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ANESTHESIA

Communiqué

A quarterly publication providing topics of interest to the anesthesia industry

Anesthesia Business Consultants has 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.

FALL 2024

Why is There a Shortage of Anesthesia Providers?

BY JODY LOCKE, MA

Vice President of Anesthesia and Pain Practice Management Services
Coronis Health, Jackson, MI

For the past few years most anesthesia practices have had trouble recruiting qualified providers to meet the needs of the facilities they serve. In June 2024 the ASA published an article entitled "Anesthesia Workforce Shortage Poses Threat to Health Care." While it is true that some practices with consistent surgical volume and a positive payer mix have relatively little trouble maintaining a strong team of providers, they are the exception rather than the rule. The vast majority have been experiencing considerable turnover and defection, which has become a significant management challenge. The question most keep asking is what caused the shortage and when will it get better?

Most observers agree there are at least three factors that have resulted in the current situation. The first is the migration of cases from traditional inpatient venues to outpatient facilities and surgicenters, the net impact of which has been a material increase in the number of anesthetizing locations.

Then, there was the long-term impact of the pandemic. Ultimately, the nature of anesthesia practice has evolved considerably. An objective assessment of the current market indicates that although training programs continue to increase the number of providers, the growth in the supply of anesthesiologists and CRNAs is out of balance with the growth in anesthetizing locations and coverage requirements.

The most significant transformation of the anesthesia market had been the dramatic increase in outpatient surgical

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INSIDE THIS ISSUE:

CEO CORNER

The Shrinking Carrot

BY TONY MIRA
Interim CEO

As we survey out clients one issue always comes up as a major concern: how do we find enough qualified providers? It has become all too obvious that the greatest challenge facing most of our clients is generating enough revenue to recruit and retain a full contingent of providers to meet the ever-changing service expectations of the various facilities they serve. A growing Medicare population and other payer mix changes have been making it increasingly difficult to generate enough revenue to meet salary requirements. What used to be free service for facilities is now becoming increasingly expensive. Some of the current subsidies are mind-blowing. And now there is a shortage of providers. Managing an anesthesia practice was never simple, but now it is becoming increasingly stressful. We have asked our familiar panel of experts to weigh in on the current state of the specialty and share their thoughts.

Our very own Jody Locke, MA, vice president of anesthesia and pain practice management services, explores the many factors that have impacted the supply and demand for anesthesiologists and CRNAs in his article, *Why is There a Shortage of Anesthesia Providers*? The fact is that even though the supply is increasing it is not keeping up with the growth in anesthetizing locations and the demand for professional anesthesia services. He identifies the various trends that practices should be tracking to formulate a survival plan.

Having defined the problem, one of Coronis Health's anesthesia experts, Gary Keeling, CPA, MBA, vice president anesthesia RCM for Coronis Health, explores the importance of strategic planning in a very comprehensive and practical review of strategic options in his article, *The Need for a Strategic Plan for Anesthesia Practices to Succeed in a Challenging Staffing Environment*. His extensive experience provides a wealth of useful ideas for every practice. This is the new frontier that today's providers must focus on.

Vicki Myckowiak, Esq, with The Health Law Partners, PC, has worked with a wide variety of anesthesia practices across the country and understands just how challenging it is to craft a contract that anticipates the changing market conditions for anesthesia services. Her review, *Practical and Legal Aspects of Hospital Support for Anesthesia*, provides an invaluable checklist for any practice about to renegotiate its hospital contract. This is a piece you will want to review carefully.

Mark Weiss, JD, owner of the eponymous The Mark F. Weiss Law Firm, is always sharing some very interesting issues from his experience negotiating contracts for anesthesia practices. *From Prehistory to Avoiding Post-History: Anesthesia Group Stipends* is an especially thoughtful review of some arcane situations.

A new author this issue, Jack Dillon, MS, MBA, MSHR, chief executive officer, Anesthesia Practice Consultants, educates readers on the Association for Independent Medicine (AIM), of which he serves as executive director. AIM is dedicated to advocating for independent healthcare professional. You can read more about the organization in *Championing Autonomy: The Vital Role of the Association for Independent Medicine in Modern Healthcare*.

We complete our review with some very useful coding updates from our Coronis Health leaders with *Creating Something New: CPT Assigns New Block Codes* by Bethanne Thomas, CPC, CPMA, CANPC, CPCO, CPB, CEMC, BHSA, manager of coding compliance, and a preview of new HIPAA guidelines with *Proposed New HIPAA Changes* from Bellinger Moody, RHIA, CPC, chief compliance & privacy officer.

Those of us who are struggling to manage anesthesia effectively are always trying to figure out how best to use the carrot and the stick, especially now that the carrot is shrinking. As always, we welcome your comments and feedback on our selections. We are always interested in your thoughts and suggestions.

Why is There a Shortage of Anesthesia Providers?

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volume. Most practices now provide care in a variety of venues, including outpatient hospital facilities, free-standing ambulatory surgery centers, colonoscopy centers and doctors' offices. The reality is that each new venue typically requires additional staffing, even though overall operating room productivity has tended to decline.

Given the very competitive environment for hospitals, many are constantly exploring new lines of business to attract more customers. A common example is the development of stroke centers which typically require additional anesthesia providers to ensure the level of service desired. Neonatology is another new line of business that may require additional staffing.

While it is true that the pandemic has pretty much faded into the past, the implications of its dramatic impact on elective surgery scheduling has had

significant impact on most anesthesia practices. Because the reduction in case volumes was so precipitous and so profound in 2021, many providers decided it was time to either retire or find new practices. Given the aging of many providers, the pandemic was the last straw. Having so many providers retire only exacerbated the problem.

Meanwhile the market for anesthesia services has been undergoing another significant change that has impacted anesthesia income and workload. There was a time when professional fee for service payments would cover the cost of the services provided. This is no longer the case. Most practices now require significant financial subsidies to balance their books. The impact of this change is that practices are now more focused on the cost of providing care and the revenue potential. For many practices that has resulted in new staffing models.

The ASA has been recommending that training programs expand their rosters to accommodate the new reality. The problem is that training more providers is not always easy to accomplish. In other words, it is the multi-disciplinary nature of the problem that makes resolution complicated. Market forces are at work but it is impossible to predict how long the current situation will last.

JODY LOCKE, MA

Jody Locke, MA serves as Vice President of Anesthesia and Pain Practice Management Services for Coronis Health. Mr. Locke is responsible for the scope and focus of services provided to Coronis Health's largest clients. He is also responsible for oversight and management of the company's pain management billing team. He is a key executive contact for groups that enter into contracts with Coronis. Mr. Locke can be reached at **jody.locke@coronishealth.com**.

The Need for a Strategic Plan for Anesthesia Practices to Succeed in a Challenging Staffing Environment

BY GARY KEELING, CPA, MBA
Vice President Anesthesia RCM, Coronis Health, Tampa, FL

I have worked with over 90 anesthesia practices in the past 25 years, and I have never seen such a shortage of qualified anesthesia providers. I have heard stories from groups that their long-time partners resigned from the group, then decided to become *pro re nata* providers for their same group for more money and no call responsibilities. These types of scenarios were unheard of in the past, but its serves as an illustration of the physician staffing crisis in anesthesia.

As for CRNAs and AAs, I attended a national trade show a few months ago and the presenter stated CRNA compensation is increasing at a rate of **over 15 percent per year,** often with additional sign-on bonuses, loan repayment programs and preferred scheduling. For virtually every anesthesia practice in the US, ***staffing is the biggest challenge***.

In a recent article published by the American Society of Anesthesiologists:

> *"The labor supply-demand imbalance for anesthesia clinicians has reached critical levels, with major implications for safe and effective patient care," said lead author Amr E. Abouleish, M.D., M.B.A., FASA, professor of anesthesiology at the University of Texas Medical Branch, Galveston*

Historically, private practice anesthesia groups were stable and prosperous organizations that would enter into facility agreements that would last for many years and would only add staff when retirements occurred or to match increased case volumes. As reimbursements per case declined due to the shift toward government payers and a reduced supply of qualified anesthesia providers, groups were forced to become employed by their facilities or join national staffing organizations.

> Basically, the business of anesthesia was being handed over to another party to manage.

For groups that want to maintain their independence, the first step should be for the partners to develop a strategic plan to manage the group with particular focus on short-term and long-term staffing challenges.

The idea of a strategic plan is to take a step back and take a look at the practice in a larger context. Anesthesia groups often come to realize that what happens outside the operating room often impacts the ongoing viability and long-term success of the practice. There is not a set structure for a strategic plan for any business and especially for anesthesia groups.

The typical anesthesia strategic plan has three areas of focus:

1. Scope of services
2. Staffing and the market for additional providers
3. Cost and budgeting

PHASE 1: SCOPE OF SERVICES

The strategy for most groups is to maintain their current facility contracts by delivering high quality clinical care without service interruptions for patients and their partner facilities.

Example of a scope of services as part of a strategic plan:

Sample Anesthesia Group believes our first responsibility is to the patients, surgeons, hospitals and facilities who

use our services. In meeting their needs everything we do will be of high quality. Advances in medical care demand that we learn and implement as appropriate.

In this stage the stakeholders need to evaluate the facility service expectations for the group and evaluate if these expectations are in line with the current reality of the department.

Utilization Compared to the Group's Anesthesia Service Contract

For example, the service contract requires staffing of 10 ORs per day, the endoscopy suite and obstetrics.

A. What do the utilization reports and standard variance reports tell the hospital and the group about the department?
   i. It may show that in the past year ORs eight, nine and ten were only utilized between 40 percent and 50 percent on a daily basis and all ten rooms were only needed 10 percent of the time.
   ii. OR surgeon block times were not utilized consistently, and the flip room report for the orthopedic surgeon who flips every Tuesday show only 50 percent utilization compared to expected.

B. All good marriages and business partnerships need to have uncomfortable discussions from time to time; so, as in this example:
   i. Hospital Contracts: Schedule a meeting with the hospital administration and review the data and explain instead of staffing 10 rooms daily, lets reduce the daily requirement to eight or nine ORs and discuss the utilization of schedule blocks and flip rooms so the hospital can approach the surgeons to change their business practices.

Since virtually all anesthesia groups now receive some subsidy from their facility, a proactive discussion about OR utilization should be a discussion that the hospital wants to engage in, and it sets the stage for a cooperative relationship regarding OR utilization moving forward.

   ii. ASC Agreements: ASCs are a little different since the owners of the facility and the surgeons are likely the same people. If the facility is not being utilized appropriately, the anesthesia group is not generating enough revenue to provide the level of compensation in order to retain and recruit new providers. Perhaps the facility can reduce the ORs being utilized, or they will provide a revenue guarantee subsidy. In recent years, many ASCs have provided subsidy arrangements because the need for consistent anesthesia coverage is crucial to the ASC's efficiency and profitability.

Example of a scope of services as part of a strategic plan:

Sample Anesthesia Group has a responsibility to our partners and members to maintain business relationships that make a sound profit. We must experiment with new ideas. Research must be carried on, innovative programs developed and new services and sites must be supported and funded.

PHASE 2: STAFFING AND THE MARKET FOR ADDITIONAL PROVIDERS

In this stage, the stakeholders and their business advisors need to evaluate their current staffing needs by location and evaluate their workforce from a short-term and long-term perspective. For example, if there are providers close to retirement, when are they planning to retire and is there an opportunity to develop a plan to retain them in some fashion either part-time or with an amended schedule?

When anesthesia practices become short staffed, the typical solution is reducing vacation time for providers and ask providers to work longer hours. This is a short-term strategy that leads to provider burnout and often compounds the problem when providers resign from the practice.

Example of staffing and market for additional providers as part of a strategic plan:

Sample Anesthesia Group is responsible to our employees, everyone must be considered an individual. We must respect their dignity and recognize their merit. They must have a sense of security in their jobs. Compensation must be fair and adequate, and working conditions clean, orderly and safe. We must be mindful of ways to help our employees fulfill their family responsibilities.

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The Need for a Strategic Plan

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In a 2023 article published by the ASA, workplace burnout has increased significantly since 2020:

> *"Anesthesiologists are experiencing unprecedented levels of workplace stress, according to a study assessing burnout levels since early 2020 published November 23, 2023 in Anesthesiology, the peer-reviewed journal of the American Society of Anesthesiologists (ASA). The study found that of the anesthesiologists surveyed in November of 2022 67.7% had a high risk for burnout, up 14.4% from March of 2020, and 18.9% had burnout syndrome, up 37% since 2020."*

In this labor market, staffing decisions are often **REACTIVE**, meaning the group is desperate for a provider, they then agree to overpay to fill the open position. Often, anesthesia groups will agree to special scheduling arrangements (i.e., no weekends or call), so the existing providers become disgruntled that the new employee has a better package than them.

The group needs to collectively and proactively evaluate and decide on different compensation packages:

A. **For example:** Long-term providers may be considering retirement; but, without call or weekend shifts, they may be willing to work longer. What is the value of the undesirable shifts? Perhaps the groups can offer no weekend/no call compensation packages to reflect these changes. The group may have other providers such as physicians recently out of training that desire higher compensation due to large school loan debt, and these extra shifts may be attractive.

B. **All position types should be evaluated:** Some CRNAs/AAs may only want to work in the ASCs and understand they will make less than the hospital staff, but the predictable schedule fits their lifestyle.

C. **Anesthesia practices should consider a CRNA/AA bonus pool:** Undesirable shifts pay a shift differential, or a bonus is paid to work shifts on weekends. I have even seen situations whereby the CRNA/AA team is purposely short-staffed to create a bonus pool. For example, the group needs 20 CRNAs and only hires 18. The compensation savings is then put in a pool and the CRNAs that work extra shifts draw from the bonus pool.

Evaluate the market and develop metrics:

Are our providers being compensated appropriately from a compensation and work/life balance standpoint. The groups business advisors need to research various job listings by state and zip code, so provider compensation keeps pace with the local market.

For this step proactive planning is key.

Develop a plan that is fair and regularly reevaluate the metrics. There are a lot of anesthesia providers "fishing in the marketplace," meaning they will ask for an extremely high compensation package and a special work schedule. In these situations, the group likely will be better off to allow the candidate to interview somewhere else.

PHASE 3: COST AND BUDGETING

No group has unlimited resources, and hospitals' cash reserves are not as plentiful after COVID 19. The group needs to look at the current "local" marketplace and anticipate the need for compensation increases in the next calendar year. The group leadership needs to know what facilities are paying their anesthesia providers within driving distance of the providers home. National and state compensation surveys are meaningless when the group's providers can drive to a new position for a significant compensation increase.

Example of cost and budgeting as part of a strategic plan:

Sample Anesthesia Group is responsible to realize a fair financial return for our partners and employees. Advances in medical care demand that we learn and implement as appropriate, as part of

*these obligations, we must constantly strive to provide **cost-effective and state-of-the-art** care to our patients, surgeons and facilities.*

At this stage, consider all options for your group:

A. Meet with the hospital to potentially lower the daily room requirements and, in turn, reduce costs
B. Discuss an additional subsidy or new subsidy at ASCs
C. Pursue new sources of revenue to replace existing business.
    i. Office-based anesthesia (i.e., a few days per week of coverage with a higher yield per case)
    ii. Specialty-focused ASC contracts (i.e., orthopedic surgery center)
D. Explore adding students to the staffing mix so they become a source for future staffing needs at a lower starting compensation.

Implement and share the strategic plan with the stakeholders:

1. Solicit feedback from the current staff and make adjustments to the plan.
2. Current group members' buy-in to the plan is key to the success of the strategic plan.
3. Share the plan with your facilities:
    a. The goal is to maintain a stable group that provides high quality care, maintains good relationships with the surgeons and contributes to the efficiency of the facility. These objectives are consistent with the facilities management team so they will appreciate sharing your strategic plan.

In my experience, meeting with facility administration and sharing the strategic plan creates a relationship of cooperation and partnership instead of coming to the facility when the group is in a staffing crisis.

This strategic plan is not a *final* document; the overall plan needs to be reviewed regularly and adjusted as needed.

The goal is to create a stable, thriving anesthesia practice for the short- and long-term success of the practice and their facility partners.

Often times, anesthesia organizations are consumed with clinical responsibilities and do not have time to develop a strategic plan. We recommend that anesthesia organizations engage outside anesthesia

industry experts to provide these services. At Coronis Health, we employ a team of industry experts that provide their business expertise and allow our clients to focus on their clinical responsibilities.

Citations:

1. **American Society of Anesthesiologists** (June 17, 2024), Anesthesia Workforce Shortage Poses Threat to Healthcare: Short- and Long-Term Solutions Needed to Critical Workforce Imbalance
2. **American Society of Anesthesiologists** (Nov 5, 2023), Anesthesiologists Burnout Increased Significantly in Two Years Since Onset of COVID-19, Study Finds

[1] https://www.asahq.org/about-asa/newsroom/news-releases/2024/06/anesthesia-workforce-shortage-poses-threat-to-health-care

[2] https://www.asahq.org/about-asa/newsroom/news-releases/2023/11/anesthesiologists-burnout-increased-significantly

GARY KEELING, CPA, MBA

Gary Keeling, CPA, MBA, serves as Vice President Anesthesia RCM for Coronis Health. Keeling has 31 years' experience in healthcare management, 28 of it devoted to anesthesia practice management and consulting. During that time, he has worked with over 90 anesthesia groups and provided ongoing practice management services and financial management services for clients throughout the US. Other duties include financial feasibility analyses, subsidy needs analysis, payer contracting, including carveouts, revenue projections and the development of chronic pain centers, as well as flat fee anesthesia rate bundled payment reimbursements. Keeling is a certified public accountant (CPA) and has an MBA with a concentration in finance. He can be reached at **Gary.Keeling@CoronisHealth.com**.

Practical and Legal Aspects of Hospital Financial Support for Anesthesia

BY VICKI MYCKOWIAK, ESQ.
The Health Law Partners, PC, Farmington, MI

Anesthesia groups are facing a significant shortage of available providers during a time of increased demand for services from the hospitals they serve, pushing groups to pay significantly more for provider compensation as they vie for the limited number of providers in the marketplace. This intense competition, and increased provider cost, has caused consternation for both the hospitals, which are already cash-strapped, and the anesthesia groups, who are often uncomfortable confronting hospitals for more money. Yet in these difficult times, reasonable financial support from the hospital may be the only means of survival for an anesthesia group.

The need for a sustainable subsidy is not driven only by the provider shortage, but also by increasing facility expectations of anesthesia groups. The days when hospital expectations were confined to providing superior anesthesia care are long gone. Hospitals often expect all of the following as well:

- Participating in effective operating room management from booking to discharge, including leadership in efforts such as the perioperative surgical home;
- Covering often far-flung non-OR anesthesia cases such as endoscopy, MRI, cardiac catheter lab and OB;
- Devising and implementing quality improvement programs;
- Assisting in the development of new service lines;
- Driving OR efficiency and developing and implementing OR cost containment strategies; and
- Aligning anesthesia with operating room goals and hospital goals.

Each of these expectations may come with the need for additional anesthesia providers.

Perhaps the most difficult hospital expectation to meet is aspirational coverage. Hospital leadership, especially in competitive markets, tends to err on the side of excess capacity in order to attract surgeons. From the perspective of the anesthesia group, the economics of anesthesia is determined by the revenue potential of each anesthetizing location with the main question being: does an operating room generate enough revenue to cover the anesthesia cost? Getting the hospital to understand the cost of wasteful practices like surgeon requests for flip rooms or underutilized surgeon block times is often a difficult task.

This article will provide: (1) practical information on the process for determining the type and amount of hospital financial assistance needed by the group; and (2) a discussion of the legal considerations that should be contemplated during the drafting of the professional services agreement.

UNDERSTANDING THE TYPES OF HOSPITAL FINANCIAL SUPPORT

There are a number of arrangements that are commonly used to structure the financial support of a hospital including:

- **Collections guarantee:** The parties agree on the amount of money needed to sustain the anesthesia practice. The hospital makes regular support payments with a periodic (or annual) audit of professional collections and a reconciliation process to ensure total revenue collected by the group does not

exceed the agreed upon amount. Under a collection guarantee arrangement, the hospital assumes the risk of empty ORs, eroding payor mix and group collection issues, leading to the common hospital demand of complete financial transparency from the anesthesia group.

- **Fixed subsidy**: The parties agree to a fixed amount of financial assistance and the hospital makes periodic support payments to the anesthesia group. There is no audit or reconciliation process as the amount is fixed regardless of collections. Under a fixed subsidy, the anesthesia group assumes the risk of empty ORs, eroding payor mix and group collection issues.
- **Hybrid arrangement:** The parties agree to a fixed amount of financial assistance and the hospital makes periodic support payments to the anesthesia group, but the parties also define a maximum threshold for professional collections, after which the group remits a portion of collections over the threshold to the hospital. There is the potential that the hospital's subsidy will decrease if collections are robust. Under this arrangement, the anesthesia group assumes the risk of empty ORs, eroding payor mix and group collection issues.

Regardless of the type of arrangement, there are five key factors that motivate the parties and put guardrails around the staffing and hospital financial support needed: (1) the number of required anesthetizing locations; (2) the staffing model; (3) the cost to staff the required anesthetizing locations; (4) the group's revenue cycle management performance; and, (5) the legal requirement that the amount of hospital financial support is at fair market value.

THE NUMBER OF REQUIRED ANESTHETIZING LOCATIONS

The OR schedule, including the number of anesthetizing locations needing anesthesia coverage at any given time, is essentially a hospital decision. The anesthesia group can try to influence the hospital decision-making process by providing data driven input on the actual use of the anesthetizing locations, the failure of a surgeon to consistently use his/her block time, and the types of cases being added on to the OR schedule at the end of the day (e.g., urgent v. emergent), but in the end the anesthesia group may have to accede to the aspirational coverage demands of the hospital with the only tool available to arrive at a reasonable coverage grid being the actual cost to provide the needed number of anesthesia providers (which often surprises hospital leadership, who greatly underestimate the cost of providing anesthesia services).

Regardless of the hospital decision on the number of anesthetizing locations, the group should ensure that the coverage grid in the professional services agreement accurately reflects the agreed-upon anesthetizing locations. This may include additional hospital or other freestanding clinics in the health system, the main OR(s) and all hospital non-OR locations. The coverage grid should also reflect the exact days and times that anesthesia is required, including call (and whether

the expectation is for in-house call). By the time the professional services agreement is signed, the parties should understand **exactly** what the coverage requirements are—there should be no room for ambiguity.

The professional services agreement should also contain provisions for daily (not permanent) expansion of coverage, whether it includes a specific protocol for adding cases and/or anesthetizing locations or whether the OR leadership (including anesthesia) jointly makes the decision. If the hospital insists on consistent late additions to the schedule, the professional services agreement might include criteria for increasing the subsidy for overtime coverage.

For permanent additions or subtractions of anesthetizing locations or coverage hours, anesthesia groups should consider including language in the professional services agreement that:

- Makes the decision to change the number of anesthetizing locations mutual rather than simply dictated by the hospital;
- Triggers a review of coverage when certain criteria are met such as the passage of time or a percentage drop in case volumes;

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Practical and Legal Aspects

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- Provides sufficient time for the group to staff up (or down) in the event of a change in coverage requirements; and,
- Places the onus on the hospital to absorb the cost of locum tenens if it does not provide sufficient notice to the group to allow for retaining of additional providers.

THE STAFFING MODEL

Hospital negotiations often include discussion of the most cost-effective staffing model. In the best of worlds, the hospital trusts the anesthesia group to use its preferred staffing model without hospital interference, but in most instances the hospital understands that the staffing model drives the cost of anesthesia and insists that it be the most cost-effective method and codified in the professional services agreement. From a staffing and billing compliance perspective, the chosen model is most often medical direction in a care team. Anesthesia groups should be wary of hospitals that insist on saving anesthesia costs by over-leveraging anesthetists and demanding "highly stretched" models or by one anesthesiologist taking call for more than one hospital/facility because of patient care and billing compliance issues.

THE COST TO STAFF THE REQUIRED ANESTHETIZING LOCATIONS

As discussed above, the number of locations and the staffing model drive the cost to staff the hospital required anesthetizing locations. The staffing cost calculation should include all of the following expenses to the group:

- Provider salaries for professional services;
- Provider benefits including, but not limited to, health insurance, retirement contributions, disability insurance and life insurance;
- Number of weeks of vacation;
- Working post-call;
- Ancillary costs like licensing and CME;
- Provider compensation for administrative services such as the Department Chair, Anesthesia Medical Director, Anesthesiologist in Charge and Perioperative Surgical Home Medical Director; and,
- Cost of running the group for such things as the total compensation for the practice administrator, cost of revenue cycle management and cost of any other administrative staff.

Groups should expect hospital leadership to require transparency regarding these costs; the hospital may want to see information confirming the quality of the group's revenue cycle management or W-2s supporting provider and administrative salaries and benefits. Groups are reminded that hospital leadership often has to justify the amount of financial support to the Board of Trustees, and unfortunately the price of taking financial assistance from the hospital is loss of privacy of business practices.

Lastly, during these times of anesthesia provider shortages, anesthesia groups may want to press hospitals for an annual fair market value subsidy adjustment tied to the consumer price index or the like. This avoids having to serially renegotiate the financial support.

THE GROUP'S REVENUE CYCLE MANAGEMENT

In the event that the parties adopt the collections guarantee or the hybrid arrangement, the amount of financial support varies depending on the anesthesia group's net collections (all fees and revenues paid by any individual and/or third-party payor as consideration for group's performance of anesthesiology services for patients at hospital less refunds to patients and payors). It is, therefore, common to include language in the professional services agreement that allows the hospital to conduct audits of relevant group books and records pertaining to the financial support to substantiate effective billing and collections. Groups should decide what records and information they are willing to share with the hospital and seek to codify those guardrails into the professional services agreement.

THE LEGAL REQUIREMENT THAT THE AMOUNT OF HOSPITAL FINANCIAL SUPPORT IS AT FAIR MARKET VALUE

To ensure compliance with regulatory requirements governing financial arrangements between hospitals and anesthesiologists (e.g., Anti-Kickback Statute, Stark and other regulatory considerations), the parties should ensure that they obtain a fair market value (FMV) review to determine a range of potential support payments that is market based and consistent with FMV parameters. The details of the applicable legal and regulatory framework is beyond the scope of this article. However, anesthesia groups should be aware that:

- Hospitals must pay fair market value for anesthesia and related services;
- The professional services agreement needs to clearly specify services that are included in cost calculations;
- The coverage expectations should be clearly outlined in the FMV report; and,
- The cost calculations should be detailed in the FMV report.

Hospitals often select their own FMV experts, but the best way to collaborate in determining an FMV subsidy is for the parties to mutually agree to the expert and share the fees and expenses. Anesthesia groups should try to include language in their professional services agreements that requires such mutual agreement, or at least the right to work with the hospital to outline the relevant facts for the expert and the right to review all draft and final FMV reports.

RECONCILIATION

The final piece of the collections guarantee or hybrid arrangement is the periodic reconciliation to determine if the hospital paid the agreed upon amount of financial support. The reconciliation can be drafted to occur at any interval agreed to by the parties, but rarely extends past one year of support. For the collections guarantee, normally the language in the professional services agreement requires that the group provide the hospital with its net collections for the designated time period. If the net collections exceed the money provided by the hospital, the group must refund the difference. If the net collections did not meet the agreed upon amount of support, the hospital must pay the difference between the collections and the guarantee amount to the group. It is common to include language that puts an end date on the hospital's right to request a refund. This is necessary so that the group can have certainty as to its financial obligations as it walks through the next year of services and collections.

CONCLUSION

As discussed above, anesthesia groups are facing unprecedented times where a significant shortage of available providers is occurring at the same time that hospital patient acuity is increasing and payor fees are decreasing—with no discernible end in sight. In these difficult times, anesthesia groups must be willing to show their hospitals that financial assistance is essential to provide requested, high quality anesthesia services.

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Vicki Myckowiak, Esq. is a partner at the Health Law Partners, PC in Farmington Hills, MI. Ms. Myckowiak has been practicing healthcare law for over 30 years and focuses her practice on representing anesthesia and chronic pain practices on issues including compliance programs, reimbursement, third-party payer coverage issues, Medicare audits, commercial payer audits, fraud and abuse defense, contracting, chronic pain informed consent and HIPAA. Ms. Myckowiak has helped implement and maintain compliance programs for dozens of anesthesia and chronic pain practices across the country. She also works extensively with third-party billing companies. A graduate of Franklin and Marshall College and The National Law Center at George Washington University, Ms. Myckowiak is a member of the American Bar Association, the American Health Lawyers Association, and the Health Care Compliance Association. Ms. Myckowiak frequently writes and speaks nationally on trends in healthcare law, including contracting, fraud and abuse, government enforcement efforts and regulatory initiatives, and compliance programs. She can be reached at **vmyckowiak@thehlp.com**.

From Prehistory to Avoiding Post-History:

Anesthesia Group Stipends

BY MARK F. WEISS, JD
The Mark F. Weiss Law Firm, Dallas, TX, Los Angeles and Santa Barbara, CA

Growing up in Los Angeles, one of my favorite places to visit was La Brea Tar pits, the death-trap in watering hole clothing that became the sticky final resting place of thousands of now extinct creatures including my favorite, the saber-toothed tiger, genus Smilodon.

Smilodon, depending on species, ranged in size from 120 to 620 pounds, and was strongly built with well-developed forelimbs and gigantically long upper canines, essentially "tooth knives" evolved for killing.

But despite their status as near perfect, apex predators which enabled them to turn bison and camels into lunch, around 10,000 years ago they simply disappeared. They no longer fit into the evolutionary plan and were wiped off the board. Gone. Dead. Extinct.

And yet, they live on in a sense, their skulls a form of fascination for children and adults alike, and yes, as an analogy for you and for other anesthesia group leaders.

Simply put, your job as a leader is to prevent your group from stepping into the sticky pit of extinction.

Today, as my friend John put it, "[is] a great time to be an anesthesiologist"—

fantastic compensation, the ability to easily relocate, part time work and so on. Just like it was once a great time to be a sabertoothed tiger.

But for an anesthesia group *qua* group, as was the case for the genus Smilodon, the times are far more dangerous.

MORE TIME TRAVEL TO THE LESS DISTANT PAST

Anesthesia groups emerged from the primordial sea of solo anesthesiologists in the late 1970s and 1980s, fueled by the need to integrate on a business level to meet coverage demands, and more importantly, antitrust (i.e., price fixing) concerns related to the need to contract with emerging managed care payors.

Prior to that time, anesthesiologists were independent practitioners bound together only by mutual membership on the medical staff. There were no financial ties among them, or between them and the hospital. Many went kicking and screaming from the status of unicellular business organisms to that of shareholders or partners within an anesthesia group.

As those early groups contracted with hospitals for coverage, aside from small administrative fees related to medical director-type services, their patient care services were as free to the hospital as were the services delivered by any other sort of physician with medical staff privileges, from allergists to vascular surgeons.

Concurrent with the maturing of the anesthesia group model, managed care expanded, the number of hospitals proliferated, and ambulatory surgery centers emerged from another sort of primordial sea—an ambulatory surgery center (ASC) is essentially an outpatient OR plus waiting room plus pre-op plus post-op that developed legs and walked out of the hospital.

Depending on the area of the country, the late 1980s into the early 2000s saw significant waves of gaps between the expense of fielding a team of anesthesiologists, and, increasingly, CRNAs, compared to incoming collections (the "Income-Expense Gap™")—resulting in waves of negotiation for hospital financial support, especially for those groups that understood how to negotiate.

TODAY

Since the COVID-19 pandemic, the trends that propelled previous episodes of the Income-Expense Gap™ and the accompanying waves of hospital financial support have intensified, with added fuel from demographic changes, both on the provider and the patient sides, and from political meddling in the market.

In general terms, the demographic issues have resulted in a significant shortage of anesthesiologists as well as CRNAs.

In respect of anesthesiologists, the percentage of those over 55 years of age remains significant, and many groups have suffered from a large number of retirements. This was exacerbated by the COVID-19 crisis, during which many older anesthesiologists decided it was time to turn in the scrubs.

Other older anesthesiologists have opted to remain, but many are interested in working part time, or in positions not involving call obligations. At the same time, many younger anesthesiologists have sought "quality of life" positions, in which their druthers map nearly completely onto that of their significantly older colleagues.

On the training side, the bureaucratic reduction in the number of anesthesia residency slots in the mid-1990s, and the longer lasting signal sent to medical students about the attractiveness of the specialty, created a long-term shortage of anesthesiologists. As to CRNAs, the more recent morphing of master's degree programs into longer, doctorate-level programs impacted the number of new anesthetists entering the labor pool.

At the same time, the tidal wave of aging baby boomers has pushed up the demand for care.

Although hospitals and entire health systems have experienced financial challenges, some resulting in bankruptcy and their own demise, the number of anesthetizing locations, when considering both acute care hospitals and ambulatory surgery centers, has increased.

Simply put, there's more work and not enough providers, with the result being lifted directly from Econ 101: higher compensation demands.

In simpler times, real or imagined, some of the pressure would be taken off through negotiations for increased anesthesia reimbursement from insurance carriers and managed care payers.

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From Prehistory to Avoiding Post-History

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However, the federal No Surprises Act (NSA) and state counterparts slammed that door shut and played a significant role in creating the current crisis. What was sold to the public by politicians as a shield against so-called "surprise medical bills" was actually a sword to be wielded by payors in slashing reimbursement against the threat of network exclusion. Payors regularly take the position that if an anesthesia group will not take a cut in reimbursement, despite all the evidence of overall inflation and the outsized increase in provider compensation demands, they will toss them out of network and into NSA hell.

The overall result is an increasing financial crisis within many anesthesia groups, both large and small: They struggle to retain their staff because offers of higher compensation lure physicians and CRNAs away. They struggle to recruit new staff because of a similar inability to meet the market. The morale of remaining group members begins to tank due to increasing workload—there's just as much overall work but fewer colleagues

to do it, leading to even more under-compensated work for each remaining physician/CRNA. The outcome is an accelerating downward spiral toward the sticky tar pit of group extinction.

AVOIDING POST-HISTORY

To dispense with a question that's crossed countless anesthesia group leaders' minds, and always comes back to bite, it is impossible to borrow one's way out of this foundational problem.

A business with costs (i.e., the cost of fielding a team of anesthesiologists and/or CRNAs) continuously exceeding its income cannot afford to bear those costs plus the cost of new bank, or even hospital, debt.

Of course, that's not to say that an anesthesia group, like any other business, shouldn't have more than a deposit relationship with a bank—the availability of a line of credit to cover short-term needs. Just don't ever believe that borrowing as a short-term solution to solve a short-term problem is of any value in respect of solving a long-term problem, that is, of the Income-Expense Gap™.

Accordingly, we're back to where we started in terms of another, this time tsunami-sized, wave of need for financial support from hospitals, and this time even from ASCs, in order for groups to remain viable.

WHAT!? NEGOTIATING FOR FINANCIAL SUPPORT ISN'T "NEGOTIATING FOR FINANCIAL SUPPORT"

Even though the need for financial support might be the impetus for negotiation with a facility, especially in the case of a hospital, it's not close to the universe of what will be negotiated in order to obtain it.

That's because financial support from any facility is an integral part of the multiple elements of an exclusive contract and can't be separated from them. Accordingly, although legal counsel will engage consultants with the necessary credentials to quantify the Income-Expense Gap™ and determine fair market value, the issues are far more complex than that.

For example, financial support is intrinsically linked to coverage, and that means that coverage must be "locked in" in concert with support (or you will create a very common, yet easily avoidable problem). What causes that "lock" to unlock, and at whose behest? What are the consequences? How can a properly negotiated agreement "stretch" with changes in coverage?

Many provisions of the facility agreement, including those pertaining to financial support, also relate to, impact, or are impacted by, a group's other agreements, both internal and external. In some cases, those agreements must be modified simultaneously.

For example, it's impossible to separate the terms of any exclusive contract from the terms by which the group owners relate to one another via the

shareholders agreement/partnership agreement. Similarly, it's impossible to separate the terms of any exclusive contract from the way the group relates to its professional staff through its various professional services (employment/independent contractor) agreements. Contractual mismatches can doom a group.

Last, because hospital financial support implicates the federal Anti-Kickback Statute and its state counterparts, as well as, potentially, depending upon the range of services a group provides, Stark, and, as to non-profit facilities, issues of private remuneration/preservation of their tax-exempt status, it's extremely important that valuation consultants be engaged through legal counsel to protect communication and valuation work product to the fullest extent possible.

Preparing for and negotiating for stipend support in the context of a new or renewed agreement with a facility is complicated and time-consuming. But for many anesthesia groups, it's required. Don't create additional problems for your group by approaching it in an ad hoc or haphazard manner or by directly embarking on valuation studies, the result of which will be to put your group into a sticky situation, perhaps one as grave as suffered by the sabertoothed tiger.

MARK F. WEISS, JD

Mark F. Weiss, JD, is an attorney specializing in the business and legal issues affecting anesthesia groups and healthcare facilities on a national basis, practicing at The Mark F. Weiss Law Firm, with offices in Dallas, Texas and Los Angeles and Santa Barbara, California. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine. He can be reached by email at **markweiss@weisspc.com**.

Championing Autonomy: The Vital Role of the Association for Independent Medicine in Modern Healthcare

BY JACK H. DILLON, MS, MBA, MSHR
Chief Executive Officer, Anesthesia Practice Consultants
Executive Director, Association for Independent Medicine, Grand Rapids, MI

As the healthcare systems become increasingly consolidated, with large hospital systems and corporate entities gaining greater control over healthcare, the Association for Independent Medicine (AIM) counterbalances this trend. It champions the belief that independent practices—those who own and operate their practices—offer unique advantages in terms of patient care, cost, autonomy and service to their communities. This article explores the role of AIM, its significance in today's healthcare landscape and the challenges and opportunities independent medical practices face.

THE ROLE AND MISSION OF AIM

At its core, AIM is dedicated to advocating for the autonomy of healthcare professionals who want to maintain control over their practice without the influence of corporate medicine or hospital systems. The organization's mission is multifaceted: it provides resources for physicians and other healthcare professionals to navigate the challenges of running their

practice, advocates for regulatory and policy changes and fosters a network of like-minded professionals who believe in the importance of patient-centered, personalized care.

One of the fundamental principles driving AIM's mission is the belief that independent physicians can provide patient-focused care. In larger healthcare systems, where physicians may face pressure to meet quotas or adhere to standardized protocols, the ability to tailor treatments to individual patients can sometimes be limited. AIM believes that independent practices allow for more flexible decision making and the ability to build stronger relationships with patients, which can lead to better outcomes.

THE IMPORTANCE OF INDEPENDENT MEDICINE

The value of independent medicine extends beyond just professional autonomy. For patients, seeing an independent physician often means receiving more personalized care. Independent physicians typically have more control over their schedules, allowing for a closer connection to their centers and deeper engagement with patients. This contrasts with many larger healthcare systems, where physicians may be required to see a high volume of patients in shorter periods, potentially leading to hurried appointments and less comprehensive care.

Additionally, independent practices are often more responsive to the needs of their local communities. AIM advocates that small, community-based practices are essential to maintaining healthcare access, particularly in underserved or rural areas. In some cases, large healthcare systems may not find it financially viable to operate in these areas, but independent physicians, driven by personal and community ties, may be

more willing to serve these populations. It is the mission of AIM to help support these practices in their success.

CHALLENGES FACED BY INDEPENDENT PRACTITIONERS

Despite the advantages of independent medicine, physicians who run their practices face significant challenges. One of the most pressing issues is financial sustainability. Large healthcare systems benefit from economies of scale, which allow them to negotiate lower costs for supplies and services. Independent practitioners, on the other hand, must absorb many of these costs themselves, which can put pressure on their finances. Additionally, the increasing complexity of healthcare regulation and insurance reimbursements can create administrative burdens that detract from patient care.

AIM addresses these challenges by offering guidance and resources to independent practitioners. The organization provides training on managing the business side of a medical practice, from billing and coding to marketing and human resources. It also supports navigating complex regulations and securing better reimbursement rates from insurance companies. By providing these resources, AIM aims to level the playing field for independent practitioners and help them thrive in an increasingly competitive healthcare environment.

AIM'S ADVOCACY AND VISION FOR THE FUTURE

AIM is not just a resource for physicians; it is also a powerful advocacy organization. It lobbies for policies that support independent medicine, such as reforms to the insurance industry that make it easier for independent physicians to receive fair reimbursement rates. It also advocates for changes to healthcare regulations around private equity and corporate investment and involvement, commonly known as the practice of medicine.

Looking ahead, AIM envisions a healthcare landscape where independent practices can thrive alongside larger healthcare systems and independent centers. The organization believes that patients should have the choice to see a physician who owns and operates their practice, and it is committed to ensuring that independent medicine remains a viable option for both doctors and patients.

The Association for Independent Medicine is critical in today's healthcare environment. By advocating for the autonomy of physicians and supporting independent practices, AIM ensures that patients have access to safe, high-quality care. While independent practitioners face challenges related to financial sustainability and regulatory complexity, AIM provides the resources, education and advocacy needed to overcome these obstacles. As the healthcare landscape continues to evolve, AIM's vision of a future where independent medicine thrives is timely and essential. Through its work, AIM supports not only the practitioners it serves but also the patients and communities that benefit from independent, patient-centered care.

COMMON QUESTIONS

If you are interested to learn more about AIM, here are some common questions:

1. **Most anesthesia practices are struggling to recruit and retain a staff of qualified providers to meet the needs of administration; how can AIM help?** AIM provides a network of practices to discuss ideas on how to best recruit and retain anesthesia staff. We discuss compensation packages, pathways for finding recruits and how best to structure practice operations to support long-term goals.
2. **How does my group take advantage of AIM?** All independent practices (in and outside of anesthesia) are welcome to join the association. We invite those interested to an upcoming meeting to learn more.
3. **Does AIM help multiple specialties or just anesthesia?** All medical specialties are invited—we have membership

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Championing Autonomy

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from radiology, dental and even veterinary medicine as part of our network.

4. **Can we use AIM to negotiate our hospital contract?** Many groups come to AIM to learn more about negotiations with hospitals, payers and other centers.
5. **How can we ensure that the confidentiality of our data will be protected?** At AIM, we know how difficult it can be to remain independent. Our network gives everyone a place to learn and share without fear of information being shared outside the organization. AIM is fully insured, and all information shared between members is held with the highest level of confidentiality.

To learn more about the Association for Independent Medicine, visit **www.associationforindependentmedicine.org** or contact us at **info@associationforindependentmedicine.org**.

JACK H. DILLON, MS, MBA, MSHR

Jack H. Dillon, MS, MBA, MSHR, is the Chief Executive Officer for Anesthesia Practice Consultants (APC), a prominent professional anesthesiology practice and organization based out of Grand Rapids, MI. APC is comprised of over 125 physicians as well as more than 90 Certified Registered Nurse Anesthetists and Certified Anesthesiology Assistants. Additionally, he also serves as Executive Director for the Association for Independent Medicine (AIM) whose mission is supporting independent medical groups by providing practice management resources and political advocacy. Possessing a master's degree in quality & patient safety from Northwestern University, as well as both an MBA (healthcare administration & economics) and MSHR (labor, leadership and industrial relations) from Loyola University, Chicago, Mr. Dillon has 19 years in healthcare and is an advocate for performance improvement in healthcare and a champion for independent medicine. He can be reached at **jack@associationforindependentmedicine.org**.

Creating Something New:

CPT Assigns New Block Codes

BY BETHANNE THOMAS, CPC, CPMA, CANPC, CPCO, CPB, CEMC, BHSA
Manager of Coding Compliance, Coronis Health, Jackson, MI

For years, Coronis Health has been advising its clients on the importance of reporting the "unlisted" block code, 64999, to reflect those peripheral block injection procedures that have yet to be assigned a more specific code in the Current Procedural Terminology (CPT) manual. Yes, it's true that reporting an unlisted code on a claim form does not guarantee payment. Reimbursement may or may not be forthcoming based on the policy or payment system programming of the specific insurance carrier. But reporting the unlisted code is nevertheless important.

The reason for submitting CPT 64999 in cases where the block administered to treat the patient does not have its own, more particular code is so that utilization for these blocks can be more accurately captured. Typically, when the unlisted code is in play, a hard copy of the claim is sent in, along with the procedure report. That allows the payer to better determine if the procedure meets medical necessity criteria and other policy parameters for payment and, if so, the amount of payment. In calculating the number of times the codeless block is being administered in the real world of medicine, a potential impetus is created among decision-makers at the American Medical Association (AMA)—the main entity that updates the CPT manual—to assign a new CPT code that reflects the particulars of that procedure. In other words, the idea is to build momentum for code creation.

A TEAM WIN

Based on the "proposed" Medicare Physician Fee Schedule (MPFS) for next year, it seems like the wait is over for some common "unlisted" blocks. Starting January 1, 2025, Medicare will reimburse for administering thoracic fascial plain blocks (6XX07-6XX10) and lower extremity fascial plane blocks (6XX11-6XX12) when reported with the newly created Category 1 CPT codes.

The proposed rule provided a breakdown of the CPT code descriptions with a placeholder X in the actual CPT code. The placeholder will be replaced with an actual number once the CPT codes have

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Creating Something New

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been released by the AMA. It should be noted that these new codes do include "imaging guidance when performed"; so, you will not be able to bill for the ultrasound guidance separately. Some of the most common thoracic fascial plane blocks that would start being reported with the new code set 6XX07-6XX10 include the below:

- Pectoral I and Pectoral II (PECs I & II)
- Serratus anterior plane
- Erector spinae plane
- Quadratus lumborum

Some of the most common lower extremity fascial plane blocks include:

- Facia iliaca plane
- PENG
- IPack

The 2025 MPFS proposed rule also indicates agreement with the work relative value units (RVUs) as recommended by the Relative Value Scale Update Committee (RUC) for this new code set. In addition, based on Table 1, there were some changes to the work RVUs for the existing transversus abdominis plane (TAP) block codes (64486-64489). This reflects a decrease in RVUs from prior years.

TABLE 1: CHANGES TO THE WORK RVUS FOR EXISTING TAP BLOCK CODES

Code	Descriptor	RUC Recommended wRVU	Proposed 2025 wRVU
6XX07	Thoracic fascial plane block, unilateral; by injection(s), including imaging guidance, when performed	1.50	1.50
6XX08	Thoracic fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed	1.74	1.74
6XX09	Thoracic fascial plane block, bilateral; by injection(s), including imaging guidance, when performed	1.67	1.67
6XX10	Thoracic fascial plane block, bilateral; by continuous infusion(s), including imaging guidance, when performed	1.83	1.83
6XX11	Lower extremity fascial plane block, unilateral; by injection(s), including imaging guidance, when performed	1.34	1.34
6XX12	Lower extremity fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed	1.67	1.67
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.20	1.20
64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)	1.39	1.39
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)	1.40	1.40
64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)	1.75	1.75

MAKING A DIFFERENCE

When a physician performs a new procedure or utilizes new technology, an unlisted code is commonly used when no other CPT code adequately describes the procedure or service. The consistent reporting of these services through the submission of "unlisted" codes as provided for in the CPT coding

manual can lead to the establishment of new codes. The AMA's recent action in this regard as it concerns the block procedures that heretofore have not been assigned a code is a testament to the importance of using the unlisted code reporting process that is available within CPT. As a result of utilization review, the AMA and now Medicare will recognize and, in effect, legitimize many block procedures that previously were in question. This, in turn, should lead to more consistent reimbursement relative to these procedures.

Coronis Health has always advocated for documentation of unlisted CPT codes, as it allows the provider to more accurately summarize services rendered. This will, in turn, ensure the correct reimbursement for not only that particular service, but the entire claim as a whole. The Medicare Physician Fee Schedule for 2025, as proposed, will expand unlisted block codes and be a step toward greater reimbursement for healthcare providers. We can put this one down as a win.

BETHANNE THOMAS, CPC, CPMA, CANPC, CPCO, CPB, CEMC, BHSA

Bethanne Thomas, CPC, CPMA, CANPC, CPCO, CPB, CEMC, BHSA, serves as Manager of Coding Compliance for Coronis Health. Ms. Thomas has been with Coronis for over eleven years. She is our subject matter expert in the fields of anesthesia and acute/chronic pain management. She also spent time as an adjunct college professor teaching coding for five years which supplements her experience in the medical coding industry. Thomas has a Certified Professional Coder (CPC) designation, as well as being a Certified Professional Medical Auditor (CPMA), a Certified Anesthesia and Pain Management Coder (CANPC), a Certified Evaluation and Management Coder (CEMC), a Certified Professional Biller (CPB), and a Certified Professional Compliance Officer (CPCO), all through the American Academy of Professional Coders. She also possesses a Bachelor Health Services Administration Degree from Baker College. She can be reached at **bethanne.thomas@coronishealth.com**.

Proposed New HIPAA Changes

BY BELLINGER MOODY, RHIA, CPC
Chief Compliance & Privacy Officer, Coronis Health, North Augusta, SC

As chief compliance officer (CCO) here at Coronis Health, I am committed to ensuring our organization stays ahead of the curve as it pertains to regulatory and compliance requirements. While recent HIPAA regulations have brought about minor adjustments, the anticipated end-of-year updates are expected to have a much greater impact on HIPAA compliance practices. These updates aim to bolster patient privacy, enhance data security, streamline access to health information and will ensure that we continue to provide the highest standard of care while safeguarding sensitive data.

There has not been a major overhaul of Health Insurance Portability and Accountability Act (HIPAA) Rules since 2013, but that is about to change. On December 10, 2020, the Office for Civil Rights (OCR) issued a Notice of Proposed Rulemaking (NPRM), proposing major changes to the HIPAA Privacy Rule. Though the Final Rule is expected to be published in 2024, the exact date and effective date have yet to be provided.

ENHANCED PATIENT ACCESS TO HEALTH INFORMATION

Clearly, empowering patients with easier access to their health information is a priority for the OCR. The days of patients waiting weeks to receive their medical records are numbered. The proposed changes mandate that patients should have prompt electronic access to their health information. This is akin to online banking, where customers can instantly view their account statements, enhancing transparency and empowering patients to take charge of their health.

STRENGTHENING PRIVACY AND SECURITY

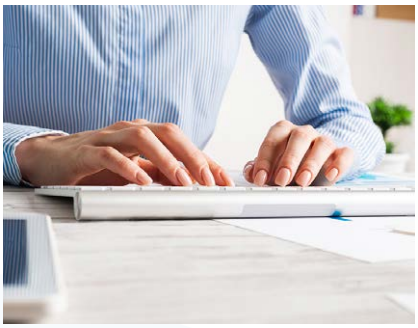
Data security is undeniably the most critical compliance risk area today. With cybercrime at an all-time high, it is imperative that healthcare organizations implement stringent security measures. Just as homeowners invest in advanced security systems to protect their properties, we must adopt cutting-edge technologies like advanced encryption and multi-factor authentication to safeguard patient data. These measures are not just about compliance; they are about protecting the trust our clients and patients place in us.

SHARING OF HEALTH INFORMATION AMONG PROVIDERS

In today's interconnected world, seamless information sharing between healthcare providers is essential for optimal patient care. One of the objectives of interoperability is to eliminate so-called "data islands." The proposed updates aim to standardize data formats and interoperability protocols, ensuring that critical health information flows smoothly between different systems. Think of it as different brands of smartphones using a common charging port—it simplifies the process and ensures compatibility, ultimately benefiting the patient through improved care coordination.

REDUCING ADMINISTRATIVE BURDEN

Healthcare compliance professionals have long grappled with the complexities of regulatory requirements. The proposed changes seek to alleviate this burden by automating compliance tasks and reducing redundant paperwork. This is similar to upgrading a manual checkout process to a self-service kiosk, making it faster and more efficient. By streamlining these processes, healthcare providers can focus more on patient care rather than administrative tasks.



IMPROVED BREACH NOTIFICATION REQUIREMENTS

Timely and effective communication in the event of a data breach is crucial. The proposed changes refine the rules on breach notifications, specifying more stringent timelines and clearer guidelines. Imagine receiving an instant alert on your phone when suspicious activity is detected on your credit card—prompt notification allows for swift action, minimizing potential damage. Similarly, quick breach notifications in healthcare ensure that patients and authorities are informed without delay.

https://www.hipaajournal.com/new-hipaa-regulations/

ADDRESSING EMERGING TECHNOLOGIES

The healthcare landscape is rapidly evolving with the advent of telehealth services, mobile health apps, and AI-driven tools. The proposed updates to HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act aim to ensure these new technologies comply with existing standards without stifling innovation. It's like updating traffic laws to safely integrate electric scooters on city streets. These regulations ensure that while we embrace new technologies, we do so responsibly, protecting patient privacy and security.

CONCLUSION

Here at Coronis Health, we are committed to maintaining the highest standards of compliance and security. The proposed updates to HIPAA/HITECH are not just regulatory requirements; they are essential steps toward enhancing patient care and protecting sensitive health information. As we navigate these changes, we remain dedicated to providing top-notch service to our clients while safeguarding their patients' data with the utmost integrity.

As we move forward, let's remember that these changes are about more than just compliance—they are about trust, transparency and the future of healthcare.

BELLINGER MOODY, RHIA, CPC

Bellinger Moody, RHIA, CPC, is Chief Compliance & Privacy Officer for Coronis Health. With over 30 years of experience in the healthcare industry, he has assisted numerous healthcare organizations through complex compliance landscapes, ensuring they thrive in a rapidly evolving industry. Mr. Moody is a nationally recognized expert in the industry. He is a nationally Registered Health Information Administrator (RHIA) through the American Health Information Management Association (AHIMA), a nationally Certified Professional Coder (CPC) through the American Academy of Professional Coders (AAPC), a nationally Certified Compliance Professional (CCP) through the Healthcare Fraud & Abuse Compliance Institute, an AAPC Approved Professional Medical Coding Curriculum (PMCC) Coding Instructor and a member of the Medical Group Management Association (MGMA). He can be reached at **bellinger.moody@coronishealth.com**.

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Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
October 18 – 22	American Society of Anesthesiologists Annual Conference	Pennsylvania Convention Center Philadelphia, PA	https://www.asahq.org/annualmeeting
October 30 – November 2	Becker's Healthcare 30th Annual Meeting The Business & Operations of ASCS	Hyatt Regency Chicago, IL	https://conferences.beckershospitalreview.com/30th-annual-ASC
November 4 – 8	California Society of Anesthesiologists 2024 Fall Anesthesia Conference	Fairmont Orchid Kohala Coast, HI	https://csahq.org/events/csa-2024-fall-anesthesia-conference/
November 7	Society For Education in Anesthesia 2024 Fall Meeting	Swissotel Chicago, IL	https://www.seahq.org/2024-fall-meeting
December 6 – 9	PostGraduate Assembly in Anesthesiology 78	Marriott Marquis New York City, NY	https://www.pga.nyc/
January 29 – February 4	California Society of Anesthesiologists 2024 Winter Anesthesia Conference	Grand Wailea Astoria Resort Maui, HI	https://csahq.org/events/csa-2024-winter-anesthesia-conference/
January 31 – February 2	American Society of Anesthesiologists ASA Advance: The Anesthesiology Business Event	Signia by Hilton Atlanta, GA	https://www.asahq.org/advance

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