

**ABC offers The Communiqué in electronic format**

Anesthesia Business Consultants, LLC (ABC) is happy to announce that The Communiqué will be available through a state-of-the-art electronic format 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. 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).

## THE FUTURE OF THE ANESTHESIA CARE TEAM

by **Jody Locke**

*Vice-President of Anesthesia and Pain Management Services  
Anesthesia Business Consultants, LLC*

and **Frank Rosinia, MD**

*Chair, Department of Anesthesiology, Tulane University*

It has been said that very often the beliefs and strategies that got us to where we are today will not get us to where we need to be tomorrow. There is no more acid test of this proposition than the current economic environment. There is no more appropriate application than to the unique feature of anesthesia services: the variety of configurations

of the anesthesia care team (ACT) that exist across the country. Many will view the current challenges as a threat but others may find them an opportunity to reevaluate old assumptions and reconsider new options. Despite the potential emotion associated with such discussions this could well be a timely and strategic issue for the specialty. As is so often the case, the option facing individual practices may well be a question of taking control of one's destiny or being at its mercy.

Currently, all anesthesia care is provided in essentially one of three ways. The vast majority of anesthesia services are provided by a team of anesthesia clinicians, typically involving



*Continued on page 4*

**► INSIDE THIS ISSUE:**

<b>THE FUTURE OF THE ANESTHESIA CARE TEAM . . . . .</b>	<b>1</b>
<b>THE ALL-ANESTHESIOLOGIST MODEL OF ANESTHESIA CARE . . . . .</b>	<b>2</b>
<b>THE MODIFIED ANESTHESIA CARE TEAM MODEL . . . . .</b>	<b>9</b>
<b>MGMA AAA 2009 CONFERENCE PROVIDES EXCEPTIONAL EDUCATION AND NETWORKING OPPORTUNITIES . . . . .</b>	<b>10</b>
<b>THE HISTORY OF INTERMOUNTAIN ANESTHESIA . . . . .</b>	<b>12</b>
<b>THE TAXATION OF DISABILITY INSURANCE PREMIUMS . . . . .</b>	<b>13</b>
<b>AVOIDING PITFALLS AS PRACTICES MOVE TOWARD CARE TEAM MODEL . .</b>	<b>14</b>
<b>COMPLIANCE CORNER: THE "CARE TEAM" BILLING RULES . . . . .</b>	<b>16</b>
<b>CODING CORNER: ICD-10: 2011 . . . . .</b>	<b>17</b>
<b>PRACTICE GOVERNANCE IN RELATION TO ORGANIZATIONAL LIFECYCLE . .</b>	<b>18</b>
<b>RE-ASSESSING ANESTHESIA GROUP ADMINISTRATION . . . . .</b>	<b>22</b>
<b>ANESTHESIA'S ROLE IN DEVELOPING EFFECTIVE OR GOVERNANCE . .</b>	<b>24</b>
<b>EVENT CALENDAR . . . . .</b>	<b>28</b>

# THE ALL-ANESTHESIOLOGIST MODEL OF ANESTHESIA CARE

**Richard Bindseil, O.D and Stephen Weddell, M.D.**

*Longmont Anesthesia Associates*

*Longmont, Colorado*

The more we experience life and work, the more we realize there are many ways to accomplish a goal. As anesthesiologists, we know different anesthetic techniques can each yield acceptable results. Likewise, different anesthesia group models can each

provide acceptable anesthesia services for their respective communities. Why different models have developed in communities depends on many factors including manpower availability, number of anesthetizing locations, and professional goals.

In our community, Longmont, Colorado, these factors have allowed us to be able to provide our clients (surgeons, medical institutions, and our patients) with an all-anesthesiologist care team. We are blessed to have a cohesive, cooperative, and happily inter-dependent

## THE CONSTANCY OF CHANGE

I am very happy to provide you with another carefully researched and thought-provoking issue of our Communiqué. Our staff and contributors have provided a significant body of material related to the ongoing challenges managing an anesthesia practice effectively in these ever-changing times and particularly challenging economy. Our goal is to give you fresh perspectives on topics of the day and practical suggestions you can implement to enhance the strategic position of your practice.

While our many authors touch on a range of topics, there is a common theme to their perspectives. Change is not only inevitable but coming at us with increasing intensity. Successful practices cannot afford to be caught off guard. The calibration of our environmental scanning must be fine-tuned. No aspect of practice management is exempt from the tinkering of legislators, regulators, payors and hospital administrators. Gone are the days of happy oblivion when strong collections and consistent cash flow made for a stable practice. It is no longer enough to simply have good outcomes. The market is always pushing us all to do more for less and to be all things to all customers.

I hope you will study each of these articles as they have all been chosen to give you a balanced perspective. I am especially proud of our core series of pieces on the Anesthesia Care Team. We have had so many questions about our view of anesthesia staffing issues we wanted to make sure we included a variety of perspectives. Our main article, The Future of the Care Team, was written jointly by our own Jody Locke and Frank Rosinia, MD of New Orleans. For balance we have also included contributions from three clients: Trevor Myers, MD of Arlington, Virginia who is president of a care team practice; Richard Bindseil, DO and Steve Weddell, MD from Longmont, Colorado, who are part of an all physician practice; and Robert Hague, CRNA who is the president of a practice of physicians and CRNAs in Idaho Falls, Idaho. Jackie Popiela, one of our vice presidents of client management also shares her experiences working with practices as the work through the issues of modifying their staffing model. This is probably one of the most timely and challenging topics of the day. I can only hope we have done it justice.

Do not shortchange yourselves, though, each of the other pieces is sure to stimulate reflection and possibly inspire some internal

discussion within your organization about opportunities to either refine your governance, manage your expenses or prepare for any of the other regulatory changes being considered. Our writers are all recognized experts in their respective fields. Just as they advise us, let them advise you.

This is why we produce the Communiqué: to stimulate debate and flush out best practices. We get lots of useful feedback on all of our issues. Please let us hear from you. If something interests you and ultimately leads to a refinement of your practice, let us know. By the same token, if we have missed or mis-stated a topic that is near and dear to your heart let us know this as well. We are committed to providing a forum for the sharing of ideas and the cultivation of successful strategies for success.

Many thanks for your continued support. All the best in this season of rebirth and recovery.



Tony Mira  
President and CEO



group that can offer high level anesthesia care at all times for all our clients. We find the all-anesthesiologist model to be the best for us and feel it is the best for our clients.

Not only have CRNAs worked in our community, but some of our group members have worked as part of an anesthesia care team before coming to work here in Colorado. We have certainly considered integrating CRNAs into our practice on numerous occasions we have simply never reached a consensus that it was the right thing to do.

One of our members observed that “anesthesiology is probably the most boring specialty to *watch* someone do, but the most exciting and fun to *actually do* yourself”. It can be a challenge to gain a patient’s trust and confidence during the pre-surgical period when they are anxious and concerned about the outcome of their procedure, but it is very rewarding to manage them safely and successfully through the trauma of surgery and recovery. We take full responsibility for knowing the patient’s history and medical circumstances so that when a problem develops, we can quickly and effectively provide a solution. It is not as if we do not already work as a team with the surgeon and the medical staff, we just do not choose to share our responsibilities for the management of the anesthesia with CRNAs.

Individually and collectively, the members of our group take responsibility for a positive peri-operative experience for our patients. We share all responsibilities such as call equally. We also share all benefits equally. Even financially, we have a shared incentive to do what is right for the patients and our customers. It has been our view that the inclusion of non-physician employees would needlessly complicate the equation. We may be forgoing some income in the process, but this is a price we have chosen to pay.

It should also be noted that since we are a relatively small practice, the logistics of coverage do not lend themselves to a care team model. Our group currently covers 11 anesthetizing locations, including OB coverage, between an outpatient surgery center and a community hospital. We seldom run more than one operating room after normal hours or on the weekends. It makes little sense to have an employed CRNA working during these times, as it would mean one anesthesiologist would be supervising one CRNA. It makes no sense, economically or otherwise, for the employed CRNA to share in the after-hours call for only one case at a time while being appropriately supervised by an anesthesiologist. Thus, were we to have CRNAs in our group, only the physicians would be working the after hours and weekend call. It makes more sense to us to dilute the undesirable working hours among all of us, rather than among a lesser number of supervisory physicians.

Some members are very familiar with the medical direction of CRNAs and have found this role to be difficult at best. From a standpoint of delivering proper medical care, adhering to the seven basic principles of medical direction can be nearly impossible when directing multiple CRNAs, especially when providing anesthesia for short cases. From a standpoint of a well coordinated team, some CRNAs have resented supervision, at times waiting too long to call for assistance. Some have addressed themselves to the patients as “Doctor”. While seeming to want equal medical status as the supervisory anesthesiologist (or other physician), the CRNAs have been notably less interested in assuming the responsibilities and commitments required of the physicians.

On the other hand, each member of our anesthesia team is an equal partner and therefore each has a vested interest



in the overall success of the group. This is manifested by each member’s willingness to step up to not only help cover any anesthesia need, but to participate in administrative functions with our institutional clients and the medical staffs. Each member of our team realizes how essential extra effort is to fulfill the contractual obligations of the group. It has not been our experience that medically directed CRNAs have the same level of commitment to the other members of the anesthesia group, nor to the efforts that must be put forward to assure the continuing excellence and success of the group.

We recognize that an anesthesia model that includes employed CRNAs can work well in many situations. We feel our all-anesthesiologist group can give the best and most consistent care to our patients, the best service to our institutional customers, and the most professional satisfaction to the members of the group. We hope that the demographics of our community and our manpower resources will allow us to continue this model of anesthesia practice for years to come. 

## THE FUTURE OF THE ANESTHESIA CARE TEAM

*Continued from page 1*

an anesthesiologist and a CRNA, AA (anesthesiologist assistant) or resident. Some anesthesiologists, mainly in the western states, prefer to provide care themselves, referred to as a physician-only model. There are also hospitals where CRNAs work alone; historically, such practices tended to be in isolated rural areas, but opt-out legislation has encouraged the expansion of such a model. (See the list of the 14 states that have opted out of medical-direction requirements in the box on page 8.)

Of special note is the distinction within the largest category of anesthesia care: the medical direction model. For a combination of historical and financial reasons some anesthesia practices employ the CRNAs they work with, while in other facilities it is the hospital that employs the CRNAs. There is an ongoing debate as to whether hospitals actually profit from the employment of CRNAs. Some administrations have been known to threaten their private anesthesia groups with the prospect of the groups' having to employ their CRNAs. The fact is that employment of CRNAs by a hospital is clearly a form of subsidy. There is some speculation that ultimately hospitals prefer not to employ the CRNAs, but despite all the discussion of options few facilities have effected the change in the past few years.

The Advisory Board white paper published in 2004, "Navigating the Anesthesia Shortage" clearly recommends the increased use of CRNAs:

*#7 Integrated CRNA model leverages anesthesiologists, boosts physician revenues*

The most effective way to boost individual anesthesiologist productivity and income potential is by

using integrated CRNA teams. A fully leveraged team allows anesthesiologists to nearly double anesthesia revenues per hour of coverage. Successful implementation will necessitate overcoming several political hurdles, as many surgeons and anesthesiologists are opposed to integrated care teams.

While such categorical recommendations tend to support the position of proponents of the care team, they also give pause for thought to those who for a variety of historical and philosophical reasons have chosen not to work with CRNAs. It is one thing to say that a particular model has distinct financial advantages, but it is quite another to agree to the necessary transition plan; what is desirable in principle may actually be impractical in its execution.

Such observations and the inherently logical perspective that the leveraging of more expensive physician time over

less expensive CRNA time will reduce the overall cost of care has clearly conditioned the thinking of many a hospital administrator. Rare is the administration that does not ask the question, "Wouldn't more CRNAs reduce your need for financial support?" It is a good and important question. Unfortunately, the answer is not as simple or clear as the question would suggest.

As is always the case when the same service is provided in a variety of ways, the very diversity of delivery options tends to encourage a discussion of best practices. Historical preferences and cultural norms tend to prejudice an objective evaluation of the facts. Nowhere is this more evident than in the heated debate that has accompanied the revision and refinement of Medicare reimbursement for anesthesia in Washington.

The politics of clinical autonomy versus supervision and of anesthesia



reimbursement have pitted the Association of Nurse Anesthetists (AANA) against the American Society of Anesthesiologists (ASA) since the late 1970s. The year 1984 saw the implementation of the first set of reimbursement rules that would attempt to define the monies due the medically directing anesthesiologist and the medically directed CRNA. (The first step was fairly modest in that it carved a portion out of the physician's payment and redirected it to hospital CRNAs.) Before long the scope of the discussion would be expanded to include independent practice for CRNAs. The ensuing evolution and refinement of the Medicare payment system for anesthesia was anything but a smooth and orderly process. Certainly many anesthesiologists expressed profound concern in 1994 that splitting the allowable equally between the medically directing anesthesiologist and the medically directed anesthetist would undermine the value of physician anesthesia. Anesthesiologists were convinced that a reimbursement system that allowed the same level of reimbursement irrespective of whether the care was provided by a physician alone, a physician directing a CRNA or a CRNA alone would ultimately compromise the quality of care provided. Perhaps the jury is still out, but despite the dire predictions, the ratio of physicians to nurses has remained relatively constant and the quality of care, as measured by the rarity of adverse outcomes, continues to improve across the board.

Any issue viewed through the lens of politics becomes distorted. Battles fought in the political arena tend to turn more on sound bites and exaggerated claims than those in the board room. The AANA



contends that more extensive reliance on nurse anesthesia will allow for more cost-effective care without compromising quality. Unfortunately for the AANA, the facts simply do not support this argument. To put it another way, it is true that CRNAs tend to have lower salaries than anesthesiologists, but this does not mean that the cost of anesthesia care to the patient or the patient's insurance goes down when there is a higher reliance on nurses.

Surveys by a variety of organizations including the AARP tend to reflect the reality that to the extent that a patient understands the potential risks associated with anesthesia they prefer to have a physician involved. Whether patients fully understand the relationship between the anesthesiologist and the CRNA in the operating room is not the key issue; they simply want to know that they are in the best possible hands. There is no turning back the clock. Those hospital administrators and surgeons

who make such decisions no longer give much consideration to operating rooms without anesthesiologists. The operative question is simply can they afford the cost. The evidence supporting this view is borne out by current levels of hospital subsidy for anesthesia.

Politics notwithstanding, economic factors have a compelling way of influencing business decision-making. Economists are convinced that in a free and competitive market the forces of supply and demand will ultimately determine both how services are provided and what their value will be. The real economic question in medicine is to what extent a truly competitive market exists. Some would argue that medical economics are conditioned by a phenomenon known as supplier-induced demand which suggests that since providers of medical care have more knowledge of the options than patients, they unduly influence

*Continued on page 6*

# THE FUTURE OF THE ANESTHESIA CARE TEAM

Continued from page 5

decision-making. While this may have been true historically the government and insurance industry have taken the lead in outmaneuvering the provider in determining the true value of medical services.

The economics of anesthesia are actually quite simple. Since rates are set irrespective of the mode of delivery (personally performed versus the care team), then the most important consideration is not revenue potential but cost. This is where the analysis and the conclusions can vary dramatically from practice to practice. It is at this level that three factors must be considered: cost, productivity and profitability.

The calculation of the cost of anesthesia care begins with a basic assessment of provider compensation as defined by some unit of measure such as a case, an hour of care or a day of coverage. Given the level of compensation paid to each category of provider, it is relatively easy to establish the most cost-effective mode of providing anesthesia services. In fact, as the following examples clearly indicate, it is the ratio of total physician compensation to total CRNA compensation that determines when the use of CRNAs will reduce the overall cost of the service and when it will not.

Our analysis begins with the establishment of some assumptions for our baseline calculations. The following are based on the most recent MGMA compensation survey data for the country as a whole. The assumptions are then used to calculate per hour and per day costs per category of provider. For purposes of analysis we should note that in the baseline data the total cost of a physician is 2.3 times the cost of a CRNA. These costs include W2 compensation, benefits, malpractice and overhead costs.

Table 1

<b>ASSUMPTIONS:</b>			
Physician cost	\$420,000	CRNA Cost	\$180,000
Physician vacation (weeks)	6	CRNA vacation (weeks)	6
Physician hours per day	10	CRNA Hours per day	8

	<b>Physician</b>	<b>CRNA</b>
Cost per Day	\$1,900.45	\$814.48
Cost per Hour	\$190.05	\$101.81

(See Table 1).

Given these calculations we can compare basic staffing models and assess the impact of each option. Most practices will view these data through one of two lenses. Many will ask what level of medical direction is necessary to materially reduce the cost of anesthesia care. The answer is that the savings at a consistent level of 1 physician to 2 CRNAs is nominal. It takes at least three CRNAs for each physician to effect a meaningful cost savings. (See Table 2). Other practices that have revenue guarantees per anesthetizing location with their hospital will ask what level of coverage is necessary to meet the compensation expectations of the physicians. In other words, they will back into the cost per day calculations by adjusting the ratio of physicians to CRNAs.

It should also be noted here that it is the ratio of total physician cost to total

CRNA cost that has the greatest impact on profitability. The greater the delta between the two, the more the practice will benefit financially from a reliance on CRNAs. It also follows, then, that the lower the delta the less the potential value of the care team. Historically, this has explained the preference for physician only anesthesia in the West where physician compensation is lower as is consistently identified in MGMA compensation surveys.

Such calculations and the conclusions they appear to suggest raise a number of very significant questions. The first is why any physician, given this information would choose to personally provide care, and yet many do. The second is why don't all practices default to the highest level of medical direction allowed, which would be one physician to four CRNAs. Hospital administrators might even look at these numbers and ask why they need anesthesiologists at all.

Table 2

	<b>Hourly</b>	<b>Daily</b>
Physician alone	\$190.45	\$1,900.45
Physician directing one of two CRNAs	\$196.83	\$1,764.71
Physician directing one of three CRNAs	\$165.16	\$1,447.96
Physician directing one of four CRNAs	\$149.32	\$1,289.59

The answers to these questions speak to the complexity of the anesthesia market place and the other factors that condition such decisions. They are the real keys to predicting the future of the care team.

But if one were to look for examples of the market imposing a solution on an anesthesia practice, one need look no further than the Baylor Medical Center in Dallas. Having long supported independent anesthesiologists in a unique practice model called surgeon request, the administration has finally concluded that it does not really need to be in the business of employing CRNAs. In one fell swoop a contract was negotiated with Pinnacle, one of the nation's largest anesthesia groups to take over the entire practice and employ the CRNAs. It was one of those career altering events that could have been anticipated but which wasn't. It was also a good example of the truth of Nikita Khrushchev's observation that economics is not a discipline that respects one's wishes.

Clearly the specialty of anesthesia has evolved significantly over the past few decades. The complexity of anesthesia practice management has increased as individual practices have coalesced into

groups and mega groups. One might even suggest that the evolution has been from the 'I' to the 'us.' Various factors and considerations drove this process. Generally, they were practical, financial and cultural. In many cases, it took a hospital contract proposal or a managed care contract to force the change. As Peter Senge reminds us in *The Fifth Discipline*, medical decision-making is often subject to a lag. Information and insight takes a while to sink in and take effect. The management of anesthesia practices is fundamentally conservative and cautious. Organizationally, most anesthesia groups are actually structured to resist change and maintain the status quo. Changes do occur, but usually only after all other options have been exhausted. Many are the practices that have considered a change in staffing model, but few are those that have actually taken the next step to effect the restructuring.

The most obvious and practical consideration is the availability of providers. Certain markets such as California have thwarted the growth of CRNA care for so long that a decision to increase the number of CRNAs in a given practice will be difficult to implement. Any increased reliance on CRNAs must

presuppose a consistent standard of care.

Most physician-only practices simply do not have the infrastructure and management expertise to deal with the recruiting and human resource issues associated with the employment of non-physician providers. Many of the physicians in such practices also worry about the potential impact on retirement plan benefits if they change the mix of highly compensated employees. Clearly, these are not insurmountable challenges, but they do engender second thoughts about a fundamental restructuring of the practice.

There is also the issue of what happens to the down-sized physicians. Few shareholders are going to endorse a transition plan that marginalizes them. Conventional wisdom suggests that physician partners are tenured, while CRNAs are expendable. More often than not any potential changes in ratio of doctors to CRNAs must be based on attrition and phased in over time, which obviously diminishes the potential benefit.

An argument can also be made that a change in the structure of an organization that introduces non-shareholder employees will inevitably have a significant impact on the culture of the organization. Physicians who practice alone tend to assume that they are solely responsible for the care they provide, that their group practice is a confederation of equally committed providers, and that they never have to worry about what is happening in the room next door. They may not be willing or comfortable delegating decision-making to non-physician providers. Many anesthesiologists pride themselves on having chosen practices that are physician-only.

The result of regional approaches to anesthesia care has created unique cultures and patterns that tend to permeate the medical staff. Not only



## THE FUTURE OF THE ANESTHESIA CARE TEAM

*Continued from page 7*

do the anesthesiologists tend to have a preference for one model over another, but their preference has rubbed off on the surgeons. A CRNA in Jackson, Mississippi was once quoted as saying that the surgeons would never put up with having to deal with the anesthesiologist in the room all the time. She believed that the CRNAs were more responsive to the surgeons' needs. By contrast, of course, certain markets such as Las Vegas, Phoenix and Honolulu have evolved as a partnership between an individual anesthesiologist and a specific surgeon.

The focus and orientation of the specialty is changing. For much of its history, the evolution of anesthesia has focused on the mastery of pain, the pursuit of safety and the enhancement of the patient's surgical and obstetric experience. The administration of good anesthesia care is often described as both art and science. Committed practitioners have learned to create something magical in that crucible of experience defined by their skills, experience and insight, the requirements and expectations of the surgeon and the unique requirements, fears and concerns of each patient. The world is now coming to understand and

appreciate the powerful role of anesthesia in medicine. As the light shines in on the specialty, its practitioners are having to come to terms with the expectations they have created in the market. It is no longer enough to just have good outcomes, customers now want good service. They have bought the promise of a pain-free and pleasant surgical experience. Anesthesiologists and CRNAs no longer operate in a vacuum. They are partners in a service proposition. The time has come to deliver more than good outcomes. The means is now as important as the end.

It is time to revisit the three goals of an anesthesia practice: ability, availability and affability. They represent a new hierarchy of objectives: ability is now a given; availability a must and affability an essential survival skill. Each of these highlights different advantages and disadvantages of the care team. The Silver study supports the view that a team of providers is better equipped to manage unanticipated complications. The fundamental challenge of meeting a variety of coverage requirements may also suggest a team approach to the delivery of care. Nurse anesthetists may even play a critical role in enhancing the public face of the specialty. Achieving optimum results and good customer service is more a matter of commitment than means. Just as there is no one right way to deliver a safe and artful anesthetic, there is no one way to structure an anesthesia practice: form must follow function, and each function is unique. Just as anesthesia is an ongoing process of feedback and modification, so too, is the effective management of the successful practice.

So what can we conclude about the respective roles anesthesiologists and nurse anesthetists will play in the provision of anesthesia services in the

### States That Have Opted Out of the CRNA Supervision Requirement

- **Iowa** (December 2001)
- **Nebraska** (February 2002)
- **Idaho** (March 2002)
- **Minnesota** (April 2002)
- **New Hampshire** (June 2002)
- **New Mexico** (November 2002)
- **Kansas** (March 2003)
- **North Dakota** (October 2003)
- **Washington** (October 2003)
- **Alaska** (October 2003)
- **Oregon** (December 2003)
- **Montana** (January 2004 and again in June 2005)
- **South Dakota** (March 2005)
- **Wisconsin** (June 2005)

years to come? History suggests that change is inevitable. For some practices, change will come too quickly and as result of a combination of political, economic and social factors seemingly beyond their control. Others will seize the opportunity to shape their own destiny. They will be the serious students of the market who have mastered the tools of business management, whose environmental scanning is more finely tuned, and whose vision is focused not on what is but what isn't. There is no doubt that tough times test organizations in ways that they often do not want to be tested. One thing is for sure, though: anesthesia is an essential component to the success of any operating suite and hospital. The country needs reliably consistent, cost effective and customer-oriented anesthesia care. There is no one best solution, just many very good options. While the discussion of best practices was once considered a good idea, it is now an essential survival skill. ▲



# THE MODIFIED ANESTHESIA CARE TEAM MODEL

**Trevor P. Myers, M.D.**

*Dominion Anesthesia, PLLC*

*Arlington, Virginia*

As a single location group in the mid-Atlantic region, our practice relies heavily on the modified anesthesia care team model for financial success. While some larger practice management companies and anesthesia super-groups have predicted the death of “orphan” groups such as ours, we continue to thrive, in large part due to our focus on OR coverage models, a strong infrastructure including effective AR management, and a healthy relationship with our administration.

As discussed at the January 2009 ASA Practice Management Conference, our group focuses strongly on customer service, recently assuming a role as OR Director, remaining active with the medical staff, and generally carrying a high profile within the hospital. We have a consistent, healthy and ongoing dialogue with the hospital administration. This relationship is a key component to our success.

Historically, CRNAs have been employed in our facility for many years, both as hospital employees and as corporate employees, at various times. The transition of CRNAs from hospital employees to corporate employees began over a decade ago, with the reorganization of the previous anesthesia group into its current structure. Fortunately, we have a deep and talented pool of CRNAs, some of whom have tenure extending to decades at this facility. This level of experience is balanced by a steady influx of new CRNA graduates, who bring in their energy and



excitement. We share the financial success of the practice with the nurse anesthetists via a profit sharing and a year-end bonus system. This wealth sharing keeps the entire anesthesia care team interested in efficiency and turnover. The CRNAs work WITH us, not just FOR us. They are a key part of our practice, and we value them highly. As a result, we have an extremely high retention rate of our anesthetists, which is difficult in our area. We trust them not only with our patients, but with also with ourselves and our families when we inevitably become patients.

Our current focus on the modified anesthesia care team model really became acute about six years ago, when our facility underwent new construction, expanding the existing OR base by approximately 33%. While the hospital supported us financially until OR volumes matched staffed locations, we realized that we needed a deeper appreciation of the staffing-revenue balance. An exhaustive analysis of OR utilization, coverage models, reimbursement, growth projections, and cost structures led us to shift from

predominately anesthesiologist-only anesthesia coverage with a CRNA “kicker” to a modified anesthesia care team model with a denser CRNA coverage model. The hospital administration was active in supporting this transition, since they perceived this strategy to be a more cost effective model. This transition has taken the practice from well below the MGMA mean salary for our region to a more financially stable situation.

Currently, we run 18 anesthetizing locations on a daily basis, with a disparate case mix including cardiac, neurosurgery, healthy pediatrics, general surgery, orthopedics, ENT, and gynecology. We also have an active obstetrical service with 3500 deliveries a year. We provide anesthesia for 2-3 rooms in the gastroenterology suite daily, as well as various off site locations in the hospital (cath. lab, MRI, etc).

Typically, we cover rooms in a 3:1 CRNA:MD ratio for 9-12 of the anesthetizing locations, depending on the day. This ratio allows us to flex up to a 4:1 ratio in cases of emergency/add-on cases or flex down to a 2:1 model for labor intensive cases. While the CRNAs are working in the OR, the covering anesthesiologist has the opportunity to interview patients, place blocks or lines for the next cases, and cover any issues in the PACU that may need attention. The surgeons are also very appreciative of this staffing model, since they don't have to “wait on anesthesia.” While

*Continued on page 11*

# MGMA AAA 2009 CONFERENCE PROVIDES EXCEPTIONAL EDUCATION AND NETWORKING OPPORTUNITIES

By Brenda Dorman, MBA

*President, MGMA AAA; Executive Administrator, Department of Anesthesia & Perioperative Medicine,  
Medical University of South Carolina, Charleston*

It is my pleasure to announce that this year's MGMA AAA 2009 Conference will be held May 17-20, 2009 at the alluring InterContinental Miami on Biscayne Bay in Miami, Florida. For those who are new to anesthesia or have never attended this conference, it is the premier anesthesia practice management event. While we continue to offer sessions on Pain Management, this year we have created a new pre-conference program. Due to the popularity of our "new to anesthesia" forum offered in previous years, we've expanded that series to a full day pre-conference on Sunday, May 17<sup>th</sup>. These sessions will cover many of the issues unique to anesthesia that every new or seasoned administrator usually spends years learning! Physicians wanting to learn more about how their practice works and how their administrator keeps it running smoothly will also find this pre-conference enlightening.

The MGMA AAA Conference is attended by nearly 300 administrators, physicians, practice managers, billing service owners, consultants and others involved in advanced level anesthesiology and pain practice administration and provides an exceptional forum for networking and information exchange. In addition to presentations by nationally known speakers, the format offers roundtable discussions on issues of interest allowing people to meet others in comparable practices or with similar concerns. It also includes a number of social events that provide



additional networking opportunities. People who have attended this meeting over the years develop friendships that provide continuing networking support throughout the year. Come find out the "Down and Dirty" of anesthesia billing and reimbursement presented by two of our very talented members Cynthia Roehr, CPA (Linn County Anesthesiologists PC, Cedar Rapids, Iowa) and Marie Walton, CMPE (iMed Group, Houston).

On Monday morning, physicians who attend the conference are invited to join Dr. Stanley Stead, Chair, American Society of Anesthesiologists' (ASA) Committee on Economics, and other colleagues for breakfast. As in past years, this "physician only" informal networking event gives physicians an opportunity to discuss current topics and exchange information pertinent to their practices.

Our keynote speaker (special thanks to Anesthesia Business Consultants, LLC for their generous sponsorship of this event) is M. Tray Dunaway, MD, FACS, CHCO, president and CEO of Healthcare Value Inc. Dr. Dunaway is a nationally known speaker who will share with us his vision on connecting the "dots of healthcare" by applying his Mutual Value Integration model to improve communications and find the chemistry to make business solutions viable. Afterward, he will follow up with a humorous look at working relationships with physicians in a concurrent session entitled *Doctors are from Jupiter and You're From . . . Well, Actually, We don't Care Where You're From!*

In addition to these excellent speakers, many of whom are our own MGMA AAA members, roundtable discussions are moderated by members who facilitate discussion while attendees share their experiences on a variety of issues of common interests.

Social events are a perfect time to network with colleagues and catch up with friends and we offer many including breakfast, lunch and networking receptions. In addition, a special reception is held prior to the opening reception to allow first-time attendees an opportunity to meet people and start networking right away.

Each year we enjoy tremendous support from many key vendors of anesthesia services and products who are "on hand" as sponsors and exhibitors

during the breaks to demonstrate their offerings, answer questions and solicit feedback. *[Please visit the ABC booth to pick up copies of – or to subscribe in your own name to – the Communiqué and our companion publication, the regular Monday “Alert.” – Ed.]* The exhibit hall provides a great forum for comparison shopping and evaluating products your practice may need either now or in the future.

The InterContinental Miami, 100 Chopin Plaza, overlooks Biscayne Bay in the heart of Miami and is just minutes from South Beach, the Port of Miami,

Coconut Grove and Coral Gables. The hotel was originally built as a casino in anticipation of legalized gambling in Florida which never evolved. It boasts 641 redecorated guest rooms and suites and is an “oasis of sophistication and world-class service.” Miami itself is an incredible locale for our meeting. It offers brilliant beaches, fine dining, an exciting and diverse culture, world-class shopping, and a vibrant nightlife – what more could you ask for!

Act now! View the brochure to register, [www.mgma.com/AAA](http://www.mgma.com/AAA) or call

1-877-ASK-MGMA (275-6462) and request information. ASA members who sign up with their administrator who is currently an MGMA AAA member may attend at the member rate. There is also a special rate available for non-members to include purchase of their initial membership and obtain the membership price for the conference. Please do not hesitate to contact me at [dormanb@musc.edu](mailto:dormanb@musc.edu) should you have questions or need more information about the conference or any aspect of MGMA AAA membership. We hope to see you in May, 2009!! ▲

## THE MODIFIED ANESTHESIA CARE TEAM MODEL

*Continued from page 9*

a 4:1 coverage model is optimal for maximizing income, our physicians feel strongly that a 3:1 model allows us to provide a consistent level of anesthesia excellence while maintaining patient safety. Occasionally, we sometimes cover rooms at a 2:1 or even 1:1 ratio, if patient safety and circumstances dictate. If rooms are idle, the CRNAs are able to give each other breaks or complete other tasks that arise during the day. Off site locations (GI, Cath lab, etc.) and cardiac surgery are generally covered by anesthesiologists only, since the distance away from the main OR often makes it difficult to meet the “induction, emergence, and immediately available” requirements. At night, we have two CRNAs in house along with one anesthesiologist, keeping the reserve call team at home, since we can cover one OR case, plus any C-sections that might crop up.

The relationship between anesthesiologists and nurse anesthetists

has been tumultuous in some regions of the country, but we have been very successful in insulating our practice from controversy. By following a consistent model of anesthesia coverage based on compliance guidelines, we have established clear precedents for any physician or nurse anesthetist in our practice. There are no “cowboys” or “cowgirls” here, and any issue or difficulty is dealt with promptly and decisively. While we do have some physicians who prefer to do their own cases, we also have a solid core who find the multi-tasking nature of the anesthesia care team model challenging and invigorating. Personally, I find that meeting three times as many patients gives me that much more satisfaction, particularly if I’m doing a peds case in one room, an ortho case in another, and a GYN case in the third. Diversity is the spice of life, perhaps not in marriage, but certainly, in my anesthesia practice.

As CRNA salaries continue to rise beyond the rate of inflation, the anesthesia care team model must be continually reevaluated. In our area, the CRNA market is highly competitive, and falling behind on the financial package can lead to rapid and wholesale defections. We examine our budget quarterly and project expenses, revenue, and income out for at least two years. In the latest Practice Management update, projections indicate a surplus of CRNAs through 2020, and a relative shortfall of anesthesiologists, so perhaps the demographics will be on our side as time wears on.

Ultimately, for our practice at this snapshot in time, a modified anesthesia care team model is working beautifully. Our physicians are happy, our CRNAs are happy, the administration is pleased, and the surgeons want to bring cases to our hospital. Fortunately, that combination tends to be a financial win for all parties involved. ▲

# THE HISTORY OF INTERMOUNTAIN ANESTHESIA

By Robert Hague, CRNA

*Intermountain Anesthesia, P.A.*

*Idaho Falls, Idaho*

Picture this: a tyrant anesthesiologist who did not understand the significance of poor customer service and the impact of his ineffective communication, frustrated surgeons whose cases were randomly cancelled at the whim of said anesthesiologist with or without medical justification, and hospital administrators trapped in an exclusive anesthesia contract, who were feeling the pressure to increase surgical volumes and surgeon and patient satisfaction in hopes of avoiding the opening of a competing surgical center. For a sleepy town in the intermountain west, an anesthesia practice was on the brink of a business disaster.

At a small diner across from the local stockyard, an anesthesiologist and a CRNA met to discuss how to save their livelihoods. They identified long term group stability, clinical excellence, and aligned business incentives as the hallmarks of a successful anesthesia enterprise. On the back of a napkin in 1981, the framework was etched to create an innovative anesthesia practice owned by both anesthesiologists and nurse anesthetists. Aided by a young state senator (Idaho state law at the time did not allow incorporation of nurses with physicians) and a business start-up loan from a hospital administrator (sealed with a good faith handshake) Intermountain Anesthesia, PA was created. The initial group consisted of three anesthesiologists and seven nurse anesthetists.

Today, we believe that Intermountain Anesthesia, PA is well positioned for the economic and political constraints facing anesthesia practices. Aligned business incentives and resource utilization are



aimed to minimize non-unit producing activities while focusing on surgeon and patient satisfaction. This unique anesthesia care team structure allows for a significantly reduced operating cost per anesthetizing location.

Our current staff of five anesthesiologists and thirteen nurse anesthetists practices in a non-medically directed modality, billing for cases utilizing either AA or QZ codes. Functionally, two anesthesiologists facilitate pre-operative evaluations, manage operative coordination at the OR desk, and resolve issues with recovering patients while two anesthesiologists and ten nurse anesthetists provide services to our twelve anesthetizing locations. Each day as the surgical volume is completed group members leave for the day as operating rooms are closed. This process is completed utilizing an “off list” where the post-call members leave first followed by the call team for the following day, repeating until the call team consisting of one anesthesiologist and three nurse anesthetists remain.

Like most anesthesia corporations, Intermountain Anesthesia elects a President, Vice President, Secretary/Treasurer, and a Department Chair. Utilizing a board of directors, with equal representation of anesthesiologist and nurse anesthetists, all financial corporate

matters, clinical decisions with a fiscal impact, and disciplinary matters are discussed and reviewed. Income goals are evaluated yearly based on industry benchmarks and call burden. The board of directors proposed incomes and operating budget are presented to the entire ownership for approval. Once approved monthly payroll is simply a percentile function of the net monthly collection. This process, coupled with a revenue guarantee arrangement for our services, has enabled the group to very accurately predict incomes.

The future of anesthesia will most assuredly encounter economic and political constraints compounded by production pressures. An increase in government insured patients will have a devastating impact on overall payor mix. Additional pay for performance regulations will likely convert to deductions from reimbursements for failure to meet future performance benchmarks. Increasing costs of employee health, disability, and other benefits threaten recruitment and retention in most anesthesia practices. Surgical services demand is likely to continue to grow as the baby boomers require services while many providers reach the age of retirement. Hospital stipends to support anesthesia practices will likely decrease in frequency and value. All the while anesthesia societies continue to attack each other rather than finding solutions together to shore up gaps in reimbursement. Will your practice consider the innovative, collaborative, leveraged anesthesia care team to help meet those challenges? ▲

# THE TAXATION OF DISABILITY INSURANCE PREMIUMS

By **Stephanie J. Zvolenski, MBA**

*Financial Manager, Anesthesia Business Consultants, LLC*



Physicians — in fact most health care professionals — are diligent in the purchase of both short and long-term disability insurance policies to protect their personal income stream in the event of an accident or illness that may render them unable to engage in gainful employment.

Most people are selective about the types of policies that they choose, carefully considering occupation specific clauses as well as eligibility waiting periods for benefits, monthly income amounts payable by the policy and monthly premium costs. Few understand the tax implications both in the present and in the future of the payment of the policy premiums, however. Each insured has the option of remitting the monthly policy premium on either a pre-tax basis or a post-tax basis. A pre-tax basis means that the policy is paid either by the insured's employer directly to the carrier or as a benefit paid that ultimately decreases the insured's annual gross compensation by the amount of the monthly premium. A post-tax basis is defined as a net payroll deduction from the insured's monthly payroll or as a personal payment from the insured's monthly household budget.

As one would assume, if and when the insured should become disabled and need to cash in on the policy, the election of the payment method for the disability insurance premiums carries with it the taxation of those policy benefits. For example, if the insured elects to have his/her disability insurance premiums paid on a pre-tax basis either by his/her employer or through a decrease in annual gross compensation, then upon a determination of disability and distribution of the policy benefits any policy benefits paid to the insured will be treated as taxable income by the federal government subject to taxation at the insured's then tax rate. On the other hand, should the insured elect to pay the policy premiums with post-tax dollars, e.g. through a net payroll deduction or as a personal payment from the insured's own bank account, then upon

distribution of the policy benefits at the time of declared disability, the insured will receive those benefits free of taxation.

The decision to pay the policy premiums on either a post-tax or a pre-tax basis is most often at the sole discretion of the insured, unless the disability insurance policy is offered as a group plan by the insured's employer. In the latter case, the employer may have specific policies relating to the taxation of the payment of the policy premiums. If the decision to treat these premiums on a post-tax or pre-tax basis is left to the insured, considerations regarding other income sources, age, and tax status should be considered. Ultimately, insured individuals should seek the guidance of their personal financial advisors before making the decision.

Often, people find it necessary to change the tax basis of the payment of these premiums. For example, as one ages it may become more advantageous to pay one's disability insurance premiums on a pre-tax basis, making them taxable upon distribution. A person early in his or her career may be more inclined to pay these premiums on a post-tax basis enjoying a tax free benefit upon distribution. Again, this decision can and should only be made based upon the considerations of future earning capacity, years to retirement, other income sources, etc.

Although it is not impossible or even difficult to make changes to the tax basis upon which one pays his/her disability insurance premiums, it must be understood that the Internal Revenue Service (IRS) is very specific regarding the taxation of the distributed benefits when there has been an inconsistent method of tax basis payment of the insurance premiums. The IRS utilizes a three-year look back rule for group insurance policies purchased with both employer and employee contributions when making a determination as to how disability insurance payments should be treated from a tax perspective. The IRS has

determined that the taxation of disability insurance payments will be determined by the pro rata calculation of the method in which the premiums were paid in the prior three-year period. For example, if the individual becomes disabled in 2009, the IRS will consider all distributions to be tax free provided that the disability insurance premiums for 2007, 2008 and 2009 were paid on a post-tax basis. However, if the premiums for 2007 were paid on a pre-tax basis and the premiums in 2008 and 2009 were paid on a post-tax basis, the IRS will treat one-third (1/3 or 33.33%) of the individual's monthly distribution as taxable and the other two-thirds (2/3 or 66.67%) will be received by the insured tax-free.

The IRS does offer an alternative to the three-year look back rule. Each individual may make an irrevocable annual written election for the tax basis treatment of that year's disability insurance premiums. Based on that irrevocable written election, any disability insurance distributions received will be taxed or not taxed dependent upon that election. The intent of the irrevocable election is to prohibit those who were not deemed disabled during the policy period and who paid the respective disability insurance premiums on a post-tax basis for the entire year from changing the payment method to a pre-tax basis at year-end.

The taxable portion of benefits paid by an individual disability insurance policy purchased with both employer and employee contributions is determined by the ratio of premiums paid by the employer to the total premiums for the current policy year.

Disability insurance is an extremely important benefit for physicians and all health care professionals. The tax treatment of the insurance premiums and the associated distributed benefits are also vitally important to one's personal finances. It is advisable that you confer with your personal financial consultant before making any elections regarding the tax treatment of your monthly disability insurance premiums. ▲

# AVOIDING PITFALLS AS PRACTICES MOVE TOWARD THE ANESTHESIA CARE TEAM MODEL

By Jackie Popiela

*Vice President of Client Services  
Anesthesia Business Consultants, LLC*

Much like the average American consumer, many anesthesia practices are finding ways to survive in today's tough economic market. There are any number of external forces influencing many anesthesia groups to join the growing trend of practices that have decided to consider the Anesthesia Care Team model for the first time. These practices are currently feeling the pinch due to decline in hospital based cases, payor mix increasingly shifting toward higher governmental payors or self-pay. In many cases there are added pressures due to increased hospital subsidy, improved OR efficiencies and addition of service lines as hospitals struggle to maintain their ground.

Before a practice actually makes the transition to the Anesthesia Care Team model, it is imperative that the first step be communication with the hospital. Some groups have actually remained in

the physician-only model simply because hospital by-laws did not allow for other qualified anesthesia personnel to practice within the hospital. Many of these same groups are finding it increasingly difficult, if not impossible, to retain and recruit physicians given the current market climate. There is the general sentiment that the surgeons would balk and take their cases elsewhere or that the hospital simply does not understand what CRNAs are. If the group is presenting the concept of adding CRNAs into the practice, approaching the hospital first to make changes to their current by-laws may be presented in such a manner that it is viewed as fostering a true partnership with the Group. Initially, the onus of educating the hospital will be placed on the Group. The Group should be prepared to provide information on CRNA education, scope of practice and medical direction guidelines and it is

important that the Group have access to the latest information regarding Medicare regulations governing medical direction. Often, the hospitals will make revisions to the existing by-laws to include other qualified anesthesia personnel (CRNAs, AAs) but may limit the medical direction to a 1:3 ratio.

For Groups that are receiving a subsidy from the hospital, this is the perfect segue into discussions of the overall impact of opening additional ORs or adding additional lines of service such as OB or cardiac coverage. One can argue that the anesthesia care team model is not only more cost-effective but will also allow the Group to meet the increased coverage demands. There are various staffing models that can meet the needs of the hospital, surgeons and anesthesia providers. Having OR utilization information based on anesthesia productivity as well as the hospital figures can provide a more complete picture of overall staffing needs. After the CRNAs have been integrated into the schedule, is also important to revisit utilization reports to ensure that the proper ratios are maintained to maximize staffing either within the anesthesia department guidelines or per hospital by-laws.

Certainly the choice to migrate toward a new model of practice comes after much consideration and with its own set of philosophical and cultural challenges. One of the greatest cultural challenges after the hospital agrees to accept the addition of CRNAs



is convincing surgeons that their patients will still be adequately cared for. This is also another opportunity for communicating with the hospital and partnering with the medical staff. Through education and proper planning, this may develop into a win-win situation for the surgeons as well.

Glenn Malmberg, Practice Administrator for Toms River Anesthesia Associates in Toms River, NJ recently addressed this issue when his primary facility agreed to include CRNAs into their medical staff for the first time in the hospital's history. Mr. Malmberg states, "A surprising success was acceptance by the surgeons. We anticipated acceptance by surgeons would take a period of time and (had) developed strategies to address the potential problem. However, acceptance by many surgeons occurred rapidly and the problem we anticipated has not occurred". One of the strategies that may be taken is to initially place CRNAs in ORs which are staffed by surgeons who may be more accepting of the care-team model approach. Once there are established successes and surgeons are comfortable with the CRNAs, this will lead to further acceptance from the surgical staff.

The surgeons are not the only medical staff who may need to be convinced of the benefits of adding CRNAs to a practice. On more than one occasion, there may be some members of the anesthesia group who need to be won over. A similar strategy may be employed within the group. There may be anesthesiologists who were accustomed to working with and medically directing CRNAs either in a previous practice or during training. These are the physicians who should initially be charged with medical direction of the new CRNAs. These physicians can also be key in running interference between the CRNAs and medical staff. If the information and support is coming directly from a colleague, this may help to allay misconceptions and misinformation.

Once the anesthesia group has identified and addressed the possible philosophical differences, cultural and clinical impacts of including CRNAs in practice, the next steps are where and how to start recruiting for these CRNAs. When Mr. Malmberg began recruiting for CRNAs on behalf of the group, he was able to use the fact that this was a new position as a selling point. According to Mr. Malmberg, "We learned to emphasize the advantages of getting in on the ground floor such as helping to develop the program and the opportunity for leadership positions as the program grew." It was important that the group find the right individual and they focused on experienced CRNAs with strong leadership skills. These first pioneers need to be more than clinically skilled; they must also be astute enough to address concerns that surgeons may have and handle these issues with finesse and in a spirit of education and partnership. This particular group chose to hire CRNAs as employees, while there are other groups who choose to work with staffing agencies initially.

Dr. Jennifer Baxter is the CFO of Surgical Anesthesia Associates in Washington D.C., a practice that successfully integrated CRNAs within the past year. Her group chose not to hire the CRNAs initially, but instead they used agencies to assist in meeting their staffing needs. Whether groups choose to use agencies or hire the CRNAs as employees, Dr. Baxter warns that the provider enrollment for CRNAs needs to be a priority and the impact of possible delays in collections needs to be monitored closely. As with hiring a new physician, it is important to obtain as much of the provider enrollment information as soon as the group has offered a position to the CRNA. When utilizing an agency, many times the agency is able to provide this information prior to the CRNA's provision of services.

Another area where changes will need to be made is with documentation. The physical record will need to be revised to meet the documentation requirements for medical direction. For groups that are currently utilizing an Electronic Medical Record (EMR), programming changes may be necessary to include such criteria as the seven steps of medical direction and to account for additional hand-offs. If the group is using a paper record, it is important to factor in the time necessary to obtain approvals from Records Committees.

Education for anesthesiologists and CRNAs on proper documentation will ensure not only that all billable procedures are captured, but also that the group meets compliance requirements. Mr. Malmberg and his Group had access to several anesthesia industry experts through his group's partnership with Anesthesia Business Consultants who not only assisted in providing revenue-impact analyses but also held physician and CRNA education in-services. If possible, informing the hospital that there are in-services to ensure documentation and medical direction compliance also serves to illustrate that the group strives to maintain top-quality standards in all aspects of anesthesia services. The emphasis should be on the anesthesia care TEAM.

The groups who have included CRNAs into practice successfully did not do so overnight. There was certainly lengthy planning, many hospital meetings to attend and often, the most difficult hurdles to overcome were internal to the anesthesia groups. The key to success was both communication and information. It is important to anticipate the difficulties and to plan accordingly. Being able to provide relevant and valuable information quickly also speaks to the commitment of the group toward achieving a seamless assimilation into the group and evolution from physician-only to anesthesia care team. 

# Compliance Corner

*As part of our desire to keep both clients and readers up to date, the Communiqué has been printing compliance information since its inception. In the Compliance Corner, we will now formally keep you abreast of the various compliance issues and/or pick out a topic that would be of interest to most of our readers.*

## THE “CARE TEAM” BILLING RULES

By Hal Nelson

Director of Compliance  
Anesthesia Business Consultants, LLC

Most people know the seven documentation requirements for medical direction (presence at induction-emergence, immediate availability, etc.), but how many understand the nuances of billing for a care team service? The information below provides a guide to navigating through this challenging issue.

### Residents

An attending anesthesiologist overseeing a single resident bills using the -GC modifier with payment at 100% of a personally performed case, as long as the CMS teaching physician guidelines are met. An alternative CMS billing rule involves the oversight of two concurrent resident cases. Here the attending anesthesiologist can oversee two residents at once and bill for the full base units of each case, while only billing for the time that the physician was present in each of the rooms respectively. In this scenario, the physician would bill using the -GC teaching physician modifier on each case, just as an attending would bill for a 1:1 resident case, only with abbreviated minutes (in-room time only) in each of the two concurrent rooms. Billing using this methodology requires meticulous documentation, as discontinuous

time needs to be documented on the anesthesia records throughout the duration of each case. The CMS teaching physician requirements also need to be met in this scenario. Minor surgical procedures performed by a resident (lines, etc.) can be billed out under the attending anesthesiologist, but only if the anesthesiologist documents physical presence during the entire minor surgical procedure. Medical direction of more than one case (involving any combination of residents, SRNAs, AAs or CRNAs) can be billed out by the anesthesiologist with the -QK modifier and payment is 50% of the personally performed rate in each case. The hospital does not receive a professional payment for any resident service, but is instead paid indirectly through the Graduate Medical Education (GME) program.

### Student Registered Nurse Anesthetists (SRNAs)

Medical direction of a SRNA is limited by CMS to a maximum of 2 concurrent cases (at least one involving a SRNA). The ASA recently issued a position paper that suggests not exceeding a 1:1 ratio with a SRNA. A 1:1 Anesthesiologist/SRNA concurrency ratio



is billed out by the anesthesiologist with the -AA modifier and is paid at 100% of the personally performed rate per CMS. 1:2 ratios are billed out as medical direction by the anesthesiologist with the -QK modifier, and payment is at 50% of the personally performed rate to the anesthesiologist in each case. SRNAs are ineligible for billing purposes, and receive no direct payment from insurance. There is no specific CMS rule addressing minor surgical procedures (lines, etc.) performed by a SRNA under the oversight of an anesthesiologist. Payment is left to the discretion of the individual insurance carrier in this scenario.

### Anesthesiology Assistants (AAs)

AAs are utilized in care team environments most frequently in areas where there are Anesthesiology Assistant programs offered, such as Georgia, Ohio, Missouri and Florida. Unlike CRNAs, who are permitted to perform non-medically directed anesthesia, AAs cannot. Anesthesiology Assistants must be medically directed and payment is at 50% of the personally performed rate to both the Anesthesiologist and the AA. For billing purposes, the modifiers submitted are -QK and -QX respectively.

### *Certified Registered Nurse Anesthetists (CRNAs)*

CRNAs have multiple billing options when providing anesthesia. A anesthesiologist medically directing a single CRNA case is billed out with the -QY/-QX modifiers respectively, while an anesthesiologist medically directing multiple CRNAs cases is billed out with the -QK/-QX modifiers. In both scenarios,

payment is at 50% of the personally performed rate to each provider. A medically supervised case involving an anesthesiologist and a CRNA is billed out with the -AD and -QX modifiers respectively and payment is limited to 3-4 total units to the anesthesiologist per CMS (4 units if documented presence at induction). The CRNA is still paid at 50% of the personally performed rate

in this instance. CRNAs who perform non-medically directed anesthesia, most commonly seen in one of the “opt-out states”, are billed out with the -QZ modifier under the CRNA’s name and payment is 100% of the personally performed rate. Some Medicare carriers have also endorsed the -QZ modifier for “incomplete medical direction” when the group employs both the anesthesiologist and the CRNA. 

## Coding Corner

### ICD-10: 2011

**SHARON HUGHES MBA, RHIA, CCS**  
Senior Director of Coding and Auditing  
Anesthesia Business Consultants, LLC

The proposed rule to modify the medical data code set standards by adopting ICD-10-CM (Clinical Modification) and the ICD-10-PCS (Procedure Coding System) was released on August 15, 2008, (and published in the Federal Register on August 22, 2008). The proposed rule anticipates a compliance deadline of October 1, 2011 (the start of Federal Fiscal Year 2012). CMS will probably make the compliance date coincide with the annual Medicare inpatient PPS updates. (A single compliance date will reduce confusion in processing claims and analyzing data.

A separate proposed rule calls for the adoption of an updated version of current Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards. This transition to the newer version of the HIPAA transaction standard must be completed by April 1, 2010, 18 months ahead of the ICD-10 implementation.

Implementation could happen earlier. Two years is the estimate for hospitals and other facilities to prepare to implement ICD-10 from the publication of the final rule. Under section 1175 of HIPAA, the earliest date CMS could implement ICD-10 could be 180 days after the issuance of a final rule, which is expected *before the end of 2009*.

CMS has recommended that health care organizations begin to document required changes for the transaction standard as early as September 2008, including initiation of education to begin by December of this year. It is time to prepare for the changes with regards to budgetary, training and information system implications for the administrative, clinical and financial departments. Improving medical record documentation practices is a tangible benefit that is gained even with the ICD-9-CM system but will be necessary for the new system.

Physicians, home health agencies, skilled nursing facilities, and post acute care settings will be affected by the change to the ICD-10-CM only. ICD-10 has approximately 68,000 diagnosis codes and 87,000 procedure codes compared to the 13,000 diagnosis and 3,000 procedure ICD-9-CM codes. The diagnosis codes each have three to seven alphanumeric characters, compared to ICD-9 which has two through five numeric digits with the exception of V and E codes where the first digit is alphabetical.

Undertaking design and system changes for compliance with the Version 5010 transaction standards must accommodate the increase in the size of the fields for the ICD-10 code sets. During the transition period, information systems software will have to support the ICD-9-CM as well as ICD-10-CM and the ICD-10-PCS coding systems potentially requiring additional data storage space. Even though data storage space is not as costly as it once was, it may be easier to run a report in the ICD-9-CM and a separate report in

ICD-10-CM and/or ICD-10-PCS, and then to add up both reports manually.

### DOMAIN REFERENCE MAPPING

CMS has released updated domain reference mapping between the two coding systems to facilitate the linking between the procedure codes in the ICD-9-CM volume 3 and the new ICD-10-PCS code set. The General Equivalence Mappings (GEMs) are formatted as downloadable “flat” text files. The file contains a list of code pairs. Documentation and a user’s guide are available online at: [www.cms.hhs.gov/ICD10/Downloads/pcs\\_gemguide\\_2008.pdf](http://www.cms.hhs.gov/ICD10/Downloads/pcs_gemguide_2008.pdf).

This guide will give you information regarding the structure and relationships contained in the mappings to facilitate correct usage. The intended audience includes but is not limited to professionals working in health information, medical research, and informatics.

Sections 1 and 2 will benefit clinical and health information professionals who plan to directly use the mapping in their work. A glossary is also available of the terms and conventions used in the mapping along with their accompanying definitions. Software engineers and IT professionals interested in the details of the file format will find the information in appendix A. Appendix B contains a table listing of the new I-9 procedure codes and their corresponding entries in the I-9 to PCS GEMs.

Also, check out this Sample ICD-10 Superbill which may be found at the following link: [http://www.cms.hhs.gov/ICD10/Downloads/Sample\\_superbill\\_icd10.pdf](http://www.cms.hhs.gov/ICD10/Downloads/Sample_superbill_icd10.pdf)

# PRACTICE GOVERNANCE IN RELATION TO ORGANIZATIONAL LIFECYCLE

By Paul Kennelly, MBA

*Regional Director of Practice Management, Anesthesiologists Associated, Inc.*

Ruth Morton, PhD

*Vice President of Administration & Organizational Development, Anesthesiologists Associated, Inc.*

Many practitioners believe that organizations go through stages of life not dissimilar to the stages in the lifecycle of living organisms. Various conceptual frameworks identify these lifecycle stages within small and large groups, and companies of all sizes and industries.<sup>1</sup> Do any of these frameworks apply to physician practices, and specifically, do anesthesia practices go through somewhat predictable (and perhaps repetitive) patterns of behavior as they grow and develop? And what impact do changes have on the maturity (or stage in the lifecycle) of a practice? We believe these questions are worthy of exploration, and that application of the concept of organizational lifecycle holds potential for informing choices about practice governance.

## ORGANIZATIONAL LIFECYCLE STAGES<sup>2</sup>

**The Dream or Idea (Conception)** – A time of imaging and planning by the founders, often based on a vision of a service or product or market potential. There may or may not be a demonstrably effective product, but there is energy and desire while the organization is “in utero”.

**Launching the Venture (Birth and Infancy)** – With the energy of the founders, the dream or idea coalesces enough to take form – to become a start up. The venture is small and changing rapidly, very flexible but not independent of considerable energy and support to keep it going. Things get done in whatever is the easiest way – with few policies, procedures, or structure,

although the entity starts delivering its product or service. Sacrifices may have to be made to keep it alive, although energy and creativity may be high, as in most entrepreneurial ventures.

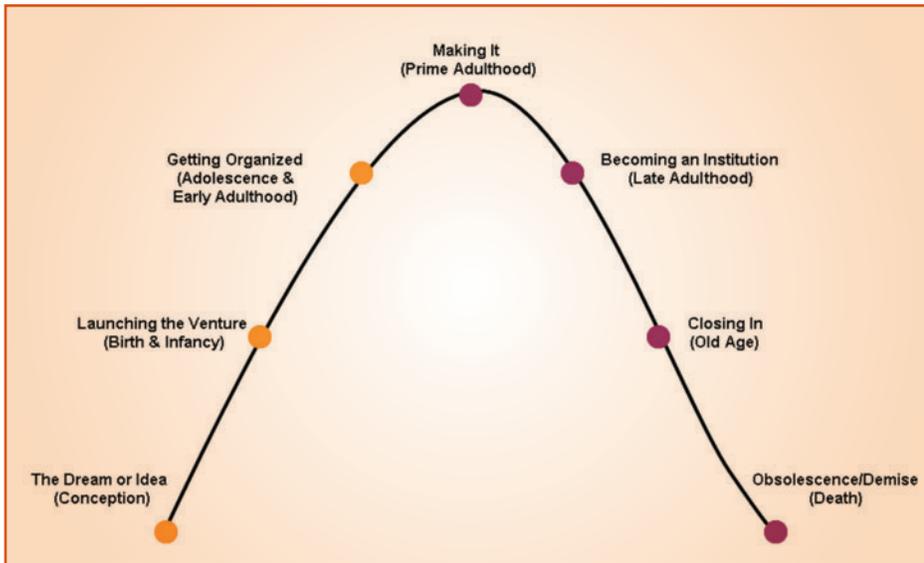
**Getting Organized (Adolescence and Early Adulthood)** – The energy of the founders is not enough to sustain the entity and its commitments. Roles become more specialized, financial controls are established or refined, policies are developed more clearly, communication channels are put into place, and it is establishing itself in the marketplace. Form and structure coalesce to help the organization operate more effectively on its own.

**Making It (Prime Adulthood)** – If the organization is successful in getting organized it moves into its own. It starts to reap the benefits of delivering its goods or services through established relationships. It has a positive reputation in the marketplace. It may successfully grow in size and profits due to its responsiveness to meeting needs and ability to deliver quality services. Importantly, it has a balance between flexibility and controls.



<sup>1</sup> Two such frameworks were developed by Ichak Adizes in *Corporate Life Cycles* (1988) and William Bridges in *Surviving Corporate Transition* (1990) and *The Character of Organizations* (2000).

<sup>2</sup> Adapted from the work of William Bridges, *Surviving Corporate Transition*, 1990, and Ichak Adizes, *Corporate Life Cycles*, 1988.



**Becoming an Institution (Late Adulthood)** – Reputation is a given, or assumed. The focus subtly shifts from externally oriented to more internally oriented, with energy directed to how things ought to be done, and who fits in and who does not. Flexibility begins to wane. Responsiveness to external changes and shifts in markets lessen. Profits may still be high.

**Closing In (Old Age)** – May grow as an outcome of self-satisfaction, continued success, and little competition from the outside. The entity turns even more inward, often with internal focus on status and rules, with less connection between the organization and its environment. The organization is sluggish in responding to change in its marketplace and displays rigidity in its processes and behaviors. Yet it can be kept alive by “life support” or a monopolistic position.

**Obsolescence / Demise (Death)** – No longer viable, organizations at this stage may go out of business, operate with only minimal staff and a diminished product, file bankruptcy, or get acquired or split up. The identity of the organization barely or no longer exists.

From reviewing the lifecycle stages adapted from Bridges and Adizes one can see the stages that an anesthesia practice potentially experiences. Thinking of the practice in organic terms can help understand the lifecycle concept and some of the “growing pains” the practice experiences. At each stage in this developmental process an organization is faced with a unique set of challenges or problems to overcome. These arise from the growth and success of the practice and from external changes in markets, competitors, technology, payors, and regulatory entities. However, it is important to realize that practices are not entirely “organic”; the practice has some control, through its decisions and actions, over how successfully it enters (or not) the next stage, and how long it will dwell in any given stage. The role and impact of group leadership appears to be a considerable factor in determining the health of movement through the lifecycle.

**What causes a practice to move from one stage to another?** External changes that impact the practice (i.e. hospital changes, payor shifts, new regulations, economic downturn) or changes within the organization (i.e. new president or

board, retirement of longstanding key members) can move the practice from one stage to the next. Although this may seem fairly intuitive, organizations frequently are caught short in planning for and responding to change. This is due to the potential delay between the change and its effects on the organization. For example, the precipitating event can be sudden such as an abrupt change in staffing or it can be slow such as longer and longer delays in reimbursement from payors. Additionally, the effect of change varies depending on where the practice is in its lifecycle. For example, delayed reimbursement may have a more severe and rapid impact on a newly formed practice than one which is established and in its prime. Another factor to consider is if the event or issue is internal or external in nature. An internal factor such as a change in the group’s compensation plan demands a certain approach while an external issue such as a state budget crisis delaying reimbursement requires a different approach. How change is addressed weighs heavily on the governance structure and approach selected.

It wasn’t too long ago when many anesthesia practices would probably have been considered established and stable. But recently the landscape is littered with anesthesia groups that have fallen apart (Death) because of conflict among the members or with their hospital. Typically these groups are reconstituted, often times with many of the same members of the old group but with one important difference — a new sense to “make things right” with the hospital (the Dream or Idea). In such a situation, one could easily see the need for a different governance approach. What may have been seen as an entrenched, inflexible approach (more typical of “closing in” stage) to the hospital must change to one favoring collaboration and service (often typical of “making it” stage). Governance

## PRACTICE GOVERNANCE IN RELATION TO ORGANIZATIONAL LIFECYCLE

*Continued from page 19*

within a newly formed group (launching the venture) may be held by a small group who are more entrepreneurial in their thinking and who favor a customer service approach to the hospital and surgical community.

Following the start up phase, a practice begins to address the need to have processes and standards. Issues such as benefits, compensation plans, equitable call scheduling, and quality measures, begin to surface and the need for the entrepreneur gives way to the “organizers”. The “idea” people may no longer be the best candidates to lead the organization as the need to refine structure and solve organizational issues intensifies. Governance that focuses on issues of structure, processes, and communication is most appropriate for a group in this stage of “Getting Organized”.

A practice that is in its “prime” enjoys a sense of wellbeing and security. The group tends to be at peace with its hospital(s) and may play an active role in managing the operating room. There is a balance between those in the group who are income driven and those who are life-style driven. Staffing issues are minimal and the group is the “provider of choice” as new anesthetizing sites develop. Life is good. Practice governance displays a balance between flexibility (creative ideas, open to new markets and products, engaging members in committees and decisions) and controls (consistent application of policy, strong communication among members, clarity of processes and decision-making, strong oversight of revenue cycle). Groups who recognize the dynamics of the marketplace and the precariousness of being satiated will elect leaders who retain a healthy sense of reality and who can walk the fine line between alarmism and naiveté.



But what of the mature practice (Becoming an Institution) — how does change affect its governance? Mature practices tend to have a solid presence in the community and may have little or no outside competitive threat. They have become an institution, may be large, and have providers that fall along the entire practice spectrum from those early in their career to those who now contemplate retirement. Maintaining a competitive advantage in balance with the diverse needs of the group’s members becomes a major point of emphasis. Managing quality of life and work ethic issues magnify as the practice grows. In many respects this can be a vulnerable time for a practice. There is little sense of urgency and the prevailing thought may be to leave well-enough alone. For the leadership, however, it should be a time of careful introspection and evaluation. A sudden change in hospital administration, the addition of an

overly-demanding surgeon, the loss of a high volume surgeon, the departure of a member(s) of the group, or an outlier shareholder who thinks cases are not distributed equally — are all examples of transitions that might shake the practice from this sense of well being. Suddenly the “organizer” yields to the “visionary” who can see the big picture and who can appease the multiple stakeholders affecting the practice. This is also a time when the practice must guard against becoming entrenched and difficult to deal with lest it hasten its own demise and death. Threats often come from within the practice as much as from forces external to the practice.

### **What can a practice do to prepare for the inevitable transitions that come from and evoke shifts in the organizational lifecycle?**

First, recognize and acknowledge that change is going to happen, and that it is a natural occurrence. The only place where change does not happen is in death. Groups that admit organic internal and external change will confront them (maybe even welcome it) and who plan for it are far better positioned to succeed than those who fail to accept organizational change.

Second, another important area to address is the group’s corporate documents such as bylaws, shareholder agreements, and employment contracts. A regular review of the governing documents to ensure they are current with state and federal law as well as guarantee practice leaders flexibility to deal with contemporary issues is an important part of maintaining organizational health and keeping it in its prime.

A third element is developing and nurturing a strong sense of trust.

Some anesthesia groups lack a sense of collaboration and joint problem solving skills. These practices are a loose coalition of providers who operate more in terms of individual needs rather than organizational needs. In such groups trust is often at a premium and concerns that the leadership will not perform in the best interest of the group is common. To cultivate the public trust of its members, and to address problems / challenges that the group faces, an anesthesia practice must promote a cooperative and “greater good” mentality if it hopes to sustain itself. To be sure, some groups have members who revel in working in a fashion that emphasizes the individual rather than the group and the concept of working “*in the best interest of the organization*” may be subject to wide interpretation. Unless the practice has the political will and leadership fortitude to address this public trust issue, it will surely flounder when external change challenges the norms and stability of the practice.

Ichak Adizes, an international figure in lifecycle management, tells us:

Leading an organization through lifecycle transitions is not easy, or obvious. The same methods that produce success in one stage can create failure in the next. Fundamental changes in leadership and management are all required, with an approach that delicately balances the amount of control and flexibility needed for each stage. Leaders who fail to understand what is needed (and not needed) can inhibit the development of their companies or plunge them into premature aging.<sup>3</sup>

For anesthesia practices, planning for change and recognizing the need for a flexible governance model means strategic planning and decision making. Planning is not just about growth or revenue streams — it involves those economic considerations, but it also

embraces an introspective look at the practice, its hospital, and primary market. It evaluates the organization’s strengths and honestly assesses the flexibility of its leadership structure. The issues facing health care are significant: the renewed debate on national health reform, the recession, the emergence of pay-for-performance, the increased shift of financial responsibility to the patient, staffing issues, higher expectations of service to the hospital, surgeon, and patient are all real factors facing anesthesia practices today. A practice must adjust to a rapidly changing environment by altering its governance structure, ensuring that it is appropriate not only to its environment but to its own developmental needs.

#### Your Practice?

As you reflect on the history of your group, are there issues or challenges that, in the context of lifecycle, can be more fully understood? Currently, in what stage of its lifecycle is your practice? Are there stage-related events or problems to be addressed? Does your governance body and structure need to change to reflect developmental needs of your group? These are a few of the questions that we hope this article has caused you to ask yourself. ▲

If you have comments, questions, or needs on matters related to this topic, we invite you to contact us:

rmorton@aai-office.com  
503.372.2789 or  
pkennelly@aai-office.com  
925.949.2318

#### Insights on the Nature of Problems in Practices<sup>4</sup>

Problems are normal and desirable. Problems are the natural result of change. The only place on the lifecycle curve where there are not problems is the place where there is no change, which is Death.

Your role as a leader is not to prevent problems or slow the pace of change. Instead, focus on accelerating your (practice’s) ability to recognize and resolve problems. Your ability to work together as a team and quickly tackle any and all situations, or decide not to, is your ultimate competitive advantage.

Some of the problems you face are normal and some are abnormal. Normal problems are those that are expected for a given lifecycle stage. Abnormal problems are those that are not expected (or desirable) in a stage of the lifecycle.

You can drive your (practice) faster when you know the road ahead. Most of the issues you face are common. . . You can save time and effort by understanding the nature of stages in the lifecycle and knowing what it will take to transition from one stage to the next. If you share a common understanding before problems arise, it will help you attack the problems, instead of attacking each other.

Prime is the Fountain of Youth for (practices). One key difference between the lifecycle for human beings versus organizations is that living things inevitably die, while (practices) need not. The “age” of a (practice) is not related to its chronological age. Instead, the lifecycle is defined by the interrelationship between flexibility and control. In Prime a (practice) has achieved a balance between control and flexibility . . . knows what it is doing, where it is going, and how it will get there. Once a (practice) reaches Prime, leadership must work to sustain that position.

<sup>3</sup> [www.adizes.com/corporate\\_lifecycle\\_overview.html](http://www.adizes.com/corporate_lifecycle_overview.html)

<sup>4</sup> Excerpted and adapted from *ibid.*

# RE-ASSESSING ANESTHESIA GROUP ADMINISTRATION AND DECISION-MAKING PROCESSES

By **John T. Mulligan, Esq.**

*McDonald, Hopkins, LLC  
Cleveland, OH*

From time to time anesthesia groups find that they need to reassess their administration or decision-making processes. This can involve everything from tinkering with how routine day-to-day administrative activities are carried out, to totally revamping the group's governance structure.

Reassessments can come about for a variety of reasons. There may have been a significant growth in the number of physicians or CRNAs, or an increase in the number of practice locations. The group may have encountered internal strife without adequate governance systems in place. The group may find itself incapable of making decisions or reaching consensus in a timely or efficient manner. A group may have relied too heavily upon busy physicians to carry out non-clinical duties, or one physician may (by choice or otherwise) be overburdened with administrative responsibilities.

**Issues in a Small Group.** One of the assumed advantages of a smaller group is that it can function in a "more efficient" manner. However this can be negated by an excessive number of decision-making layers. Anesthesia groups often function through a legal entity such as a corporation or a limited liability company including shareholders/members, directors/managers, and officers.

An issue that comes up regularly in the context of a small group involves the physicians having to remember which decision-making "hat" ("is this



a 'shareholder' or a 'Board' decision?") they are wearing. An alternative that is available under the laws of many states is to eliminate the Board of Directors and have the shareholders function as the Board. If your group does so, make certain that you understand the full implications of the change under your state's laws. As an example, there may be implications with regard to the giving of, or the content of or notice of meetings.

Smaller groups often concentrate decision-making in one or two persons. While a case could be made that the 'wise benevolent dictator' is the most efficient governance structure, not all dictators are either wise or benevolent. At the other extreme, a rotating presidency which periodically results in persons occupying leadership positions who possess neither the desire nor the ability to lead will also cause problems. At the risk of oversimplifying the matter, the best system is the one that works for your particular group at a particular time.

Whether a system for both making and implementing decisions is "working" depends not only on the whether the "right" decisions are being made in a timely manner, but also on whether the group's physicians feel comfortable with the manner in which they are made ("why wasn't I consulted on that?"). The only way to know this is to have periodic reassessments of how your group's governance or decision-making structure is working. Far too often the sum total of a group's review of its governance or decision-making structure is limited to an annual "I move that we re-elect the current officers."

Another issue that faces small groups involves the determination of when to seek the services of a full or part-time practice manager. There are typical objections to hiring such a person ("we don't need one;" "we can't afford one;" "our accountant can do all that for us."). While small groups may not need one, and while having the wrong manager can be worse than having none at all, this is a topic that even a small group should examine from time to time.

The starting point is a candid internal discussion of the shortcomings of your current practice management, perhaps with the assistance of outside advisors. Is the wrong person in a leadership position? Should administrative responsibilities be shared within the group? Are the others willing and able? Is the group taking advantage of the services that its current

outside consultants can provide? How could a practice manager solve these problems?

**Issues for Larger Groups.** For larger groups, particularly groups which have experienced rapid growth, there can be different issues. The group may have a situation where historically every physician-owner (a shareholder or member) has a seat at the table for all decisions. This may no longer be practical. Scheduling meetings, or assuring attendance at meetings, may be a problem, particularly where the group practices at multiple hospitals. A further problem that large groups often encounter involves trying to reach consensus or make a decision, particularly where it has been historically felt that “consensus” means unanimous approval. At some point the need for unanimity becomes the tyranny of the minority.

The solution for many groups is a Board of Directors or managers that consists of fewer than all practice owners. While this may be a difficult decision to make in a situation in which the physician-owners have been accustomed to participating in all decision-making, at some point it may become necessary. In moving to a smaller governing body, consider the following issues and questions:

(1) How large should the Board be? To some extent the answer to this question depends on how large the group is, or how many “constituencies” (e.g. different hospitals or practice subspecialties such as pain management) need to be represented.

(2) How should the Board be selected? Should certain persons (e.g., the chair of the department) be automatically on the Board? Is there any need to allocate Board positions

among the various “constituencies?”

(3) What should be the term of office of a Board member, and how can the Board member be removed from office? Often groups will choose multi-year staggered terms for the sake of continuity, with the ability to remove a Board member with or without cause. To the extent that Board members have been considered to be “representatives” of certain constituencies, who must approve a removal?

(4) What decision-making authority should be retained by the owners of the practice? What about the hiring or termination of a physician, the sale of an ownership interest to a physician, entering into a hospital service agreement, or incurring a significant financial obligation? A group needs to decide what power should be reserved to the owners, or what veto power they should have over decisions by the Board. However, it needs to be recognized that at some point the owners could have retained so much authority that it will eliminate much of the benefit of a Board.

(5) How can the feeling of disenfranchisement by non-Board member physicians be addressed? To some extent a feeling of disenfranchisement is inevitable on the part of those persons who will see their role in the decision-making processes reduced. One way to address this feeling is to make sure that there is adequate regular communication from the Board and the solicitation of input before important decisions are made.

(6) The group should also continue to maintain regular meetings of all the physicians or all owner-physicians. That being said, Board meetings should not be conducted as part of an overall meeting of the physicians in the department or of the owners of



the business. Doing so will undercut the notion of the Board as having a separate and distinct function.

(7) Before a group makes this change, it should do it in a manner that is not only consistent with state law, but also consistent with the terms of any existing contracts. For example, employment contracts with physicians may contain provisions that provide that certain decisions (e.g., involuntary termination) can be made only by the owners.

There are many ways to structure the administration and governance of a group medical practice. Administration and governance should be the subject of periodic group discussion. ▲

John T. Mulligan is a Member of the law firm McDonald Hopkins, LLC, in its Cleveland, Ohio office. McDonald Hopkins has other offices in Chicago, Detroit, Columbus, West Palm Beach, and Dennis, Mass. John’s practice focuses on the representation of physicians and physician groups, with a particular focus on the representation of hospital-based groups. He is listed in the “Best Lawyers in America” for health care law. He can be reached at (216) 348-5435 or [jmulligan@mcdonaldhopkins.com](mailto:jmulligan@mcdonaldhopkins.com).

# ANESTHESIA'S ROLE IN DEVELOPING EFFECTIVE OR GOVERNANCE

By Jerry Ippolito, BA, MHSA

Director, Perioperative Services Business Development  
Southeast Anesthesiology Consultants, PA  
Charlotte, North Carolina

A lot is written in the literature these days and there is ongoing debate in both the anesthesiology and OR-management communities with regard to who should be running the OR – Nursing Directors or Medical Directors of Anesthesiology. At the ASA's recent conference on Practice Management one speaker referred to anesthesiology groups as “*Super Groups*” and “*Orphan Groups*”. In summary, the “*Orphan Groups*” continue to wring their hands, point fingers, and position themselves as “victims” — “*Super Groups*”, on the other hand, position themselves as “*Champions of Program Excellence*” partnering with their hospital / ASC customers in fostering quality, efficiencies and business growth. First and foremost, *if anesthesiology wants to be respected as a leader in program governance, it must position itself as a “Super Group”*.

Simply stated, anesthesiology needs to be proactively involved in OR operations and planning with specific emphasis on schedule planning and administration. If not involved in schedule planning and administration, then anesthesia can only react to the decisions of others. When in a reactive vs. proactive mode, customer service can not be optimized. Who runs the OR (or best stated the perioperative services program) is a far more complex set of circumstances. The correct question is: “*What does Effective Perioperative Services Program Governance Look Like?*”

When anesthesia does not take a



proactive role in fostering and enforcing effective governance, then anesthesia will remain in a reactive mode and will not be able to optimize satisfaction levels of its customers (surgeons, administration, nursing and last but not least the patient). Too frequently we hear of anesthesia being referred to by nursing and administration as “*A Necessary Evil*” – “*Orphan Group*”. In my experiences anesthesia typically has a sound grasp on what is necessary to run an efficient and marketable OR program. Maintaining program efficiencies and garnering new business is even more important to anesthesia than to the

hospital as an anesthesia group does not have the same level of financial reserves as a hospital. Unfortunately, however, rather than being a “*Champion*” for program reform by promoting program development, anesthesia typically points fingers at administration and nursing. Due to the perception of anesthesia being a “*necessary evil*” or “*having an agenda of its own*”, regardless of how sound recommendations may be, nursing and administration seldom listen to anesthesia.

Running the OR and fostering development of effective governance are two different issues. I was recently

interviewed by the publication *OR Manager* and asked whether anesthesia or nursing should run the OR and my response was that if effective governance is in place, then it does not matter which constituency of the four-legged stool (anesthesia, nursing, surgeons or administration) runs the OR on a daily basis. [ABC addressed the same question in our March 13, 2009 Alert. We are grateful to Mr. Ippolito for providing much of the background material for our Alert entitled “Should Anesthesia Run the OR?” There we identified the many assets of anesthesiologists, who have a long and successful history of managing the OR – success being contingent, of course, on the requisite leadership and organizational skills as well as the knowledge of the anesthesiologist. If you would like a copy, or if you would like to be on the e-mail distribution list for the Monday Alerts, please contact [cortney.shepherd@anesthesiallc.com](mailto:cortney.shepherd@anesthesiallc.com). –Ed.]

Running the OR is the implementation, execution, and enforcement of the policies and

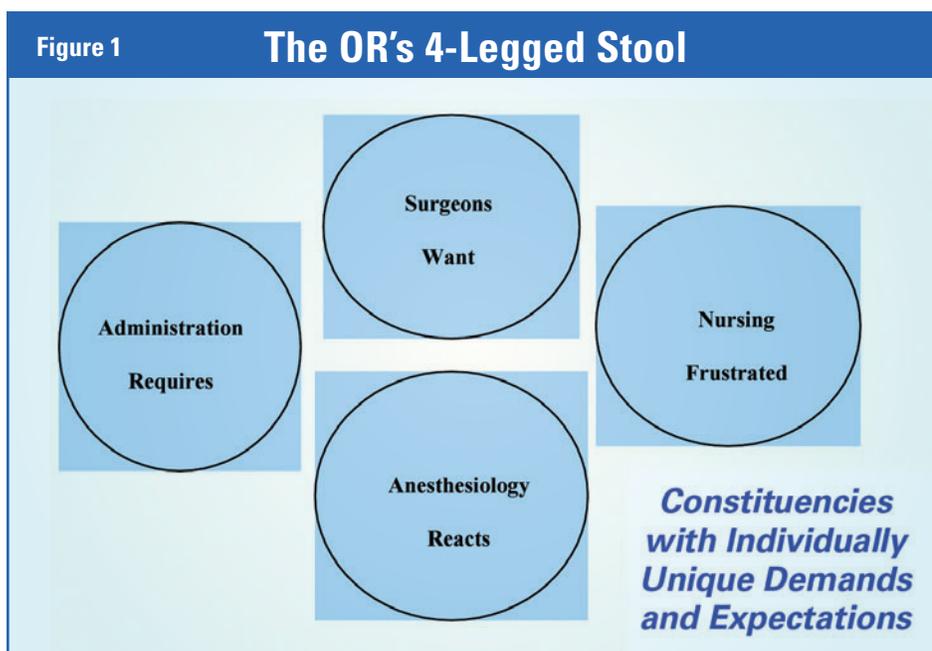
procedures developed by the governance body. Some feel that anesthesia should run the OR because in order to maintain an effective OR program physicians must be positioned to police physicians. Others feel anesthesia should run the OR as OR Directors come and go from institutions and anesthesia is generally a more stable entity. Lastly, there is a school of thought that anesthesia should run the OR because anesthesia is “ever-present” in the OR. I don’t totally disagree with any of this thinking but must indicate that making anesthesia the “policeman” of the OR without holding other constituencies accountable will only result in fostering the reputation of that “necessary evil”. About eight years ago I was engaged by a major mid-Atlantic university hospital to assist in improving operating room efficiencies. To this day I use this case study as an example of what happens when effective governance is lacking. In this instance the Chairman of the Department of Anesthesia was sponsoring the engagement for the hospital. The anesthesia chair had been directed by

the Dean of the university and hospital CEO to “fix the OR”. The OR was totally dysfunctional; surgeons did whatever they wanted, whenever they wanted; the environment was total chaos. The Chair continues to be a highly regarded individual and has a sound grasp of what is required to maintain an effective OR program. The Chair proposed sound strategies for change and promoted sound policies and procedures. Needless to say the Chair remained very frustrated as progress was not being made and it was alleged to be the fault of anesthesia. Progress was not being made as only one constituency of the four legged stool was being held accountable – only anesthesia was being held accountable. I was simultaneously engaged at a university on the opposite side of the city where effective governance was developed and each of the constituencies was held accountable. Anesthesia championed the process through its “ever-presence in the OR” and tremendous progress was made.

Generally when there is a lack of effective governance silos develop among the four constituencies and it is difficult to have effective program management and optimized satisfaction levels among the constituency members. Indeed each of the constituencies does have an agenda so to speak.

### THE OR’S 4-LEGGED STOOL

Typically in siloed environments constituency members maintain an expectation that their wants and needs will be fulfilled by others, to a 100 percent level, 100 percent of the time. In this environment constituent members do not take accountability for their actions and are unwilling to police themselves much less each other (See Figure 1). The Director of Surgical Services and anesthesia remain in a “NO-WIN” situation until both



# ANESTHESIA’S ROLE IN DEVELOPING EFFECTIVE OR GOVERNANCE

*Continued from page 25*

anesthesiologists and surgeons recognize that they must be accountable for their actions, be responsible for development of solutions, not maintain expectations that their needs will be fulfilled by others, be champions of program change and prosperity as opposed to complainers.

Effective surgical program governance is best achieved by considering the OR as a business corporation. The OR is the “Financial Engine of a Hospital” and should be governed as such. Corporations have boards of directors and CEOs. CEOs do not make unilateral decisions; CEOs brief boards of ongoing situation, changes in the environment, provide data and information, guide decision making after having analyzed facts and circumstances. Boards develop strategic and tactical plans and develop policies and procedures. CEOs and management teams implement and enforce decisions of the board. In this regard, what we typically refer to as the hospital’s OR Committee acts as the board; the Director of Surgical Services in partnership with anesthesia acts as the CEO. To this point you may say to yourself, “Our hospital has an OR Committee, but the OR is still dysfunctional and chaotic. In my experiences most hospitals’ OR Committees are dysfunctional, lack value and clout for reasons as follows.

Generally the OR Committee lacks clout because it has not been formally charged by the hospital’s CEO as an empowered hospital operations committee (as to differ from the Department of Surgery which is a medical staff body). Similarly, if the CEO does not bestow formal authority on the OR Committee and support Committee decisions, disgruntled individuals (usually surgeons) make “end-runs” to the hospital’s CEO around

TYPICAL OR COMMITTEE CHALLENGES	
TYPICAL SITUATION	RESULT
Composed of large numbers of surgeons	Unable to reach decisions; becomes a complaint forum
Inadequate representation from other key groups (e.g. anesthesiology, OR management, administration)	Discussions become slanted, personal and political in nature
Lacks factual information, data and absence of authority / clout	Reliance on anecdotal information and absence of authority does not result in change
Meets infrequently	Can not engage in pressing issues
Poor attendance, tardiness	No quorums for decisions, lack of vested interest by membership, results in downward spiral

the Committee. In these instances the CEO typically intercedes, makes decisions based on the anecdotal evidence provided by the disgruntled party and undermines the Committee’s authority and effectiveness. Committee members lose interest and are unwilling to invest their personal time; a negative spiral develops.

The foundation of effective surgical services program governance is based on the composition, authority, mission, charge and enforcement of the OR Committee. The foundation of effective OR governance is that where a culture is developed and programs are developed and governed by that culture and not one or several individuals. Some key elements of an effective OR Committee follow:

- Maintains a charge of fostering development of and maintaining a quality oriented, effective, efficient and marketable surgical services program through the development

and enforcement of effective policies and procedures

- Is charged and supported by the hospital’s board and CEO as a hospital operations committee; decisions of the Committee are not to be overruled by hospital administration, the Board or departments of the medical staff. The OR Committee is not subordinate to, nor needs approval of, medical staff bodies (e.g. Department of Surgery or medical staff as a whole)
- Maintains a philosophy that the OR is a shared and common work place, is no one person’s or constituency’s domain, is a place where compromise and consensus is paramount
- Maintains a manageable size – typically of 11 to thirteen members
- Maintains representation of key and high volume surgical specialties

- Assures that physician committee members (particularly surgeons) have a vested interest in the hospital and are personally affected by Committee decisions:
  - operate frequently at the hospital and use the hospital as their primary place of surgery;
  - have an interest in developing their practices;
  - have a willingness to foster program change and success for the greater group;
  - have a willingness to enforce policies and procedures and a willingness to approach their colleagues;
  - chiefs of service who do not have the referenced characteristics should not be on the OR Committee
  - have an ability and willingness to enforce policies and procedures against physician friends and business associates
- Committee members should be effective formal and informal leaders
- Maintain representation of anesthesia by an anesthesiologist with

good interpersonal, communicative, organizational and data interpretation skills; an anesthesiologist who takes a lead role in the planning and administration of the schedule on a daily basis (this may not necessarily be the chief of anesthesiology)

- Include representation of OR management (Director of Surgical Service, OR Manager) and administration (VP over surgery, CNO, but not CEO)
- Meet on a monthly basis and have a planned agenda
- Be guided by data and factual information presented by the Director of Surgical Services in partnership with anesthesiology
- Charge the Director of Surgical Services and anesthesia to implement and enforce policies and procedures developed by the OR Committee

Where this structure is developed anesthesia is positioned to assist in championing program development

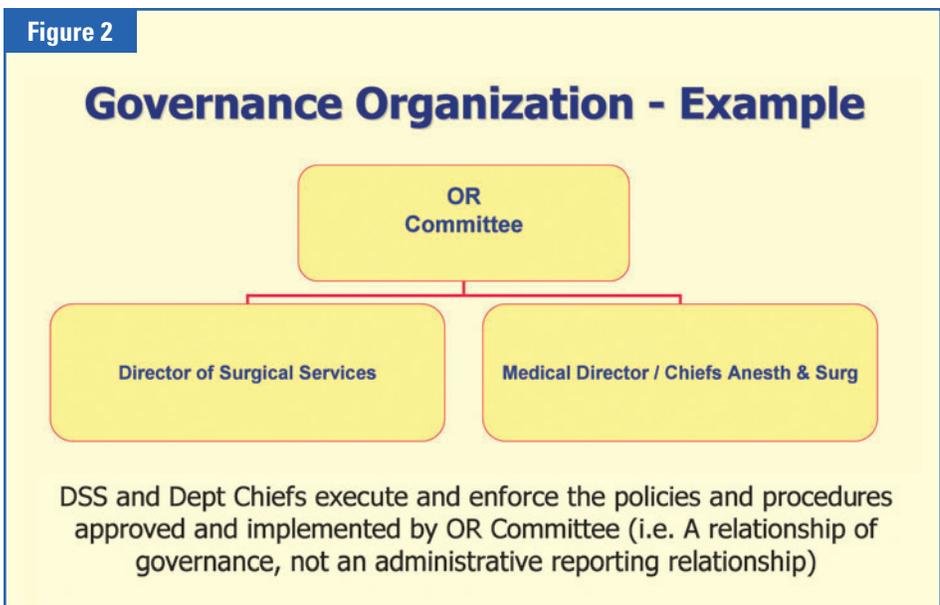


and success but is not regarded as a “policeman or necessary evil”. Where this structure is developed each of the schools of thought referenced earlier in this article as to why anesthesia should run the OR is addressed and applied, but in a formal and organized manner:

- Anesthesia participates in enforcing policies and procedures among anesthesiologists and surgeons (physician to physician communication);
- Anesthesia maintains the ever-presence in the OR
- Directors of Surgical Services come and go, but a “culture” sustains program success
- Regardless of which constituency is the “organizational leader” nurses continue to be evaluated by nurses in terms of clinical competencies

Where this governance structure is developed, it does not matter whether anesthesia or nursing runs the OR. Neither does. In partnership the two implement policies and procedures developed by a higher authority; nursing and anesthesia guide the higher authority in decision making. (See Figure 2.)

Additional articles by Jerry Ippolito and complimentary learning tools can be downloaded from [www.OREfficiencies.com](http://www.OREfficiencies.com).





255 W. MICHIGAN AVE.  
 P.O. Box 1123  
 JACKSON, MI 49204

PHONE: (800) 242-1131

FAX: (517) 787-0529

WEB SITE: [www.anesthesiallc.com](http://www.anesthesiallc.com)

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

## PROFESSIONAL EVENTS

DATE	EVENT	LOCATION	CONTACT INFO
June 10, 2009	Tristate Anesthesia Administrators Group	United Anesthesia Services, P.C. Bryn Mawr, PA	<a href="mailto:Stephen.Comess,stevecomess@earthlink.net">Stephen Comess, stevecomess@earthlink.net</a>
June 12, 2009	Washington DC Area Anesthesiology Administrators Group	University of Maryland Medical Center, Baltimore, MD	<a href="mailto:Kim.Flayhart,Kflayhart@ANES.UMM.EDU">Kim Flayhart, Kflayhart@ANES.UMM.EDU</a>
June 26-27, 2009	Florida Society of Anesthesiologists Annual Meeting	The Breakers Resort & Spa, Palm Beach, FL	<a href="http://www.fsahq.org/calendar.cfm#e7">www.fsahq.org/calendar.cfm#e7</a>
Aug. 8-12, 2009	American Association of Nurse Anesthetists Annual Meeting	San Diego Convention Center, San Diego, CA	<a href="http://www.aana.com">www.aana.com</a>
Sep. 24-27, 2009	New England Society of Anesthesiologists Annual Meeting	The Sagamore Resort, Bolton Landing, NY	<a href="http://www.nesa.net">www.nesa.net</a>
Sep. 18-20, 2009	Ohio Society of Anesthesiologists Annual Meeting	The Hilton Columbus at Easton, Columbus, OH	<a href="http://www.osainc.org">www.osainc.org</a>
Oct. 16, 2009	American Society of Critical Care Anesthesiologists Annual Meeting	New Orleans, LA	<a href="http://www.ascca.org">www.ascca.org</a>
Oct. 16, 2009	Society for Pediatric Anesthesia Annual Meeting	New Orleans, LA	<a href="http://www.pedsanesthesia.org">www.pedsanesthesia.org</a>
Oct. 16, 2009	Society of Neurosurgical Anesthesia & Critical Care Annual Meeting	New Orleans Marriott, New Orleans, LA	<a href="http://www.snacc.org">www.snacc.org</a>
Oct. 17-21, 2009	ASA Annual Meeting	Morial Convention Center, New Orleans, LA	<a href="http://www.asahq.org">www.asahq.org</a>
Oct. 11-14, 2009	MGMA Annual Conference	Colorado Convention Center, Denver, CO	<a href="http://www.mgma.com">www.mgma.com</a>
Oct. 26-30, 2009	CSA Fall Hawaiian Seminar	Grand Hyatt Kauai Resort & Spa, Poipu Beach, Kauai	<a href="mailto:trowe@csahq.org">trowe@csahq.org</a>
Nov. 6-8, 2009	Association of Anesthesiology Program Directors/Society of Academic Anesthesiology Chairs Annual Meeting	Boston Park Plaza, Boston, MA	<a href="http://www.aapd-saac.org">www.aapd-saac.org</a>
Dec. 11-15, 2009	New York State Society of Anesthesiologists Postgraduate Assembly in Anesthesiology	Marriott Marquis, New York, NY	<a href="http://www.nyssa-pga.org">www.nyssa-pga.org</a>
Jan. 17-22, 2010	Clinical Update in Anesthesiology, Surgery and Perioperative Medicine	Paradise Island, Bahamas	<a href="mailto:Helen.phillips@mountsinai.org">Helen.phillips@mountsinai.org</a>
Jan. 18-22, 2010	CSA Winter Hawaiian Seminar	Hyatt Regency Maui Resort & Spa, Ka'anapali Beach, Maui	<a href="mailto:trowe@csahq.org">trowe@csahq.org</a>
Jan. 29-31, 2010	ASA Conference on Practice Management	Marriott Marquis, Atlanta, GA	<a href="mailto:m.teister@asahq.org">m.teister@asahq.org</a>