to get paid for those services are essential keys to success. Perhaps the biggest difference, however, is that the anesthesia practice is captive to the facilities it serves for surgical case volume and payer mix while the clinic-based practice has much greater potential to control and manage both volume and sources of payment. It should also be noted that physicians will typically manage up to six infusions concurrently, which is similar to the management of multiple labor patients in the OB suite.

It is the number of variables that have to be managed that can make a clinic practice riskier. The goal must be to manage the business as efficiently as possible. Management and financial reporting must be specifically tailored to the unique nature of the services being provided. Payer rules for infusion therapy are quite different than those pertaining to payment for surgical and obstetric anesthesia. Contracting with insurance is not necessarily the best strategy for a ketamine clinic. While it is true that patients are expected to pay at time of service, many can also submit claims to their insurance that may reimburse them for the monies they have paid.

One of the complicating factors is the coding of infusions. In the office setting (POS 11), there is a code for intravenous infusion: 96365. This applies to intravenous infusion, for therapy, prophylaxis or diagnosis; initial, up to 1 hour. Code 96366 should be added for each additional hour.

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Profile of an Anesthesia Ketamine Clinic

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These codes are not applicable in the facility setting (POS 22, 24, etc.) where a E/M visit code must be used. Based upon the face-to-face time documented, it is suggested to use 99354 for prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for office or other outpatient evaluation and management or psychotherapy service).

Many insurance plans do pay for the infusion codes, excluding the VA, depending on the patient's benefit level. The clinic has not seen an unusual percentage of denials for these services, although in some markets pre-authorization may be required. In the case of this clinic, the practice chooses to bill patients first as a matter of expediency.

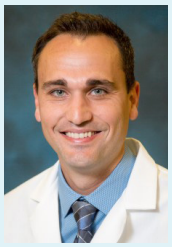
The Value of a Ketamine Clinic

As anesthesia practices explore alternative lines of business, should they be investigating a ketamine clinic? The answer is yes, but there are a number of critical criteria that should be met first.

- Is there a market for infusion therapy in your area? Ideally, the practice should be providing a service that is not otherwise available in the immediate area. Some market research will be necessary to determine this.
- Is this a buy or make decision? In other words, does the practice wish to develop a clinic from scratch or become affiliated with an existing clinic practice? Affiliating with an existing and established practice minimizes some of the start-up challenges, but may diminish some of the potential returns.
- Are existing providers interested in providing such a service? Without willing and available providers such an enterprise cannot be undertaken.
- Is there a champion for the service? A member of the group or a small group of members needs to take ownership of the enterprise. This person needs to research the options and orchestrate the project. This could be an opportunity for a younger member of the group to exercise leadership.
- What is the practice's tolerance for risk? Is it willing to make an investment and live with the consequences?
- What are the business objectives for the venture and how will they be measured? Any new venture should contribute to the value of the practice. This value is either financial or strategic. There needs to be accountability and transparency for the venture to be successful.

Anesthesia practices in the current environment need to be exploring ways to expand and diversify their practices. Options are limited, but they do exist. Although it is easy to get paid for ketamine infusions in the right market—patients simply scan their credit cards and start treatment—getting payment from insurance can be tricky. This is why it is so important to establish a fee schedule that is appropriate to the market and the patient population. Mission Viejo is a particularly affluent area; nevertheless, there is obviously a need for the service. A properly managed clinic should have great potential in almost any market.

Michael Bronson, MD is co-founder and Chief Executive Officer of Wellness Clinic of Orange County which operates the Ketamine Wellness Clinic of Orange County. Mr. Bronson joined Mission Viejo Anesthesia Consultants (MAC) in 2013 after completing residency at UC San Diego where he served as Chief Resident. Bronson currently sits on the MAC Board of Directors, Mission Hospital Medical Executive Committee and function as the OR Director of Orthopedic and Neurosurgical services. Current projects include designing the infrastructure for a hybrid physical and virtual preoperative clinic as well as developing software to automate the daily anesthesia assignments. He can be reached at michaelpbronson@gmail.com.



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"Boutique" Anesthesia Services

Kendall R. Lutz
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I've been involved in anesthesia billing and practice management for over 30 years. During that time I've witnessed groups of various sizes cover all types of anesthesia services within the hospital environment. Occasionally, a group may have carved out or created a separate chronic pain department, but for the most part, any and all anesthesia services were expected to be covered by the group. Recently however, we have seen a new type of "boutique" anesthesia practice. Is this a new niche in the market, a sliver of opportunity for those who wish to pursue a bit of independence or both?

We are seeing corporations of one to two providers, as well as small groups of 10-20 providers, emerging to cover unique types of cases. Most of these practices operate in offices and surgery centers rendering anesthesia for endoscopy, ophthalmology, dental, orthopedic, plastic, podiatry and chronic pain procedures. Others maintain a hospital presence, including a unique obstetric anesthesia-only group and an independent pediatric anesthesia service.

While this is not entirely new, gastroenterology groups have hired CRNAs for their office-based procedures for years and chronic pain providers have broken away from groups to focus on their specialty, it appears we are seeing more of these unique or *boutique* anesthesia practices.

Why Pursue Boutique?

There may be many reasons for this new boutique service. For some, it's the ability to potentially achieve higher earnings while dedicating fewer working hours (equaling an increased hourly value). This could be achieved by limited or no call, unique payer contracts, better

OR utilizations or all of the above. For others, it can be as simple as clinical and/or business autonomy.

Another factor in this new type of business may be the current shortage of both anesthesiologists and CRNAs. This shortage may require current staff to work additional hours with potentially no additional income. Many groups are also attempting to cover multiple locations with limited staff, which can create stress on the already overworked staff. Perhaps this leads to the quest for a better lifestyle.

A third factor appears to be the large national anesthesia groups' lack of either the desire or staff to cover the needs of the smaller office-based locations.

The boutique businesses are able to focus on managing their smaller practices with fewer group restrictions/distractions. Payer contracts may be negotiated with data that may prove more efficient and less costly care. This can be based on quicker case times, lower facility fees and possibly lower provider cost based on more efficient OR utilization rates. Payer mixes tend to have fewer government payers (particularly less Medicaid) at some of these facilities.

The new boutique models are not without risk. Obviously being a small business in the big business healthcare market can be risky. But there appears, at least at this time, to be a demand and as all entrepreneurs know, there is no reward without some risk.

Kendall R. Lutz serves as Vice President of Client Services for Anesthesia Business Consultants. Prior to joining ABC, Mr. Lutz was the owner/CEO of his own anesthesia-specific billing and practice management firm located in the Greater Chicago Area. Mr. Lutz's 30 years of service to anesthesia providers was highlighted by cutting edge data collection to create time and productivity models used by many in the industry today. Mr. Lutz continues to dig beyond the average billing metrics to find meaningful data to further future anesthesia business models. You can reach him at 847-980-8987 or Kendall.Lutz@AnesthesiaLLC.com.

COVID-19: Historic Breakthrough in Telemedicine

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During the past few weeks, healthcare attorneys have received an unprecedented number of questions from healthcare providers regarding telemedicine.

Before additional data became available, healthcare attorneys were not able to provide much comforting assurance to their clients. Medicare previously only reimbursed providers for certain telemedicine services in rural areas at certain locations or for certain brief "virtual check-ins." But now, in light of the coronavirus (COVID-19) pandemic, the telemedicine landscape has become dramatically different.

On March 17, 2020, President Trump announced that "Medicare patients can now visit any doctor by phone or video conference at no additional cost, including utilizing commonly used services like FaceTime and Skype—a historic breakthrough. This has not been done before…" This announcement follows the prior announcement that the federal government would authorize $500 million in new spending for the expansion of telemedicine.

Medicare covers a population that is 65 years or older and others who qualify because of a disability—a population that is especially susceptible to the coronavirus. These recent telehealth developments are a meaningful step forward in protecting individuals across the country from the coronavirus and ensuring increased access to healthcare.

One of the most helpful summaries of the new flexibility to provide telehealth services to Medicare beneficiaries is set forth in a Medicare Telemedicine Health Care Provider Fact Sheet, published March 17, 2020 by the Centers for Medicare and Medicaid Services (CMS). See also the related Medicare Telehealth Frequently Asked Questions (FAQs) issued the same day.

Virtual Services

The Fact Sheet clarifies that there are three types of virtual services physicians and other professionals can provide to Medicare beneficiaries: Medicare telehealth visits, virtual check-ins and e-visits. It goes on to summarize the requirements for billing each type of service and a chart comparing them. Medicare will pay the same amount for telehealth services as it would if the services were furnished in person. CMS has clarified that physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives may provide telehealth services. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists and registered dietitians or nutrition professionals may also furnish services under certain circumstances. Providers that engage in telemedicine are encouraged to take the time to read the guidance referenced in this paragraph to fully understand the billing and other parameters, which go beyond the scope of this article.

The U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG) also issued a Policy Statement to provide increased flexibility for healthcare providers to reduce or waive beneficiary cost-sharing for telehealth visits paid for by federal healthcare programs and related guidance. The guidance states that "[O] ordinarily, if physicians or practitioners routinely reduce or waive costs owed by Federal healthcare program beneficiaries, including cost-sharing amounts such as

coinsurance and deductibles, they would potentially implicate the Federal anti-kickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries…. OIG will not enforce these statutes if providers choose to reduce or waive cost-sharing for telehealth visits during the COVID-19 public health emergency."

Further, the DHHS Office of Civil Rights (OCR) announced that it would refrain from enforcing certain aspects of HIPAA to encourage the use of telemedicine for seniors. The OCR Notice states: "OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered healthcare providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency." The Notice goes on to identify those applications that may be used without risk that OCR may seek a penalty for noncompliance (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts video or Skype) and those that should not be used in the provision of telehealth by covered healthcare providers (e.g., Facebook Live, TikTok or similar applications that are public facing). During February 2020, OCR also issued a helpful bulletin regarding HIPAA requirements for sharing patient information during the pandemic.

Providers should remember that the CMS guidance announced on March 17, 2020 applies only with respect to services payable by Medicare. The federal government has also encouraged states to expand the use of telehealth in their Medicaid programs for low-income individuals. It is hoped that commercial third-party payers will follow suit. Because the new CMS guidance only applies with respect to Medicare, providers must review the requirements of their state Medicaid programs and commercial third-party payers when applicable. Providers who have opted-out of Medicare and operate on a cash basis have the greatest flexibly with respect to telemedicine.

If providers engage in telemedicine, they must ensure that their program is consistent with applicable state laws, including licensure and prescribing requirements. In particular, note that when providing telemedicine services, providers generally must comply not only with the state law in which the provider is located, but also the state law where the patient is located. Accordingly, providing telemedicine services to a patient in another state may require telemedicine providers to comply with a regulatory regime with which they are not familiar. States are currently in the process of substantially increasing flexibility in this area to respond to the pandemic and providers should stay abreast of current developments regarding state licensure requirements.

It's important that providers obtain strong healthcare compliance and legal guidance before proceeding with a new telemedicine program to ensure that all applicable state and federal requirements are satisfied. There are several layers of applicable legal requirements. Healthcare attorneys are available to assist providers in identifying these compliance requirements and structuring a telemedicine program to withstand regulatory scrutiny.

From a practical perspective, the American Medical Association (AMA) has also developed an excellent quick guide to telemedicine in practice. The guide includes invaluable and practical advice with respect to professional liability coverage, coding and payment, practice implementation and other helpful resources. Providers offering telemedicine services during the coronavirus pandemic are strongly encouraged to take a few moments to review the AMA materials.

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At the time of publishing, we find ourselves in mid-July and are able to look back on what has been an extraordinary time for our country and global community. Our readers, anesthesiologists, CRNAs, hospital and anesthesia group administrators, have spent the past four months navigating an unprecedented set of challenges. First, there was the panic of cases being canceled and operating rooms being closed. Then, clients had a new set of financial challenges as they wondered how to manage their staff in the face of declining revenue. No one could predict how the recovery would look or how surgical volumes would ramp back up. Even now, no one quite knows what the new normal will look like.

One of things I so admire is the resiliency of anesthesia providers—there is always a solution. We saw that determination most clearly displayed in the heroic efforts of our healthcare workers, especially in the hospital sector—the front lines of the battle against COVID. At the time of this writing, we are seeing an easing of restrictions and an uptick in elective surgeries, but the danger still persists. No matter how long the threat from the virus lasts, we know we can count on our hospital employees to be there for the rest of us, providing expert healing and genuine care. We at Anesthesia Business Consultants salute you for your valiant efforts during the national health emergency, and we wish you success in all you do.

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