BACKGROUND

It is often suggested that an anesthesiology department should have more complete and readily accessible data about the clinical care provided in the operating rooms and the delivery suite than any other department of the facility; but how often is this actually the case? Anesthesia providers review and document enormous amounts of clinical detail and critical events for every patient they see, but little of this information is actually captured in a way that allows for its logical indexing and retrieval. Most anesthesia groups and their billing services have been so focused on the data necessary to calculate a charge and generate a claim that they have virtually ignored what is potentially the most valuable of information of all. The implementation of electronic medical records is slowly inspiring a change in a very traditional way of thinking about the clinical details of the peri-operative continuum. Progress, however, is slow.
SECURING THE FUTURE FOR ANESTHESIOLOGY AND PAIN MEDICINE PRACTICES

The decisions that anesthesiologists and pain medicine specialists must make are more fundamental and consequential than ever as we enter the final months before implementation of Obamacare in January 2014. Adding staff, adding locations or even altering income distribution systems are easy decisions in comparison, especially since they lend themselves to well-defined quantitative analysis. Creating and selecting options that involve the very nature and identity of groups is much more challenging. Three of the articles in this issue of the Communiqué explore different aspects of the answer to the question, “How do we secure our future?”

The broadest view and the most basic recommendations are to be found in Will Latham’s article Strengthening Your Anesthesiology Group. Mr. Latham proposes two steps groups can take to reduce the pervasive environmental uncertainty: strengthen group governance and, with a more predictable decision-making process in place, develop a group-endorsed strategic plan. From defining the group’s collective vision through recognizing opportunities and dangers on to setting objectives and strategies, strategic planning is critical for groups that want to control their direction and identity.

Jody Locke’s article Timing is Everything: Divining the Wisdom of Anesthesia Aggregation in the Current Environment describes an example of anesthesia practices that have merged to create an important new player in the region, implementing a highly strategic long-range plan.

In Creating a Clinical Database: Opening Pandora’s Box or Mining the Treasure Trove, UCLA Anesthesiology Department Chair Aman Mahajan, MD and Jody Locke take a new look at the role of databases in creating power and influence in groups’ hospital relationships. The authors clarify the differences between familiar databases that serve billing and accounts receivable purposes, on the one hand, and those that can answers larger questions about quality, potential savings and clinical opportunities for practice expansion, on the other. They consider frequently-heard arguments against developing powerful clinical databases such as cost, time spent away from patients, and the already-high quality of anesthesia care and demonstrate that all of these are outweighed by the potential benefits of databases designed to capture and logically index all the information generated case by case. The most successful groups seek to manage their data in such a way as to identify issues that no one else has thought about and to change the existing practice paradigm. “Vital to that goal is having valuable data that can be shared with hospital administrators to identify rate-limiting steps in existing processes and to propose solutions that uniquely reflect the value anesthesia brings to the facility. It is only when this is the focus and intent of the data, that it becomes truly useful.”

In the shorter term, groups need to ask themselves whether their preparations for the implementation of ICD-10 diagnosis coding next year are on track. Joette Derricks’s article Are You Ready for ICD-10? points the way.

Groups who work with trainees—whether medical residents or allied health professionals such as emergency medical technicians—should take note of the need to match the patient to the trainee’s skill level, as illustrated by Brian Thomas, Esq. in Student Training Programs May Pose Significant Liability Exposure to Anesthesiologists. Kim Riviello, DNP, CRNA examines another risk management issue In A Retrospective Study of Gastroenterology Facility: Are the Patients Sicker? and provides a synthesis of published studies to show that outpatient facilities that anesthetize patients without anesthesia professionals should be aware of the prevalence and consequences of co-morbidities.

Readers often ask me how we are able to come up with new topics for this quarterly publication and our weekly Alerts. You know as well as I do that we live and work in a dynamic, exciting environment. There is always something new to say even when the topic is a familiar one such as the need for data. There are always new voices, too. If you would like to share an analysis, review or study in these pages—or to comment on what you have read—we are eager to hear from you.

With best wishes,

Tony Mira
President and CEO
**Strengthening Your Anesthesiology Group**

Will Latham, MBA  
President, Latham Consulting Group, Inc. Chattanooga, TN

“Most people choose unhappiness over uncertainty.” – Timothy Ferris

Anesthesiology groups are facing unprecedented challenges. How will the Affordable Care Act affect them? What will happen when ACOs get up and running? Should our group sell to an investment group? Should we pursue hospital employment?

These are truly uncertain times. Unfortunately many groups are in a reactive mode, struggling with how to deal with threats and opportunities in the marketplace. This is often because their governance and management processes were formed at a time when there were fewer stressors and challenges. Some group are sprinting towards relationships that appear to offer financial reward and some level of security, but at the same time have the potential to severely limit the group’s and the physician’s autonomy.

While there are situations where employment may be appropriate, many groups that pursue this course are “choosing unhappiness over uncertainty.”

If your group intends to remain independent, or if you are independent now and are still trying to decide which long-term option to choose, there are two steps that you can do to reduce uncertainty. You can’t eliminate the environment threats, but you can significantly strengthen your organization’s ability to cope with such threats.

**Strengthen Group Governance**

The first step is to strengthen your group’s governance. You can find a number of resources to help you do this on our website at [www.lathamconsulting.com](http://www.lathamconsulting.com) (choose “Resources” and then “Special Reports”), including Special Reports on:
- Practical Governance for Medical Groups
- Characteristics of Effective Boards
- A Code of Conduct Improves Behavior

However, many groups have never established even basic agreements about how they will decide things and govern their practice. Many groups still suffer from what we call “the dirty little secret.” This “secret” goes like this—once decisions have been made by the group, many physicians believe that supporting the decision is optional depending on whether or not they like the decision. If they didn’t vote for it, they feel like they don’t have to do it, support it or adhere to it!

As you may have already discovered, this can prevent a group from moving forward on important decisions and initiatives.

How can the group improve its ability to make and stick to decisions? Group members must ask themselves three fundamental questions. We believe these are the most important questions that any group can ask itself:

1. **How will the group make decisions?** It is critical that the group agree on how it will make...
and there continues to be a general reluctance to invest time and resources in clinical databases. The Anesthesia Quality Institute (AQI) has made a start, but its database of 10 million cases represents only a small percentage of total U.S. surgical volume and thus far relatively few of these cases include any clinical outcomes data. Small-scale individual initiatives are being undertaken across the country but few groups or departments can truly claim a robust clinical database. This state of affairs raises some fundamental philosophical, economic and practical questions about the value of such data in the current health care environment where the purported focus of policy is on quality improvement, safety and cost containment.

**Defining a Database and Its Purpose**

The term “clinical database” has varying definitions depending on the community. What data elements would be most useful in the current debate? Today’s clinical documentation tends to include two types of information: specific events and ongoing data streams. If all the data streams from physiologic monitoring, drug administration and provider interactions were captured, each case would result in a massive file of questionable value, except to those seeking to answer clinical research questions. The key elements would be those potentially predictive of complications or that confirmed the outcome of care. In comparison, creating the database for billing and accounts receivable management would be considerably easier because the basic elements were defined in the form of the standard CMS 1500 claim form. Inevitably the requisite clinical elements have to be defined in reference to those already being captured for billing.

The standard anesthesia billing dataset includes patient demographics, date of service, surgical procedure, diagnosis, start and end time and the details of any incidental procedures performed. These bits of information are intended to define what services were provided and by whom. We call the current system of reimbursement fee-for-service because it pays providers for individual patient services. Although payor policies purport to identify unnecessary services, little attention is actually focused on the appropriateness of cost-effective care, especially in anesthesia. The diagnosis code is a case in point. ICD-9 is supposed to provide a reasonable justification for the services provided but today’s diagnosis codes focus only on the rationale for the surgical procedure and not the need for or mode of anesthesia. Their application to the specialty is little more than a vestigial inconvenience. There should be a code that justifies the administration of anesthetic care in terms of the pain and inconvenience, medical management and complexity of monitoring during the surgery.

If a provider indicates that a general anesthetic was administered, it is never questioned by a payor. The appropriate-
base as a daunting enterprise that will require expensive consultants, significant resources and the serious commitment of key members of the practice. While one should never minimize the significance of adding data elements to a database, the process need not be perceived or promoted as an insurmountable task. Consider the bits of information that are only captured haphazardly today, indicators such as ASA physical status and diagnosis. Too often these are only retained when they have an impact on charge calculation or payment. Databases should evolve logically and be driven by a set of reasonable and practical questions. The fact is that most anesthesia providers already have a good idea of the issues that merit monitoring and areas where potential improvements in care can be realized.

**Building a Database: Challenges and Pitfalls**

The peri-operative continuum offers us three clearly defined areas of investigation: pre-operative observations, intra-operative events and post-operative complications. Because anesthesia risk factors have been so well studied over the years, reasonable and appropriate lists are available for each phase of care. Any of these would represent a good starting point for the formulation of a data capture strategy.

How would this additional data be captured? The good news is that computer memory continues to get cheaper and more powerful. For practices implementing automated anesthesia records, capturing additional data is easy. Others that are not so technologically advanced may want to consider including key elements from pre-operative assessment or intra-operative complication forms into their data entry process. Suffice it to say that with all the technological options available, data capture is not the practical obstacle that it used to be. There is more than ample evidence that practices that truly want to distinguish themselves in the market have found ways to consistently and cost-effectively capture the data they feel they need.

Too often the potential value of a robust clinical database is more of a theoretical proposition than a practical reality. Why is this? Standard arguments tend to fall into three broad categories: the philosophical, the economic and the practical. Considering the concerns one cannot help but wonder to what extent they are serious arguments versus veiled excuses for inaction.

Every anesthesia practice distinguishes itself based on the values, beliefs and outlook of its principals. Philosophy an especially powerful factor in the specialty. If you want to appreciate its impact just ask anesthesiologists across the country their feelings about working with other anesthesia providers. The geographic distribution of practices corresponds quite neatly to a philosophical spectrum of views where those in the East find nurses integral to the specialty to those in the West who tend to avoid working with CRNAs at all cost.

Philosophical attitudes clearly underlie the arguments surrounding the need for more clinical data capture. A strong belief in the value of American clinical training, the appropriate use of monitoring and a broad armamentarium of powerful drugs tends to result in a belief that trending and analysis are both unnecessary and inappropriate. There are many providers who remind patients that they are at greater risk driving to the hospital than undergoing general anesthesia. How much better can clinical outcomes possibly get? And then they drive the point home with a cautionary note. Capturing risk factors and outcomes can only be used against providers who, for one reason or another, are perceived as outliers.

Further, philosophical prejudices focus proponents primarily on the evidence that supports their position than what might undermine it. The stronger the position, the more impenetrable the filter. There is no greater obstacle to change than the belief that change can only be for the worse. The next bastion of opposition tends to cloak itself in economics. The economic realities of fee-for-service medicine have conditioned physicians to accept that if the market values something, it will pay you to do it. Conversely, if the market is not willing to pay for a service, then it is probably not a service that needs to be provided. This mentality has infused the specialty, conditioned thinking about compensation systems and ultimately proved to be one of the greatest challenges to group governance. Why should someone spend valuable time doing work for the group as a whole if they do not get compensated for it?

To a large extent data capture strategies continue to be defined by the economics of health care. Data elements such as PQRS Quality Data Codes are only added when there is a financial motivation to do so. The fact that capturing a particular indicator or piece of information would not result in a reward would
Creating a Clinical Database: Opening the Pandora’s Box or Mining the Treasure Trove

Continued from page 5

be a huge disincentive. The government understands this principle all too well. “Meaningful Use” of electronic health records is a perfect example.

The reality, of course, is that there are short and long-term economic lenses. Those who believe that the Accountable Care Act is going to usher in more cost-cutting and a focus on gain-sharing argue that having the data to identify and develop strategies for improving productivity and profitability is actually the most important economic argument one can offer. They argue that the beliefs and strategies that have gotten us to where we are today will not get us to where we need to be tomorrow.

None of this is to imply that the practical challenges in capturing more data from each anesthetic are inconsequential. Every additional data element captured from clinical practice requires three distinct steps. First the information expected must be clearly defined and providers must know exactly where and how it will be captured. A process or mechanism must then be established to capture the information and include it in a database of some sort, either in the practice’s master billing database or some other database. Ideally, all required information would be captured in one large integrated database but this is not always possible. Finally, any additional data must be validated.

Here is a case in point. A practice decides that it wants to start capturing the anesthetizing location where each case is performed. A decision has been made that having this information will allow for the calculation of much more precise productivity metrics. In this case the group must first define how each location will be labeled and work with the software vendor to establish a field for the data to be captured. Providers are instructed where to note the location on the anesthesia record. A month passes and a QA process must be performed on the resulting data. 25% of the providers either did not mark the location for each case or did not report it consistently. In some cases the data entry team missed some of the locations. Ultimately, it takes three of four months for the group to achieve 95% data capture.

Capturing risk factors and outcomes that could potentially be used against the provider poses even greater challenges and issues. Self reporting requires great discipline and honesty. Inevitably the practice must ensure the confidentiality of the information and make certain that it will be used only in a blinded statistical manner. For maximal success, the practitioners need to perceive this process as being essential, unbiased and helpful.

While these are all legitimate and practical concerns, they should not be used as reasons not to forge on. Rather, they should be part of a serious conversation about an appropriate approach. The fact is that many practices have already embarked on this path. Those that find the process too daunting are likely to be left behind by those who rolled up their sleeves and worked it out.

Process changes such as those presented here should ideally be implemented with an eye to addressing issues of specific relevance to the practice or to anticipating changes believed to be taking place in the market. So what are the big clouds on today’s anesthesia landscape? Most observers would agree that virtually all anesthesia practices must deal with three general practice management concerns. These could be defined as (1) the revenue challenge, (2) the security challenge and (3) the strategic challenge. In order to remain viable, every anesthesia practice must secure a revenue stream sufficient to recruit and retain appropriate numbers of qualified providers to meet the expectations and service requirements of their facilities. Given the reality of expanding coverage requirements and limited revenue opportunities, most practices must find ways to justify hospital support.

Asking for financial support from a hospital comes with its own set of risks. When administrators pay for services they typically want assurances that they are getting value for the money they spend. Today’s hospital contracts are more extensive and complicated than ever. They often include metrics and standards of care that must be met. Anesthesiology practices find themselves caught between accepting the hospital’s data and metrics and building their own databases.

This new reality has given rise to a significant concern about the security of a practice’s contract. The increasing use of Requests for Proposal (RFPs) and the growth of national management companies only heighten the anxiety of the providers. Clearly, many practices are seriously at risk of losing their franchises. The problem is that many do not appreciate just how much they are at
risk of being displaced. The anecdotal evidence from around the country can be quite disconcerting.

Practices now have to consider options and formulate fall back strategies. The fundamental strategic question being discussed by large numbers of practices around the country is whether it is worth trying to remain independent versus joining a larger entity. In other words, every group must consider whether it can sufficiently distinguish itself and provide consistently superior care or let some other entity define its destiny.

Ironically, for all the observations and experience of its providers, anesthesia has let others define the quality of care provided rather than defining it themselves. The result has been a fairly myopic focus on negative or unexpected anesthesia outcomes. The ASA supports considerable research in anesthesia safety and modalities, but most of the papers, their conclusions and recommendations are intended only for the specialists themselves. The result, of course, has been dramatic increases in quality and significant reductions in anesthesia morbidity and mortality. As clinicians, anesthesia providers have tended to live in the shadows in their respective medical communities. This is why an article about the chairman of anesthesia at North Shore University Hospital in Manhasset, New York was entitled, "Who is This Masked Man?" While a sense of humility has served the specialty quite well thus far, it is unclear it will serve the specialty well in the competitive medical marketplace of the future.

These general themes are playing themselves out in three specific arenas. There is an increasing focus on the cost of anesthesia care. Customer service has become the issue of the day. All practices are scrambling to find new services and venues so that they can remain viable. Each of these has significant practice management and governance implications. Growing numbers of physicians are simply throwing in the towel rather than radically redefine what they do and how they do it.

The cost question is particularly challenging to many practices. How do you reduce the cost of a service where the only significant factor is the compensation of the providers? Physician-only practices have to consider care team options. Care team practices are looking at using more CRNAs. There are no really good options, however, when the real driver of their costs is the unrealistic coverage requirements of administration. Few practices have many good tools or strategies to reset administration expectations. This is where having reliable data and a compelling way to use it becomes so critical.

Customer service is another particularly frustrating issue for practitioners who have always seen theirs as the quintessential customer service specialty. The fact is, though, that in the customer’s eyes good clinical outcomes are a given and not the definition of good customer service. They want all three of the traditional anesthesia As: ability, affability and availability.

Today’s hospital administrators have high expectations. They want accountability, collaboration and innovation. They want business partners who are willing to share ideas and risk. They want anesthesia to take ownership of what happens in the O.R., not simply to profit from it. Committee involvement and the sharing of data and ideas are the new reality of today’s medical staff.

So how does more data make a practice more secure? In and of itself, it doesn’t. Today’s large anesthesia practices and staffing companies are taking a very different approach to data management. Perhaps inspired by the Googles and the Facebooks of the world, they are not just looking to validate what they know, but to identify issues that no one else has thought about. Differentiation and innovation are the driving factors in today’s marketplace. The new anesthesia mega-group strategy is to use the power of the anesthesia database as leverage to gain recognition and acceptance. These anesthesiologists are no longer willing to accept a role of subservience. There is no security in being useful to the administration, the surgeons and the rest of the medical community. Power comes from control and influence. Their goal is not simply to profit from the existing paradigm but to change it. Vital to that goal is having valuable data that can be shared with hospital administrators to identify rate-limiting steps in existing processes and to propose solutions that uniquely reflect the value anesthesia brings to the facility. It is only when this is the focus and intent of the data that it becomes truly useful.

Ironically, this is what most hospital administrators have been waiting for. The following is a short summary of a typical hospital administrator’s wishlist for its anesthesia department.

- Anesthesia should be a significant contributor to ongoing process improvements.
- Departments of anesthesia should be constantly monitoring and managing their own resource allocation.
- They should be models of customer service.

Continued on page 8
Creating a Clinical Database: Opening the Pandora’s Box or Mining the Treasure Trove

Continued from page 7

Why would they have such expectations? In large part they have such expectations because this is what the biggest and most aggressive of the nation’s practices are offering and providing. Once the bar gets raised every group must compete at a new level.

The landscape of anesthesia has clearly changed. Is it too late for most practices? Have they already fallen so far behind as to make it impossible to catch up or compete? Absolutely not. For one thing, not every administration wants to deal with a mega-group or national provider organization. For another, being competitive is less about the “what” than the “how.” While commitment and enthusiasm will never overcome substandard service or inconsistent care, they still count for a lot.

Expanding a practice’s database to include more than just the requisite details necessary to bill a patient and his or her insurance is a fundamental exercise in change management. Like many other initiatives that an anesthesia practice might consider, this one must be clearly framed and sold to the membership. Selling it is about overcoming concerns and objections. Effective change management inevitably requires three things: a champion, a vision and a plan. The importance of leadership in managing change in an anesthesia practice cannot be overstated. Given the independent nature of so many anesthesiologists, it is essential that there be a unifying force and focus to the initiative. This is not something that will ever happen spontaneously. Independent thinkers need to have all their issues addressed and their objections overcome. The leader must be able to address each category identified earlier in this discussion: the philosophical, economic and practical.

What is the vision that inspires physicians to report more details of each clinical encounter that could potentially be used to identify them as outliers, or worse yet, as providers of inferior care? It is not an easy question to answer, especially for doctors who believe that the quality of care they provide is already very good. It must be a vision of something more profound than clinical outcomes. It must remind providers that their very success has consistently diminished the perceived value of the services provided. It must inspire the specialists to think beyond their own individual value and compensation. It must remind them of the fundamental nature of the specialty, as the quintessential service specialty. It must speak to the heart and core of customer service, which always seeks to provide a safe, comfortable and compassionate surgical experience. It must remind each and every member of a practice that quality is defined by the least effective clinician in the practice. It must offer a compelling argument for doing things differently, and for being willing to innovate and take risks. Where these kinds of thoughts are persuasively communicated there will be a more enthusiastic endorsement.

Too often, however, the vision is neither clear not compelling and that makes the challenge ever more difficult.

There is a saying in sales that when the customer is confused, he will not buy. Being able to sell the concept of a robust clinical database is important, but it is only the beginning of the process. Anesthesia providers tend to think through issues very systematically and to solve problems based on their well-ingrained sense of decision-tree models. This is why the planning process is so critical. Most people prefer off-the-shelf solutions. The leader must not only sell a vision, he or she must clearly outline the roadmap to implementation.

This may all sound daunting. Effecting a change that affects provider behavior and requires the commitment and involvement of IT resources that might not yield the desired results is a risky proposition, but is there really an option? That is the question that every practice must address in today’s rapidly changing economic landscape.

Aman Mahajan, M.D., Ph.D., FAHA, is Chair at the Department of Anesthesiology, as well as Professor of Anesthesiology and Bioengineering and he holds the Ronald L. Katz Endowed Chair in Anesthesiology at the David Geffen School of Medicine at UCLA. Dr. Mahajan is a leader in the field of cardiac anesthesia and cardiac electrophysiology & biophysics. A holder of numerous patents, Dr. Mahajan serves on various medical and scientific committees including the National Scientific Research Board. He can be reached at (310) 267-8680 or amahajan@mednet.ucla.edu.

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

Continued from page 3

decisions. Typically the group has four choices as outlined in Table 1. In our experience, the best option is to seek consensus first, and then vote if consensus cannot be reached. Often the president is charged with the responsibility of determining when the group should move to vote.

2. What is expected of each physician once a decision has been made? This is the crucial question. The best groups answer this question by agreeing that once a decision has been made in the agreed-upon decision-making method, every physician (whether they agreed with the decision or not) will actively and fully support the decision, to include encouraging others to support the decision. “Fully support” means doing what they have agreed to, actively promoting implementation, and not sabotaging the decision.

3. What are a physician’s options if he or she still doesn’t like the decision? There should be only three options:
   a. Do it anyway—that’s group practice.
   b. Try to get it changed in the appropriate forum, but keep adhering to the decision until it is changed.
   c. Self-select yourself out of the group.

This last option is the one that causes people heartburn, but without it people will believe they have the option to stay with the group while not adhering to group decisions. We know that it is unrealistic to believe that all physicians will adhere to the commitment to leave the practice if they don’t adhere to group decisions. However, by asking and answering these questions, the group can remind outliers that they all agreed to support group decisions once they were made. Since many physicians consider themselves the last “gentlepersons” in the world, and that their word is their bond, this often brings them back into line.

Groups also frequently develop formal processes to deal with those that don’t live up to their commitments. These processes might include a “Code of Conduct” that outlines acceptable physician behavior. They also typically develop a step-by-step process that the group can use to resolve physician issues. An example of such a process can be found at the end of this article.

A few years ago we worked with a group that had this discussion at the beginning of their strategic planning retreat. One of the physicians said, “So, if we make a decision, we are really going to do it?” I responded in the affirmative, to which he replied, “Well, I guess I will have to pay attention at this meeting!”

If your group is having a problem making (and sticking to) decisions, it is probably because your group has not asked, and answered, these three critical questions.

Table 1 — Decision-Making Methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. All decisions require unanimity.</td>
<td>A bad idea, typically leads to no decision.</td>
</tr>
<tr>
<td>b. Decisions require consensus.</td>
<td>Consensus means working to a point where all don’t agree with the decision, but all will support it. The key positive is that it improves the chance of success in implementation. The negative is that it takes longer to reach “a deal” that all feel reasonably good about.</td>
</tr>
<tr>
<td>c. Decisions are made by a vote with majority ruling.</td>
<td>Good to use when you have limited time to make a decision, or when there are fundamental differences of opinion that are unlikely to be changed via discussion.</td>
</tr>
<tr>
<td>d. Seek consensus first, but if it cannot be reached vote on the issue.</td>
<td>In our experience, this tends to be the best decision-making approach for medical groups. Someone must direct the group (often the group’s President) as to when to move from consensus-building to voting.</td>
</tr>
</tbody>
</table>

Group Strategic Planning

A second step in strengthening your group is to develop a group-endorsed strategic plan. Decisions facing anesthesiology groups today are significant and have long-range implications.

Each of these decisions require substantial resources and lead times. In addition the decisions are often interrelated.

But the significance of the needed decisions is only one factor highlighting
the importance of long-range planning. Without planning, physicians in anesthesia groups rarely have a common vision of the direction their firm is moving. This can result in inefficient utilization of resources, lack of direction for the administrative staff, and lack of any progress for the group.

Why is long-range planning important?

- Significant changes in the environment can hurt or help the group. Planning helps identify these issues and prepare for them.
- The planning process allows each physician to communicate his or her vision of the future, and work to develop consensus in their objectives and goals.
- Key issues are highlighted, discussed and resolved.
- The plan provides direction to and sets priorities for the administrative staff for implementation.
- The planning process and completed plan improves communication to both physicians and staff.
- If progress is tracked against the plan, performance measurement can be improved.
- Physician recruitment may be enhanced as potential recruits can quickly understand if their long range goals are in line with the group.

Resistance to long-range planning is normally the result of at least one of the following factors:

- Physicians do not understand the importance or benefits of long-range planning.
- The physicians have no clear decision-making process to initiate planning.
- Planning has been tried, but the physicians are not convinced of its benefits.

In each of these instances, group leadership should communicate the need for and benefits from long-range planning and then work to implement a process to develop the plan.

What Is Strategic Planning?

All organizations, at one time or another, struggle with the following questions:

- Where are we going?
- How will we get there?
- Why do we want to do it as a group?

To answer these and other important questions, many anesthesia groups are turning to a formal strategic planning process for their organization.

Strategic planning has been defined as a process of developing an integrated, coordinated and consistent long-range plan of action for the organization. One of the first steps in the process is to develop a “vision” statement for the group. This statement describes the group’s preferred future and what it intends to become.

Developing this statement involves answering the following key questions. Looking out over the planning horizon (which is likely 3-5 years at the most):

- What services and specialties do you plan to offer?
- What geographic region do you intend to serve? How many locations are you likely to have?
- How big will the group become? Will you grow to fill the service needs of the market, or will you set an upper end limit on the number of physicians in the group?
- What type of relations will you have with others? Will you remain an independent group? As previously discussed, this is a very important question in today’s environment.
- What benefits do you hope to provide for the owners and employees?

The next step in the strategic planning process is to look at all forces outside of the group that could affect the
group’s functioning. This step is called *environmental analysis*, and its purpose is to identify opportunities and threats that the group faces.

The environmental analysis looks at three areas:

1. **External Constituent Demands:** An external constituent is a group or individual who is capable of taking action or has needs which could favorably or unfavorably impact the group. For example, a major external constituent for an anesthesiologist group might be the hospital it is associated with. It is very important for this type of a group to understand the actions that the hospital might take or the needs they have.

2. **Competitors:** Individuals or organizations who compete for the same set of “customers” as the group are identified and analyzed for major actions which might affect the group.

3. **Macro-environment:** The macro-environment includes large scale fundamental forces that shape opportunities and pose threats of the group. The group should review significant economic, political, demographic, and technological events and trends and their impact on the group.

Once the major actions, events or trends are identified, they should be categorized as opportunities or threats.

**Opportunities** are any favorable situations in the group’s environment that support demands for a new service or permit the group to enhance its position. **Threats** are challenges posed by unfavorable trends or specific events in the environment that would lead, in the absence of purposeful action, to the stagnation, decline or demise of the group or one of its services.

The third major step in strategic planning is to look within to identify the **strengths and weaknesses** of the group. Significant areas of the practice (e.g., personnel, management, decision making) are reviewed to identify areas either capabilities that will lead to or limitations that will prevent the group reaching its objectives.

It is important to identify strengths so that they might be used in planning how to achieve objectives. Weaknesses, on the other hand, may point to the need for programs to correct them.

At this point the group has collected significant data about itself and its environment. Now it is time to put that information to use by **setting objectives**.

An objective is a description of some situation in the future that you would like to see come about, and which you have a reasonable expectation of accomplishing. Objectives should be developed when:

- Something is wrong (a weakness) and needs to be corrected;
- Something is threatening (a threat), and needs to be prevented;
- Something is inviting (an opportunity), and needs to be pursued.

Objectives should flow from the previous work you’ve done in developing a vision statement, identifying opportunities, threats, strengths and weaknesses, and from your vision of the future of the group.

The final step in developing a strategic plan is to develop and agree on **strategies** to be used to attain your objectives. Strategies are decisions and/or major action programs employed by the group to fulfill its vision. Once strategies are identified, the group can assign responsibilities and completion dates.

It is important that both the physicians and administrative staff understand that this is their plan and requires their input and participation. If your group has not developed such a plan, how does it know where it’s going?

**Will Latham, MBA, President, Latham Consulting Group, Inc., Chattanooga, TN.** Latham Consulting Group helps medical group physicians make decisions, resolve conflict, and move forward. For more than twenty-five years Mr. Latham has assisted medical groups in the areas of strategy and planning, governance and organizational effectiveness, and mergers, alliances and networks. During this time he has: facilitated over 900 meetings or retreats for medical groups; helped hundreds of medical groups develop strategic plans to guide their growth and development; assisted over 130 medical groups improve their governance systems and change their compensation plans; and advised and facilitated the mergers of over 120 medical practices representing over 1,200 physicians. Latham has an MBA from the University of North Carolina in Charlotte and is a Certified Public Accountant. He is a frequent speaker at local, state and national, and specialty-specific healthcare conferences. He can be reached at (704) 365-8889 or wlatham@lathamconsulting.com.
The specialty of anesthesiology is experiencing an unprecedented level of merger activity and practice acquisitions. The idea of two or more practices joining forces to secure their market position or enhance their strategic options is hardly a new phenomenon. The past few decades has seen the emergence of some very large anesthesia organizations that have dramatically changed the landscape in their respective markets. Once a pioneer in large group practice management, the Anesthesia Service Management Group (ASMG) and its 150 plus physicians in San Diego has become a model to emulate and refine. By some accounts, we have already reached a point where fewer than 100 organizations employ more than 15 percent of all anesthesia providers, but this is only a rough calculation, made especially challenging by the recent infusion of venture capital money that is inspiring an impressive list of practice acquisitions across the country. This dramatic rethinking of the very nature of an anesthesia practice as not just a way of satisfying the requirements of an exclusive contract with a particular facility. There is no shortage of anesthesia practices that could well meet this criterion. Independent rural hospitals tend to be a case in point. Specialty hospitals that have very unusual service requirements may also be candidates for small, monogamous practices. What does not fit the bill is the practice that simply chooses not to be a competitor and which chooses not to focus its energies on the highest level of customer service. In the current environment, going it alone can be a very risky strategy. With increasing frequency, unsuspecting physicians are coming to appreciate just what it means to be the recipient of a Request for Proposal (RFP). No three letters evoke such anxiety.

Second, groups that don’t have a plan or a strategy of their own may consider selling out. Practices that have never invested in the development of a strong administrative infrastructure may choose to affiliate themselves with entities that have more evolved business structures. The leadership must believe they have a significant strategic advantage to leverage. Maybe they are the preferred anesthesia practice within a strong hospital network. Maybe they are a practice that has invested in their administration and infrastructure. It is also possible that they have an in-house billing service they are hoping to offer other anesthesia groups. While many practices talk about leading the pack, it is the rare group that is successful. The challenges can be significant. What worked in one practice is not always transferable to another. The vision of one leadership is not always the vision of another, especially when that vision is tested by the practical realities of governance, compensation and ownership. The political challenge of getting multiple practices to agree on one billing solution is often the fatal flaw in the equation. Even those that do agree to merge do not always stay merged.

The first option is to stand firm and find ways to define the group as a niche practice uniquely qualified to meet the specific expectations and requirements of a particular facility. There is no shortage of anesthesia practices that could well meet this criterion. Independent rural hospitals tend to be a case in point. Specialty hospitals that have very unusual service requirements may also be candidates for small, monogamous practices. What does not fit the bill is the practice that simply chooses not to be a competitor and which chooses not to focus its energies on the highest level of customer service. In the current environment, going it alone can be a very risky strategy. With increasing frequency, unsuspecting physicians are coming to appreciate just what it means to be the recipient of a Request for Proposal (RFP). No three letters evoke such anxiety.

Second, groups that don’t have a plan or a strategy of their own may consider selling out. Practices that have never invested in the development of a strong administrative infrastructure may choose to affiliate themselves with entities that have more evolved business structures. The leadership must believe they have a significant strategic advantage to leverage. Maybe they are the preferred anesthesia practice within a strong hospital network. Maybe they are a practice that has invested in their administration and infrastructure. It is also possible that they have an in-house billing service they are hoping to offer other anesthesia groups. While many practices talk about leading the pack, it is the rare group that is successful. The challenges can be significant. What worked in one practice is not always transferable to another. The vision of one leadership is not always the vision of another, especially when that vision is tested by the practical realities of governance, compensation and ownership. The political challenge of getting multiple practices to agree on one billing solution is often the fatal flaw in the equation. Even those that do agree to merge do not always stay merged.
A review of today’s largest practices, all of which are the result of at least a few mergers, reveals three essential criteria for success: rationale, structure and infrastructure. Large groups survive and thrive because their members have confidence in their vision, leadership and management. This is not an easy combination of qualities to achieve and the law of entropy definitely applies to anesthesia practices: there are more factors working against their survival than for it.

**Rationale and Structure for a Merger**

As is true of any business proposal, the vision comes first. How will the group distinguish itself in the market place; how will it get and keep customers and what will its value proposition be? There has to be a clear and compelling rationale for the merger that makes sense and which can be simply articulated by all participants. It is not enough to claim that a bigger group will get better rates or reduce its cost of doing business, however important these may be perceived to be. Strong leadership and vision can often finesse the objections but ultimately if there is no consensus, the new entity will forever be encumbered by its history and diverse cultures and outlooks of its members.

The proposed structure can also prove critical. This is where lawyers earn their fees. This is much more than a simple question of C-Corp, S-Corp, partnership or LLC. These are just labels. The form and structure of the entity must support its function. It is a delicate balancing act to find the right structure that will make new members feel comfortable enough to join but which will give the entity the legal leverage to achieve its business objectives.

Infrastructure is critical and the final necessary prerequisite. Too many practices are simply too naïve about the breadth and depth of their administrative infrastructure. The administrative team or its surrogate must have the resources and experience to smoothly integrate new shareholders and employees. Seriously disgruntled employees can derail even the most compelling plan.

A newly emerging and already quite substantive entity, Midwest Anesthesia Partners, Ltd. (MAP) is the brain child and offspring of Park Ridge Anesthesiology Associates, Ltd. (PRAA) and Lake County Anesthesiologists, Ltd., significant practices based at Lutheran General Hospital in Park Ridge, Illinois and Condell Hospital in Libertyville, IL. Well known preeminent anesthesia groups in the area associated with one of the prominent hospital systems, Advocate Health, their leadership believes the time is right to leverage their combined position in the local market. Preliminary numbers indicate that MAP could manage more than 150 physicians and CRNAs by the end of the year. The enthusiasm of MAP’s president, David Rosen, MD, inspires at least three obvious questions: Why now? What does MAP hope to accomplish? How likely is the group to succeed?

The timing of the formation of MAP is no accident. It is directly related to the implementation schedule for the Patient Protection and Affordable Care Act (ACA). There are always necessary and sufficient causes for launching a new practice initiative. PRAA’s long history at Lutheran General and its reputation in the community were necessary prerequisites but until the ACA was signed into law there was no one specific and sufficient motivation to dramatically restructure the practice model. MAP founders believe, and they are certainly not alone in this belief, that three factors set the stage for the passage of the law and that these will continue to be the factors that will drive future developments in health care.

Any discussion of health care starts with the cost. The national cost of health care has been one of the fastest growing items in the Federal budget for years, despite tight price controls on Medicare and Medicaid rates. The cost of health care is the number one cause of personal bankruptcy. Increasingly businesses have had to opt out of health care coverage due to spiraling premiums. Numerous provisions of the ACA are intended to address the cost of health care and availability and affordability of health insurance.

One of the fundamental concerns with the current system is that it rewards physicians for providing services whether necessary or helpful or not. This tradition of fee-for-service medicine has been the basis for the entire medical payment system for as long as anyone can remember. The standard bible of all billing personnel is the AMA’s CPT book that numerically codifies all medical services so that payors can develop fee schedules and payment criteria. The system has become so complicated that it spawned yet another reference, the Correct Coding Initiative (CCI) to identify which procedures can reasonably be billed with others. It started as a good idea and a very logical way to ensure that providers got paid for the services they deemed appropriate for good patient care. The system has clearly encouraged the development of hundreds of new modalities that have contributed to an ever higher standard of care. The problem is that for all the good it did, it has also encouraged providers to exploit the system through creative coding and unbundling. The ACA includes various provisions for pilot projects and other initiatives to change the incentive from fee for service to fee for outcomes, or pay for performance (P4P).

Continued on page 14
TIMING IS EVERYTHING: DIVINING THE WISDOM OF ANESTHESIA AGGREGATION IN THE CURRENT ENVIRONMENT

Continued from page 13

GROWTH OF MIDWEST ANESTHESIA PARTNERS, LTD. (MAP)

<table>
<thead>
<tr>
<th>Founding Groups</th>
<th>Physicians</th>
<th>CRNAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Park Ridge Anesthesiology Associates, Ltd.</td>
<td>46</td>
<td>6</td>
</tr>
<tr>
<td>Lake County Anesthesiologists, Ltd.</td>
<td>21</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Joining Groups</th>
<th>Physicians</th>
<th>CRNAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest Suburban Anesthesiologists, Ltd.</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Lincoln Park Anesthesia and Pain Management, Ltd.</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>113</td>
<td>24</td>
</tr>
</tbody>
</table>

The second major driver behind the ACA is a concern with the quality of care provided. By most accounts, Americans pay more for healthcare than most industrialized nations but our outcomes and quality rank us well below the leaders. This problem has inspired a concerted effort to implement and expand the use of Electronic Medical Records (EMRs). There is considerable consternation across the country as hospital administrations and health systems move forward with EMRs. Not all providers accept that capturing more details about each patient interaction will necessarily improve the quality of care and outcomes. Most observers believe, however, that the underlying theme here is already quite clear. Physicians must do a much better job of substantiating the quality of care provided and whether the desired outcome was achieved. The belief is that this will become a significant factor in the payment calculation. This intense focus on the justification for payment is at the heart of the new diagnosis coding system (ICD-10) that is scheduled to be implemented next October.

At the heart of MAP’s strategic plan is a belief that only organizations of a sufficient mass can afford to develop the infrastructure necessary to reposition anesthesia practices to compete aggressively in what is anticipated to be a far more competitive market for health care. Ultimately, every hospital administration that must select a new provider group hopes to base its decision on cost, quality and a belief that the entity is positioning itself for the future of health care.

MAP is a partnership of corporate members. The intent is to provide sufficient freedom and flexibility for groups that want to join to maintain their corporate culture and integrity while achieving economies of scale. Essentially, the structure encourages individual member groups to continue to focus their energies and efforts on customer service for the facilities they serve. The role of the partnership, by contrast, is to negotiate with payors for optimum payment rates, provide corporate and support services and to market the entity as a whole.

Thus far the strategy appears to be working. Interest in the partnership has been intense.

The formation of this new entity raises a number of interesting questions about why, when and how markets for anesthesia services change. In some senses, MAP is late to the game. Cities like San Diego and Portland have been experiencing the market impact of very large anesthesia groups for years. The NAPAs of the world are a more recent phenomenon. Why did it take so long for such an entity to coalesce in the Chicago market? There are two prevailing theories. The first focuses simply on economics. Chicago practices have done fairly well compared to those in the rest of the Midwest. While anesthesia compensation levels have not been the highest in the country, they have been very competitive. There have simply not been the kind of dramatic market forces imposed by managed care plans that have distinguished places like Philadelphia and Houston, where other very large entities were organized a dozen or so years ago. Even now the initiative inspiring MAP is more pro-active than reactive.

The other factor is far more subtle. For reasons that are unique to the local market one management firm, Merus Management, has enjoyed the trust and respect of a significant percentage of the area’s anesthesia practices for years. In effect, Merus has provided a level of service and practice management that other practices have felt they needed to create for themselves. It comes as no surprise that the formation of MAP is the logical next step in the evolution of Merus’s influence in the market.

So what does the future hold? The founders of MAP are cautiously optimistic. They would be thrilled if MAP represents 200 providers by the end of 2014. In their view the logic of consolidation is selling itself. They are also realistic enough, however, to understand that the group must deliver on its promises. This will be the ultimate validation of the concept but what they would say is that if you get enough people believing in the future of MAP and willing to work to make it a strong force in the Chicago market, it will be.

Jody Locke, CPC, serves as Vice President of Pain and Anesthesia Management for ABC. Mr. Locke is responsible for the scope and focus of services provided to ABC’s largest clients. He is also responsible for oversight and management of the company’s pain management billing team. He will be a key executive contact for the group should it enter into a contract for services with ABC. He can be reached at Jody.Locke@AnesthesiaLLC.com.
Anesthesiologists are frequently requested to participate in student training programs for emergency medical technicians (EMTs), student nurse anesthetists (SRNAs), medical residents and students and respiratory therapists to provide training and supervision for intubation proficiency and airway maintenance. While most professional liability carriers provide coverage for participating in these student training programs, the following case summary underscores the significant liability exposures that can arise.

A 20 year old female, 5’4”, 38.5 kg, with a medical history significant for kidney removal, duodenal obstruction and persistent vomiting for 4 days presented for Roux-en-Y gastric bypass and appendectomy. A nasogastric (NG) tube had been placed on the day of the procedure, but the NG tube had been “sneezed out” approximately two hours prior to the procedure. The surgeon was aware the NG had come out; however, that information was never conveyed to anesthesia.

The anesthesia group had a contract with the county emergency medical services (EMS) program for teaching EMT students intubation. An EMT student being supervised by an anesthesiologist and a certified registered nurse anesthetist (CRNA) attempted a standard intubation. The EMT student intubated the patient’s esophagus on his first attempt. The patient aspirated a “significant amount” of gastric contents that was suctioned. The esophageal intubation was immediately recognized and the CRNA successfully intubated on the second attempt. An NG tube was placed and approximately 600 cc of gastric contents was suctioned from the patient’s stomach.

The surgery was completed without further complication. However, a chest x-ray showed aspiration pneumonia requiring prolonged intubation and ventilation. On the seventh post-operative day, the patient had a period of ventricular tachycardia and it was thought she was having an acute myocardial infarction. The patient was transferred to another facility where she underwent urgent cardiac catheterization. The patient had a complicated medical course following the aspiration requiring various hospital admissions for pneumonia, aspiration, strokes and complications from tracheostomy. The patient was subsequently diagnosed with significant brain damage and was unable to perform activities of daily living.

The patient’s parents, on behalf of their daughter, sued the hospital, the supervising anesthesiologist and his anesthesia practice group. Plaintiffs’ allegations included, but were not limited to, failing to employ adequate diagnostic procedures and tests to determine the nature and severity of the plaintiff’s medical status and/or conditions; failing to employ appropriate treatments and procedures to correct such conditions; negligently permitting, without notice to and/or the consent of the plaintiff, an EMT student to attempt intubation; negligently failing to inform the plaintiff of the risks reasonably associated with permitting an EMT student to attempt intubation; and failing to exercise reasonable care in the treatment and management for the complications and sequelae associated with aspiration of gastric contents.

1 The term “Emergency Medical Technician” (EMT) encompasses several different levels of training, responsibility, experience and skill. EMT-Basic is an entry level certification including basic airway management. EMT-Intermediate is a step between Basic and Paramedic and includes additional education and skills instruction. EMT-Paramedic requires either a two year degree or a certification program and is the most advanced level of EMT. Paramedic skills include, among others, advanced airway management including endotracheal intubation, forcep use for airway obstruction and emergency surgical airway skills.

2 Plaintiffs did not sue the EMT student despite the fact the county employer carried $1,000,000 in insurance coverage for claims against its EMT students.

Continued on page 16
causing permanent and irreversible brain damage and related injuries.

Plaintiff’s anesthesiology expert, Corey Burchman, MD from York, Pennsylvania, was prepared to testify that the supervising anesthesiologist violated the standard of care by allowing an EMT student to attempt intubation on a patient with a significant risk of aspiration due to her bowel obstruction. Plaintiff’s expert additionally criticized the failure to perform a rapid sequence induction. Dr. Burchman was also critical of the response and intervention to the observed aspiration.

The defense anesthesiology expert opined there was no deviation in the standard of care to have performed an esophageal intubation that was recognized immediately with the tube removed and reintubated. The defense expert also asserted that aspiration is one of the recognized risks associated with intubation and not the result of a breach of the standard of care. The defense expert was prepared to testify it was not below the standard of care to allow an EMT student to perform the intubation under supervision. However, the defense expert conceded he would not have allowed an EMT to attempt intubation on this patient due to her increased risk for aspiration.

The plaintiff’s economic expert estimated the plaintiff’s lost earnings at present value were $1,606,554. Plaintiff’s economic expert estimated future care costs for in-home care at $16,155,770 to $21,969,117 and in a care facility at $29,945,398 to $30,246,075.

The anesthesia defendants participated in a court-ordered, pre-trial settlement conference with the hospital and plaintiffs. Based on the significant damages and potential liability exposure, the professional liability carrier for the anesthesia defendants contributed to a $7,000,000 global pre-trial settlement with the hospital.

### Risk Management Tips for Participation in Student Training Programs

- Carefully review any student training agreements or contracts.
- Determine if students have malpractice insurance coverage through the hospital, employer or school.
- Obtain copies of certificates of insurance confirming student malpractice insurance coverage.
- Verbal and written anesthesia informed consent must specifically disclose that students may be involved in the patient’s care.
- Patients must have an opportunity to refuse to allow students to participate in their care.
- Ensure students have been carefully screened and have the appropriate level of education, training, experience and skills to participate in training program.
- Carefully select appropriate patients to be intubated by students (For example, patients with no significant co-morbidities, easy airways and class 1 or 2 on Mallampati classification).

---

Brian J. Thomas, JD, serves as Senior Claims Attorney & Director of Risk Management for Preferred Physicians Medical in Shawnee Mission, KS. Mr. Thomas has over twenty-one years of insurance industry experience, including fourteen years devoted exclusively to defending anesthesiologists and their anesthesia practices. Thomas leads Preferred Physicians Medical’s risk management efforts for the development of enhanced risk management tools for its policyholders and is the Editor-in-Chief for PPM’s risk management newsletter, *Anesthesia & the Law*. He also serves as Senior Claims Attorney managing high severity claim and litigation files in twenty states. Mr. Thomas is a 1995 graduate of Washburn University School of Law. Thomas is a frequent speaker at risk management seminars, national and state professional society meetings, and defense counsel seminars. He can be reached by email at brian.thomas@ppmrrg.com or at (913) 262-2585.
On October 1, 2014, the United States health care system will undergo a major transformation. We will transition from the decades-old Ninth Edition of the International Classification of Diseases (ICD-9) set of diagnosis and inpatient procedure codes to the Tenth Edition of those code sets—or ICD-10. The Tenth Edition is the version currently used by most developed countries throughout the world. ICD-10 allows for greater specificity and detail in describing a patient’s diagnosis and in classifying inpatient procedures, so reimbursement can better reflect the intensity of the patient’s condition and diagnostic needs.

This transition will have a major impact on anyone who uses health care information that contains a diagnosis and/or inpatient procedure code, including hospitals, physicians, other providers, payers, clearinghouses, billing companies, etc.

The change will affect all covered entities as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Covered entities are required to adopt ICD-10 codes for services provided on or after the October 1, 2014 compliance date. For inpatient claims, ICD-10 diagnosis and procedure codes are required for all stays with discharge dates on or after October 1, 2014.

Note that the transition to ICD-10 does not directly affect provider use of the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

In 1990, the WHO updated its international version of the ICD code set for mortality reporting. Other countries began adopting ICD-10 in 1994, but the United States only partially adopted ICD-10 in 1999 for mortality reporting.

The National Center for Health Statistics (NCHS), the federal agency responsible for the United States’ use of ICD-10 developed ICD-10-CM, a clinical modification of the classification for morbidity reporting purposes, to replace our ICD-9-CM Codes, Volumes 1 and 2. The NCHS developed ICD-10-CM following a thorough evaluation by a technical advisory panel and extensive consultation with physician groups, clinical coders, and others to ensure clinical accuracy and usefulness.

**How Do ICD-9 and ICD-10 Differ?**

There are several structural differences between ICD-9-CM codes and ICD-10 codes. Table 1 on page 18 illustrates the difference between ICD-9-CM (Volumes 1 and 2) and ICD-10-CM.

ICD-10-CM/PCS consists of two parts:

1. ICD-10-CM for diagnosis coding in all health care settings
2. ICD-10-PCS for inpatient procedure coding in hospital settings

The General Equivalence Mappings (GEM) are a reference mapping that attempts to include all valid relationships between the codes in the ICD-9-CM diagnosis classification to the ICD-10-CM.

By moving to an expanding code system, ICD-10 will provide governmental agencies and payers with more specific

---

data than ICD-9. This expanded data capability will aid in:

- Capturing Quality data
- Reducing coding errors
- Analyzing disease patterns
- Tracking and responding to public health outbreaks
- Identifying fraud and abuse

**Preparation for the Transition**

Most hospitals, physicians groups, payers, clearinghouses, and billing companies have been preparing for the transition for several years. The conversion to ICD-10 requires adequate planning, training of coders, billers and clinical providers, converting system programs, testing and developing backup contingency scenarios. In addition, every organization needs to assess their current workflow and processes to determine if and how the conversion to ICD-10 may impact production or service to patients. For example, the pre-authorization process generally requires diagnosis information. Hospitals and physician practices need to look at how that process works today in their organization and what may need to change.

**TABLE 1: DIAGNOSIS CODE COMPARISON**

<table>
<thead>
<tr>
<th>CHARACTERISTIC</th>
<th>ICD-9-CM (VOLS. 1 &amp; 2)</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field length</td>
<td>3-5 characters</td>
<td>3-7 characters</td>
</tr>
<tr>
<td>Available codes</td>
<td>Approximately 14,000 codes</td>
<td>Approximately 69,000 codes</td>
</tr>
<tr>
<td>Code composition (numeric or alpha)</td>
<td>Digit 1 = alpha or numeric, Digits 2-5 = numeric</td>
<td>Digit 1 = alpha, Digit 2 = numeric, Digits 3-7 = alpha or numeric</td>
</tr>
<tr>
<td>Available space for new codes</td>
<td>Limited</td>
<td>Flexible</td>
</tr>
<tr>
<td>Overall detail embedded within codes</td>
<td>Limited detail in many conditions</td>
<td>Generally more specific (allows description of comorbidities, manifestations, etiology/causation, complications, detailed anatomical location, sequela (aftereffects of a disease, condition, or injury such as scar formation after a burn), degree of functional impairment, biologic and chemical agents, phase/stage, lymph node involvement, lateralization and localization, procedure or implant related, age related, or joint involvement)</td>
</tr>
<tr>
<td>Laterality</td>
<td>Does not identify right versus left</td>
<td>Often identifies right versus left</td>
</tr>
<tr>
<td>Sample code</td>
<td>81315, Open fracture of head of radius</td>
<td>S52122C, Displaced fracture of head of left radius, initial encounter for open fracture type IIIA, IIIB, or IIIC</td>
</tr>
</tbody>
</table>

Since ICD-10 is more specific, research has shown that physicians may need to document differently to ensure that the medical record has sufficient information to allow coders to assign the ICD-10 code. Many hospitals and large physician groups are putting in place a clinical documentation improvement process (CDI) at this time to help communicate and educate physicians on what additional information may be required when the conversion to ICD-10 occurs. A CDI process requires the coder to examine the physician’s current documentation and identify whether it is or isn’t sufficient to allow an ICD-10 code to be identified. Feedback is then provided to the physician on what additional information should be incorporated into the medical record documentation going forward so when the transition occurs, the complete and accurate documentation will be available and thus the risk of delays or denials will be diminished. The additional documentation is information that the physician would know at the time of the service. It includes information such as location, laterality, type of visit (initial or subsequent), etc.
Anesthesia Business Consultants, LLC has been working internally for several years to provide our clients with a successful transition to ICD-10. We have made the necessary system changes, educated our certified coders and developed a Clinical Documentation Improvement (CDI) process that we will be implementing in early January 2014. Our goal is to communicate directly with our clients and provide various education and training programs customized to their specific needs to ensure that the transition is as seamless as possible.

Helpful Resources

The CMS has a dedicated website with some excellent tools for hospitals and physician practices of all sizes. In addition, the American Medical Association (AMA), specialty associations, major health insurance payers and clearinghouses all have information on their websites to help providers with the transition. If you have not yet heard from your coding or billing department it may be beneficial to review some basic information and then reach out and see where your organization is in regards to the ICD-10 transition.

Following are some links to learn more:

- http://www.cdc.gov/nchs/icd/icd10cm.htm

Joette Derricks, CPC, CHC, CMPE, CSSGB serves as Vice President of Regulatory Affairs and Research for ABC. She has 30+ years of healthcare financial management and business experience. Knowledgeable in third-party reimbursement, coding and compliance issues, Ms. Derricks works to ensure client operations are both productive and profitable. She is a long-standing member of MGMA, HCCA, AAPC and other associations. She is also a nationally-acclaimed speaker, having presented at AHIMA, Ingenix, MGMA and HCCA national conferences. You can reach her at Joette.Derricks@AnesthesiaLLC.com.

Anesthesia Business Consultants, LLC has been working internally for several years to provide our clients with a successful transition to ICD-10. We have made the necessary system changes, educated our certified coders and developed a Clinical Documentation Improvement (CDI) process that we will be implementing in early January 2014. Our goal is to communicate directly with our clients and provide various education and training programs customized to their specific needs to ensure that the transition is as seamless as possible.

Helpful Resources

The CMS has a dedicated website with some excellent tools for hospitals and physician practices of all sizes. In addition, the American Medical Association (AMA), specialty associations, major health insurance payers and clearinghouses all have information on their websites to help providers with the transition. If you have not yet heard from your coding or billing department it may be beneficial to review some basic information and then reach out and see where your organization is in regards to the ICD-10 transition.

Following are some links to learn more:

- http://www.cdc.gov/nchs/icd/icd10cm.htm

Joette Derricks, CPC, CHC, CMPE, CSSGB serves as Vice President of Regulatory Affairs and Research for ABC. She has 30+ years of healthcare financial management and business experience. Knowledgeable in third-party reimbursement, coding and compliance issues, Ms. Derricks works to ensure client operations are both productive and profitable. She is a long-standing member of MGMA, HCCA, AAPC and other associations. She is also a nationally-acclaimed speaker, having presented at AHIMA, Ingenix, MGMA and HCCA national conferences. You can reach her at Joette.Derricks@AnesthesiaLLC.com.

Advanced Institute for Anesthesia Practice Management

The Advanced Institute for Anesthesia Practice Management Seminar has become the Advanced Institute for Anesthesia Practice Management. The Advanced Institute for Anesthesia Practice Management (AIAPM) is being held April 11–13, 2014.

SAVE THE DATE for the Advanced Institute for Anesthesia Practice Management

Securing the Future for Anesthesia Practices

The Anesthesia Billing & Practice Management Seminar has become the Advanced Institute for Anesthesia Practice Management. The Advanced Institute for Anesthesia Practice Management (AIAPM) is being held April 11–13, 2014.

MARK YOUR CALENDAR:

April 11–13, 2014
The Cosmopolitan of Las Vegas, Nevada

Conference information and active web site will be available in September 2013. Check your email at that time for more information.

This live activity has been approved for AMA PRA Category 1 Credit™. Questions: Contact info@AIAPMConference.com
A RETROSPECTIVE STUDY OF A GASTROENTEROLOGY FACILITY: ARE THE PATIENTS SICKER?

Kim Riviello DNP, MBA/HCM, CRNA
President, Anesthesia Services Group, Tipp City, OH

There has been substantial growth in the number of ambulatory surgery centers across the United States. With the advancement in technology for non-invasive procedures, and shorter-acting anesthetics, more patients are being seen in the freestanding surgery facility (FSF). However, the trend in patient co-morbidities, i.e., obesity, diabetes, cardiac, and respiratory diseases has also risen, increasing the anesthetic risk even though low risk procedures are performed. The most common malpractice claims have been associated with diagnostic procedures performed in ambulatory surgery centers under monitored anesthesia care (MAC) with patient co-morbidities as contributing factors. The morbidity and mortality of ambulatory surgery patients has led to an increased concern for patient safety in freestanding facilities. Of particular concern is sedation, specifically in gastroenterology (GI) centers. Yet, the Journal of the American Medical Association (JAMA) recently reported that two-thirds of the anesthesia procedures provided during colonoscopies and endoscopies (EGDs) were on “low-risk patients;” suggesting a lack of need for professionally administered anesthesia in GI facilities and implying that specialist-monitored anesthesia would contribute to the increased cost of these procedures (Liu, Waxman, Main, & Mattke, 2012).

This study represents a retrospective chart review of 3,252 patients conducted at a GI center over a ten-month period in 2011. The patient’s ages were from 18 to 95. Procedures involved were either an EGD and/or a colonoscopy with MAC. The pre-operative assessment and anesthesia record was used to gather the information on each patient. A data analysis table was developed to log the co-morbidities on a monthly basis for total number and percentages. The co-morbidities of the MAC patients were correlated with the American Society of Anesthesiologists (ASA) risk classification system to stratify the patients based on disease entities. This was then compared to provide evidence of an increased trend in the percentage of high risk patients and associated morbidity and mortality.

In 1983, there were approximately 239 FSFs in the United States (Durant, 1989). By 2003 there were over 3,300 (Casalino, Devers, & Brewster, 2003) (Winter, 2003) and by 2010 the number of FSF’s increased by 61% to 5,316 (“ASC Services,” 2012, p. 115). The U.S. Department of Health and Human Services conducted a study in 2006 to determine the number of surgical and non-surgical (diagnostic) procedures performed in outpatient settings and freestanding surgery facilities. They collected the data using the 2006 National Survey of Ambulatory Surgery (NSAS). The sample
consisted of 398 FSFs; 295 responded to the survey for a 74.1% response rate. NSAS estimated that 53.3 million surgical and non-surgical (diagnostic) procedures were performed in ambulatory surgery centers, 14.9 million occurring in FSFs. The most frequently performed procedures were colonoscopies (5.7 million), upper endoscopies (3.5 million), extraction of lens (3.1 million) and insertion of prosthetic lens (2.6 million). General anesthesia was performed in 30.7 percent of the FSFs with greater than 20.8 percent providing monitored anesthesia care (MAC) (Cullen et al., 2009). The Medicare Payment Advisory Commission (MedPAC) reported that in 2010, 3.3 million Medicare beneficiaries were seen in FSFs (“ASC Services,” 2012).

Metzner and Domino performed a closed claim analysis in areas outside the hospital operating rooms but within the hospital setting to determine the risk associated with anesthesia being performed in these remote locations. They felt that even though the procedures were relatively non-invasive, serious outcomes could occur. They analyzed claims in the ASA Closed Claims database (1990-1999) comparing injuries associated with care in remote sites (n=87) against hospital operating rooms (n=3286). Patients in the remote locations who were greater than 70 years of age (>20%), were sicker (69%, ASA 3-5) and underwent more emergent procedures by 36 percent. The predominant anesthetic in these locations was MAC, which produced eight times more claims than operating room procedures (50% vs. 6%). The locations most commonly involved in claims were the gastrointestinal (GI) suite (32% of the claims) and the cardiology catheterization laboratory (25% of claims). The severity of injury was greater in remote locations than in the operating rooms, with the proportion of death almost double. Adverse respiratory events, oxygen/ventilation being the most common, were shared by both remote and operating room locations, but remote locations had seven times the occurrences. Respiratory depression due to over-sedation and loss of airway was responsible for 26 remote location claims, more than half in the endoscopy suite. Patient factors attributable to loss of airway and over-sedation were obesity, sleep apnea, ASA status 3-4 and age greater than 70 years (Metzner & Domino, 2009).

In February 2006, closed claims analysis of MAC cases found that the patients who were older (> 70 years) and sicker (ASA 3-4) had higher claims associated with morbidity and mortality (40%) (Bhananker et al., 2006). Bishop, Ryan and Casalino also examined malpractice claims, comparing outpatient (free-standing and hospital-based) and operating room procedures from 2005 to 2009. In the outpatient setting, the most common claim was for diagnostic procedures under MAC (45.9%).

The ASA scoring system (Dripps, 1963) is a valuable tool in evidence-based anesthesia practice, helping to determine intra-operative and post-operative complications for patients based on their overall health status. It is also valuable in ascertaining quality outcome measures and patient safety indicators based on the co-morbidities presented by patients. The tracking of risk indicators in hospitals has been an important tool to improve quality of patient safety and is now an incentivized program for hospitals (CMS, “Hospital Initiatives,” 2011). However, this has not occurred in FSFs. In 2009, a study surveyed diagnosis-based risk adjustment for surgical and procedural outcomes in ambulatory surgery centers. The seven-day mortality rates for hospital based outpatient surgery (HBOS) and FSFs were examined based on the co-morbidities reported by the facilities on each patient. The study revealed that HBOS reported patient co-morbidities more frequently than FSFs: 59.64% versus 8.65% in cataract patients, and 90% versus 45% in GI patients (Chukmaitov, Harless, Menachemi, Saunders, & Brooks, 2009). Requiring this data from FSFs could be a valuable tool in determining future morbidity and mortality of patients seen in these facilities.

Studies have demonstrated that FSFs have definitive risks associated with the patient co-morbidities and the type of anesthesia provided; diagnostic centers and endoscopy centers providing MAC sedation have the most associated claims. Yet in the 2006 NSAS report there was no data on the co-morbidities of the 14.9 million people seen in the FSFs and the risk associated with anesthesia. NSAS stated that procedures in FSFs and outpatient hospital based facilities increased by 300% over a ten year span. If this trend continues, by 2016, 44.7 million people will be seen in FSFs. Six million will be over the age 65 obtaining gastrointestinal procedures (Cullen et al., 2009).

In this study over 50% of the patient population seeking GI procedures was between the ages of 51 and 70 years of age. The co-morbidities of HTN, hyperlipidemia, sleep apnea, GERD, diabetes, smoking, CAD, and COPD were the most frequently exhibited by the patient population. These co-morbidities increased over time and the increase was statistical-
ly significant. However, body mass index did not change over time in a statistically significant manner.

ASA 3 cases demonstrate an increase in trend over ten months, as well as the highest percentage of variance explained by time (52.55%). The ASA 2 trends were not significant and the ASA 1 category represented only 2.58% of the population of patients. The AMA states that 66% of anesthesia given in GI facilities is to “low risk” patients (Liu et al., 2012): however this study found that the combination of ASA 1 and 2 represented only 43.45% of the patients receiving anesthesia. ASA 4 patients were identified initially in the study but a decline in the trend was exhibited for them due to anesthesia improving awareness of the increased morbidity and mortality associated with this classification. Studies have shown the higher the ASA classification the greater the risk odds ratio for developing a postoperative complication. The mortality rates have been reported as 0.3%-1.4% for ASA 2, 1.8%-5.4% for ASA 3, and 7.8%-25.9% for ASA 4 (Wolters, Wolf, Stutzer, & Schroder, 1996). In a more recent study, Bishop, Ryan and Casalino reported that major injury and death occurred in the outpatient setting 36.1% and 30.6% of the time, respectively (Bishop et al., 2011).

As the number of ASA 3 patients seen in FSFs continues to increase are the risks associated with these patients acceptable? Unfortunately, as the study indicates, this is the trend for our society, with the largest generation now being between the ages of 50-75. The safety of these patients is determined by their co-morbidities and the assessment performed by the anesthesia clinician and the consultants they deem necessary to determine what is best for each patient. The ASA classification system is subjective in classifying patient risks; however, the anesthesia professional is trained to make this determination with the patient’s safety in mind.

With the continued increase in demand for FSFs, analysis and documentation of a patient’s co-morbidities needs to be tracked to get a better understanding of the type of patients being seen in these isolated locations and how to address associated patient safety issues. Administrators and federal/state agencies need to be aware of the level of risk associated with these diseases to ensure the proper clinician is determining which patients are or are not at risk for a procedure. Bishop et al. (2011) suggested that because of the high percentage of claims linked to diagnostic procedures under MAC anesthesia, safety initiatives should be developed focusing on the outpatient setting. Chukmaitov et al. (2009) recommends that federal and state agencies mandate HBOS and FSFs to provide comprehensive information on all patients related to co-morbidities to help determine patient safety guidelines and risk-adjustment measurers.

A performance measure recommended by MedPAC states that incentives should not discourage providers from accepting riskier or more complex patients, yet the outcome measures that MedPAC encouraged CMS to incorporate for ambulatory centers do not require any risk adjustment. Patient falls, burns, wrong site and wrong side surgery, wrong patient, wrong procedure, wrong implant, hospital transfer/admission and surgical site infections are all preventable outcome measurements and are not affected by a patient’s health status (“ASC Services,”2012, p. 131). Quantifying patient co-morbidities and ASA classifications as exemplified in this study would help evaluate risk adjustments as the acuity of the patient population increases.

The advantage of having anesthesia during GI cases has been demonstrated...
through pre-operative screening, intra-procedural safety, and post-operative satisfaction (Hass, 2013). This study revealed that most of the patients receiving anesthesia were ASA 3. So is cost still an issue knowing that the majority of the patients are sick? According to Liu, by advocating patient safety, anesthesia is helping to decrease the cost of health care by decreasing intra-operative and post-operative complications (Liu et al., 2012). Hass found that examining cost and procedural factors alone only creates a barrier to anesthesia. It is through a comprehensive analysis of patient assessments that the societal advantages of patient safety and satisfaction can be found (Hass, 2013). Anesthesia intervention is pivotal in FSFs, including GI centers, to ensure proper evaluation of patient co-morbidities and risk factors to ensure that the appropriate anesthetics are administered and patients remain safe. Regardless of the practice environment patients should be assured they are receiving a safe and quality anesthetic from an anesthesia professional.

References

Kim Riviello DNP, MBA/HCM, CRNA, is President of Anesthesia Services Group in Tipp City, OH. Ms. Riviello has been a practicing CRNA for 26 years. Anesthesia Services Group provides consulting, management and anesthesia clinicians for ASCs in Ohio. She has a Doctorate of Nursing from Robert Morris University, 2013, an MBA from Wright State University, 2010, her CRNA from University of South Carolina, 1987 and a BSN from Ohio State University, 1982. Riviello is a member of The American Association of Nurse Anesthetists, The Ohio State Association of Nurse Anesthetists, Sigma Theta Tau, Honor Society of Nursing, The Society of Perioperative Assessment and Quality Improvement, Lifetime Alumni Member of The Ohio State University, President’s Club of Robert Morris University, and The American Quarter Horse Association. She can be reached by email at kim.riviello@frontier.com or (937) 287-8178.
Introducing F1RSTUse

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

Professional Events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Location</th>
<th>Contact Info</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 12 – 16, 2013</td>
<td>American Society of Anesthesiologists Annual Meeting</td>
<td>Moscone Center San Francisco, CA</td>
<td><a href="https://www.asahq.org/Annual-Meeting.aspx">https://www.asahq.org/Annual-Meeting.aspx</a></td>
</tr>
</tbody>
</table>

ABC offers The Communiqué in electronic format

Anesthesia Business Consultants, LLC (ABC) is happy to provide The Communiqué electronically as well as the regular printed version. The Communiqué continues to feature articles focusing on the latest hot topics for anesthesiologists, nurse anesthetists, pain management specialists and anesthesia practice administrators. We look forward to providing you with many more years of compliance, coding and practice management news through The Communiqué and our weekly e-mail alerts. Please log on to ABC's web site at www.anesthesiallc.com and click the link to view the electronic version of The Communiqué online. To be put on the automated email notification list, please send your email address to info@anesthesiallc.com.