

THE COMPANY MODEL



The most important event of the year to date, for anesthesiologists and for everyone involved in health care in any way, was of course the Supreme Court decision upholding the Affordable Care Act. Also of great consequence to the anesthesia community was the “company model” Advisory Opinion issued by the Office of the Inspector General on June 1, 2012. Mark Weiss, Esq., whose name is familiar to many readers and for whose frequent contributions to the Communique we are very grateful, describes the company model and the management fee model “other schemes” and explains why these are illegal if they represent payment to the ambulatory surgical center for giving physicians access to Medicare patients. Mr. Weiss’s article adds further clarity by placing the OIG’s June opinion in the context of earlier determinations.

A set of other frequent contributors, Abby Pendleton, Esq., Carey Kalmowitz, Esq. and Adrienne Dresevic, Esq., all members of the Health Law Partners firm, offer a complementary view of the company model advisory opinion.

They remind us, notably, of the key role of the intent of the parties to a financial arrangement in which the entity controlling access to the patients receives remuneration from the anesthesiologists. If the purpose of the arrangement is to enhance quality and efficiency, there is no anti-kickback violation – unless *even one* purpose is to compensate the entity for patient referrals.

Read these two articles in tandem, and you will be very well equipped to understand whether a proposed deal in which you, the anesthesia practice, are asked to make any kind of economic contribution to the other party’s bottom line.

In my Spring 2012 Communique editorial, I suggested that the issue was a keeper because it laid out in a series of detailed tables the “meaningful use” measures of Stages 1 and 2 of the Medicare Electronic Health Record (EHR) incentive program. This issue, too, is intended as a keeper. Neda Mirafzali, Esq.’s article *A Survey of State Prompt Pay Laws, Part I* is a summary in tabular form of the statutes in all 50 states that penalize health plans that fail to pay providers for

clean claims within the prescribed time frame. Knowing your rights to timely payment can be critical to effective A/R management.

The third in a series of articles by ABC Director of Client Services Arne Pedersen, MBA, FACMPE, *Approaches to Collecting from Self Pay and High Deductible Patients*, elaborates on some of the issues raised in the Summer 2012 issue of the Communique. We all recognize that anesthesiologists and other physicians or providers with whom the patient has a limited personal relationship can end up at the back of the line when it comes to collecting payment directly from the patient. Did you know that there are multiple medical credit cards that are one way for patients to finance their medical treatment – among other strategies?

Other ABC staff contributions include Vice President Jody Locke’s discussion of the benefits of and options for participating in *Anesthesia Quality Databases*, and Vice President Joette Derricks’s review of coding and documentation requirements in billing for transesophageal echocardiography. What other topics would you, our esteemed readers, like to see in future issues of the Communique? We will do our best to satisfy the interests that you share with us.

With best wishes

Tony Mira
President and CEO



A SURVEY OF STATE PROMPT PAY LAWS, PART I

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Many states have laws or regulations in place that require health insurers in the state to reimburse claims within a certain timeframe or face penalties, oftentimes in the form of interest applied to the amount of the claim. Such laws or regulations are typically called “Prompt Pay” laws or “Clean Claim.” While each state or, sometimes, insurer, defines the requirements for a claim to be a “clean claim,” generally, a “clean claim” is a claim that has all of the information an insurer needs to either pay or deny the claim.

A “non-clean claim” is a claim that requires additional information or documentation to make it clean. Each state sets forth the timeframes in which insurers have to reimburse a clean claim. Absent certain exceptions (*e.g.*, instances of suspected fraudulent activity, contractual provisions setting forth alternative timeframes, etc.), failure to adhere to the timeframes results in penalties oftentimes in the form of interest applied to the amount of the claim and some states impose administrative penalties

upon insurers that regularly fail to adjudicate claims in a timely fashion.

The purpose of this two-part survey is to outline and list the key elements of states’ prompt pay laws as they pertain to anesthesiologists, focusing on the relevant timeframes in place for insurance companies as well as the potential penalties for failure to comply. Of course, every instance of reimbursement is unique and should be addressed based on its distinct facts and circumstances.

STATE	STATUTE OR REGULATION	APPLICATION	TIME PERIOD FOR PAYMENT OR DENIAL OF CLAIM	NOTICE PERIOD FOR NON-CLEAN CLAIMS	PENALTY
Alabama	Code of Ala. §27-1-17 Code of Ala. §27-21A-23	<ul style="list-style-type: none"> • Insurers • Health service corporations • Health benefit plans • HMOs 	Upon receipt of a clean claim: <ul style="list-style-type: none"> • Written: 45 calendar days • Electronic: 30 calendar days Upon receipt of amended claims/ supplemental information: 21 calendar days	Upon receipt of a claim: <ul style="list-style-type: none"> • Written: 45 calendar days • Electronic: 30 calendar days 	<ul style="list-style-type: none"> • 1.5 % per month, prorated daily • Willful violations could result in fines of up to \$1000 per claim
Alaska	Alaska Stat. §21.36.495	<ul style="list-style-type: none"> • Insurance companies • Hospital or medical service corporations • Fraternal benefit societies • HMOs • Multiple employer welfare arrangements • Church plans • Certain governmental plans 	Upon receipt of a clean claim: 30 days Upon receipt of amended claims/ supplemental information: 15 days	Upon receipt of a claim: 15 calendar days	15% annually, but is not required if the interest is \$1 or less
Arizona	ARS §20-3102	<ul style="list-style-type: none"> • Disability insurers • Group disability insurers • Blanket disability insurers • Healthcare services organizations • Prepaid dental plan organizations • Hospital service corporations • Medical service corporations • Dental service corporations • Optometric service corporations • Hospital, medical dental and optometric service corporations 	Upon receipt of a clean claim: <ul style="list-style-type: none"> • 30 days to adjudicate • 30 days to pay Upon receipt of amended claims/ supplemental information: 30 days to adjudicate and pay	Upon receipt of a claim: 30 days	10% per annum
	ARS §20-462	Enrollees who have paid providers directly for covered out-of-network services	Upon receipt of an acceptable proof of loss by the insurer containing all the information necessary for claim adjudication: 30 days	N/A	10% per annum

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requested by an ASC or its referring physician practice to adopt a company model. Not surprisingly, those 125 practices reported that out of the total 332 requests to participate in a company model entity, the group lost the contract in at least 159 instances.

COMPANY MODEL REFRESHER

If an ASC or its owner approached you and flat out demanded a kickback, “Bob, if you want to provide anesthesia at Greenacres ASC, you’ve got to pay us 30 cents on the referred dollar,” it’s clearly illegal.

But what if, instead, the conversation goes like this: “Bob, if you want to provide anesthesia at Greenacres ASC, you’ve got to become an employee of our entity, Greenacres Anesthesia Services, owned by my surgical group. We’ll even pay you commensurately with your production. In fact, we’ll pay you the lion’s share, 70 cents on the dollar!”

These entities become the “companies” of the company model. Of course, demanding 30% as a direct kickback has the same economic effect as forcing the anesthesiologists into an entity that rewards them with a 70% share.

But is the company model structure legal? That’s the \$25,000 fine plus five years in jail plus exclusion from Medicare and Medicaid question. And don’t forget possible civil monetary penalties.

The Company Model Business Model

In its most direct form, the company model involves the formation, by the surgeon owners of an ASC, of an anesthesia services entity to serve as the “company” that provides all of the anesthesia services at those surgeons’ ASC.



Prior to the formation of the company, all anesthesia services were provided by the anesthesiologists working at the ASC, either for their separate accounts or for the account of their anesthesia group. However, after the formation of the company model entity, those anesthesiologists, or others if they are unwilling to play ball, are employed or engaged as subcontractors by the company, with a significant share of the anesthesia fee being redirected to the company model’s owners, the surgeons.

MANAGEMENT FEE MODEL

In the management fee model, the ambulatory surgery center charges the anesthesiologists a fee in respect of their “use” of portions of the ASC facility in the context of providing anesthesia to the patients of that facility, or for services rendered by the ASC’s staff, or, for the “rent” of space within the facility for their delivery of anesthesia services to the ASC’s patients.

KEY COMPLIANCE ISSUES

The federal anti-kickback statute (AKS) prohibits remuneration—that is, the transfer of anything of value—for referrals. State laws differ in their treatment, scope and interpretation, but generally contain similar provisions barring remuneration for referrals, sometimes expressed as anti-kickback or fee-splitting prohibitions. Because of the variations in state laws, this article focuses on the federal concepts applicable to patients covered under Medicare and Medicaid.

Courts have interpreted the AKS to apply even when an arrangement may have many legitimate purposes; the fact that one of the purposes is to obtain money for the referral of services or to induce further referrals is sufficient to trigger a violation of the law.

Certain exceptions, known as safe harbors, define permissible practices not subject to the anti-kickback statute because regulators believe they are unlikely to result in fraud or abuse. The failure to fit within a safe harbor does not mean that an arrangement violates the law; there’s just no free pass.

The question, then, for the company model or for management fee deals is whether the arrangement runs afoul of federal anti-kickback law. To be sure, each deal must be analyzed carefully.

PRIOR OIG GUIDANCE

The U.S. Department of Health and Human Services Office of Inspector General (OIG) previously issued two fraud alerts applicable to the analysis of company model deals: its 1989 Special Fraud Alert on Joint Venture Arrangements, which was republished in 1994,

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- The aggregate payments to the owner vary based on the owner's referrals to the new business.

Those elements hint at a company model structure in which an ASC (or some or all of its surgeon-owners) forms an anesthesia company solely for the purpose of providing anesthesia services to itself. Little capital is required. The anesthesiologists, not the owners, provide the services. But for their engagement by the company, they would be providing anesthesia services for their own account. The company's owners capture a share of the anesthesia revenue. And, importantly, the more cases the ASC or its surgeons refer to the company, the more money those company owners make.

The bulletin states that despite attempting to fit the contracts creating these joint venture relationships into one or more safe harbors, such protection might not be available. The OIG views the discount given within the joint venture's common business enterprise (e.g., the anesthesiologists agree to be paid less by the company than they would receive if they billed independently of the joint venture) as not qualifying for the safe harbor applicable to discounts.

Even if the contracts could fit within one or more safe harbors, the bulletin states that they would protect only the payments from the owner to the manager/supplier for actual services rendered, not the "payment" from the manager/supplier back to the owner in the form of its agreement to provide services to the joint venture for less than the available reimbursement—that is, the "discount" given within the joint venture.

Again, the failure to qualify for safe harbor protection does not mean that



a venture is illegal; it does mean that it might receive additional scrutiny that could lead to prosecution.

In 2009, the American Society of Anesthesiologists (ASA) requested that the OIG issue a special advisory bulletin on the company model. The ASA renewed that request in June 2010. More recently, the ASA responded in February 2011 to a public invitation by the OIG for comments on additional Special Fraud Alerts, urging an expedited alert on the company model. The OIG has yet to issue a special advisory.

Advisory Opinion 11-03

In response to requests from one or more parties to a particular proposed or existing arrangement, the OIG will issue an advisory opinion as to that specific situation. Although only binding in respect to the requestor, advisory opinions provide a window into the OIG's analysis of how the anti-kickback statute applies in particular instances.

In 2011, the OIG issued its Advisory Opinion 11-03, not in respect a company model anesthesia deal, but as to a very similar pharmacy company. In the proposed facts disclosed to the OIG, a pharmacy providing products and services to long-term care facilities would form a new long-term care pharmacy to be owned in common with one or more long-term care facilities. The long term care facilities would, of course, now share in the profits of pharmacy services.

The OIG found the proposed arrangement problematic, focusing on the similarity between the proposed deal and the suspicious arrangement outlined in the 2003 Special Advisory Bulletin, with the long-term care facility owners doing nothing to operate the new venture but receiving a share of the profits. Those facility owners would have little or no business risk and the payment to the new joint venture would vary with the volume or value of referrals from the facilities to the new business.

2012 ADVISORY OPINION 12-06

Although Advisory Opinion 11-03 addressed an analogous situation, the OIG's June 1, 2012, Advisory Opinion 12-06 was that agency's first pronouncement directly on the propriety of the company model. And, importantly, that advisory opinion also addresses a prevalent alternative method of extracting money from anesthesiologists, the management fee arrangement.

In Advisory Opinion 12-06, the requestor, an anesthesia group, set out two alternative proposed scenarios in regard to its relationship with a group of ASCs owned by surgeons.

Alternative "A:" The Management Fee

In alternative "A," the anesthesia group would continue to serve as the ASC's exclusive anesthesia provider of anesthesia and to bill and collect for its own account. However, the group would begin paying the ASCs for "management services," including pre-operative nursing assessments, adequate space for all of the group's physicians, including their personal effects, adequate space for the group's physicians' materials, including documentation and records, and assistance with transferring billing documentation to the group's billing office.

Although both Medicare and private payors set their reimbursement to the ASCs taking into account the expenses of the type included with the management fee, the ASCs would continue to bill Medicare and private payors in the same amount as currently billed.

The management fee would be at fair market value and determined on a per patient basis. No management fee would be charged in connection with federal health care program patients.

Consistent with its longstanding viewpoint, the OIG found that carving out federally funded patients was ineffec-

tive to remove the proposed arrangement from within the purview of the AKS, because the payment of the fee in connection with private payors would influence the decision to refer all cases, thereby not reducing the risk that their payment is made to induce the referral of the federally funded ones.

The OIG stated that the AKS seeks to ensure that referrals will be based on sound medical judgment, and competition for business based on quality and convenience, instead of paying for referrals. But under the management fee proposal, the ASCs would be paid twice for the same services, by Medicare or by the private payor via the facility fee, and then also by the anesthesiologists via the management fee. That double payment would could unduly influence the ASCs to select the requestor as the ASCs' exclusive provider of anesthesia services.

Alternative "B:" The Company Model

In alternative "B," the surgeon owners of the ASCs would set up a series of entities to provide anesthesia services, on an exclusive basis, at each of the ASCs. Those entities, commonly known as the "anes-

thesia companies" of the company model, would be wholly owned either directly by the surgeon's entities or by the ASCs.

Those anesthesia companies would, in turn, engage the requestor anesthesia group on an exclusive basis as an independent contractor to provide the actual anesthesia care and certain related services, described in the Opinion as including:

- recruiting, credentialing, and scheduling anesthesia personnel;
- ordering and maintaining supplies and equipment;
- assisting the anesthesia companies in selecting and working with a reputable anesthesia billing company;
- monitoring and overseeing regulatory compliance;
- providing financial reports;
- implementing quality assurance programs; and
- providing logistics (including, if necessary, assisting the anesthesia companies in structuring independent contractor or employment relationships with anesthesia personnel and assisting in establishing a separate anesthesia corporation).

In turn, the anesthesia companies would pay the requestor a negotiated rate for the services. The fees for the services would be paid out of the anesthesia related collections, with the anesthesia companies retaining any profits.

In analyzing the proposed company model arrangement, the OIG stated that even if one assumed that the surgeon investors qualified for the ASC safe harbor in respect of their investment in the surgery center, there was no safe harbor available in respect of the distributions that they would receive from



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their anesthesia company. The ASC safe harbor protects returns on investments only in circumstances where the investment entity itself is a Medicare certified ASC, which is an entity that operates exclusively for the purpose of providing surgical service, and anesthesia services are not surgical services.

Additionally, even if the safe harbor for payment to employees applied (if the anesthesiologists were employed) or if the safe harbor for personal services contracts applied (if the anesthesiologists were subcontractors), and, therefore, the payments to the anesthesiologists were protected by a safe harbor (note that this means that the payments to the anesthesiologists were at fair market value, which is what many “experts” think is the magic bullet in terms of all compliance—it is not), neither of those safe harbors would apply to the company model profits that would be distributed to the ASC’s physician-owners, and

such remuneration would be prohibited under the anti-kickback statute if one purpose of the remuneration is to generate or reward referrals for anesthesia services.

After stating that the failure to qualify for a safe harbor does not automatically render an arrangement a violation of the anti-kickback statute, the OIG then turned to an analysis pursuant to the 2003 Special Advisory Bulletin on Contractual Joint Ventures, discussed above, and found that the physician owners of the proposed company model entity would be in almost the exact same position as the suspect joint venture described in the Bulletin: That is, in a position to receive indirectly what they cannot legally receive directly—a share of the anesthesiologists’ fees in return for referrals.

Therefore, the OIG stated that the proposed company model venture would pose more than a minimal risk of fraud and abuse.

In total, the OIG concluded that either of the proposed arrangements, the management fee arrangement or the company model arrangement, could potentially generate prohibited remuneration under the anti-kickback statute and the OIG could potentially impose administrative sanctions on the requestor.

THE BOTTOM LINE ...

The bottom line is that both company model ventures and management fee arrangements are fraught with kickback danger for all parties involved. Additionally, note that there is no requirement that there be a third entity, the so-called anesthesia company, involved for the analysis applied by the OIG to apply: Similar arrangements directly between an ASC and the anesthesiologists trigger the same concerns.

Each situation must be analyzed carefully as there is a high chance of an AKS violation leading to criminal fines, civil penalties, exclusion as a provider and even imprisonment. ▲

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APPROACHES TO COLLECTING FROM SELF PAY AND HIGH DEDUCTIBLE PATIENTS

Arne Pedersen, MBA, FACMPE

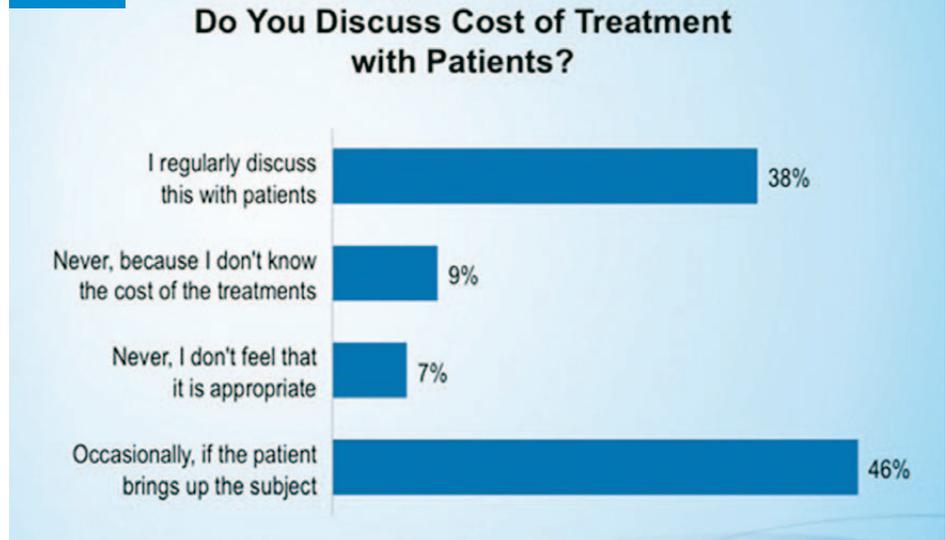
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With the ever-rising cost of healthcare, all parties are looking for ways to finance it. From high deductible health plans with savings components to consumer credit tools such as credit cards and loans, the face of healthcare financing is changing. The challenge for anesthesia in this ever-changing world comes back to the physician-patient relationship.

As noted in previous articles “The Benefits of Strategy” from the Winter 2012 issue of The Communique and “Planning for Payor Negotiations” from the Spring 2012 issue of The Communique, high deductible health plans (HDHPs) are a growing health insurance product line. This puts a greater emphasis on collecting larger sums of money from the patient. Moreover, the current economic climate has put a strain on the safety nets that are in place to help those with fewer resources. The self-pay category is growing and the need to address this issue is at the forefront in collecting patient liabilities for anesthesia services rendered. This article will explore the various payment options available today along with some cautions.

One of the criticisms levied against the healthcare industry is the transparency of costs associated with care. The challenge is sharing a reasonable estimate with a patient prior to surgery. In cases when the surgery is an emergency, the ability to discuss pricing tends to take a back seat in the interest of taking care of the patient. However, elective procedures are another story. Medscape conducted an interesting study¹ earlier in 2012 that primarily focused on physician compensation across a broad spectrum of specialties including primary care. One of the questions asked referred

FIGURE 1



to discussing the cost of treatment with the patient. As shown in figure 1, only 38% of the respondents regularly discussed the cost of treatment with their patients.

The other interesting note is that 46% of the respondents discuss the cost of treatment if the patient brings it up. The second point is interesting only because of an important driver of the HDHPs was to get the patient actively involved in containing the cost of care. For anesthesia, this is tricky since the relationship with the patient is brief. The ultimate goal for anesthesia is to develop and nurture the relationship with the various facilities to assist in taking advantage of patient payment programs that those facilities might be involved with such as healthcare credit cards or health care loans. This will not apply in all cases. Groups may need to consider other strategies.

Outpatient Surgery magazine online published an informative article earlier this year about the financing of surgeries.² In it, the author described the various financing options to include the use of healthcare credit cards, healthcare loans, and shared risk approach. These approaches seemed to be more appropriate for ambulatory surgery centers than for hospitals. The author walks through the basics of how to accomplish this and then provides some live examples of the positive impact to the centers.

In further research on these options, creditcards.com³ walks through some of the companies who are offering the credit card options including the use of debit cards in health savings accounts, which are used as part of the HDHPs. There is some concern about patients using revolving credit to pay for procedures. The author spent some time researching the various options; as summarized in Table 1 on the next page.

¹ <http://www.medscape.com/features/slideshow/compensation/2012/public?src=ptalk&viewnow>

² Paige, Leigh, Contributing Editor, Let Patients Finance Their Surgeries, *Outpatient Surgery Magazine* Online, January 2012

³ Prater, Connie, Health care credit cards rise to fill insurance gap, <http://www.creditcards.com/credit-card-news/medical-bill-payment-options-credit-1271.php>, September 3, 2012

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TABLE 1

Credit issuer (type)	Treatment covered	Terms, restrictions	Interest rate	Credit limit, fees
 CareCredit from GE Money (credit card)	Dental, vision, cosmetic, hearing, veterinary from approved provider list	3 to 18 months with 3 percent minimum payment each month or fixed rate installment loan for up to 60 months; only accepted by GE Money medical providers	Zero percent if paid in full at end of term or 11.9 percent for fixed rate installment plan	Credit limit: \$4,000 average Late fee: \$15 to \$39
ChaseHealthAdvance (installment loan)	Dental, orthodontic, vision, cosmetic, hair restoration from approved provider list	3, 6, 12, 18 or 24 months; fixed rate installment loans for patients with good and excellent credit	Zero percent to 11.99 percent	Credit limit: \$5,000 to \$20,000
 Citi Health Card (credit card)	Dental, vision, hearing, veterinary from approved provider list	Three different plans: Zero interest for 3 to 18 months; Budget plan for 48 months at 12.96 percent; Regular revolving credit at 21.98 percent variable interest; only accepted by Citi medical providers	Zero percent to 21.98 percent, depending on plan Default APR: 25.98 percent	Credit limit: varies by account Late fee: \$29 to \$35
 Humana Advance Visa Card (credit card)	Any health-related products or services	Zero interest; balances repaid within 6 months from payroll deductions. Must sign up through employer	Zero percent	Credit limit: \$500 to \$5,000 depending on salary Annual fee: \$96 paid by employer and/or employee
 Prepaid Healthcare Card (debit card)	Approved health-related products and services	Available through employers' Health Reimbursement Accounts (HRAs)	Allows employers to give employees tax-free reimbursements of qualified health expenses	Load amounts from \$25 to \$5,000 Fees: \$4.95 per card, plus \$2.95 to reload and \$12.95 to replace lost or stolen cards
 Wells Fargo Visa (debit card)	Anywhere Visa debit cards are accepted	Available only to employees enrolled in high-deductible health insurance plans using health savings accounts (HSAs)	Employees use their own money or contributions from employers; HSA earns tax-deferred interest	Credit limit: Based on account balance Maintenance fee: \$4.25/month for individual accounts

There is another option called AccessOne Medcard (<http://accessonemedcard.com/index.aspx#2>). As with any of the options presented above, research is a key to better understand these approaches. Again, staying engaged will help groups to explore these options to capture patient liabilities early on in the billing process.

Groups with a robust chronic pain practice may want to look into these approaches. Any one of these approaches may provide a more regular stream of cash flow for the practice. As stated earlier, it is important to do the homework to understand the impact to the patient especially considering this is a more retail environment.

While these are certainly laudable approaches to collecting patient liabilities,

they are not the only approaches. Groups can look to execute a billing holdback strategy, which holds filing claims for a period of time to allow surgeons and facilities to file theirs earlier. The outcome is that the anesthesia groups collect more from the insurance carrier (payor) providing a more positive impact to the bottom line. This approach focuses on the timing of claims submission. It has proven to work well for multiple ABC clients.

The ultimate decision is up to the group. Each strategy has pros and cons. With a little homework and correct set of expectations, a group can make a solid strategic decision for itself.

Be sure to encourage clients with questions to contact Arne! 

Arne Pedersen, MBA, FACMPE, serves as Director of Client Services for ABC. He is a Fellow of the American College of Medical Practice Executives. His distinguished background includes



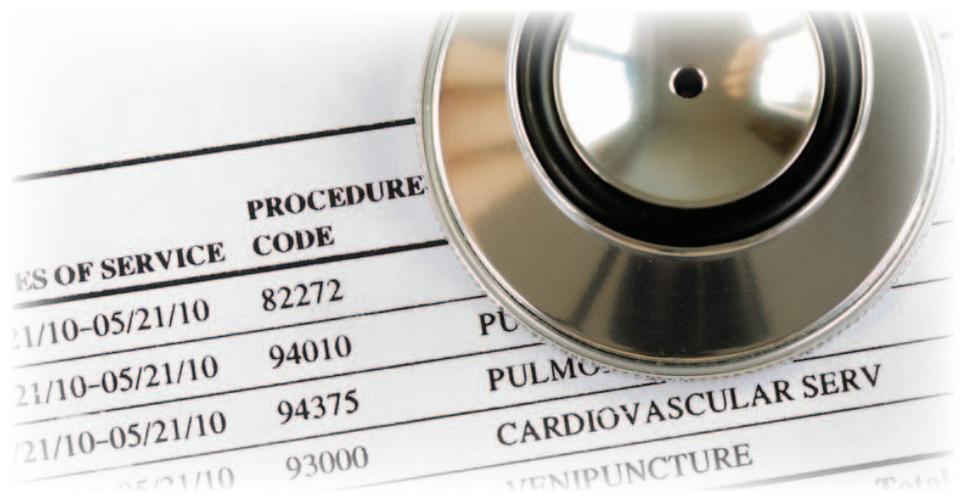
serving as a former Anesthesia Group Administrator, an expert on leadership, and a Bronze Star Medal recipient from the Persian Gulf War. Mr. Pedersen authored the book, "Lead with Intent" a comprehensive, yet practical leadership bible with a vision of training leaders. Mr. Pedersen serves an adjunct professor at the University of Notre Dame in the Executive Education Certificate Program and teaching Performance Management.

CLARIFYING TEE'S CODING AND DOCUMENTATION REQUIREMENTS (CPT 93312-93318)

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Several clients have inquired as to the documentation and correct coding and billing for Transesophageal Echocardiography (TEE) services. A TEE is a special diagnostic tool, which may be used by properly trained physicians (i.e., anesthesiologists, cardiologists) to benefit patient care. A separately reported TEE may be performed for monitoring and/or diagnostic purposes. However, many payers will only reimburse diagnostic studies.

For example, to establish conditions such as myocardial ischemia or cardiac valve disorders, the anesthesiologist will be utilizing the transesophageal echo for diagnostic purposes. In this case, when the anesthesiologist has the additional certification or documented training in residency, and is privileged by the hospital to do the complete procedure, the anesthesiologist can and should bill separately for the TEE in addition to the anesthesia. The correct CPT code for the complete procedure is 93312. When you bill for both the anesthesia and the TEE, the coder must append the modifier 59 (Distinct Procedural Service) to this procedure or the national Correct Coding edits (NCCI) will consider the TEE bundled with the anesthesia – which will result in zero reimbursement for the TEE that the anesthesiologist performed. When the entire diagnostic TEE is performed by the anesthesiologist, it is important to remember that the anesthesiologist must perform and document the probe placement, image acquisition retention and retrieval if requested, and a



written interpretation and report in order to correctly bill for these services.

In cases when the anesthesiologist places the probe and another physician maintains the image acquired and does a written interpretation and report, the placement-only diagnostic TEE code 93313 is used with the 59 modifier. In order for the diagnostic TEE probe placement to be payable, some payers will be requiring the corresponding image acquisition, interpretation and report to be billed by the other physician.

This payer specific requirement is related to CPT coding rules which state, "Report of an echocardiographic study, whether complete or limited, includes an interpretation of all obtained information, documentation of all clinically relevant findings including quantitative measurements obtained, plus a description of any recognized abnormalities. Pertinent images, videotape, and/or digital data

are archived for permanent storage and are available for subsequent review. Use of echocardiography not meeting these criteria is not separately reportable."

However, the anesthesiologist should not be penalized if the other physician does not document or report the work that they do. Therefore, we recommend that when only the probe is placed for a diagnostic procedure the 93313-59 code should be reported and billed.

When a TEE is performed by an anesthesiologist for intraoperative monitoring purposes only, the probe placement may not be billed separately as CPT coding conventions do not allow an option for the placement to be separately billed from the total intraoperative monitoring service. In addition, many payers bundle the entire monitoring TEE code 93318 into the anesthesia services, or consider the monitoring as a non-payable service.

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STATE	STATUTE OR REGULATION	APPLICATION	TIME PERIOD FOR PAYMENT OR DENIAL OF CLAIM	NOTICE PERIOD FOR NON-CLEAN CLAIMS	PENALTY
Arkansas	ACA §20-66-215; 054 00 CARR 043 §12-13.	<ul style="list-style-type: none"> HMOs Hospital medical service corporation Disability insurance companies Self-insured governmental or church plan Third party administrators that administer or adjust disability benefits for a disability insurer 	Upon receipt of a clean claim: <ul style="list-style-type: none"> Written: 45 days Electronic: 30 days Upon receipt of amended claims/supplemental information: 30 days	Upon receipt of a claim: 30 days	12% per annum
California	Cal. Ins. Code §10123.13	Every insurer issuing group or individual policies of health insurance covering hospital, medical or surgical expenses, including those of telemedicine services covered by the insurer	Upon receipt of a claim: 30 working days Upon receipt of additional information: 30 working days	Upon receipt of a claim: 30 working days	10% per annum
	Cal. Health & Saf Code §1371.35 28 CCR 1300.71	Health care service plans	Upon receipt of a complete claim, or portion thereof: <ul style="list-style-type: none"> General: 30 working days HMOs: 45 working days 	Upon receipt of a complete claim: <ul style="list-style-type: none"> General: 30 working days HMOs: 45 working days 	The greater of \$15 per year or interest at a rate of 15% per annum
Colorado	CRS §10-16-106.5	<ul style="list-style-type: none"> Any entity providing health coverage Franchise insurance plan Fraternal benefit society HMO Nonprofit hospital and health service corporation Sickness and accident insurance company 	Upon receipt of a clean claim: <ul style="list-style-type: none"> Electronic: 30 calendar days Submitted by any other means: 45 calendar days Claims requiring amendments/supplemental information: 90 days from the date the claim was received by the insurer	Upon receipt of claim: 30 calendar days	Clean claims: 10% per annum Amended/supplemented claims: 20% of the total amount of the claim
Connecticut	Conn. Gen. Stat. §38a-477 Conn. Gen. Stat. §38a-815	<ul style="list-style-type: none"> Insurers Other entities responsible for providing payment to a healthcare provider pursuant to an insurance policy 	Upon receipt of a claim that is not deficient: 45 days Upon receipt of the deficient information: 30 days from the date the information was received by the insurer	Upon receipt of claim: 30 days	15% per annum
Delaware	CDR 18-1300-1310	Any entity that provides health insurance in Delaware, includes: <ul style="list-style-type: none"> Health insurance company Health service corporation HMO Entity providing a plan of health insurance or health benefits Third party administrator Entity that adjust, administers or settles claims in connection with health benefit plans 	Upon receipt of a clean claim: 30 days Upon receipt of additional information: 15 days	Upon receipt of claim: 30 days	The maximum rate allowable to lenders under Delaware law
	19 Del. C. §2322F	Employer or insurance carrier.	Upon receipt of a clean claim: 30 days	Non-preauthorized claims must be referred to the utilization review within 15 days	1% per month for non-preauthorized claims Violation of this law could result between a \$1000-\$5000 fine

STATE	STATUTE OR REGULATION	APPLICATION	TIME PERIOD FOR PAYMENT OR DENIAL OF CLAIM	NOTICE PERIOD FOR NON-CLEAN CLAIMS	PENALTY
District of Columbia	DC Code §31-3132	Any person that provides one or more health benefit plans or insurance in DC, including a/an: <ul style="list-style-type: none"> • Insurer • Hospital and medical services corporation • Fraternal benefits society • HMO • Multiple employer welfare arrangement • Any other person providing a plan of health insurance subject to the authority of the Insurance Commissioner 	Upon receipt of a clean claim: 30 days Upon receipt of additional information: 30 days	Upon receipt of claim: 30 days	<ul style="list-style-type: none"> • Days 31-60 = 1.5% interest • Days 61-120 = 2% interest • Days beyond 120 = 2.5% interest
Florida	Fla. Stat. §627.613 Fla. Stat. §627.622	Out-of-State Providers and Policyholders Types of Insurance: <ul style="list-style-type: none"> • Hospital and medical expense incurred policy • Minimum premium plan • Stop-loss coverage • HMO • Prepaid health clinic contract • Multiple-employer welfare arrangement contract • Fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract 	Upon receipt of a claim: 45 days Upon receipt of additional information: 60 days All claims must be paid or denied within 120 days of receipt of the claim	Upon receipt of a claim: 45 days	10% per year
	Fla. Stat. §627.6131 Fla. Stat. §641.3155 Fla. Stat. §627.622	In State Providers and Policyholders Types of Insurance: <ul style="list-style-type: none"> • Hospital and medical expense incurred policy • Minimum premium plan • Stop-loss coverage • HMO • Prepaid health clinic contract • Multiple-employer welfare arrangement contract • Fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract 	Upon receipt of a claim: <ul style="list-style-type: none"> • Electronic: 20 days • Non-Electronic: 40 days Upon receipt of supplemental information <ul style="list-style-type: none"> • Electronic: 90 days • Non-Electronic: 120 days All claims must be paid or denied within 120 (electronic) or 140 (non-electronic) days of receipt of the claim	Upon receipt of a claim: <ul style="list-style-type: none"> • Electronic: 20 days • Non-Electronic: 40 days 	12% per year

A SURVEY OF STATE PROMPT PAY LAWS, PART I

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STATE	STATUTE OR REGULATION	APPLICATION	TIME PERIOD FOR PAYMENT OR DENIAL OF CLAIM	NOTICE PERIOD FOR NON-CLEAN CLAIMS	PENALTY
Georgia	OCGA §33-25-59.14	<ul style="list-style-type: none"> Accident and sickness insurer Fraternal benefit society Nonprofit hospital service corporation Nonprofit medical service corporation Healthcare corporation HMO Provider sponsored healthcare corporation Any similar entity providing for the financial or delivery of health care services through a health benefit plan, the plan administrator of any health plan or the plan administrator of any health benefit plan 	<p>Upon receipt of a clean claim:</p> <ul style="list-style-type: none"> Electronic: 15 working days Paper: 30 calendar days <p>Upon receipt of additional information:</p> <ul style="list-style-type: none"> Electronic: 15 working days Paper: 30 calendar days 	<ul style="list-style-type: none"> Electronic: 15 working days Paper: 30 calendar days 	12% per annum
Hawaii	HRS §431:13-108	<ul style="list-style-type: none"> Accident and health or sickness insurance providers Mutual benefit societies Dental service corporations HMOs 	<p>Upon receipt of a clean claim:</p> <ul style="list-style-type: none"> Electronic: 15 calendar days Paper: 30 calendar days <p>Upon receipt of additional information:</p> <ul style="list-style-type: none"> Electronic: 15 calendar days Paper: 30 calendar days 	<p>Upon receipt of a claim:</p> <ul style="list-style-type: none"> Electronic: 7 calendar days Paper: 15 calendar days 	15% per annum
Idaho	Idaho Code §41-5602	<ul style="list-style-type: none"> An insurer that sells hospital, medical, long-term care, or vision insurance policies or certificates Managed care organizations Third party administrators 	<p>If the claim is submitted within 30 days of the date of service: 30 days</p> <p>If the claim is submitted within 45 days of the date of service: 45 days</p> <p>If the provider or facility submits supplemental information within 30 days of receipt of the notice: 30 days</p>	<p>Upon receipt of a claim:</p> <ul style="list-style-type: none"> Electronic: 30 days Paper: 45 days 	12% per year
Illinois	215 ILCS 5/368a	<ul style="list-style-type: none"> HMOs Managed care plans Healthcare plans Preferred provider organizations Third party administrators Independent practice associations Physician-hospital organizations 	<p>Periodic Payments: within 60 days after the healthcare professional or healthcare facility has been selected or the effective date of the selection, whichever is later, and according to the periodic monthly cycle thereafter</p> <p>Non-Periodic Payments: 30 days after receipt of written proof of loss</p>	<p>Upon receipt of a proof of loss: 30 days</p>	9% per year
Indiana	Ind. Code Ann. §27-8-5.7-5	Insurance company that issues accident and sickness insurance policies, including a preferred provider plan, and an insurance administrator that collects or charges premiums and adjusts or settles claims	<p>Upon receipt of, or establishing, a clean claim:</p> <ul style="list-style-type: none"> Electronic: 30 days Paper: 45 days 	<p>Upon receipt of a clean claim:</p> <ul style="list-style-type: none"> Electronic: 30 days Paper: 45 days 	Statutory interest rate pursuant to <i>Ind. Code 12-15-21-3(7)(A)</i> (formulaic)

STATE	STATUTE OR REGULATION	APPLICATION	TIME PERIOD FOR PAYMENT OR DENIAL OF CLAIM	NOTICE PERIOD FOR NON-CLEAN CLAIMS	PENALTY
Iowa	Iowa Code §507B.4A 191 IAC §15.32	<ul style="list-style-type: none"> • Insurers providing accident and sickness insurance • HMOs • Organized delivery systems • Any other entity providing health insurance or health benefits 	Upon receipt of a clean claim or properly completed billing instrument: 30 days	N/A	10% per annum
Kansas	KSA §40-2441	<ul style="list-style-type: none"> • Any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident, or both • Any hospital, dental or medical expense policy • Health, hospital, medical service corporation contract issued by a stock or mutual company or association • HMO or any other insurer • Third party administrator • Any other entity that pays claims pursuant to a policy of accident and sickness insurance 	<p>Upon receipt of a clean claim: 30 days</p> <p>Upon receipt of supplemental information: 15 days</p>	N/A	1% per month
Kentucky	KRS §304.17A-702 806 KAR §17:310	<ul style="list-style-type: none"> • Any insurance company • HMO • Self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA • Provider-sponsored integrated health delivery network • Self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky 	<p>Upon receipt of a clean claim: 30 days</p> <p>Upon receipt of a clean claim involving organ transplant: 60 days</p>	<p>Upon receipt of a claim:</p> <ul style="list-style-type: none"> • Electronic: 48 hours • Nonelectronic: 20 calendar days 	<ul style="list-style-type: none"> • For claims 1-30 days overdue: 12% per annum • For claims 31-60 days overdue: 18% per annum • For claims over 60 days overdue: 21% per annum
Louisiana	La. R.S. §22:1831 <i>et seq.</i> LAC §37:XIII.6001 <i>et seq.</i>	Any entity that offers health insurance coverage through a policy, contract or certificate of insurance, including HMOs	<p>Upon receipt of a clean claim:</p> <ul style="list-style-type: none"> • Non-electronic, participating provider, claim submitted within 45 days of the date of service or date of discharge: 45 days • Non-electronic, participating provider, claim submitted more than 45 days of the date of service or date of discharge: 60 days • Non-electronic, non-participating provider: 45 days • Electronic: 25 days 	Upon receipt of an electronic claim: 5 days	12% per annum

A SURVEY OF STATE PROMPT PAY LAWS, PART I

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STATE	STATUTE OR REGULATION	APPLICATION	TIME PERIOD FOR PAYMENT OR DENIAL OF CLAIM	NOTICE PERIOD FOR NON-CLEAN CLAIMS	PENALTY
Maine	45-A MRS §2436	Claims submitted under a policy or certificate of insurance delivered or issued for delivery in Maine	Upon receipt of an undisputed claim: 30 days Upon receipt of supplemental information in connection with a disputed claim: 30 days	Upon receipt of a claim: 30 days	1.5% per month
Maryland	Md. Ins. Code §15-1005	<ul style="list-style-type: none"> • Insurers • Nonprofit health service plans • HMOs 	Upon receipt of a clean claim or any undisputed portion of a claim: 30 days Upon receipt of supplemental information in connection with a disputed claim: 30 days	Upon receipt of a claim: 30 days	<ul style="list-style-type: none"> • Days 31-60: 1.5% • Days 61-120: 2% • Days 121 and beyond: 2.5%
Massachusetts	ALM GL ch. 176G, §6	HMOs	Upon receipt of a claim: 45 days	Upon receipt of a claim: 45 days	1.5% per month, not to exceed 18% per year
Michigan	MCL §500.2006	<ul style="list-style-type: none"> • An insurer providing benefits under an expense-incurred hospital, medical, surgical, vision, or dental policy or certificate, including any policy or certificate that provides coverage for specific diseases or accidents only, or any hospital indemnity, Medicare supplement, long-term care, or 1-time limited duration policy or certificate, but not to payments made to an administrative services only or cost-plus arrangement. • A MEWA regulated under chapter 70 that provides hospital, medical, surgical, vision, dental, and sick care benefits. • A health maintenance organization licensed or issued a certificate of authority in this state. • A health care corporation for benefits provided under a certificate issued under the nonprofit health care corporation reform act, but not to payments made pursuant to an administrative services only or cost-plus arrangement. 	Upon receipt of a clean claim: 45 days Upon receipt of supplemental information in connection with a defective claim: 45 days minus the number of days until the healthcare provider received notice of the claim's defects	Upon receipt of a claim: 45 days	12% per annum

STATE	STATUTE OR REGULATION	APPLICATION	TIME PERIOD FOR PAYMENT OR DENIAL OF CLAIM	NOTICE PERIOD FOR NON-CLEAN CLAIMS	PENALTY
Minnesota	Minn. Stat. §62Q.75	<ul style="list-style-type: none"> • HMOs • Community integrated service networks • Preferred provider organizations • Licensed insurance companies • Nonprofit health service corporations • Fraternal benefit plans • Any other entity that establishes, operates or maintains a health benefit plan or network of healthcare providers where the providers have entered into a contract with the entity to provide healthcare services 	Upon receipt of a clean claim: 30 calendar days	N/A	1.5% per month
Mississippi	Miss. Code. Ann. §83-9-5	Accident and health insurers	Upon receipt of a clean claim: <ul style="list-style-type: none"> • Electronic: 25 days • Paper: 35 days Upon receipt of supplemental information: 20 days	Upon receipt of a clean claim: <ul style="list-style-type: none"> • Electronic: 25 days • Paper: 35 days 	1.5% per month
Missouri	R.S. Mo. §376.383	<ul style="list-style-type: none"> • Any entity subject to the Missouri insurance laws • Self-insured plans allowed by federal law • Third party contractors 	Upon receipt of a clean claim: 30 processing days Upon receipt of supplemental information pursuant to the first request: 10 processing days Upon receipt of supplemental information pursuant to the second request: 5 processing days	Upon receipt of a claim: 30 processing days Upon receipt of supplemental information pursuant to the first request: 10 processing days	1% interest per month 1% penalty per day



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CLARIFYING TEE'S CODING AND DOCUMENTATION REQUIREMENTS (CPT 93312-93318)

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As with all documentation, it is important that the anesthesiologist clearly document in the record whether the study is for diagnostic or monitoring purposes. TEE studies for monitoring billed as diagnostic, or diagnostic TEE studies without the necessary written report and pertinent images, would not withstand the scrutiny of an audit.

This code is used when the patient's condition, as described under 93312, requires *repetitive evaluation* of cardiac function in order to guide ongoing management. CPT code 93318 is unique in that no permanent images are created.

USE OF MODIFIERS

As discussed earlier, if the TEE is performed for diagnostic purposes by the same anesthesiologist who is providing anesthesia for a separate procedure, modifier 59 should be appended to the TEE code to note that it is distinct and independent from the anesthesia service. If the anesthesiologist does not own the TEE equipment, she/he reports only the professional component of the TEE service and should append modifier 26 (Professional Component) to the TEE code, along with modifier 59. ▲

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in third-party reimbursement, coding and compliance issues, Ms. Derricks works to ensure client operations are both productive and profitable. She is a long-standing member of MGMA, HCCA, AAPC and other associations. She is also a sought-after nationally-acclaimed speaker, having presented at AHIMA, Ingenix, MGMA and HCCA national conferences. You can reach her at Joette.Derricks@AnesthesiaLLC.com.

USE OF TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) CPT CODES

93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation, and report
	This service involves placement of the transesophageal probe, obtaining the appropriate images and views and critical analysis of the data. Patients with increased risks of hemodynamic disturbances may require probe insertion and interpretation of the echocardiogram. This includes, but is not limited to, histories of congestive heart failure, severe ischemic heart disease, valvular disease, aortic aneurysm, major trauma and burns. It may also be indicated in certain procedures that involve great shifts in the patient's volume status. Such procedures may include vascular surgery, cardiac surgery, liver resection/transplantation, extensive tumor resections and radical orthopedic surgery. The use of TEE may also be indicated when central venous access is contraindicated or difficult and it is not possible to adequately assess blood loss and replacement, impairment of venous return, right and left heart function without the TEE.
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
	Although the procedure is generally safe, the proper insertion of the probe requires skill and judgment. There are a few inherent risks to placement of the probe, including pharyngeal and/or laryngeal trauma, dental injuries, esophageal trauma, bleeding, arrhythmias, respiratory distress and hemodynamic effects.
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
	This code is used when one physician inserts the probe and another physician interprets the images. Physicians who obtain and retain the images and provide a written interpretation but who did not place the TEE probe should use this code to report their service.
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
	This service involves placement of the transesophageal probe, obtaining the appropriate images and views, and critical analysis of the data in patients with congenital cardiac anomalies. This includes, but is not limited to, congenital valve problems, such as bicuspid aortic valve, septal defects, including patent foramen ovale, and more complicated congenital heart defects. Patients undergoing both cardiac and complicated non-cardiac surgery would benefit from the use of TEE to evaluate anticipated and unanticipated hemodynamic disturbances and the patient's response to therapy. This includes, but is not limited to, all the indications listed for code 93312, but in patients with congenital cardiac anomalies.
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
	Although the procedure is generally safe, probe insertion in patients with congenital cardiac anomalies requires skill and judgment. There are a few inherent risks to placement of the probe, including pharyngeal and/or laryngeal trauma, dental injuries, esophageal trauma, bleeding, arrhythmias, respiratory distress and hemodynamic effects. There have even been some case reports of perioperative death attributed to TEE probe placement.
99317	Transesophageal echocardiography for congenital cardiac anomalies; acquisition, interpretation and report only
	This code is used when one physician inserts the probe and another physician interprets the images in patients with congenital cardiac anomalies. Physicians who obtain and interpret cardiac images and provide a report but who did not place the TEE probe should use this code to report their service.
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis.
	In contrast to the traditional echocardiography examination which focuses on a description of anatomic structure and cardiac function under more or less stable conditions at one point in time, the use of TEE for dynamic monitoring of cardiac function is not intended to provide specific anatomic details, pathological diagnosis, or assessment of the efficacy of the surgical correction (e.g., anatomic and functional integrity of a prosthetic cardiac valve). The code differs from the other TEE procedures in that it is solely for monitoring purposes to allow the physician to make immediate decisions at the point of care intra-operatively.

ANESTHESIA QUALITY DATABASES

Jody Locke, CPC

Vice President of Anesthesia and Pain Management Services, ABC

The focus on quality outcomes in health-care has been long in coming. As the cost of health care continues to rise faster than the cost of living, the nation finds itself facing a dilemma. Perhaps a free market approach to healthcare is not the best approach after all. Economic incentives and ground breaking research have clearly provided significant advances in some areas, but what has been their impact on cost? As diverse and independent as the specialty of anesthesiology is, its practitioners have challenged the leadership to take the lead in finding ways to provide quality care more consistently so that anesthesia is not a contributor to the cost of healthcare but a regulator of spending.

While virtually all anesthesiologists and CRNAs have now become familiar with the current requirements of the Physician Quality Reporting System (PQRS), this is just one example of a public approach to ensuring consistency based on process rather than outcomes. As a rule, anesthesia practices have access to more and better data about what actually happens in operating rooms and delivery suites than any other single agent or source in a hospital. Deciding how to mine it from an outcomes perspective and how to apply the lessons learned is the question of the day. While the discussion may appear arcane and abstract to practitioners in the field, the fact is, the stakes are significant. For many, what is at stake is the independence and autonomy of the specialty: better to set standards for ourselves than to have them defined by others.

While CMS took the lead in capturing some rudimentary quality indicators, the Medicare requirement to report the pre-surgical administration of prophylactic antibiotics, active temperature management and the use of sterile techniques for placement of central venous catheters actually just represents the most obvious manifestation of what is becoming a proliferation of private quality initiatives. The process really started to take shape with the activities of the anesthesia subspecialties. The best known of these was undertaken by the



Society for Ambulatory Anesthesia (SAMBA) which has been working on a list of clinical indicators and an outcomes database for many years now. The SAMBA Clinical Outcomes Registry (SCOR) currently includes indicators for about 10,000 patients.

While other subspecialty societies are also focused on the formulation of a list of indicators and a database specifically relevant to their areas of focus, two organizations have taken the lead in the development of a national, specialty-wide approach to quality and outcomes data capture.

- The Anesthesia Business Group (ABG) represents 12 of the nation's largest private anesthesia groups, which have been meeting four times a year to address issues of interest and special concern to the nation's largest anesthesia practices, the so-called mega groups such as North American Partners in Anesthesia (NAPA) and Greater Houston Anesthesiology (GHA). Their membership is geographically diverse and especially significant with regard to volume of cases performed and variety of venues served. In 2002 the ABG established the ABG Anesthesia Data Safety Group, LLC (ADSG), which was intended to provide a vehicle and support for its efforts to capture clinical outcomes data from its member groups. As of June 2011 the participants had collected over 2 million

clinical records and corresponding administrative data. Information about the Anesthesia Business group and its activities can be obtained via its website at www.Anesthesiabusinessgroup.com.

- The other organization that is forging a path in this arena is the American Society of Anesthesiologists (ASA). As the national specialty organization for anesthesiologists, the ASA brings its own clout and credibility to the challenges of defining a meaningful list of clinical indicators and capturing member data. The ASA's quality Institute (AQI) efforts are being led by Richard P. Dutton, M.D. M.B.A. who is responsible for the development of the National Anesthesia Clinical Outcomes Registry (NACOR). The stated goals of the registry and its database are specifically relevant to all the strategic challenges facing today's anesthesia practices: personal benchmarking, quality reporting, hospital credentialing, maintenance of licensure, maintenance of certification and clinical research. Dr. Dutton has written several articles for previous issues of the Communique (most recently, the Summer 2012 issue) describing AQI, NACOR and AIRS (Anesthesia Incident Reporting System) developments. While the data base is still in a state of evolution, subscription is growing, as is the number of ABC client practices that are participating. Questions about the AQI can be addressed via its website at www.aqihq.org.

Having access to data, however, is a mixed blessing; the opportunity to mine all the demographic and physiological data about all the surgeries that are performed in the country is huge but so are the challenges; the diversity of forms and systems is almost unfathomable. What to extract, how to validate it and where to store it and how to package the results so that the specialty can continue to improve

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ANESTHESIA QUALITY DATABASES

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quality, consistency and surgical outcomes requires focus, commitment, and leadership. Historically anesthesia practice management has tended to focus more on revenue opportunities and compliance risk reduction rather than cost savings; and so this new focus on outcomes requires some serious rethinking of budgetary priorities. The return on investment is not quite so clear or compelling, but as recent developments continue to highlight, no less necessary. The immediate focus of CMS policy is the automation of clinical record keeping and meaningful use but this is not just a governmental initiative. Defining pay for performance criteria is clearly the issue of the day.

In the meantime, both the ASA and the ABG are inviting all anesthesia practices to support their efforts by contributing data. Which is the best vehicle, given the ultimate objective of being able to bench mark practices and identify common risks and challenges? It probably does not matter (except for ABC clients, for whom arranging to participate in AQI-NACOR involves no changes in the data or formats sent to us). Since the objectives of both organizations are the same it would appear inevitable that they will come together and work in a unified or, at least, a coordinated manner.

Security and the integrity of clinical details is an issue, to be sure. If a practice shares information about reportable events and these are shown to be outliers what might the consequences be? Attachments are a serious issue. No alternative is without some risk. This is why the ABG and the ASA made it such a priority to be certified by the Anesthesia Patient Safety Foundation but this is only the beginning. As the development of national anesthesia quality databases progresses, special attention will have to be given to ensuring the protection and privacy of each practice's contributions. Important precedents were established with the implementation of the Health Insurance Portability and Protection Act (HIPPA) in 1996 for the protection of individually identifiable health care information. If the intent of quality indicators is to identify and prosecute individual providers it will never succeed. The goal must be a feedback loop of quality trends for the advancement of all.

Self-reporting is another challenge. What is to motivate providers to report honestly? Legal precedent has been so punitive in this area. This is where the leadership of the practice must take a stand and reframe the issues. Anesthesiology has a long history of independence and autonomy. Its practitioners believe that the consistent quality of care they provide is a function of good training, timely and reliable monitoring data and the sound judgment that comes from years of practical experience. Why should they think more data or other people's input would make it better? While not wrong, there is one piece most providers don't consider and that is how the customer views the services they provide. The time has come to demonstrate just why and how anesthesia morbidity and mortality have fallen so dramatically in the past few decades.

The database will eventually contain both basic demographic data about the population of patients who undergo anesthesia across the country and the kinds of complications they may experience under anesthesia. Participation does not require the practice to have an Anesthesia Information Management System (AIMS). Encouraging participation has become a priority of the ASA, which has supported its development.

The ABG began collecting data from its member groups but is now encouraging other non-member practices to contribute. Like the AQI, it has paid staff who are dedicated to data evaluation and statistical analysis. The organization has dedicated considerable time and resources to ensuring the accuracy and reliability of all its data elements.

Recognizing that quality reporting is the next wave of anesthesia practice management all of the nation's billing companies are looking at ways to serve as a vehicle for their clients to participate. ABC has made this a special priority. Ultimately, the nation's billing industry will no doubt play an invaluable role in resolving many of the technical and logistical questions that practices will have about what data elements to track and how to capture them. These efforts will give all practices that outsource their billing a tactical advantage

with regard to these national clinical initiatives but it is certainly not to say that those which chose to do their billing themselves cannot find other ways to participate.

In other words, concerns about how to capture data can be readily addressed by a variety of options currently available to all groups. The real question each practice must come to terms with is their appreciation of what is at stake here. This is one of those longer term strategic questions, the kind that has more to do with how members see the role of their specialty in the future and what they are prepared to do to redefine their practice value proposition.

Change is never easy and the requirement that individual anesthesia providers start sharing more details about the care they provide is being viewed in many quarters with great concern and no small amount of skepticism; the Orwellian overtones of such initiatives can often lead to considerable paranoia, especially among those not willing to change the way they practice. As is so often the case, in anesthesiology the real challenge may have less to do with contributing data and more to do with convincing partners that the business of healthcare really has changed the specialty that much. To those who think effective anesthesia practice management is just about effective billing and accounts receivable management, welcome to a future in which you must be able to sell your services to get paid for your services. ▲

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



CLIENT ALERT

VIEWING THE RECENT OIG COMPANY MODEL ADVISORY OPINION FOR WHAT IT TRULY IS: MEANINGFUL GUIDANCE THAT MUST BE INCORPORATED INTO THESE ARRANGEMENTS (BUT CERTAINLY NOT THE DEATH KNELL TO ALL COMPANY MODELS ACROSS THE COUNTRY)

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On June 1, 2012, the Department of Health and Human Services Office of Inspector General (the “OIG”) issued its Advisory Opinion No. 12-06, which provides long-awaited guidance to the health care industry regarding the legal permissibility of an anesthesia delivery service model commonly referred to as the “company model.” Insofar as Advisory Opinion No. 12-06 is the initial OIG guidance that specifically focuses on such an arrangement and determines that the factual paradigms presented implicate risks under the Medicare and Medicaid Antikickback Statute (the “AKS”), this Advisory Opinion understandably is capturing broad attention within the medical and legal communities. While OIG Advisory Opinion 12-06 clarifies the almost-axiomatic observation that company model arrangements, especially those that contain the indicia that the OIG historically has identified as problematic under the AKS, certainly have the potential to violate the AKS, the legal permissibility of each company model arrangement should continue to be analyzed based upon each arrangement’s unique facts and circumstances. Stated otherwise, OIG Advisory Opinion 12-06 should not be interpreted to mean that all company model frameworks necessarily are violative of the AKS; rather, the Advisory Opinion reinforces the consistent guidance provided by The Health Law Partners that these arrangements need to incorporate the requisite structural safeguards.



BROAD OVERVIEW OF COMPANY MODEL ARRANGEMENTS AND RELATED CONTROVERSY

A significant percentage of ASC procedures involve anesthesia services provided by an anesthesiologist or a certified registered nurse anesthetist (“CRNA”). Due to changes within the health care environment, including, in particular, contraction to reimbursement and an increased emphasis on quality and efficiency of patient care, an increasing number of ASCs around the country have transformed their relationships with the anesthesia providers from the normative arrangement (under which an independent anesthesia group bills fee-for-service for the anesthesia services that it furnishes at the ASC) to “company model” arrangement. Although there are a number of permutations of the structure, the company model generally involves the ASC or some or all of its physician owners (hereafter, in either case, the “ASC Physician Members”) establishing a separate legal entity that will provide anesthesia services

to the ASC by employing or contracting with anesthesia providers (the “New Company”). The New Company separately bills for the anesthesia services and then pays the anesthesia providers an agreed-upon rate (or contractual compensation in the case of employed anesthesiologists). As a result, the ASC Physician Members capture a portion of the anesthesia revenue generated from procedures furnished at the ASC (which, under the traditional paradigm, had been exclusively realized by the anesthesiologists).

The company model debate has prompted vigorous discussion within the health care bar. The legal dialogue, in particular, focuses upon the application of the AKS to the company model structure. In pertinent part, the AKS prohibits anyone from knowingly and willfully soliciting, receiving, offering or paying remuneration, in cash or in kind, to induce or in return for referrals of items or services payable by any federal health care program. Liability is imposed upon both parties to an impermissible transaction. The AKS has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for referral of services or to induce further referrals, even if other salutary purposes exist. Violation of the AKS constitutes a felony punishable by a maximum fine of \$25,000, imprisonment up to five years or both. Conviction will also lead to automatic exclusion from federal health

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VIEWING THE RECENT OIG COMPANY MODEL ADVISORY OPINION

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care programs, including Medicare and Medicaid and may result in the imposition of civil monetary penalties.

In the company model context, the profit that the ASC Physician Members derive from the anesthesia revenue at the ASC, in an improperly structured arrangement, potentially represents impermissible remuneration in the AKS context. In its most basic terms, the issue is whether, in substance, the ASC Physician Members are “converting their referral stream into a revenue stream.” The theory is that the anesthesiologists would essentially be required to forego the anesthesia profit (in favor of the New Company) in exchange for the ability to provide (or, in the case of a then-current anesthesia provider, continue providing) anesthesia services at the ASC, and the ASC Physician Members would earn such profit, based in part, upon their referrals of such services to the anesthesiologists. As discussed below, the fact that the company model affords the ASC Physician Members the ability to capture anesthesia revenue, by itself, does not violate AKS insofar as the determinative element of any AKS violation is impermissible intent. Further, the Federal government is particularly concerned with arrangements that have the ability to negatively affect patient care and/or to result in overutilization. OIG Advisory Opinion No. 12-06 states “[t]he anti-kickback statute seeks to ensure that referrals will be based on sound medical judgment, and that health care professionals will compete for business based on quality and convenience, instead of paying for referrals.” Any AKS analysis requires consideration of the aggregate facts and circumstances in light of available Federal guidance.

In our view, OIG Advisory Opinion No. 12-06 should be seen as corroborative of the AKS principles that the OIG has articulated in prior guidance. Thus, there is no unique company model

jurisprudence. Rather, to the extent that a company model arrangement contains the suspect indicia that the OIG has consistently identified, then such an arrangement will assume a higher level on the risk spectrum, whereas, by contrast, company models that both demonstrate a clearer nexus between the ASC Physician Members and New Company’s business (especially in the form of active participation, particularly focused towards the elevation of clinical care), and which avoid correlations between distributions to the ASC Physician Members and their referrals, the risks will be comparatively lower.

RECENT OIG ADVISORY OPINION No. 12-06 AND HLP COMMENTS

In OIG Advisory Opinion No. 12-06, the OIG reviewed two proposals (i.e., Proposal A and B) (the “Proposed Arrangements”) for modifying the relationship between certain ASCs and their exclusive provider of anesthesia services (the “Requestor”) and determined that both of the Proposed Arrangements could potentially violate AKS and result in administrative sanctions.

At the outset, we note that Proposal A itself is not truly a “company model” arrangement. Proposal A involved the Requestor continuing to serve as the exclusive provider of anesthesia services and to bill and retain collections for its services, subject, however, to the requirement that it would pay the ASCs a per-patient fee for certain “management services” with respect to non-federal health care program patients. The OIG clarified that the proposed “carve out” of federal health care program patients does not insulate the otherwise-defective structure from AKS scrutiny. The Federal government would view the relationship between the Requestor and the ASCs (which also included the provision of services to federal health care program

patients) as a whole. The OIG noted that the ASCs were already essentially paid for such management services through the facility fee that the ASCs receive from Medicare and therefore, under Proposal A, the ASCs would be paid twice for the same services. Further, such management fee would have the potential to inappropriately dictate which anesthesia provider was selected by the ASC. The OIG’s disapproval of Proposal A reaffirms the position that HLP has consistently taken that conditioning a provider’s (e.g., an anesthesiologist’s) right to perform services upon entry into a contractual arrangement with a group of physicians who potentially control the referrals to such provider (e.g., ASC Physician Members) can implicate substantial regulatory risks.

In contrast to Proposal A described above, Proposal B represents a more normative variant of company model arrangement (albeit one against which we have counseled). Under Proposal B, the ASC Physician Members would indirectly (through their professional entities or the ASC itself) own a new subsidiary entity (the “Subsidiary”). The Subsidiary would engage the Requestor as an independent contractor to provide a broad (i.e., substantially the full spectrum of required) anesthesia-related administrative services through the new Subsidiary entity in return for a negotiated fee. Further, the Subsidiary would employ anesthesia providers (some or all of whom would be affiliated with Requestor) or contract with the Requestor’s anesthesia providers on a contractor basis. The Subsidiary would furnish and bill for all anesthesia services provided at the ASC and pay the anesthesia providers agreed-upon compensation. Simply stated, insofar as the ASC Physician Members would indirectly own the Subsidiary, there would be a correlation between the number of procedures performed at the ASC that require anesthesia and the

profit distributions to the ASC Physician Members from the Subsidiary. (It should be noted, in the context of this discussion, that such correlation between referrals and profit distributions exists in legally permissible in-office ancillary service arrangements, even among single specialty group practices.) Among other factors, the OIG also found it significant that the ASC physicians would not be involved in the operations of the Subsidiary and that substantially all of the operations would be contracted out to Requestor. Further, it is noteworthy that the anesthesia services would be provided by the same provider that historically furnished the anesthesia services before entry into the company model arrangement. Relying heavily upon its previously issued joint venture guidance, the OIG concluded that Proposal B would pose “more than a minimal risk of fraud and abuse.”

The OIG’s conclusions with respect to Proposal B are consistent with the advice that HLP has previously provided: if a company model arrangement (such as Proposal B) is implemented (or appears to be implemented) to convert referrals (by ASC physicians to anesthesiologists) to a revenue stream and to incentivize overutilization and undue influence over choice of anesthesia provider, such company model involves a high level of risk and is likely impermissible. Factors that increase the risk of inappropriate utilization through the ordering of unnecessary procedures and anesthesiology services to generate revenue have the ability to increase costs to the federal health care programs, interfere with clinical decision-making and raise patient safety or quality of care concerns. By contrast, if a company model arrangement is organized and operated for legally permissible goals (i.e., improving quality and efficiency of care), the ASC Physician Members participate actively in the business’ conduct, and the profit distribution mechanism does not bear a connection between distributions and the ability to generate procedures, its legal risk is significantly mitigated and the

arrangement is in a far better position to be defensible, especially if all the requisite structural safeguards are included.

CONCLUSION

OIG Advisory Opinion No. 12-06 reminds us that company model arrangements must include meaningful safeguards to mitigate legal risk and to be defensible from an AKS perspective. That being said, the value of such safeguards depends upon the manner in which they are implemented and the actual intent that underlies their inclusion.

Any company model arrangement must be structured, and most importantly, actually implemented, in a good faith manner and involve circumstances that reflect good intent, such as improving quality, efficiency and coordination of care or other permissible purposes. Meaningful efforts to coordinate care through increased integration and alignment among providers is a favorable factor. Employment of the anesthesiologists and CRNA’s by the new ASC or physician owned anesthesia entity would promote such a nexus. Further, if the objective of the new entity is genuinely to improve quality and efficiency, all the physician owners should be meaningfully engaged in the operations of the Company, especially with regard to the development and continuous refinement to policies and protocols (e.g., “best practices”) designed to enhance the quality and efficiency of services furnished at the ASC.

We also take the opportunity to emphasize that distributions from the new company under a company model arrangement to the physician owners (directly or indirectly) should be made in accordance with such physicians’ respective ownership interests (or some other factor unrelated to referrals) and certainly not based upon the number of procedures they perform at the ASC. Accordingly, it is imperative that such new company not determine the ownership interests of the physicians based upon their anticipated referrals or business generated, not encourage physician

investors to divest their ownership interest if they fail to generate a certain level of referrals or business generated, and not track the source of referrals to or business generated for the company. ▲

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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
October 12, 2012	SAMBA 2012 Mid Year Meeting	Walter E. Washington Convention Center Washington DC	http://www.sambahq.org/professional/upcoming-society-meetings/
October 13 - 17, 2012	American Society of Anesthesiologists Annual Meeting	Walter E. Washington Convention Center Washington DC	www.asahq.org
October 25 - 27, 2012	Ambulatory Surgery Centers Conference Fall 2012	Swissotel, Chicago, IL	http://www.beckersasc.com/19th-annual-ambulatory-surgery-centers-conference.html
November 10, 2012	Midwest Anesthesiology Conference – Illinois Society of Anesthesiologists	Northwestern University Chicago, IL	http://www.isahq.org/Education/MidwestAnesthesiologyConference/tabid/112/Default.aspx
December 15 - 17, 2012	Postgraduate Assembly in Anesthesiology	New York Marriott Marquis New York, NY	www.nyssa-pga.org
January 16 - 19, 2013	University of California, San Diego Anesthesiology Update 2013 Conference	Catamaran Resort and Spa San Diego, CA	http://anesthesia.ucsd.edu/Pages/default.aspx
January 25 - 27, 2013	American Society of Anesthesiologists Practice Management Conference	Paris Hotel & Casino Las Vegas, NV	http://www.asahq.org/For-Members/Education-and-Events/Calendar-of-Events/2013/January/COPM-2013.aspx
April 5 - 7, 2013	Anesthesia Billing & Practice Management Seminar 2013	Caesar's Palace Las Vegas, NV	http://cme.uchicago.edu/
April 14 - 16, 2013	Medical Group Management Association 2013 Anesthesia Administration Assembly Conference	InterContinental Miami Miami, FL	http://www.mgma.com/solutions/marketing.aspx?id=29938

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