Clinicians in the specialty of anesthesiology have much for which we should be proud. Advances in our specialty have made the anesthetic experience both safer and more convenient even as we have advanced the care of our patients both in terms of who can safely receive anesthesia and where it is delivered. In fact, the rest of medicine and health care generally views us as pioneers in the patient safety movement.

Anesthesiology blazed the patient safety trail utilizing a variety of approaches: prudent adoption of improved technology, advances in pharmacology, advanced monitoring techniques, adoption of clinical practice guidelines and standards and by adopting some basic system theory and team-based behavioral principles and models to name just a few. Today, patients with even significant underlying health issues have higher expectations of successful surgical experiences than was thought possible a generation ago. These advances, embraced by us and persistent

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Value for Hospitals, Anesthesiology Practices and Physicians

As we head into the final quarter of the year, the departmental and group stability that anesthesiologists seek remain elusive. Hospitals and health systems continue their drive toward consolidation. National management companies report more and more acquisitions of anesthesia practices. The Affordable Care Act’s Health Insurance Exchanges will have begun to enroll beneficiaries by the time this issue of the Communique is in your hands, with much of the uncertainty over the functioning unresolved. Indeed, after forty attempts by the House of Representatives to repeal the Affordable Care Act, much of the law will be in effect by January 1, 2014, unless there is a successful forty-first or forty-second attempt, which strikes us as unlikely. Defunding may yet kill the ACA, but for now we must proceed on the assumption that the law will be very much with us next year.

The new environment demands accountability as well as “value” and not “volume” from providers, as we have heard many times. “Value” is the aggregate measure of patient outcomes (e.g., mortality rates, patient satisfaction, and absence of complications) divided by total cost per patient over time. Michael Hicks, MD, MBA introduces a value concept that is relatively new to health care—but a natural fit for anesthesiology—in the cover article, A New Approach to Anesthesiology and Health Care System Safety: High Reliability Organizing (HRO). HRO differs from Lean and Six Sigma in that it involves a culture of mindfulness; it is more than a set of process-improvement tools. Read the article to discover the five basic requirements of HRO mindfulness (preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience and deference to expertise). Plan to attend the Advanced Institute for Anesthesia Practice Management in Las Vegas April 11-13, 2014 to hear Dr. Hicks’s presentation on HRO.

A very different angle on the relationship between outcomes and cost is the heart of Jody Locke’s article, What is the Value of a Chronic Pain Practice to an Anesthesia Group? Every hospital-based anesthesia group considering adding a chronic pain medicine service line should consider the risks and the known costs that lead to disappointment in many cases. To succeed, the chronic pain division must attract the right patients with the right insurance, which will probably require analysis and marketing; the pain specialists must develop and follow individualized patient treatment plans, and the practice must anticipate greater expenses for billing, scheduling, insurance verification, pre-authorizations and record-keeping. That is just the beginning. Constant monitoring and oversight are also necessary. Keeping the anesthesiologists’ and pain physicians’ workloads balanced is difficult. Venture into this realm with your eyes open.

Sometimes the relationship that founders is not with the facility or colleagues, but with patients. In our context, this means pain patients. Neda Ryan, Esq. provides an overview of the relevant considerations in How to Legally Break Up with Your Patient.

For those who may conclude that the rigors of increased accountability and the hassles of growing the revenue stream are excessive, Mark Weiss, Esq. sounds an alert in his article The Siren Song of Hospital (Un)Employment. Hospitals’ quest for “alignment” of physicians is a different word for “control.” Hospital control may not be benign, and it may not entail the income security sought by many anesthesiologists.

Malpractice expert Christopher Ryan, Esq. discusses yet another set of pros and cons in his article So You’re Thinking about Serving as an Expert Witness? Here’s What You Need to Know. The most obvious benefit is the compensation. Interested anesthesiologists who are new to the exercise should check their employment contracts, as these sometimes provide that expert witness fees belong to the practice rather than the physician. On the negative side, “most of the time testifying as an expert means being cross-examined by attorneys for hours on end,” in Mr. Ryan’s unflinching words.

As is often the situation, much of the information we provide to the anesthesia community consists of “Don’ts” and various warnings. That is not to convey the impression that we fear the future. We think it remains very bright for anesthesiologists who try to anticipate and creatively adapt to the many changes in our near and long term futures. We hope that you will keep proving us right.

With best wishes,

Tony Mira
President and CEO
Many anesthesia practices across the country are hybrid entities, consisting of a subgroup of anesthesiologists and CRNAs who provide only surgical and obstetric anesthesia and another subset who spend part or all of their time in the management of chronic pain. The circumstances that have encouraged the development of such entities vary considerably, but it is a common phenomenon across the country in all types of settings.

In some cases, the different sets of providers appear to work quite harmoniously but these are the exceptions rather than the rule. Most struggle with a consistent set of challenges that derive directly from the fundamental differences between the two types of practices. Even a cursory review of any of these practices reveals just how different the criteria are for success in chronic pain as compared to O.R. or obstetric anesthesia. Simply put, the demands of a hospital-based anesthesia practice bear little or no resemblance to those of an office-based pain practice. While the one thrives on harmony and collaboration, the other feeds on individualism and a desire to take more control of one’s destiny. Some would even say that is it almost paradoxical for the two to co-exist successfully in the same entity. It is not at all uncommon for such arrangements to ultimately end in a complicated and messy divorce. Why then do we see so many such arrangements and why does the question keep coming up: what is the value of chronic pain medicine to an established anesthesia practice?

**Etiology of Pain Practices**

Two factors are typically attributed to the initiation of a chronic pain practice within the anesthesia group: one is an offshoot of the very nature of the specialty and its preference for individualism; the other is a more subtle and sometimes elusive strategic argument. Consider the following prototype: twenty anesthesiologists have bound themselves together into a group practice. Over time two or three members start to perform nerve blocks on a very selective list of patients in the recovery room during their downtime in the afternoon. Based on this limited experience they pursue the concept of a more active chronic pain service. One or two physicians often make the argument that a dedicated pain service would be in the best interest of the practice and the relationship with the hospital. Sometimes a few other providers will agree to contribute to the new service. Once the practice starts down the path it is not at all uncommon for the result to be a dedicated practice model that requires separate management to accommodate the needs of all the patients being scheduled. Inevitably, despite the arguments to the contrary, it is fundamentally the desire of the pain physicians to do something different and have more personal control over their practice and activities that encourages the evolution of the practice.

This is not to say a business case cannot be made for an expansion into chronic pain. A hospital-based anesthesia practice, especially one that is fundamentally tied to one facility or system, has limited strategic options. The volume of cases is tied to the community of surgeons and the reputation of the facility. The payer mix is a function of the population being served. By all accounts the practice is captive to the system for its revenue potential and viability.

The good and the bad news about chronic pain is that the practitioner starts each day with a blank slate or an open schedule. As a practical matter he or she has relatively free rein to take the practice in whatever direction suits the preference of the provider. There is ample evidence to indicate that motivated and strategically insightful pain physicians have the ability to work as hard as they choose. They have a unique opportunity to build referral bases and thereby change their payer mix by encouraging more referrals from physicians with patients with better insurance. Pain physicians can also dramatically impact their income by virtue of the kinds of services and procedures they perform. Well managed pain practices typically see their providers generating at least 50% more in gross collections per clinical day than their colleagues working in the operating room. To put this in concrete terms: most anesthesia staffing models for physician-only practices are based on a gross
in our application, have become part of our culture of vigilance.

**Reducing Error in the Health Care System**

Unfortunately, our vigilance has been slow to spread far from our operating rooms to the rest of the health care system. Health care remains beset with errors, dangerous places and practices, and risks that our patients would not voluntarily tolerate in other aspects of their lives (Kohn et al., 1999; Richardson et al., 2001; Richardson et al. et al., 2001; Landrigan et al., 2010). We, as patients, are no different. Why then, as caregivers, do we not only tolerate a health care system that carries such risks but also actively work every day as integral participants without doing as much as possible to make it better?

In my career I have heard many reasons for our reluctance to change the system. Fears of malpractice or personal litigation, perceived loss of clinical autonomy, lack of authority, fear of retribution, the variability of individual patients, fear of being replaced by production driven surgeons and administrators, lack of financial incentive or even just apathy are just some of the reasons with which I am familiar. I have even heard it suggested that it is not a lack of intention or motivation on our part but that health care is fundamentally different than other process-driven enterprises and is incapable of achieving the performance standards demanded and produced elsewhere. However, increasing numbers of stakeholders—patients, payers, regulators and the government most notably—are demanding greater attention and accountability for the care that we collectively deliver. How then should we proceed?

**Beyond Lean and Six Sigma to a New Approach: HRO**

We have attempted to incorporate many tools from other industries with varying degrees of success. Lean, Six Sigma and other approaches are all in use and in some cases achieve almost mystical status in the minds of some in the industry. To be fair, when applied correctly these tools can produce significant performance improvements. In many cases, however, they ultimately fall short and produce only limited-term gains. Sometimes, because of misunderstanding and misapplication, they produce results worse than the baseline issues they were intended to improve. A primary reason for this is that these approaches are merely tools to address isolated processes. They are not changers of an organization’s underlying culture and so whatever gains are made erode over time, as behavior is subservient to culture and routine in nearly every circumstance.

Fortunately, there is much we can learn from outside of health care. There are organizations and industries that continue to demonstrate lasting success in minimizing errors, reducing opportunities for failure and generating value. From them we can learn the necessary tools and more importantly a solid theoretical construct that results in a great deal of practical success (at least in other industries) from which we can draw our own applications.

One such theory, known as High Reliability Organizing (“HRO”), was developed by observing the behaviors, process design, and ultimately the cultures of other industries that for various reasons have very, very low fault tolerances or alternatively, very high expectations for reliability (Weick & Sutcliffe, 2001; Vogus, Sutcliffe, & Weick, 2010). Note that the acronym “HRO” can refer to both the theory (High Reliability Organizing) as well to organizations that have embraced the theory (High Reliability Organizations) and the reader should use the context to discern the difference as the acronym is applied.

The classic examples of HRO industries are commercial aviation, the nuclear power industry and aircraft carrier operations. These industries have embraced the HRO culture because failure for them typically means catastrophic outcomes. Increasingly, however, organizations within health care such as The Joint Commission and the Agency for Health Care Research have proposed that health care organizations should be added to the list of HRO disciples, not as current examples of HRO in practice but as entities that could benefit from the aspirational goals of HRO thinking (The Joint Commission, 2012; Hines, 2008).

**Five Key Principles of Mindfulness**

It should be emphasized that the key principles of HRO can be explained fairly easily but that their successful application both drives and is dependent on an underlying “mindfulness” of an organization’s
operation. The concept of mindfulness is for most people the most difficult concept to grasp. In simple terms, mindfulness refers to an ongoing, overall sense of operational and situational awareness that involves yet transcends the particular task that one is performing. In other words, and borrowing from the American Society of Anesthesiologists’ motto, mindfulness in my view is another manifestation of being vigilant on a continuous basis about the totality of the process. In our world it is akin to being the patient’s advocate when patients cannot do that for themselves.

High reliability organizations adhere to five key principles that serve as underpinnings for the general culture of mindfulness (Weick, Sutcliffe, & Obstfeld, 2008). Interestingly, and suggestive that HRO theory should resonate with anesthesiology clinicians, the precepts of HRO are completely consistent with fundamental aspects of our daily practices as outlined below. My intent here is to explain in simple terms the core of HRO and to suggest that we as anesthesia clinicians are uniquely suited to embrace and promote the concept as we move the specialty forward into the future. While I believe that HRO concepts are actually the bedrock upon which the safe practice of anesthesiology rests, my frequent use of clinical examples from our specialty is largely for illustration purposes as the concept of HRO is applicable to any process where minimal defects are required and where consequences are great when errors do occur. In my opinion, our daily clinical application of these principles uniquely qualifies us to offer expertise in other areas of the health care system. That being said, let’s explore the basic concepts of high reliability organizing and organizations.

First, HROs are preoccupied with failure (or variance). HROs are constantly looking for signals, even very weak ones, that failure is occurring. Weak signals of failure, like a slight decrease in oxygen saturation, an increase in heart rate or airway pressure or even a drug vial in the wrong slot of the drug storage unit can be suggestive of a much greater systemic failure. A hallmark of HRO theory relative to failure or variance is not just a hyper-attention to these weak signals, but also that strong responses are taken when even weak signals are noticed.

For example, how many of us when confronted with a drug ampule in the wrong place merely move it to the correct slot and move on with our day, happy that we have caught the mistake? Or better yet, particularly as we try to expand our practices outside of the OR and the ICU, simply order a missing lab or imaging study that we need before proceeding on with a surgical case? Have we really solved the real problem when we see such a patient preoperatively lacking an adequate workup or just solved it for at that particular moment?

The answer to both of these questions is only a partial yes—for that particular patient we have but for the system we have not. Maybe the next patient won’t be so lucky and reducing the possibility for error, or catastrophe, for the next patient—for the next opportunity—is what sets high reliability organizations apart. In an HRO culture we still take care of that individual patient, but we elevate our observations up and out to the organization as a whole so that the processes can be appropriately modified. Only by doing this is the risk of failure—system failure—lower the next time. On a practical level, how will the pharmacy staff or the primary care practitioner ever learn of our downstream issues if we don’t do otherwise?

The concept of failure at the system level is an important one. HROs approach failure prevention at the system level by being mindful at the level of the individual and of the environment in which they operate and have prepared mitigating interventions when problems do occur. In an HRO culture, negative events such as errors or near misses are seen as opportunities to learn and improve. Reporting of actual events or near misses is encouraged, rewarded and treated in an open and non-punitive fashion. To do otherwise, results in less reporting, less data and information, and less learning. The organization that engages in the latter is the poorer for it as are the consumers of its services.

The second fundamental concept underlying the culture of HROs is a reluctance to simplify. This is counterintuitive for most people in that being organized is generally characterized as the ability to organize a large number of items, events, tasks or, in clinical terms, even physiologic symptoms and drugs into a much smaller number of categories. This categorization allows for more coordinated and thoughtful responses. But as Einstein reportedly said, “Everything should be as simple as possible, but not simpler.” Unfortunately, early warning signs of potential failure can be hidden with too much simplification. Details, meaningful ones, can be lost when we strip away too much of the alleged noise from the signal and categorize too broadly.

Even the names and labels that we attach to events and things can hide weak signals that if observed without the
assigned categorization would portend possible negative outcomes. HROs recognize that they operate in complex environments and that failure, even repetitive failures, can occur in new and novel ways. Oversimplification can mask the signals of impending failure or lead one down the wrong path in terms of dealing with seemingly known issues.

A third characteristic of HROs is their attention to continuous situational awareness. This “sensitivity to operations,” as it is called, means that HROs pay attention to the work that is being done as it occurs and not how it is expected by policy or procedure to occur. In our world, for example, a lack of sensitivity to operations is why we continue to have an epidemic of wrong site, wrong drug, or wrong procedures being performed even though we likely all have universally adopted “time-out” procedures as supposed standards.

Sensitivity to operations also means that HROs focus not only on specific issues of the moment, but also broader ones that the system relies on to reduce the potential errors. For example, is the crash cart where it is supposed to be and fully stocked? Does the anesthesia machine check out before a moderate sedation case? Has the anesthesiologist or CRNA assigned to a case had adequate rest or training for the case at hand? This type of attention may seem trite to some, but to workers in an HRO environment it is just part of the organization’s continuous scanning of the situation. Once again, this should be second nature for us in anesthesiology.

Interestingly, and of particular importance to us in our field, is that one of the threats that HROs face regarding vigilance to sensitivity to operations is for routine tasks to become so routine that they become casual, even mindless. Consider for a moment the danger of this in caring for the surgical patient. How many times have you heard a colleague (anesthesiologist, surgeon, nurse) make a statement that an upcoming procedure is going to be simple or that a more thorough workup isn’t necessary? The fact that we frequently “get away” with accepting these circumstances does not diminish the real underlying threat that is present for the patient where we aren’t so lucky. Our experiences in situations like these and how we handle them on a system level is translatable to other aspects of health care and presents us opportunities to apply our experiences to the theory.

A fourth key HRO concept relates to an organization’s ability to deal with errors and issues as they arise. This ability is driven by what is characterized as a commitment to resilience and is predicated on the knowledge that the system, no matter how well designed, will still have failures. Handling errors, whether expected or not, requires training, forethought and an anticipation that errors can and will occur.

Much like our room preparation before administering an anesthetic, an HRO continually prepares for what ostensibly has already been prevented or can’t be anticipated by stressing teamwork training, mitigation strategies and by minimizing variations from the norm as a situation unfolds. In other words, although the events playing out are not exactly unfolding as planned, much like an unanticipated difficult intubation, the system (and us in the intubation example) has the necessary capacity and redundancy to handle the current crisis, return as close to normal as possible and learn from the endeavor as well.

Finally, HROs’ have a marked deference to expertise wherever it is in the organization. Expertise here refers to that person who has the most relevant knowledge of the situation that is unfolding. Expertise does not mean the most experienced or the most senior person as neither experience nor seniority necessarily carries with it the knowledge of the given situation at that moment in time. Expertise can mean that an individual only recognizes that something is amiss
and the only action available to them is to bring the production process to a halt until other mitigating strategies can be implemented.

This, among all of the HRO strategies in my opinion, would be the most meaningful and easiest in theory to implement in health care. Unfortunately, health care remains a rigid, hierarchical industry that more encourages silence, silos, and passing issues on to others to discover and solve instead of an environment based on transparency, open communication, and non-punitive responses to error handling.

**A Natural Fit for Anesthesiology**

Taken together, the precepts of high reliability organizing should be applicable to all of health care. In my opinion, anesthesiology practice in its purest form is based on HRO principles whether we know the HRO theory or not. Because of this, and because we have excelled in its application, even unknowingly, I think that there is a role for us to be both disciples and advocates for high reliability organizing being embraced throughout the health care system.

While the motivations should be intrinsic, however, the reality is that very little changes in clinical practice or within the health care system without the application of external forces and the passage of time. This is unequivocally true for the changes in culture that HRO requires. There is no lack in the scientific literature of references to high reliability organizing and the health care system or the clinical practice of anesthesiology (Sutcliffe, 2011; Chassin & Loeb, 2011; Dixon & Shofer, 2006; Wilson, Burke, Priest, & Salas, 2005; Gaba, 2000). Despite the applicability of HRO concepts and culture to anesthesiology our uniquely applied expertise in this area remains largely unrecognized even within our own ranks. This may be ripe for change, however, as increasingly both internal and external forces are now working to bring HRO to health care.

For example, large purchasers of health care such as the government and employers don’t understand why what they take for granted as common sense business practices aren’t being applied to the care they purchase and receive. Similarly, the health care industry continues to consolidate and seek opportunities to create greater value and one of the compelling ways to do this is by embracing an HRO culture. High reliability organizing offers the opportunity to increase value, decrease harm and its potential associated costs, and improve system performance.

Finally, influential entities such as The Joint Commission, the Agency for Healthcare Research and Quality and the Institute for Healthcare Improvement have embraced the concept of HRO and are advocating for its adoption and implementation (The Joint Commission, 2012; Dixon & Shofer, 2006; Resar, 2006). The interest and direction of these organizations will likely drive further implementation of high reliability organizing in health care. As anesthesiology clinicians, however, we should embrace the opportunity that our experience in this area gives us and be at the forefront as the high reliability movement proceeds.


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What is the Value of a Chronic Pain Practice to an Anesthesia Group?

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revenue potential per anesthetizing location day of between $1,900 and $2,100. It is not at all uncommon for pain medicine professional fees, not including facility payments, to exceed $3,000 per provider day. Those willing to accept the risks and responsibilities of managing a free-standing pain clinic can net significantly more per clinical provider day.

Given these facts, why wouldn’t every anesthesia practice want to find a couple of qualified pain specialists and set them up in practice? It is the answer to this question that reveals just why so few anesthesia-based chronic pain practices are successful and why so many group practices that have a pain component wish they didn’t. As is so often true in business, the devil is in the details. A failure to understand and appreciate the management complexity of a busy chronic pain practice probably explains most of the frustration and dissatisfaction.

It is probably worth noting that most successful anesthesia practices don’t realize how good they have it. There is an oft-quoted, but unfortunately quite misleading, notion that success begets success. The anesthesia practice that has benefitted from a favorable location, payer mix and consistently strong surgical volumes may prove to have very unrealistic and naïve ideas about launching an entirely different practice model whereas the practice that has always had to focus on every aspect of the budget to hire and retain qualified providers to meet the expectations and service requirements of the hospital probably has a better understanding of what is involved in building an entirely new service line. After all, they probably have nothing to lose.

Managing the Patient and Payer Mix

Simply put, any surgical practice relies on patients, procedures and payments for its livelihood and success. This might sound simple, but these requirements can be deceptively complex to consistently achieve. Having the necessary management oversight, monitoring tools and infrastructure are critical prerequisites. Invariably an unwillingness to hire the necessary staff, invest in appropriate technology and commit resources to monitor the practice closely sets these practices up for failure from the outset.

The ultimate challenge in each case lies in knowing what the right objective is. It is easy to say that patients make the practice but too many pain physicians confuse filling the schedule with developing a referral base. They tend to accept all comers initially and then, if they are lucky and still in business, end up paying the price down the road. Just as it can be said that many college students spend their sophomore year trying to distance themselves from the friends they should not have made their freshman year, so too, pain physicians often spend their second or third year in practice wondering why they are working so hard but making so little money when the answer is quite simple: they should have been more selective in the early phases of the practice.

The ideal sweet spot for a chronic pain practice involves a population of patients that allows for two things: the ability to manage patients for a limited period of time and patients whose insurance will cover the costs of providing the care. Three to five encounters with a patient is probably optimum. This would involve a comprehensive evaluation, a series of procedural interventions and a discharge. This would absolutely not involve the patient who has been referred for medication management that requires regular follow-up visits for refills without any opportunity for procedural intervention.

The mix of patient insurance is absolutely critical but often challenging to manage effectively. Every American physician understands that what Medicare pays does not really cover the cost of care and Medicaid in most states is even worse. Having a population of patients with good commercial insurance is essential. In some states, Workers’ Compensation can be a godsend, but this, too, is changing, especially in states like California. What too few pain physicians understand is both the need to encourage referrals and the impact this can have on their bottom line. Fundamentally, they do not appreciate the need for marketing and promotion. A practice whose physicians believe they are too busy to promote the practice is a practice that is doomed never to change its financial viability or profit potential. Let us suppose that the number of Medicare patients is a given. The practice cannot improve its revenue potential by reducing the number of Medicare patients, but it can do so by increasing the number of non-Medicare and commercial patients. Sometimes you solve one problem by creating a bigger problem.
Volume and Value in Chronic Pain Practice

Another dimension of the chronic pain practice that is poorly understood by the non-pain provider is the distinction between the evaluation of patients and the interventional modalities used to address their conditions. Consultative pain physicians must distinguish the value of the service they perform by critically evaluating their patients before any interventional modalities are performed. The practice that does not appreciate this will be relegated to the category of “block shop” and quickly displaced by cheaper alternatives more willing to provide services and discount their rates. Medicare policy makes it abundantly clear that any injection of steroids must be preceded by a comprehensive review of previous attempts to address the patient’s condition and an assessment of appropriate treatment options. Since the typical chronic pain patient is a 43 year old male who has been to see 6.8 other providers prior to contacting the pain physician, the expectation is that that specialist will be a better diagnostician than the previous providers. The objective, therefore, is not to default to the role of replaceable technician but to define a different value proposition for the patient.

When we talk about the financial significance of the procedural aspect of the pain practice it must be viewed through the lens of the overall management of the patient. While it is true that a pain physician who can consistently perform three or four steroid injections an hour can make a considerable income in the short term, his earning potential will be quickly eclipsed by either boredom or competitive options that are more focused on the whole patient. Unfortunately, too few practices have reliable or comprehensive outcomes data, because this is what patients and payers want. Each treatment plan should be carefully considered based on the patient’s history, medical condition and resources for improvement.

Pain Management Practice Costs

Even so, having good providers doing all the right things for their patients is still no guarantee of success. All is for naught if they cannot be paid appropriately. Here is where anesthesia practices are at their most naïve. They think that just because they have negotiated a favorable percentage-of-revenues fee with their billing agent, they will get the same level of service in chronic pain. Despite what claims may be made by billing agents, it is an absolutely impossible proposition. A quick review of the basic economics of the matter underscores the problem. Suppose the typical anesthesia case nets $400 on average and the cost of billing is four percent. This results in $16 of revenue per case for the billing office to code, bill, resolve the patient’s account and provide the necessary reporting so that the practice has a level of comfort that they got what they were entitled to. Now let us consider the average revenue per pain encounter, which we will define as all the services rendered to a patient on a date of service. Under the very best of circumstances this could be as high as $200 but is more likely to be closer to $150 and might be even lower than that. Now the revenue potential to the billing office has dropped from $16 to $8 or less per encounter. Ask any coder or biller and he or she will tell you that the average pain claim inevitably involves more interaction and follow-up than the corresponding anesthesia claim. The challenge is then further compounded by the very complexity of treatment options and payment modalities. Instead of wanting confirmation that all Blue Shield claims were paid at the contractual per unit rate, the pain physician wants to know that every CPT code billed was paid according to the contractual fee schedule and reflected the appropriate application of such things as the multiple surgical payment rules and special considerations for bilateral procedures. Is it any wonder why some billing companies simply refuse to take pain practices? Effective pain management billing necessitates line item billing and the ability and resources to identify all inaccurately paid claims and review them.

In addition to these anxiety-creating realities for the billing staff, consideration must be given to the basic management requirements of scheduling, insurance verification and pre-authorization that are virtually nonexistent in anesthesia.

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practice management. Record keeping can be another area of huge concern and consternation. Dictating, reviewing and approving patient evaluations and operative reports is considerably more time-consuming and onerous than completing anesthesia records, especially when the typical surgical anesthesiologist sees an average of five patients per day while a moderately busy pain physician sees between 12 and 20. While the average total practice overhead for an anesthesia practice should not exceed 10 percent, including billing, it is not uncommon for the overhead of the pain practice to be two or three times this much. It is true that the anesthesia practice that is able to partner with the facility may be able to avoid some of these costs, but in so doing they also limit their revenue potential.

UNDERSTANDING THE LOAD AND THE REWARDS

All of these considerations start to explain why pain physicians tend to believe that they work much harder than their colleagues in the operating room. The principle that perception is reality in often the single most divisive factor in a hybrid practice, especially one that pays all shareholders or physicians equally. Why should a pain physician go out of his or her way to work longer hours, offer flexible office hours or aggressively pursue referrals if there is no financial incentive to do so? Any group that does not recognize the unique requirements and opportunities associated with chronic pain practice in the details of its compensation plan will ultimately sell itself short. Human nature being what it is, people need a reason and a motivation to work harder and take more risks.

Other issues can prove equally divisive. The allocation of call assignments can be especially problematic, especially when the assumption is that those physicians who perform chronic pain service must share the surgical and OB call burden. More than a few practices have separated based on this issue alone.

There is a perception that the inclusion of a chronic pain practice is perceived as a positive service enhancement by hospital administration. The anecdotal data is somewhat inconclusive on this point. It is certainly true that the ability to draw patients to a hospital and to generate facility fees for the institution should be considered a positive aspect of any pain practice. One could even argue that in the current environment, with the anticipated changes of healthcare reform around the corner, a hospital administration would view any expansion of services as positive. Some have even entered into serious discussions with groups that have provided a limited scope of pain management services to explore co-management options. The politics of chronic pain can be a little tricky in cases where anesthesia has not been involved historically. More often than not the revenue potential is not viewed as significant enough to disrupt established relationships. It is always an angle worth pursuing but it is clearly one that should be carefully and completely analyzed. The administration will no doubt expect a full pro forma and probably expect an outside consultant to perform a qualified analysis. Administrators are notoriously skeptical of propositions that propose a significant influx of new revenue. They are trained to look for the catch, or the capital they are being asked to invest so that the pain practice can be successful.

Anesthesia practices need to be especially prudent in any discussion of the establishment of a free-standing clinic. The last thing an administrator wants to hear is that the group intends to set up an independent entity that may well compete with the hospital for patients even if this is ultimately the most profitable option for the group. It is always best to play this card very carefully and only after all other options have been considered and discussed.

With all these considerations in mind we return to our original question: should anesthesia practices pursue chronic pain management as a reasonable way of diversifying the practice and mitigating some of the market risk they face in the current environment? The answer is yes, if, and only if, they are willing to make the investment in developing a business plan that is realistic and practical, in hiring or identifying qualified providers, in giving them the necessary tools and rewards to be successful and investing in the necessary infrastructure. It is an all or nothing proposition. A poorly-managed pain practice is much worse for all concerned than no pain practice. The opportunity lies in careful planning, committed execution and constant monitoring and oversight. Ultimately, it is the very challenges that will provide the opportunities for those practices willing to do it right.

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.
At some point toward the beginning of their careers, physicians are required to take the Hippocratic Oath in which the physician covenants to heal the sick or to prescribe measures for the good of the patient. Unfortunately, in an environment in which overdoses on prescription medication are quickly rising to the top of the list of causes of death, zealous adherence to this portion of the Oath could leave pain management physicians exposed to liability. Furthermore, blind adherence to the Oath is not a legal defense to injury or death associated with the misuse or diversion of prescriptions. Luckily, there are steps that pain management physicians can follow early on to promote a beneficial relationship for the patient and to minimize legal risk to the physician. Still, even when preventative steps do not produce the intended results, there are measures that can be taken to legally terminate the relationship with the patient.

Prescribing Controlled Substances: Legitimate Medical Purpose

The laws and regulations surrounding prescribing include the Federal Controlled Substances Act, the Drug Enforcement Administration’s (DEAs) regulations and guidance, and relevant state law and guidance from medical boards. The Supreme Court and the DEA have both made clear that controlled substances must be prescribed for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice.

It is clear that this standard is vague and, thus, a physician’s prescribing is analyzed on a case-by-case basis.

Warning Signs for Problematic Patients

The DEA has set forth a number of warning signs for problematic patients that include the following:

- Patients demanding to be seen immediately;
- Patients stating that they are visiting the area and are in need of a prescription to hold them over until they return to their local physicians;
- Patients feigning symptoms in an effort to obtain narcotics;
- A patient indicating that non-narcotic analgesics do not work for him or her;
- A patient requesting a particular narcotic drug;
- A patient complaining that a prescription has been lost or stolen and must be replaced;
- Patients requesting more refills than were originally prescribed;
- Patients using pressure tactics or threatening behavior to obtain prescriptions; and
- A patient showing visible signs of drug abuse (e.g., track marks, etc.).

The appearance of one or more warning signs is not dispositive of inappropriate use or diversion of prescriptions. As such, the pain management physician should take into account each individual patient’s condition and medical history prior to determining whether action must be taken.
HOW TO LEGALLY BREAK UP WITH YOUR PATIENT
Continued from page 11

PROACTIVE STEPS YOU CAN TAKE NOW

The DEA does not require that pain management physicians prevent all instances of diversion and abuse. It also does not require that all drug abusers be denied all drugs. Rather, law enforcement officials will look to the steps the pain management physicians took to meet his or her legal responsibilities to prevent diversion and abuse. The questions that will be considered include the following:

• Was there a legitimate medical purpose for the prescription?
• Was the pain management physician acting in the usual course of his or her professional practice?
• Has the pain management physician taken reasonable measures to prevent diversion (e.g., were the actions taken tailored to the specific patient, did the provider exercise the appropriate degree of medical supervision, etc.)?

The determination is extremely fact specific with special attention being given to those patients who are known drug abusers.

In addition to DEA regulations, there are many other steps pain management physicians may take to prevent abuse and diversion of the medications they are prescribing to their patients:

• Evaluate the Patient—Obtaining, evaluating and documenting a medical history and physical examination, indicating the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse.
• Develop a Treatment Plan—A written plan of the patient's treatment should, in addition to setting forth the patient's plan, state objectives that will be used to determine the success of the treatment. The plan should be fluid and flexible enough to evolve with the patient's progress and needs.
• Obtain Informed Consent—The risks and benefits of the treatment should be explained to the patient. Sometimes, a signed form may be necessary to inform patients of certain prescriptions and to document that consent was obtained.
• Execute a Treatment Agreement—If the patient is at high risk for medication abuse, the physician may consider using a Treatment Agreement that sets forth the obligations of the patient with respect to the medication as well as the consequences for failure to adhere to the agreement. Specifically, the Treatment Agreement could address the following: obtaining medications (or certain medications) from a single source, safeguarding the medications, the use of illegal substances, standards or requirements for refills, submission for drug testing, terminating the relationship for failure to comply and monitoring any state databases, as applicable.
• Periodically Review Treatment—The provider should periodically review the patient's course of treatment and any new information about the etiology of the patient's health and/or pain. As stated above, the treatment plan should be fluid enough to permit for changes arising out of any new information uncovered during a periodic review.
• Refer Patient to Another Provider—In some instances, patients must be referred to another provider or specialist for additional or contin-
ued treatment of the patient. Care should be taken to ensure at-risk patients are properly managed and cared for during the transition.

- Check State Prescription Monitoring Programs—Some states have prescription monitoring programs in which providers may access the database to see if their patients are obtaining certain medications from other sources. For state having such prescription monitoring programs, pain management physicians should confirm whether or not accessing the database is mandatory.

- Document in the Medical Record—As with all other facets of treating and managing a patient’s care, all of the steps the provider takes to protect against, and prevent misuse of, prescription medications should be documented in the patient’s medical record. This will serve as one of the most important defenses against allegations of the pain management physician’s failure to prevent diversion and abuse of prescription medications.

In addition to the steps noted above, it is important that all providers consult their own state’s laws and regulations with respect to prescribing, especially as they relate to prescriptions for controlled substances.

**The Break-Up**

Sometimes, pain management physicians will find that despite all of the preventative measures they took to prevent abuse or diversion, the patient still shows signs that he or she is diverting or abusing the medications prescribed to him or her. Some reasons for terminating the relationship include: (1) the patient fails to comply with a Treatment Agreement or other terms set forth by the physician, (2) the patient is unreasonably demanding, and (3) the patient threatens the provider or staff.

When the issue of breaking up with a patient arises, concerns regarding patient abandonment also arise. Abandonment is defined as the termination of a professional relationship between the physician and patient at an unreasonable time and without giving the patient a chance to find a replacement. Mere termination of the relationship does not amount to abandonment. Abandonment may arise when the relationship is terminated at a critical stage of the treatment, without good reason or sufficient notice and the patient was injured as a result.

To properly terminate the relationship, physicians including pain medicine specialists should take the following steps:

- Giving appropriate written notice;
- Giving a brief explanation of the reasons for the termination of the relationship;
- Agreeing to continue to provide treatment and access to services for a reasonable period of time (e.g., 30 days) to allow the patient to secure care from another person;
- Providing resources and/or recommendations to help a patient locate another physician of like specialty; and
- Offering to transfer the patient’s records to a designated person.

Of course, it is important to recognize that some states may have laws that specifically define abandonment and set forth a process that must be followed to ensure terminated patients are not abandoned.

According to the DEA, in 2006, more than 6 million Americans were abusing prescription drugs—exceeding the number of Americans abusing cocaine, heroin, hallucinogens and inhalants, combined. Thus it is with great fervor that both State and Federal agencies have turned their attention to preventing diversion and abuse of controlled substances. That is why pain management physicians must be aware of preventative steps they can take to prevent abuse and diversion of prescription drugs as well as know their legal rights when treating a patient who has turned south, leaving the physician with little choice but to break up.
It’s a tough world out there for anesthesiologists. At least, that’s what many anesthesiologists think.

Many believe that hospital employment is the panacea: the new “safe” career option. And why not—that’s the song that hospitals are singing loud and clear, and it’s the one they’re encouraging you to sing, too, via “alignment.”

Are anesthesiologists being guided into a safe harbor from the storm of uncertainty, or are they being lured by the siren song of a creature lethal to physician success?

**Siren Song**

In Greek and Roman mythology, sirens lured mariners to their deaths. Lethal creatures that they were, they didn’t kill with knives, spears, or other observable weapons; they didn’t even give rise to a threat.

Instead, they used their enchanting voices in song to lure their victims’ ships aground on the rocky shore.

Today, there are a number of trends creating a storm in the sea of medical practice.

**The Perfect Storm**

Let’s consider a few of the trends contributing to the current state of affairs.

**Healthcare Reform**

Certainly, there’s the incredible uncertainty of the financial future resulting from Obamacare. Even though the Supreme Court upheld the challenge to its individual mandate and ruled that its fee . . . err tax . . . for noncompliance is constitutional, Obamacare continues to make waves. Will healthcare exchanges be implemented on time or implemented at all? Will the law be defunded by Congress? Will bundled payments, accountable care organizations (ACOs), and cost-cutting masquerading as quality initiatives gut the private practice of medicine?

**Complementary Medicine**

In many areas of the country, complementary and alternative medicine practitioners, from chiropractors to naturopaths, are asserting their “right” to independent or equal practice. Many patients are receptive to their care and their aspirations—and to emptying their pocketbooks in their favor.

As federal and state governments, employers and payers seek to reduce healthcare costs, they, too, are becoming increasingly supportive of alternatives to physician-delivered care.

This is resulting in increased pressure on physicians: in some specialties, it’s the pressure of potential replacement; for others, including anesthesiologists, it’s the impact of a lessened flow of patients due to the growing percentage of the public seeking alternative care.

**National Groups**

As anesthesiologists know all too well, national and large regional groups are putting tremendous competitive pressure on historical local practice, promising subspecialty coverage and superlative customer service . . . even though opinion on what they actually deliver varies.

**Direct Financial Pressure**

As payers become squeezed by rising administrative costs and the pressure to
provide broader coverage, they are putting increasing pressure on physicians to accept smaller increases in reimbursement or even outright reductions. In addition, hospitals, which once freely doled out stipend support, are beginning to use the threat of replacement by national groups and the induced pressures of requests for proposal to dash anesthesiologists’ expectations of stipends.

**THE SIREN SONG**

Faced with the difficulties described above, along with the time, effort and financial requirements of running independent practices in good times or bad, many physicians are becoming disillusioned with private practice.

The timing could not be better for hospitals.

Note that not all hospitals are in a position to do something: in fact, a significant number of hospitals close each year.

Of those hospitals with (relatively) healthier balance sheets, many see a future in which healthcare services, even services that were routinely delivered in an independent physician’s office, are provided through a hospital-centric system. Encouraged by the Medicare Shared Savings Program provisions of the Patient Protection and Affordable Care Act, they seek to “align” physicians, often through employment, either directly or via a hospital-controlled practice entity or foundation.

**THE ROCKS**

But from an anesthesiologist’s viewpoint, are hospitals really in a better position—practically, businesswise and financially—to manage a physician practice?

On a meta-level, why is it that physician “alignment” requires more control by hospitals when the general impact of the microchip revolution has been the flattening of organizations, making it much easier for independent producers of both products and services to conduct business and to coordinate their activities with other independent entities?

Wasn’t the entire notion of HIPAA that individuals’ health data had to be secured because independent entities would be coordinating the sharing of electronic health information?

And, regarding the central issue for most anesthesiologists, the protection of their incomes, hospital employment comes with a challenge that has no real equivalent in the physician-owned practice world: the restrictions of fair market value compensation levels, as defined for healthcare compliance purposes, are neither generally fair nor at market value. Linked to national surveys, over time they will result in a spiraling down of anesthesiologist income as hospital-engaged valuation consultants opine at less than top compensation percentiles—today’s 75th percentile will become tomorrow’s 99th percentile.

Finally, all employment contracts have a term—and most have a real term provision: the one pertaining to early termination. What safety is there in an “alignment” that might only last for the next 60 to 90 days, or the notice period for termination without cause?

As you consider these issues, you need to determine if you want a job or a career. If it’s a career, how much control do you want to have over your future? Is there more or less safety in hospital employment? Is it a safe harbor or a rocky death trap?

Is there, in reality, more safety on the sea of uncertainty than there is in the hospital’s siren song?

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Attorneys in various specialties are always keeping an eye out for outgoing, charismatic, smart physicians willing to provide expert testimony. Common cases in need of expert testimony include medical malpractice, personal injury, wrongful death and auto accidents.

Testifying as an expert witness requires qualifications that vary from state to state. Whether you have never testified as an expert witness, or testify routinely, this article will outline some considerations to keep in mind when providing (or deciding whether to provide) expert testimony.

**What it Means to Serve as an Expert**

You may be approached to provide expert testimony as a treating physician, or in your capacity generally as an anesthesiologist or pain management specialist in a case with which you were not involved. Sometimes, the testimony of an anesthesiologist or pain management specialist will be requested simply to explain the treatment rendered to a patient. For example, if a patient was involved in a car accident and was administered a series of injections to relieve his or her pain, the physician administering the injections may be asked to testify concerning the treatment rendered, the reasons for the treatment, the expected outcomes of the treatment, and whether or not the treatment provided benefit to the patient. In this type of case, sometimes the anesthesiologist may be asked to render an “opinion” concerning the cause of the injury itself.

In other cases, an anesthesiologist may be called upon to judge the care rendered by one of his or her colleagues, or to give a medical opinion regarding the cause of an injury. Most of the time, medical malpractice cases require expert witnesses on both sides (testifying for the treating doctor and against the treating doctor). Providing testimony in medical malpractice cases can benefit the medical community as a whole by helping to ensure that proper and appropriate care was provided.

**What to Consider Prior to Serving as an Expert**

As with all things, there are benefits and drawbacks to serving as an expert and the anesthesiologist or pain management specialist should consider each of them prior to making a commitment to serve as an expert. One of the most obvious benefits of providing expert testimony is the compensation. The amount charged varies from provider to provider. The attorney hiring the expert will likely discuss fees up front. Although no statistics could be located specific to anesthesiologists, rates for medical experts typically range from between $200 to $400 per hour to review records and have informal telephone conversations with counsel. The rates often increase for time spent providing testimony. Anesthesiologists should be careful when structuring their fee schedule as there are often prohibitions against charging a fee that is contingent upon the outcome of the litigation. For example, in Michigan, it is a misdemeanor for an expert witness in a medical malpractice case to testify on a contingency fee basis. Additionally, before engaging in this work, anesthesiologists should carefully review their employment contract, which may address expert testimony. Many employment contracts specify that any money received providing expert testimony belongs to the group, instead of to the individual physician. Additionally, some employment contracts may have conditions addressing the ability to serve as an expert. If you are a physician who regularly serves, or who is looking to serve as an expert, you may consider negotiating this point in your next employment agreement.

While the compensation for serving as an expert may be appealing, many practitioners refuse to provide expert testimony whenever possible. Cross-examination, and litigation in general, are adversarial by nature and many people find this environment uncomfortable. As explained below, while the procedures vary from state to state, most of the time testifying as an expert means being cross-examined by attorneys for hours on end.
What to Expect

If you have never served as an expert, but you are interested in doing so, there are a number of things you should expect. Because trial procedures vary from state to state, when you are approached to act as an expert, you should feel free to ask the attorney what he or she anticipates the process to be. For example, in a medical malpractice case, the first step for the expert is typically to review the patient’s medical records. If the anesthesiologist has been hired by the attorney representing the healthcare provider, he or she will also likely be provided with the allegations brought by the patient. After the records are reviewed, the attorney will probably contact the expert to discuss his or her opinions. Using the example of the expert hired by the defense attorney in a medical malpractice case, this is the time when the expert will tell the attorney whether he or she thinks the attorney’s client committed malpractice. If you think he or she did, then your involvement in that particular case will probably end.

If you believe the healthcare provider acted appropriately, your deposition may be requested. A deposition is an out-of-court proceeding where you will give sworn testimony and be asked questions by the opposing counsel. In cases where your deposition is not taken before trial, the first time you testify may be at trial in front of a jury.

When giving testimony, it may seem as though the attorneys are asking questions that do not have anything to do with the litigation. For example, attorneys often probe into the educational background, medical training, and experience of a witness. The attorney will also want to know each document that the witness reviewed to prepare for the testimony. These types of questions may be posed for a number of reasons including building up or tearing down the credibility of a witness. Giving expert testimony may take as little as half an hour, or as long as four or more hours.

Guidelines

The most important guideline when rendering expert testimony is to be truthful in your responses. Failure to abide by this guideline may subject you to court sanctions or criminal penalties. If it is proven that you lied under oath, it is likely that you will not be asked to testify as an expert again. Similarly, make sure that you understand the question you are answering. If you do not understand the question, ask for clarification.

In 2003, the American Society of Anesthesiologists (ASA) issued guidelines for expert witness qualifications and testimony. The guidelines were established to “limit uninformed and possibly misleading testimony.” Although the legal qualifications of expert testimony vary from state to state, the ASA guidelines state that the physician should have an unrestricted license to practice medicine, should be board certified in anesthesiology and be actively involved in the clinical practice of anesthesiology. The guidelines also state:

A. The physician’s review of the medical facts should be truthful, thorough and impartial and should not exclude any relevant information to create a view favoring either the plaintiff or the defendant. The ultimate test for accuracy and impartiality is a willingness to prepare testimony that could be presented unchanged for use by either the plaintiff or defendant.

B. The physician’s testimony should reflect an evaluation of performance in light of generally accepted standards, reflected in relevant literature, neither condemning performance that clearly falls within generally accepted practice standards nor endorsing or condoning performance that clearly falls outside accepted medical practice.

C. The physician’s testimony should make a clear distinction between medical malpractice and adverse outcomes not necessarily related to negligent practice.

D. The physician should make every effort to assess the relationship of the alleged substandard practice to the patient’s outcome. Deviation from a practice standard is not always causally related to a poor outcome.

E. The physician’s fee for expert testimony should relate to the time spent and in no circumstances should be contingent upon outcome of the claim.

F. The physician should be willing to submit such testimony for peer review.

ASA allows for the submission of complaints by ASA members against other ASA members for violation of these rules. Sanctions for violating these rules can come in the form of a censure, suspension, or expulsion from the ASA.

Conclusion

When an anesthesiologist is giving expert testimony, it is important that he or she understand exactly what he or she is getting into. This will probably be different depending on whether you are being hired to testify concerning treatment you rendered, or whether you are being hired for another purpose such as to opine on whether another physician complied with the standard of care. Because the format of litigation differs from state to state, you should consider asking the attorney who hired you what to expect from the process.

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CMS defines surgical anesthesia time as “the continuous, actual presence of a qualified anesthesia provider. This time begins when the anesthesia provider begins preparing the patient for anesthesia in the operating room or equivalent area. Anesthesia time ends when the anesthesia provider is no longer in personal attendance.” The ASA Relative Value Guide has a similar definition: “anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the patient is safely placed under post-anesthesia supervision.” This is a typical “clear as mud” definition when it comes to anesthesia and CMS. Exactly what is an equivalent area? Is this “equivalent area” ambiguity something we can use to our advantage or is it a disadvantage? Could it be both? It all depends on how or who does the interpretation of the anesthesia record; nevertheless, as long as it is documented properly and with medical necessity, the precise words can become unimportant.

Auditors have become more aggressive in the pursuit of improper payments. Recovery Audit Contractors (RAC) auditors are paid to find an issue, irrespective of its validity. It is hard to say what sparked this added target. One might speculate that a recent upsurge in the number of claims for the placement of post-operative pain blocks may be the contributing factor. These post-operative nerve blocks are usually separately billable, as long as the documentation supports that the placement was requested by the surgeon for post-operative pain management. The question of double dipping may result, though. Specifically, when nerve blocks or invasive monitoring lines are placed before the start of a surgical case, the time spent performing these services should not be included in the reported anesthesia time. Hence a poorly documented record could result in what appears to be “double dipping.”

Typically, a surgical case and the anesthesia start time will correspond to the provider in-room time and end when the patient is safely turned over to a PACU or ICU nurse. When nerve blocks are performed for purposes of post-operative pain management or when invasive monitoring catheters are placed prior to induction, however, the time associated with these procedures should be deducted from the anesthesia time. Exceptions always exist. For instance, an unstable patient coming to surgery from an I.C.U. with lines in place may require the continuous attendance of an anesthesia provider during transport to manage the patient. This time should be included in the total time billed. A cardiac patient may need to have general anesthesia prior to the insertion of the lines. As with any rule, situations arise that require the use of the provider’s best judgment.

Documentation is the key to validate coding for the post-operative pain blocks and invasive monitoring lines. No “double dipping” for time is of the essence.

Darlene Helmer, CMA, CPC, ACS-AN, CMPE, MBA
Vice President of Provider Education & Training, ABC

Compliance Corner

Darlene Helmer, CMA, CPC, ACS-AN, CMPE, MBA serves as Vice President of Provider Education and Training for ABC. She has 30+ years of healthcare financial management and business experience. Knowledgeable in billing, third-party reimbursement, coding and compliance issues, Ms. Helmer works to ensure the foremost information is presented at client in-services. She works closely with the compliance department and is a member of the ICD-10 training team. She is a long-standing member of MGMA, AHIMA, AAPC and other associations. She is a frequent speaker at local and state conferences. You can reach her at Darlene.Helmer@AnesthesiaLLC.com.
TIPS FOR IMPROVING ANESTHESIA PRE-ADMISSION TESTING PROCESSES

The pre-admission testing (PAT) process can be crucial to assessing patient risks associated with anesthesia and to help decrease surgery delays and cancellations.

Experts at this year’s MGMA 2013 Anesthesia Administration Assembly in Miami offered the following tips to help anesthesiology organizations optimize their PAT processes:

• If the hospital or surgery center provides patients with a packet of information before surgery, consider including a letter that outlines their financial responsibility to prevent miscommunications on the day of surgery regarding co-pays or insurance coverage.

• Work with your hospital or surgery center to standardize all PAT requests from anesthesiologists, nursing staff and surgeons. If all members of the team have the same expectations for patient care before surgery, the less likely there is to be a delay or cancellation.

• Consider implementing your own PAT procedures at the hospital with which you contract. This can be an opportunity to standardize PAT procedures to improve patient outcomes, strengthen your relationship with your contracted hospitals and the surgeons with whom your anesthesiologists work.

• If your staff performs pre-admission testing, train them to communicate effectively with patients and to ask detailed questions. Patients may share information during the PAT questionnaire that affects other tests or procedures, such as details about family history or medication.

• Make sure your staff knows the appropriate timeframe for the anesthesiologists and surgeons to review the PAT results before surgery. Some hospitals and surgery centers require 48 hours notice; some may require up to a week.

Madeline Hyden
Staff Writer/Editor, MGMA
Corporate Communications

MARK YOUR CALENDAR
April 11-13, 2014
The Cosmopolitan of Las Vegas, Nevada

The Advanced Institute for Anesthesia Practice Management
Securing the Future for Anesthesia Practices

The Advanced Institute for Anesthesia Practice Management (formerly the Anesthesia Billing & Practice Management Seminar) hosts some of the finest experts in the field of anesthesia billing and management. This conference will focus on practice management issues with the goal of enlightening attendees on broader group strategy issues and it will also include numerous talks on billing, coding and compliance.

This conference is a must for Anesthesiologists, CRNAs, Practice Administrators, Medical Billing Companies, Billing Managers, Professional Coders, Healthcare Consultants and Attorneys. 300-400 attendees are anticipated. To receive the program and registration details, please contact info@AIAPMConference.com or visit www.AIAPMConference.com.

This live activity has been approved for AMA PRA Category 1 Credit™.
Introducing **F1RSTUse**

Join the anesthesiologists who have already fulfilled the first reporting period of Meaningful Use and have collected over $8,000,000 from CMS; and the thousands more who stand to collect a possible $30,000,000 during 2013. **F1RSTUse** is the first complete electronic health record (EHR) platform built exclusively for anesthesiologists and pain management specialists to easily satisfy Stage 1 of Meaningful Use as required to earn the Medicare EHR incentive payment. **F1RSTUse** is entirely web-based; you don’t even need to have an existing EMR (PHR) system. All management activities are handled by ABC, all you have to do is enroll in the meaningful use program and then contact us. Email meaningful.use@anesthesiallc.com today.

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**Professional Events**

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<tr>
<td>October 11, 2013</td>
<td>Society for Ambulatory Anesthesia Mid Year Meeting</td>
<td>Moscone Center</td>
<td><a href="http://www.sambahq.org/future-meetings/">http://www.sambahq.org/future-meetings/</a></td>
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<tr>
<td>October 24 – 26, 2013</td>
<td>Ambulatory Surgery Centers 20th Annual Conference</td>
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<tr>
<td>November 9 – 10, 2013</td>
<td>ASA Quality Meeting: Creating and Measuring Quality in Anesthesiology</td>
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**ABC offers The Communiqué in electronic format**

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