

# THE DARK SIDE OF QUALITY

**Karen S. Sibert, MD**

Anesthesiologist and Columnist, Los Angeles, CA

Nobody stands up to argue against quality and value in healthcare. You might as well argue against motherhood, or puppies. Yet many physicians are inherently skeptical of definitions of “quality” that are imposed from above, whether by outside evaluators like The Joint Commission, or (worse) by the government.

There’s good reason for skepticism. Some of the “evidence” behind “evidence-based medicine” has turned out to be flawed, tainted by financial conflict of interest or outright fraudulent. Any experienced physician knows that there are fads in healthcare just as there are in fashion, and today’s evidence-based medicine may be tomorrow’s malpractice. Let’s take a closer look at what’s really going on in the world of quality metrics, and why it matters if payments to you and your hospital are increasingly linked to how you score.



## Surgical Site Infections

The financial toll of surgical site infections (SSIs) is huge, estimated in the U.S. at more than \$10 billion a year.<sup>1</sup> A recent retrospective review from the Veterans Affairs Surgical Quality Improvement Program showed that the majority of SSIs are diagnosed only *after* hospital discharge, and that 57 percent will require hospital readmission within 30 days.<sup>2</sup> The Centers for Medicare and Medicaid Services (CMS) stopped paying for

<sup>1</sup> Scott II R. The Direct Medical Cost of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. 2009 Atlanta Centers for Disease Control and Prevention. [www.cdc.gov/HAI/pdfs/hai/Scott\\_costPaper.pdf](http://www.cdc.gov/HAI/pdfs/hai/Scott_costPaper.pdf)

<sup>2</sup> Morris S et al. The relationship between timing of surgical complications and hospital readmission. JAMA Surg. Published online February 12, 2014. doi:10.1001/jamasurg.2013.4064.

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# QUALITY AND OTHER COMPONENTS OF THE VALUE PROPOSITION

No anesthesiologist has ever told me that he or she thought that the measures established by Medicare's Physician Quality Reporting System (PQRS) or even the Surgical Care Improvement Project (SCIP) provided much insight into the quality of his or her practice. To the contrary, clients and friends have often asked me, "Why are we reporting these process measures? What do they prove?"

We are very pleased to welcome the well-known anesthesiologist and writer Karen S. Sibert, MD to the pages of the Communiqué and to bring you Dr. Sibert's thought-provoking reflections on the PQRS and SCIP quality measures. In *The Dark Side of Quality*, Dr. Sibert systematically reviews the literature and leads the reader to share in the conclusion that, at best, the PQRS/SCIP measures have not reduced surgical site infection rates and, at worst, in the case of tight glucose control for cardiac surgery patients and preoperative beta blockade for non-cardiac surgery patients, they may even have contributed to higher mortality rates. In contrast, the rigorous process analysis underlying the protocol for the prevention of catheter-related bloodstream infections has yielded improvements in quality. The Centers for Medicare and Medicaid Services (CMS) are pursuing other, less demonstrably effective measures such as patient satisfaction and hospital readmission rates. The financial penalties attached to failure to document adherence to all these measures do not bode well for hospitals, anesthesiologists or their patients.

Robert Stiefel, MD is also an anesthesiologist writing for the Communiqué for the first time. As Dr. Stiefel makes abundantly clear in *What Do Hospitals Want From Anesthesia Groups?*, the pressures to comply with the quality measures questioned in Dr. Sibert's article are considerable. However well-researched and principled arguments against slavish adherence to the measures might be, they could cost anesthesia groups their hospital contracts—their livelihood. Hospitals are experiencing intense local quality and service competition and the anesthesia group that helps their administration score highly on the

standard measures, including patient satisfaction, helps its own position. Even more important to keeping the contract, as Dr. Stiefel explains, are contributions to efficiency and cost savings—and on the Five Cs of leadership: culture, consistency, communication, customer service and collaboration.

One important way for physicians to exercise leadership is through ownership of an MSO, as long-time anesthesia administrator Joe Laden explains in *The Physician-Owned Management Services Organization*. These MSOs allow physicians to maintain 100 percent control of their practices while optimizing efficiencies, enhancing quality (in the true sense) and building long-term financial assets. Mr. Laden's detailed description of the economies of scale that are possible when groups centralize their administrative functions should be read by every anesthesia practice as part of its strategic planning, whether or not an MSO turns out to be the best option.

Another way in which many anesthesiologists consider enhancing their revenues is by investing in ambulatory surgical centers. The investment may be purely voluntary, or it may result from pressure from the ASC owners who have an anesthesia franchise to award. Healthcare attorney Neda Ryan, Esq. provides a thorough refresher on the applicability of the federal anti-kickback statute and Stark law to these transactions in *Thinking of Investing In, or Renting Space In, an ASC? Have You Taken Compliance into Consideration?*

Despite doctors' best clinical efforts, sometimes things will go wrong and a patient may end up with an injury. "Medical errors happen," writes Christopher Ryan, Esq. and Danial Laird, MD, JD in *Should You Apologize for a Poor Outcome?* The authors are litigators (one of whom, Dr. Laird, previously practiced as an anesthesiologist) and their focus is on the implications of apologies in malpractice lawsuits. While acknowledging the argument that expressing regret shows compassion, which may prevent a claim, they raise concerns about the ability of patients to recall, years after the fact, whether the doctor voiced sympathy

or actually made a statement of culpability. State laws on what constitutes an apology and whether it may be used at trial vary. The take-away message is that doctors who would like to apologize for a poor outcome should always involve their risk management department.

Unless this issue of the Communiqué is the only practice management publication you have read in recent memory, you are already aware that the deadline for implementation of ICD-10 is just about six months away. Darlene Helmer, ABC Vice President of Provider Education and Training, reviews the six key steps in preparing for the transition—planning, communicating and training, assessing and improving workflow, testing software and processes, implementing changes and surviving the first months after implementation—in *ICD-10 is the Latest Y2K: The Potential Impact on Provider Revenue*. The clock is running, but those who are following these steps, or who begin to take them now, still have time to prepare.

ABC is embarking on a new educational venture for anesthesiologists and others interested in the business side of anesthesia practice. Together with the Center for Continuing Education at Tulane University Health Sciences Center and Medical Business Solutions, we are sponsoring the Advanced Institute for Anesthesia Practice Management (AIAPM) that will take place in Las Vegas on April 11-13, 2014. We certainly hope to see you there. We would also be most interested in hearing from readers who want to learn about—or to present—a topic at the 2015 AIAPM. As always, we would also like your suggestions for future issues of the Communiqué.

With best wishes,



Tony Mira  
President and CEO



# WHAT DO HOSPITALS WANT FROM ANESTHESIA GROUPS?

Robert Stiefel, MD

Co-Founder and Principal, Enhance Healthcare, Aventura, FL

In today's healthcare environment anesthesia groups have many issues to deal with, including Accountable Care Organizations (ACOs), pressure on reimbursement, quality tracking, the perioperative surgical home and pressure on hospital subsidies. Despite these concerns, it is important to remember that for groups that enjoy exclusive arrangements with one or more facilities, their key asset is their hospital contract. Without a contract for services, the patients at that facility might well be serviced by another entity, and all other issues would become irrelevant. Since hospital contracts are awarded and retained at the pleasure of facility administration, a fundamental consideration for groups should be to understand the expectations of facility leaders from their anesthesia providers.

This article will address that issue from the perspective of the author, an anesthesiologist who consults for both hospitals and providers, giving a unique perspective on these expectations. As the world of healthcare continues to shift from pay-for-volume to pay-for-value, and as patient satisfaction and transparency become our new reality, the expectations of facility leaders shifts as well. We will approach hospital expectations of anesthesia groups at a high level and as a "Top 10 List" in the David Letterman format—counting down to the most important expectation.

**10. Help Us Be "Accountable."**  
Implementation of the Accountable



Care Act (ACA) has had many impacts, one of which is a focus on ACOs. While these entities currently impact a minority of anesthesia groups, many facilities are carefully considering creation of or involvement in an ACO. Since ACOs involve closer integration of care throughout the patient experience, anesthesiologists are ideally positioned to take control of the perioperative experience for patients. While hospital leaders typically do not specifically describe it as such, these expectations are fairly consistent with the perioperative surgical home initiative championed by the ASA.<sup>1</sup>

Facility leaders are looking for anesthesia providers to oversee and manage surgical care from time of booking to time of discharge. These efforts include preoperative preparation, pain management to facilitate recovery and discharge, participation in procedure specific protocols (such as total joint programs) to

optimize patient safety, efficiency and satisfaction, and assistance in the ICU as indicated.

**9. Advise on Technology.** Part of the ACA focuses on hospital adaptation of technology. Terms such as "meaningful use" are now part of the daily lexicon for hospital leaders, and technology adaptation across the entirety of patient care continues to advance at a rapid pace. Facility incentive revenue, which may be in the millions of dollars, is at risk for not meeting meaningful use parameters. Perioperative and Anesthesia Information Systems (AIMS) are only a part of that spectrum, but these are the areas where anesthesia providers are looked to as value added experts. For perioperative systems, anesthesiologists are commonly expected to participate as part of a larger team determining the system to either implement or upgrade.

The installed base of AIMS has increased dramatically in recent years, with almost 50 percent of hospitals with a system live, being implemented or under contract.<sup>2</sup> When it comes to AIMS, hospital leaders view anesthesia groups as their subject matter experts and expect at least one group member to be well-versed in the desirable attributes of a system, the pros and cons of various options, and to actively participate in the choice of a system. During the implementation of a new anesthesia IT platform, it is important that all group members participate willingly in the transition, and are not seen as impediments to the initiative moving forward.

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<sup>1</sup> Schweitzer, M. et. Al, June 2013, The Perioperative Surgical Home Model, ASA Newsletter, v. 77 no. 6, 58-59

<sup>2</sup> Stonemetz, J., November 2013, 2013 AIMS Market Update, ASA Newsletter, v. 77 no. 11, 28-30

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care related to SSIs in 2008 by designating them as “never events,” or non-reimbursable serious hospital-acquired conditions. Now SSIs are part of a long list of hospital-acquired conditions that can result in reduced CMS payments to hospitals, and will bring further reduction in payments over the next several years with the implementation of “value-based purchasing.” More than 1,400 hospitals will see their Medicare payments cut by as much as 1.25 percent this year—a margin that could spell financial disaster for hospitals already struggling.<sup>3</sup>

You may already be among the more than 50 percent of anesthesiologists who have been reporting performance metrics to the Physician Quality Reporting System (PQRS), which is administered by CMS. When the system started in 2007, CMS offered a bonus payment of 1.5 percent for successful participation, but that soon shrank to 0.5 percent and will be discontinued after 2014. Starting in 2015, CMS will impose a 1.5 percent payment reduction for physicians who do not participate in PQRS, and will push the pay cut to 2 percent in 2016.

If you participate in PQRS reporting, you know that two of the measures that anesthesiologists report are directly aimed at SSI prevention: perioperative temperature management and antibiotic timing. PQRS measure #193 specifies that the patient must receive “active warming” or have a temperature above 36°C recorded within 30 minutes before or 15 minutes after anesthesia end time. Measure #30 specifies that prophylactic parenteral antibiotics must be administered within one hour



before skin incision. Compliance with these two measures isn't hard to achieve, though no one seems to question the cost to the American healthcare system of all those forced-air warming blankets and machines, or ask why giving antibiotics 61 minutes instead of 59 minutes before skin incision is an automatic “fail.”

But have CMS threats and PQRS compliance done any good? A just-published editorial in *Anesthesiology* concluded: “Despite early efficacy literature establishing the value of specific antibiotic timing and active warming, repeated large database analyses have not observed robust effectiveness across hundreds of hospitals.”<sup>4</sup> Simply put, as many of us have noticed in our own hospitals, SSI rates have remained about the same.

### *What About Skin Preparation?*

Did your hospital, like so many, abruptly switch from povidone-iodine antiseptic solution to ChloroPrep®? If so, a 2010 study from the *New England Journal of Medicine* (NEJM), “Chlorhexidine-Alcohol versus Povidone-Iodine for Surgical Site Antisepsis,”<sup>5</sup> was probably

cited as proof that ChloroPrep would be more effective. No doubt, the staff was warned of the increased risk of operating room fires with ChloroPrep, since it contains 70 percent isopropyl alcohol in addition to chlorhexidine. But the future benefit in reducing SSIs would outweigh the risk of fire, or so the story went.

Imagine our surprise when the U.S. Department of Justice (DOJ) announced in January that ChloroPrep's manufacturer, CareFusion Corp., would pay the government a \$40.1 million settlement to resolve allegations that the company violated the False Claims Act by paying kickbacks to boost sales of ChloroPrep and promoting it for uses that aren't FDA-approved.

Who received kickbacks? According to the DOJ's press release<sup>6</sup>, the complaint alleged that “CareFusion paid \$11.6 million in kickbacks to Dr. Charles Denham while Denham served as the co-chair of the Safe Practices Committee at the National Quality Forum, a non-profit organization that reviews, endorses and recommends standardized health care performance measures and practices.” Another physician with close ties to CareFusion, Dr. Rabih Darouiche, was the lead investigator on the NEJM article, and one co-author, Cynthia Crosby, was an employee of Cardinal Health, the parent company of CareFusion.

The Leapfrog Group, launched by the Business Roundtable in 2000, claims that its hospital survey is “the gold standard for comparing hospitals' performance on the national standards of safety, quality and efficiency.” On January 30, Leapfrog announced that it accepted the resignation of Dr. Denham, who had served as chair of Leapfrog's Safe Practices Committee since 2006, amid concerns that Dr. Denham had failed to reveal his “potentially compromising relationship with CareFusion.” At the same time,

<sup>3</sup> Rau J. Nearly 1,500 hospitals penalized under Medicare program rating quality. Kaiser Health News. Published online November 14, 2013. [www.kaiserhealthnews.org/stories/2013/november/14/value-based-purchasing-medicare.aspx](http://www.kaiserhealthnews.org/stories/2013/november/14/value-based-purchasing-medicare.aspx)

<sup>4</sup> Kheterpal S. In the land of the blind, the one-eyed man is king. *Anesthesiology* 2014; 120(3): 523-525.

<sup>5</sup> Darouiche R et al. Chlorhexidine-alcohol versus povidone-iodine for surgical-site antisepsis. *N Engl J Med* 2010; 362:18-26.

<sup>6</sup> Department of Justice, Office of Public Affairs. CareFusion to pay the government \$40.1 million to resolve allegations that include more than \$11 million in kickbacks to one doctor. Published online January 9, 2014. <http://www.justice.gov/opa/pr/2014/January/14-civ-021.html>

Leapfrog said it would undertake “a thorough scientific review of its full slate of endorsed safe practices.”<sup>7</sup>

Meanwhile, the Washington State Surgical Care and Outcomes Assessment Program was busy between 2011 and 2012 conducting a prospective cohort analysis comparing commonly used skin antiseptic agents for patients undergoing clean-contaminated surgery (including colorectal cases).<sup>8</sup> Among the 7,699 patients (a much larger group than the 849 in the NEJM study), the researchers compared chlorhexidine, chlorhexidine in isopropyl alcohol, povidone-iodine and iodine-povacrylex in isopropyl alcohol. Their conclusion: “For clean-contaminated surgical cases, this large-scale cohort study did not demonstrate superiority of any commonly used skin antiseptic agent in reducing the risk of SSI, nor did it find any unique effect of isopropyl alcohol. These results do not support the use of more expensive skin preparation agents.”

In other words, we don't yet have the “magic bullet” that will reduce the rate of SSIs to zero. Simplistic efforts to link SSI rates to “quality” measures such as active warming, antibiotic timing, or using one type of skin antiseptic, fail to take into account obvious risk factors such as diabetes, socioeconomic status, obesity and poor general health. Looking at the larger issue of postoperative complications and 30-day hospital readmission rates, a recent editorial in *JAMA Surgery* concluded, “Accounting for these differences may be a critical prerequisite before penalizing hospitals that disproportionately and admirably care for populations at higher risk for readmission.”<sup>9</sup>

### *The Saga of Tight Glucose Control*

The Surgical Care Improvement Project (SCIP) is responsible for defining many of the quality measures that your hospital probably tracks. These are subsequently endorsed by the National Quality Forum (where Dr. Denham formerly headed the Safe Practices Committee) and included in The Joint Commission's Specifications Manual for hospital quality core measures. One measure, known as SCIP-INF-4, tracks the percentage of “cardiac surgery patients with controlled postoperative blood glucose.” To meet this quality target, a cardiac surgery patient must have a blood glucose less than or equal to 180 mg/dl “in the timeframe of 18 to 24 hours after anesthesia end time.”

The rationale for this quality measure is that hyperglycemia has been associated with increased in-hospital morbidity and mortality for multiple medical and surgical conditions. The SCIP measure has been revised several times, and the blood glucose target hasn't always been 180. Starting around 2001, there was an international push toward much tighter control of blood glucose levels in ICU patients, aiming for a target of 80-110 mg/dl. The evidence basis for tight control was a single-center study that associated intensive insulin therapy with all sorts of improved outcomes, from fewer infections to less time on the ventilator and a lower incidence of acute renal failure.<sup>10</sup>

The only problem was that those results couldn't be replicated, and in fact more patients on tight glucose control ended up dead. In a landmark 2009 project now known as NICE-SUGAR, a multi-center, multi-national group of



42 hospitals including the Mayo Clinic conducted a randomized study of 6,100 patients.<sup>11</sup> Compared with conventional management and glucose level maintained at less than 180, the patients on intensive insulin therapy with glucose levels kept between 81 and 108 were shown to have more hypoglycemia, higher mortality, and no difference in morbidity or length of stay. Suddenly tight glucose control was no longer the rage.

In March 2014, the *Journal of Thoracic and Cardiovascular Surgery* published an article with the straightforward title, “Surgical Care Improvement Project measure for postoperative glucose control should not be used as a measure of quality after cardiac surgery.”<sup>12</sup> The authors looked at outcomes from 1,703 patients, 90 percent of whom achieved postoperative 6 a.m. blood glucose levels of less than 200. No significant differences were observed in major morbidity, mortality or resource usage among the propensity-matched cohorts. Concluded the authors, “These data suggest that this metric might not be a valid measure of postoperative surgical quality.”

<sup>7</sup> The Leapfrog Group accepts resignation from Dr. Charles Denham. Published online January 30, 2014. [http://www.leapfroggroup.org/policy\\_leadership/leapfrog\\_news/5126937](http://www.leapfroggroup.org/policy_leadership/leapfrog_news/5126937)

<sup>8</sup> Hakkarainen T et al. Comparative effectiveness of skin antiseptic agents in reducing surgical site infections: a report from the Washington State Surgical Care and Outcomes Assessment Program. *J Am Coll Surg*. 2014 Mar; 218(3): 336-44. [www.ncbi.nlm.nih.gov/pubmed/24364925](http://www.ncbi.nlm.nih.gov/pubmed/24364925)

<sup>9</sup> DiBrito S, Makary M. Forecasting hospital readmission after surgery: Data and the hard-to-measure role of culture. *JAMA Surg*. Published online March 5, 2014. doi:10.1001/jamasurg.2014.10.

<sup>10</sup> Van den Berghe G et al. Intensive insulin therapy in critically ill patients. *N Engl J Med* 2001; 345:1359-1367.

<sup>11</sup> The NICE-SUGAR Study Investigators. Intensive versus conventional glucose control in critically ill patients. *N Engl J Med* 2009; 360:1283-1297.

<sup>12</sup> Lapar D et al. Surgical Care Improvement Project measure for postoperative glucose control should not be used as a measure of quality after cardiac surgery. *J Thorac Cardiovasc Surg*. 2014 Mar; 147(3): 1041-8. [www.ncbi.nlm.nih.gov/pubmed/24418668](http://www.ncbi.nlm.nih.gov/pubmed/24418668)

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### Fraud, Stroke and Beta-Blockade

SCIP has defined beta-blocker use in non-cardiac surgery patients as another core measure of hospital quality. SCIP-CARD-2 tracks the percentage of “surgery patients on beta-blocker therapy prior to arrival who received a beta-blocker during the perioperative period.” The medication must be taken, SCIP says, either the day before or the day of surgery, and on either postoperative day 1 or 2.

Is there a controlled study that demonstrates conclusively that the SCIP beta-blocker measure makes surgical patients healthier? Or that they recover better from surgery? No, there isn't. Does the SCIP measure track whether the patient's blood pressure or heart rate are maintained within a normal range? No, it doesn't. All it says is that the patient should receive an unspecified dose of one of a number of drugs in the beta-blocker class. A physician can be “compliant” with the SCIP measure by prescribing only a tiny dose of esmolol. It doesn't take a cardiologist to determine that this is ridiculous. What's worse is that aggressive beta-blocker use around the time of surgery may be hazardous. A 2013 review and meta-analysis of the medical literature concluded that starting beta-blockers before surgery caused a 27 percent increase in 30-day all-cause mortality.<sup>13</sup> Beta-blockade reduced the incidence of heart attacks, but increased the incidence of stroke and significant hypotension.

The authors of SCIP-CARD-2 cite scientific evidence to support their recommendations. Unfortunately, much of



the science has been discredited. Dr. Dan Poldermans, a prolific Dutch researcher, led the DECREASE-IV study, which is no longer considered credible. The authors of the previously cited meta-analysis remarked about DECREASE-IV that “the key data required to judge outcomes were missing and the adjudication committee was fabricated.”

Larry Husten of [forbes.com](http://forbes.com) has been reporting the damage caused by the Poldermans research misconduct with the overwrought headline: “Medicine or Mass Murder? Guideline Based on Discredited Research May Have Cause 800,000 Deaths in Europe Over the Last 5 Years.”<sup>14</sup> Even if Husten exaggerates, the SCIP beta-blocker measure certainly warrants critical reexamination. Good control of a patient's blood pressure and heart rate is common sense, and another medication might be better than a beta-blocker for a specific patient's perioperative needs.

### It's Complicated: Lessons From Primary Care

Improving quality in primary care seems to be just as tough as it is in the perioperative world. A major article in

*Journal of American Medical Association* (JAMA) recently reported on the three-year experience of trying to transform primary care practices in Pennsylvania, with the goals of improving quality and containing costs.<sup>15</sup> The pilot practices received technical assistance to establish registries to identify patients overdue for chronic disease services, create monthly quality indicator reports, and implement electronic prescribing. They were encouraged to establish a “team-based model” of primary care practice, and received annual bonus payments per full-time equivalent clinician ranging from \$28,000 to \$95,000.

Electronic prescribing increased from 38 percent to 86 percent, and the use of registries to identify patients overdue for chronic disease services increased from 30 percent to 85 percent. Of note, six of the pilot practices were “nurse-managed health centers.” Pilot participation was significantly associated with greater performance improvement on only one quality measure: nephropathy monitoring in diabetes. On 10 other quality measures—including screening for cervical cancer and colon cancer, and monitoring LDL and Hba1c—the pilot practices showed *no* statistically significant performance improvement relative to comparison practices. Perhaps most important, the results demonstrated *no* reduction in hospital admissions, emergency department visits, ambulatory care services, or total costs.

The results were a disappointment to the Obama administration, which has heavily promoted the “patient-centered” primary care model, as the *Wall Street Journal* (WSJ) pointed out on in a February 25 article.<sup>16</sup> The WSJ quoted Dr. Mark W. Friedberg, a researcher at RAND Corp. and lead author of the study, who said people have been convinced that the new model “is a proven intervention that doesn't even need to

<sup>13</sup> Bouri S et al. Meta-analysis of secure randomised controlled trials of  $\beta$ -blockade to prevent perioperative death in non-cardiac surgery. *Heart*. Published online July 31, 2013. <http://heart.bmj.com/content/early/2013/07/30/heartjnl-2013-304262.full?eaf>

<sup>14</sup> Husten L. Medicine or mass murder? Guideline based on discredited research may have caused 800,000 deaths in Europe over the last 5 years. [forbes.com](http://www.forbes.com/sites/larryhusten/2014/01/15/medicine-or-mass-murder-guideline-based-on-discredited-research-may-have-caused-800000-deaths-in-europe-over-the-last-5-years/). Published online January 15, 2014. <http://www.forbes.com/sites/larryhusten/2014/01/15/medicine-or-mass-murder-guideline-based-on-discredited-research-may-have-caused-800000-deaths-in-europe-over-the-last-5-years/>

<sup>15</sup> Friedberg M et al. Association between participation in a multipayer medical home intervention and changes in quality, utilization, and costs of care. *JAMA*. 2014; 311(8): 815-825.

<sup>16</sup> Beck M. Study questions “medical home” programs for chronically ill. *The Wall Street Journal*, February 25, 2014. <http://online.wsj.com/article/SB10001424052702304834704579405444193946228.html>

be tested or refined. Our findings will hopefully change those views.” An accompanying editorial in *JAMA* noted that the model “has been promoted for widespread adoption, using a fairly generic and fixed set of structural practice features, even before being fully developed in targeted high-risk populations or before clearly understanding which features or combination of features are most effective with which patients. It is time to replace enthusiasm and promotion with scientific rigor and prudence.”<sup>17</sup>

### What Should We Conclude?

Scientific rigor and prudence are standards that have been sadly lacking in the evolution of a number of “quality measures,” from SSI prevention to perioperative beta-blockade and tight glucose control. One notable exception is the reduction of infection rates in central venous catheters placed in the ICU, with consistent use of a simple standardized protocol of hand-washing, full barrier precautions, skin cleansing with chlorhexidine, avoidance of the femoral site and prompt removal of unnecessary catheters. These were common-sense measures that resulted in immediate and sustained reduction in ICU central line infections and the enormous cost of treating them.<sup>18</sup>

Dr. Peter Pronovost’s success in reducing catheter-related infections is a good illustration of how standardizing routine, well-defined processes can improve quality and reduce errors. This is a basic business principle with broad application to any process that can be broken down into components, analyzed, modified, studied and improved. It is also a guiding principle behind the Perioperative Surgical Home concept, which aims to take the same kind of rigorous process

analysis, led by anesthesiologists, and apply it to the care of patients before, during, and after surgery.

Unfortunately, the direction CMS is taking—led by a nurse (Marilyn Tavenner) rather than a physician—lacks any semblance of scientific rigor and prudence. The “value-based” system will increasingly link payments made to physicians and hospitals with patient satisfaction scores. While this may appeal to consumer advocates, the fact is that the delivery of medical care is not like running a restaurant, and the customer is not always right. A 2013 study in *JAMA Internal Medicine* reported that patient preferences for shared decision-making were associated with longer inpatient stays and with 6 percent higher total hospitalization costs.<sup>19</sup> Dr. Frederick Greene, a nationally recognized general surgeon, wrote recently, “We have all experienced patients who demand certain drugs, imaging studies, surgical procedures and home care strategies that may be unwarranted, unhelpful or downright wrong!”<sup>20</sup> Physician pay should not be tied to Press Ganey scores, Dr. Greene argued. “The only winners in this game of linking pay to patient satisfaction are the entities created to measure and promulgate these highly suspect data.”

CMS also plans to link higher percentages of hospital payment to clinical outcomes: hospital-acquired complications of care, and 30-day mortality rates for acute myocardial infarction, heart failure and pneumonia. The list of linked outcomes is certain to expand and include 30-day mortality, morbidity, and hospital readmission rates surrounding specific surgeries. This trend will incentivize community hospitals to funnel every complicated, frail or high-risk patient to the nearest tertiary care center which won’t be able to turn

them away. How CMS expects tertiary care public and teaching hospitals to remain financially viable is unclear.

Perhaps the only positive note to less reliance on fee-for-service payment is that we might see more appropriate clinical decision-making for high-risk patients *before* they are subjected to major invasive procedures. Too often these patients spend their last weeks of life enduring a series of painful interventions in the ICU, when conservative medical management might have been more appropriate than surgery. The time to have that conversation with a patient and family is before the episode of care begins, not in the preoperative holding area.

Otherwise, the future of the clinical anesthesiologist appears to include increasing attention turned away from the patient and toward a computer screen so that adherence to “quality measures” is documented to the satisfaction of CMS, NQF, SCIP, and any other acronym that hospital administrators want to appease. The “rules” will become increasingly arbitrary and less rational, as they seem to do with every Joint Commission visit. Humanistic, individualized medical care? We’ll see that, maybe, in old movies. ▲

**Karen S. Sibert, MD,** is a full-time practicing anesthesiologist in Los Angeles, specializing in anesthesia for thoracic surgery. She is a native of Amarillo, Texas. After college, Dr. Sibert worked first



as a reporter for the Wall Street Journal before she went back to Texas and graduated from Baylor College of Medicine. She maintains a lively interest in writing for the public as well as for professional journals, and particularly enjoys critical observation at the intersection of politics and medicine. As her husband, Dr. Steven Haddy, has said, “Karen believes everyone is entitled to her opinions.” She can be reached at [karen.sibert@cshs.org](mailto:karen.sibert@cshs.org).

<sup>17</sup> Schwenk T. The patient-centered medical home: One size does not fit all. *JAMA*. 2014; 311(8): 802-803.

<sup>18</sup> Pronovost P et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *N Engl J Med* 2006; 355: 2725-2732.

<sup>19</sup> Tak H et al. Association of patient preferences for participation in decision-making with length of stay and costs among hospitalized patients. *JAMA Intern Med*. 2013; 173(13): 1195-1205.

<sup>20</sup> Greene F. A flawed process: Physician reimbursement linked to patient happiness. *Anesthesiology News*. Published online February 21, 2014. [http://m.anesthesiologynews.com/Article.aspx?d=Web+Exclusives&d\\_id=175&i=February+2014&i\\_id=1036&a\\_id=25977](http://m.anesthesiologynews.com/Article.aspx?d=Web+Exclusives&d_id=175&i=February+2014&i_id=1036&a_id=25977)

## WHAT DO HOSPITALS WANT FROM ANESTHESIA GROUPS?

*Continued from page 3*

Other areas of technology where anesthesia groups are expected to contribute include the choice of anesthesia quality tracking tools and purchase of anesthesia machines, as well as the purchase of items such as ultrasound machines and infusion pumps.

**8. Help Us Meet Hospital P4P Items.** Another component of the ACA which directly impacts hospital revenue is the Value Based Purchasing Initiative (VBP). The percentage of CMS payments at risk based on VBP to hospitals gradually increases each year to 2 percent by 2017. In 2014, this program is based on measurements of quality and is 45 percent based on process of care, 30 percent on patient experience and 25 percent on mortality rates for certain conditions including heart attacks. Process of care items influenced by anesthesia providers includes antibiotic administration, venous thromboembolism (VTE) prophylaxis and proper glycemic management for cardiac surgical patients. Patient experience items that anesthesia providers influence include pain control, patient communication and responsiveness of hospital staff.

With many hospitals operating on thin profit margins, the escalating VBP revenue at risk becomes increasingly important each year. Furthermore, in the new age of transparency, much of the data gathered in the VBP program is publicly available at [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov). For these two reasons, hospital leaders are understandably focused on excellent VBP performance. Since anesthesia providers are involved in all surgical care, we can expect administrators to increasingly look to us to “take ownership” of all perioperative related areas of VBP.



**7. Cover “Out of OR” cases.** Over the past decade, we have seen rapid growth in requests for anesthesia services outside of the operating room and obstetrical floor. Endoscopy, MRI, cath lab and interventional radiology are some common, and often far flung, locations anesthesia groups are asked to cover. As an example of the growth in Out of OR services, one study showed that the anesthesia payments for endoscopy services more than doubled from 2003 to 2009.<sup>3</sup>

Hospitals, of course, want to facilitate volume growth of these cases which contribute to revenue and profits. To do so, availability of safe and immediate anesthesia services helps to support the satisfaction of the proceduralists, and to continue caseload growth. Unfortunately, these cases are often scheduled on the day of the procedure and not coordinated with the OR schedule, and cases in various locations are not efficiently coordinated among themselves.

This leads anesthesia groups to the risk of inefficient use of expensive providers, or of alienating the proceduralists and, therefore, facility leadership. We recommend that groups take a proactive

approach to Out of OR cases. Gather data on caseload and revenue opportunities as well as manpower costs for coverage. Develop a pro-forma to assess the profitability or expense for coverage of these cases. Then work with resources in the hospital and medical staff to develop a coordinated approach to scheduling these procedures. In our experience, properly managed Out of OR anesthesia coverage can be profitable, while refusal to provide coverage can cause significant friction with hospital leadership.

**6. Address Post-Op Pain.** As described above, pain control is part of the patient satisfaction component of VBP scoring. In addition, proper attention to pain control has the potential to improve post-operative ambulation, reduce length of stay and reduce complications. From the perspective of hospital administration, in addition to the above items, excellence in post-operative pain control can be a significant driver of surgeon satisfaction which can have a positive influence on surgical market share.

In 2014, the ability of anesthesia providers to place blocks for many orthopedic procedures is a core expectation.

<sup>3</sup> Liu, H; Waxman, D; Main, R; Mattko, S, 2012, Utilization of Anesthesia Services During Outpatient Endoscopies and Colonoscopies and Associated Spending in 2003-2009. JAMA, v.7 no. 11, 1178-1184

We now often see the use of continuous catheters, home infusions and orthopedic block services. Both surgeons and administrators often expect these capabilities, and the ability or lack thereof can significantly move local market share.

Beyond orthopedics, expectations are escalating for anesthesiologists to be aggressively involved in addressing post-operative pain for all surgical patients. As the focus continues on patient satisfaction and reduced length of stay, the ability to provide these services will be seen as a differentiator between anesthesia groups. The challenge from the group perspective is to secure the expertise and resources to provide these services profitably. This is a challenge we believe must be met, as it appears likely that the ability to provide advanced pain management services will be a fundamental requirement to maintain surgeon and hospital support in the age of transparency.

**5. Drive OR Efficiency.** As reimbursement for healthcare continues to get squeezed, facilities recognize the imperative to maximize efficiency. In a fee for service model the operating room typically accounts for the majority of hospital profits and revenues, while in an ACO or flat payment model it becomes an area of

expense. In either model, the focus on OR efficiency is high on the list of many hospital leaders. Despite this recognition many leaders are not experts in the details of OR efficiency improvement. They naturally look to their anesthesia providers as experts to lead ongoing OR performance improvement in conjunction with nursing leadership.

From the hospital perspective it is no longer acceptable for anesthesia providers to simply provide quality intraoperative care. The expectation is for groups to take an active role in managing the OR board, to create flexibility in scheduling to meet the OR's needs, to help drive OR efficiency improvement efforts, and to be the "eyes and ears" of administration on the OR. In 2014, groups that choose not to provide these value-added services are frequently viewed as not meeting the requirements of their facilities.

**4. "Own" Pre-op Preparation.** As an important driver of on time starts and reducing day of surgery cancellations, preoperative preparation is recognized as an important anesthesia deliverable by hospital administrators. As with OR Efficiency, CEO understanding of the details of preadmission testing is often limited. They look to their provider group to prepare patients for a seamless start to the day of surgery. As a rule, administrators are flexible in the route taken to achieve this goal. They are typically comfortable with triage mechanisms where only a subset of patients are seen by anesthesia prior to the day of surgery. A common theme is the desire for all providers within groups to develop consistent parameters defining an acceptable pre-operative workup. A great dissatisfier is where a patient is deemed cleared prior to the day of surgery by one anesthesia provider, and then further testing is requested by a different provider on the day of surgery.

Finally, it is generally recognized that there is a great deal of variability

in preoperative tests ordered. Hospital leaders expect standardization of testing, and to limit testing to that which is medically indicated. Once again, they look to their anesthesia group to coordinate and implement consistent, efficient rules to optimally prepare preoperative patients.

**3. Reduce Our Subsidy.** It is estimated that 80 percent of hospitals pay some financial support to ensure anesthesia services. Many of these subsidies are over \$1 million. Consistent with the theme of pressured hospital profit margins, anesthesia subsidies are receiving increased scrutiny with each passing year. In order to understand opportunities for reduction, hospital leaders should understand the factors that drive subsidies. In evaluating a subsidy, we identify four key drivers:

- Fair Market Value compensation
- Required anesthetizing locations
- Staffing model
- Anesthesia revenue cycle performance

When analyzing subsidies we attempt to isolate each of these factors and identify opportunities for cost savings. One of the most important expense drivers is the required number of anesthetizing locations. OR leaders, especially in competitive markets, tend to err on the side of excess capacity in order to attract surgeons with available first case starts. This is a business decision for the facility, but it must be understood that poor utilization of expensive anesthesia resources adds to anesthesia subsidy costs.

Our advice to anesthesia groups regarding facility support is to be proactive in communicating with hospital leadership about subsidy spending. Offer solutions as a partner, rather than be seen as wanting to passively sit back and collect a large ongoing payment. In your discussions stay fact-based, attempt to isolate the impact of the drivers on the subsidy at your facility, and develop recommendations to mitigate subsidy.



## WHAT DO HOSPITALS WANT FROM ANESTHESIA GROUPS?

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### 2. Leadership, Leadership, Leadership.

Over the past decade we have been involved in hundreds of anesthesia-hospital negotiations. While subsidy spend rates are almost always near the top of the agenda on the part of both parties, behind closed doors it is extremely common to hear concerns about anesthesia group leadership from the facility C-suite executives.

As a contracted service, facility leaders look to the anesthesia department for an aligned direction, continually improving operating room performance and services. The culture of anesthesia groups varies greatly from facility to facility. Some groups have a mindset of customer service, responsiveness and play an active role in advancing operating room performance. Others groups are perceived as the opposite. In fact, when asked who anesthesia groups feel is their main customer, surgeons and administrators often say that the group perceives itself as the customer. In other words, the groups' goal is to minimize their own work, maximize time off and to maintain the status quo wherever possible.

Needless to say this is not a great strategy for long term contract retention!

In the current environment, with many large national and regional entities seeking to earn hospital contracts, being perceived as self-serving and non-customer friendly is a dangerous strategy. We believe that group leaders should recognize that they are in a service business and that they should understand and service their customers—surgeons, administrators, patients and OR nursing leadership. We recommend a focus on the “5 Cs of leadership.”

- Culture (of customer service)
- Consistency (in delivery of services)
- Communication (with all other members of the perioperative team)
- Customer Service (for administration, surgeons and patients)
- Collaboration (on initiatives to improve OR safety and efficiency)

**1. Please, Please, Please Keep The Surgeons Out Of My Office!!** After all, the bottom line is the bottom line! Hospital C-Suite executives are constantly inundated with issues from all areas of

their facilities. To a meaningful degree their perception of hospital-based service providers comes from the feedback of the medical staff. In the case of anesthesia groups that is, of course, focused on surgeons. Surgeons don't tend to be shy about voicing their opinions, which form the basis for the view of the anesthesia group from the C-Suite.

In order to maintain a positive rapport with surgical colleagues, focus on many of the items in #2. In our experience, communication is the cornerstone of maintaining good relationships. Patient care is fraught with many variables that can derail the daily schedule and negatively impact surgical colleagues. If anesthesia providers focus on physician-to-physician communication, many problems may be nipped in the bud and the surgeons will (hopefully) stay out of the C-Suite.

For anesthesia groups the current environment includes our primary hospital customers feeling extreme cost sensitivity and intense local quality and service competition. By always keeping in mind what the needs of our surgeons (and their patients) are, we can keep the support of our hospital customers who control our most vital professional assets—our contracts. ▲

**Robert Stiefel, MD,**  
Co-Founder and  
Principal, Enhance  
Healthcare Peri-  
operative & Anes-  
thesia Consulting,

is a board-certified anesthesiologist who has in-depth experience advising providers and hospitals on both the clinical and financial aspects of anesthesia service delivery and operating room performance. He can be reached at [rstiefel@enhancehc.com](mailto:rstiefel@enhancehc.com).



# THE PHYSICIAN-OWNED MANAGEMENT SERVICES ORGANIZATION

Joe Laden

*President, Ohio River Valley Associates, LLC, Louisville, KY*

A Management Services Organization (MSO) is a legal entity created to provide management and administrative services to other organizations. For the purpose of this article, we will describe the physician-owned MSO that provides services to multiple independent anesthesiology groups and is owned and governed by the owners of the anesthesiology groups the MSO serves.

The physician-owned MSO is designed to allow private practice physicians to maintain 100 percent control of their practice while optimizing operating efficiencies, enhancing the care they provide and building long-term financial assets. The MSO model allows anesthesiologists to provide services to healthcare facilities, surgeons and patients in a more efficient and cost-effective manner. Following are the specifics of how this is accomplished.

An anesthesiology group can divide its general functions into clinical and business. Over the years, anesthesiologists have found that their business operation has increased in importance and complexity as adequate reimbursement becomes more of a challenge and government regulation increases. Business operations usually consume 5–10 percent of anesthesia practice revenue with the remainder paying clinicians' salary and benefits. Two non-clinical goals of a well-run anesthesia practice should be to decrease business overhead and provide the best possible business and financial management. Success in these goals will maximize income of the anesthesia practice owners.

## ORGANIZATION

The MSO can be used to achieve these goals for several anesthesiology



groups by placing their business management and financial functions within a single corporation, the MSO. The anesthesia clinical practices are relieved of direct involvement in these functions and of personnel who may have been carrying out these functions.

The end result is that anesthesiologists continue ownership in their anesthesia clinical practice and also own a portion of the MSO that provides services to the practices. If, for example, three anesthesia practices got together to form an MSO, and the practices had 10, 20 and 30 owners, the MSO would be owned equally by 60 anesthesiologists. Each anesthesiologist would purchase an equal number of shares to capitalize the MSO. The MSO, in this model, would be owned by individuals, not by the three practices. The MSO would be governed by a representative board of directors (or managing members if a LLC-limited liability corporation). Each practice would

have proportionate representation on the board of directors. Using this example, the MSO board may have one member from the smaller practice, three from the largest practice and two from the remaining practice. The operating agreement of the MSO would have provisions to delineate the powers of the board and to assert minority rights that would prevent the smaller practices from being outvoted on important matters.

It is important to note that after the formation of the company by the three anesthesia practices in the example we are using, there are now four companies and the MSO is subservient to the owners of the three independent practices. Nothing changes about the clinical practices. They go on as usual, staffing facilities and providing anesthesiology and pain management services. Each practice maintains its existing contracts with

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# THE PHYSICIAN-OWNED MANAGEMENT SERVICES ORGANIZATION

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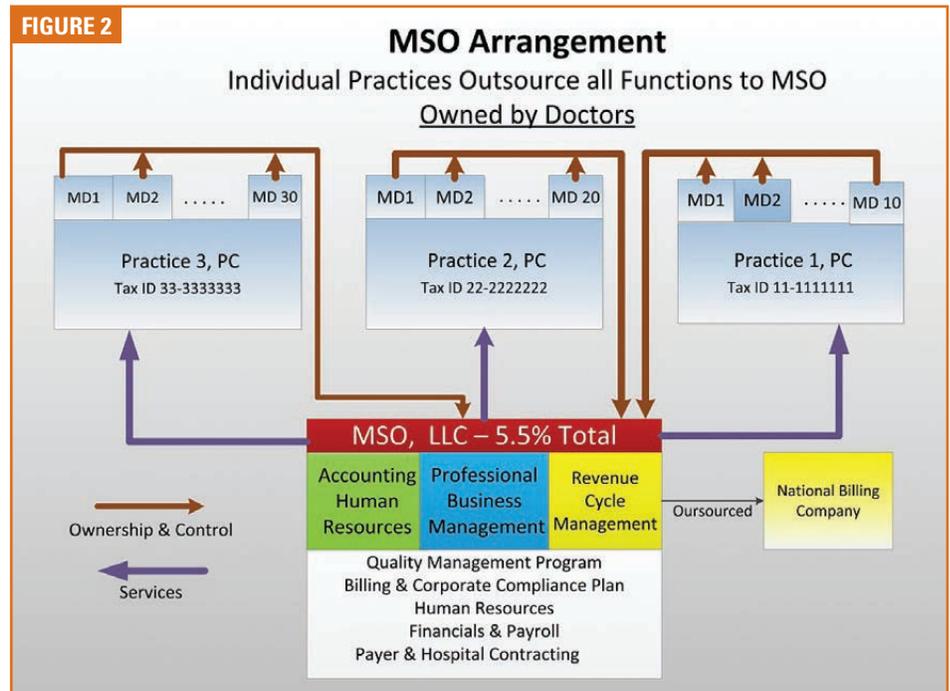
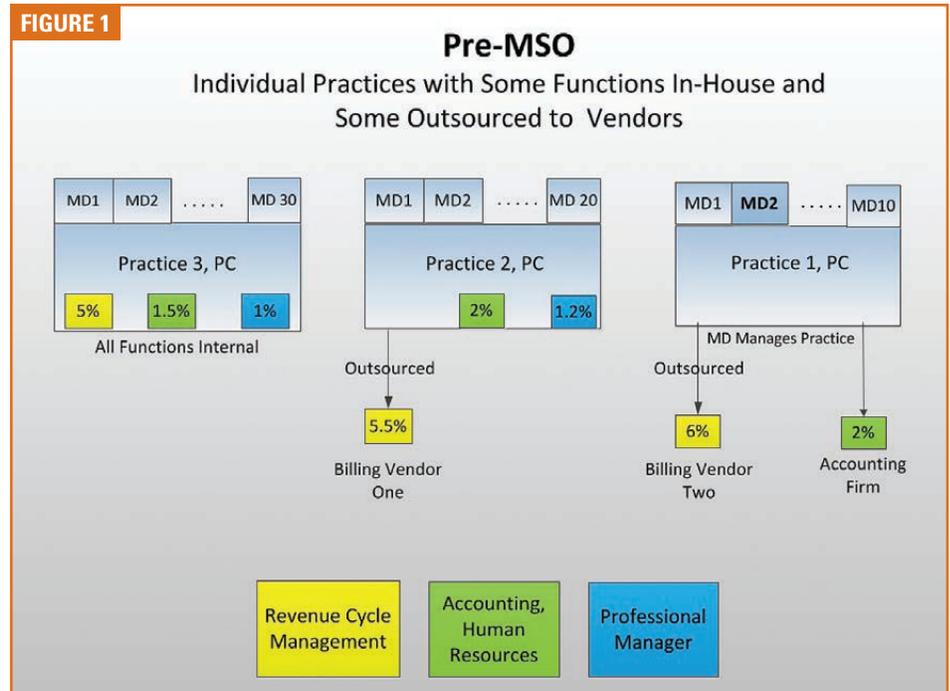
hospitals, payers and its employees. The transformation from pre- to post-MSO is illustrated in Figures 1 and 2.

The MSO will be capitalized with a small investment by physician owners, typically \$1,000-\$4,000 per physician. Each anesthesiology group will be charged a service fee by the MSO that includes all management, accounting and billing fees with the total less than 6 percent depending on the size of the MSO and its ability to negotiate favorable vendor contracts. The MSO service fee replaces the total practice overhead costs each group incurred prior to being serviced by the MSO.

## SERVICES

The first order of business for the MSO is to consolidate business and financial management services in an efficient and practical manner with the goals of functional improvement and lower costs. It will be necessary to consolidate billing and collection, accounting, payroll, financial reporting, employee benefit administration, credentialing and hospital privileging. There will be a significant savings achieved by this centralization and standardization.

Let's continue with our example and assume that prior to the creation of the MSO two of the practices outsourced their billing to two different billing companies and the third did in-house billing. The choice will be whether to take all billing in-house or to outsource all billing to a single outsourced provider. It is best to take care of this decision before the MSO is formed by obtaining and comparing bids for consolidated billing. A lower price and enhanced service can be obtained when multiple groups with one management team negotiate together. Billing would be done under the separate tax IDs of the three groups but the cost of billing will be based on the



aggregated patient revenue of the three groups with 60 owners and additional non-owner MDs, CRNAs and AAs. It will be the job of the MSO management team to prepare outsourced billing RFPs,

analyze bids, interview companies and make a final recommendation to the MSO governing board and leaders of the individual practices. If in-house billing is to be considered, the management

team will analyze the current in-house operation, compare with outsourcing and produce a report and a recommendation for the physician owners.

At this point, you may ask, “how can a group of 10 help a group of 30?” The larger group probably has lower costs than the group of 10 and it may have a professional manager and be a historically well-run group. One benefit is simply the numbers the smaller group adds. The larger group needs all the smaller groups to bring up the collective count of providers and patient revenue. Another benefit is that the MSO has demonstrated that it can bring multiple groups together under common business management and therefore has an excellent chance of increasing to four, five or more groups. The potential expansion of an MSO that has already demonstrated its synergy can be used as a negotiating advantage with vendors. Vendors will appreciate the fact that when the MSO adds another practice it will be easy and profitable for the vendor to simply provide the same services to more doctors and other clinical personnel.

You are likely wondering how the MSO can help with payer negotiations. Basically, it cannot. In our example, the three clinical practices do not change other than consolidating vendors and transferring business personnel to the MSO. They are still three small practices without much influence over large commercial insurance companies. The MSO management team will do independent payer negotiations for the individual clinical practices and will have knowledge of all the groups' current rates. Hopefully, the MSO negotiating team will be more successful with payers than the individual practices had been. There is no guarantee that this will be the case given the current reluctance of large payers to increase fees. We will address a solution to this problem later.

Following is a list of services that can be negotiated using the advantage of size.

MSO Services to Anesthesia Practices	
Revenue Cycle Management	Billing and Payment Audits
Accounting Services	HIPAA Compliance Plan Admin
Payables and Cash Management	Billing Compliance Plan Admin
Payroll Processing	Information Technology Services
Hospital Contract Negotiations	Practice Financial Dashboard
Payer Contract Negotiations	Advanced Analytics
Provider Recruiting	Quality Assurance Plan Admin
Hospital Privileging	Group Purchasing
Payer Credentialing	Attendance at Group Meetings
Employee Benefit Administration	Strategic and Tactical Planning
Human Resources Administration	Provider Compensation Planning
Retirement Plan Administration	Practice Website Maintenance
Financial Statements	Marketing Anesthesia Services
Oversight of Billing Operation	Provider Scheduling Assistance
Billing (RCM) Oversight	Business Records Storage

*Certain services such as revenue cycle management and payroll processing may be outsourced to other service providers.*

If multiple groups use multiple vendors, the existing vendors can be contacted and offered the option of working for a larger number of doctors or for none. This strategy should easily reduce unit pricing on these services.

- Revenue Cycle Management (RCM) services (billing and collection)
- Accounting including financial statements and taxes
- Payroll services including timekeeping
- Outsourced paying of practice expenses and cash management
- Banking and use of lockboxes
- Credit card processing of patient payments
- Software for scheduling, credentialing and human resource services
- Compliance services
- Patient satisfaction surveys (online and on paper)
- Quality management software and systems
- Office supplies
- IT hardware, software and service
- Independent retirement plans run through the same vendor platform

Some services can be consolidated with the advantage of better service that will be provided to a larger entity. These are:

**Insurance brokerage services.** Using a single large broker for all employee benefit insurance and corporate liability insurance can be an advantage. Brokers are rapidly losing lucrative medical group clients due to hospital employment, group mergers and practice buy-outs. Brokers who affiliate themselves with an MSO that is expanding should be willing to deliver dedicated premium service and provide products to a large group at lower negotiated prices.

**Malpractice insurance.** It will be difficult to reduce malpractice premiums for doctors who remain in individual, small groups but the MSO management team should be able to exert some leverage on these insurers. There can be pricing benefits when all doctors are on the same renewal date with the same insurer. When the MSO reaches sufficient size, establishment of a captive insurance company may be possible.

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## THE PHYSICIAN-OWNED MANAGEMENT SERVICES ORGANIZATION

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**Collection Agencies.** These companies will be willing to lower their fees and provide individualized service to the MSO participants. It is a large advantage to the collection agency to have accounts from multiple practices sent from a single billing entity in a standard format.

### MANAGEMENT

The job of the MSO representative board of anesthesiologists is to make sure the business of the practices is run efficiently and effectively. However, the physician board is not expected to carry on the consolidation and efficiency measures outlined above and maintain them on an ongoing basis. An extremely important feature of the MSO is that a larger organization can afford to attract experienced, top notch business management personnel.

It is the management team that carries out day-by-day administrative tasks designated by the physician board of directors. The management team should be led by a medical practice administrator experienced in the unique characteristics of anesthesiology and pain management

practices. The MSO will assemble a team of anesthesia support personnel that will provide local support to all the anesthesia groups served. When the MSO is formed, it will have the opportunity to take on competent practice business personnel who have been working for the founding anesthesiology groups.

### WILL THE MSO CONCEPT WORK FOR YOU FINANCIALLY?

The MSO works with the business expenses of the anesthesiology practice, which normally range from 5–10 percent. Assume the MSO will save 1–4 percent in reduced billing and other overhead costs. Multiply by practice patient revenue and divide by the number of anesthesia practice owners. If patient revenue per owner ranges from \$600,000–\$1,200,000, the range of potential savings is \$6,000 to over \$40,000 per anesthesiologist owner per year on a continuing basis.

### AN APPRECIATING ASSET

An operating MSO with tens of millions of dollars of anesthesia practice revenue

under management is a significant asset that increases in value to its owners over time as managed practices increase in size and new anesthesiology practices are added.

The MSO can be designed to keep its service fees to its anesthesiology groups as low as possible resulting in no profit. Alternatively, it may be engineered to produce profits that would be distributed with a possible small tax advantage to physician owners. If the owners want the MSO to expand through marketing activities it will allocate a portion of services fees to this activity. Keep in mind that the MSO physician board determines the service fee and the level of profit the MSO will produce.

### WHAT IS NEEDED TO MAKE THIS WORK?

In order to set up the MSO, routine legal and accounting work by experienced professionals is required. What can be challenging, however, is the task of obtaining agreement from dozens of anesthesiologists who are owners of multiple independent anesthesiology groups. This will be successful only if a few leaders emerge during the planning process and if all anesthesiologists truly understand and buy into the concept. It will be very helpful to bring in someone who has already been through the process of forming a medical group MSO.

Anesthesiologists need to understand that although the MSO is not a panacea, change will be needed to maintain future independence. The MSO is, for many groups, the best alternative. Following the implementation of the Affordable Care Act there will be increasingly intense pressure on anesthesiology groups by hospitals to operate more efficiently, lower costs and provide more demonstrable value to hospitals. It will be





a primary goal of the MSO management team to guide the MSO's clinical practices on the path to maintain physician incomes while enhancing deliverables to anesthesia group facilities and other stakeholders.

### MSO vs. ALTERNATIVES

Most anesthesiologists are organized in independent groups and it is probable that most want to stay this way. Hospital employment is not the route for anesthesiologists unless their salaries are so low that hospital employment at hospital-determined "fair market value" salaries is attractive. In the last few years, there has been a wave of practice buyouts. Anesthesiologists have traded their independence and ownership for cash and stock compensation, usually resulting in lower future income. For most anesthesiologists, a sale is neither possible nor desirable. The opportunity to "go big" and preserve independence while achieving economies of scale is the main attraction of the physician-owned MSO.

### SINGLE TAX ID STRATEGY

We previously emphasized that formation of an MSO does not create

an entity that can collectively negotiate with payers on behalf of its anesthesiology group practices. What is possible, however, is to eventually clinically merge some or all of the practices served by the MSO. The least invasive method is to merge into a single tax ID "practice without walls" where business operations are centralized in the MSO but clinical practices remain at their respective hospitals and patient revenue streams and expenses are allocated to the individual clinical divisions. When multiple anesthesiology groups are organized via their MSO and financial operations are standardized and centralized, a subsequent merger into a single tax ID is not difficult and will be guided by the MSO management team.

### MSO EXPANSION

After the MSO is up and running, additional anesthesia practices can be invited to become owners in the MSO by buying in at a share price established by the original owners. The share price for second tier groups will be higher than original groups because they do not have to contribute startup company "sweat equity" and emotional risk taken on by the original MSO founders. However, the second tier participants will obtain the immediate benefits of lower costs, seasoned management and a proven operation. The expanding MSO increases economies of scale as well as negotiation advantage with vendors. For example, if billing service fees are negotiated with an outsourced vendor on a sliding scale based on total MSO anesthesia group patient revenue, the billing fee percentage for the original MSO anesthesia groups will decrease as more practices have their billing outsourced to the selected vendor.

After the MSO is established and successfully operating for its anesthesiologists it can offer services to specialties

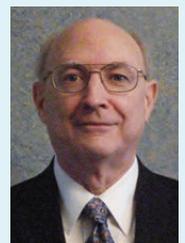
other than anesthesiology, adding each specialty in a unique division. While billing for other specialties is different from anesthesia, management, accounting, human resources and other MSO services can be scaled to accommodate these specialties, providing increased economies of scale to all MSO owners.

### WHERE TO GO FROM HERE

There needs to be a meeting of minds among the members of two or more anesthesiology groups. This usual impetus for action is the perception of negative influences on the business of anesthesiology from outside sources. A meeting of anesthesia group representatives to discuss the future is a good place to start. The groups will need to decide early on that a combination of anesthesiology groups is the path that should be followed and that there is strength in numbers. The physicians will also need to agree that groups of different size and care models need to be treated equally.

An immediate merger of multiple anesthesiology groups is a possibility, but this may be too large a leap for the groups involved. Formation of an MSO may be the answer. It would be wise to investigate the MSO concept further by contacting anesthesiology groups that have already implemented a successful physician-owned Management Services Organization. ▲

**Joe Laden** has worked for anesthesiologists for 33 years and is currently President of Ohio River Valley Associates, LLC, a physician owned and governed management services organization. He can be reached at [Joe.Laden@onemso.com](mailto:Joe.Laden@onemso.com).



# SHOULD YOU APOLOGIZE FOR A POOR OUTCOME?

**Christopher Ryan, Esq.**

*Giarmarco, Mullins & Horton, PC, Troy, MI*

**Danial Laird, MD, JD**

*Gage Law Firm, Las Vegas, NV*

Medical errors happen. Healthcare providers are human and humans are not infallible. For many healthcare providers, making a mistake or even being involved in a case with an untoward outcome can be unnerving, frightening, or even devastating to their practice. In such a situation, many healthcare providers feel a natural and understandable urge to express sympathy, remorse, or regret to the patient or perhaps the patient's family. This article will outline some considerations when deciding whether or not to engage in such conduct.

There is a clear distinction between a disclosure of an unexpected medical result and an apology. The American Medical Association's Code of Ethics 8.121 states in part that: "Physicians must offer professional and compassionate concern toward patients who have been harmed, regardless of whether the harm was caused by a health care error. An expression of concern need not be an admission of responsibility. When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future. Such communication is fundamental to the trust that underlies the patient-physician relationship, and may help reduce the risk of liability."

The focus of this article is on whether an apology should be offered as part of such a disclosure.

There are a number of reasons why a healthcare provider might choose



(or choose not) to express sympathy in conjunction with a disclosure of an unexpected medical result. The most obvious reason is the potential impact on the physician's liability. If statements of sympathy are perceived as statements of culpability, the patient may pursue litigation that he or she otherwise might not have considered. On the other hand, some argue that expressing sympathy shows compassion, which actually reduces claims.

Assuming for a moment that a claim is inevitable, an apology can have a large impact on future medical malpractice litigation. This is especially true of verbal apologies. Verbal statements are subject to the recollection of the physician and the patient, and almost invariably, those recollections are different. Apologies that are recalled after two or more years are not likely to be recalled the same way

they were delivered. What may have been a seemingly innocent statement by a physician, "I am very sorry, but we have to do another procedure" may genuinely be remembered by the patient years later as a statement of culpability after a lawsuit has been filed. Many states have adopted legislation to encourage disclosures by preventing apologies from being used during litigation. For example, in Michigan, statements that express sympathy are inadmissible in a malpractice trial as evidence of liability. Importantly, however, statements of fault, negligence, or culpable conduct are not protected by the law.

Untoward outcomes can be complex and involve systems issues. In other words, medical errors are often multifactorial and can involve multiple parties. For example, consider the following scenario: An anesthesia provider is called upon to report emergently to a Code Blue



in which the Code Team has had difficulty establishing an airway in a patient in full cardiac arrest. Several other health care providers have unsuccessfully attempted numerous times to intubate the trachea. The oropharynx is now edematous and hemorrhaging. The hospital recently cut its equipment budget and the only fiberoptic laryngoscopy equipment is being sterilized. In the heat of the moment, no one is able to locate a cricothyroidotomy kit that for some reason is missing from the Code Blue crash cart. The anesthesia provider makes every effort to secure an airway but as a result of a combination of factors, the patient dies of hypoxemia.

Should the anesthesia provider apologize to the decedent's family? It is unlikely the anesthesia provider is aware of all the circumstances that led to the patient's death. It is likely there is a complex explanation as to why the providers attempted numerous laryngoscopies before calling for help, why the hospital had no fiberoptic laryngoscopy equipment available, and why the crash cart was missing a cricothyroidotomy kit. An anesthesia provider offering an apology over her inability to secure an airway is almost certainly going to provide the family with an incomplete explanation of the factors that led to the outcome. The

provider risks facing an argument that by providing an incomplete or inaccurate explanation, she was attempting to conceal the truth.

Perhaps rather than an apology, the anesthesia provider should simply express empathy to the family and truthfully state she does not know exactly what happened and why. In such a complex situation, the anesthesia provider may be better off reporting the incident to the risk management department and requesting that an internal investigation be conducted to determine the various causes and how they can be prevented going forward.

Assuming you have made the decision to apologize, it must be done with great care. If at all possible, you should contact your risk management department and have them involved in the process. There may be specific procedures in place that should be followed. Also, the risk management department may be able to document the discussion to assist, if necessary, during future litigation. If contacting risk management is not possible or feasible, then discussion with an attorney is advisable. An attorney (or your risk manager) will be in a better position to advise you about your state's laws that may be implicated in these settings (such

as whether your state has a law that protects physician apologies). Additionally, your risk management department will be able to activate internal peer review procedures to help reduce future errors.

This topic is the subject of an ongoing debate and there is no clear cut answer that can be applied in all settings. There are numerous considerations that need to be analyzed and each situation will be dependent upon the facts and circumstances involved. One piece of advice that most people can agree on is that it is important to involve your risk management department. Not only can this help reduce the likelihood that the practitioner will open himself or herself up to litigation, but it can be the first step in trying to prevent similar instances from happening in the future. ▲

**Christopher Ryan, Esq.** is an attorney at Giarmarco, Mullins & Horton, PC in Troy, MI. Mr. Ryan's practice is focused on defending healthcare providers faced with claims of medical malpractice. He also has experience assisting clients with a variety of general healthcare law needs. He can be reached at (248) 457-7154 or at [crayan@gmhllaw.com](mailto:crayan@gmhllaw.com).



**Danial Laird, MD, JD** is an associate with the Gage Law Firm in Las Vegas, NV. Mr. Laird is a litigator who focuses on representing patients and their families against hospitals, nursing homes, pharmaceutical corporations, insurance carriers, and the federal government. He has a particular interest in wrongful death and catastrophic injury due to systems issues and corporate negligence. He can be reached at [dlaird@gagelawfirm.com](mailto:dlaird@gagelawfirm.com).



# THINKING OF INVESTING IN, OR RENTING SPACE IN, AN ASC? HAVE YOU TAKEN COMPLIANCE INTO CONSIDERATION?

**Neda M. Ryan, Esq.**

*Clark Hill, PLC, Birmingham, MI*

When was the last time you considered investing, or renting space, in an ambulatory surgery center (ASC)? While issues of whether the transaction makes good business sense are, naturally, at the forefront of any business person's mind, often physicians (including anesthesiologists) fail to take into account the compliance considerations that are the drivers of many of the underlying business decisions. Unfortunately, in today's healthcare regulatory arena, no anesthesiologist can ignore the importance of ensuring compliance with State and Federal Laws when considering a relationship with an ASC.

For purposes of this article, an ASC is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed twenty-four hours following an admission. The entity must have an agreement with the Centers for Medicare and Medicaid Services to participate in Medicare as an ASC, and must meet the conditions of participation and conditions of payment set forth by regulation.

## I. FIRST THINGS FIRST

There are many ways in which becoming an owner or investing in, or renting, an ASC comes to fruition. The



business decisions that will undoubtedly face any prospective purchaser or lessee are beyond the scope of this article, though it goes without saying with every transaction must come thorough due diligence. Although much of the focus of any deal is a numbers game, considering the compliance implications of those numbers is critical prior to investing in, or renting, an ASC.

One key compliance-related matter tied to due diligence is investigating your potential partners. This is an easy element to overlook and one that, if not properly investigated, will lead to considerable government exposure. The government considers individuals who contract with excluded providers or those without

licenses one of the easiest targets in their fight against healthcare fraud. Therefore, it is critical that, prior to entering into any transaction, while due diligence is being conducted on the business itself, due diligence is conducted on the *people* involved in the transaction. In other words, it is just as important to investigate your partners' backgrounds, as it is to investigate the viability of the business in which you may be investing or from which you may be leasing. Such checks are relatively simple and involve looking at websites such as the OIG's list of excluded providers and state licensing board sites. These are some of the easiest, and least expensive, methods of protecting one's self in a transaction as discovery by government enforcement is all too easy. It does not require an attorney to run a Google search, an exclusion check, or a licensure check.

Concurrent with due diligence investigations, when considering transactions involving ASCs, all parties involved should consider whether, and how, the federal Anti-Kickback Statute (AKS), federal Physician Self-Referral Law (Stark Law), and relevant State laws affect the manner in which the transaction may commence. These laws underlie every transaction in the healthcare industry and, while they may not necessarily be implicated, must always be taken into consideration.

The AKS prohibits the knowing and willful soliciting, receiving, offering, or paying of remuneration (which is anything of value, in cash or in kind) to induce referrals of items or services payable by any State or Federal healthcare program. It has been interpreted by courts (and the Office of Inspector General (OIG)) to the effect that if even one purpose of the transaction is to promote referrals, the entire transaction is unlawful, despite any other proper purposes that may exist. Violation of the AKS could result in civil penalties, criminal penalties, fines, prison time, exclusion from any State and/or Federal healthcare program, and/or loss of state licenses. The AKS has a number of safe harbors that, if an arrangement fits squarely within, are presumed by the government to be lawful. Failure to fit within a safe harbor, however, does not make the arrangement unlawful; rather, it requires an analysis of the specific facts and circumstances at hand.

The Stark Law prohibits referrals by a *physician* (note: the AKS does not require the referral to be from, or to, a physician) for certain designated health services (DHS) to a person or entity in which that physician has a financial interest, unless an exception applies. DHS includes (1) clinical laboratory services, (2) physical therapy services, (3) occupational therapy services, (4) outpatient speech-language pathology services, (5) radiology and certain other imaging services, (6) radiation therapy services and supplies, (7) durable medical equipment and supplies, (8) parenteral and enteral nutrients, equipment, and supplies, (9) prosthetics, orthotics, and prosthetic devices and supplies, (10) home health services, (11) outpatient prescription drugs, and (12) inpatient and outpatient hospital services. Financial relationships include ownership or investment interests or other compensation arrangements. Violation of the Stark Law could result in civil penalties, program exclusion, the implication of



other civil or federal laws that carry with them other hefty fines, and/or loss of state licenses. In contrast to the seeming flexibility afforded by the AKS, the Stark Law is more rigid. The Stark Law has a number of exceptions that, an arrangement failing to fit squarely within, will be considered unlawful, without further evaluation.

By providing anesthesia services alone, an anesthesiologist does not make a referral for a DHS and does not come within the Stark prohibition on self-referral; nor does the provision of anesthesia services without more entail a referral for purposes of the AKS. Pain medicine services are subject to a different analysis because pain specialists do refer patients for PT or radiology services, for example. Every assessment of anesthesiologists' Stark or AKS exposure begins with the question whether the anesthesiologists are referring patients to others or whether the patients are being referred to them.

## II. RENTING SPACE IN AN ASC

Renting space in an ASC carries with it its own AKS safe harbors and Stark Law exceptions with which anesthesiologists must comply in order to avoid violations. In this case, because the requirements of

the AKS safe harbors for the lease of space, the lease of equipment, and personal services are similar to the requirements of the Stark Law exception, if the Stark Law is implicated, there is little no flexibility in whether to comply. Remember: if implicated, compliance with a Stark Law exception is mandatory or else the entire relationship is unlawful. If the Stark Law is not implicated, there is some flexibility in whether the parties wish to set the relationship squarely within the AKS safe harbor. Of course, the closer a transaction is to a safe harbor, the less it is exposed to risk; however, transactions not fitting within a safe harbor are not necessarily considered illegal.

If the parties desire to structure the transaction to fit squarely within the safe harbor for equipment and space rental or personal services, it must satisfy the following requirements:

1. A written, signed agreement must be in place between the parties;
2. A lease covers all of the premises, equipment, or services involved for the term of the lease and specifies the premises, equipment, or services covered by the agreement;

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3. If the arrangement is for a part-time basis (versus on a full-time basis), the agreement specifies exactly the schedule of such intervals, their precise length, and the exact compensation for such intervals;
4. The term of the lease is not less than one year;
5. The aggregate amount paid under the agreement is set in advance, consistent with fair market value in an arms-length transaction and is not determined in a manner that takes into account the volume or value of referrals or other business generated by the relationship for which payment may be made in whole or in part under State or Federal healthcare programs;
6. The aggregate space, equipment, or services do not exceed that which is reasonable necessary to accomplish the commercially reasonable business purpose for the rental.

For purposes of these safe harbors, *fair market value* means the value of the rental property, or equipment, for general commercial purposes, not adjusted to reflect the additional value that one party would attribute to the property as a result of the transaction.

If parties desire to structure a transaction that does not fit within a safe harbor, depending on the facts and circumstances at hand, a number of mitigating factors may be incorporated to minimize the amount of overutilization of services payable by the State and Federal healthcare programs. The OIG regularly issues advisory opinions in which it provides guidance on satisfactory mitigating factors relative to various arrangements.

### III. PURCHASING, OR SELLING, AN ASC

In purchasing or selling an ASC, the foundational compliance issues that must be taken into consideration are (a)

whether the purchase price represents fair market value, and (b) whether there is a commercially reasonable business reason for the transaction.

The definition of fair market value in the business world is considered the price when there exists a hypothetical willing, able, and informed buyer and a hypothetical willing, able, and informed seller, acting at arms-length in an open and unrestricted market, when neither is obligated to buy or sell. Fair market valuations can take into account historical earnings, contracts with third party payors, certificate of needs laws and can be conducted by certain accounting firms with specific healthcare knowledge and experience. Commercial reasonableness hinges on whether the transaction makes sense if referrals were not part of the picture.

When considering whether or not to purchase an ASC, the purchaser should consider, and understand, the specialties of any other physician owners involved in the ASC as the requirements for satisfying the AKS safe harbors for ASC ownership and investment vary depending on whether the owners are all physicians or if the owners include a hospital. The requirements of this safe harbor are considered in Section IV of this article.

### IV. OPERATING THE ASC

After considering the foundational compliance issues noted above, there should be consideration given to whether the transaction should (and whether the parties desire for the transaction to) meet the AKS safe harbor for ASC ownership. The path of least risk would involve having the ownership or investment fit squarely within the ASC safe harbor.

Such arrangements falling outside of a safe harbor should be carefully structured with the assistance of an attorney.

For all ownership or investment interests in an ASC, the ASC's operating room and recovery space must be dedicated exclusively to the ASC. Patients who are referred by an investor in the ASC must be fully informed of the investor's investment interest. As mentioned in the previous section, there are also requirements of the ASC safe harbor that vary depending on the identity of the owners of the ASC. For purposes most germane to anesthesia, this article only reviews the requirements for multi-specialty ASCs and hospital-physician ASCs (the other considerations of the ASC safe harbor include surgeon-only ASCs and single-specialty ASCs).

#### A. Multi-Specialty ASCs

For purposes of the safe harbor, multi-specialty ASCs may be owned by (i) physicians in a position to refer patients directly to the ASC and perform procedures on such patients; (ii) group practices composed exclusively of physicians; or (iii) investors who are not employed by the ASC or by any investor and are not in a position to provide items or services to the ASC or any of its investors and are not in a position to make or influence referrals to the ASC or any of its investors. Assuming the owners fit one of the aforementioned categories, to satisfy the safe harbor, anesthesia investors must meet the following seven elements:

1. The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the ASC.
2. At least one-third of each physician investor's medical practice income from all sources for the previ-



- ous fiscal year or previous twelve month period must be derived from the physician's performance of Medicare-covered procedures for ASCs.
3. At least one-third of the Medicare-covered procedures for ASCs performed by each physician investor for the previous fiscal year or previous twelve month period must be performed at the investment entity (*i.e.*, the ASC at issue).
4. The entity or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.
5. The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.
6. All ancillary services for Federal health care program beneficiaries performed at the entity must be

directly and integrally related to primary procedures performed at the entity, and none may be separately billed to Medicare or other Federal health care programs.

7. The entity and any physician investors must treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.

Elements 2 and 3 comprise what is commonly referred to as the One Third-One Third Test.

#### B. Hospital-Physician ASCs

ASCs owned by hospitals and physicians (including anesthesiologists) must be owned by at least one hospital investor and (i) surgeons, physicians of a single-specialty, or physicians comprising multiple specialties; (ii) group practices; or (iii) investors who are not employed by the ASC or by any investor, are not in a position to provide items or services to the ASC or any of its investors, and are not in a position to refer patients

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directly or indirectly to the ASC or any of its investors. Assuming the ownership requirements have been met, for anesthesiologists looking to be owners or investors in an ASC alongside, at least, a hospital, the following nine elements must be satisfied:

1. The One Third-One Third Test must be satisfied for each physician owner.
2. The terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the entity.
3. The ASC or any investor (or other individual or entity acting on behalf of the entity or any investor) must not loan funds to or guarantee a loan for an investor if the investor uses any part of such loan to obtain the investment interest.
4. The amount of payment to an investor in return for the investment must be directly proportional to the amount of the capital investment (including the fair market value of any pre-operational services rendered) of that investor.
5. The ASC and any hospital or physician investor must treat patients receiving medical benefits or assistance under any federal health care program in a nondiscriminatory manner.
6. The ASC may not use space, including, but not limited to, operating and recovery room space, located in or owned by any hospital investor, unless such space is leased from the hospital in accordance with a lease that complies with all the standards of the space rental safe harbor (explained in greater detail in Section II of this article); nor may it use equipment owned by or services provided by the hospital unless such equipment is leased in accordance with a lease that complies with the equipment rental safe harbor (explained in greater detail in Section II of this article), and such services are provided in accordance with a contract that complies with the personal services and management contracts safe harbor (See 42 CFR 1001.952(d)).
7. All ancillary services for federal health care program beneficiaries performed at the entity must be directly and integrally related to primary procedures performed at the entity and none may be separately billed to Medicare or other federal health care programs.
8. The hospital may not include on its cost report or any claim for payment from a federal health care program any costs associated with the ASC (unless such costs are required to be included by a federal health care program).
9. The hospital may not be in a position to make or influence referrals

directly or indirectly to any investor or the entity.

As can be seen with both of these ASC safe harbors, the key issue on which anesthesiologists must focus is the One Third-One Third test. In fact, it is in every ASC owner's interest to ensure all physician owners are satisfying this requirement as one person who is non-compliant precludes the entire arrangement from fitting squarely within the safe harbor. It is important to note that some courts raised issues of directly linking remuneration to referrals when ASCs had a specific and explicit requirement that physicians perform at least one third of their procedures at the ASC.

### C. Other Operational Considerations

While beyond the scope of this article, other operational considerations must be given to the relationship between the parties of an ASC. Namely, the business models that may be adopted to operate the ASC may be considered with their respective risks and benefits. Such business models may include:

- The Service Agreement Model—This model involves an ASC contracting with an anesthesiologist or anesthesia group in which the ASC provides office space, equipment, and administrative support to the anesthesia providers in exchange for a fee.
- The Endoscopy Suite Model—This model involves gastrointestinal physicians setting up a surgical practice in an office-based setting in which they obtain the space, personnel, and accreditation for the facility. This space is then, in turn, subleased to the anesthesiologists who also contract for equipment and administrative support in exchange for a fee.
- The Company Model—This model involves the owners of the ASC



developing a separate company (NewCo), owned by the owners of the ASC, that is formed to provide anesthesia services to the ASC. NewCo then contracts with anesthesiologists or an anesthesia group either as employees or independent contractors. The excess profits earned by NewCo, which bills for the anesthesia services, after paying the anesthesiologists, then flow back to its owners.

- The Employment or Independent Contractor Model—This model involves the ASC directly hiring the anesthesiologists as employees or independent contractors.

Other considerations must also take into account in a sale include whether federal securities laws are implicated and whether the transaction is subject to registration and disclosure requirements.

### V. ALL TRANSACTIONS ARE UNIQUE

Although the compliance issues raised in this article raise a number of considerations when anesthesiologists are looking to invest, or rent space in, an ASC, it is important to recognize that

each and every transaction is unique and each requires its own analysis. While no transaction is devoid of all risk, the owners or prospective-owners or lessee should engage competent counsel to assist in analyzing the risk associated with a given transaction. Failure to take compliance into consideration in such an arrangement could result in substantial fines, potential prison time, exclusion from state or federal healthcare programs, and potential loss of license. 

#### Neda M. Ryan, Esq.

is an associate with Clark Hill, PLC in the firm's Birmingham, MI office. Ms. Ryan practices in all areas of health care law, assisting clients with transactional and corporate matters; representing providers and suppliers in health care litigation matters; providing counsel regarding compliance and reimbursement matters; and representing providers and suppliers in third party payer audit appeals. She can be reached at (248) 988-5884 or at [nryan@clarkhill.com](mailto:nryan@clarkhill.com).



# ICD-10 IS THE LATEST Y2K: THE POTENTIAL IMPACT ON PROVIDER REVENUE

**Darlene Helmer, CMA, CPC, ACS-AN, CMPE, MBA**

*Vice President of Provider Education & Training, ABC*

Looking back fourteen years ago, Y2K was all a buzz and everyone, especially the IT department, was busy waiting for the impact of Y2K to reveal itself. The ball dropped in 2000 and nothing happened. No planes fell out of the sky, computers did not crash. All of the preparation and expenditure for naught, or was it? What did we learn from the Y2K experience? Even though the impact was negligible, preparation was the key. We know that had something occurred, some were not prepared and many were well prepared.

Let's fast-forward to 2014. ICD-10 is this year's Y2K. Rest assured, ICD-10 will have a profound effect on providers; in fact, it is the largest modification ever to hit the healthcare arena. Providers who delay or ignore their implementation process will suffer a negative financial impact whereas those who work to prepare should be able to steer themselves through the issues encompassing this change. Once again, preparation is the key. This time we are guaranteed that there will be an impact. The Centers for Medicare and Medicaid Services (CMS) proclaims that ICD-10 will provide benefits such as increased specificity that will lead to accurate and timely reimbursements, better quality of care, and improved care management. The CMS also claims, due to the increased specificity of the new system, it will be more difficult to gain reimbursement for an improper claim. Regardless of these statements, the implementation of this new code set will impact the entire realm of healthcare. The total effect of converting to the ICD-10 system for the United States is unknown. There are studies that discuss



the impact of ICD-10 in other countries, but a true estimation cannot be predicted, due to other mitigating factors (i.e. different payer environments, and different levels of implementation, etc.). Utilizing the information that we have gained from other countries will contribute to suitable preparation. It will assist us in alleviating many of the negative outcomes with the variety of practices who navigate the transition with success. However, the question of the degree of impact remains unknown.

Clinical documentation is a vital part of ICD-10. It captures the medical condition of the patient and has always played a vital role in medical coding and billing. CPT codes explain **what** was done during the visit, operation and/or treatment while ICD coding explains **why** it

was done. A valid “what” and “why” code, which is supported by medical record documentation, must be submitted on the claim form for payment. Medical necessity denials happen when the “what” and “why” are not in agreement with CMS or other payers coverage policies (e.g. National or Local Coverage Determinations (NCD/LCD)). CMS will be reviewing and updating all of these policies for ICD-10 conversion. The Medicare Coverage Database states that all ICD-10 LCDs will be published by April 10, 2014, and any other LCDs which do not contain ICD-10 information will be published no later than September 4, 2014. CMS also indicated that all LCDs will be given new numbers.

In order for practices to prepare appropriately for the implementation of

ICD-10. There are six key steps that have been identified to successfully manage the risks associated with the change in code sets: planning, communicating and training, assessing and improving workflow, testing software and processes, implementing and surviving post-implementation. Planning is crucial to a successful transition. It is fundamental to ensure that top leadership understands the extent and significance of the change. It all starts at the top; leadership buy-in will trickle down.

The next critical step is to create an ICD-10 project team, no matter how small the practice. It is important to take time to review the ICD-10 resources from CMS, trade associations, payers and vendors. Make sure the staff is aware and informed of the upcoming changes. A project team is critical. Charge the project team to identify how ICD-10 will affect your particular practice. Make sure to ask these two key questions: (1) How will ICD-10 affect your people and processes? (2) How can we include ICD-10 as we plan for projects like meaningful use of electronic health records? A budget should be part of the ICD-10 project plan for your practice as there are definite costs associated with implementation. It

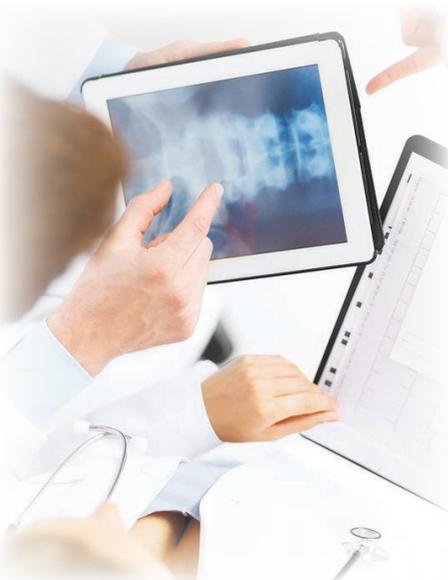


is important to identify each task as well as designating the person responsible for that task. Create deadlines so you do not fall short in your plan. A critical part of this plan is to ensure sign-offs from all of the stakeholders, physicians, nurses, coder/billers and all office personnel.

Communication is a critical part of implementing your plan as is training all of your stakeholders. Review the potential changes in documentation and educate your practice. Remember: training is a considerable part of communication. Training should be customized for the different roles in your organization. It is important to explore what options are available to train the staff. Explore the need and resources available for outsourcing coding, both during training implementation, and post-implementation. Run a report from your system of the top 10 ICD-10 codes and crosswalk them to ICD-10 for a reference point. Table 1 illustrates a few examples.

Examine your workflows and processes to determine the need for

change to accommodate the new code set. Review your authorization, referral registration clinic and hospital encounters, orders, testing, interfaces; contracts, research participation, financial operations, quality reporting as well as payer relationships. There will be some financial impact; productivity backlog alone will cause an impact to your revenue. There are many predictions regarding the effect on revenue, but on average the estimate is 25 to 65 percent. According to our assessment, anesthesia should be at the lower end. Nevertheless, you must ask yourself the question, can you handle a 25 percent decrease in production and revenue due to this new code set? Physician clinical documentation plays a vital role in this conversion. It must be your focal point for assessing ICD-10 readiness. Spend time reviewing the need for more specific documentation and the ramifications of poor documentation on the practice. Previously, we have focused on documentation for procedures, (i.e.



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TABLE 1

ICD-9	ICD-10
<b>724.2 Lumbago</b>	M54.5 Low back pain
<b>715.00 Osteoarthritis, generalized, site unspecified</b>	M15.0 Primary generalized (osteo)arthritis M15.4 Erosive (osteo)arthritis M15.8 Other polyosteoarthritis M15.9 Polyosteoarthritis, unspecified
<b>789.00 Abdominal pain, unspecified site</b>	R10.9 Unspecified abdominal pain **There are more specific code choice selections available in ICD-10-CM. These include: R10.0 Acute abdomen R10.10 Upper abdominal pain, unspecified R10.11 Right upper quadrant pain R10.12 Left upper quadrant pain R10.13 Epigastric pain R10.2 Pelvic and perineal pain R10.30 Lower abdominal pain, unspecified R10.31 Right lower quadrant pain R10.32 Left lower quadrant pain R10.33 Periumbilical pain R10.84 Generalized abdominal pain
<b>170.9 Malignant neoplasm of bone and articular cartilage, site unspecified</b>	C41.9 Malignant neoplasm of bone and articular cartilage, unspecified **There are more specific code choice selections available in ICD-10-CM. These Include: C41.0 Malignant neoplasm of bones of skull and face C41.1 Malignant neoplasm of mandible C41.2 Malignant neoplasm of vertebral column C41.3 Malignant neoplasm of ribs, sternum and clavicle C41.4 Malignant neoplasm of pelvic bones, sacrum and coccyx
<b>724.00 Spinal stenosis, unspecified region</b>	M48.00 Spinal stenosis, site unspecified **There are more specific code choice selections available in ICD-10-CM. These include: M48.01 Spinal stenosis, occipito-atlanto-axial region M48.02 Spinal stenosis, cervical region M48.03 Spinal stenosis, cervicothoracic region M48.04 Spinal stenosis, thoracic region M48.05 Spinal stenosis, thoracolumbar region M48.06 Spinal stenosis, lumbar region M48.07 Spinal stenosis, lumbosacral region M48.08 Spinal stenosis, sacral and sacrococcygeal region

upper 1/3 of the ureter, upper vs lower abdomen) to gain additional units for reimbursement. Now we have to focus on documentation of the diagnosis to be assured that the diagnosis correctly matches the procedure and supports the medical necessity.

Testing internal systems and processes will identify key vulnerabilities such as volume, capacity and other performance parameters. Create some test data, which is scenario driven, that will assist in evaluating the performance impact of the available diagnosis codes submitted per claim. Request your vendor's testing plan and how it will involve coding and other practice staff. Question your vendor staff about their plan. What will be the claims and reports? What is the process for rejections and re-submissions related to incorrect codes? Are there charges for these updates? Will training be provided and do you have a plan to assist us in extracting the information necessary? Create an inventory of external systems and processes with which you exchange data, i.e. payers, hospitals, outsourced billing and coding and government entities.





Many practices request information regarding the potential impact on reimbursement. Again, it is difficult to determine the total impact of the conversion. Communicate with payers about anticipated changes in reimbursement schedules or payment policies. The nature of these changes will vary based upon your particular practice. ICD-10 should be included in future contract negotiation discussions with the payers to decrease the risk of compliance errors and claims denials. During the transition period following ICD-10 implementation, payers will continue prior reimbursement policies. Challenges with billing productivity combined with potential payer claims processing challenges may result in significant impact to cash flow. Taking out a line of credit to cover this impact would be prudent.

The last step, post implementation, is just as important as the first step. Rely on

your contingency plan for each potential failure point to assure business continuity. Monitor the systems and functions and correct the errors, or identified problems, immediately so that reoccurrence does not create continual problems. Start with the highest volume issue and work your way down, so as to release the greatest amount of claims for reimbursement. Monitor your coding accuracy and productivity and implement strategies to address identified problems. ABC clients will not have to be concerned about coding itself, but will need to focus on documentation and preparation throughout the practice, especially for pain practices. The risks associated with a less successful ICD-10 implementation are decreased productivity, financial, delayed payments, increased AR and more denials. The causes are many: inaccurate and incomplete documentation, inadequate training at varying levels within the organization, failure

to address system readiness to process ICD-10 codes, failure to make administrative form, documentation and policy updates, as well as failure to assess and prepare for payer readiness. Prepare the way for ICD-10, the latest Y2K. ▲

**Darlene F. 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. She works closely with the ABC 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](mailto:Darlene.Helmer@AnesthesiaLLC.com).





255 W. MICHIGAN AVE.  
 P.O. BOX 1123  
 JACKSON, MI 49204  
 PHONE: (800) 242-1131  
 FAX: (517) 787-0529  
 WEB SITE: [www.anesthesiallc.com](http://www.anesthesiallc.com)

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## PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
April 11-13, 2014	The Advanced Institute for Anesthesia Practice Management	The Cosmopolitan Las Vegas, CA	<a href="http://www.AIAPMConference.com">www.AIAPMConference.com</a>
April 12-13, 2014	American Society of Anesthesiologists Quality Meeting 2014	Grand Hyatt DFW Dallas, TX	<a href="http://education.asahq.org/aqm">http://education.asahq.org/aqm</a>
April 24-27, 2014	California Society of Anesthesiologists 2014 Annual Meeting & Workshops	Hyatt Regency San Francisco, CA	<a href="http://www.csahq.org/up-more.php?idx=54">http://www.csahq.org/up-more.php?idx=54</a>
April 27-29, 2014	Medical Group Management Association 2014 Anesthesia Administration Assembly Conference	Hyatt Regency San Francisco, CA	<a href="http://www.mgma.com/AAA13-exhibitors/">http://www.mgma.com/AAA13-exhibitors/</a>
May 2-4, 2014	Advanced Techniques for Anesthesia Pain Management 2014 Conference	MotorCity Casino Hotel Detroit, MI	<a href="http://www.amspc.net/index.cfm?pageId=1744">http://www.amspc.net/index.cfm?pageId=1744</a>
May 5-7, 2014	American Society of Anesthesiologists, 2014 Legislative Conference	J.W. Marriott Hotel Washington, D.C.	<a href="https://www.asahq.org/For-Members/Advocacy/Legislative-Conference.aspx">https://www.asahq.org/For-Members/Advocacy/Legislative-Conference.aspx</a>
May 16-18, 2014	Arizona Society of Anesthesiologists 2014 Annual Scientific Meeting	Scottsdale Resort & Conference Center Scottsdale, AZ	<a href="http://www.az-anes.org/annualmeeting/annualmeeting.html">http://www.az-anes.org/annualmeeting/annualmeeting.html</a>
May 17-18, 2014	Idaho Society of Anesthesiologists 2014 Conference	Hampton Inn Boise, ID	<a href="http://idsahq.org/blog/2014-conference/">http://idsahq.org/blog/2014-conference/</a>
June 13-15, 2014	Florida Society of Anesthesiologists 2014 Annual Meeting	The Breakers Resort & Spa Palm Beach, FL	<a href="http://www.fsahq.org/meeting/annual-meeting/">http://www.fsahq.org/meeting/annual-meeting/</a>
September 4-7, 2014	Texas Society of Anesthesiologists 2014 Annual Meeting	Hyatt Lost Pines Resort Lost Pines, TX	<a href="http://tsa.org/">http://tsa.org/</a>
September 6, 2014	Washington State Society of Anesthesiologists Fall Scientific Meeting	Bell Harbor International Conference Center Seattle, WA	<a href="http://www.wa-anesthesiology.org/event-calendar">http://www.wa-anesthesiology.org/event-calendar</a>
September 19-21, 2014	The Ohio Society of Anesthesiologists 2014 Annual Meeting	Columbus, OH	<a href="http://www.osainc.org/">http://www.osainc.org/</a>
October 11-15, 2014	American Society of Anesthesiologists Anesthesia 2014	Ernest N. Morial Convention Center New Orleans, LA	<a href="http://asahq.org/Annual-Meeting.aspx">http://asahq.org/Annual-Meeting.aspx</a>

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