Three ways your ASC can profit from professional anesthesia

In the past, ASCs and their owners have typically not profited from the professional component of anesthesia. Even though there’s a contractual relationship between the anesthesia group and the facility, no money flows between them. However, a growing trend has emerged that has ASCs looking for ways to profit from professional anesthesia.

Historically, ASCs have stayed with this business model because aside from the potential regulatory obstacles to profiting from anesthesia, there are also quality issues. “Many ASCs have opted not to go after the anesthesia professional profit because they believe these services are better performed from a quality perspective if the anesthesiologists handle it completely independently from the ASC,” says healthcare attorney Jerry J. Sokol, Esq., a partner with McDermott, Will & Emery in Miami.

We spoke to Sokol to learn about three legal business models ASCs can consider to profit from professional anesthesia. We’ll also tell you about two models ASCs should avoid pursuing because of their potential legal ramifications.

Three legal profit models

Sokol says to consult with your legal counsel to ensure that you navigate applicable state and federal laws before moving your ASC in one of the three following directions:

1. **Open an additional line of business.** Rather than the ASC contracting an anesthesia group to come into the facility and administer anesthesia, the ASC would employ or contract directly one or more anesthesiologists. The ASC, in addition to billing for the facility fee, would now bill for the professional anesthesia. “The ASC entity is essentially operating two businesses—a licensed, Medicare-certified ASC and an anesthesiology group practice within the same facility,” Sokol says. So the ASC’s profit for the professional anesthesia would be the difference between what the facility bills and collects and what it pays the anesthesiologist.

There are a few potential issues of which to be wary as you pursue this model, says Sokol. Your ASC will have to register with Medicare as a group practice. You will also need approval from all of your payers to provide the professional anesthesia, and you may face challenges from commercial payers when trying to receive the same level of reimbursement as an independent anesthesia group, Sokol says. There is also a statute in many states called “corporate practice of medicine prohibition,” which says that a physician...
cannot work for a company unless that company is owned exclusively by doctors. This means nonphysicians cannot own physician practices. So if your ASC has any nonphysician owners, your state may not allow it to enter into this business model. You must also structure this model to navigate the federal anti-kickback statute and state anti-kickback and self-referral laws.

2. Enter a joint venture with an anesthesia group. In this model, a new entity is established that is owned jointly by the ASC and an anesthesia group. The entity obtains commercial contracts for anesthesia, registers with Medicare as a group practice, and the two joint venture partners (i.e., the ASC and anesthesia group) split profits after paying for the cost of the anesthesiologist. A new ASC entering this business arrangement faces fewer regulatory hurdles than an existing ASC providing anesthesia that seeks to change the arrangement to allow it to capture a portion of the profits. “The former is less likely to be deemed a kickback than the latter,” says Sokol, because the anesthesia group did not previously provide the anesthesia group. The entity obtains commercial contracts for anesthesia, registers with Medicare as a group practice, and the two joint venture partners (i.e., the ASC and anesthesia group) split profits after paying for the cost of the anesthesiologist.

3. Enter a contracted agreement between the group practice and the anesthesiologists. Similar to our first model, the group practice is comprised of the surgeons who use the ASC contract directly with the anesthesiologist to provide anesthesia. The group practice bills under the group practice number for the anesthesia fees in addition to billing for the professional fee, says Sokol. This model is easier to implement by ASCs that are affiliated with one or two practices (e.g., gastroenterology and ophthalmology) because the anesthesia group has fewer group practices to contract.

Beware anti-kickback laws

The three models described above are legal business models you can consider for your center. However, there are other methods to capturing anesthesia profits that could lead to serious legal ramifications, says Sokol.

Don’t charge anesthesiologists to see patients. Some ASCs have approached anesthesiology groups and asked them to pay a fee to provide anesthesia at the facility. This is something the ASC should never do.

“...This has very real anti-kickback exposure,” Sokol says. When an anesthesiologist sees a patient, that patient has been referred to the anesthesiologist by the surgeons of the surgery center. If the anesthesiologists pay the ASC to provide services and see patients, they are essentially paying the ASC for the right to receive referrals, which is considered a kickback.

Don’t ask anesthesiologists to pay for meds. Although it may seem as though the anesthesiologist should pay for the anesthesia drugs, it is illegal for the ASC to ask the provider to cover this expense. It is the ASC’s responsibility to cover these costs because the nonprofessional component of anesthesia (i.e., drugs) is reimbursed as part of the facility fee.
Work closely with business associates to ensure compliance

Your business associates (BA) could create Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance risks for your center. HIPAA allows organizations to terminate BA contracts if a privacy or security breach occurs, but placing too much emphasis on terminating contracts and not enough on correcting these breaches will discourage open communication with BAs and could increase your facility’s liability.

That’s why it’s not a good idea to have language in a BA agreement stating that your organization will terminate the contract automatically if a violation occurs, says Todd Frech, senior partner at Ocius Medical Informatics, a consulting company in Ravenel, SC. “There are going to be minor violations,” he says.

The key to dealing with these minor violations is open communication and a good overall relationship with BAs so they report all violations without the fear that you will terminate their contract, he says. “It’s important for them to know that your tolerance for behaviors that lead to violations will be very low. But they also need to understand that you want to know about the violations, are interested in what they’re doing, and are willing to work with them,” Frech says.

Instruct the members of your staff who work the closest with your BAs (e.g., software companies for surgery center patient accounts and operational management, or a billing clearinghouse for your claims processing) to let you know of any suspensions or actual incidences of violations, says Sandra Jones, MBA, MS, CASC, FHFMA, director of management services for Woodrum/Ambulatory Systems Development.

Don’t count on OCR to monitor compliance

Contact the Office for Civil Rights (OCR) when a violation occurs that the BA is unwilling to correct and immediately terminating the contract isn’t feasible for your organization, says Reece Hirsch, JD, partner at Sonnenschein Nath & Rosenthal, LLP, in San Francisco. “For example, the covered entity may have a major [information technology] outsourcing contract and can’t just pull the plug at a moment’s notice,” Hirsch says.

But although you are responsible for reporting these BAs, OCR is not yet prepared to publish this information. And having a list of noncompliant BAs won’t help you maintain compliance. This increases the need to include appropriate provisions in your agreements to minimize your liability. “Fines are bad, but the bad publicity that comes with a violation is 10 times worse. It’s a huge marketing and public relations issue that will affect your business,” Frech says. Take matters into your own hands with strong BA agreements.

Use strict provisions to ensure compliance, quick resolution

Some organizations roll their BA agreements into the actual contracts, Frech says. “If the [BA’s effect] on protected health information [PHI] is minimal, that’s fine.” But if they work extensively with PHI, you need a separate agreement, he says. “You’ll want to very clearly spell out restrictions on access and use and required policies and procedures.”

Along with restrictions and required policies and procedures, Frech and Hirsch recommend including the following provisions in your agreements:

- Notification. Require BAs to notify you of all unauthorized uses or disclosures within a short time frame (e.g., five business days, or immediately), Hirsch says. Nineteen states have notification laws with specific requirements. For example, in California, you must notify victims of a breach within 10 business days.

- Correction. Grant BAs an opportunity to cure breaches, unless they are severe, Hirsch says. This may be as easy as taking away an employee’s access to PHI. Also limit the amount of time they have to fix the problem —within 30 days is ideal, he says.

- Monitoring. Include in agreements a way to monitor the BAs’ compliance, Frech says. That may include periodically reviewing policies and procedures or even making onsite visits for BAs that work regularly with PHI, (e.g., those that do billing). That doesn’t mean policing all of your vendors, Hirsch says. Whether you should actively monitor compliance depends on the business relationship, he says. “For major contracts, you may want to audit and conduct further due diligence. For smaller ones, it’s not feasible.”

- Termination. Violations of the terms of the agreement, rather than a breach, should be grounds for immediate termination of the contract, says Frech.
Resolve to improve

The New Year may have just passed, but it’s not too late to make some resolutions to improve your facility for the upcoming year. We reached out to the ASC

Ten . . .

• Develop a compliance plan. Compliance plans are one strategy for staying on the straight and narrow and keeping the federal government from becoming interested in your facility. But they are just as helpful if you do run afoul of the law. The inspector general (IG) for the U.S. Department of Health and Human Services evaluates six different factors to determine whether to bring a healthcare fraud prosecution. One factor is whether the potential defendant had an effective compliance plan in place. In two factually identical situations, if one provider has an effective compliance plan and the other does not, the IG would look more favorably upon the facility with the compliance plan, and think twice before bringing an enforcement action.

• As the old saying goes, ignorance of the law—or of the facts—is no excuse. Facility owners should understand the extent to which their facilities comply with various regulatory and billing requirements and attempt to address deficiencies that may exist. Conduct a compliance audit to get a handle on where you’re compliant and where you’re not.

—Eric Zimmerman, Esq., healthcare attorney with McDermott Will & Emery, LLP, in Washington, DC

Nine . . .

• Help all of the surgeons who work at your ASC to feel like they are more a part of the center. For examples start a newsletter, have more meetings, or have a periodic reception. This will make them utilize the ASC more—instead of the hospital or other ASCs—and add to the bottom line.

—Michael Schaff, JD, healthcare attorney with Wilentz, Goldman & Spitzer in Woodbridge, NJ

Seven . . .

• Review all contractual relationships.
• Create spreadsheets for service and payer contracts.
• Look for the date the contract started and the renewal dates. Review this monthly to ensure that you take action in a timely manner, if any action needs to be taken prior to renewal.
• Use these steps to ensure that you evaluate all contracts annually as part of the quality improvement program of the center.

—Dawn Q. McLane-Kinzie, RN, MSA, CASC, CNOR, vice president of National Surgical Care in Chicago

Eight . . .

• Present a work plan to your compliance committee annually to ensure that you stay on top of any compliance issues
• Review all case cost versus revenue data to ensure that you receive adequate reimbursement
• Add new service lines (e.g., total joints)
• Educate employers on the cost benefits and quality of an ASC

—Rebecca R. Craig, RN, BA, CNOR, CASC, administrator for the Harmony Ambulatory Surgery Center, LLC, in Fort Collins, CO

Six . . .

• Fine-tune the quality improvement program to incorporate all of the monitoring performed daily
• Network with other ASCs to create a benchmarking culture between facilities

—Karin du Raan, RN, nurse manager for Belmar ASC, LLC, in Lakewood, CO
your facility in 2006!

community and asked your colleagues, lawyers, consultants, and industry leaders for their suggestions to help make 2006 your best year yet.

Five . . .

- Stay on top of cost-cutting measures due to lack of increased reimbursements
- Encourage more referring physicians to refer patients to your facility when procedures can be scheduled within two weeks
- Continue to put patients first in service

—Christina Haven, RN, CGRN, center director for The GI Endoscopy Center in Middletown, OH

Four . . .

- Build a relationship with your state senator and representative and your U.S. representative and two U.S. senators. These five elected officials will learn about your ASC, the role you play in the ASC, and your desire that they have a first-hand understanding of the value of your ASC to the community.
- Contribute $150–$1,000 to one or more of your five elected officials to support their reelection campaign.

—Craig Jeffries, executive director of the AAASC in Johnson City, TN

Three . . .

- Commit the operational resources to do the heavy lifting for your ASC. Negotiate select in-network contracts rather than attempt to survive as an out-of-network facility.
- Recognize that the ASC business is a people business—keep your friends close and take care of the personnel on whom you depend.
- Do business only with honorable people and invite only those with proven integrity into your organization. Forthright, honest, and intelligent people can deal with facts—even if the facts are disappointing at times.

—Woodrow Moore, founder of the Texas Ambulatory Surgery Center Society and The Physician’s Advocate

Two . . .

- Decrease surgical supply costs by maximizing vendor contracts and standardizing equipment/supplies. The cost of surgical supplies is so burdensome to profit margins, it is beneficial to all to maximize savings.

—Cheryl Curcin, RN, CNOR, director of nursing for Cypress Surgery Center in St. Visalia, CA

One!

- Resolve to increase revenue by
  - reducing days in accounts receivable (A/R)
  - getting clean claims out the door in 24–48 hours
  - having accurate and timely posting, reviews, and appeals
  - tracking denials
  - knowing contract discounts
- Resolve to reduce case cost by
  - standardizing packs, supplies, and drugs
  - shopping around for competitive prices
  - planning provider education
  - decreasing waste
- Resolve to review your fee schedule
  - for high-ticket procedures that may need fee increases
  - to determine whether your fees are competitive
  - to establish a need for a fee increase, either overall or specialty-specific
- Resolve to use benchmarking to improve your facility by
  - using national benchmarks provided by FASA, AAASC, Medical Group Management Association
  - asking your management company to benchmark against similar facilities

—Caryl Serbin, RN, BSN, LHRM, president and founder, and Judith L. English, vice-president of business operations for Surgery Consultants of America, Inc., and Surgery Center Billing, LLC, in Fort Myers, FL
Q: Can I report a CPT code for the injection described in the following ASC operative report excerpt?

“The scope was advanced to the cecum without difficulty. Of note, there were some occasional diverticula seen. Also note, there was a 2 cm colon polyp in the sigmoid colon that was removed by submucosal saline lift and hot snare cautery. Hemostasis was achieved. Retro-flexion was performed and was otherwise normal.”

A: Per the January 2004 American Medical Association CPT Assistant newsletter, the procedure report may indicate that a provider injected a polyp with saline or “lifted” it prior to removal by another technique.

In other cases, providers will perform an injection to tattoo an area with India ink for later identification during a subsequent procedure or surgery. In both of these cases, providers should report a code for endoscopy and report submucosal injection as an additional service to any other therapeutic procedure.

Thus, code the case described in the question as follows:

- **45381**—Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance
- **45385**—Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Editor’s note: Lolita Jones, RHIA, CCS, the author of the upcoming book Gastroenterology Coding Guide for Ambulatory Surgery Centers published by HCPro, Inc., answered this question. For more information, go to www.hcmarketplace.com and click on the “Ambulatory Surgery” tab at the top of the screen, or call 877/727-1728.
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