

A quarterly publication providing topics of interest to the healthcare industry

Anesthesia Business Consultants has recently merged with Coronis Health, creating a leading platform that provides end-to-end technology-enabled solutions to healthcare companies across the US. We are excited to start this next chapter and continue bringing the best thought leadership to our esteemed colleagues in healthcare.

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Reducing Adverse Events:

Technology Takes Center Stage

BY JUSTIN VAUGHN, MDIV

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“Do no harm” is seen as the central tenet and prime directive of an oath traditionally taken by physicians since the time of Hippocrates (c. 400 BC). Though this precise phrase is not found in the oldest extant Greek copy (c. AD 275) of the so-called Hippocratic Oath, that copy does contain a phrase of similar sentiment: “I will abstain from all intentional wrong-doing and harm.” While not universally accepted today, over half of modern doctors still bind themselves to some version of this oath. Indeed, modified versions of the oath have found their way into codified law within some jurisdictions.

Regardless of its origin and irrespective of its legal status, the Hippocratic Oath remains as the lodestar and the keystone upon which all of medicine is fixed. With that in mind, it would seem to behoove those engaged in the profession of healing to proactively remove—to the extent reasonable—every identified risk to patients’ health during a care episode and/or hospital stay.

Such risks, when actualized, become known as adverse events—a fall, a fever, an unforeseen complication that further

compromises the patient’s condition or overall health. It is the task of both the clinical staff and the facility to ensure that the rate of adverse events is continually reduced. This is not only for the purpose of abiding by the ancient prime directive but also to ensure that the hospital maintains a positive standing in the eyes of the public. There is nothing more damaging to a facility’s reputation than getting only one out of five stars on the social media apps. Patients fill out satisfaction surveys. These become transparent, which means that potential customers are going to know which hospital in town has the worst record for patient safety and outcomes.

THE RISK IS REAL

The *New England Journal of Medicine* recently published a study that points to a significant incidence of adverse events in hospitals, generally. In a random sample of 2809 admissions, researchers identified at least one adverse event in 23.6 percent of admissions. Among these 978 adverse events, 222 (22.7 percent) were judged to be preventable and 316 (32.3 percent) had a severity level of

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**CEO
CORNER**

Overcoming the Challenges of Today

BY TONY MIRA
Interim CEO

Managing an anesthesia practice in the current environment can be quite challenging, which explains why so many independent practices are either choosing to merge with larger entities or relinquishing their independence to become hospital employees. Given a manpower shortage and the impact of growing Medicare and Medicaid populations, too many anesthesia practices are struggling with the same challenge to generate enough revenue to recruit and retain a sufficient number of qualified providers to meet the service expectations of the facilities they serve. As students of the specialty we at Coronis we have always been dedicated to exploring and assessing strategies that will allow our clients to achieve their clinical and financial success. To that end, this issue of the Communiqué includes six insightful articles by industry experts that should help you explore new opportunities and avoid current risks.

Our very own Justin Vaughn leads us off with a cautionary tale of medical mistakes. His is a big picture view of adverse events that can greatly impact the reputation of hospitals and anesthesia practices. He shares four particularly useful strategies that groups can implement.

We often remind our clients that anesthesia has more and better data about what actually happens in the operating rooms and delivery suites



than any other source. The challenge is knowing how to use this data effectively. Jody Locke's article is a particularly interesting review of surgeon production patterns. He shares some very practical advice about ways to enhance the relationship between anesthesia departments and administration.

Mark Weiss, JD is always sharing his perspective on legal issues affecting our clients. There has been much discussion of the Company Model over the past few years. It is a tricky topic. His discussion of a recent OIG opinion sheds some valuable light on the potential perils.

Corporate practice of medicine laws have been established in 30 states. They can be especially challenging to today's Friendly Physician model organizations. Kathryn Hickner, Esq. addresses the particular challenges associated with physician organizations that are owned and managed by non-physicians.

Ever since the specialty of anesthesia first started to encourage the notion

of the pre-surgical home and the importance of having anesthesia providers take more responsibility for the management of patients through the entire continuum of the surgical experience, practices have been trying to figure out how to make it a reality. The most common approach has involved the establishment of pre-surgical testing clinics. Most would agree they enhance the quality of clinical care; the challenge is their economics. Rita Astani, our president of anesthesia services, explores the arcane world of Evaluation and Management codes in an effort to put things in perspective.

We are especially proud of this Communiqué and welcome your comments and feedback. We are especially interested in your suggestions for future topics.



Reducing Adverse Events

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serious (caused harm that resulted in substantial intervention or prolonged recovery) or higher.

The study concluded with the following summation:

Adverse events were identified in nearly one in four admissions, and approximately one fourth of the events were preventable. These findings underscore the importance of patient safety and the need for continuing improvement.

So, the risk to patients who enter your facility is all too real. Ensuring that the “do no harm” mantra is followed with consistent vigilance, therefore, becomes all the more critical. Now, with the help of technology, that job has just become easier.

SEEKING SOLUTIONS

According to a March 12 *Wall Street Journal* report—as recounted by *Becker’s Hospital Review*—modern technology is being used in some hospitals to address and further reduce four specific adverse events. Accordingly, the report encourages hospitals to consider incorporating these four strategies to strengthen their patient safety efforts:

1. **Medication Mistakes.** Issuing incorrect medications or dosages remains as among the most common causes of adverse events. To combat this, several hospital systems are using artificial intelligence (AI) to identify patterns in medication reporting, logging, etc., in an effort to detect errors. The system can also “notify clinicians of potential harm in real time by, for example, catching changes in lab results that show a medication may be causing harm to the kidney.”
2. **Patient Falls.** Enhancing patient education coupled with technology can reduce the rate of adverse events. For example, Brigham and Women’s Hospital in Boston developed a program to identify a patient’s risk of falling in 2007 and later worked with a New York hospital system to further enhance it. Now, nurses calculate fall risk for each patient and take appropriate preventative actions, like moving medication lower or scheduling bathroom breaks. They also display fall risk warnings for the patients to see and have seen fewer falls as a result.
3. **Surgical Mistakes.** Tools, such as the patient risk calculator developed by the American College of Surgeons or the University of Florida’s AI-powered

system called MySurgeryRisk, aim to better prepare surgeons and predict which patients might need more specialized care or who could be at higher risk for complications related to surgery.

4. **Stopping Infections.** Implementing use of a quality and safety dashboard that works with electronic medical records (EMRs) can act to alert clinicians in real time concerning issues that may need to be addressed to prevent infections, such as for central lines and urinary catheters.

According to the previously-referenced *New England Journal of Medicine* study, nearly 25 percent of all adverse events are preventable, but this will require medical institutions to take increasing advantage of the strategies and technologies that are available to assist in the “do no harm” directive. Protocols must be put in place and training must occur to enhance the efficacy of the care being provided by hospital staff and clinicians with hospital privileges. An aggressive and focused effort on the part of all in avoiding these adverse events will help the hospital’s reputation, improve patient outcomes and create a boost in staff morale. It’s just the thing that would cause an ancient Greek physician to smile.



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at multiple national healthcare events. He has written two books on compliance-related issues and is the author of numerous articles relevant to the hospital space. Justin can be reached at Justin.Vaughn@coronishealth.com.

Surgeons are Critical

Anesthesia Stakeholders

BY JODY LOCKE, MA

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In many of his presentations to participants at the ASA Practice Management Seminars, Dr. Amr Abouleish often suggested the following three levels of American healthcare. In fact, these were basically his leitmotif for understanding practice management.

Healing is an art.
Medicine is a science.
Healthcare is a business.

Anesthesia training programs focus extensively on the first two, but economic realities make it imperative that practices come to terms with the third. The greatest challenge facing most American anesthesia practices today is to generate enough revenue to recruit and retain a sufficient number of qualified providers to meet the expectations and contractual requirements of the administrations they serve.

It has been said that the effective management of the operating room suite can be compared to sitting on a three-legged stool where administration represents one leg, the surgeons the second leg and anesthesia the third. While there may be a close working relationship between administration and anesthesia, the relationship between

administration as customer and surgeons as providers can be somewhat mercurial, which often leaves the anesthesia department captive to challenging, inconsistent and unpredictable staffing and call requirements. It should be obvious that the overall objectives of the administration and the anesthesia department are aligned; both want optimal productivity and reasonable profitability, but this is not always clear. The fundamental problem is that surgeons only use operating rooms as they need them. Fortunately, hospital administrators are starting to welcome input from the anesthesia department to explore options for more effective O.R. management. Some forward-thinking anesthesiologists such as Michael Roizen, MD of Chicago have been suggesting that anesthesia should play a much more active role in the management of the operating rooms. There is clearly an opportunity for anesthesia departments to share insights gleaned from their comprehensive billing database.

Limited personal experience often conditions anesthesia perceptions of surgeon behavior and motivation. The reality is that a detailed assessment of one surgeon's goals and objectives is just that: an assessment of one

surgeon's practice. Every practice is a unique reflection of the personality of the surgeon, the nature of his or her specialty, economics and the requirements and expectations of the community. Some anesthesia providers have been tempted to generalize based only on their personal experience with surgeon behavior. While there is always some truth to these perceptions, as is often the case, most generalizations are simply not true. Understanding the complex factors that determine surgeon behavior is the key to the development of effective management strategies. As we all know, managing surgeon behavior can be a challenging business, but no single set of providers has more experience and more powerful data tools than those in anesthesia.

Obviously, the pandemic had a dramatic impact on American medicine. From March 2020 to the end of that year, hospitals adopted a wide variety of strategic measures to mitigate the potential impact of the virus. Many suspended the scheduling of elective cases for a period of time, which had a dramatic impact on surgeons and anesthesia providers. The good news is that, by the end of 2021, most facilities had returned to normal and surgical case volume was at or above pre-pandemic

levels. Now is an especially good time to identify significant patterns and trends and formulate new strategies for the future. As a result, the focus of this analysis is the surgical activity of 10 significant anesthesia practices during calendar year 2022. The basis of our analysis is date of service (DOS) billing data from multi-site practices across the country. The goal was to identify those unique measures and metrics that anesthesia providers have access to as a result of their billing database that are especially useful in understanding the practices of their surgical colleagues. Because the focus is surgical activity in the operating room, we have excluded obstetric and endoscopic cases. The data does, however, include all types of surgical venues, including inpatient and outpatient venues.

As one can imagine, the resulting dataset is huge. Even relatively small facilities might have a list of hundreds of surgeons who book cases. Given the fact that 20 percent of surgical practices typically generate at least 80 percent of surgical cases, we have focused on the top surgical practices that are most responsible for overall operating room utilization and trends. One of our client practices, for example, provides services to 963 surgeons, of which 202 generate 80 percent of total surgical case volume. We have further refined our focus to the top 20 surgeons for each anesthesia practice because for most practices the top 20 surgeons generate 30 percent of total surgical revenue. The goal here is to provide templates and models that will allow the typical practice to better understand the strengths and

weaknesses of their surgeon community in measurable and comparable economic terms.

CRITICAL METRICS

The three most important questions to ask when assessing a given surgeon’s practice are as follows.

- »» How important is the surgeon to the anesthesia practice? What percentage of cases is the surgeon responsible for and what percentage of total surgical revenue does this generate? Surgeon loyalty is also a critical factor. How likely is the surgeon to continue current levels of productivity?
- »» How productive is the surgeon? Does he or she generate a full line up of cases each day such that anesthesia can count on productive days of at least 50 billed ASA units per day, and is there a fair amount of down time? Most surgeons want their 7:30 starts, but how often is there a lineup of cases to follow?
- »» What is the impact of payer mix? Payer mix is the key to profitability. The higher the percentage of Medicare and Medicaid units billed, the lower the average yield per billed unit.

Tracking surgeon production patterns can prove to be an interesting exercise that requires some practice and attention to detail. The ability to consistently extract meaningful data may require some refinement and experience. Ultimately, the goal is to be able to determine the profitability of the top surgeons’ practice by comparing the cost per anesthetizing location day and its revenue potential.

TABLE 1: THE TOP 20 SURGEONS

Rank	Specialty	% of Cases	% of Units	% of Collections
1	Orthopedics	4.72%	3.39%	2.47%
2	Pain Management	3.17%	1.66%	1.63%
3	Fertility	3.11%	1.50%	2.16%
4	General Surgery	2.16%	2.28%	2.40%
5	Fertility	2.16%	1.02%	1.41%
6	Orthopedics	2.04%	2.56%	2.32%
7	Orthopedics	1.99%	1.48%	1.47%
8	Orthopedics	1.76%	1.80%	1.59%
9	Oncologist	1.71%	1.70%	1.79%
10	OB-GYN	1.62%	0.77%	1.12%
11	Cardiologist	1.60%	1.59%	1.50%
12	Orthopedics	1.56%	1.25%	1.11%
13	Plastic Surgery	1.43%	1.47%	1.05%
14	Orthopedics	1.37%	0.59%	0.40%
15	Orthopedics	1.33%	1.48%	1.57%
16	Orthopedics	1.21%	0.83%	0.89%
17	Neurosurgery	1.17%	1.97%	1.80%
18	Ophthalmology	1.16%	0.61%	0.42%
19	Orthopedics	1.14%	1.26%	1.24%
20	Ophthalmology	1.12%	0.65%	0.47%
		37.54%	29.86%	28.83%

Surgeons are Critical

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THE TOP 20 SURGEONS

It is always helpful to identify the top 20 surgical practices. Table 1 presents the data for one of the sample practices. The top 20 surgeons were determined based on case count, which is perhaps the most common units of measure for surgical volume. The total billed units are one indicator of anesthesia revenue potential. The collections represent what has actually been collected and posted for the surgeon based on the date of service (collections are matched to the charges they are paying off).

This table is quite representative of all the sample practices in the fact that the majority of surgical practices in the top 20 are orthopedics. These inevitably rise to the top of the list for two reasons: a majority of their patients have commercial insurance that pays at premium rates and many orthopedic anesthetics involve the use of nerve blocks for which there is separate payment. Of particular note in this table is the relationship between the percentage of cases and the percentage of total collections. This is a clear indication of the profitability of the practice. Neurosurgery, for example, involves fewer but longer cases, which makes it more profitable. When the percentage of collections is at or above the percentage of cases it indicates a very profitable surgical practice. It should be noted by contrast that eye surgeons do mostly Medicare cases so their percentage of collections is well below the percentage of cases.

SURGEON PRODUCTIVITY

There are two kinds of surgeons in most hospitals. There are those that bring most of their surgical cases to the facility and who have a good relationship with administration. These are the loyal ones that often get special favors from the facility. It is not uncommon, for example, to have a hospital build a separate wing for a busy orthopedic practice. The significance of these surgeons to the success of the facility and the anesthesia practice cannot be overstated. The irony is that, for the most part, anesthesia providers are more

responsible for the quality of the patients' surgical experience than the surgeons. While it used to be that anesthesia providers were primarily focused on the comfort and safety of their patients, administrators are increasingly focused on customer service; in other words, they want surgeons to feel well treated and well cared for.

Giving surgeons block time is the most common form of recognition facilities grant their favorite surgeons. This is one of the most common tools facilities use to encourage surgeon loyalty. The question, of course, is how consistently

TABLE 2: INPATIENT

	Total Cases	Medicare Cases	Medicare %	Medicaid Cases	Medicaid %	PPP
1	4	2	50%	0	0%	50%
2	479	221	46%	34	7%	53%
3	8	6	75%	0	0%	75%
4	1	1	100%	0	0%	100%
5	44	24	55%	3	7%	61%
6	7	6	86%	0	0%	86%
7	285	133	47%	0	0%	47%
8	109	47	43%	17	16%	59%
9	1	0	0%	0	0%	0%
10	0	0	0%	0	0%	0%
11	31	22	71%	0	0%	71%
12	34	25	74%	0	0%	74%
13	195	128	66%	8	4%	70%
14	81	44	54%	0	0%	54%
15	30	25	83%	0	0%	83%
16	195	99	51%	25	13%	64%
17	242	105	43%	1	0%	44%
18	21	9	43%	7	33%	76%
19	43	32	74%	0	0%	74%
20	282	144	51%	52	18%	70%
	2,092	1,073	51%	147	7%	58%

TABLE 3: OUTPATIENT

	Total Cases	Medicare Cases	Medicare %	Medicaid Cases	Medicaid %	PPP
1	1,040	354	34%	2	0%	34%
2	448	210	47%	22	5%	52%
3	821	443	54%	128	16%	70%
4	665	159	24%	0	0%	24%
5	545	110	20%	1	0%	20%
6	562	26	5%	1	0%	5%
7	239	66	28%	0	0%	28%
8	410	160	39%	34	8%	47%
9	484	36	7%	1	0%	8%
10	485	222	0%	0	0%	0%
11	452	288	64%	1	0%	64%
12	437	53	12%	2	0%	13%
13	272	154	57%	0	0%	57%
14	375	177	47%	0	0%	47%
15	424	100	24%	1	0%	24%
16	255	134	53%	21	8%	61%
17	207	79	38%	0	0%	38%
18	417	140	34%	5	1%	35%
19	393	81	21%	0	0%	21%
20	145	47	32%	38	26%	59%
	9,076	3,039	33%	257	3%	36%

each uses his or her block time. Block time can only be an effective tool when it is managed closely.

Table 2 Inpatient and Table 3 Outpatient, provide an example of useful metrics for evaluating surgeon productivity.

While the operating room staff is usually focused on the number of cases a surgeon performs per day, what is far more useful and relevant to the anesthesia department is the average number of billable units generated. Billable units are a function of average cases per day multiplied by the average units per case. The data indicates how much variability there is among practices. The key metric here is the number of billable units generated per clinical day. Conventional wisdom holds

that a provider needs to generate at least 50 ASA units paid at a reasonable average rate to cover the cost of providing the care.

THE IMPACT OF PAYER MIX

There are two realities that are continuing to challenge all medical practices in the United States. They are the aging American population and the increasing percentage of patients who are covered by Medicare and Medicaid, the rates for which are set by federal and state governments, and not the market. Most practices are seeing a one percent increase in their Medicare population per year. Medicaid percentages are also increasing for many, but for different reasons having to do with the local

economy. The average Medicare rate is about \$22 per ASA unit while many commercial rates can be as much as \$60 per unit. Medicaid rates vary considerably from state to state but are most discounted in the Empire State where New York Medicaid only pays \$10 per unit.

Table 2 Inpatient and Table 3 Outpatient, provide examples of the analysis of payer mix by place of service. First, it should be noted that for the anesthesia practice from which this data comes, 81 percent of all cases for the top 20 surgeons were performed on an outpatient basis in 2022. Understanding why cases are performed on an outpatient basis versus in a hospital is a function of many factors most of which relate to the convenience of the patient and the surgeon. Clearly, it is easier to book a case in a surgery center than in a traditional hospital. For the patient, access is also much easier. There is a belief in some practices that surgeons may tend to book their Medicare cases in the hospital while they take their patients with good insurance to outpatient facilities. While this may be a factor for some surgeons, it is not the primary consideration.

In Tables 2 and 3, Medicare and Medicaid cases are broken out. This allows for the identification of a Medicare percentage and a Medicaid percentage. The combination of the two is referred to as the public payer percentage, noted here as the PPP. It is certainly true that the PPP is higher for inpatient cases than outpatient, 58 percent versus 36 percent, but it should be noted that there is considerable variability from surgical practice to surgical practice.

TABLE 5: TYPICAL AVERAGE DAILY PRODUCTION METRICS

Surgeon	Units Per Day	Units Per Case	Yield Per Unit	Yield Per Day
1	41.61	14.04	\$42.39	\$1,763.86
2	35.16	12.91	\$33.95	\$1,193.64
3	53.38	14.97	\$34.18	\$1,824.51
4	33.79	8.10	\$50.98	\$1,722.65
5	39.28	14.90	\$46.69	\$1,833.84
6	108.56	6.10	\$31.47	\$3,416.68
7	39.70	13.16	\$43.23	\$1,715.89
8	40.55	13.48	\$43.53	\$1,764.89
9	56.46	14.95	\$38.64	\$2,181.53
10	37.37	13.60	\$40.89	\$1,527.85
11	26.89	12.00	\$43.61	\$1,172.52
12	33.00	12.57	\$44.59	\$1,471.65
13	25.15	13.99	\$31.57	\$794.26
14	15.18	7.80	\$92.53	\$1,404.95
15	38.49	14.85	\$45.62	\$1,755.80
16	27.61	12.61	\$37.37	\$1,031.76
17	18.77	6.89	\$36.80	\$690.84
18	18.43	9.35	\$43.94	\$809.95
19	24.62	6.89	\$42.05	\$1,035.44
20	49.34	21.80	\$37.35	\$1,842.60
Average	35.13	12.33	\$41.60	\$1,461.61

Table 5 shows actual metrics for the top 20 practices for a typical anesthesia practice. Ideally, this should be prepared for your practice as a way of identifying how each surgeon achieves his or her results. As has been discussed, every facility offers privileges to an extensive list of surgeons, but it is usually the top 20 percent that generate 80 percent of the cases and revenue. It is because of this that every anesthesia practice must ensure that the top surgeons are as productive as possible.

Typically, the average daily yield for the top surgeons should be \$2,000. As the chart indicates, there are a number of notable exceptions, but they are clearly outliers. The concern is that all the rest of the surgeons yield much less per day. The actual cost of providing the

care will vary considerably based on the configuration of the care team and compensation levels. The point is that for most practices there is simply not enough revenue generated from patient collections to cover the cost of the care required; this explains why most practices require financial support.

Table 5 shows the critical production metrics that determine the yield per clinical day. The actual formula multiplies the number of cases per day by the average units per case by the actual net yield per unit. Some surgeons perform more cases with fewer units per case, as is true of endoscopists whose average case only generates about six or seven units, while others perform fewer longer cases. The yield per unit can be a big differentiator. Cardiac surgeons,

for example, perform long cases that generate 40 to 50 units per case but because these are mainly Medicare patients the yield per unit is limited by discounted Medicare rates and so their yield per day may also be low.

QUALITIES OF THE BEST SURGEONS

The best surgeons typically embody the following, and these are qualities that anesthesia providers should look for and encourage as part of their commitment to excellent customer service.

1. Top surgeons understand and appreciate the value of anesthesia and are always open to collaborative approaches to the management of their patients. They recognize the importance of quality anesthesia care. There is no better example of this than orthopedic surgeons that encourage the use of nerve blocks for post-operative pain management.
2. The best surgeons are loyal to the institution and consider themselves partners with administration. There is no greater challenge to anesthesia practices than surgeons who might decide to take their cases elsewhere. Anesthesia needs to be able to count on consistent surgical volume.
3. O.R. utilization can be very significant. When surgeons insist on 7:30 starts, the hope and the expectation of the anesthesia providers is that they will get the to-follow cases. Everyone likes full days of cases without significant gaps. Nothing is more challenging than the surgeon who schedules a couple of cases in the morning then goes to his office, only to bring one or two add on cases late in the day.

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4. The acuity of care, as measured in average units per case, can be especially relevant. The relationship between the anesthesia providers and each surgeon is greatly enhanced when there is a certain degree of predictability with regard to the types of cases performed and anesthetic requirements.
5. Although quality of care has nothing to do with a patient's insurance or ability to pay, as mentioned at the outset, healthcare is a business. Payer mix and financial yields are always important aspects to monitor and track. The more surgeons that have productive and profitable practices, the less support that will be needed from the facility.

FINAL THOUGHTS

One might wonder how the data and concepts presented here will help the typical anesthesia practice that sees itself captive to a system over which it has no control. For many practices, the information and analysis presented here might simply provide

an entertaining confirmation of their current perceptions of the surgical practices they work with daily. To those who are willing to give this information serious consideration, however, there are a variety of possibilities. This article is dedicated to the spirit of partnership that most administrations are now seeking with their anesthesia providers. Building on the themes of accountability, collaboration and innovation, these data and metrics can prove relevant on at least three levels.

First, the sharing of timely and reliable data is a necessary prerequisite to collaboration. Maybe the administration has drawn many of the same conclusions about its surgeons as the anesthesia team, but maybe not. Maybe they only see part of the picture and are limited by the requisites of hospital administration. There is always great value in helping administrators understand and appreciate the specific economics of anesthesia. This can only be helpful, especially when it comes to the negotiation of a stipend.

Second, the anesthesia providers are critical stakeholders in the management of the operating rooms. The data and insights gleaned from their billing system offer a unique set of opportunities and insights for process improvement. No one has more and better information about how surgeons actually work and what makes them more or less efficient. The challenge and opportunity for all anesthesia practices is to take more control of the factors that determine their income and lifestyle.

Drilling down on surgeon behavior is the next level of involvement for most anesthesia practices. It is one thing to know what the collections are and what the impact of payer mix is, but it is quite another to know where the surgical cases are coming from and how important surgeon loyalty is to the future of the practice. Not only will the kinds of information presented here be of interest to your administrators, but sharing them will open up a whole new level of dialogue and partnership.



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More Bad News For the Company

Model and its Sponsors

BY MARK F. WEISS, JD

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“Everyone is doing it” is no more of a defense to a federal Anti-Kickback Statute (AKS) violation, than the fact that dozens of people are selling crack on street corners is a defense to drug charges.

A recent OIG Advisory Opinion serves as a stark reminder that deals in which “anesthesia management companies” sponsor and manage captive anesthesia groups owned by surgeons, aka “company model deals,” come fraught with danger of criminal prosecution.

Although OIG Advisory Opinion 23-05, made public on August 18, 2023, addresses a proposed business arrangement involving intraoperative neuromonitoring (IONM), the scheme it shot down is completely analogous to the sponsored form of the company model of anesthesia services.

Whether prosecutions and whistleblower actions will follow is anyone’s guess, but an educated guess is that it’s simply a matter of time.

A PRIMER ON THE COMPANY MODEL

Let’s begin with a quick primer on the company model.



Although it can take various forms, the most prevalent are a direct model and a sponsored model.

The direct model involves the formation of an anesthesia services company by the surgeon-owners of an ambulatory surgery center (ASC). The purpose of the company is to provide all of the anesthesia services for the center. Prior to the company’s formation, all anesthesia services were provided by anesthesiologists (working alone or in concert with CRNAs) either for their separate accounts or for the account of their anesthesia group. After the formation of the company, the anesthesiologists and CRNAs are employed or subcontracted by the company, with a significant share of the anesthesia fee being redirected to the company model’s owners, the surgeons.

In the sponsored model, a so-called anesthesia management company fosters the creation of an anesthesia company for the surgeons, who become its owners. The management company continues to provide operational support from a menu including recruiting, credentialing, managed care contracting, billing and collection—in many cases providing a turnkey management solution to the surgeon-owners. As in the direct model, after the formation of the company, the anesthesiologists and CRNAs are employed or subcontracted by the company, with a significant share of the anesthesia fee being redirected to the company model’s owners, the surgeons.

The Proposed Arrangement

The entity requesting the Advisory Opinion 23-05 (Monitoring Company) contracts with various hospitals and ASCs for IONM, which involves a technical component performed by a neurophysiologist and a “live,” but often remote, monitoring of the test results and waveforms by a neurologist.

Currently, the Monitoring Company employs neurophysiologists and has a management services agreement with a physician practice (Practice)

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that employs and/or subcontracts with neurologists. Surgeons schedule IONM services for their surgical cases by making a referral to the Monitoring Company. The Monitoring Company then schedules one of its neurophysiologists to perform the technical component and contacts with Practice to assign a neurologist to perform the professional component. Generally, the Monitoring Company bills the hospital or ASC at which the case is performed for the technical component, and Practice bills the surgical patient or insurer, as applicable, for the professional component.

The “Proposed Arrangement” involves a contractual joint venture in which the referring surgeons would profit from their referrals. Specifically, the Monitoring Company would assist surgeons (Surgeon Owners) who request IONM monitoring with the formation and operation of a turnkey physician-owned entity (Newco) that would perform IONM services.

The Surgeon Owners would form the Newco and would set the terms of their respective ownership interests and the methodology for the distribution of profits amongst themselves. Neither the Monitoring Company nor the Practice would have ownership in Newco.

After formation, the Surgeon Owners would have limited participation in Newco’s day-to-day business operations and would instead contract with the Monitoring Company and Practice for the

performance of the following business operations:

1. Pursuant to a billing services agreement between the Monitoring Company and Newco, the Monitoring Company would provide to Newco billing, collection and certain other administrative services in exchange for a fee from Newco (the “Billing Services Agreement”).
2. Pursuant to a personal services agreement between Practice and Newco, Practice would provide to Newco the services of its neurologists and the services of neurophysiologists (which Practice would lease from the Monitoring Company under the management services agreement between the Monitoring Company and Practice) in exchange for a fee from Newco (the Personal Services Agreement).

The Monitoring Company certified that the services provided by the Monitoring Company and Practice under these contracts would constitute virtually all of the day-to-day requirements of an IONM business. The Monitoring Company does not expect that Newco would need to hire any dedicated employees because the Monitoring Company and Practice would provide all necessary services for Newco.

Newco would contract with various hospitals and ASCs under an IONM services agreement that would govern Newco’s provision (or arranging for the provision) of the technical and professional components of IONM



services for surgeries at such facilities. Generally, Newco would bill the hospital or ASC for the technical component and would bill the surgical patient or insurer, as applicable, for the professional component.

Although Newco’s billing would be handled by the Monitoring Company under the Billing Services Agreement, the Monitoring Company would take direction from the Surgeon Owners regarding the amounts to be billed for services.

Why Would Monitoring Company Do This?

Why would the Monitoring Company want to do this? It’s because other IONM companies are engaging in the scheme, and surgeons, seeking to profit from IONM referrals, are demanding it.

In its request to the OIG, the Monitoring Company stated that it seeks to retain business from its existing surgeon clients that otherwise would be lost to competing IONM companies willing to engage in the scheme, and certified that it would adopt the Proposed

Arrangement only as required in specific situations where its existing surgeon clients wish to own their own IONM company and may not continue to do business with Requestor otherwise.

Although Newco would pay a fee to the Monitoring Company under the Billing Services Agreement and would pay a fee to Practice under the Personal Services Agreement, the Monitoring Company anticipates that Newco would achieve substantial profits from the Proposed Arrangement (i.e., the difference in fees paid to the Monitoring Company and Practice under the services agreements and reimbursement received from third parties) and anticipates that Monitoring Company and Practice would earn substantially less profit under the Proposed Arrangement than under their current business model.

This is primarily because, as the Monitoring Company certified: (i) reimbursement for the professional component of IONM can far exceed the cost of providing the service; and (ii) Practice would charge Newco less than it could bill a third-party payor for the same services under the Monitoring Company's and Practice's current business model because competing IONM companies marketing similar arrangements to surgeons have aggressively discounted their charges for such services.

The Underlying Law

The federal anti-kickback statute (AKS) prohibits the offer of, demand for, payment of or acceptance of any remuneration for referrals of Medicare or Medicaid patients. There are exceptions, most notably regulatory "safe harbors," that describe certain arrangements not

subject to the AKS because they are unlikely to result in fraud or abuse.

Broad OIG Guidance

The OIG has issued two fraud alerts applicable to the analysis of joint venture model deals: its 1989 Special Fraud Alert on Joint Venture Arrangements, which was republished in 1994, and a 2003 Special Advisory Bulletin on Contractual Joint Ventures.

Note that the term "joint venture," as used by the OIG in the alerts, is not limited to the creation of a legal entity; rather, it covers any arrangement, whether contractual or involving a new legal entity, between parties in a position to refer business and those providing items or services for which Medicare or Medicaid pays.

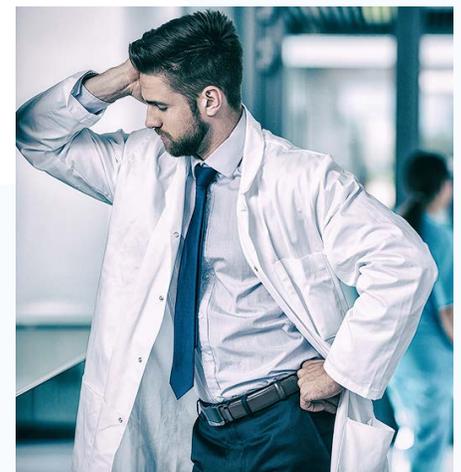
The OIG has made clear that compliance with both the form and the substance of a safe harbor is required in order for it to provide protection. The OIG demands that if even one underlying intention is to obtain a benefit for the referral of patients, the safe harbor would be unavailable, and the AKS would be violated.

Although each alert is illustrative of the regulatory posture of the OIG, the 2003 Special Advisory Bulletin is particularly on point in connection with analyzing structures such as presented in regard to IONM as well as other "popular" arrangements designed to capture referral profits.

In it, the OIG focuses on arrangements in which a healthcare provider in an initial line of business (for example, a surgeon) expands into a related business (e.g., IONM or anesthesiology) by contracting with an existing provider of the item or service (e.g., neurophysiologist, neurologists, anesthesiologists or nurse anesthetists) to provide the new item or service to the owner's existing patient population.

The 2003 bulletin lists some of the common elements of these problematic structures in general terms, with bracketed examples inserted by the author:

- >>> The surgeon expands into [IONM or an anesthesia business] that is dependent on direct or indirect referrals from, or on other business generated by, the owner's existing business [such as the surgeon's practice or ASC].
- >>> The surgeon does not operate the [IONM or anesthesia] business—the [IONM provider or anesthesiologist] does—and does not commit substantial funds or human resources to it.



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- »» Absent participation in the joint venture, the [IONM provider or anesthesiologist] would be a competitor [of the surgeon's IONM or anesthesia company], providing services, billing and collecting [for the IONM company's or the anesthesiologist's own benefit].
- »» The [surgeon] and the [IONM company or anesthesiologist] share in the economic benefit of the [surgeon's] new [IONM or anesthesia] business.
- »» The aggregate payments to the [surgeon] vary based on the [surgeon's] referrals to the new [IONM or anesthesia] business.

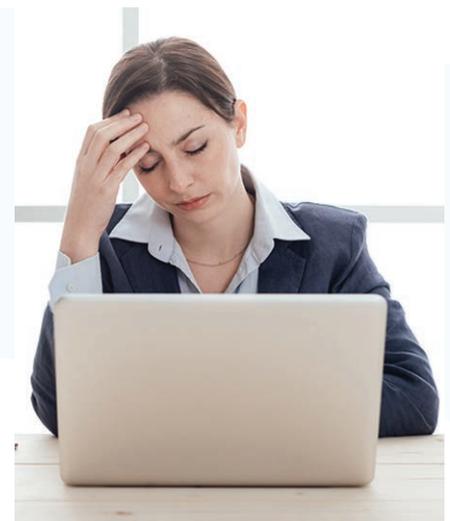
The OIG's Opinion

The OIG determined that the Proposed Arrangement would involve several forms of remuneration, including, but not limited to: (i) discounts under the Personal Services Agreement provided by Practice to Newco; (ii) the

opportunity for Newco to generate a profit through the difference between the fees paid by Newco to each of the Monitoring Company and Practice under the services agreements and the reimbursement Newco would receive for such services from third parties; and (iii) returns on investment interests in Newco to the Surgeon Owners. These streams of remuneration could induce the Surgeon Owners to make referrals of IONM services for which payment could be made by a federal healthcare program.

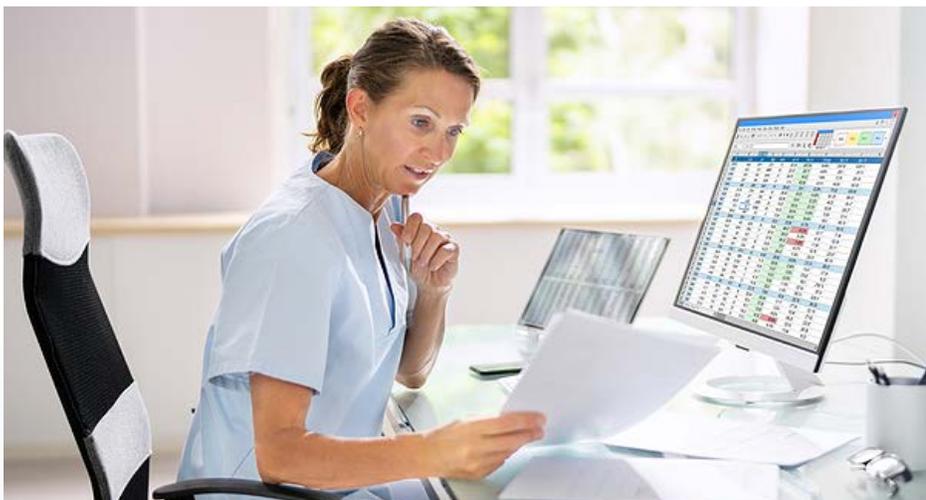
The OIG found that there was no safe harbor protection for the Proposed Arrangement's streams of remuneration, and that it would have many of the indicia of suspect contractual joint ventures about which the OIG has longstanding and continuing concerns.

The Proposed Arrangement would present a host of risks of fraud and abuse under the federal AKS, including patient steering, unfair competition,



inappropriate utilization and increased costs to federal healthcare programs. The OIG stated that it is possible that the Proposed Arrangement could enable the Monitoring Company and Practice to do indirectly what they could not do directly: pay the Surgeon Owners a share of the profits from their referrals for IONM services that could be reimbursable by a federal healthcare program.

Even if the Monitoring Company could ensure that no IONM services reimbursable by a federal healthcare program would ever be referred to Newco, the remuneration to Newco under the Proposed Arrangement could induce the Surgeon Owners to refer their IONM services reimbursable by a federal healthcare program to the Monitoring Company and Practice, thereby disguising remuneration for federal healthcare program beneficiary referrals through the payment of amounts purportedly related to non-federal health care program business.



TAKE HOME THESE ESSENTIAL POINTS

1. The term “company model” is an industry descriptor of certain types of arrangements. It’s not the case that any specific law or regulation makes, in blanket fashion, company model deals illegal.
2. Just because the facts of Advisory Opinion 23-05 involve IONM and neurologists doesn’t lessen the value of the opinion as an indication of the OIG’s position *vis-à-vis* other joint venture arrangements, such as the role played by so-called anesthesia management companies in helping surgeons, e.g., gastroenterologists, set up and manage captive anesthesia companies for their ASCs.
3. Although they give great insight into the minds of the federal enforcers of the AKS, that is, of the OIG, advisory opinions themselves are binding only on the specific requestor. The AKS is a criminal statute, and, as such, intent to provide/accept remuneration to induce referrals must be proven. That means that the analysis is highly fact-specific.
4. In similar fashion, when an alleged company model scheme underlies a federal False Claims Act (i.e., whistleblower) lawsuit, specific facts relating to the kickback-tainted claims for payment must be pleaded with particularity, although there is some variance among the federal court circuits as to the required degree.
5. The bottom line is that each arrangement within the rubric of the company model must be scrutinized extremely carefully. The “chance” of criminal conviction, or of civil judgment on the False Claims front, may be low, but the criminal penalties (jail time, civil monetary penalties, exclusion from participation in federal healthcare programs) and trebled civil damages judgments are high. Low odds times high penalties equals high risk.



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Friendly Physician Models:

The Basics Through

Five Frequently Asked Questions

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During the past several years, many health law practices have noticed a dramatic increase in the number of telehealth businesses and private equity-backed healthcare providers. Both of these trends often rely heavily on corporate structures commonly referred to as “friendly physician,” “captive PC” or “MSO” models. Although friendly physician models are used by non-physician healthcare providers (e.g., physical therapists, psychologists and dentists), this article focuses on physicians and how the model is used in connection with the provision of professional medical services. Below

is a summary of some of the questions often asked by law firm clients as these organizations are structured, developed and operationalized.

WHY DO ORGANIZATIONS ADOPT A FRIENDLY PHYSICIAN MODEL?

Friendly physician models have developed as a result of state law commonly referred to as the corporate practice of medicine doctrine. In corporate practice of medicine states, non-physicians are unable to own an

entity that employs or contracts with physicians to provide professional medical services. These entities must instead be owned by licensed physicians. Many corporate practice of medicine states require that physician owned entities that provide professional medical services be organized as professional entities that satisfy certain state-level organizational requirements. The doctrine is intended to protect the independent medical judgment of physicians—to protect the sanctity of the physician-patient relationship.

Over 30 states have adopted some form of the corporate practice of medicine doctrine pursuant to either statutes or case law. Each state’s requirements are unique. States such as New York, California and Texas have robust corporate practice of medicine doctrines that are actively enforced. Other states are less stringent. Some states like Michigan permit certain entities to be owned by physicians licensed in other states, while some states limit ownership to physicians licensed in the state. The process in New York and Illinois to form a professional entity often takes months but professional entities in other states



can be formed within an hour. In Florida, unlicensed individuals may own a medical group, but the group is generally required to obtain a Health Care Clinic Act license if not physician owned. Organizations that provide professional medical services in multiple states need to review these laws carefully on a state-by-state basis as the geographic footprint of the organizations evolve.

WHAT IS A FRIENDLY PHYSICIAN MODEL?

Friendly physician models are used to permit non-physicians to indirectly invest in physician practices when the state law prohibits non-physicians from directly investing. In general, a friendly physician model involves at least two entities: (a) a professional entity that is owned by one or more licensed physicians, and (b) a management services organization (or MSO) owned in whole, or in part, by non-physicians.

In a friendly physician model, the professional entity employs or contracts with physicians and other licensed healthcare professionals and is the direct provider of medical services to patients. The patients pay the professional entity for the services rendered. The professional entity is often enrolled with Medicare, Medicaid and/or third-party payors unless the practice is cash based. The professional entity also typically maintains the professional liability insurance covering the services provided.

The management entity may have both physician and non-physician owners. The management entity often provides a turnkey operation to the professional entity. Typical management services provided by the management entity to the professional entity include, for example, the following: (a) development services; (b) provision of real property; (c) provision of information technology and other equipment; (d) provision of office and medical supplies; (e) purchasing and contracting guidance; (f) provision of support personnel; (g) human resource services; (h) patient and case scheduling services; (i) training; (j) credentialing guidance and payor contracting; (k) billing and coding services or advice; (l) financial management, cash management, accounting and related reporting; (m) compliance, quality and risk management activities; (n) intellectual property; and (o) marketing services. In exchange for the management services provided, the professional entity pays the management entity a management fee.

WHAT ARE SOME OF THE REGULATORY CONSIDERATIONS OFTEN AT ISSUE WHEN STRUCTURING A FRIENDLY PHYSICIAN MODEL?

In addition to addressing the nuances of the applicable states' corporate practice of medicine doctrine requirements, friendly physician models are often carefully structured to mitigate risk under the federal Anti-Kickback Statute and parallel state laws and state fee-splitting requirements. Common safeguards to mitigate regulatory risk

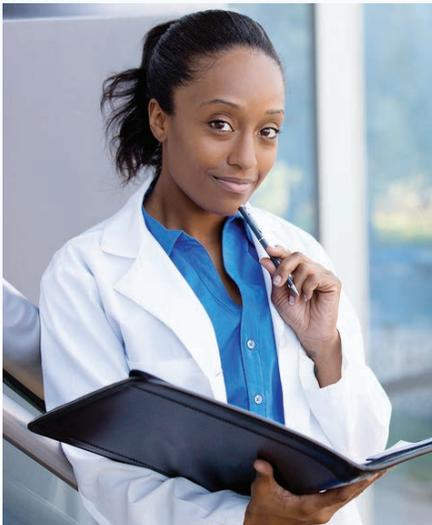


include ensuring that the management fee is within the range of fair market value for *bona fide* services actually provided, is not a percentage-based fee or other fee that varies based upon the volume or value of services provided to patients, and is set in advance and not changed more than once a year. In general, it is advisable to have the management fee be a flat fee or based upon a cost-plus structure.

A third-party valuation of the management fee by a qualified and experienced healthcare valuation consultant is typically advisable but usually not *per se* required. In the event that the parties make a reasonable good faith determination of what the management fee should be, such determination must be reasonable and documented. Attorneys, even those that focus on health law, are generally not qualified to opine on what is or what is not within the range of fair market value. When valuation consultants are engaged, it is often a good idea for attorneys to engage the consultants under attorney-client privilege.

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HOW DO INVESTORS PROTECT THEIR INTERESTS IN A FRIENDLY PHYSICIAN MODEL?

In addition to mitigating regulatory risk by incorporating safeguards as discussed above, non-physician owners of the management entity want to protect their investment and limit financial risk from a business perspective. One way to do that is through buy/sell provisions that provide that non-physician investors can

essentially replace the friendly physician owner of the professional entity with another licensed physician in various circumstances. These agreements are often called nominee agreements or member transfer restriction agreements.

HOW CAN FRIENDLY PHYSICIANS LIMIT THE FINANCIAL AND LEGAL RISK ASSOCIATED WITH BEING THE OWNER OF THE PROFESSIONAL ENTITY THAT PROVIDES PROFESSIONAL SERVICES?

There are several ways that physician owners of professional entities within a friendly physician model can mitigate legal risk. First, physician owners should ensure that the friendly physician model is structured properly and includes safeguards to mitigate regulatory risk. See discussion above. Second, the physician owners should ensure that those managing the day-to-day operations cause funds to flow

in accordance with the governing documents. Legal documents are not helpful if they do not reflect reality. The structure needs to be respected. Third, physician owners should ensure that the organization has an active and robust healthcare regulatory compliance plan and that the culture of compliance starts from the top. The healthcare regulatory enforcement environment is often punitive. Physicians have a license to lose and non-physician investors typically do not. Accordingly, physicians have more risk than non-physician investors in the event of non-compliance. Fourth, physician investors should understand whether the governing documents require the physician owner of the business to make capital contributions, cover management fee payment shortfalls or personal guarantees. They should confirm that such provisions are acceptable and have their own attorney review the documents before signing.



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Presurgical Clinics:

A Growing Strategy for Anesthesia Practices

BY RITA ASTANI, MBA

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Over the years, anesthesia groups have investigated certain strategies—beyond standard anesthesia services—to enhance their revenue opportunities. There has been the widespread incorporation of acute pain services, additions of a chronic pain component, the seeking of new places of service and experimenting with ketamine clinics. In addition to these, there is another avenue of additional reimbursement potential that some practices are now pursuing: presurgical testing. What does this service entail, and what can anesthesia groups expect to reap by adding this component to their line of services?



DEFINING OUR TERMS

Over the years, we have noticed a growing interest within the anesthesia community in the concept of presurgical clinics. Often, this interest was sparked by a speaker at a state or national event or by a hired consultant who presented the idea to the group as a “can’t miss”

revenue opportunity. Essentially, these clinics perform what is sometimes called pre-anesthesia testing (PAT) or presurgical clearances on patients who are scheduled for various surgeries—surgeries that will ultimately involve anesthesia services. For convenience, we will use the acronym PAT to identify this service.

In many cases, it is not the anesthesia providers performing the PATs. Rather, the group hires a nurse practitioner (NP) or advanced practice nurse (APN) to see the patient, perform the testing (e.g., vitals, blood work, etc.) and generally evaluate the patient to determine if he or she can be expected to successfully withstand the scheduled procedure. For example, if the upcoming surgery involves the cardiovascular system and the surgeon has reason to believe the patient may have difficulty with the surgery or the anesthesia, the surgeon may refer the patient to the PAT clinic to get a full workup and recommendation as to the suitability of the patient for the operative session.

DETERMINING THE PROPRIETY

Seeking to add value to the group in the eyes of the surgeons and hospital



administration is certainly commendable. And looking for ways to add another revenue stream in this financially challenging time is quite understandable. The PAT clinic concept would seem to check both of these boxes. There are, however, some factors that anesthesia groups should take into consideration before dipping their toe into these waters.

The first thing to consider is the propriety of this arrangement. How appropriate is it for an anesthesia group to submit a claim for evaluating a patient in connection with a scheduled case for which the same anesthesia group will be billing for anesthesia services? The anesthesia provider is already required to perform a pre-anesthesia assessment (PAA) prior to the anesthesia service. That PAA is bundled into the anesthesia code that appears on the claim form. In other words, the PAA is not separately

Presurgical Clinics:

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billable. But now we have this additional evaluation, in the form of a PAT session, for which anesthesia providers are seeking separate payment.

Typically, claims for these services would be submitted with a relatively low-paying evaluation and management (E/M) code. And, of course, groups will have to provide human resources to staff the clinic and perform these pre-surgical clearances. The question is this: are the compliance risks and resource requirements worth the reward?

There are three typical ways in which an anesthesia provider obtains payment from the E/M code set: (a) a postoperative pain round, (b) the PAA where the case was canceled prior to induction, and (c) an anesthesia consult. In scenario “a,” the service is separate and apart from the anesthesia service.

In scenario “b,” the PAA that is usually bundled becomes payable only because the anesthesia service never took place. In scenario “c,” the consult is only payable if it represents a service that is above and beyond the bundled PAA. The question is, does the PAT constitute an anesthesia consult; and, if so, does it meet above-and-beyond criterion?

To answer the above question, we need to determine the following: (a) who is performing the PAT, and (b) what does this evaluation service actually entail? According to the Medicare State Operations Manual in its treatment of the conditions of participation (CoPs)—that is, the conditions that hospitals have to meet in order to participate with Medicare—we are given a list of provider types that are authorized to perform a PAA. That list does not include an NP. A nurse practitioner is not an anesthesia provider, so an NP cannot perform a pre-anesthesia assessment. It follows that an NP cannot also perform an anesthesia

consult. If these PATs are essentially an anesthesia consult, then it is entirely inappropriate for such services to be performed by the NP.

If these PATs or presurgical clearance screenings are not an anesthesia consult, then what are they? Our understanding is that patients undergoing these screenings are being referred to the anesthesia group by the patients’ surgeons. Again, the purpose is purportedly to check out whether the patient is a legitimate candidate for surgery and/or anesthesia. But why isn’t the surgeon doing this? Isn’t this determination part of the surgeon’s own health and physical (H&P) exam prior to surgery? Why does there need to be an additional step in the process—additional to the surgeon’s H&P and the anesthesiologist’s PAA? Furthermore, if the PAT service is more analogous to an H&P than the PAA, why is the anesthesia group’s NP more competent to perform this service than the patient’s own surgeon? The point we’re trying to make here is that some payers may eventually question the medical necessity of this supplemental and relatively amorphous evaluative service (in addition to the bundled H&P and the bundled PAA).

PROCEED WITH CAUTION

Despite the concerns addressed above, the case can be made that the service being provided in these PAT clinics may be deemed medically appropriate or necessary and thus payable in at least some instances. As with anesthesia

consults, claims for these screenings should not be routine, i.e., not submitted for every patient or just any patient. In assessing both the risk and opportunity relative to presurgical testing services, one anesthesia compliance attorney has indicated the following:

1. Preoperative assessments can be billed, provided that very rigid controls and prerequisites are implemented and followed, and further provided that the anesthesia group has a tolerance for some risk.
2. As to the risk, *U.S. v. Chen*, a False Claims Act (FCA) case, may be somewhat instructive. The case was brought against Dr. Chen, an anesthesiologist, for submitting consultations (the highest consult code available) for each of his anesthesia cases. The jury found that he submitted over 3,500 claims inappropriately, and the court of appeals affirmed. So, if claims for PAT services are (a) deemed to be akin to an anesthesia consult claim, and (b) submitted routinely, it could result in an FCA action.
3. The Chair of the Committee on Economics for the American Society

of Anesthesiologists (ASA) wrote an article in 2014, explaining the circumstances under which the ASA believes these PAT-type services can and cannot be billed, as follows:

- a. The service must be significantly above and beyond the usual pre-anesthesia evaluation, and as such would need to address items that are not addressed in the routine pre-anesthesia eval.
- b. The conditions examined could include a comprehensive exam of the patient's entire medical condition, as well as management of those issues that need to be corrected or optimized prior to surgery.
- c. These visits would be billed "under rare conditions."
4. Where the PAT or pre-surgical clearance clinic sees a large percentage of surgical candidates, such as all those with a physical status indicator of III or higher, the provider of the PAT services may pop up on the payer's radar, and an audit may ensue. The provider and/or group would need to be able to accept that risk.



Of course, the above does not directly address the scenario where an NP employed by the anesthesia group is the one who is performing the bulk of these screenings. Since an NP cannot perform an anesthesia consult, any evaluative work performed by the NP may be deemed by the payer (or the government) as necessarily outside the scope of the PAA and thus not an attempt to unbundle the PAA. Nevertheless, it would be wise for anesthesia groups that are looking to employ NPs for this very purpose to recognize there is risk and that such services should not be routine.



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With degrees from The University of Michigan and Ohio State University, Rita has a Masters Degree in Business Administration in hospital and health services administration. Her vast array of knowledge and expertise in anesthesia practice management makes her a valuable addition to our team. She can be reached at Rita.Astani@CoronisHealth.com.

CIGNA's New CRNA Payment Policy

Adds Fuel To The Fire

BY KATHERINE BOWLES, RN, ESQ.

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This following article describes the Provider Non-Discrimination Law, its potential violation by CIGNA in approximately 36 states and the legal battle that could potentially ensue.

THE AFFORDABLE CARE ACT'S ANTI-DISCRIMINATION LAW: AN OVERVIEW

Since January 2012, the Affordable Care Act (ACA) has prohibited insurance plans, insurance providers and others from discriminating against providers who are acting within the full scope of their license or certification under applicable state law.¹ In 2021, Congress, acting through Section 108 of the Consolidated Appropriations Act (CAA), required the U.S. Department of Labor, the U.S. Department of Health & Human Services and the U.S. Treasury (the Departments) to issue a notice of proposed rulemaking, followed by a final rule, to fully implement section 2706(a) of the Public Health Service Act (PHSA).² In response, the

Departments indicated that the statutory language is self-executing and may be enforced without further regulatory action.³ This means that the Provider Non-Discrimination Law is enforceable in any state where an insurer, a group or individual health plan or other payors impose discriminatory payment policies.

The Provider Non-Discrimination Law prohibits provider discrimination in two key areas: (1) a provider's participation in the group or individual health insurance plan; and (2) coverage under the group or individual health insurance plan. The Law makes clear that insurance plans, insurance providers and others may not reject a provider from participating in-network simply because he or she is licensed as a Certified Registered Nurse Anesthetist (CRNA) and not as a physician anesthesiologist. The Law also prohibits insurance plans, insurance providers and others from establishing varying reimbursement rates based on licensure status, although insurance plans and insurers may continue to discriminate on the basis of quality or



performance measures. In other words, reimbursement for anesthesia services must be the same for nurse and physician anesthesiologists who have equivalent quality and performance indicators.

The Provider Non-Discrimination Law is applicable to all non-grandfathered group health plans and health insurers offering group or individual health insurance.⁴ The Law is also incorporated into Section 715(a)(1) of the Employee Retiree Income Security Act (ERISA) and Section 9815(a)(1) of the Internal Revenue Code.⁵ Similar language is included in Section 1852(b)(2) of the Social Security Act regarding Medicare Advantage Plans.⁶ Hence, the Law is broadly applicable to most

¹ Public Health Service Act section 2706(a) "Non-discrimination in health care is codified at 42 U.S. Code section 300gg-5. See also <https://www.govinfo.gov/content/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf> (last accessed March 19, 2023).

² <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/listening-session-announcement-regarding-provider-nondiscrimination-under-section-2706a-of-the-phs-act.pdf> (last accessed March 19, 2023).

³ https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15 (last accessed March 19, 2023).

⁴ See footnote 3.

⁵ See footnote 3.

⁶ See footnote 3.

insurance plans, insurance providers and employer-sponsored health plans throughout the United States.

THE RESTRICTION TO CRNAS WITH INDEPENDENT PRACTICE

The Provider Non-Discrimination Law protects all providers practicing within the full scope of license and certification in their respective state. As of this writing, 22 states, Guam and the District of Columbia have opted out of CRNA supervision requirements.⁷ During the Public Health Emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) waived the supervision requirements for CRNAs, resulting in CRNAs having independent practice authority in approximately 36 States.⁸ At its broadest possible application, the Law would have prevented payment discrimination in these 36 states. However, with the expiration of the PHE this past May 11, the Law was allowed to sunset, except in those states that adopt the opt-out process.⁹ Following the end

of the PHE, CRNAs in the 22 opt-out states will remain protected by the Law.

CIGNA'S FUEL TO THE FIRE

On March 12, 2023, Coronis Health (formerly Anesthesia Business Consultants) published a blog post, noting that CIGNA would lower reimbursement by 15 percent for non-medically directed procedures performed by CRNAs.¹⁰ In other words, a physician anesthesiologist billing under modifier "QZ" would be reimbursed 15 percent more than a nurse anesthetist billing under the same modifier. CIGNA's timing is odd, given the shortage of providers and the increased number of providers practicing within the full scope of their license due to pressures placed on the system by the COVID-19 pandemic.¹¹ CIGNA's proposed payment policy adds fuel to fire by lowering reimbursements for facilities and provider groups already facing significant anesthesia payment pressures.

Notably, CIGNA's stated policy threatens to violate the Provider Non-



Discrimination Law for any provider practicing independently (billing modifier QZ) in 36 states through the end of the PHE and in 22 states, Guam and the District of Columbia, thereafter. Providers who see a decreased reimbursement under CIGNA's new policy may have the right to pursue declaratory and injunctive relief, unfair competition laws, breach of contract and other claims, depending on applicability to the individual provider and/or provider group. Rather than saving money, CIGNA's new plan is likely to spur lawsuits seeking equal protection and application of the Provider Non-Discrimination Law.

⁷ [https://www.aana.com/docs/default-source/sga-aana-com-web-documents-\(all\)/801-fact-sheet-concerning-state-opt-outs-pdf.pdf?sfvrsn=450743b1_34](https://www.aana.com/docs/default-source/sga-aana-com-web-documents-(all)/801-fact-sheet-concerning-state-opt-outs-pdf.pdf?sfvrsn=450743b1_34) (last accessed March 19, 2023).

⁸ <https://www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency#:~:text=CMS%20will%20end%20this%20emergency,Reg.> (last accessed March 19, 2023).

⁹ See footnote 9.

¹⁰ <https://www.anesthesiallc.com/publications/blog/entry/a-change-in-the-wind-new-policy-further-complicates-anesthesia-practices> (last accessed March 19, 2023).

¹¹ CRNAs were among the most utilized providers in the nation during the COVID-19 pandemic, according to a CMS report summarized by the AANA. See <https://www.aana.com/news/press-releases/2021/01/18/nurse-anesthetists-among-most-utilized-healthcare-providers-according-to-cms> (Last accessed March 19, 2023).



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Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
October 13-17, 2023	American Society of Anesthesiologists Anesthesiology® 2023 Annual Meeting	Moscone Center San Francisco, CA	https://www.asahq.org/annualmeeting
October 25-28, 2023	Becker's Healthcare 29th Annual Meeting: The Business & Operations of ASCS	Swissotel Chicago, IL	https://conferences.beckershospitalreview.com/beckers-october-asc-annual-conference-2023?utm_source=email&utm_content=dropdown
November 2-5, 2023	Northwest Anesthesia Seminars Keys In Anesthesia	Key West, FL	https://www.nwas.com/keywest/23nkw.php
November 6-10, 2023	California Society of Anesthesiologists Fall Anesthesia Conference	Grand Hyatt Kauai Poipu, HI	https://csahq.org/events/csa-2023-fall-anesthesia-conference/
November 27 - December 1, 2023	Survey of Current Issues in Surgical Anesthesia	Ritz-Carlton Golf Resort Naples, FL	https://www.clevelandclinicmeded.com/live/courses/surganes/default.asp
December 8-11, 2023	Postgraduate Assembly In Anesthesiology 77	New York City, NY	http://www.pga.nyc/

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