Meet AAI client William Binegar, MD, who practices in the relatively small market of Boise, Idaho. Boise is a small city (pop. 200,000) surrounded by a rural area where a board certified anesthesiologist might not see much potential for building a pain practice. But Binegar possessed the vision, motivation, business acumen, and clinical skills to build what has become a successful pain practice.

Dr. Binegar started practicing in Boise in 1991 after completing his anesthesia residency at the Mayo Clinic in Rochester. As a member of a group providing anesthesia at a local hospital he was given some pain cases that utilized his training in the sub-specialty of Interventional Pain Management. Binegar became board certified in Pain Management in 1994, shortly after the first certification exam was offered. From there, responding to the need in the Boise community, the pain practice gradually grew as he transitioned from the OR into a full pain practice through the hospital’s pain management services.

Continued on page 4
GROUP CONSIDERATIONS IN ANESTHESIOLOGISTS’ PAIN PRACTICES

By Paul Kennelly
Regional Director, Practice Management
Anesthesiologists Associated, Inc. (AAI)

In a time of reduced reimbursement and decreasing OR activity, many anesthesia groups look for alternative revenue streams. They may entertain the idea of establishing a pain practice. As with all practice decisions, however, there are considerations and consequences to weigh. A pain service is not a panacea to cure the financial or staffing ills of an anesthesia practice and the decision to enter the market should not be taken lightly.

It is important to understand the difference between an anesthesia practice and a pain practice. Anesthesia is a hospital-based service, while a pain practice is considered office-based. A pain practice depends on steady referral business and physicians providing the service must be willing to cultivate and develop these referral sources (see Ruth...

PAINFUL CONSIDERATIONS

It goes without saying that times are tough and money is tight. As a company, our auditors have prepared us for a five percent drop in revenues in 2009. We are not alone. Our clients are already starting to feel the cumulative effects of recession, consumer-driven healthcare and fewer elective cases. Because of this we are all tasked with exploring new and creative ways to maintain cash flow to support current salary and compensation levels for our clients. If ever there were a time for out-of-the-box thinking, this is it.

All too often our clients tend to see themselves as captive to such host institutions and at effect of such market factors. This need not be the case. In this issue of Communiqué we explore just one possible avenue of opportunity: pain management. The argument for expanding the anesthesia practice into the realm of chronic pain is clear: few physicians are as adept at needle placement and the management of pain as those whose training in pharmacology and physiology makes them experts in the effective management of analgesics and physiology makes them experts in the effective diagnosis and management of complicated symptomatology. For many the counter argument is equally as compelling: effective management of an outpatient pain practice represents a paradigm shift from the hospital-based service most of our clients provide so successfully and a potentially perilous diversion from core competencies.

In our quest for answers to these potentially perplexing questions we have called upon some of our most qualified staff and friendly clients to help you sort out the pros and cons, and practical considerations. Pain management is a broad term for a broader spectrum of practice options. No matter where you fall on the continuum, our contributions will take you from the general to the specific, allowing you to explore and contemplate the strategic and financial considerations of pain. Whether these ideas and insights allow you to further grow and develop your practice or the wisdom of caveat emptor, they are sure to pique your interest and challenge your assumptions.

As always, we strive to provide you with relevant contemporary experiences and practical tips and guidelines from across the company and across the country. Portland’s Ruth Morton profiles success factors for one client’s practice in our opening piece, while Seattle’s Paul Kennelly outlines how a pain management practice fits in the context of a larger anesthesia group. Pittsburgh’s Cathy Reifer then shares some of her research and knowledge of OIG risk areas. Atlanta’s Hal Nelson adds his list of the ten most common missed revenue opportunities for the pain practitioner. Deena Andrews in our Michigan headquarters contributes an explanation of the bell-shaped curve of evaluation and management services.

We also offer variety with a discussion of retirement plan options by Jill Thompson, information on important changes to the PQRI for 2009 along with some ideas on how PQRI pay-for-reporting will set the stage for pay-for-performance and pay-for-perfection from Karin Bierstein, an update from MGMA-AAAs president, Brenda Dormman, on the social networking tool that has replaced the AAA list serv, and some insight into the future of diagnosis coding from Sharon Hughes. In this issue, we are also very pleased to offer you the reflections of the anesthesiologist who wrote “Have You Hugged Your Anesthesiologist Today?” We are sure you will recognize moments from your own professional lives in this beautiful entry from the author’s blog, Notes of an Anesthesiologist.

These are all important aspects of the ever changing and always fascinating discipline we call anesthesia practice management. May they offer you new insights, stimulate your thinking about your own practice and, ultimately, help you plot the future of your practice.

Thanks for your continued support.

Tony Mira
Founder and CEO
Morton’s article “Building a Successful Pain Practice” in this issue of the Communiqué). It is here where many anesthesia groups face their first test. A service approach to both patient and referring physician is critical and failure to cultivate one can prove fatal. Often, anesthesia groups have physicians who have an interest in pain management but who are not prepared to devote their entire energy to the effort. Additionally, if a group’s culture is to view pain services as an adjunct to its core anesthesia business and not as a stand-alone practice which requires adequate resources, the pain service is destined to struggle. Unless the group decides they are “all in” they may find that this part-time approach yields more problems than expected. If your group is considering a part-time approach, make certain you understand the expectations of the marketplace and the ramifications that a part-time approach can have for your practice.

Operational matters such as call and vacation coverage should be discussed. How will the group respond to after-hour calls if the pain physician is unavailable and how will it cover the pain practice during vacations and other absences? Will the practice cancel the clinic when the pain physician is unavailable, on vacation, or caught in an OR case – and run the risks of damaging referral relationships and inconveniencing patients? Referral physicians and patients expect smooth access to coverage. Inconsistent service and a high hassle factor will shift their business to other providers.

Staffing may be an important factor for anesthesia practices when deciding on a pain practice if OR volume is low. Using the pain service as a safety valve to cover the operating room can be a short-term solution. Note the following caveats about such an approach. While it takes someone out of the OR rotation, groups may forget to plan for what happens when OR volume increases or pain referrals drop off. How will the practice respond when the pain physician wants to return to the OR pool on a full-time basis? How quickly can he or she come back in to the OR pool, and what is the impact on other pain providers when someone drops out of the pain service? In its most general terms a practice cannot allow the pain providers to simply roll in or out of the OR rotation based on the current economics of the group. Practices must have a clear understanding of how a clinician enters or exits the pain practice. The group should also address how the pain service fits into the OR call schedule. If the pain specialists are covering pain call they may balk at carrying an equal share of the anesthesia call. That means an increased call burden for the other members of the group.

Outline and agree clearly how the pain physicians will share in the group’s revenues and costs. Carving pain into its own compensation pool makes sense but decide up front how items such as overhead, call stipends, billing fees, and other practice expenses will be allocated to the pain pool.

Pain practice is on the radar for the payer community. It is very important to understand each of your payers’ policies and to investigate if the payer will negotiate a stand-alone pain contract. Review the agreement carefully to understand key issues such as pre-authorization requirements. In states that include pain medicine services in CRNAs’ scope of practice, some groups employing CRNAs may believe that the profit margin will be higher if they rely on lower cost providers to deliver pain care. This may be a red herring; some health plans may adjust their fee schedules to account for this difference. Be certain to evaluate the compensation exhibit carefully.

While a pain service makes sense for many groups, it is not for everyone. Give careful consideration when considering pain management as part of your practice ensuring you understand the internal dynamics and culture of your Group, the economics of your marketplace, who your competitors will be, and health plan reimbursement policies. Failure to address these issues may result in larger and more complex internal concerns for the practice. If the group is serious about developing a pain service, consider the use of a consultant conversant on group governance, pain billing, compliance, and market analysis to help with the process.
BUILDING A SUCCESSFUL PAIN PRACTICE

Continued from page 1

With a sound business plan that included an emphasis on marketing, Dr. Binegar launched his own practice in early 2004. He bought and rehabilitated a building in the city core with good visibility and in a high traffic location. His RN wife, Wendy Binegar, with sound business and marketing instincts, guided many aspects of the construction, clinic set-up, and marketing. They hit the ground running. While he initially feared that business would be slow and that he would need to tap the line of credit he had arranged, the fear was unwarranted. In four years the business has experienced steady growth. Today, Dr. Binegar enjoys a robust and satisfying practice – Pain Care Boise - that employs a PA, five medical assistants, a Nursing Administrator, and a Practice Representative at his pain clinic and AAAHC fully accredited ambulatory surgery center in downtown Boise.

FACTORS CONTRIBUTING TO GROWTH AND SUCCESS

When Dr. Binegar started he was among the first in the greater Boise area to provide chronic pain services. But today there is more competition with at least 15 pain practitioners and a pain center at one of the two largest hospitals. Several factors have contributed to the growth and success of Pain Care Boise despite the increasingly competitive environment.

Clinical Expertise and Motivation

Dr. Binegar is board certified in both Anesthesiology and Pain Medicine, and he keeps current with new technology, techniques, and treatments through CME courses. He has gained the confidence of referring physicians, whom he regards as customers in this context, with referrals from well over 200 referring physicians in a year. Among them are orthopedic surgeons, neurosurgeons, neurologists, chiropractors, oncologists and family practitioners. By providing services in both a clinic and an ASC, he has diversified his product line to include:

- Spinal Cord Stimulation
- Radiofrequency Ablation
- Peripheral Nerve Injections
- Discograms
- IntraDiscal ElectroThermal Annuloplasty
- Coblation/Nucleoplasty
- IDD Therapy / Advanced Traction Technology
- Stellate Ganglion Blocks
- Lumbar Sympathetic Blocks
- Epidural Steroid Injections / Interlaminar Technique
- Nerve Root Injection / Tranforaminal Epidural
- Facet Joint Injections

Dr. Binegar uses his skills and has invested in current technology and competent staff to aid him in providing “treatment for improved life.” In part, this tag line of his practice informational material reflects his motivations. He enjoys performing interventions, talking with patients and getting to know them. Helping patients with their pain – having them return and say “You saved me” – is very satisfying. The gratitude of patients is evidenced by several hand-written “thank you” notes posted behind the scenes on the clinic lunch room bulletin board. Beyond the satisfaction of his work, clinic and ASC ownership provides independence from the dynamics of the hospital and surgeon relationships, and supports his own quality of life and family lifestyle with no call or night-time trauma work. And, in turn, he is dedicated to improving the quality of life for all whom he treats.

Patient Focused Care and a Caring Clinic/ASC Environment

Observation of the Clinic and
ASC during business hours reveals many examples of intentional patient-focused practices and protocols that Pain Care Boise has developed. Patients are welcomed warmly by front office staff. Wait times are kept to a minimum by appropriate scheduling and efficient work flow design, so patients feel valued and important. Interactions with patients are respectful and friendly without seeming patronizing. Staff members take time to listen to patient stories and field their expressions of angst. Patients are provided with written information about procedures and treatments that help them make informed decisions. The practice web site provides downloadable patient forms that can be completed at the convenience of the patient. When scheduling new patients who have no internet access the office mails a packet complete with information about the practice, financial information, printed forms, a business card, and HIPAA materials.

The clinic and ASC physical environments were carefully designed and decorated to be friendly and comforting as well as safe, efficient, and professional. Dr. Binegar intentionally reinforces the facility design as he purposefully takes his time with patients, and focuses on enjoying what patients bring to him, while also staying on task and on time.

Exceptional Marketing and Communication

Pain Care Boise utilizes a multi-dimensional approach to marketing and branding that others can emulate. First and foremost they have a clear marketing plan. Second, they have one individual in charge of marketing. Their approach to patient care, the patient experience, and “treatment for life” are integral to their branding and the practice identity.

All elements of their marketing weave similar messages and themes – whether in their user-friendly web site (http://www.PainCareBoise.com), their print informational materials for patients and physicians, or their billboard, newspaper, or radio ads. They utilize patient testimonials excerpted from the patient satisfaction surveys they routinely conduct and from voluntary expressions of gratitude sent to the practice. Testimonials, along with information about Dr. Binegar, are played while telephone callers are placed on hold. Patients recently gave live testimonials for radio spots produced at a local station studio.

Two other elements are key components of their marketing and communication process: 1) a strong tracking and referral program, and 2) a comprehensive internal marketing program.

Referral Program - Essential to launching any new specialty practice is the referral chain. Wendy Binegar initially took on the role of Practice Representative to reach out to potential referring physicians, educate them about services, and ensure that communication is effective in maintaining a referring relationship once established. Care is taken to provide appropriate patient information to referring physicians so they are assured of their patient’s care. When patients come on their own, they are asked the identity of their primary care physician, and if it is permissible to share treatment information with the other physician. If the patient agrees, Dr. Binegar sends a report to the primary care physician as a courtesy. In this process of “reverse referral”, the Practice Representative follows up with a letter and visit to the physician, providing information on all the services provided by Pain Care Boise.

Additionally, referrals often come from satisfied patients. When patients are

Continued on page 6
the source of a referral, Dr. Binegar calls them to thank them for their trust and their referral. Dr. Binegar also annually meets individually with physicians who give him frequent referrals, seeking to learn if he is accomplishing what the referring physicians intend.

Internal Marketing – Office staff are responsible for helping the practice deliver on its brand promise. They reinforce, through their behavior, a caring and competent practice. They also utilize protocols and “scripts” that help them listen to potential patients carefully; ask questions that solicit information relevant to future treatment; provide information about Dr. Binegar, treatments, insurance, and costs, and guide patients and potential patients appropriately.

Excellent Employee Programs Employees are selected and developed in alignment with the practice goals of high clinical quality and a caring environment. Clinical protocols were developed and documented to guide staff in preparing and assisting in the treatment of patients. Office procedures were also developed and documented and all medical assistants are cross-trained in their roles in both the clinic and ASC, as well as in office positions. An employee manual spells out employment policies, benefits, and expectations. Innovative incentives for efficiency and new patient scheduling, celebrations of marriages, birthdays, and births, and employee social events build staff camaraderie and enhance staff commitment to the practice. The range of excellent employee programs increases the capability of employees, in marketing terms, “to deliver on the brand promise.”

Billing Partner that Supports the Business Goals Integral to the successful growth of Pain Care Boise has been its relationship with its billing company – Anesthesiologists Associated, Inc. (AAI), which is now the West Coast division of ABC. Based in Oregon, AAI, with a nearly 50 year history of serving anesthesiologists, provides expertise in facility and anesthesia and pain billing. AAI’s approach to business echoes Dr. Binegar’s approach to his customer – it makes the practice feel “valued” and know that AAI will do what it takes to make things better. This has meant being responsive to his questions and concerns, providing great follow-up, and delivering information and reports that he needs. For example, when Dr. Binegar needed to know which procedures were profitable, AAI implemented a tracking system that provided data on payments by insurance carriers. Overall, AAI was and is very willing to work with Dr. Binegar and his staff and to grow with the practice. ABC is likewise delighted to continue supporting AAI and ABC clients in all their endeavors.

Starting or Growing Your Pain Practice The decision to start or grow a pain practice is one that merits in-depth consideration – of market, lifestyle, finance, clinical expertise, referrals, human resources, facilities, etc. Dr. William Binegar’s success in building his pain practice provides a solid model for those posed to make such a decision.

For a review of factors to consider in starting a pain practice, see “Group Considerations in Anesthesia Group Pain Practices” by Paul Kennelly, AAI Regional Director, in this issue of the Communiqué.
Coding for chronic pain management is a challenging task. Each pain practice must be well versed in the billing nuances of this specialty. Otherwise, dollars are left on the table each day, without the practice even being aware of what it should be receiving for a case. Below is a list of the ten most common items that I have seen practices fail to document correctly and thus fail to receive full payment for a patient encounter.

1. **Failure to document “bilateral” for facet joint injections.** Fee schedule payments for these injections are for one side only. Bilateral injections need to be indicated on the superbill and procedural note. Coders need to double the charge for these injections and also need to append either the -50 (bilateral) modifier or the –LT and –RT modifiers in order for the payer to consider both injections for payment.

2. **Failure to document “bilateral” for transforaminal epidural injections.** Fee schedule payments for these injections are for one side only. Bilateral injections need to be indicated on the superbill and procedural note. Coders need to double the charge for these injections and also need to append either the -50 (bilateral) modifier or the –LT and –RT modifiers in order for the payer to consider both injections for payment.

3. **Failure to document “bilateral” for transforaminal joint injections.** Fee schedule payments for these injections are for one side only. Bilateral injections need to be indicated on the superbill and procedural note. Coders need to double the charge for these injections and also need to append either the -50 (bilateral) modifier or the –LT and –RT modifiers in order for the payer to consider both injections for payment.

4. **Failure to document fluoroscopy used for radiological guidance in pain injections.** Almost all payers will reimburse for fluoroscopy used in association with pain injections. Yet many groups neglect to bill for this service. Coders should be aware that facets, transforaminals and SI joints cannot be done without fluoroscopic guidance.

5. **Failure to document Consultations vs. New Patient Visits.** When a patient is sent to a pain consultant to render an opinion and possibly initiate treatment, a consultation should be billed. Consults pay 25% more than a new patient visit code, so failure to bill for these codes can cost a practice a lot of money. Documentation needs to include a written request for the opinion from the referring physician and a copy of the consult note needs to be sent to the rendering physician after the encounter.

6. **Failure to document IV conscious sedation.** Sedation is often used by pain practices during injection procedures. IV conscious sedation is billable and is reimbursed by many payers. Be sure to document this item in order to receive full payment from insurance carriers.

7. **Failure to document individual levels in a discogram study.** Per the AMA, a pain physician can bill two codes for each disk evaluated in a discogram. One code is for the injection of dye and the other code is for the radiological supervision and interpretation. So when a practice bills for a three level discogram, they should be billed for two codes.

**Continued on page 15**
Understanding the Bell-Shaped Curve of Evaluation and Management Services

Deena Andrews, CPC
Coding Department Manager
Anesthesia Business Consultants, LLC (ABC)

Many practices at ABC not only perform anesthesia and pain medicine services, but also see patients for evaluation & management services (E&Ms). The reasons for providing these services vary. They include assessing chronic pain conditions or performing a history and physical to determine the appropriateness of anesthesia. Correct documentation and coding is essential to make sure that the documentation and coding represent what you did for the patient. In this article, we will attempt to give you some fundamentals of these services. We will also look at the bell shaped curve of E&M services.

When documenting an E&M service, the first thing a practitioner needs to decide is whether the patient is new or established. In general, a patient is considered new if he or she has not been seen by anyone of the same specialty in your group within the last 3 years. To clarify, if a provider has the specialty designation of either interventional or chronic pain and the patient had anesthesia by an anesthesiologist in the group without these designations in the last three years, the pain service can be billed as a new patient. On the other hand, if the pain physician does not have an interventional or chronic pain designation, and is billing under the anesthesiology designation, a new visit would not be billable. If a patient is not a new patient based on the above criteria, bill for an E&M service for an established patient.

The next step is to decide the type of service you will be performing: a consult or a visit. A consult can be billed when your opinion is requested by an appropriate source. If the referring provider wants you to take over the care of the patient for the particular condition, you will not have a consult, but a visit (e.g., if you received a referral script for injections). The other requirements of a consult are that there must be an order in the chart for the opinion (in both the requesting & consulting physician’s records), there must be a written report, and this report must be shared with the referring provider.

Should your evaluation not be for a new patient or a consult, you would be looking at a follow-up visit. Note that a follow-up visit is billable separately from and in addition to a procedure only approximately 1-2% of the time. The reason for this is that in order to bill for the visit you must have a separately identifiable diagnosis that does not relate to the procedure that is being performed. The evaluation of the patient prior to a procedure is included in the fee schedule for the procedure.

Once the questions above have been answered, one can move forward with the documentation of the evaluation and management service. The three primary components of an E&M
service are: History, Examination, and Medical Decision Making. Another key consideration in deciding the level of service is medical necessity.

“Medical necessity” is the overarching criterion for payment, in addition to the components mentioned above. The volume of documentation should not be the primary influence for choosing a level of service. Therefore, after meeting the documentation requirements as stated above, determine whether the level of service is necessary for the condition evaluated.

All health insurance carriers compare data at national and local levels to target outliers for audits. In general terms, carriers expect the graph that represents the different levels (intensity) of E&M codes to take the shape of a bell curve. To help limit your practice’s vulnerability to an insurance audit, you should compare the data for your practice to national and local benchmarks. On page 8 is a graph (Figure 1) that represents national benchmarks for the second quarter of 2008 for consults and new visits in the ABC claims database. You will see the bell-shaped curve mentioned above. You will further observe that the intensity (CPT level I-V) of new visits skews to the left and the intensity of consults is skewed to the right. This skewing might be explained by the fact that consultations are by definition requested by another provider, which would indicate that the patient likely needs a more comprehensive evaluation than the typical Level III.

The second graph (Figure 2) represents follow-up visits. This includes (1) visits that were not performed in conjunction with a procedure, (2) visits that were performed in conjunction with a procedure but are separately billable and (3) visits that are not separately billable. You will see that there is the same bell shaped curve, but it is narrower. This is because follow-up visits tend to be non-crisis related and therefore would not have the extremes that you would have in consults and new patient visits.

The majority of practices do not follow the bell precisely. There are reasons why a provider might be skewed one way or the other. Some of the reasons for skewing to the left could be that hand-written notes are used. In ABC’s experience with hand-written notes, we find that these notes typically do not support higher levels of service.

In the same vein, you might have such a busy practice that there is less time for thorough documentation and therefore, even though the work has been performed, it is not documented to the extent needed to support a higher level of service.

Reasons for the curve skewing to the right include the possibility that you have a newer practice. If so, you may be seeing higher acuity patients and spending more time with them. You also have more time for thorough documentation of your services since you have a smaller volume of patients. Another reason for a skew to the right could be that your practice has a high percentage of elderly patients who require prolonged services for chronic illnesses. In ABC’s experience, the major factor contributing to higher levels of service is the use of electronic medical records (EMRs). EMRs, by nature, help the provider better document the services that are performed in a shorter period of time. An EMR also requires documentation at the time of service and that is when the details of the service that was delivered are in the physician’s immediate awareness.

There are other reasons for skewing to the left or right, but note that upon an audit either direction will be questioned. Your best strategy is to understand the rules for billing evaluation and management codes and to document correctly.
HEALTH CARE QUALITY AND MEASURING PERFORMANCE

Karin Bierstein, JD, MPH
Vice President for Strategic Planning and Practice Affairs
Anesthesia Business Consultants, LLC (ABC)

MEDICARE PHYSICIAN QUALITY IMPROVEMENT INITIATIVE (PQRI)

The third year of reporting quality under the PQRI began on January 1, 2009. The bonus that physicians and other providers may earn by successfully reporting the requisite number of measures has increased from 1.5% to 2.0% of their total Medicare allowables for the year. To be eligible for a $5,000 bonus, the practice would need to have $250,000 in allowed Medicare charges, i.e., almost 1,000 anesthesia cases (average units per case: 12 x average 2009 conversion factor: $20.92 = $251.04 average payment per case, not including lines or postoperative pain management).

For many anesthesiologists, the “virtue” of ensuring antibiotic prophylaxis or minimizing the risk of catheter-related bloodstream infections will be a greater incentive than the PQRI monetary reward.

There have been important changes to the two measures applicable to anesthesiology:

1. Measure #30: Timing of Prophylactic Antibiotic—Administering Physician
   • This measure should now be reported when the anesthesiologist performs one of approximately 218 distinct services as defined by CPT™ codes (00100, 00102, etc.). Previously it was reported in all cases for which there was an order for antibiotic prophylaxis. The complete list of eligible codes is available at http://www.asahq.org/Washington/2009pqri.htm

   • Code 93503, insertion and placement of flow-directed catheter (e.g., Swan-Ganz) for monitoring purposes, is now on the list of denominator codes. This makes Measure #76 much more important in anesthesiology practice than it was in 2007 or 2008, when it was only reported with codes 365XX, insertion of a central venous catheter.
   • The Measure #76 catheter insertion protocol now allows “acceptable alternative antiseptics per current guideline” and not just 2% chlorhexidine for cutaneous antisepsis.

THE PQRI IS JUST THE BEGINNING OF MEASURING “PHYSICIAN QUALITY IMPROVEMENT”

In addition to the bonus payment, nonmonetary incentives are leading anesthesiology practices to participate in the PQRI. First, as noted above, virtue is its own reward. Research and reported hospital data have shown that prophylactic antibiotics are administered less than 100% of the time in many operating rooms – in some cases, considerably less than 100% of the time. Anesthesiologists have responded to these data by adopting protocols that improve the performance rate because “it’s the right thing to do.”

Many anesthesiologists also recognize
that more and more systems will be scoring their performance in the future. Whether or not the metrics selected by third parties are valid indicators of the quality of medical work, they are here to stay.

Many physicians are already accustomed to receiving ratings from commercial organizations such as Health Grades, which sells reports comparing doctors on a five-star scale and also makes available at no charge the results of patient ratings (http://www.healthgrades.com). The California Office of the Patient Advocate, an independent state office within the Department of Managed Health Care, maintains a web site (http://www.opa.ca.gov/report_card/doctors.aspx) on which patients and others can check relative ratings of medical groups in two domains: (1) “meeting national standards of care” and (2) “patients rate medical groups.” Groups are evaluated on 14 specific national standards of care, including testing cholesterol for diabetic patients, not giving children with upper respiratory infections antibiotics for colds and other viruses, and screening patients for colorectal, breast and cervical cancer. See Figure 1.

A new entrant in the field of public reporting of physician quality is the Maine Health Management Coalition, whose 50 members include hospitals, medical groups, health plans and employers who work together to measure and report on quality and safety of care (http://www.mhmc.info). The MHMC, like most entities that measure physician performance, is still limited to primary care. Health Grades offers reports on numerous specialties, not including anesthesiology. There are too few nationally-recognized metrics for anesthesiologists – as well as minimal opportunities for patient-consumers to choose one group over another – for third parties to be reporting on our specialty today.

Some anesthesiology groups themselves have selected dozens of validated measures in addition to antibiotic prophylaxis (e.g., perioperative myocardial infarction, unanticipated return to OR) and have begun to measure their own performance. One large group in North Carolina, Southeast Anesthesiology Consultants, developed the Quantum Clinical Navigation System™ beginning in the mid-1990s to track and improve the quality of its clinical services and is now reporting its performance against national benchmarks to hospitals, health plans and even its malpractice insurance carrier to support higher compensation rates and lower premiums. The Quantum Clinical Navigation System™ is available through ABC. For more information, see the Fall 2008 issue of the ABC Communiqué (http://www.communiquenews.com) and/or contact ABC at 517.787.6440, Extension 4113.

As more anesthesiology quality measures work their way through the national endorsement process in which

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**Figure 1** California Office of the Patient Advocate Medical Group Ratings (Partial Table)

### Medical Group Ratings At-a-Glance

**Meeting National Standards of Care:** We compared each medical group’s patient records to a set of national standards for quality of care.

**Patients Rate Medical Groups:** We compared how medical group patients rate their care and service.

<table>
<thead>
<tr>
<th>Los Angeles - Westside</th>
<th>Meeting National Standards of Care</th>
<th>Patients Rate Medical Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Managed Care/Access Medical Group</td>
<td>★★★</td>
<td>Not rated</td>
</tr>
<tr>
<td>Accountable Health Care IPA</td>
<td>No report due to incomplete data</td>
<td>Not rated</td>
</tr>
<tr>
<td>Axminster Medical Group</td>
<td>★★★</td>
<td>★★★</td>
</tr>
<tr>
<td>Bay Area Community Medical Group</td>
<td>★★★</td>
<td>★★★</td>
</tr>
<tr>
<td>Cedars-Sinai Health Associates</td>
<td>★★★</td>
<td>★★★</td>
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<tr>
<td>Cedars-Sinai Medical Group</td>
<td>★★★</td>
<td>★★★</td>
</tr>
<tr>
<td>Family/Senior Medical Group</td>
<td>★ ★</td>
<td>Not rated</td>
</tr>
</tbody>
</table>
Quality Information leads to Quality Healthcare.

Have you had time to read the Federal Register proposed rule on adoption of the ICD-10 published last August? I’ve noted a few interesting items for you from the following proposal. The Notice of Proposed Rulemaking (NPRM) for the adoption of ICD-10-CM and ICD-10-PCS was published in the August 22, 2008 Federal Register (CMS-0013-P) (http://edocket.access.gpo.gov/2008/pdf/E8-19298.pdf).

ICD-10 was adopted by the World Health Assembly in 1990. Currently, the United States is the only G7 nation (the other G7 nations are Canada, France, Germany, Great Britain, Italy and Japan) continuing to use ICD–9 for morbidity reporting. Furthermore, Great Britain, Denmark, Finland, Iceland, Norway, Sweden, France, Australia, Belgium, Germany, and Canada use a clinical modification of ICD–10 for reimbursement and/or administrative purposes.

The lack of specificity in ICD–9–CM also limits our ability to develop rapid interventions for emerging diseases affecting international populations. Diagnosis and procedure information are captured from administrative data that are submitted on health care claims, and admission and discharge summaries, but if the codes do not match the international standard and are unable to be compared, their significance is lost. Additionally, hospitals utilize diagnosis and procedure codes for utilization review, disease management, and research. Therefore, in addition to the need for precise diagnosis and procedure codes for payment purposes, detail and precision in coding are critical to the national and international health care community for mortality reporting, biosurveillance, treatment of patients, hospital management, and research. (See Figure 1 below).

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.

Proposed ICD-10 Rule Published

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Figure 1: Improvement in Response Time to Cross-Border Public Health Warnings of Disease Threats as a Result of ICD-10 Implementation
Health Care Quality and Measuring Performance

Continued from page 11

Multiple stakeholders including payers and other specialties reach consensus on the adoption of new measures, it seems inevitable that quantitative scoring of comparative performance will become common. In our specialty, consumer reporting may never assume the importance that it has in primary care, but hospital and payer credentialing and maintenance of certification are going to involve evaluation of standardized performance data for anesthesiologists as well as other physicians.

Many anesthesiologists have begun participating in the PQRI to prepare themselves for a day when health plans will base differing payment amounts on individual performance data. For hospitals, that day arrived six years ago, when CMS began to reduce the annual payment update for hospitals that did not successfully report specific quality measures under one of the Medicare Hospital Quality Initiatives. Also in 2003, partnering with the Premier 300-hospital system in another Quality Initiative, CMS launched a demonstration project giving higher annual Medicare payment updates to the top-performing hospitals and, later, reducing the annual update for the lowest-scoring performers.

On October 1, 2008, CMS implemented regulations that limit payments to hospitals for treating patients for events that should “never” have occurred — the Hospital Acquired Conditions (HAC) regulations. Medicare will no longer pay a higher amount for certain cases having a secondary diagnosis for a condition that (1) was not present on admission and (2) could reasonably have been prevented by following evidence-based guidelines. If, for example a patient is admitted for pneumonia and is discharged with a new secondary diagnosis of a traumatic hip fracture, Medicare will not pay the hospital for treating the knee injury.

Medicare will still pay the surgeon and the anesthesiologist who perform the open reduction of the fracture. It is not hard to imagine that once there is an acceptable methodology for allocating a pro rata share of responsibility for a perioperative injury — think of wrong-site surgery — to the doctors as well as to the hospital, the payers will deny some or all of the claims for the physicians’ services.

It is in this light that anesthesiologists with long-range vision are preparing and practicing for a pay-for-performance future through the PQRI today.
An increasing number of highly compensated individuals are finding that contributions made to their 401(k) and profit sharing accounts have reached the maximum allowable amounts. Now those same individuals can increase their contributions through the increasingly popular Cash Balance Plan.

As the fastest-growing retirement plan in the United States, 401(k) plans allow participants to contribute up to $22,000 for 2009, depending on the participant’s age. A profit-sharing plan allows employers to contribute another $32,500 on behalf of the participant. However, once the annual maximum contribution has been reached ($54,500 for those 50 years of age and over or $49,000 for those under 50 years of age), then no further contributions can be made for that participant on a pre-tax basis.

On the other hand, a Cash Balance Plan contribution can be as much as $200,000, which varies by age, per year. For individuals making in excess of $245,000 per year, and who have a need for additional tax deductions, a Cash Balance Plan provides a welcome respite from the low retirement plan contribution levels available through a 401(k)/profit sharing plan.

Since 1985, when Bank of America implemented the first Cash Balance Plan, thousands of companies have followed suit. Citing predictability and ease of administration, firms often opt for Cash Balance Plans because of portability, which helps attract employees, especially the young, mobile workforce in high-turnover industries. Initially, corporations with more than 10,000 employees, such as AT&T, Bell Atlantic and IBM, adopted Cash Balance Plans. However, a change in the tax law in 2001 allowed contributions to increase by as much as 60%, making Cash Balance Plans much more attractive to successful businesses and professional service firms. The Pension Protection Act of 2006 further cemented the future of Cash Balance Plans by allowing for substantial increases in contributions and tax savings.

A Cash Balance Plan is a defined benefit plan that specifies the amount of contribution to be credited to each participant. The contribution can be either a flat dollar amount or a percentage of pay. The plan credits interest on those contributions at a guaranteed rate. Each participant has an individual account which resembles the accounts in a 401(k)/profit sharing plan. All participant accounts are maintained by the plan actuary who generates annual participant statements.

The guaranteed rate of return is spelled out in the plan document and is not dependent on the plan’s investment performance. The rate of return changes each year and for many plans is equal to the yield on the 30-year Treasury bond, which in recent years has been around 5%. Once participants terminate employment, they are eligible to receive the vested portion of their account balance determined by the plan’s vesting schedule.

Companies that are good candidates for Cash Balance Plans have one or more of the following characteristics:

1. Owners who desire to contribute more than $49,000/$54,500 per year—a Cash Balance Plan allows for...
both an acceleration of retirement savings and a large tax deduction.

2. Owners over 40 years of age who desire increased tax deductions or wish to catch up on their pension savings—the maximum contributions allowed in Cash Balance Plans are age dependent. Therefore, the older the participants, the faster they can accelerate their savings.

3. Companies that have demonstrated consistent profit patterns—because a Cash Balance Plan is a defined benefit pension plan with required contributions, a consistent cash flow is important.

4. Companies that are already contributing 3% or more to employees’ accounts or are at least willing to do so—while Cash Balance Plans are often established for the benefit of owners and other highly compensated individuals, other employees also benefit. The plan normally provides a minimum contribution of 5% to 7% of pay for the company’s other employees.

The types of businesses that are candidates for Cash Balance Plans include professional service businesses such as CPA and law firms, medical groups and family or closely-held businesses where there are a number of owners who are at their 401(k) and profit sharing contribution limit. Cash Balance Plans may not be right for everyone. Because they are a type of defined benefit plan, Cash Balance Plans require a commitment to specific contribution level for two to three years. It is important that a company display consistent profit patterns in order to consider a plan. One should also consider company demographics and company culture. Cash Balance Plans can allow for large contributions for select employees such as the owners; however, some company cultures dictate all employees are treated equally with regards to retirement plan contributions.

Cash Balance Plans have to be amended in order to change contribution levels because they are not profit sharing plans under which contributions can vary year to year, depending upon profitability. Employers can designate different contribution amounts for various participants. However, the frequency of amendments to change benefits may be restricted in the absence of a valid business reason. For example, if a company’s profit is not expected to support the Cash Balance Plan contribution, the plan can be amended. The plan can also be frozen or terminated.

If you are looking for additional tax deductions and need to catch up on retirement contributions, you may want to evaluate the merits of a Cash Balance Plan, which provides a significant opportunity to increase contributions into a qualified retirement plan, as well as defer taxable income.

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**THE TOP 10 LOST REVENUE ITEMS IN CHRONIC PAIN MANAGEMENT**

Continued from page 7

discogram (i.e., L3-4, L4-5, L5-S1) six codes should be billed.

8. **Failure to properly appeal unlisted procedures.** Unlisted procedures are procedures which have not yet been assigned a CPT code by the AMA. Unlisted procedures will always be declined by payers without an accompanying medical necessity letter. These procedures can best be appealed by having peer review literature supporting the medical necessity for the procedure. Appeals should be sent to the attention of the medical director of the insurance company.

9. **Failure to bill for ultrasonic guidance.** Similar to fluoroscopic guidance, ultrasonic guidance can also be billed separately when used for guidance in pain injections. The difference is that with ultrasound, there needs to be an archived image of the ultrasound in the patient’s medical record in order to bill.

10. **Failure to document “counseling” or “coordination of care”.** When a pain practitioner spends more than 50% of an office visit either counseling or coordinating care, the physician can use the total time spent on the encounter to substantiate the E&M code selected. This is the only occasion where time is used to select an E&M code in chronic pain management.
Have You Hugged Your Anesthesiologist Today?

Reprinted with permission from Notes of an Anesthesioboist, the journal (http://anesthesioboist.blogspot.com) of a gifted Boston area anesthesiologist, musician and writer.

That’s it. I’ve had it. I’ve read yet another piece of writing that demonstrates a complete lack of understanding of what anesthesiology is and entails, and I need to vent.

So allow me to lower the mysterious drapes for a moment and let you into my world.

No one gets up one day and says, “I want to be an anesthesiologist when I grow up.” I wanted to be a ballerina, or a bookstore-café owner, or an artist of some kind – someone who was required to pay close attention to the world, take real notice of it, and take creative and compassionate action. But I am neither a ballerina nor a bookseller. I am an anesthesiologist.

Frequently people ask me a version of “What on earth made you choose that?” I try to explain that I love the way anatomy and physiology come alive moment-to-moment in daily practice. Or I try the concrete approach and admit that I actually enjoy placing intravenous lines and breathing tubes. The response I get is usually a glassy-eyed “Uh-huh” or, occasionally, a nose-wrinkling “Eew.” If the conversation progresses beyond “eew,” the more people talk to me about what they think I do – that is, if they think I actually do anything in the first place – the more bewildered I get over how difficult it is to convey to others an understanding of my work.

One time I visited a patient the day before her planned surgery. After I explained what she could expect, she exchanged a few words with her family in her native language. They clearly assumed I couldn’t understand them. An older woman instructed my patient not to bother asking me too many questions, saying, “She’s just an anesthesiologist; what do they know?”

After years of annoyance at many people’s assumptions that I was not a physician because of my gender or my young appearance, this remark – not the first I’d heard along those lines – made me take stock. I realized that not even other physicians understand what we anesthesiologists do, sitting back there in our little cockpits behind some blue drapes (“the blood/brain barrier”), periodically looking up at large machines but appearing otherwise idle.

One doctor asked me once, “You have to take an oral exam? For anesthesia? Is there enough material in anesthesiaology for an oral exam?” Considering the profound suffering the ordeal of the orals caused me, and causes many anesthesiologists, I felt like shaking the guy by the hair – except he didn’t have any. If other doctors don’t get it, how could I hope to find anything but murkiness and misunderstanding in the perceptions of non-doctors?

I did a little experiment. I constructed a detailed questionnaire about what kind of physician people would want to come to their rescue if they collapsed in a public place. No one wrote down that they would be glad if an anesthesiologist were around.

I figured out about four broad, wide-spread misconceptions about anesthesiologists:

• we are not doctors
• what we do is easy
• we don’t establish rapport with our patients
• if anything goes wrong, “it’s Anesthesia’s fault.”

Then I realized something else: because people have absolutely no idea what to imagine about our work, they decide to make stuff up. It’s amazing.

People react to the mysterious in one of three ways: with fear, with fabrication, or with efforts to deepen their understanding. The fear I see daily. The fabrication – well, let’s just say if I hear one more person declare that all I do is put people to sleep, then sit next to my anesthesia machine and—what? Daydream? Wait for the patient to wake up? Twiddle my thumbs—that will be one person too many. But that is what people say.

I have heard more times than I can count, “Well, all you do is knock people out. How hard can that be?” My hairdresser asked me when we first met, “So, once you put the patient to sleep, do you leave the room since your job is done?” Excuse me? My job is done? Then who did he think was keeping the patient...
alive while the surgeon was mucking around with his vital organs and causing all sorts of dangerous disturbances to his vital signs? Who was going to make judgments about what was specifically appropriate for that patient’s particular brand of heart defect, or lung disease, or neurologic abnormality? And then there’s my personal favorite: “You mean, anesthesia for appendicitis is different from anesthesia for heart surgery?” Hmm. 1-inch abdominal incision versus sawing through a person’s chest. Yes, it’s different.

My husband once tried to mollify my irritation by pointing out that people just couldn’t be expected to know about anesthesia. “Do you know what a machinist does? Or a gaffer?” To which I replied, “Of course not. I have no idea. But I don’t assume that their jobs are easy, and I don’t presume that their work can be summed up by one simple task.” Even my lawyer husband had to admit I had a point. “Well,” he said, “what DO you do, and what do you want people to know about it?”

I don’t think of myself as a doctor whose function is to induce sleep. My primary function is to resuscitate those who need resuscitating. Yes, about 1% of what we do does involve calculating the appropriate dose of the appropriate drug, drawing it up into a syringe, and injecting it into the veins of people who would like to avoid feeling pain or hearing unfamiliar noises during surgery. But I spend most of my energy making sure that I can bring them back. Designing an anesthetic is a thoughtful act. My resuscitation of my patients often begins the night before I meet them, when I am going over safety plans in my head.

Most of my training, in fact, was focused on becoming an expert at resuscitation in its various forms – reviving patients who were dead or near death; intubating those who could not breathe; rehydrating the dehydrated; unparalyzing those I had paralyzed chemically for surgical purposes; awakening the unconscious with judicious use of anesthetic drugs and gases; creating pain relief and anti-nausea regimens for the afflicted; and making sure failing heads, hearts, or lungs functioned well enough to ensure survival of a given surgical procedure.

Late in my training, I realized our level of expertise when I asked a resident in a different specialty – one whose members also take pride in their resuscitation skills – how many intubations she had done after two years. I was expecting to hear perhaps half of my quota of about 1200. “I’ve logged about 84,” she replied. And this was the physician-type people wanted nearby if they collapsed in a public place and needed a breathing tube to stay alive.

Anesthesia affects consciousness, blood pressure, heart rate, respiration, and a whole host of other body processes. If I am not there to watch over you, that first injection can harm you. And that’s just the first step. I should be breathing for you if you stop (and you will), administering fluids when your surgeon nicks a “bleeder,” and giving you the medications you need to wake up safely and comfortably. This can mean a lot of scurrying around, checking, and readjusting within the confines of my “cockpit.” Is the IV running too fast? Is the machine blowing in enough air with each breath? How’s the urine output? Oh, they’re closing – should I turn the gas down now, or will he take a while? Is that heart rate a little too high for his aortic or mitral valve problem? Did I give the drug to slow it down? Let me dive down under the drape to make sure his eyes are still protected…This is all behind-the-scenes, largely unacknowledged work, but it makes even the tiniest task a meaningful act, and I love that about my job.

And that’s just in the O.R.

I’ve written elsewhere about my E.R. and I.C.U. intubations, but I haven’t even addressed the expertise anesthesiologists bring to laboring women, not only in placing and ensuring the safety of epidurals for labor and spinals for C-section at any given moment, day or night, but also in caring for mothers when childbirth becomes dangerous. On occasion help is needed for an alarmingly sluggish newborn, and yes, we are useful for that too. The code that made my heart beat the fastest was when “Anesthesia, Stat” was paged overhead to the labor and delivery suite and I realized the person coding wasn’t one of the moms, but rather a minutes-old newborn. The family practice attending physician handed over the amount of sweat and tears it took to acquire and prove those capabilities. This is not a job you can commit to just for the pay and be truly happy. It’s too hard.

Nor can anesthesiologists be motivated simply by glamour and prestige – there’s too much ignorance about anesthesiology to allow for either. For me, real job satisfaction has to rest on tenacity, self-respect, humility, kindness, and happiness with the work itself. The big pay-off, in my mind, lies in my relationships with my patients, whom I may meet only briefly but during intensely significant moments in their lives, when they may need the most comfort. All the scientific gobbledygook that goes into the practice of anesthesiology has a chance to get sifted and transformed into a true human connection, into resuscitation that goes well beyond the needs of the body.

It’s my hope that someday, when a person collapses in the bookstore-café that I don’t own, or in the opera house in which I’m not dancing (or playing the oboe!), and an anesthesiologist responds, it will be common knowledge that the professional responding to the situation is providing expert care in the truest sense of the phrase. ▲
Members of the Medical Group Management Association (MGMA) Anesthesia Administration Assembly are now part of an online social-networking community – a benefit of our membership. The MGMA Member Community is the first of its kind – created for medical practice administrators. Because our members consistently rank networking with other members as their primary reason for belonging to MGMA, the Association looked for ways to enhance and centralize networking technology.

MGMA, headquartered in Englewood, Colo., is the premier membership association for professional administrators and leaders of medical group practices. It provides networking, professional education, resources and political advocacy for 21,500 members nationwide. Members have the opportunity to identify themselves with a particular medical specialty for networking purposes. There are 15 different such assemblies. In addition, there are already more than 35 MGMA created member communities to choose from and currently over 1500 members have identified anesthesia (AAA) as their primary networking community!

“Our members have already found each other on public social-networking sites, but can get lost amid the clutter – and millions of other users,” said William F. Jessee, MD, FACMPE, president and CEO of MGMA. “We know our members best and understand what features will be most valuable to them in their jobs. This is truly the next generation of professional interaction and we’re proud to be among the first adopters.”

Features of the new MGMA Member Community social networking platform include:

- Discussion groups – Members can create ad hoc, event-based or issue-related groups;
- Blogs – Members can create their own blogs for other members to read, respond to and score;
- File repository/resource library – Members can upload, download and search documents to share with their peers;
- Expanded subscription options – Members can participate online, via e-mail or both; and
- Enhanced member directory and member profiles – Members can search for one another by name, location, certification level, membership participation, organization type, practice type, practice setting, specialty, physician count, interest areas, education and more.

**Enhancements planned to make Member Community even more robust**

MGMA plans to enhance the Member Community over the next several months, adding:

- RSS (Real Simple Syndication) feeds – Members can opt for notification when information on topics of their choosing is posted on the MGMA Community;
- Study groups – Driven by members for professional certification exams;
- Wikis – Member-generated encyclopedias of practice management or specialty-specific information; and
- Polling – Member-generated questionnaires for all members or subsets of the MGMA membership.

By taking the lead in online networking, MGMA hopes to increase members’ satisfaction and the value of their dues.

MGMA members can go online now and begin a new and enhanced interaction with colleagues. Non-members can find out how to join by visiting www.mgma.com.

For more information contact Nancy Cross at MGMA 303.799.1111, ext 1250 or ncc@mgma.com.
The Government is Watching Facet Joint Injection Claims

Cathy Reifer, CPC
Regional Director of Client Services
Anesthesia Business Consultants, LLC (ABC)

According to a report issued by the HHS Office of the Inspector General (OIG) on September 17, 2008 (http://oig.hhs.gov/oei/reports/oei-05-07-00200.pdf), 63% of all claims for facet joint injections submitted to Medicare in 2006 were coded incorrectly. The report goes on to state that the miscoding resulted in Medicare’s overpaying approximately $96 million.

The publication of this report serves to remind anesthesiologists and pain specialists that this is a potential high risk area for “fraud and abuse.” You should be paying close attention to the way your practice is billing and documenting facet joint injections. Be completely familiar with the Medicare carrier policies (Local Coverage Determinations) for these procedures.

We can expect that the OIG’s efforts have also alerted private payers to the potential for preventing and recovering some payments for these procedures. Heightened caution is in order across the board – especially if the services are provided in private office settings, where more billing errors were found than in hospitals or ambulatory surgical centers. Make sure that you have copies of any applicable private payer policies on facet joint and other pain medicine injections.

Common Errors in Documentation

- Lack of documentation, either missing altogether, or lacking a description of the procedure performed
- Missing key details such as cervical or lumbar levels
- Insufficient documentation to support the diagnosis and demonstrate medical necessity

Know the Rules for Bilateral Procedures

Both the cervical facet joint injection code, CPT™ 64470, and the lumbar code, 64475, are for single level injections. Codes 64442 and 64476 are the respective add-ons for each additional level. Using multiple lines of the add-on codes instead of modifier 50, which designates bilateral services, yields a 50% overpayment.

- 64470 and 64475 are primary codes
- 64470 and 64475 are unilateral procedures
- 64472 and 64476 (each additional level) are add on codes
- Can not bill independent of primary code
- Paravertebral facet joint injection coding is per facet joint NOT number of needles inserted (CPT Assistant September 2004)
- Multiple surgery rules apply to primary codes, not add-on codes

By paying careful attention to this area of heightened OIG scrutiny, you will be better able to prevent any unwanted attention from governmental or private payers.
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<td><a href="mailto:joyceFAAA@embarqmail.com">joyceFAAA@embarqmail.com</a></td>
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