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Communiqué

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You Finally Got Some Assistance: How Should You Distribute It?

BY SHENA J. SCOTT, MBA, FACMPE
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After months of negotiation, you finally receive some much-needed support from your facility partner. Everyone should be happy, right? Well, yes, but how should you distribute it? Should everyone get the same amount? Should it be allocated according to your existing compensation system? Or should you consider adjusting your existing system to better align with the facility's intended purpose for its investment in your group?

Compensation systems provide incentives that drive behavior, so it is important to think about what behaviors you are trying to incentivize when you are designing them. If you value certain types of work, times of day or procedures more than others, people will gravitate towards that work. The problem with changing the system is that, for one person to get more, someone else typically needs to get less, and self-preservation trumps altruism every time. This can make the beginning of a new support arrangement an ideal time to consider a change. While all boats are rising, it may be a less contentious time to make independently needed changes, as well as those that are necessary to fulfill the intended objectives of facility support.

Anesthesiologist compensation systems fall along a spectrum from "equal share" on one end to "eat what you kill" (EWYK) on the other. In between, we have shift/hourly systems, units/points systems, and multiple iterations of all the above. In my experience, there are few systems at the extremes of the spectrum anymore. Most equal share systems have found a way to value weekends, call, and perhaps vacation weeks, to allow physicians at least some flexibility to work more (or less). And most EWYK models have taken steps to equalize using a blended unit for payer blindness or only a portion of base units to improve equity among case types.

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I believe that the best systems are the ones towards the center of the spectrum. Yes, the productivity incentive of modified EWYK methods can be a positive incentive to move cases along and reward people for what they work. But every positive has a negative side when taken to an extreme. It is not uncommon to see posturing and cherry-picking of shifts under these arrangements. Some physicians are inevitably more focused and adept at this than others. Often under these systems, the reward is not necessarily commensurate with the difficulty of the case, the patient or other aspects of the work. Some groups have added "acuity units" (like physical status units used in billing) for the more complex patients and/or allow more base units for certain procedures to try and improve equity. Many groups have expanded time credits to place a greater emphasis on time and try to neutralize possible over- or under-weighting that can result from variation in base units. But none of these systems address the less efficient days that can happen due to unplanned delays, slower surgeons, schedule gaps (e.g., as often seen with non-operating room anesthesia, or NORA, sites), flip rooms, trauma/cardiac/liver services and other inherently inefficient service lines that may be critically important to the hospital. This can be accomplished via a shift or hourly system, but many proponents of EWYK fear that, without a tie to productivity, laziness or work avoidance could set in.

Appeals for facility support are often based upon the need for the hospital to supplement inefficient services it chooses to offer either for its own financial benefit, or to satisfy surgeons who bring cases to the hospital. Often, a significant portion of what the facility is paying for is to support the cost of providing this coverage that does not generate sufficient revenue on its own. Facility stipends are not gifts intended to make the rich richer. They are "compensation for under-compensated services" that the hospital is requesting the anesthesia group provide availability to cover.

As such, taking this money and adding it to a system that already rewards productivity may be counterintuitive to the hospital's intention in providing funding. Its intention is to support services it wants that cannot be supported by revenue. Part of this relates to payer mix but most groups have found a way to balance that inequity. The other big part of this is inefficient service lines, call and other times that anesthesia availability is needed but may not generate sufficient revenue to cover cost. Supporting these inefficiencies is often what the money is intended for and, in my opinion, how it needs to be allocated.

Systems that already have mechanisms in place to compensate for inefficiency, typically through payment of shift/hourly rates, availability fees and/or minimum guarantees, may need less tweaking. Availability fees are paid for the intrusion on one's life of being on call. In my opinion (and the opinion of most anesthesiologists I know), being required to stay in the hospital (restricted, or in-house call) presents a greater intrusion and should be valued at a higher level than calls that are unrestricted and can be taken from home. Yes, the latter is also an intrusion in that you are tethered to your home and the surrounding area and there are restrictions on what you can do but is it not the same level of restriction as having to remain inside the hospital. Typically, I see restricted call availability fees set at rates up to fifty percent higher than home call.

Some groups also adjust the rates paid for time associated with cases done on nights/weekends/holidays. This can skew compensation in favor of these shifts but, to be fair, the least desirable shifts should have the most associated pay to incentivize people to work them. This can also compensate for the fact that some calls are busier than others. In my mind, the availability fee should be the same without regard to the likelihood of working. That fee is for the intrusion on your life of being on call. But a call where you work all night long is more taxing than a call where you only work minimally (or not at all). The productivity component, whether paid hourly, by case points or some other method, is how to address this. If call pay has both an availability and productivity component, those who work more will make more but at least those who gave up their night or weekend but did not have any cases at all are paid something.

Some groups offset for inefficient daytime assignments by simply paying straight time (from start of first case, or whenever you are required to be there, until end of last case, or when you can

go home). Others on productivity-based methods use daytime availability fees to offer something to people who may be stuck in an inefficient room or "forced off." People who have been on productivity-based systems for a while may balk at the idea of "paying people for not working" as being against group culture. But the reality is that someone must cover these assignments and, it is the (un)luck of the draw who gets them. You can try to distribute them equitably but that does not always work out as they are more prevalent in some facilities than others. In a vacuum, most people would prefer to be in a productive room (particularly if it impacts their pay), but all rooms do not run that way and, hard as we might try to make it so, it doesn't always "come out in the wash." This is a concern for equal share systems as well. Proponents of these systems may say "no worries, it all evens out over time." But shifts vary significantly from day to day and week to week, so it does not necessarily even out over time, even if assignments are equalized.

Minimum guarantees are another way to approach paying for underutilized time. Here you pay according to a productivity system, but assure some minimum amount is earned for people who must either stay in the hospital or remain available to come into the hospital (like restricted versus unrestricted call, these amounts should be different in my opinion).

However it is done, it is important to include some type of payment for availability that does not result in production. Failure to do this makes the more productive daytime work the best (or only) way to "profit" under the system. Most people would prefer to work daytime shifts as opposed to nights and weekends. If undesirable shifts are not incentivized with appropriate pay, people will gravitate away from them, and it can be difficult to get call shifts covered.

It is important to remember that no system will be perfect. There will always be unintended consequences and people will figure out a way to "game" any system. So, it is important to remain flexible and be willing to make needed changes when glitches become apparent. But it is also important not to tweak the whole system because you have one bad actor who is manipulating it. Many groups end up overcomplicating what is otherwise a good system, putting in stopgaps to prevent abuse, often by a single outlier. If that is the situation, deal with the behavior and the person. Don't turn your system into an administrative nightmare that nobody can understand or track simply because you do not want to deal with outlier behavior.

Keeping it as simple as possible is also a critical element of success. In this competitive workforce, it is important to be able to explain the system to potential recruits and offer transparency for people to be able to verify that they have been paid correctly. If the rules become too complicated, that becomes an advantage to those who understand the system better, which leaves new hires (who are usually the most vulnerable) feeling disadvantaged.

In summary, there are many elements to consider in redesigning a compensation system. Doing it at a time where there is an influx of new money is likely to make it less contentious as everyone should see some benefit. Engaging people in the process and hearing potential concerns is critical to ultimate buy in of the change. Thinking about what seems fair *before* you put numbers to it is typically the best way to develop an equitable proposal, but then you need to do a "dry run" (prospectively or retrospectively) so that people can understand what it will mean for them individually before implementation. Like most forms of change, fairness, inclusion, communication, transparency and flexibility are the cornerstones of a successful result.

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Shena J. Scott, MBA, FACMPE, founder and CEO of Scott Healthcare Consulting, Inc., has been actively involved in anesthesia practice administration for over 30 years. She has spent the last six years consulting with over 100 anesthesia practices and hospitals across the country in many areas of practice improvement, most often assisting them with hospital contract negotiations, strategic planning and governance. She spent the first 22 years of her career as the executive director of a mid-sized anesthesia practice in Melbourne, FL. In 2013, she led that practice through a merger with five other practices in three different specialties to form Brevard Physician Associates, a 200+ provider group that provides all of the anesthesia, emergency medicine and radiology services to the largest integrated delivery system in Brevard County, Florida. Ms. Scott is a former chair of the MGMA Board of Directors, president of the MGMA Anesthesia Administration Assembly, and a current member of the ASA Committee on Practice Management. She is a frequent lecturer at ASA Practice Management, AIABPM, MGMA and other conferences. She can be reached at **scotthealthcareconsulting@gmail.com**

Have You Sold Out Your Future for Stipend Support?

BY MARK F. WEISS, JD
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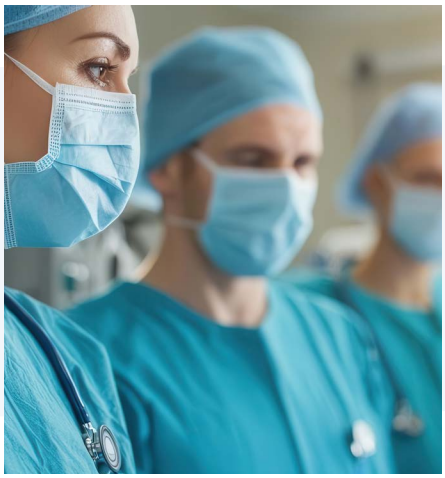
No one who understands the current shortage of anesthesiologists and CRNAs, the increased compensation demands that flow from the shortage, and the whipsaw effect of lower "reimbursement" from commercial and governmental payers questions the fact that nearly every anesthesiology group requires some form of financial support from the hospital.



But in fighting for vital financial support, many anesthesiology groups make the dual mistakes of confusing the deal for dollars with negotiating the exclusive contract of which it's a part, and of ignoring the interplay between exclusive contracting and overall group strategy.

Sometimes this occurs through naivete. Sometimes it occurs because someone played lawyer. Sometimes it occurs because of a mistaken belief that you're stuck negotiating from the hospital's so-called "standard" document. And, well, sometimes the money just looks too good, and the relief of apparent financial stability is so tempting that the contract just gets signed.

But here's the question every physician leader should be asking: *At what point does a stipend stop being support and start being the functional sale of your group without a purchase price?*

THE SHORTAGE AND THE LEVERAGE

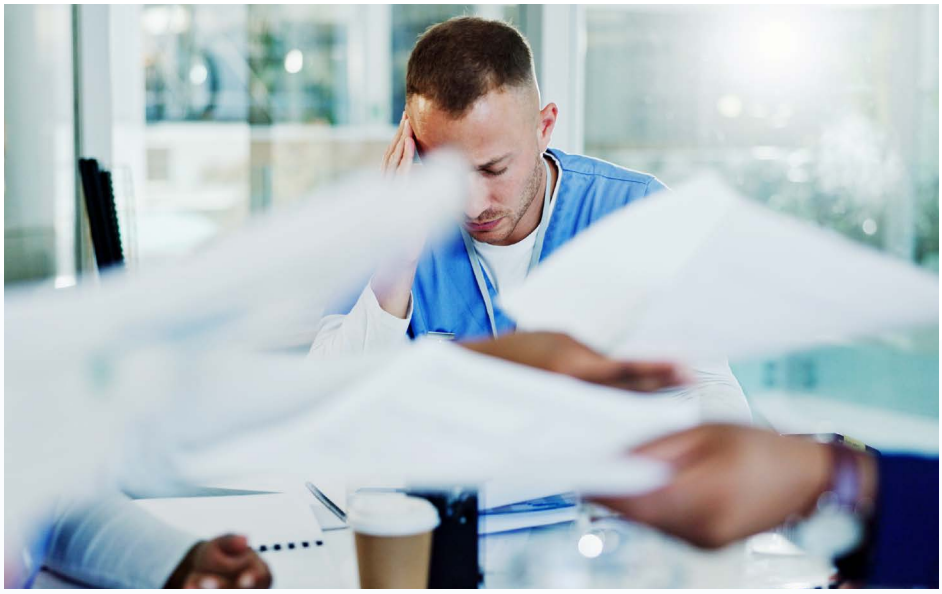
To be sure, the growing shortage of anesthesiologists, fueled by the needs of an aging patient population, the impact of an equally aging anesthesiologist workforce sailing into retirement, and the limited capacity of residency programs training new specialists, has given anesthesia groups substantially more negotiating leverage vis-à-vis hospitals than they've had in decades.

But it's essential that anesthesia group leaders appreciate the fact that leverage in this context is extremely different from, say, the ability of many other sorts of businesses to leverage a shortage, real or manufactured, into increased *profits* by extracting more from the customer.

Think, for example, of the way that Ferrari dealers leverage off the intentionally restricted availability of limited productions models, requiring already great customers to buy multiple "lesser" models before even being considered as a potential buyer of a coveted model such as a LaFerrari. Call it rent-seeking or call it smart thinking, the leverage is used to extract pure profit for the business.

In the anesthesia group financial support context, leverage isn't used to line the pockets—it's used by the group to bridge the financial gap between what's being collected and what must be paid out to its professional staff to meet fair market value compensation expectations, i.e., to retain and recruit. Sure, the staff members' compensation, whether measured by the hour or the unit or the month or the year, will increase due to the support dollars, but the group, not those anesthesiologists and nurse anesthetists, is the party bound by agreement. None of the individuals, unless they are fools (. . . and I have seen it happen), are personally bound to perform the group's obligations to the hospital.

The kicker is that, for the group, even in the face of that elevated negotiating power, when a significant chunk of your revenue comes from the hospital, you are no longer just a contractor. You are its appendage.



TO WHAT DID YOU AGREE TO GET THOSE DOLLARS?

In that context, to what extent did you as a group leader agree to the group becoming bound so tightly to the hospital that it achieved appendage status?

Did you permit the power dynamic to shift, such that your "independent" group is now, or with the short passage of time will be, functionally no different than a passthrough form of hospital employment, just without any benefits?

Among the dozens of common mistakes are ceding to the hospital virtual operational authority over the group (exclusivity without control), failing to conceive of how timing (termination, renewal, etc.) births control for the hospital, sloppy thinking as to staffing limits and dealing with change in demand, the related failure to build in adjustments to financial support, not understanding the array of rights of first refusals and first negotiation, and even permitting the actual decapitation of the group via traps such as "national search" or the similarly named, but very different, "search firm" ruse.

Even though anesthesiologists think that their bargaining strength is at an all-time high, financial support comes at a cost. I'm certainly not telling you to forego negotiating for financial support—I've been representing groups in that context for decades, and the significant financial support that we negotiate is, in today's anesthesia economy, the life blood of nearly all groups.

Instead, I'm telling you that the issues are far more complex and intertwined with the other provisions of the related exclusive contract as well as with your group's overall business strategy.

After all, inadvertently ceding control over your group's operations at a particular facility has an indelible, and potentially irreversible, impact on your overall business, potentially reverberating outside of your group's operations at that facility to impact its operations at others, for example, in the most common form, at ambulatory surgery centers at which it also provides service. It also impacts the ability to expand to new sites of operation. And, last, it potentially sets your group up to have its existence made moot.

One more point on overall business strategy. Understand that the less reliant you are on any deal, meaning that your group's entire existence is not wedded to one facility or even to one system, the more actual bargaining strength you have. At the end of the day, if you can't walk away and continue as a viable entity, your power is far feebler than you imagined.

MARK F. WEISS, JD

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Strategies for Measuring Accounts Receivable Performance

BY JODY LOCKE, MA
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The question every anesthesia provider wants to answer is whether the billing staff is collecting everything that is collectable for the valuable services provided. Predicting the expected value of all the service provided by an anesthesia practice is not such an easy task that requires a detailed understanding of the services provided and payor guidelines for each. While there are many ways to evaluate performance, most are shortcuts that don't provide accurate results. Anyone who says anesthesia billing is easy is either a terrible biller or a terrible liar. Anesthesia billing is unlike that of any medical specialty. The calculation of anesthesia charges an arcane discipline that requires a careful review of each anesthesia record to determine the billable services. Many payers have their own specific rules for calculation allowable payments. The challenge is that the billing staff must capture a number of details for each case so that they have what they need to prepare a specific payer claim. The reason so many anesthesia practices outsource their billing is that billing is simply too complicated to perform consistently without a qualified team of experts. As is true of any service relationship, the client must understand the complexity of the task to appreciate the accuracy of the results.

The irony is that while anesthesia providers have a powerful armamentarium of monitors to evaluate the appropriateness and effectiveness of their anesthesia technique, they lack the necessary tools to know exactly how well the billing process is being managed because the adjudication of claims is somewhat of a black box. This is why the relationship between the provider and the billing staff is always based on a high degree of trust. While monthly management reports provide a considerable amount of data with regard to production trends, collections and key performance metrics, such as days in AR (DAR) and the percentage of AR over 90 days, such metrics don't reflect unique idiosyncrasies of anesthesia billing.

SURGICAL ANESTHESIA CHARGES AND PAYMENTS

Billing for anesthesia services requires identifying three types of charges: time-based surgical anesthesia (85 percent), obstetric anesthesia (13 percent) and non-time-based procedural services (3 percent), each of which has its own rules and conventions. It is these distinctions that make anesthesia billing unique. Failure to track each of these component parts will result in an incomplete understanding of the practice. The key to effective billing is to be able to predict

the expected value of each month's services. If the volume of services declines or if there are payer processing problems the billing staff should be able to predict the extent of the impact.

The majority of anesthesia charges and payments are calculated based on a tally of base and time units, typically based on a 15-minute unit. The total billable units are calculated for each case and then multiplied by a practice conversion factor, or charge per unit, to determine the total charge and them by a payer conversion factor to determine the allowable payment by each payer. One might assume that this makes it easy to determine whether the payment is for a given case, but it is not that simple. Actual payments are adjusted by a variety of factors including copayment and deductible. The net collection percentage measures the disparity between the expected payment and the actual payment. Most management reports include a net collection

percentage, but it is only valid if it only refers to surgical payments.

How do you know what you should be collecting per surgical unit? The key is payer mix. Knowing what percentage of billable surgical units are billed to each insurance plan is the key to revenue potential. Payers can be grouped into three broad categories: public payers (Medicare and Medicaid), commercial payers and self-pay. Since public payment rates are set by the government they tend to be significantly discounted, which draws the overall average down. Commercial rates may be meaningful, which helps raise the average rate. Obviously, patients with no insurance have a very limited ability to pay.

Table 1 indicates a sample of Coronis Health practices from across the country for a period of three years. Rates are very reflective of the payer mix.

This table demonstrates three key aspects of reference data. As discussed above, payer mix has a significant impact on the rate for each practice. The good news is that despite Medicare rates remaining basically flat, the overall averages have been trending up by two to three percent per year. The bad news is that the rate of increase is decreasing. Eventually rates will probably start to decrease.

Projecting the expected value of each month's surgical activity involves two variables, the number of billed units and the projected yield per billed unit, which is typically total actual date of service collections for an extended period of time divided by billed surgical units for the same timeframe. Best results are obtained if this calculation is based on a six-month lag.

TABLE 1: AVERAGE NET YIELDS PER SURGICAL UNIT

	2022	2023	% change	2024	% change
CA	$38.18	$37.75	99%	$37.13	98%
CT	$66.78	$70.54	106%	$72.52	103%
ID	$36.63	$37.72	103%	$37.88	100%
GA	$41.61	$42.62	102%	$52.87	124%
CO	$54.24	$58.52	108%	$59.08	101%
MA	$41.70	$43.64	105%	$44.61	102%
MD	$37.45	$36.85	98%	$37.12	101%
MI	$35.59	$36.58	103%	$37.98	104%
NJ	$45.26	$43.70	97%	$43.68	100%
NY	$37.55	$34.91	93%	$37.09	106%
OH	$36.58	$39.94	109%	$36.34	91%
OK	$28.23	$25.72	91%	$24.01	93%
OR	$33.15	$34.65	105%	$36.71	106%
SC	$30.99	$28.80	93%	$27.50	96%
TX	$26.31	$35.52	135%	$32.56	92%
Overall Average	$39.35	$40.50	103%	$41.14	102%

OBSTETRIC ANESTHESIA CHARGES AND PAYMENTS

Why is it essential to separate obstetric anesthesia performance? Obstetric anesthesia charges are calculated based on a modified surgical formula. Base values are not based on the complexity of the case, *per se*, but on the mode of anesthesia and the outcome of the delivery. Time units may be calculated on a variety of conventions depending on the preference of the practice. The notion of a 15-minute unit does not reflect billable obstetric anesthesia time. One common method for calculating OB anesthesia time, for example, assigns two or three units for the setting of the epidural and one or two units per hour of epidural monitoring. Some Medicaid programs even require documentation of the precise attendance of the provider to the epidural. With regard to payment for OB anesthesia services, major payers tend to have unique criteria. Most will recognize ASA base values but limit the number of payable units.

Because of this the accuracy of OB payments must be based on the specific rules for each payer. Trying to calculate the average yield per unit billed does not tell one much. A much more useful reference metric is the yield per case. The best way to predict obstetric revenue potential is to multiply the average yield per case by the number of cases.

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Strategies for Measuring Accounts Receivable Performance

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FLAT FEE PROCEDURE CHARGES AND COLLECTIONS

Revenue for non-time-based procedures such as invasive monitoring, nerve blocks and evaluation and management services (E&M services) never represents a large percentage of total revenue, but such procedures are nevertheless important to monitor because these may represent revenue opportunities. Charges for invasive monitoring, arterial lines, CVPs, Swan-Ganz catheters and TEE are for CABGs and cardiovascular cases. It is important to ensure that these are being captured. Charges for nerve blocks represent a significant adjunct to anesthesia for orthopedic cases. For many practices these represent one of the fastest growing sources of additional revenue.

The point is that these charges are all based on flat fees and are paid from fee schedules established by each payer. While the ASA assigns base values to all

of these procedures it is important to note that these units cannot be evaluated as similar to surgical units because the allowable payments are not based on ASA units. What most practices are concerned about is whether all these procedures are actually being paid.

What is the point of all this? Reliable performance assessment involves the ability to determine the expected revenue potential of each aspect of the practice so that one can measure what percentage of the expected in being collected based on the ability to post payments against the charges that they are paying off, a methodology referred to as date of service (DOS). Optimal results should be at least 95 percent. Anesthesia providers should use these guidelines as a template for evaluating their performance.

Many anesthesia providers have a tendency to believe that the purpose of the billing staff is to ensure that they will optimize the collections for the valuable services they perform. While it is true that qualified billing staff is critical to the effective management of accounts receivable, effective billing is a partnership. Providers must know how to document the services completely and in compliance with all current guidelines and requirements. They must also know when there are questions or problems that require their prompt attention. Just as they must always know how their patients are responding to the drugs and agents they are administering; they must also know and appreciate the challenges the billing staff is experiencing. This is why a detailed understanding of the arcane nature of anesthesia billing is so critical to the optimal results they desire.

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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 Health. Mr. Locke can be reached at **jody.locke@coronishealth.com**.

Working Together to Remain Compliant and to Avoid Potential Auditing

BY LYNN COOK, CHC
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The goal of this article is to help you gain an understanding of the various governmental auditing programs and help to ensure you and your RCM team are working together and can avoid an external audit.

Working with your revenue cycle management team is key to maintaining compliance with coding and billing requirements. The anesthesia record should tell the story of your encounter with the patient. It is the communication between the anesthesia provider and the coder. Not only are we looking for supporting documentation of the surgical procedure and diagnosis, but we are reviewing types of providers on the case and ensuring documentation supports various models such as medical direction and teaching. We are reviewing the documentation of your ancillary services and ensuring your services are authenticated with a signature.

Ask yourself, are you receiving requests for additional information from your coding team? What types of information are they requesting? Information requests are not only needed to ensure we can properly code and bill the service, but they should also be considered a opportunity for the provider to correct deficiencies, and volumes for such requests should be decreasing over time if providers remain aware.

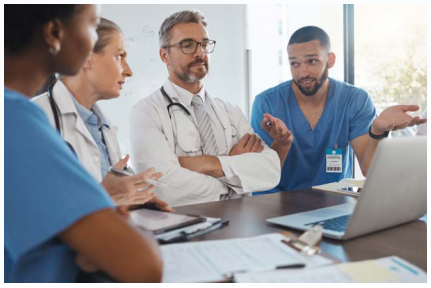
The goal of audit programs processed through the Centers for Medicare and Medicaid Services (CMS) is to identify improper payments. Anesthesia providers are not immune from audits by CMS.

Over the years we have seen specific audits that have targeted anesthesia services. Some of them include:

- The improper use of anesthesia payment modifiers to reflect personally performed cases vs. medically directed or supervised
- Anesthesia performed for pain management procedures
- Overuse of modifiers, specifically in chronic pain management and the use of modifier 25 for an evaluation & management service on the same date as a procedure
- Chronic pain management services
- Ultrasound guidance for needle placement
- Accurate reporting of anesthesia time

From a management perspective, we must remain informed of changes in coding and carrier policies. We review our resources to identify what may be on the audit horizon. Some of the resources include:

- **The OIG Work Plan.** The Office of Inspector General work plan includes active items of audits and evaluations as well as archived items. The site



is updated monthly and is fairly easy to review. Work Plan | Office of Inspector General | U.S. Department of Health and Human Services

- **Targeted Probe and Educate (TPE).** CMS began the TPE program in 2014 and then in 2017 authorized the Medicare contractors (MACs) to conduct reviews utilizing a TPE review. Their goal is to identify errors and work with providers for improvement. They use data to identify providers that have high claim error rates or unusual billing practices. The TPE programs can be found on your MAC website. A simple understanding the program can be found here. IMPROVING THE MEDICARE CLAIMS REVIEW PROCESS
- **Local Coverage Determinations.** These are policies issued by CMS and their Medicare contractors outlining specific items or services to determine if they are a covered

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service. There are several LCDs related to anesthesia services, and they could vary depending on your Medicare contractor. Some include monitored anesthesia care, TEEs, pain management as well as anesthesia for pain management services. Local Coverage Determinations | CMS

- **Medicaid and Commercial Carrier Policies**. These would be specific to your state and Insurance plan. We dive into the requirements for anesthesia billing and documentation guidelines in place by your state carriers to ensure compliance with documentation, coding and billing requirements.

THE VARIOUS AUDIT PROGRAMS

MACs – Medicare Administrative Contractor

- MACs are private companies, usually subsidiaries of large insurance companies, that have contracted with CMS to administer the Medicare program.

RAC – Recovery Audit Contractor

- RACs are private companies contracted by CMS to identify Medicare overpayments and underpayments.

CERT – Comprehensive Error Rate Testing

- The CERT program was created by CMS to measure the paid claims error rate for claims submitted to Medicare. CERT Documentation Contractors (CDCs) are retained by CMS.

PERM – Payment Error Rate Measurement

- The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program

UPIC – Unified Program Integrity Contractor (Formerly ZPIC)

- UPICs are private companies contracted by CMS to conduct audits for Medicare and Medicaid overpayments to detect and then recover possible fraudulent activities.

It is important to maintain an action plan in the event of an audit.

- Audit letters are received via mail. Sometimes they may be sent to a providers' physical location. Be sure to contact your RCM team immediately upon receipt. Dates identified for returning information are crucial.
- Work together with your RCM team to ensure all medical records are pulled at the facility.
- Track dates submitted and confirmation of receipt.
- Do a self-audit of the records in question. This review should not delay the submission of information for the audit.

Needless to say, it is not on anyone's bucket list to go through a carrier audit. Therefore, partnering with your RCM team to understand any documentation deficiencies and cure them as well as having a plan to address an audit should one occur. Avoiding a CMS audit could be possible by ensuring you are actively engaged and understanding your data.

LYNN COOK, CHC

Lynn Cook, CHC serves as vice president of anesthesia practice management for Coronis Health. Ms. Cook has over 35 years' experience in healthcare management with the majority devoted to anesthesia. Lynn is a high-performing business leader with substantial experience in anesthesia operations, regulatory compliance and education with the ability to analyze and address complex issues and implement workable solutions. She is certified in Compliance Healthcare through the Health Care Compliance Association. Lynn can be reached at **lynn.cook@coronishealth.com**

Disinformation or Misinformation by Any Other Name

BY KELLY DENNIS, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I
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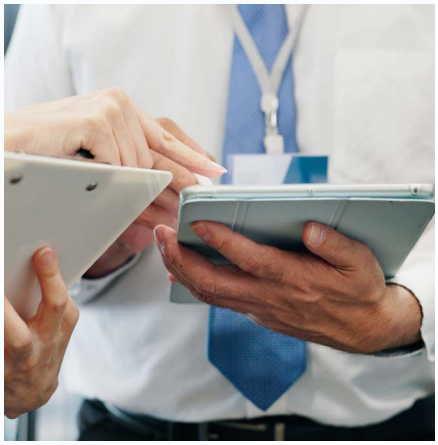
Whomever said knowledge is power perhaps should have said accurate or true knowledge is power! Misinformation or "alternative facts" are rampant. It is difficult to believe that anyone would share information that isn't accurate or fact based, but it happens. Whether intentional or not, one has to apply an idiom we heard as youngsters, and "learn to separate the wheat from the chaff."

Recently, I listened to a speaker with over thirty years of experience in coding share information on a webinar that was extremely outdated. Prior to both 2004 and 2010, teaching anesthesiologists were unfairly penalized for teaching residents, as anesthesia was the only specialty financially penalized for teaching residents. During both time periods, only 50 percent of the allowed amounts were paid for teaching two residents and the allowed amount was based on the documented amount of time spent in each case.

According to the information provided in a 2024 webinar, the "*Anesthesiologist received 100% reimbursement if they are supervising a single case with a resident*" and *"Anesthesiologist received 50% reimbursement if they are supervising 2 – 4 cases involving residents/CRNAs."* That is partially true—until 2010! Teaching guidelines last updated in MLN006347, dated November 2024, limit the number of cases to two concurrent anesthesia cases involving residents, not four concurrent cases.

Pursuant to the Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS) Transmittal 1859, dated November 20, 2009, *"Effective for services furnished on or after January 1, 2010, payment may be made under Section 139 of MIPPA based on the regular fee schedule amount for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or two concurrent anesthesia cases. We are also applying this same policy if the teaching anesthesiologist is involved in one resident case that is concurrent to another case that is paid under the medical direction payment rules. However, the medical direction payment policy would apply to the concurrent case involving the certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA) or student nurse anesthetist."*

Those of you who read anesthesia industry alerts or keep up to date with information provided by the American Society of Anesthesiologists (ASA) will recall several articles that support this updated information and



directly contradict the misinformation provided. It would be a financial loss and detrimental to your practice if the guidance provided during the webinar is or was followed. Until 2004, the CMS rules limited the physicians reported time units to the actual time spent in each of the two cases. After 2010, the CMS rule did not include the same language and allowed full base plus time to be billed for each case with a resident using the AA and GC modifiers. As indicated in the October 19, 2020, alert resourced below, "the teaching anesthesiologist has gradually gained greater reimbursement when involved in two resident cases," although I prefer "greater payment" over the term "greater reimbursement." I recall using the term "reimbursement" early on and having an anesthesiologist ask why they were being reimbursed!

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Disinformation or Misinformation by Any Other Name

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Further, the ASA published a press release on November 9, 2009, providing scenarios to explain how anesthesia practices would be impacted by the approved changes as follows:
"The teaching anesthesiologist receives 100% of the fee schedule amount for the following cases:

- The teaching anesthesiologist is involved in one resident physician case (which is not concurrent to any other anesthesia case);
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case); or
- The teaching anesthesiologist is involved in one resident physician case that is concurrent to another case paid under medical direction payment rules."

Coders and billing staff place a lot of trust on those of us who provide continuing education. When sharing information with others, one has an inherent obligation to check current guidelines and make certain information being shared is accurate and up to date.

Suffice it to say that whether misinformation, as I believe this to be unintentional, or disinformation, and I'm certain this is not done intentionally or with malice, one cannot simply accept information provided as the gospel. When resources are not provided to support the information given, the onus will be on the meeting attendees or you, dear reader, to determine whether it is fact or fiction.

Resources:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R59SOMA.pdf

https://www.anesthesiallc.com/publications/anesthesia-provider-news-ealerts/1372-the-clinical-classroom-anesthesia-in-the-teaching-environment

https://www.asahq.org/about-asa/newsroom/news-releases/2009/11/cms-releases-final-rule-for-2010-physician-fee-schedule

KELLY DENNIS, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I

Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I, has over 41 years of experience in anesthesia coding and billing and has been speaking about anesthesia issues nationally since 2002. She has a master's degree in business administration, is a certified auditor, coder and instructor through the American Academy of Professional Coders. Kelly is an advanced coding specialist through the Board of Medical Specialty and served as lead advisor for their anesthesia board. Kelly also serves as a practice management and reimbursement consultant for the American Society of Anesthesiologists. She is a certified health care auditor and has owned her own consulting company, specializing in anesthesia, Perfect Office Solutions, Inc., since November 2001. She can be reached at **kellyddennis@attglobal.net**.

A Thousand Cuts: A Short History of Shortchanging Anesthesia

BY JUSTIN VAUGHN, MDIV
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It comes from the ancient Chinese practice of *lingchi*. "Death by a thousand cuts" is our way of describing a long, slow, gradual process where the culmination of an entire series of misfortunes ultimately ends in ruin. In ancient China, *lingchi* was a manner of execution reserved only for the most egregious of criminals. Rather than a quick dispatching of the prisoner, a series of small slices would be administered throughout the entire body over a prolonged period of time. No single cut could kill, but the cumulative effect of the many wounds would eventually lead to the victim's demise.

Not long ago, we received a communication from one of our clients whom we'll refer to as "Dr. X." He was responding to an alert we had published that reported on yet another Medicare policy that would negatively affect anesthesia reimbursement. The way he expressed his disappointment over the news was priceless. "Wonderful news! That's right, let's keep undercutting and denying and lowering physician reimbursement!" The sarcasm was thick, and the ire was evident.

Then, Dr. X had an inspired idea. He suggested we chronicle all the ways in which physicians, and anesthesia providers in particular, have been undercut over the last 20 years from a reimbursement perspective. He wanted us to show how "this little snowball

is becoming an avalanche" and to summarize all that's transpired "to cause our death by a thousand cuts." Well said, Dr. X. The following is our summary.

THE LIST OF GRIEVANCES

Here are just a few of the challenges with which the anesthesia community has had to contend over the last two decades:

1. **Falling Conversion Factors.** It's no secret to anyone who has been paying attention that, over the last several years, the Medicare Physician Fee Schedule (PFS) final rule has mandated increasingly lower RBRVS and anesthesia conversion factors. This translates to lower Medicare reimbursement each year for both surgical procedures (e.g., invasive lines, postoperative pain blocks) and anesthesia services, except in those years where Congress has stepped in to ameliorate the reductions. The PFS proposed rule for 2025 contains similar cuts to both conversion factors.

2. **Fee Disparity.** While conversion factor reductions have been absorbed by practitioners, such as anesthesiologists and CRNAs, Medicare payments to hospitals have generally kept increasing to keep up with the rate of inflation. It is not surprising then that some would see this disparity between hospital payments and professional fee payments as a bit unfair.

3. **Fading Physical Status Payment.** Not all payers pay extra for at-risk patients based on higher physical status (e.g., PS 3, 4 and 5). We cited in a recent alert that yet another major payer is now eliminating payment for these modifying conditions in some of their jurisdictions.

4. **Fighting Denials.** As a revenue cycle management company, we are all too familiar with the increasing effort it takes to get insurance plans to pay up. Some commercial payers have become quite creative in finding new ways to delay or deny payment. Fighting with insurance companies can be time-consuming and costly. Providers who take on this task themselves often just give up because they don't have the time or manpower to make the calls and file the appeals. That's why it's good to have a partner like Coronis Health to fight on your behalf.

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A Thousand Cuts: A Short History of Shortchanging Anesthesia

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5. **Flagging GI Bill.** Years ago, we began to notice that some health plans were making it more difficult to get paid for certain GI cases where anesthesia was involved. For example, for an anesthesia provider to get paid in a colonoscopy case, the provider would have to ensure that certain patient metrics were met in order to prove to the payer that there was medical necessity for the anesthesia service. To add insult to injury, there was also a decrease in the colonoscopy base units in 2018 from five to four. There was a further reduction for screening colonoscopy base units to three for Medicare and certain other payers that follow Medicare, causing revenue reductions for this promising revenue stream.

6. **Facets and Epidurals.** Not long ago, the Medicare administrative contractors (MACs) published policies that essentially made it impossible to get paid for anesthesia services in connection with a chronic pain injection—specifically, epidural and facet injections. So, again, what had been a reimbursement opportunity for some time has now been effectively taken away.

7. **Foggy Cataracts.** For years, Medicare only paid four units for 00142 (anesthesia for cataracts), while the ASA's relative value guide (RVG) listed six units as the suggested value of the service.

But in 2009, the RVG came into alignment with Medicare when it listed the base units for cataracts at four, reducing revenue across the payer spectrum.

8. **Fiddling with CRNA Reimbursement.** While Medicare and most commercial payers have historically paid CRNA services at the same rate as that paid to an anesthesiologist, there have been some outliers. That trend may be growing as a major payer (Anthem) announced that, for certain localities, beginning this past November, it has now reduced payments for the anesthesia services performed exclusively by a CRNA (reflected by the QZ modifier) to the 85-percent level, while still reimbursing anesthesiologists at 100 percent of the allowable.

9. **Foregoing Balance Billing.** Anesthesia providers who wished not to be limited by a commercial carrier's contract rates could always opt to be non-participating with that payer, which allowed them to bill their full unit rates to the patient. With the No Surprises Act (NSA), non-par anesthesiologists and CRNAs are now limited to billing the patient at the in-network rate.

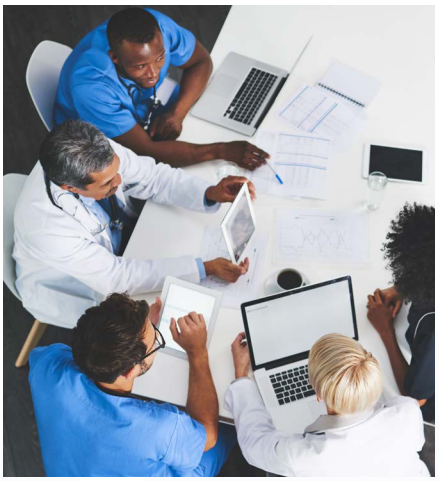
10. **Finagled Contracts.** Because the NSA and its implementing regulations called for payers to reimburse nonparticipating providers based on the median contracted rate, some commercial payers began to lower the rates they offered participating providers so they could establish a lower median. Some even terminated the group's contract to force the group into a lower contract rate. In other words, a few payers used the NSA to lessen the pay for everyone—participating and nonparticipating.

11. **Forced Pre-authorizations.** We have reported on a recent trend involving a noticeable increase in the number of surgical cases requiring a preauthorization. If the procedure is not effectively approved by the insurance plan prior to surgery, then reimbursement is jeopardized for both the surgeon and the anesthesiologist. This means that anesthesia providers may need to take a more active role in ensuring prior to surgery that any preauthorization requirements that exist have been met by the surgeon, etc.

12. **Faltering Imaging Payment.** Over the last several years, we have seen a tendency among Medicare and/or the American Medical Association (AMA)—which produces the CPT coding manual—to incrementally bundle imaging, whether that involve fluoroscopy in certain chronic pain procedures or ultrasound guidance (USG) in connection with certain peripheral blocks. So, whereas you could once get paid for both the block and the USG; now, the USG is not separately reimbursable for the code set in question. Those blocks pay more now, but the increase does not reach the level of compensation previously received by billing blocks and USG separately.

13. **Finessing Time.** For decades, anesthesiologists and CRNAs were able to bill anesthesia time during their placing of invasive lines and postoperative pain blocks—assuming those placements occurred in the OR. But since the AMA back in 2007 indicated that placement time would need to be deducted from total anesthesia time if the placement occurred prior to induction, potential time unit reimbursements were now lost.

14. **Federal Incentive Programs.** When Medicare began the implementation of various so-called "incentive programs" (read "coercive



programs"), like the old PQRS, EHR, E-Prescribing and VBPM programs, they were setting up a pay for performance structure. If you were eligible to participate and failed to do so or failed to meet the various metrics, a percentage of your Medicare pay would be taken away. That same dynamic continues with today's QPP and MIPS.

THE LONG GAME

The above represents just a few of the developments that have taken place over the past 20 years or so that compromised provider revenue—especially in terms of the anesthesia space. Gradualism is a term that can be applied to science, politics and other disciplines. For example, a gradualist approach to political change involves incremental adjustments in law and policy implemented over a multi-year period, so as to avoid civil unrest and revolt that can break out in response to sudden dramatic change. From the perspective of many, there appears to be a gradual process in place where, over a period of time, incremental hits to anesthesia reimbursement are creating a real financial and psychological hardship: the drip, drip, drip of bad news, the final piece of straw that causes the camel's collapse. I like the way Dr. X puts it:

> *It's pretty evident "they" are [set] on destroying independent physician practices so that we all are employed in some fashion, so that we go out of business and become a controlled widget, a commodity.*

So, from the perspective of Dr. X and others, this is what it's like to experience death by a thousand cuts. So, what can anesthesia providers do to combat this discouraging trend? Two suggestions come to mind. First, voice your concerns to the ASA and your other specialty organizations. They maintain a lobbying effort with Congress and federal regulatory agencies. Second, take full advantage of the opportunity to submit your comments to Medicare when these proposed rules come out. If you see something in their proposals that will be detrimental to anesthesia reimbursement, that's your chance to make your voice heard.

JUSTIN VAUGHN, MDIV

Justin Vaughn, MDiv, serves as vice president of anesthesia compliance for Coronis Health. Mr. Vaughn has over 20 years of experience in anesthesia compliance and has been a speaker 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**.

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Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
April 4 - 6	California Society of Anesthesiologists 2025 Annual Anesthesia Conference	Disneyland Hotel Anaheim, CA	CSA 2025 Annual Anesthesia Conference and Board Meeting - California Society of Anesthesiologists
May 15	Massachusetts Society of Anesthesiologists (MSA) Annual Meeting	The Hilton Boston/Dedham Dedham, MA	Massachusetts Society of Anesthesiologists - Home
May 18 – 21	Advanced Institute for Anesthesia Billing & Practice Management Conference	The Rosen Centre Hotel Orlando, FL	https://aiabpm.com/
June 6 – 8	Florida Society of Anesthesiologists Annual Meeting	The Breakers Palm Beach, FL	https://www.fsahq.org/2025-annual-meeting/
August 9 – 13	American Association of Nurse Anesthetists Annual Congress 25	Music City Center Nashville, TN	AANA | Register for Annual Congress

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