



# WORKING FOR TIPS...

**Sonya Pease, MD, MMSC**

*Chief Medical Officer, TeamHealth Anesthesia, Palm Beach Gardens, FL*

Date night with my husband usually involves going out to one of our favorite restaurants where we get to enjoy each other's company in a relaxed atmosphere without worrying about who's doing the dishes. So how can a night out at a restaurant have anything in common with having a total joint replacement?

My husband and I feel that every waiter or waitress generally deserves a 20 percent tip. From the time we get seated at the table to the time we pay the tab, my husband and I are unconsciously measuring both the restaurant's and the servers' performance and quality. We are not concerned about the fact that our waitress has to go to the bar for our glasses of wine or that the bartender may be busy serving happy hour drinks; we just want our drinks timely and exactly as we ordered. Same goes for the food we order. We don't care that the appetizer kitchen is backed up or that the kitchen crew is trying to perform miracles by having the seared Ahi and well-done steak come out at the same time from two different grills. We expect the restaurant and our server



to coordinate all of this seamlessly in the background so our food arrives together, is served hot and tastes great. If our server forgot to put the salad dressing on the side or the steak was undercooked, then we simply note our dissatisfaction with the poor quality and unmet expectations by giving a lower tip. Restaurants with fantastic quality and service thrive while those with poor quality and service don't.

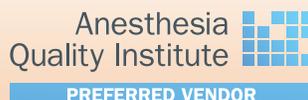
We have all entered into this brave new world of healthcare with its focus on the triple aim of increasing patient satisfaction, improving patient outcomes and

*Continued on page 6*

## ► INSIDE THIS ISSUE:

<b>Working For Tips</b> .....	1
<b>M&amp;As Still Going Strong: Position Your Anesthesia Practice</b> .....	2
<b>Pre-Op Your Anesthesia Practice</b> .....	3
<b>What's Your Anesthesia Group Worth? And Why it Might Not Make Any Difference</b> .....	5
<b>Management Service Organizations and Anesthesia Practices Today and In The Future</b> .....	10
<b>Changes Involving Payment for Post-Operative Pain Procedures</b> .....	12
<b>The Role of Anesthesiologists in the Intensive Care Unit</b> .....	14
<b>Improving the Documentation of Anesthesia Procedures</b> .....	16
<b>Reporting Critical Care Services</b> .....	18
<b>Field Avoidance and Special Positioning</b> .....	21
<b>Event Calendar</b> .....	24

*Anesthesia Business Consultants is proud to be a*



# M&As STILL GOING STRONG: POSITION YOUR ANESTHESIA PRACTICE

Analogies make us stop and think. Sonya Pease, MD, chief medical officer of TeamHealth, invites us to consider that customers of service industries such as restaurants reward outcomes rather than work processes in this Communique's lead article, *Working for Tips...* Much as patron satisfaction is key to success in the restaurant business, patient satisfaction is an outcome that physician compensation is going to reflect, whether we believe that patients are appropriate judges of quality medical care or not.

Patients' perception of the caliber of the care they receive is determined in part by their doctors' communication skills. Implementing multimodal pain and post-operative nausea and vomiting programs are very important, and so are the clinician's self-introduction and expressed concern for the patient's comfort. Think about the waiter's keeping customers informed about delays and asking whether they need anything. These are skill sets most physicians "didn't learn in residency but it is imperative we learn [them] and use [them] going forward," as Dr. Pease writes.

The quality of the outcome in anesthesiology care depends, too, on the pre-operative work. Identifying and treating anemia before surgery, in Dr. Pease's example, can have a "profound impact on patient outcomes as well as costs." Analogously, solid preparation for the type of corporate restructuring of which we are seeing so much—takeovers, mergers, practice sales or offers of hospital employment—by identifying one's group's strengths and weaknesses is key to successful negotiations and reorganizations. In *Pre-Op Your Anesthesia Practice*, Howard Greenfield,

MD of Enhance Healthcare provides a practical checklist for an anesthesia group "preoperative assessment" with such familiar categories as "age" (e.g., length of hospital contract), "height/weight" (e.g., number of MDs/CRNAs/AAs) and "past surgical history" (e.g., change in group governance), as well as a "review of systems" in which "neurological" encompasses the "group's ability to communicate internally ... and externally...."

A fundamental question in the pre-op assessment of a practice is its net worth. Mark Weiss, Esq. explains succinctly that an anesthesia practice is worth exactly as much or as little as a willing buyer will pay—and how its value may differ according to the perspectives of the senior and junior anesthesiologists who are considering selling.

There are still many alternatives to a sale or acquisition, Mr. Weiss reminds us in *What's Your Anesthesia Group Worth? And Why It Might Not Make Any Difference*. One of those involves forming or joining a management services organization (MSO), as discussed by self-styled MSO "evangelist" William Hass, MD, MBA in *Management Service Organizations and Anesthesia Practices Today and in the Future*. Another might focus on expanding *The Role of Anesthesiologists in the Intensive Care Unit*. Jody Locke reviews the requirements for realizing the potential of the ICU for anesthesia practices.

As always, we devote a portion of the Communique to reporting clinical services in compliance with the ever-evolving rules laid down by Medicare and other payers. Articles in this issue range from the general principles of good

documentation described by Darlene Helmer in *Improving the Documentation of Anesthesia Procedures* to the very specific review of *Field Avoidance and Special Positioning* by Kelly Dennis. If you are involved in providing pain medicine or critical care services, you will also want to read the articles by Neda Ryan, Esq. and Joette Derricks.

We hope that all our readers are having a successful summer. We look forward to bringing you new information this fall.

With best wishes,



Tony Mira  
President and CEO



# PRE-OP YOUR ANESTHESIA PRACTICE

Howard Greenfield, MD

*Founder and Principal, Enhance Perioperative & Anesthesia Consulting, Aventura, FL*

Anesthesiologists routinely perform a “pre-operative” assessment of a patient scheduled to undergo an invasive procedure that requires anesthesia services. This assessment is a standard of care that has benefits that are guided by the provider’s intention to limit surprises. No physician wants to be in the middle of a complex surgical case and first find out about an underlying chronic condition that has deleterious effects on the patient. It is our observation that more anesthesia groups than ever are about to undergo the business equivalent of an invasive procedure. Shouldn’t you apply the same standard to your own practice, and find out how your group will look to a possible partner, investor or employer before your group is in the middle of negotiations with another entity? The radically changing healthcare world will confront all hospital-based anesthesia group practices with complex and difficult choices. Do you stay the course and try to postpone the inevitable, or pursue alternatives to the status quo? Either way, aren’t you better off mitigating the surprise factor now, rather than in the middle of a group take-over, merger, sale or offer of hospital employment?

There is no best single answer to any of the questions above. In fact, each option brings many additional questions to the forefront. One of the most important first steps is to perform a SWOT analysis (Strengths, Weakness, Opportunities, Threat) of your group. What are your group’s strengths and weakness? Do you have hospital contracts, and how secure are they? Are there opportunities, such as partnering with other similarly-situated groups? What are the real versus imagined threats? For example, is your hospital really interested in forcing



employment on your group or is the hospital just tired of dealing with difficult members of your group? Where are your threats coming from, and do you have the ability to recognize them from the inside? Many small- to medium-sized groups are worried about the larger anesthesia group across town and fail to realize that the more likely threat comes from within their own hospital system. With hospital margins rapidly decreasing, hospital administrators are looking for different ways to minimize the physician spend at their facility.

In the past, a good anesthesia group providing quality services at the lowest possible cost would not have to worry that a competitor could underprice them without reducing services. That is no longer true, as more entrepreneurial physician organizations have a menu of hospital-based specialties to offer: Emergency, Radiology, Intensivists, etc.

The opportunity for such a group is to use the substantial profitability of the other hospital-based services to “pay down” the anesthesia subsidy. This type of marketing has opened a whole new world of competitive bidding. These same large multi-specialty groups often have geographic leverage with payers and favorable national contracts to substantially increase anesthesia revenue and decrease the subsidy for their hospital customers.

In order to decide which route may be best for your group, let’s go back to the common starting place where all anesthesiologists begin patient care—the anesthesia pre-op assessment.

As you fill out your Anesthesia Pre-op Assessment sheet, remember to check the boxes that best describe your present anesthesia practice. (See Table 1 on page

*Continued on page 4*

## PRE-OP YOUR ANESTHESIA PRACTICE

Continued from page 3

**TABLE 1** Anesthesia Group Pre-Op Assessment

<p><b>Age</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Length of present hospital contract</li> <li><input type="checkbox"/> Number of contract renewals with hospital or system</li> <li><input type="checkbox"/> Age variance of partners in group</li> <li><input type="checkbox"/> Partners preparing to retire or go part time</li> </ul> <p><b>Height/Weight</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Number of physicians (partner vs. employed)</li> <li><input type="checkbox"/> Number of CRNAs/AAs</li> <li><input type="checkbox"/> Number of administrative staff</li> </ul> <p><b>Medicines/ Supplements</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Increasing subsidy requests</li> <li><input type="checkbox"/> Additional stipends—medical leadership, OR utilization, etc.</li> <li><input type="checkbox"/> Leadership positions with Board of Directors, Medical Staff or OR management</li> </ul> <p><b>Allergies</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Difficult managed care negotiations with payers</li> <li><input type="checkbox"/> Unsettled contract negotiations with hospital</li> <li><input type="checkbox"/> Unsettled HR or professional liability lawsuits</li> <li><input type="checkbox"/> Disruptive physicians or poor medical staff relationships</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Inability to cover required OR sites</li> <li><input type="checkbox"/> Multispecialty group providing other hospital based specialties</li> </ul> <p><b>Past Medical History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Partnership or independent contractors practicing together</li> <li><input type="checkbox"/> All MD or Anesthesia Care Team</li> <li><input type="checkbox"/> Productivity model or equally divide work and compensation</li> <li><input type="checkbox"/> Exclusive hospital contract or follow the surgeon</li> <li><input type="checkbox"/> No hospital contract</li> </ul> <p><b>Past Surgical History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hospital or ASC contracts gained or lost</li> <li><input type="checkbox"/> Change in group governance or partnership structure</li> <li><input type="checkbox"/> Group contraction</li> <li><input type="checkbox"/> Financial or legal obligations to former employees</li> </ul> <p><b>Family History of Anesthesia Problems</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Partner in-fighting</li> <li><input type="checkbox"/> Inability to recruit quality specialty providers (cardiac, peds)</li> <li><input type="checkbox"/> Issues with local competitor, hospital system</li> </ul>
--	--

4). Truthful answers to these questions will help you determine your anesthesia group's ASA status—its *Ability to Sell to Another*. This is equally important in retaining your present contract or marketing your group to a hospital

system, individual facility, national buyer or regional partner.

In the typical anesthesia pre-op process, the review of systems follows the collection of pertinent patient data and past medical and surgical history.

As you begin to review your own group, it is important to look at and determine how well the key systems are functioning in your practice. (See Table 2). In many cases groups will need to bring in outside consultants to help them thoroughly evaluate a particular system.

At this point a simple question to pose to your group is, “If our practice sold shares to investors, with a promise of return on that investment, would you buy additional shares of our own practice?” Whatever the initial reply to that question, isn't it incumbent on the partners or owners to determine “pre-operatively” what value the practice may have before potential investors or employers are about to “operate”? ▲

**Howard Greenfield, MD** is a board-certified anesthesiologist and graduate of Temple University School of Medicine with anesthesia training at Jackson Memorial/University of Miami.



He is an experienced clinician, and has served as Chief of Anesthesia at Memorial Regional Hospital. He became one of the original founding partners of Sheridan Healthcare.

Greenfield later went on to found Enhance Healthcare with Dr. Robert Stiefel. Together, they have extensive national experience helping hospitals and anesthesia groups structure and negotiate anesthesia service agreements, optimize the revenue cycle, and implement operating room improvement initiatives. Enhance Healthcare partners are actively involved in the anesthesia merger and acquisition space. They have advised a number of anesthesia practices on strategic alternatives, and have worked with investment banking and private equity to help complete a number of group transactions. Dr. Greenfield can be reached at [hgreenfield@enhancehc.com](mailto:hgreenfield@enhancehc.com).

**TABLE 2** Review of Anesthesia Group Key Systems

**Cardiovascular** — lifeblood of any group is the clinical quality, commitment of their providers and the effectiveness of group leadership.

**Pulmonary** — the sustaining “oxygen” all groups need are quality payer contracts and robust revenue cycle management.

**Neurological** — group's ability to communicate internally with providers and externally communicate value to its customers. Information systems to provide

quality and productivity data to hospital customers.

**Endocrine** — value-added services such as OR management, pre-admission testing process, post-op pain management.

**Gastrointestinal** — development and maintenance of relationships with administrators and surgeons.

**Renal** — development and maintenance of relationships with OR nursing and staff.

# WHAT'S YOUR ANESTHESIA GROUP WORTH? AND WHY IT MIGHT NOT MAKE ANY DIFFERENCE.

Mark F. Weiss, Esq.

*The Advisory Law Group, a Professional Corporation, Los Angeles, CA*

[Author's note: This article is based on a piece I wrote for *Anesthesiology News*.]

“What’s our anesthesia group worth?”

I hear that question on a frequent basis. In fact, you’re probably thinking it right now.

There are a lot of people out there who are happy to fool you with their answer. They might say something like, “well, your practice is worth X times pro forma earnings before income tax depreciation and amortization, otherwise known as ‘EBITDA.’” Or, they might even have a super-complicated formula, sort of like the ones economists use to make you think that they are scientists.

But that’s all BS.

The real answer is that your practice is worth exactly what an actual buyer will actually pay you to acquire your practice. So, if buyer A will actually pay you \$30,000,000 and buyer B will actually pay you \$40,000,000, then the practice is worth \$40,000,000. That’s the case even if buyer B is a fool. Forty million dollars is the exact answer. It is not off by even one penny.

On the other hand, if no buyer is interested in your practice, then any notion of its value is simply academic. Or, it’s zero; your choice.

Although you can look to the greater market for trends, such as the fact that anesthesia practices have been selling like hotcakes, to obtain some cold comfort that there is a potential buyer in the wings, the only way of actually knowing whether



one or, preferably, multiple interested buyers are there for you, and discovering what they will pay, is to engage in the process of looking for them.

As to the pace of the market, while no one has a crystal ball and there will always be exceptions, there are likely two years or so left in the merges and acquisitions (M&A) binge. By then, the large buyers will have acquired the groups they find most desirable. Certainly there will be some room for smaller, add-on acquisitions, but most large groups will shift to growing “organically;” in other words, they’ll respond to RFPs and otherwise try to wrest control over contracts. The fact of the matter is that there will be little need to buy a group if they can simply take away its facility contract.

In this period of rapid change, anesthesia practices react differently to the resulting uncertainty.

Many anesthesia groups are interested in seeking shelter from uncertainty through a sale to a large regional or national group or to a private equity backed venture. Yet others are forging new routes, alone or in alliance with other practitioners and creating their own futures.

Which route is best for you?

## ACQUISITIONS

It’s important to understand the basic economic structure of an anesthesia group acquisition.

*Continued on page 8*

## WORKING FOR TIPS...

*Continued from page 1*

reducing costs. Getting paid to perform a service as a physician used to be fairly straightforward. The Current Procedural Terminology® (CPT) manual designated the service we provided, and the Relative Value Guide® (RVG) furnished the base units for providing that service. Simple! It didn't really matter if the service we provided didn't benefit the patient or if the patient developed a complication—we still got paid the same for the service we provided.

But now the Centers for Medicare and Medicaid Services (CMS), the largest health insurer in the United States, has begun to measure the quality as well as the level of service we provide to our patients. The Physician Quality Reporting System (PQRS) has now become mandatory, and penalties for not reporting are on the horizon. PQRS measures are predominantly process measures shown to correlate with improved clinical outcomes, but these measures are not actual measures of outcomes. For example, we are getting graded on whether or not we properly documented administration of the antibiotics on time,

not whether or not the patient developed a post-op wound infection. As time passes and these types of process measures change our practice, many will be retired since they no longer represent a gap in care or an opportunity for quality improvement. Therefore, these targets will continue to change.

We have also entered into the new era of Value-Based Purchasing (VBP). A new payment modifier that Section 3007 of the Affordable Care Act mandated states that, by 2015, CMS must begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS). Both cost and quality data are to be included in calculating payments for physicians. The VBP modifier is essentially a conversion factor applied to your payment, 25 percent weighted on outcomes, 45 percent based on process quality measures as mentioned above, and 30 percent on patient satisfaction as measured by Healthcare Consumer Assessment of Healthcare Providers and Services (HCAHPS). The look-back period for our 2015 VBP payment modifier of HCAHPS scores started in 2013.

So, just as our waitress or waiter get a lower tip when the quality of our food or the service provided does not meet our expectations, so will we as providers receive a lower payment if the quality of our care or the level of our service fails to meet expectations.

Our challenge becomes how do we deliver seamlessly coordinated care where patients feel like they were treated with the utmost respect and given five-star service while, at the same time, improve outcomes, prevent complications and shorten length of stay to drive down costs?

For a lot of patients, it starts in the emergency department. We know that longer wait times cause patient dissatisfaction and lower HCAHPS scores. We also know that when a patient sees and is a part of a physician-to-physician or nurse-to-nurse handoff, these scores are positively impacted; so communication to the patient, about the patient, and to other caregivers is a major factor in patient satisfaction. A good waiter, for example, will introduce him/herself, keep you informed of delays (“I’m sorry the bread isn’t out yet—we’re baking a fresh batch so yours will be nice and warm”), and check back often enough to know you have everything you need to enjoy your meal. As physicians, this is a skill set most of us didn’t learn in residency but it is imperative we learn it and use it going forward.

Post-operative nausea and vomiting (PONV) and post-operative pain (POP) are not only major patient dissatisfiers as reflected in HCAHPS scores, but they also lead to additional costs. By implementing a multimodal PONV program and a multimodal pain program with acute regional pain blocks, we can have a profound impact on patient satisfaction, improve the quality of our care by





preventing these complications and drive down cost. These are basic business skills required in all industries to be successful.

In the restaurant business it starts with acquiring quality ingredients for food prep. Unfortunately we don't get to pick and choose our patients but we can make sure our patients are optimized prior to surgery and that we are implementing "best practices" in a uniform, more standardized fashion that reduces risks. A good example is anemia, an independent risk factor for all patients presenting for surgery but not routinely identified or treated prior to surgery. This increases the risk of blood transfusions which, in turn, increases cost and complication rates associated with those blood transfusions. By implementing a Patient Blood Management program and identifying and treating anemia pre-operatively we can have a profound impact on patient outcomes as well as costs.

Determining our future "gratuities" is easy as long as we take to heart Dairy Queen's "Good isn't good enough." We must learn to look beyond excellent execution of the clinical task before us, and consider not only the impact on the immediate clinical outcomes, but also the impact of our "customers'" perception of care on our financial outcomes for our own group as well as for our hospital partner. ▲

#### References:

- Effect of a PBM programme on the preoperative anaemia, transfusion rate, and outcome after primary hip or knee arthroplasty: a quality improvement cycle. A. Kotze, L.A. Carter and A. J. Scally. Rao SV, et al. *JAMA* 2004; 292; 1555-62
- National Quality Forum (NQF), *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report*, Washington, DC: NQF; 2010.
- Sentinel event data: root causes by event type 2004-2012. The Joint Commission Web site.
- [http://www.jointcommission.org/assets/1/18/Root\\_Causes\\_Event\\_Type\\_04\\_4Q2012.pdf](http://www.jointcommission.org/assets/1/18/Root_Causes_Event_Type_04_4Q2012.pdf). Published February 7, 2013. Accessed September 6, 2013.
- Kitch BT, Cooper JB, Zapol WM, et al. Handoffs causing patient harm: a survey of medical and surgical house staff. *Jt Comm J Qual Patient Saf.* 2008; 34(10):563-570D
- Gan TJ, Meyer TA, Apfel CC, et al. Society for Ambulatory Anesthesia Guidelines for Management of Postoperative Nausea and Vomiting. *Anesth Analg* 2007; 105:1615
- Apfel CC, Laara E, Koivuranta M, Greim CA, Roewer N. A simplified risk score for predicting postoperative nausea and vomiting. *Anesthesiology* 1999; 91:693-700.
- The Economic Implications of a Multimodal Analgesia Regimen for Patients Undergoing Major Orthopedic Surgery A Comparative Study of Direct Costs
- Christopher M. Duncan, MD,\* Kirsten Hall Long, PhD,<sup>P</sup> David O. Warner, MD,\* and James R. Hebl, MD\*
- Post op pain stats: Apfelbaum, Gan et al.

Anesthesia and Analgesia 2003.2 Warfield, et al, *Anesthesiology* 1193,3 and Gan, TJ ASRA 2012 abstract

- Readmission for same day surgery: Coley KC, et al, *J. Clinical Anesthesia* 2002;14:349-353
- Oderda G, Gan, TJ Poster 46th ASHP, December 4-8, 2011, New Orleans, LA.
- The economic Implications of a Multimodal Analgesic Regimen for patients undergoing major orthopedic surgery; Duncan, MD, ASRA 2009
- [http://www.jointcommission.org/assets/1/18/General\\_Information\\_1995-2Q2013.pdf](http://www.jointcommission.org/assets/1/18/General_Information_1995-2Q2013.pdf)
- American Society of Anesthesiologists Task Force on Management of the Difficult Airway, *Anesthesiology* 1993; 78: 597-602. [Clinical Practice Guideline, Level of Evidence A]
- American Society of Anesthesiology. Statement on Documentation of Anesthesia Care. Approved October 22, 2008. [Clinical Practice Guideline, Level of Evidence A]

#### Sonya Pease, MD, MMSC

has served as CMO of TeamHealth Anesthesia since 2008 and has been a diplomate of the ABA since 1998. She received her Masters of Medical Science in Anesthesiology from Emory University and an M.D. with high honors from the Medical College of Georgia. She completed her residency in anesthesiology at the Jackson Memorial Medical Center in Miami and remains a clinically active anesthesiologist. She is a past president of the Florida Society of Anesthesiologists and serves on several national committees with the American Society of Anesthesiologists (ASA). Dr. Pease helped develop and implement the anesthesia quality outcome database used within TeamHealth Anesthesia nationwide called "Optimetrix". Optimetrix drives quality improvement through actionable data that is protected within TeamHealth's Patient Safety Organization (PSO). Dr. Pease is very engaged in the ASA's work to develop the Perioperative Surgical Home model, a model of healthcare focused on the perioperative patient to improve quality, patient satisfaction and reduce healthcare costs. She can be contacted at [spease@teamhealth.com](mailto:spease@teamhealth.com).



## WHAT'S YOUR ANESTHESIA GROUP WORTH? AND WHY IT MIGHT NOT MAKE ANY DIFFERENCE.

*Continued from page 5*



As opposed to the sale of, for example, a manufacturing business that includes inventory, machinery, raw materials and real estate, all of which can be valued and sold, the only thing that most anesthesia groups have to sell is their future cash flow.

Accordingly, the usual anesthesia practice acquisition is essentially a valuation, at a multiple, of the group's reconstructed earnings; reconstructed because most groups don't have significant, or any, earnings in the technical sense due to the fact that they annually distribute all of their available cash to their physician owners.

To illustrate, if the group is normally distributing \$100x to the physicians when the amount of compensation required to recruit and retain is a lesser \$70x, then a purchaser would, conceivably, value the group based on a multiple of the difference, that is, on a multiple of \$30x.

As a part of the sale, the group's physician owners would receive an employment contract for, in our

simplified example, \$70x per year, often for a guaranteed number of years.

The astute reader might realize that, all things being equal, the group has financed the purchase price by forgoing the collection of the additional \$30x. That's correct.

However, those physicians nearing the end of their active careers may be more than happy to obtain four, or five, or six or more times that \$30x up front because they have no intention of working for more than one or two additional years.

Even those physicians who foresee many years of continued practice sometimes favor an acquisition because it results in a shifting of risks. For example, consider the risk that the hospital contract might be terminated, or that collections will plummet one year into the term of a multiple year employment guaranty.

While certain risks can be shifted, sellers do assume other risks, such as the fact that continued practice, without a sale, might be more remunerative or that the lump sum purchase price received

might not actually deliver a higher return than would a continued investment in their own careers.

### *Alternatives*

Just because the acquisition market is hot doesn't mean that you should be interested in a sale. Again, unlike the calculus used by the owner of a manufacturing business, no one is likely to pull enough cash out of a sale to head off and buy a villa on Lake Como or even a nice second home in Aspen.

And, for the many who seek to control their own future, no sale can deliver that ability.

There are multiple alternatives to a sale. Let's explore some of them in four easy steps:

### **1. Step Up Your Game**

Immediately begin taking steps to cement your relationship with the facilities at which your group currently provides services and intensify your efforts on securing additional services contracts.



At the same time, tighten up your group's internal operations. Get your governance structure in order to enable your group to make quick decisions. Review your compensation plan to make certain that it creates the proper incentives and motivators. And begin to bank capital to enable the group to expand on multiple fronts.

## 2. Create A Profit Stream From Your Internal Business Function

If your group has an internal business operation with a dedicated practice manager, consider expanding that function into a separate spun-off business entity that provides MSO type services to other groups as well as to your own.

For example, you can sell your manager's, and your group's leaders', business expertise, you can repackage billing services, and you can operate a locum's service with your own group's physicians or with third parties.

Importantly, your MSO structure can be a vehicle to create initial relationships that might later be expanded to make the client a merger or acquisition target.

## 3. Do Your Own Mergers and Acquisitions

Instead of simply thinking of M&A from the perspective of a target, consider that your group can become an acquirer.

Although you might actually consider buying another local group, that is, engaging in a true acquisition, there's no reason why you need to restrain your thinking to paying cash.

Your group can combine with other groups through merger to form your own larger entity. Although size itself doesn't necessarily secure success, it can enable your group to establish a wider geographic presence, achieve economies of scale and potentially create stronger payment rate contracting power. It also serves to create leverage in connection with facility contract negotiations.



There is a plethora of ways to structure mergers, from those in which your group essentially makes itself larger by subsuming other groups into its fold, to structures in which your group and another create a new entity.

## 4. Non-Traditional Models

Within bounds permitted between competitors (although the truly entrepreneurial reader will realize that there's no need to deal only with competitors), there's really no limit on the types of non-traditional or hybrid ventures that can be constructed.

Consider, for example, the use of co-operative (commonly referred to as "co-op") ventures, limited scope joint ventures and alliance models.

## CONCLUSION

There are always more options than you've considered to date. There are always alternative structures to a sale and alternative strategies for the success of your practice.

Even if you're committed to seeking a buyer, you can't stop or even slow your efforts to develop your business while you're searching. There might not be a

buyer. If there is, you may not like the price. You might realize that you don't want to sell. You might actually want to buy.

In closing, remember that the best strategy formulation is not a straight-line process. It's not an on-off, sell or don't sell, merger or don't merge situation. Rather, it's a fluid, circular process, keeping options open even as you explore a primary one, continuing to build as you, for example, continue to search for the right deal, that is, the right deal for *you*. ▲

**Mark F. Weiss, Esq.** is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at [markweiss@advisorylawgroup.com](mailto:markweiss@advisorylawgroup.com).



# MANAGEMENT SERVICE ORGANIZATIONS AND ANESTHESIA PRACTICES TODAY AND IN THE FUTURE

**William Hass, MD, MBA**

*Co-Founder, PhySynergy, LLC, Huntsville, AL*

Management Service Organizations (MSOs) will have an increasingly important role in anesthesia practices. What today are cooperatives of independent anesthesia groups may morph into something quite different in the future.

The original goal of an MSO was to be a cooperative of local independent anesthesia services that reduced costs and gained management expertise for its members. The desired functions and advantages were similar to those offered by cooperatives in other industries. Traditional and attainable goals to be sure, but then reality got involved.

Here's one version of reality. Some anesthesia groups and anesthesia professionals are concerned (read terrified) that the "sharks" of the anesthesia business world, anesthesia management companies (AMCs) and private equity investors (PEIs), will devour local practices. The facts behind this assumed reality are quite different than imagined; more people die each year from being crushed by vending machines than from shark bites. Here's another reality. Many more anesthesia practices will perish due to their poor governance, leadership, management and human resource management (HRM) than will be gobbled up by AMCs and PEIs.

If the risks from AMCs and PEIs are small, why should a local independent anesthesia group worry? Why do anything? It's another, but different, reality this time. The probability of an anesthesia service having insight into



its strengths and weaknesses is about as common as a shark attack. Many anesthesia services not only don't know where they are headed, they don't have a clue where they are. Are they:

- A success to be sustained,
- In need of organizational "tweaking" for realignment,
- Doomed without an extensive turn-around,
- A candidate to be restarted, or
- A sucking black hole of resources and careers?

They don't know. Worse, the conventional wisdom inside anesthesia groups is that they are above average. Just ask them.

There are anesthesia groups that are well led and well managed. They can make decisions and prosper. They see the future and see the possibilities. There is also a vast wasteland of dead, dying, lost and confused anesthesia services. Sort of sounds like the definition of zombies, doesn't it? In you're waiting for them to make a decision, particularly a difficult business decision, you are wasting your time. The chances of that happening are less than that of a shark attack in a vending machine.

Why? Failed governance is the costly, and possibly lethal, flaw in many anesthesia services. Decisions are just about impossible to make given voting requirements in their operating agreements or the realities of their day-to-day functioning. Veto power maybe given to a minority of members more interested in preserving their prerogatives than in making difficult and/or uncomfortable decisions. Senior members may seek short-term solutions that are not in the best long-term interests of their junior associates, allied anesthesia professionals or the facilities they serve. Not only do these groups not know who they are or what their problems are, they can't do anything to fix their situation. This is a case of suicide by failed governance.

This presents a significant problem for governing boards and facility administrators. If they:

- Can't depend on the local group to make a decision,

- Don't want the complications of an employed anesthesia service,
- Want to avoid the entanglements of an AMC compounded by the complexities of PEI involvement.

What should the facility leadership do? The best possible answer is to engage an MSO to transition their existing zombie anesthesia service into one that can provide long-term clinical excellence and community service, as well as the operational and financial performance needed for the future.

How does this work? Simply, the facility will enter into a “caretaker” contract for anesthesia services with an MSO to:

- Evaluate services needed and provided,
- Reorganize clinical, operational and financial operations, and
- Return the anesthesia service to local independent owners.

The newly-reorganized and revitalized local independent group and its staff will become new independent members of the MSO in order to continue low costs, proactive management and the valuable association with other successful groups.

At this point anesthesiologists and other anesthesia professionals might cry foul. Aren't MSOs dealing with the enemy when they work with governing boards and administrators? With rare exception, anesthesiologists will be business partners with governing boards and facility administrators for their entire career. Reality again. Neither party can succeed without the other over the long term. When a governing board works with a MSO, the goal is to develop a local independent anesthesia service so that neither party is subject to the whims of distant AMC corporations or PEIs. The goal of the local facility-MSO relationship is to direct the resources of the



practice to the local community, not the operating costs and profit of distant corporations or investors.

It is possible that governing boards and management would cry foul too. The concept of working constructively with anesthesiologists might seem so foreign that the whole idea is more like science fiction than a reasonable alternative. So what are the alternatives? Doing nothing doesn't seem like a viable plan in today's environment. The problems with employment are becoming increasingly apparent. Becoming an ATM for an AMC and their PEI investor doesn't seem like a good idea, either. MSOs provide the greatest potential for the best possible operational and financial performance at the lowest possible—and sustainable—cost.

There is a significant potential that MSOs will go beyond being cooperatives of member anesthesia groups to actually developing new MSO member groups. Using caretaker contracts, these MSOs will steward troubled anesthesia groups though the process of becoming successful local independent anesthesia services. While voluntary membership in an MSO is preferred, given flaws in many groups' decision-making, this transition may eventually be led by governing boards, administrators and managers who understand the opera-

tional and financial benefits of local and independent practices. Building on strong relationships with facilities, MSOs may provide a full range of medical services including hospitalists and other hospital-based services. This is happening already.

Why will MSOs succeed? Because there is strength in cooperative and collaborative efforts based on mutually advantageous local relationships. In fairness it should be noted that there are well-led and well-managed AMCs, but their business model gets in the way. If you rob Peter to pay Paul long enough, Peter is going to figure that there is something wrong with the relationship and that there must be a better way.

For a proactive physician group, facility or multi-site corporation, an MSO is the best choice now and in the future. If your organization is better served by being subject to the whims and entanglements of management companies and their investors, that's your decision to make. If you feel that your organization's financial resources can be better used supporting the operating expenses and investor expectations of other companies, that too is your decision to make. Just know that MSOs will be around to pick up the pieces long after your bad choices are gone. ▲

**William Hass, MD, MBA** has been actively involved in anesthesia practice management for more than thirty years. He currently is the medical service organization (MSO) evangelist for PhySynergy, an MSO based in Huntsville, Alabama. PhySynergy executives had more than 100 years cumulative service in anesthesia service management. Dr. Hass is also the medical director for the Madison Surgery Center in Madison, Alabama. He can be reached at [whass@physynergy.com](mailto:whass@physynergy.com).



# CHANGES INVOLVING PAYMENT FOR POST-OPERATIVE PAIN PROCEDURES

Neda M. Ryan, Esq.

Clark Hill, PLC, Birmingham, MI

For as long as anesthesia providers can remember, the payment for post-operative pain procedures has been bundled into the surgeon's global fee. The exception to this general rule arises when the surgeon requests the anesthesiologist to administer the service. Although the National Correct Coding Initiative (NCCI) Coding Policy Manual for Medicare Services (Manual) provision has not changed, Medicare contractors' payment for post-operative pain procedures is beginning to shift and the anesthesia community must be aware of this shift and ensure compliance with The Center for Medicare and Medicaid Services' (CMS') and its contractors' documentation requirements.

The CMS annually releases the NCCI Manual, which was developed to "promote national correct coding methodologies ... to control improper coding leading to inappropriate payment in Part B claims." The Manual includes a section specifically pertaining to billing for anesthesia providers furnishing post-operative pain procedures. This section provides that post-operative pain services are included in the surgeon's global fee for the surgical procedure and payment to an anesthesia provider is appropriate when medically necessary and when the surgeon documents in the record that the service was referred to an anesthesia provider and the reason for the referral. Specifically, the Manual states as follows:

*Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the*



*procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required that cannot be rendered by the surgeon. **The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner.***

(Emphasis added.) Although the requirement that the surgeon document the medical necessity for referring the service to the anesthesia provider has long existed, in practice, CMS contractors have not typically referred to the surgeon's records to determine whether this requirement has been satisfied. However, this practice is quickly changing, especially in two Part B jurisdictions.

Effective for services performed on or after June 9, 2014, Noridian Healthcare Solutions, LLC (Noridian), the Part B Medicare Administrative Contractor (MAC) for Jurisdiction F, covering Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming, post-operative pain management services are separately reimbursable to the anesthesia provider under Part B if a need for transfer of pain management is documented and ordered by the surgeon and the accepting provider documents the need for and acceptance of transfer of care (See local coverage determination (LCD) 33188, *Nerve Blockade: Somatic Selective Nerve Root Block, and Epidural*). Noridian's recent change has brought the LCD's documentation requirements in

line with those set forth in the Manual. In other words, for anesthesia providers to receive payment for post-operative pain management services, both the surgeon and the anesthesia provider must also document the medical necessity for the transfer. Simply stating that a surgeon requested the transfer of care to the anesthesia provider will likely be insufficient for payment.

Although Noridian is the only MAC officially revising its LCD at this time, some anesthesia providers in Wisconsin Physician Services (WPS) Jurisdiction 8, covering Michigan and Indiana, have experienced claim denials and requests for additional documentation when they have submitted claims for post-operative pain management services. Importantly, WPS has been requesting the surgeon's documentation to confirm medical necessity. More importantly, WPS recently stated in a teleconference that it intends to deny *all* claims involving post-operative pain blocks and, in doing so, will request that the surgeon's documentation be submitted with the appeal.

In light of these recent shifts in official, and unofficial, local policies, it is of utmost importance that anesthesia providers ensure that their documentation properly reflect the request by a surgeon to administer post-operative pain management services as well as the medical necessity for



the request. It is also imperative that anesthesia providers communicate with the surgeons the need for the surgeon's record to include documentation of the medical necessity of the request. Failure of both parties to include adequate documentation in the record will result in claim denials and/or a request for overpayments on the part of the carriers enforcing the more stringent policies.

Although the national guidelines in the Manual have enunciated the surgeon's obligation, in practice, anesthesia providers have received payment for services without the MAC reviewing the surgeon's documentation. As we can see, two jurisdictions have begun to take a rather aggressive approach in implementing the long-standing national guidelines. Although the new local policy shifts appear to affect only Noridian's and WPS's jurisdictions thus far, as CMS continues to strengthen its grip on payment for services, all anesthesia providers should expect this requirement to affect their jurisdictions in the near

future. As such, the sooner anesthesia providers in other jurisdictions ensure both they and surgeons comply with the national requirement, the easier the transition will be when it takes place in their respective jurisdictions and the less anesthesia providers will be faced with claim denials and/or requests for overpayments. ▲



**Neda M. Ryan, Esq.**

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



# THE ROLE OF ANESTHESIOLOGISTS IN THE INTENSIVE CARE UNIT

Jody Locke, MA

*Vice President of Anesthesia and Pain Management Services, ABC*

For all the time most anesthesiologists spend in the operating room and the Post-anesthesia Care Unit (PACU) there is a curious firewall when it comes to the Intensive Care Unit (ICU). Most anesthesia practices are actively pursuing ways to generate additional revenue and further strengthen their relationship to administration and yet rarely do such considerations include any discussion of the ICU. As a large national billing company with hundreds of clients across the country, we only bill for a few clients that cover the ICU. One might therefore ask, "Are these practices visionaries of a future reality or isolated exceptions?" What is the opportunity and what would be involved in exploring it? Why are the very physicians who promote themselves as ideal managers of the entire perioperative continuum not pursuing a more active role in the ICU? It would appear to be a logical and integral part of the Perioperative Surgical Home.

The scope of billable services for an intensive care unit is limited to specific intensive care service Current Procedural Terminology® (CPT) codes, (99291 and 99292), subsequent hospital visit codes (99231-99235) and a relatively short list of interventional modalities including the insertion of arterial lines, CVPs and Swan-Ganz catheters. In certain, limited situations there could also be an opportunity to bill for ventilator management. Anesthesiologists who provide anesthesia to cardiac patients must be careful in their use of these codes, however, because ventilator management is included in the scope of cardiac anesthesia.

The ICU codes are time-based. Code 99291 is intended to reflect an hour of management of a critically ill patient.



As a practical matter, not all patient encounters last exactly 60 minutes and so CPT established a convention whereby the code can be used for any encounter lasting longer than 34 minutes or less than 74 minutes. The second code, 99292, is intended to reflect each subsequent half hour of care. Key to code selection is the acuity of care. Once patients are stabilized and no longer at significant risk, then subsequent hospital visit codes must be used. (For further information, see Joette Derricks's article *Reporting Critical Care Services* on page 18.)

The economics of ICU coverage hinge on three factors: volume of patients, payor mix and the nature of the services provided. It is not uncommon for busy academic centers with multiple step-down units to have enough patients such that the typical provider will bill for 10 or more hours of care per day. Managing a small population of post-cardiac surgery patients, on the other hand, would not typically result in very significant billings. The impact of payor mix is the same as in the operating room where the Medicare payment rate of approximately \$120 per hour is at the low end of the spectrum. This implies that 10

hours of billable time for a Medicare population would result in \$1200. If even a few commercial PPO patients are included in the mix, the daily yield could approach that of the operating room. Given current levels of anesthesiologist compensation, most services must be subsidized by the facility.

As an outgrowth of the PACU, critical care units are now found in all major medical facilities throughout the United States. Anesthesiologists are uniquely qualified to coordinate the care of patients in the intensive care unit because of their extensive training in clinical physiology/pharmacology and resuscitation. Some anesthesiologists pursue advanced fellowship training to subspecialize in critical care medicine in both adult and pediatric hospitals. In the ICU, they direct the complete medical care for the sickest patients. The role of the anesthesiologist in this setting includes the provision of medical assessment and diagnosis, respiratory and cardiovascular support and infection control.

Anesthesiologists also possess the medical knowledge and technical expertise to deal with many emergency and trauma situations. They provide airway management, cardiac and pulmonary resuscitation, advanced life support and pain control, all of which are essential skills to the intensivist. As consultants, they play an active role in stabilizing and preparing the patient for emergency surgery.

The staffing requirements of ICUs may also create an opportunity for anesthesia practices. Given the level of activity and service provided it may be more cost-effective for anesthesia to rotate members of the group through the unit. This might also provide greater flexibility in staffing and coverage.

Lutheran General Hospital in Park Ridge, Illinois is a useful case study. Park Ridge Anesthesia has four intensive care-trained anesthesiologists who cover the ICU five days a week. The origin of the service goes back in time to a point where the hospital believed that its patients would be better served by a single service that could provide a continuum of care to patients undergoing major surgery. The assumption was that anesthesiologists who were familiar with the care received in the operating room would be better qualified to manage post-surgical complications in the ICU. The Park Ridge anesthesia team argues this has been the explanation for the consistently low levels of post-surgical complications and high levels of patient satisfaction.

Two common factors deter most anesthesia practices from any consideration of ICU coverage. The first is the revenue potential and the second is the politics of cardiac care. Because the reality of most intensive care services is that they are inherently unprofitable, they are not viewed as good opportunities for expansion in an era when Ambulatory Surgery Centers (ASCs) and endoscopy centers have tended to be such logical places to look for additional revenue potential. Why mine the unprofitable when the profitable is so readily at hand? Ironically, chronic pain management has become the next area of exploration, despite the fact that many chronic pain practices deliver such disappointing results. The underlying thread is the potential for independence. Rare is the practice that wants to build a practice model based on the need for subsidy from the facility. There may come a point, however, where all opportunities for independent, profitable expansion are exhausted.

If the primary focus of an intensive care service is post-cardiac surgical patients then this implies competition with the cardiologists who referred the patients to the facility for surgery in the first place. The cardiovascular surgeon makes his money performing complex surgical interventions, but the cardiologist makes his money managing patients over

time. I have personal experience with a Long Island heart center that brought in an anesthesiologist to manage the ICU. In that case, it was a very profitable service, but the politics ultimately made it so challenging that the doctor left the facility.

There is also a curious chicken and egg phenomenon at work here, as indicated by the following abstract for an article in *Anesthesia and Analgesia*: *The number of anesthesiology residents pursuing critical care medicine (CCM) fellowship training has been decreasing in recent years. A significant number of training positions remain unfilled each year. Possible causes of this decline were evaluated by surveying residents regarding their attitudes toward practice and training in CCM. All 38 anesthesiology programs having accredited CCM fellowships were surveyed. Four of these and one program without CCM fellowships were used to develop the survey instrument. Four programs without CCM fellowships and 34 programs with CCM fellowships make up the survey group. Returned were 640 surveys from 37 (97 percent) programs accounting for over 30 percent of the possible residents. Resident interest in pursuing CCM training decreased as year of residency increased ( $P < 0.0001$ ). Residents in programs with little patient care responsibility during intensive care unit (ICU) rotations expressed less interest in CCM training ( $P < 0.012$ ). The administrative role of the anesthesiology department in the ICU also influenced resident interest ( $P < 0.014$ ). Written responses to open-ended questions suggested resident concerns with the following: stress of chronic care, financial consequences of additional year of training, ICU call frequency and load, ICU role ambiguity, and shared decision-making in the ICU. A recurring question was, "Are there jobs (outside of academics) for anesthesiologist intensivists?" Most residents knew a CCM anesthesiologist they admired and knew that there were unfilled fellowship positions available. Defining the job market, improving curriculum and teaching, supporting deferment of student loans, and introducing residents and medical students to the ICU earlier may increase the interest in*

*CCM practice among anesthesiology residents (Anesthesia and Analgesia 1993).*

With the changing focus of healthcare, is the ICU a clinical opportunity that anesthesia practices should be pursuing? Three factors would appear to support a revision of traditional thinking. If we assume that other opportunities for practice expansion are slowly drying up it might be time to revisit the potential of the ICU. As an increasing number of anesthesia practices receive stipends and other forms of financial support from facilities, there is a growing concern about justifying financial support. If anesthesia can expand its scope of services this could have distinct strategic advantages. An active role in the ICU is also logically indicated by the current focus on the Perioperative Surgical Home. In an era of customer service, hospitals love the concept of accountability for quality of care. Clearly a comprehensive service that includes co-management of the ICU with surgery has great potential to accomplish this.

As is true of so many other developments in healthcare, the real challenges to changing the practice model may be more educational and strategic than financial. Sometimes changing the culture of a facility is simply a matter of clearly delineating the advantages of a new approach. Some serious stakeholder analysis might reveal significant opportunities. It is all in the packaging. 

#### Jody Locke, MA

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](mailto:Jody.Locke@AnesthesiaLLC.com).



# IMPROVING THE DOCUMENTATION OF ANESTHESIA PROCEDURES

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

*Vice President of Provider Education and Training, ABC*

Reimbursement pressures for anesthesia practices are continuing to escalate due to fluctuations in our healthcare environment. Safeguarding collections is critical and it has become more important than ever to collect every dollar without leaving anything on the table. Good clinical documentation supports accurate coding and the impending ICD-10 implementation increases that significance. For anesthesia providers to facilitate the reduction of coding errors, it is imperative that they have a sound understanding regarding the relationship between good clinical anesthesia documentation and accurate coding. Incomplete documentation requires a return visit to the provider or a review of the operative report which in turn delays the processing and payment of a claim. Delays in claims processing decreases revenue.



## PROCEDURE UNDERCODING

Lack of detail by the anesthesia provider concerning the procedure description is one of the top reasons for undercoding. Detail is vital for accurate coding and optimal reim-

bursement. Opening the lines of communication between providers and their surgical colleagues is essential. Discussions between the surgeon and anesthesia provider regarding both procedure and diagnosis descriptions for documentation purposes are critical. Working collectively will become evident with the implementation of ICD-10. Documenting this important information not only assists in accurate coding but saves time, creating an efficient process. Querying the providers and searching operative reports is not only time consuming but causes unnecessary delays in claims submission as well as reimbursement. Operative reports are actually the documentation for the surgeon, not the anesthesia provider. Good clinical documentation should

**TABLE 1**

Procedure	Location	Base Value Units
<b>Abdominal Procedures</b>	<ul style="list-style-type: none"> <li>designate the procedure location as upper or lower abdomen</li> <li>umbilicus is the point of reference</li> </ul>	<ul style="list-style-type: none"> <li>upper abdominal procedures increase the base value units by one</li> </ul>
<b>Cysto Procedures</b>	<ul style="list-style-type: none"> <li>designate if the procedure location is the upper 1/3 of the ureter</li> </ul>	<ul style="list-style-type: none"> <li>upper 1/3 of the ureter procedures increase the base value units by two</li> </ul>
<b>Femur Procedures</b>	<ul style="list-style-type: none"> <li>designate the procedure location as proximal or distal</li> <li>designate if the fracture is open or closed</li> </ul>	<ul style="list-style-type: none"> <li>open proximal fractures increase the base value units by two</li> <li>**hip revision documentation increases four additional base value units**</li> </ul>
<b>Integumentary Procedures</b>	<ul style="list-style-type: none"> <li>designate the procedure location and the type of involvement (nerves, muscles, bone, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>integumentary procedures involving the head, neck and posterior trunk increases the base value unit by two</li> </ul>
<b>Lymph Node Procedures</b>	<ul style="list-style-type: none"> <li>designate the procedure location</li> </ul>	<ul style="list-style-type: none"> <li>lymph node procedures involving the esophagus, thyroid, larynx, trachea and lymphatic system of neck increases the base value unit by three</li> <li>lymph node procedures nerves, muscles, tendons, fascia and bursa of shoulder and axilla increases the base value units by two</li> <li>**radical hysterectomies and breast procedures with lymph node involvement, based upon the detail of the clinical anesthesia documentation would choose the code with the highest base value units. The main procedure may have less base value units than the lymph node procedure**</li> </ul>

TABLE 2

Procedure	Technique	Base Value Units
<b>Diagnostic vs Surgical</b>	<ul style="list-style-type: none"> <li>designate the type of arthroscopic procedure, i.e. diagnostic vs surgical</li> <li>The diagnostic scope still has a role in orthopedic procedures, yet diagnostic arthroscopy is becoming obsolete. Imaging quality has definitely reduced the number of patients going to the OR without a firm diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>surgical arthroscopic procedures increase the base unit value by one</li> </ul>
<b>Spinal Surgery</b>	<ul style="list-style-type: none"> <li>document the utilization of instrumentation (i.e. screws, plates or rods) and/or the number of vertebral bodies with their associated intervertebral spaces as well as the location on the spine</li> </ul>	<ul style="list-style-type: none"> <li>extensive spinal surgery procedures increase the base value unit by five</li> </ul>
<b>One Lung Technique</b>	<ul style="list-style-type: none"> <li>document one-lung technique</li> </ul>	<ul style="list-style-type: none"> <li>one lung-technique procedures increase the base value unit by four</li> </ul>
<b>Cardiac By-Pass</b>	<ul style="list-style-type: none"> <li>document the utilization of cardiac by-pass and the age of the patient (under or over one year of age)</li> <li>document the redo of CABG more than 30 days out</li> </ul>	<ul style="list-style-type: none"> <li>cardiac by-pass procedures could change the base value units up to 10</li> <li>**since documentation of the patient's age is included usage of qualifying circumstances is not applicable**</li> </ul>
<b>Trans-Rectal Ultrasound</b>	<ul style="list-style-type: none"> <li>document the utilization of trans-rectal ultrasound including interstitial radioelement application or biopsy, if applicable</li> </ul>	<ul style="list-style-type: none"> <li>trans-rectal ultrasound procedures increase the base value unit by two</li> </ul>
<b>Pacemaker Procedures</b>	<ul style="list-style-type: none"> <li>document the technique utilized as well as type of pacemaker</li> </ul>	<ul style="list-style-type: none"> <li>pacemaker procedures with radiofrequency ablation increases the base unit value by ten</li> </ul>

Shown in Table 1 on page 16 are examples of some common elements of clinical anesthesia documentation that are necessary for accurate coding and optimal reimbursement.

## TECHNIQUE

Good clinical documentation of technique, similarly, is important for accurate anesthesia coding. Shown in Table 2 are examples of the role of technique in anesthesia documentation, coding and, ultimately, optimal reimbursement.

As you can see, there is significant potential to leave many dollars on the table over the course of a year. It is imperative for both the anesthesia providers and coders to embrace continuing education to ensure good clinical documentation and accurate coding. Frequent updated continuing education will both guarantee a reduction of errors and assist in achieving optimal reimbursement. This will safeguard a practice in many ways, especially during an audit where good clinical documentation is readily available to support the coding. Now is a great time to begin practicing these skills so that ICD-10 implementation will be a “piece of cake.” ▲

reside in the anesthesia record, not the operative report. In the near future, it is certainly reasonable to expect payers to check that all diagnosis and procedure codes submitted will match for all providers and facilities across the board.

## LOCATION

The catchy phrase “location, location, location” is touted as vital in real estate, and is, in fact, necessary for good clinical anesthesia documentation. Location becomes even more significant involving ICD-10 coding, as it is required to assist in the selection of the correct diagnosis code. In preparation for next year's ICD-10 implementation, creating good clinical documentation for both procedures and diagnoses will ease this process.

**Darlene F. Helmer, CMA, CPC, ACS-AN, CMPE, MBA** serves as Vice President of Provider Education and Training for ABC. She has 30+

years of healthcare financial management and business experience. She works closely with the ABC compliance department and is a member of the ICD-10 training team. She is a long-standing member of MGMA, AHIMA, AAPC and other associations. She is a frequent speaker at local and state conferences. You can reach her at [Darlene.Helmer@AnesthesiaLLC.com](mailto:Darlene.Helmer@AnesthesiaLLC.com).



# REPORTING CRITICAL CARE SERVICES

Joette Derricks, CPC, CHC, CMPE, CSSGB

Vice President of Regulatory Affairs & Research, ABC

Anesthesiologists are uniquely qualified to coordinate the care of patients in the intensive care unit because of their extensive training in clinical physiology/pharmacology and resuscitation. Some anesthesiologists pursue advanced fellowship training to subspecialize in critical care medicine in both adult and pediatric hospitals. In the intensive care unit, they direct the complete medical care for the sickest patients. The role of the anesthesiologist in this setting includes the provision of medical assessment and diagnosis, respiratory and cardiovascular support and infection control. Clinical competence and expertise in meeting the needs of a critically ill or injured patient unfortunately does not automatically transfer to payer's documentation and coding requirements. The following article reviews the critical care services documentation, coding and billing guidelines.

\* \* \*

The American Medical Association's Current Procedural Terminology® (CPT) Codebook defines critical care as the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or critically injured patient. A critical illness or injury "acutely impairs one or more vital organ systems such that there is a *high probability of imminent or life threatening deterioration* in the patient's condition".

Critical care involves *high complexity* decision making to assess, manipulate and support vital system functions(s) to treat single or multiple vital organ failure and/or the prevention of further life threatening deterioration in a patient's condition. Examples of vital organ system failure include, but are not limited to:

central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure.

Delivering critical care in a moment of crisis, or upon being called to the patient's bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient's condition in threatening imminent deterioration, while not necessarily emergent, is also required.

The presence of a patient in an Intensive Care Unit (ICU) or Critical Care Unit (CCU), or the patient's use of a ventilator, is not sufficient to warrant billing critical care services. The service must be medically necessary and meet the definition of critical care. Medically reasonable and necessary services that do not meet all the criteria to report critical care should be reported with the appropriate evaluation and management code (e.g., CPT codes 99231-99233).

Since critical care is a time-based service, the physician's critical care note(s)

*must document* the total time spent evaluating, managing and providing critical care services to a critically ill or injured patient. Critical care time may be continuous or intermittent in aggregated time increments. Time spent performing other, separately billable procedures/services cannot be used to support critical care time.

The time spent providing critical care services must be at the immediate bedside or elsewhere on the floor or unit as long as the physician is immediately available to the patient. Therefore, the physician cannot provide services to any other patient during the same period of time.

In the teaching environment, the teaching physician must be present for the entire period of time for which the claim is submitted. Time spent teaching may not be counted towards critical care time. Teaching physicians, in addition, cannot bill for time spent by the resident providing critical care services in their



absence. Only time that the teaching physician spends with the patient, or that he or she and the resident spend together with the patient, can be counted toward critical care time. Provided that all requirements for critical care services are met, the teaching physician's documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment. However, it is the teaching physician's stand-alone documentation that determines whether a critical care service can be billed.

The teaching physician medical record documentation must provide information including the time the teaching physician spent providing critical care; that the patient was critically ill during the time the teaching physician saw the patient; what made the patient critically ill; and the nature of the treatment and management provided by the teaching physician.

The following is an example of acceptable teaching physician documentation:

Patient seen and examined with Dr. Resident. Reviewed and agree with his note and the plan of care we developed together. One hour of critical care time personally performed due to patient's hemodynamic instability. Patient was resuscitated with 2 units of packed red blood cells. Additional studies were obtained to determine possible causes for patient's instabilities.

In 2014, the CPT Codebook lists the following services as included in critical care services and provides that they should not be reported separately: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), blood draw for specimen (36415), blood gases and information data

stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090), gastric intubations (43752, 91105), pulse oximetry (94760, 94761, 94762), temporary transcutaneous pacing (92953), ventilator management (94002-94004, 94660, 94662), and vascular access procedures (36000, 36410, 36415, 36591, 36600).

Time involved performing procedures that are not bundled into critical care (i.e., billed and paid separately) may not be included and counted toward critical care time. The physician's progress note(s) in the medical record should document that time involved in the performance of separately billable procedures was not counted toward critical care time. For example, an emergency intubation may be billed separately as 31500 if supported by the documentation and the time is excluded from critical care time if both are being reported. What services are and are not bundled into critical care change from time to time and physicians along with their billing staff should review the list each January.

Routine daily updates to family members are considered part of critical care services and not separately billable. However, time spent with family member or other surrogate decision makers may be counted toward critical care time when these criteria are met:

- The patient is unable or clinically incompetent to participate in giving a history and/or decision making and
- The discussion is necessary for determining treatment decisions.

A summary of any family discussion is to be documented within the medical record and should show that the patient was unable or incompetent to participate as well as the necessity for the discussion and any treatment decisions made.

Telephone calls to family members and/or surrogate decision makers may be counted provided that they meet the

same criteria as described above. All other family discussions, no matter how lengthy, may not be counted towards critical care time.

## CRITICAL CARE SERVICES CODES

- Code 99291 (critical care, first hour) is used to report the services of a physician providing constant attention to a critically ill patient for a total of 30 to 74 minutes on a given day.
- Only one unit of code 99291 may be billed by a physician for a patient on a given date.
- If the total duration of critical care provided by the physician on a given day is less than 30 minutes, the appropriate evaluation and management code should be used. In the hospital setting, it is expected that the Level 3 subsequent hospital care code 99233 would most often be used.
- Code 99292 (critical care, each additional 30 minutes) is used to report the services of a physician providing constant attention to the critically ill patient for 16 to 30 minutes beyond the first 74 minutes of critical care on a given day.
- The following illustrates the correct reporting of critical care services:

### Total Duration of

Critical Care	Code(s)
Less than 30 minutes	99232 or 99233
30-74 minutes	99291 x 1
75-104 minutes	99291 x 1 and 99292 x 1
105-134 minutes	99291 x 1 and 99292 x 2
135-164 minutes	99291 x 1 and 99292 x 3

### Important Coding Requirements

- Only one physician may bill for critical care services during any **one single period of time** even if more

*Continued on page 20*

## REPORTING CRITICAL CARE SERVICES

Continued from page 19



than one physician is providing care to a critically ill/injured patient. Documentation in the patient's medical record must support the specific time that the physician was present at bedside or engaged in work directly related to the individual patient.

- Physicians assigned to a critical care unit (hospitalist/intensivist) may not report critical care based on a "per shift" basis.
- Claims for seemingly improbable amounts of critical care on the same date are subjected to review to determine if the physician has filed a false claim.
- Services cannot be reported as a split/shared service when performed by a physician and a nonphysician provider (NPP) in the same or another group practice.
- Physicians in the same group practice, with the same specialty, may not report 99291 for the same patient on the same calendar date. The initial critical care time, billed as CPT code 99291, **must be met by a single physician** or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician or qualified NPP on the same calendar date.
- CPT Code 99292 (subsequent critical care visits) are for additional critical care time performed on the same calendar date. The service may represent **aggregate time met by a single physician or physicians in the same group practice and in the same medical specialty** in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.
- Concurrent care by more than one physician representing different specialties is payable if the services meet critical care requirements, (i.e., must be medically necessary and non-duplicative time and services.)
- Hospital emergency department services are not payable for the same date as critical care services when provided by the same physician or physicians of the same specialty.
- Critical care services will not be paid on the same calendar date that a physician reports an unbundled preoperative procedure with a global surgical period, unless the critical care is billed with modifier -25 to indicate that a significant, separately identifiable E/M service was performed. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.
- Postoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the

constant attendance of the physician, and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. In order for these services to be paid, two reporting requirements must be met. Codes 99291/99292 and modifier "-24" (Unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation. ▲

### Resources

1. AMA/CPT 2014 Critical Care Services
2. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>, Section 30.6.12
3. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>, section 100, Teaching Physician

**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. She is a member of MGMA, HCCA, AAPC and other associations and a regular speaker at practice management conferences. She can be reached at [Joette.Derricks@AnesthesiaLLC.com](mailto:Joette.Derricks@AnesthesiaLLC.com).

# FIELD AVOIDANCE AND SPECIAL POSITIONING

Kelly D. Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I

*Perfect Office Solutions, Inc., Palmetto, FL*

According to Socrates, “Education is the kindling of a flame, not the filling of a vessel.” A thirst for knowledge by one who is new to the field can be just as important to an employer as an employee with years of experience—even more so if the experienced employee believes they know all there is to know. This is especially true about anesthesia billing—just when you think you have the rules down pat, something changes. Staying on top of your game requires constant learning, and the vessel will never be full. Knowledge is power and, literally, at our fingertips. Much of what one seeks to find can be accessed through search engines. Now it seems the hardest part of learning is an understanding of how to whittle down the vast amounts of data into just the information one needs.

Qualifying circumstances, including field avoidance and special positioning, are unique to anesthesia services. To capture these services, the coder must have an understanding of the services and when they may be reported. Field avoidance and special positioning are not specifically mentioned in the minimal section of Anesthesia Guidelines found in the Current Procedural Terminology® (CPT) Codebook, although they may be considered as services under the Special Report section. These unique circumstances are defined by the American Society of Anesthesiologists’ Relative Value Guide® (ASA RVG) as “Any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy,” and have “a minimum Base Value of 5, regardless of any lesser base



value assigned to such procedure in the body of the Relative Value Guide®.” Since the definition includes a minimum base value of five units, this automatically *excludes* reporting with anesthesia services having a base value of five or more units. As there are eighty-three codes with a base value of fewer than five units, there is a good chance your anesthesia providers will qualify for additional payment for some of their anesthesia services, providing the documentation supports the reported circumstance.

For special positioning, surgeries performed in either the supine (patient is lying on their back) or lithotomy (patient is on their back with the hips and knees flexed and the thighs apart) are also

excluded. Coders should be watchful for any other position documented, particularly if the patient is morbidly obese, and remember to check whether the anesthesia base value is less than five (5) units. According to *Anesthesia & Pain Coder’s Pink Sheet*, a study of positioning found that the reverse Trendelenberg was the optimal position for morbidly obese patients.

Field avoidance indicates that the anesthesia provider does not have access to the patient’s airway during surgery. This may be due to the nature of the case (i.e. face or shoulder surgery) or because the surgeon has the patient in a

*Continued on page 22*

## FIELD AVOIDANCE AND SPECIAL POSITIONING

*Continued from page 21*



different position. Both field avoidance and unusual positioning make the case a higher risk for the patient and the anesthesia provider.

Qualifying circumstances, which include field avoidance and special positioning, are not services covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractors (MACs), even though these exclusions are not mentioned in the Payment for Anesthesiology Services section of the Medicare Claims Processing Manual Chapter 12—Physicians/Nonphysician Practitioners (Section 50). As an added difficulty, there are no specific procedure codes or modifiers to describe field avoidance and special positioning. To find a relevant example, one may use other anesthesia qualifying circumstances, such as CPT 99100 (*Anesthesia for patient of extreme age, younger than 1 year and older than 70*) to determine whether these services have a “B” or bundled

status with anesthesia services. CGS Administrators includes anesthesia qualifying circumstances under Status B codes in the publication *Bundled, Inactive and Non-Payable Codes for 2014: Medicare Physician Fee Schedule Data Base* and indicates “Payment for these services is always included in payment for other services not specified. There are no RVUs (Relative Value Units) or payment amounts for these codes, and separate payment is not made.”

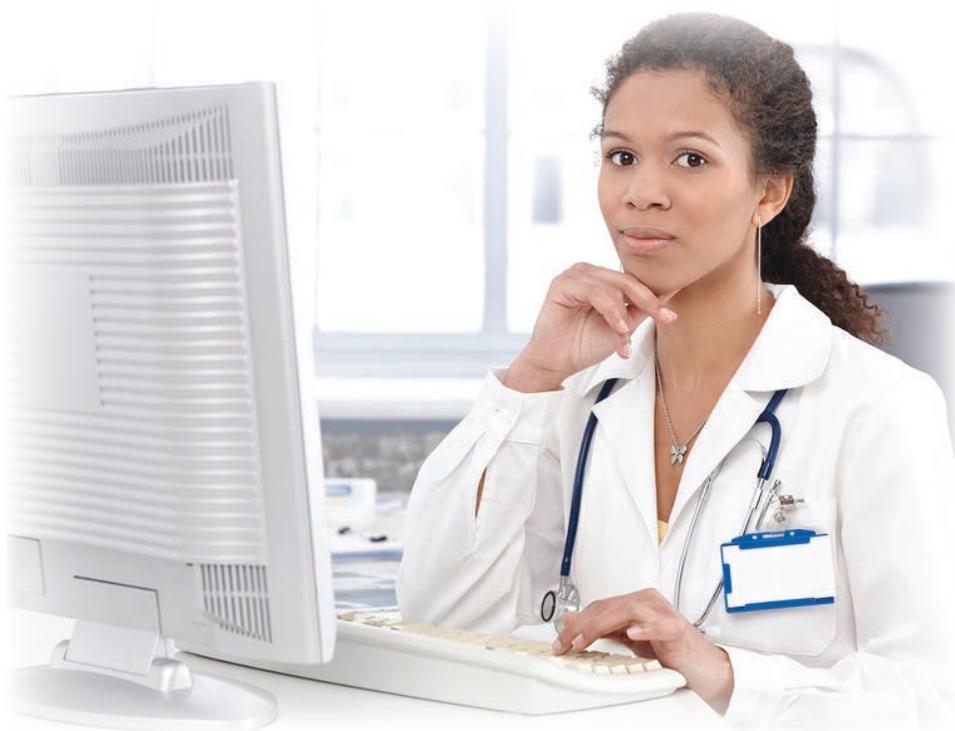
However, it important to understand that even though Medicare does not cover qualifying circumstances, this is not always true for Medicaid programs, which vary by state. For example, the Medicaid program for California, MediCal, allows additional payment for anesthesia procedures complicated by unusual position or surgical field avoidance when identified with a -22 modifier to indicate increased procedural services.

Commercial insurance policies often recognize the value of these services,

although the reporting processes may differ. Blue Cross Blue Shield of Hawaii requires the use of a -23 modifier (unusual anesthesia), and specifies it “should be used to indicate anesthesia services complicated by procedures performed in the prone position or by field avoidance.” If carrier policy does not define whether qualifying circumstances are covered, they should be billed and reported—no policy will cover unbilled or unreported services. Unless otherwise specified, coders may report either of these circumstances with a -22 modifier, and “field avoidance” or “xxx Position” in box 19 or the electronic equivalent.

It is helpful for anesthesia providers to understand that qualifying services may be missed if they are not clearly documented, and it is helpful for coders to understand when these services might be performed and how they are documented. Remember the adage “if it wasn’t documented it wasn’t done?” Coders cannot capture billable services that are not indicated





on the anesthesia record, even if they are marked on an internal billing sheet. Billing sheets are not usually considered as part of the patient's medical records. There is no universal anesthesia record and a typical anesthesia billing company sees many different records, so coders must determine where on each record the anesthesia providers document these types of services, which can be quite challenging with paper records and handwritten notes. It is also difficult if the anesthesia providers are using stick figures to draw the patient's position on a paper anesthesia record. Sometimes the coders can't tell whether the feet are up (supine) or down (prone). With a paper record, the clearest way to document is a legible note in the remarks or comments section. Electronic Anesthesia Records (EARs) are much easier to read and may have a field summary that includes an area to document qualifying circumstances. If the EAR doesn't have a field summary, look within the body or comments section. Learn where qualifying circumstances information is documented in your practice.

Specific anesthesia policy and anesthesia billing rules are often non-existent or difficult to find. If a policy is found, and doesn't address qualifying circumstances, they should be reported. If no policy is found, they should be reported. If they are denied, contact the insurance company to determine the reason. If an appeal is necessary, the best way to help an insurance company understand the value of the service is to be able to explain why the services have a higher value. Coders, regardless of the length of their experience, are continuously learning—one of the constants of the coding industry is change. Excellent coders are invaluable—they ask questions and look for answers. ▲

#### Resources

BC/BS of Hawaii

[http://www.hmsa.com/PORTAL/PROVIDER/zav\\_pel.ph.ANE.900.htm](http://www.hmsa.com/PORTAL/PROVIDER/zav_pel.ph.ANE.900.htm)

CGS Administrators, LLC, Bundled, Inactive and Non-Payable Codes for 2014

[http://www.cgsmedicare.com/pdf/J15\\_FeeSchedules2014.pdf](http://www.cgsmedicare.com/pdf/J15_FeeSchedules2014.pdf)

Medi-Cal

[http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom\\_11675\\_3.asp](http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_11675_3.asp)

[https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/anestcms\\_m00.doc](https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/anestcms_m00.doc)

Medicare Claims Processing Manual Chapter 12 - Physicians/ Nonphysician Practitioners

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>

#### Positioning Resources

[http://www.openanesthesia.org/Patient\\_Positioning\\_and\\_Injury](http://www.openanesthesia.org/Patient_Positioning_and_Injury)

[http://commons.wikimedia.org/wiki/File:Supine\\_position\\_2012-02-02.jpg](http://commons.wikimedia.org/wiki/File:Supine_position_2012-02-02.jpg)

[http://commons.wikimedia.org/wiki/File:Lithotomy\\_position\\_01.jpg](http://commons.wikimedia.org/wiki/File:Lithotomy_position_01.jpg)

<http://www.medtrng.com/posturesdirection.htm>

<http://www.aaos.org/news/aaosnow/jan13/managing7.asp>

[http://en.wikipedia.org/wiki/Surgical\\_positions](http://en.wikipedia.org/wiki/Surgical_positions)

[http://commons.wikimedia.org/wiki/File:Reverse\\_trendelenburg\\_position\\_01.gif](http://commons.wikimedia.org/wiki/File:Reverse_trendelenburg_position_01.gif)

**Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I**, has over 30 years experience in anesthesia and speaks about anesthesia issues nationally. She has a Master's Degree in Business Administration, is certified through the American Academy of Professional Coders, is an Advanced Coding Specialist for the Board of Medical Specialty Coding and serves as lead advisor for their anesthesia board. She is also a certified health care auditor and has owned her own consulting company, Perfect Office Solutions, Inc., since November, 2001. She can be reached at [kellyddennis@attglobal.net](mailto:kellyddennis@attglobal.net).





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

PRSR STD  
 US POSTAGE  
**PAID**  
 HOLLAND, MI  
 PERMIT NO. 45

## Introducing TelePREOP

**TelePREOP** is the first and leading provider of telemedicine solutions suited to manage the complex workflows associated with the pre-surgical clinical environments. It is designed to streamline the process between surgeons, hospitals, ASCs and anesthesia.

**TelePREOP** leverages an industry leader in the technology platform we selected, ePREOP. **TelePREOP** can engage all Hospital Information Systems that power your healthcare facilities without the overwhelming burden of implementation. The system is already deployed within our environments and allows you to decide to the level of integration thus reducing the time to implementation. Additional information is available on the website at [www.TelePREOP.com](http://www.TelePREOP.com).

## PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
September 4-7, 2014	Texas Society of Anesthesiologists 2014 Annual Meeting	Hyatt Lost Pines Resort Lost Pines, TX	<a href="http://www.tsa.org/professional/annual_meeting/">http://www.tsa.org/professional/annual_meeting/</a>
September 6-7, 2014	Washington State Society of Anesthesiologists 75th Annual Meeting	Bell Harbor International Conference Center Seattle, WA	<a href="http://www.wa-anesthesiology.org/event-calendar">http://www.wa-anesthesiology.org/event-calendar</a>
September 6-7, 2014	Wisconsin Society of Anesthesiologists 2014 Annual Meeting	The Osthoff Resort Elkhart Lake, Wisconsin	<a href="http://www.thewsa.org">http://www.thewsa.org</a>
September 18-21, 2014	The American Academy of Pain Management's 25th Annual Clinical Meeting	JW Marriott, Phoenix Desert Ridge Phoenix, AZ	<a href="http://www.aapainmanage.org/2014-annual-clinical-meeting/">http://www.aapainmanage.org/2014-annual-clinical-meeting/</a>
September 18-21, 2014	The Ohio Society of Anesthesiologists 75th Annual Meeting	Columbus, OH	<a href="http://osainc.org/index.php?option=com_content&amp;view=article&amp;id=9&amp;Itemid=8">http://osainc.org/index.php?option=com_content&amp;view=article&amp;id=9&amp;Itemid=8</a>
September 18-21, 2014	New England Society of Anesthesiologists 57th Annual Clinical Meeting	Woodstock Inn & Resort Woodstock, Vermont	<a href="http://www.nesa.net/NESA/AnnualMeeting%20Pages/AnnMtg2014prov.html">http://www.nesa.net/NESA/AnnualMeeting%20Pages/AnnMtg2014prov.html</a>
Sept. 26- Oct. 1, 2014	American Health Information Management Association 2014 Convention and Exhibit	San Diego Convention Center San Diego, CA	<a href="http://www.ahima.org/convention">http://www.ahima.org/convention</a>
October 3-4, 2014	AAOS/AAOE/NAON/ASA Orthopaedic Surgical Safety-How to Build Safe Surgical Teams and Improve Patient Outcomes-2014	Capital Hilton Washington, D.C.	<a href="http://www7.aaos.org/education/courses/course_detail.aspx?ProductID=26640">http://www7.aaos.org/education/courses/course_detail.aspx?ProductID=26640</a>
October 10-15, 2014	American Society of Anesthesiologists Anesthesia 2014 Annual Meeting	Ernest N. Morial Convention Center New Orleans, LA	<a href="http://www.asahq.org/Annual-Meeting.aspx">http://www.asahq.org/Annual-Meeting.aspx</a>
October 23-25, 2014	Ambulatory Surgery Centers 21st Annual Conference	Swissotel Chicago, IL	<a href="http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/">http://www.beckersasc.com/annual-ambulatory-surgery-centers-conference/</a>
November 7-8, 2014	Society of Academic Anesthesiology Associations Annual Meeting	Chicago, IL	<a href="http://www.SAAAhq.org">http://www.SAAAhq.org</a>
November 8-9, 2014	ASA Quality Meeting 2014	ASA Headquarters Schaumburg, IL	<a href="http://education.asahq.org/aqm">http://education.asahq.org/aqm</a>

## 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](http://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](mailto:info@anesthesiallc.com).

©2014 Anesthesia Business Consultants, LLC. This Communiqué contains both content that we create and that our partners create. All material published in the Communiqué is either protected by our copyrights or trademarks or those of our partners. You may not modify, create derivative works of, distribute, publicly perform, publicly display or in any way exploit any of the materials or content in part without our express permission.

You may reprint in its entirety any of the content in this newsletter, either online or in a print format. We ask only that you attribute this information to us by including this statement: "Copyright © 2014 Anesthesia Business Consultants. All rights reserved. Reprinted with permission."

-  Follow Us
-  Like Us
-  Connect With Us
-  Add Us to Your Circles

Connect with ABC here:  
<http://www.anesthesiallc.com/index.php/industry-info/social-media>