

ABC offers Communiqué in electronic format

Anesthesia Business Consultants, LLC (ABC) is happy to announce that Communiqué will be available through a state-of-the-art electronic format as well as the regular printed version. 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 Communiqué. Please log on to ABC's web site at www.anesthesiallc.com and click the link to view the electronic version of Communiqué online.

MEDICAL DIRECTORSHIP OF ANESTHESIA SERVICES: ARE YOU A PLAYER . . . OR ARE YOU JUST BEING PLAYED?

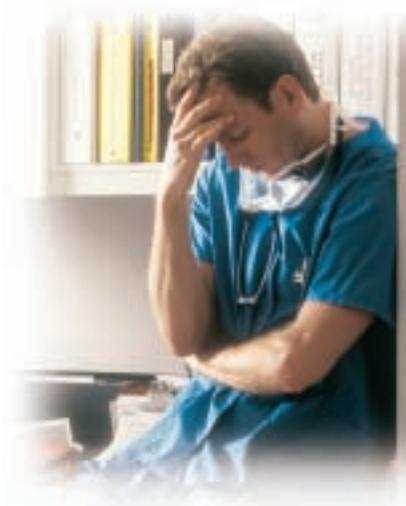
By Mark F. Weiss, J.D.

Wow, what a day! You've just left a meeting with the hospital's CEO. Of the fifteen anesthesiologists in your open-staffed department, the CEO wants *you* to be the new, first medical director of anesthesia services. You've been the department's chair for the past two years, but now you've been offered an administrative stipend of \$2,500 a month. It doesn't appear to be any more work than what you've been doing, and the \$2,500 is more than you need for the payments on a new Porsche!

Just as you feel your grip on the steering wheel, the alarm clock jars you awake. Should you savor the memory . . . or be thankful that it was only a nightmare?

DREAM ANALYSIS 101

Relax. Put your feet up. In order to analyze the dream, we need to back up a bit



and consider the operation of an anesthesia department, as an element of the medical staff, in the absence of any mandate from hospital administration.

Without the overlay of hospital administration, an anesthesia department

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SECOND ANNUAL MGMA/ASA COST SURVEY FOR ANESTHESIA PRACTICES RELEASED

By Shena J. Scott, MBA, FACMPE

Immediate Past President, Medical Group Management Association Anesthesia Administration Assembly (MGMA AAA), Administrator, Brevard Anesthesia Services, PA, Melbourne, FL



We are pleased to announce the recent publication of the MGMA *Cost Survey for Anesthesia Practices: 2005 Report Based on 2004 Data*, conducted in conjunction with the American Society of Anesthesiologists

(ASA). In response to input from ASA members on the survey committee and feedback received following the publication of last year's inaugural survey, this year's report has expanded certain sections

to more easily benchmark different practice sizes and styles (compare "apples" to "apples") and has added several new items, such as a comparison of malpractice premiums and limits.

Turning Unanticipated Challenges Into Unforeseen Opportunities

While long summer days here in Michigan afford us an all too brief chance to enjoy the diverse natural beauty of the great lakes, our clients in Florida are quick to remind us that our much anticipated warm weather heralds their season of greatest vulnerability. My last trip to Miami was a poignant reminder of the devastation wrought by last year's merciless series of unanticipated hurricanes. If there is one thing I have learned over the past 28 years in this business, it is that we must all be prepared for the unexpected. None of us can afford the luxury of complacency. Today's feast is quickly forgotten in the face of tomorrow's famine. Is it any different in the world of anesthesia practice management? More and more it

is the ability to turn an unanticipated challenge into an unforeseen opportunity that defines that fine line between success and failure.

And so we present you with another issue of the *Communiqué* to prepare you for the unexpected. The following pages offer a wealth of good advice from people who have made their living preparing others for the inevitability and uncertainty of change. Each of these carefully selected articles provides some valuable insight gained at the expense of another's misfortune. Our panel of industry experts has been down a path that you may be currently on. Their experience and wisdom is your advantage. If even one of them provides you with that critical insight or option that helps

you keep your practice in good stead with your customers and a viable force in the lives of your employees our investment will have been amply rewarded.

It is in this spirit of vigilance that I also share our recently revised and solidly reaffirmed company mission, vision and values. I include them here as an example of the company's ongoing strategic planning. While our core values and commitment to the specialty remain unchanged, we must each acknowledge that all too often the beliefs and strategies that got us to where we are today will not get us to where we want to be tomorrow. In addition to the continued support and loyalty of our clients, ABC's success hinges directly on its ability to identify those beliefs and strategies that no longer serve our strategic purpose and to develop and embrace new ones that will. How can we be a model of change management if we are unwilling to deal with our own sacred cows? And so it is with great excitement that I look forward to the challenges and opportunities that lie ahead for all of us. May you be equally optimistic about your practice's mission and vision for the invaluable role you will play in the lives of those you serve.



The mission of Anesthesia Business Consultants, LLC is to provide innovative and valuable management solutions that enhance our clients' ability to compete in today's dynamic healthcare market.

Our vision is to be the recognized standard of excellence in anesthesia practice management to which all other solutions are compared.

In all our interactions we must embody the values of:

- **Respect** for the dignity of the individual;
- **Integrity** of word and deed;
- **Service** that is uncompromised by personal inconvenience or other challenges;
- **Education** that allows for the realization of personal and professional fulfillment; and
- **Teamwork** that results in a whole greater than the sum of its parts.

Tony Mira, President & CEO

MGMA AAA members joke that comparing “apples” to “apples” is somewhat of an oxymoron in reference to anesthesia practices. If you have seen one anesthesia practice, you have seen one anesthesia practice; if you have seen ten anesthesia practices, you have seen ten and chances are there was little about them that was the same. With differences in each practice, finding common ground for benchmarking is challenging at best. There are many variables that must be taken into account – private versus academic practice (more on this later); staffing model; payer mix; case mix; trauma versus no trauma; group size; hospital size; patient population; pain versus no pain; critical care versus no critical care; the list goes on. One of the difficulties in constructing survey instruments is devising a questionnaire that asks *enough* questions to allow the data to be “sliced and diced” in enough meaningful ways but not to make the process too cumbersome so as to discourage participation. Participation is critical to providing meaningful survey data.

The survey team was pleased with the

participation and the number of ways we were able to separate the data for 2005. Usable responses were up 13% from the 2004 survey. The booklet has six different sections of tables for anesthesiology practices: all practices, small (less than 10 physician) practices; medium (11-30 physicians) practices; large (31 or more physicians) practices; by staffing model (physician only, less than one anesthesiologist per physician, and more than one anesthesiologist per physician); by level of government payer mix (30% or less, 31-49%, 50% or more); and number of trauma centers (none versus one or more). There is also a separate section for anesthesia practices with pain management, which will be addressed later in this article.

Each section contains up to 29 different tables (depending on the distribution of responses). MGMA guidelines do not allow publication of data with less than ten responses. As such, some tables could not be populated. Hopefully, greater participation in the future will solve this problem. In addition to the ever-popular stipend data, these tables include staffing,

cost and financial data on an aggregate basis, per physician, as a percent of medical revenue, per case, per ASA unit, per facility and, newly added this year, per anesthetizing location. The survey team is especially excited about this latest addition because we believe it can mitigate some of the variables relating to staffing model.

Staffing model permeates so many aspects of an anesthesia practice that it can be difficult to make comparisons without taking note of its impact at every juncture. For example, one of the “key findings” listed in the front section of the report is that the number of physician units per physician varies by practice size, with the smallest practices indicating the highest number (13,577) and the medium (10,198) and larger (10,143) practices significantly lower. A closer examination reveals that the staffing models for the three groups are significantly different. The respondents in the small group section had a median of 6.27 FTE physicians and 9.39 anesthesiologists (“anesthesiologist heavy”), while the medium group has a relatively equivalent distribution of provider types with a median of 19.38 FTE physicians and 17.5 anesthesiologists. The respondents in the large practice group reflected a median of 40 FTE physicians and 17 anesthesiologists (“physician heavy”). Is this a reflection of a trend by practice size or simply the particular respondents who participated in this year’s survey? Although the answer is not necessarily clear, what *is* clear is the way it will muddy the waters when attempting to make comparisons by group size.

The addition of statistics by anesthetizing location was an effort to cut through some of these problems and provide general benchmarks which are not impacted by staffing model. Among other things, this year’s survey includes data for expected number of units, and revenue, per anesthetizing location. This data

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should provide a meaningful way for people to compare the productivity of their practices against a norm. For example, while revenue per unit comparisons can indicate how a poor payer mix at a facility is hurting your practice, it cannot address utilization or efficiency issues. While the survey does include questions about utilization, last year's responses indicated that many people seemed to be approximating these numbers rather than providing actual data. Some members of the survey committee have been active in working with key software vendors to provide reports that will allow this data to be accurately tracked and we are hopeful that we will soon be able to report actual utilization statistics, rather than estimates. In the meantime, looking at units per anesthetizing location should provide a measure of how the efficiency of the practice or facility compares with others. Revenue per anesthetizing location will capture all of these factors and reveal where a facility might be excelling or falling short in terms of all factors, including payer mix and operating room efficiency.

Two focus areas for improving next year's survey are academic practices and pain management. The survey committee was disappointed that, once again, only nine (9) academic practices participated. As explained earlier, this precluded the survey team from being able to provide a separate set of tables for academic practices. Since academic practices are so inherently different than private practices, the decision was made simply not to include the data for these nine practices, even in the "all practices" section. We have enlisted some academic leaders to help

encourage participation and are most hopeful that the "third time will be the charm" and that we will be able to include separate academic tables in the 2006 report.

The other area of focus for 2006 is pain management. Although the 2005 survey does include a set of tables for anesthesiology practices with pain management (divided into columns by percent of pain management cases in the total case mix – less than 10% and 10% or greater), the problem is that the volume of anesthesiology cases relative to pain management cases is so great in most practices that it is difficult to discern meaningful differences. The pain management numbers are often lost amidst the anesthesia numbers. As such, the committee believes that the best way to expand this critical area of the survey will be to put together a separate pain management section in the anesthesia survey and have integrated practices provide separate sets of anesthesiology and pain management data. This change will allow practices to look at pure anesthesiology and pure pain management data to benchmark themselves against appropriate norms.

In summary, the more participation we are able to garner in these survey instruments, the more meaningful the data becomes. Survey data is critical to all of us as we conduct our day to day businesses. Greater participation means more opportunities to "slice and dice" the data. As such, we encourage you to become familiar with the survey instruments and structure the financials of your practice in a way that makes it easy for you to participate. Please talk to your administrator, practice management advisor or billing



company about participating in the survey on your behalf. Participants in the survey receive a *free* copy, so if you have not done so in the past, please plan to participate in the future. MGMA members will receive a copy in the mail. ASA members will have a link through their website to the MGMA website where you can download a pdf format or complete the survey online. Please plan to help your practice, your colleagues and your specialty by participating in this important project.

In the meantime, if you did *not* participate last year and would like to gain access to all of the valuable data included in this year's report, you may purchase a copy of the survey by visiting www.mgma.com or by calling 1-877-ASK-MGMA. ASA members can order the survey at the affiliate price of \$305 — a \$160 savings versus the non-member price — by using promotion code ASA050T04. As always, please feel free to contact me (shenascott@cfl.rr.com) or MGMA AAA president Jack Beecher (jack.beecher@yale.edu) if you have any questions or would like more information about any aspect of MGMA AAA. ▲

WAIVER OF COPAYMENTS AND DEDUCTIBLES: TO WAIVE OR NOT TO WAIVE

By Vicki Myckowiak

Myckowiak Associates, P.C.

Anesthesiologists and chronic pain practices are often faced with a dilemma: hospitals, patients, friends, and colleagues asking them to waive copayments and/or deductibles. Although it may seem harmless to comply with a waiver request, in fact the law is clear that physicians can only waive copayments and/or deductibles in a limited number of circumstances. In fact, the Government has made clear that the routine waiver of copayments and deductibles may be considered fraudulent. What is a practice to do?

THE PROBLEM

The legality of waiving copayments and/or deductibles has been an issue for over ten (10) years. In 1994 the Office of Inspector General (“OIG”) issued a Special Fraud Alert on Routine Waiver of Copayments or Deductibles under Medicare Part B. *See*, 59 F.R. 242 (1994). In this fraud alert, the OIG advised that:

Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.

The OIG reemphasized its concern with routine waiver of copayments and deductibles in its Compliance Program

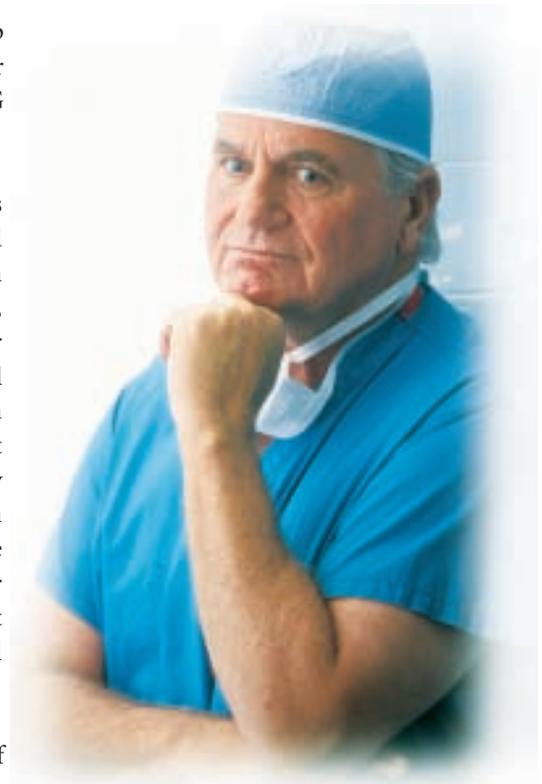
Guidance for Individual and Small Group Physician Practices published on October 5, 2000 (65 F.R. 59434) in which the OIG stated that:

Remuneration for referrals [such as routine waiver of copayments and deductibles] is illegal because it can distort medical decision-making, cause overutilization of services or supplies, increase costs to Federal health care programs, and result in unfair competition by shutting out competitors who are unwilling to pay it. Remuneration for referrals can also affect the quality of patient care by encouraging physicians to order service or supplies based on profit rather than the patient’s best medical interests.

See, 65 F.R. 59440. In the area of waiver of copayments and deductibles, the Government has been consistently concerned with false claims and violations of the anti-kickback laws.

FALSE CLAIMS

The Government believes that a physician who waives copayments or deductibles is misstating his/her actual charge. For example, if a physician claims that its charge for a service is \$100, but waives the 20% copayment, the Government believes that the provider’s actual charge is \$80. Therefore, a provider who submits a claim for which it has



waived the copayment or deductible may be submitting a false claim and may be subject to criminal sanctions under 42 U.S.C. 1320a-7b of a maximum fine of \$25,000, imprisonment of up to five years, or both. Additionally, a conviction would lead to automatic exclusion from all federal health care programs.

The Government can also proceed under the Civil False Claims Act (31 USC 3729-3733) against a provider who waives copayments and deductibles on Federal health care program claims.

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operates on either an “open staffed” or a “closed staffed” basis. Note that this article does not address the somewhat rare instance in which all of the anesthesiologists are direct employees of the hospital itself.

In an open staffed department, any anesthesiologist can apply for privileges. If the applicant meets the medical staff’s and department’s credentialing and procuring requirements, he or she attains medical staff membership and clinical privileges in the department. In a closed staff department, no new applications for staff privileges through the anesthesia department are accepted: the hospital’s governing board, after approval by the medical staff, has determined that there are a sufficient number of anesthesiologists and that admitting more would be detrimental to keeping existing members busy enough to prevent them from seeking work elsewhere, thereby affecting patient care.

In either case, open staffed or closed staffed, absent some business entity relationship that exists among the anesthesiologists, the physicians each operate an independent “business” and need only meet the requirements set forth in the medical staff and departmental rules to retain their right to a full share of the workload. In other words, if they decide to take time off or if they block out every other Tuesday so that they can work in some surgery center there is little that the department can do.

MEDICAL DIRECTORSHIP

Although they are sometimes split into two written documents, the usual medical directorship agreement between an anesthesiologist and a hospital imposes two classes of obligations on the medical



director: The first involves administrative and supervisory duties. The second involves coverage obligations. Each of these classes of duties is discussed in detail below.

Administrative and Supervisory Duties

As is obvious, a medical director agreement obligates the anesthesiologist who enters into it to become the “medical director” of the anesthesiology department. Generally speaking, the agreement obligates the director to supervise the delivery and performance of all anesthesia services required at the hospital.

In addition to this general charge, the usual medical director agreement imposes on the medical director a host of specific supervisory and administrative duties. For example, the medical director is required to establish the anesthesia schedule; to supervise the development and implementation of quality assurance and quality improvement programs and procedures; to advise on the selection, retention and termination of all non-physician personnel who may be required for the proper operation of the department; to serve as the liaison between the anesthesiology department and hospital administration; to direct non-physician

department personnel in the performance of their services; to assist the hospital in the connection with preparation for and participation in JCAHO and other surveys; and to devote significant time to serving on various hospital administrative, as distinguished from medical staff, committees.

Coverage Obligations

In addition to administrative and supervisory services, medical directorship agreements generally require the director to assure coverage of all of the hospital's anesthesia requirements. In other words, the medical director usually takes on the responsibility of guarantying 24 hour a day, 7 days a week coverage by a sufficient number of properly trained anesthesiologists to meet the needs of the facility.

The Dilemma

You're right if you think the supervisory and coverage duties imposed pursuant to a medical director agreement seem to be the same as those imposed on the holder of an exclusive contract. In fact, the combination of administrative and coverage obligations imposed on a medical director pursuant to a medical director agreement is nearly, if not exactly, the same as those imposed under an exclusive contract. However, an exclusive contract has one, essential element that is lacking from the medical director agreement relationship – the medical director agreement does not give the director the right to exclusive control of the professional staffing of the department. The problem is, without the grant of exclusivity, it may be difficult, if not impossible, for the medical director to fully perform his or her obligations pursuant to the medical director agreement.

Anesthesiologists offered medical

directorships often undervalue the distinction between a directorship and an exclusive contract. They tend to view the grant of exclusivity as a tool to fend off competition; the holder of an exclusive contract has the ability to determine who may, and therefore who may not, practice in the department. In reality, the power created as a result of exclusivity is not merely external in its focus, it is also used internally — to control the business activity of, and the anesthesiologists within, the department.

For example, in the case of an open-staffed department consisting of ten independent anesthesiologists, how can the one physician holding the medical director contract gain sufficient control over the department members so as to be able to guaranty coverage? Absent the power to remove someone from the schedule or to otherwise discipline the other department members, a power that comes with exclusivity, the director won't have the teeth to force the department members to act in the manner required to meet the director's obligations under the hospital contract.

Exclusive contracts generally deal with the issue of coordinating administrative control with medical staff department control. But in the case of a medical director agreement, there is usually no contract language synchronizing these two positions. If the medical director can't force his or her appointment as chair of the anesthesia department, he or she will lack the medical staff-level authority to control the schedule and will not have the ability to use the implicit threat of medical staff discipline to enforce cooperative behavior.

Conclusion

Whether your medical directorship will be a dream or a nightmare turns on several factors. Central, of course, is

whether or not the proposed relationship includes an obligation on your part to guaranty full coverage of the facility's anesthesia needs. If you are a member of a group without an exclusive contract, are there also independent anesthesiologists practicing in the department? Are there locums anesthesiologists who might later demand a full time share of the schedule? Can any non-group members be persuaded to join the group, so as to be able to gain administrative control over them by way of employment or shareholder/partnership contracts? Do the medical staff bylaws and departmental rules provide a way for the department chair to be appointed as opposed to elected? If not, a contracted medical director might be at odds with both the business independence of the majority of the anesthesia department as well as the department's elected medical staff leadership.

Let me end on a word of caution. Out there in the real world, I am more than aware that the legal and business advice I pass along to my clients is blended with many other factors, wants and needs, one of the big ones being money. But weigh carefully the fact that the amount of a monthly stipend, from the Porsche-payment variety to ten times that amount, might not be sufficient to offset the damages that the hospital might seek if you are unable to perform pursuant to the contract. ▲

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WHO IS REALLY MANAGING YOUR PRACTICE?

By Jerry Ippolito, Vice President & Principal
The Surgery Management Improvement Group, Inc.



Once again I've been flattered by the request to write an article for the *Communiqué*. On this occasion the question was posed, "what do you see as most challenging issues to anesthesiology practices in the area of perioperative services?" One might readily respond reimbursement, however I believe that is a prevailing challenge to the healthcare industry overall and not unique to anesthesia. Others might suggest low OR and anesthesiology utilization. In my consulting practice I have the opportunity to work with fifteen to twenty hospitals and anesthesiology practices each year. The most prevailing and challenging issue encountered for anesthesiology, and the question I'm posed most often by anesthesiologists is, "should we have a services agreement and should we be involved in the schedule?" Some anesthesia groups, and physicians in general, still maintain an old-school outlook of being independent practitioners on a voluntary medical staff and functioning independently of the hospital. In other instances, even where there is an exclusive contract between a hospital and anesthesia group, expectations are not clearly defined. Yet in additional instances, anesthesiologists will suggest to me, "Why would I want to participate in managing the schedule? – Why would I want that headache?" My response to these issues is that if a services agreement and expectations are not in place (even where there is no exclusive contract) you, anesthesia, will never be able to meet cus-

tomers expectations. Keep in mind that anesthesia's customers are numerous including at least surgeons, hospital administration, the director of surgical services, and oh yea, the patient (not even yet addressing GI; OB; radiology; Cysto; etc). Also keep in mind that the perception is always that, "The OR would run better if anesthesia stepped up to the plate". If expectations are not defined and anesthesiology is not proactively participating in schedule planning and administration in collaboration with OR management, then anesthesiology can only be reactive and subject to the decisions of OR management; this frequently results in

dissatisfaction and conflict. *If expectations are not in place and anesthesia is not involved in the schedule, then "YOU ARE NOT IN CONTROL OF YOUR BUSINESS"*.

If anesthesia is to successfully step up to the plate and fulfill expectations there needs to be reasonable definition of expectations. (Where are the plates located; Do you mean a plate or a bowl? How big a plate do you want? When do we serve meals?). No group or body or person can successfully deliver services and fulfill expectations on an ongoing basis without definition and direction. To this point, and for anesthesiology and perioperative



services, development of expectations should at least include definition of:

- Numbers of rooms staffed by hour of day and day of week;
- Call coverage (in v. out-of-house; anesthesiologist or CRNA; etc);
- What services are required by obstetrics and what is considered timely delivery of services;
- Development and delivery of effective and efficient pre-admission screening services;
- Case/patient familiarity prior to day of surgery;
- What services are provided to peripheral sites and when (endo; radiology; response to codes; etc);
- What is the role anesthesia plays in schedule planning and administration?
- How are the requested/expected anesthesia services compensated for if there is insufficient revenue from anesthesia professional fees?

Anesthesia's proactive involvement in schedule planning and administration is most paramount to the successful delivery/fulfillment of expectations. When anesthesia is not involved in the schedule, then anesthesia is continuously in a reactive mode; communication breaks down; expectations remain unfulfilled; dispute results even with best intentions for success.

A formalized charge anesthesiologist or board-runner function needs to be considered for every OR program each weekday, during normally active working hours (and on weekends where there is an active elective schedule). Charge anesthesiologist function and responsibilities (i.e. expectations) should be uniformly developed and one lead anesthesiologist should be assigned. The lead charge anesthesiologist position must be assumed by an individual with strong leadership, administrative and organizational skills and

personal attributes. The lead anesthesiologist should be given responsibility for organizing all facets of the position; establishing protocols with nursing, OR management, the OR committee and training the others assigned as back-up charge anesthesiologists in the established protocols.

In most programs, the back-up charge anesthesiologist position generally rotates among remaining anesthesiologists. Frequently the daily responsibility is assigned to the physician on call as it may



have already been determined that the on-call anesthesiologist serves in a "light-duty" capacity. Ideally, the daily charge anesthesiologist position should be limited to as few individuals as possible (although typically no one person relishes this position). Regardless of the number of individuals assigned to the function, it is critical that decision making, policy/procedure enforcement and OR scheduling/operations support be maintained in a consistent manner.

Individuals assigned to the daily charge position should have their direct care responsibilities minimized as greatly

as possible. For practices maintaining an MD-Direct Care model, where anesthesiologists are in rooms and directly administering anesthesia to patients, anesthesiologists assigned the charge position should make efforts to schedule themselves in rooms with shorter, lower complexity cases and to patients of lower acuity levels. For practices using the Care Team model of physicians medically directing CRNAs, in addition to supervising assigned CRNA cases of routine complexity, the charge anesthesiologist can provide support to PACU, Pre-admission Screening, the holding area, and emergency case coverage. Whenever possible no more than two CRNAs should be under the medical direction of the charge anesthesiologist.

The most critical role of the charge anesthesiologist is to work with nursing in management and maintenance of the schedule; optimize case throughput; and to organize, from an anesthesiology coverage standpoint, all add-ons/changes to the schedule. The charge anesthesiologist is also responsible for reviewing the following day's schedule and making anesthesiology assignments for following day's schedules. In collaboration with the charge nurse, the charge anesthesiologist should be reviewing and assisting to coordinate OR scheduling as far out as 72 hours prior to time of surgery. The charge anesthesiologist functions, in very general terms, as the "go to person for anesthesiology", however the function is proactive in participation of schedule planning and administration rather than reactive to daily and immediate needs of the schedule.

The charge CRNA should round throughout the OR as frequently as possible and be knowledgeable regarding status of individual cases and rooms. In practices without CRNAs, the charge anesthesiologist should circulate throughout the OR as frequently as possible/allowable based on direct care responsibilities

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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.

3 COST-EFFECTIVE COMPLIANCE TIPS TO JUMP START YOUR COMPLIANCE EFFORTS

By Abby Pendleton

Wachler & Associates, P.C.

As most physician practices are aware, compliance is a necessary part of running a practice in today's environment. Physicians are well advised to budget compliance costs into their annual budgets for activities such as conducting annual compliance audits and annual education. However, many compliance efforts can be accomplished with little or no expense on the part of the anesthesia or pain practice. The following compliance tips are offered to assist physicians in implementing certain cost-effective compliance measures.

TIP 1 OBTAIN BILLING AND DOCUMENTATION POLICIES:

A vital component of any effective compliance program for an anesthesia or pain practice is to ensure that the practice is apprised of all major third party payor billing, coding and documentation policies and guidelines applicable to the services provided by the practice (i.e., anesthesia and pain services). The practice should be mindful that different payors often have different policies and thus compliance with one payor's policy



does not necessarily equate to compliance with another's policy. In addition to being aware of all applicable policies, the practice must also understand these policies.

In order to make sure the practice is obtaining necessary billing and documentation rules and guidelines, the practice

should designate an individual who is responsible for (1) determining which third party payors have published policies and guidelines (this can be accomplished by making telephone calls and researching websites); (2) creating a list of the payors (with applicable websites) that have policies and guidelines and keeping the list updated; and (3) obtaining the available information. The Medicare Carriers all have websites and many have email services that are easy to register with.

TIP 2 CREATE A DISTRIBUTION SYSTEM:

Once the practice is obtaining necessary billing and documentation information, the information must be appropriately disseminated to physicians. As the policies may contain requirements regarding documentation and frequency limitations in addition to coding issues, the physicians and providers in the practice should be included in the distribution. Many physicians believe that they do not need to review the materials as long as their billing company/administrative staff is aware of the policies. Physicians must

understand that they are personally responsible for services billed under their numbers. Moreover, that the payor policies often contain information necessary for the physician such as specific documentation elements that must be contained in the record to support billing of a service. In addition to the potential audit and overpayment exposure that exists for failing to comply with payor policies and guidelines, physicians should be aware that certain patterns can lead to the physician being de-participated from a payor program.

In order to make sure that the practice has an effective distribution process in place, the practice should designate an individual responsible for (1) creating a distribution process and (2) ensuring that the process is carried out. The distribution process can be handled in a number

of ways including having a person responsible for initially reviewing all materials and copying or highlighting pertinent portions to be distributed via email, mailboxes or in another manner. The person responsible may also consider creating a distribution spreadsheet that is marked off when materials are distributed. This will serve as a double-check to ensure that all individuals who need the information were provided the information.

TIP 3 INCLUDE EDUCATION IN REGULARLY SCHEDULED MEETINGS:

As a compliment to TIPS 1 and 2, the practice should make compliance education a component in regularly scheduled Board or other corporate meetings. For example, when a new policy is published

by Medicare that impacts the practice (e.g., a policy on anesthesia for endoscopy cases, etc.), the policy should be discussed at the meeting to ensure that everyone has received the information and understands the information. If there are no new policies to discuss, the allotted time for education can be used to provide refresher education on other issues. For example, the definition of anesthesia time could be discussed to ensure everyone is tracking and documenting time appropriately.

The practice should also document these educational efforts. This can be accomplished by drafting simple meeting minutes that reflect that compliance education on a particular topic took place. It is important to document that the education occurred. The documentation does not have to include all of the substance of the discussions. ▲

WHO IS REALLY MANAGING YOUR PRACTICE?

Continued from page 9

ities. The OR charge nurse should maintain this practice regardless of anesthesiology delivery model. Together, the charge anesthesiologist and charge nurse maintain responsibility for expediting the day's activities through their familiarity with each room's status and determining when to call following patients to holding or OR. The burden of rounding in the OR and maintaining effective communication with the charge anesthesiologist is more greatly assumed by OR charge nurses in practices using the physician direct care model. The function of being knowledgeable of each case and room status and maintaining communication between nursing and anesthesiology remains the same regard-

less of anesthesiology model and in the MD-direct model the need to proactively plan the schedule in advance is even more paramount in order to minimize anesthesiologists' distraction from direct patient care on any given day. Zone phones provide a reliable means of communicating with a charge anesthesiologist when that individual must leave the OR proper to attend to responsibilities in peripheral sites.

Case assignments for following day's cases are typically made by the charge anesthesiologist enabling anesthesiologists and CRNAs to familiarize themselves with the following day's schedule; patients' conditions and case requirements; facilitate general planning of

following day's activities. Specific protocols regarding how assignments are to be made and the time they will be made should be established and followed by all charge anesthesiologists.

Indeed, some may correctly contest that being too specific in delineating expectations will also lead to unfilled expectations and dispute. OR management, administration, surgeons and anesthesiology must come to reasonable compromise as to definition, direction, expectations, and responsibilities. *Ignoring or evading the need for expectations development and anesthesiology's participation in schedule planning and administration only "Puts Someone Else in Control of Your Anesthesiology Practice"*. ▲

ANESTHESIA CUSTOMER SERVICE

By Jody Locke, Vice President

Anesthesia Business Consultants, LLC

If you believe that clinical excellence will ensure your continued success and prosperity as anesthesiologists or CRNAs, you are in for a rude awakening. A growing body of objective evidence clearly indicates that in today's competitive healthcare market a solid commitment to service excellence is a far more critical determinant of the longevity of an anesthesia practice. The problem for the typical anesthesiologist or CRNA who was trained to anticipate the physiologic responses of surgery and a complicated array of pharmacological options and respond with an appropriate alternative in a matter of seconds is that the economic forces affecting the future of all medical specialties do not respond to the same kinds of quick fixes and historical solutions as does the human anatomy. The problem-solving skills that were so carefully learned during residency have little relevance outside the operating room. It has become one of the great ironies of modern medicine that experienced clinicians who can make life or death decisions in a matter of seconds become hopelessly paralyzed in the face of today's economic realities.

Every anesthesiologist and CRNA understands the value of good customer service when dining out with the family or getting the car serviced. We can all appreciate the value of a promise that is consistent with reality. Who does not appreciate the employee that goes out of his way to deliver an unexpected service? We all understand why the waiter comes back to the table after the food has been served at a good restaurant to ensure that expectations have been met; it clearly demonstrates the restaurant's commitment to satisfying the customer so he or



she will not only come back but rave about the experience to others.

Perhaps the real problem in anesthesia is that patients are not seen as customers, but they are. So too are the surgeons who bring them to the facility, the administration that makes it all possible and the various other professionals without whose diligence and persistence operating rooms would not run at all. To the extent that the focus of one's efforts is viewed as a patient the interaction is limited to a dispassionate exercise in clinical problem solving, but when these same patients become customers then their hopes, fears, expectations and requirements all become part of a much more complicated and dynamic equation.

The situation is further complicated by the variety of customers and the diver-

sity of their expectations and requirements. While the goals and objectives of anesthesia administration can be clearly defined, it is not so easy to reconcile the often conflicting expectations of patients, surgeons, operating room staff and hospital administrators. Sorting them all out is a much less objective process; in fact, it can be highly subjective and unpredictable. It is all too easy to suggest that anesthesia providers are not good at it because this was not part of their training. Anyone who can get an "A" in organic chemistry can figure this out.

Market competition is based on the premise that customers have options that they will seek service providers who they believe are most committed to meeting their specific needs and expectations. This is the part of the equation that does not fit the clinical mindset and training. Clinicians want to believe they do what is necessary and appropriate because it is the right thing to do, not because it will win them points on a customer satisfaction survey. Just as college professors must now prepare their lesson plans with an eye to the evaluations their students will give them, so too are anesthesia providers increasingly being evaluated on their ability to communicate effectively and allay their patient's anxiety about surviving surgery.

The clinical algorithm does not allow for contradictions and inconsistencies; the medical scientist does not view the world through the same lens as the social scientist. Each anesthetic experience must be neatly packaged like a five act play. While the experience is designed to anticipate the almost limitless number of options that are created by diverse patient populations, thousands of surgical

options and different operative conditions it is not a free-form improvisation. Most options and variations on the theme are carefully scripted and the product of experience. Ultimately, all the data and indicators should be reconcilable and result in a clear course of action. The specialty understands that its practitioners must strive for and embody ability, availability and affability except when these qualities conflict or do not seem to fit the circumstances. There appears to be an unwritten rule that if in doubt stick to ability and hope that the other two will eventually sort themselves out. This is analogous to the age-old advice that it is always easier to ask for forgiveness *than* permission.

Ironically, the specialty's greatest asset is also its most critical liability. The clinician's ability to be so focused and disciplined in the operating room is his greatest liability outside the operating room where problems are not solved in a matter of seconds, nor even by the appli-



cation of a unilateral solution. There is no doubt that customer service represents a different paradigm. Customers must be enrolled in the promise of good service. Communication lies at the core of their experience and satisfaction. The good

news is that figuring it out requires much less training and experience than giving anesthesia; it just requires a willingness and commitment to accept its relevance and importance and to practice it until it becomes second nature. ▲

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WAIVER OF COPAYMENTS AND DEDUCTIBLES: TO WAIVE OR NOT TO WAIVE

Continued from page 5

Violations of the Civil False Claims Act include fines of up to \$11,000 for each false claim submitted, plus up to three times the amount unlawfully claimed. A provider who violates this Act is also subject to possible exclusion from Federal health care programs.

KICKBACK VIOLATIONS

When physicians forgive financial obligations such as copayments or deductibles, they may be unlawfully inducing the patient to purchase items or services in violation of the antikickback statute's proscription against offering or paying something of value as an inducement to generate business payable by a federal health care program.

Likewise, when physicians forgive patient financial obligations at the request of a surgeon, referring practice or hospital, they may be violating the anti-kickback statute. The anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. 42 U.S.C. 1320a-7b(b). Violation of the criminal anti-kickback statute can lead to a felony conviction punishable by a maximum fine of \$25,000, imprisonment of up to five years, or both. A conviction can also lead to exclusion from federal health care programs.

The Government can also choose to proceed civilly for kickback violations under the Civil Monetary Penalties Law (42 USC 1320a-7a). The Civil Monetary Penalties Law prohibits a provider from offering remuneration to a Medicare or Medicaid beneficiary which the provider knows or should know is likely to influence the benefici-



ary to obtain items or services billed to Medicare or Medicaid from a particular provider. The penalty for violation of this law is a fine of up to \$10,000 per item or service, and up to three times the amount claimed. The Government can also seek to exclude the provider from Federal health care programs.

PERMISSIBLE WAIVERS OF COPAYMENTS AND DEDUCTIBLES

Not all waivers of copayments and deductibles are per se illegal. In fact, there are certain circumstances in which the Government will permit the waiver. Each patient's case must be reviewed individually and the waiver must fit the following criteria:

- (1) the waiver is not offered as part of any advertisement or solicitation;
- (2) the person making the waiver does not routinely waive the amounts; and,

- (3) the person making the waiver: (a) determines in good faith that the individual is in financial need; or (b) fails to collect after making reasonable collection efforts.

42 U.S.C. 1320a-7a. Providers should maintain documentation of the need for a waiver in their files.

CONCLUSION

Anesthesia and chronic pain practices may face pressure to waive copayments and deductibles. As this article showed, medical practices that waive copayments and deductibles may risk severe criminal and/or civil sanctions. Physicians must educate surgeons, patients, friends, and colleagues as to the laws surrounding payment of copayments and deductibles. For further information, or to obtain copies of the authorities cited in this article, please contact the author. ▲

Coding Corner

IMPORTANT ROLE OF CPT SURGICAL CODES

By Jody Locke, Vice President

Anesthesia Business Consultants, LLC

Many anesthesiologists believe that the ASA codes developed by the American Society of Anesthesiologists in the 1970s are the only codes they need to know in order to bill appropriately for the services they perform. Even though it is true that more than 75% of insurance claims for anesthesia charges are now submitted using ASA codes, it would be a very serious mistake to ignore the important role CPT surgical codes continue to play in correct coding. Certified coders understand that the only accurate way to determine the appropriate ASA code is via the ASA Cross-Walk. They understand that you can go from the specific to the general, but not the other way around. Ignoring the Cross-Walk can lead to significant under- and over-billing. The following are just a few examples of the subtle interplay between the procedure-specific CPT codes and the more generalized ASA codes. Each example highlights the kind of confusion that can be created by referring only to the ASA Relative Value Guide.

❑ Consider an inguinal hernia repair. The typical inguinal hernia is coded with CPT code 49505, which cross-walks to ASA code 00830 with a basic value of 4 units. A laparoscopic hernia repair, by contrast, should be coded with CPT code 49650, which corresponds to ASA code 00840 with

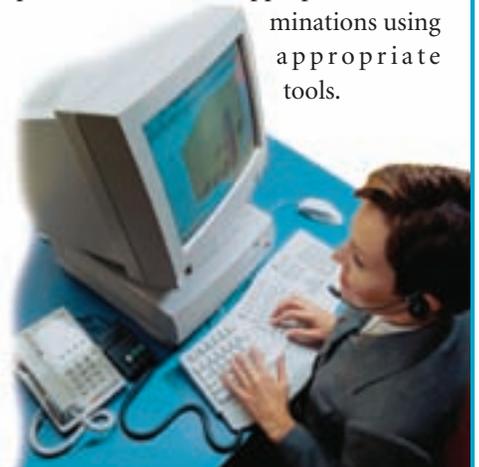
a basic value of 6 units. Our experience is that an inexperienced coder or a physician coding only from the ASA Relative Value Guide would miss the subtle distinction more often than he or she would catch it and lose 2 billable units each time as a result.

❑ Another very common area of confusion relates to the distinction between the two most common codes for abdominal procedures, ASA code 00790 with a base value of 7 units and ASA code 00840 worth 6. Because much of the large intestine lies in the lower abdomen there is a tendency to code any procedure on the cecum or large intestine with code 00840, but this would be a costly mistake. A sigmoid resection is properly coded with CPT code 44141, which is mapped to ASA code 00790 in the ASA Cross-walk. If the only point of reference were the ASA guide the result would be a loss of one billable unit per procedure.

❑ Sometimes the confusion is related to a slightly different aspect of coding. When there are multiple code options, as occurs when multiple surgical procedures are performed during a case correct coding guidelines involve picking the code with the highest relative value. To code a

case involving an EGD and a bronchoscopy the coder must consider the code for the EGD (43235) and the code for the bronchoscopy (31622). Since the first corresponds to ASA code 00740 with a base of 5 units and the second to code 00520 with a base of 6 units, the correct code for the case is 00520 and not 00740 even though it might seem that the EGD is the more significant component of the service.

These are just a few examples of the many discrepancies routinely identified by the ABC coding department when client physicians do their own coding based exclusively on the ASA Relative Value Guide. As the old saying goes, anyone that believes anesthesia billing is easy is either a terrible biller or a terrible liar. If you want optimum results let professionals make appropriate determinations using appropriate tools.



PROFESSIONAL EVENTS

DATE	EVENT	PLACE	CONTACT INFO
Aug. 5-9, 2006	American Association of Nurse Anesthetists Annual Meeting	Cleveland Convention Center, Cleveland, OH	www.aana.com
Sep. 14-17, 2006	New England Society of Anesthesiologists Annual Meeting and Conference	Cranwell Resort, Lenox, MA	www.nesa.net
Sep. 8-10, 2006	Ohio Society of Anesthesiologists Annual Meeting	Hilton at Easton, Columbus, OH	www.osainc.org
Oct. 13, 2006	American Society of Critical Care Anesthesiologists Annual Meeting	Hilton Chicago, Chicago, IL	www.ascca.org
Oct. 13, 2006	Society for Ambulatory Anesthesia Mid-Year Meeting	Chicago Marriott Downtown, Chicago, IL	www.sambahq.org
Oct. 13, 2006	Society for Pediatric Anesthesia Annual Meeting	Chicago Marriott Downtown, Chicago, IL	www.pedsanesthesia.org
Oct. 13, 2006	Society of Neurosurgical Anesthesia & Critical Care Annual Meeting	Hilton Chicago, Chicago, IL	www.snacc.org
Oct. 14-18, 2006	ASA Annual Meeting	McCormick Place, Chicago, IL	www.asahq.org
Oct. 14, 2006	American Association of Clinical Directors Annual Meeting	Las Vegas Convention Center Chicago, IL	www.aacdhq.org
Oct. 22-25, 2006	MGMA Annual Conference	Las Vegas, NV	www.mgma.com
Oct. 27-29, 2006	Association of Anesthesiology Program Directors/Society of Academic Anesthesiology Chairs Annual Meeting	Fairmont Olympic Hotel, Seattle, WA	www.aapd-saac.org
Dec. 8-12, 2006	New York State Society of Anesthesiologists Postgraduate Assembly in Anesthesiology	New York Marriott Marquis, New York, NY	www.nyssa-pga.org
Jan. 26-28, 2007	ASA Conference on Practice Management	Pointe Hilton-Tapatío Cliffs Resort, Phoenix, AZ	www.asahq.org
May 16-19, 2007	Society of Obstetric Anesthesia and Perinatology Annual Meeting	Fairmont Banff Springs, Alberta, Canada	www.soap.org
April 21-25, 2007	Society of Cardiovascular Anesthesiologists Annual Meeting and Workshops	Palais des Congrès de Montréal Montreal, Quebec, Canada	www.scahq.org
April 29-May 2, 2007	MGMA AAA Annual Conference	Sheraton Seattle Hotel & Towers, Seattle, WA	www.mgma.com



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