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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.

SPRING 2024

Anesthesia Stipend Requests in Today's Environment

BY DAVID J. PLATT, MPA

Senior Vice President, Anesthesia, Coronis Health, LLC, Everett, WA

Anesthesia provider shortages have been commonplace across health systems since the turn of the century, resulting from fewer anesthesia residency graduates and increased demand for surgeries, especially in the outpatient setting. In turn, we saw a surge in hospitals providing anesthesia stipends so anesthesia departments, mostly staffed by traditional private anesthesia groups, could maintain provider retention and successfully recruit for adequate anesthesia group maintenance.

According to a survey by the *American Society of Anesthesiologists*, overall, 50 percent of hospitals provided an anesthesia stipend in 2000 and 57 percent by 2005. Today we seem to have reached another new high in the anesthesia provider shortage, which has fueled the stipend trend as this percentage has increased to greater than 80 percent today, according to most industry surveys. Chances are, if you are a staff member of a private anesthesia group or a private equity-backed anesthesia corporation, you are already the recipient of a stipend.

BUT IS IT ENOUGH FOR CONTINUED VIABLE OPERATIONS?

A theme becoming increasingly common are anesthesia providers, especially anesthesiologists, working more hours and with fewer days off to maintain the same salary, or worse, for lesser income, while staff retention and recruitment suffer as the average cost of hiring an anesthesiologist has risen twenty to forty percent since 2022.[1] It's no surprise that this is causing anesthesia stipend requests to surge even higher. This trend is expected into the foreseeable future with a predicted shortage of 12,500 anesthesiologists by 2033, according to the *Association of American Medical*

[1] Becker's ASC Review, November 15, 2023

Continued on page 3

INSIDE THIS ISSUE:

CEO CORNER

Pandemic in the Rear View and a Manpower Shortage Ahead

BY TONY MIRA
Interim CEO

As we compile the articles for our quarterly newsletter, *Communiqué*, we try to identify the most significant trends affecting our clients and the specialty of anesthesia. The good news is that the pandemic is now disappearing in the rearview mirror. The bad news is that the national anesthesia manpower shortage is affecting most of our clients. The evolving impact of payer mix changes and hospital administration scope creep is making it increasingly difficult for practices to survive without substantial subsidies. When we started in this business, our focus was simply on maximizing collections for the valuable services our clients were providing. Now we are increasingly helping them to manage their practices as businesses in an even more competitive environment. Data management is essential, and we are helping our clients use their databases to great advantage to negotiate contracts that allow them to succeed and thrive.

One of our senior vice presidents, Dave Platt, MPA, Senior Vice President, Anesthesia for Coronis Health, provides a very practical strategic roadmap for the process of renegotiating a service agreement in his article, *Anesthesia Stipend Requests in Today's Environment*. His years of experience managing anesthesia practices across the country make this an invaluable tool for those preparing for their next sit-down with administration.

We always rely on our legal advisors, Kate Hickner, Esq. and Marc Weiss, JD, to keep us abreast of the changing legal environment for practice. Kate shares her timely review of new reporting requirements for businesses in *Another Transparency Obligation: The FinCEN Beneficial Ownership Information Reporting Requirements*. The good news is this should not adversely affect most of our clients. Mark shares his interesting take on a common practice challenge in his article, *Sure, Dr. Chuck Was A Creep, But Did He Kill Your Facility Agreement... or Worse?* In it, he explores the effect of an individual provider's adverse performance in terms of the group's hospital contract.

Coronis Health's own Jody Locke, MA, Vice President of Anesthesia and Pain Practice Management Services, has been monitoring the evolution of anesthesia practice management for years and shares five key metrics that practices should be tracking to remain viable in the current environment. While we provide lots of useful management information to our clients on a regular basis, his five metrics offer a useful framework for making sense of key trends.

We are also very pleased to feature an article from one of our clients, Michael Bronson, MD, from Mission Viejo Anesthesia Consultants, Inc. in Mission Viejo, CA. As an active member of his group's management team, he shares their invaluable experience with a new management option for their staff in his article, *Enhancing Anesthesiology Practices: The Benefits of AnesthesiaGo*.

Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I of Perfect Office Solutions gets many coding questions for anesthesia practice managers and administrators. Her Q & A piece, *Coding Conundrum for Labor Epidurals*, provides a fascinating insight into the correlation between the evolution of clinical practice and current coding conventions. She definitely keeps us all on track.

As a bonus, we received a very practical guide to the challenge of managing a team in the current environment. Kai Williams, MHRM, Chief Human Resources Officer for Coronis Health, offers us *Mastering the Hybrid Workflow: A Symphony of Communication, Performance, and Inclusivity*. There are some good ideas here.

We hope you enjoy these pieces and find them useful as you manage your practice through the turbulent waters of American healthcare. We are always interested in your response to these diverse perspectives. Feel free to share other topics of particular interest to you.

Anesthesia Stipend Requests

Continued from page 1

Colleges. However, potentially tempering this impact is that the current CRNA shortage may subside by the end of the decade with approximately 2,400 CRNAs graduating each year.[2] So, while the number of anesthesiologists is projected to decline, CRNA numbers are expected to show a growth trend and can offset the anesthesiologist shortage.

While many anesthesia practices have secured a stipend from their facilities, many feel the need for an increase in that stipend. As such, this article covers key preparations an anesthesia group may consider in advance of approaching its facility for a stipend or additional subsidy support.

KEY STEPS TO OPTIMIZE THE RESULT OF YOUR STIPEND REQUEST:

1) **Positive Facility Engagement and Communication**
Ideally, this starts at the inception of the Anesthesia Services Agreement, though it's never too late to embrace this concept. So, rather than providing baseline anesthesia coverage to meet contractual requirements, strive to work as a partner *with* the facility. The group should appoint an Anesthesia Chair or leader, who attends medical staff meetings and participates in the facility's committees. Taken a step further, this may involve taking the lead on OR management, aligning with the facility's goals of ideal OR utilization and meeting quality metrics. Tracking and sharing such data with the facility via routine reports will go far in this regard. Frequent, formal and casual communication with facility administrators reinforces both sides' understanding of each other's goals and challenges, and as such, financial support requests should not be a surprise.

2) **Prudent Business Management**
With the need and degree of the anesthesia stipend being key drivers in adequately staffing the anesthesia department, along with net patient revenue to the group, be ready for full disclosure to support the market reasonableness of each. The facility will oftentimes utilize an outside consultant to evaluate the need, based on the following areas.

a) **Staffing Mix:** A topic facility administrators and consultants frequently broach when a stipend request is on the table is the care team model consisting of at least a 1:3 physician to CRNA ratio, thus potentially reducing costs from a 1:2 ratio or all-anesthesiologist personally performed model. This, however, may not be practical or feasible, in view of several factors. Patient acuity is always a factor. CRNA wages are increasing sharply each year as the provider shortage persists; *Business Wire*® recently reported the median total cash compensation for CRNAs saw an increase of 9.6 percent in 2023 alone.[3] As such, adding CRNAs is becoming less of an option due to their rising costs and scarcity. Though a lesser deployment of the care team model may be reasonable for certain pockets of the practice, such as in ASCs.

b) **Compensation & Benefits:** Sharing current provider salary information is usually necessary when building the case for additional stipend support, as the facility will want to compare this to industry benchmarks. However, given the rapid annual increases in anesthesia provider salaries as noted in this article, it is difficult to accurately track market wages. Hospitals typically rely on industry salary surveys that utilize the previous year's data when published. A more "real-time" view would include compensation packages offered in current regional job advertisements on websites among competitive anesthesia practices and larger private equity-backed anesthesia organizations.

[2] "What Healthcare CFOs Should Know About the CRNA Shortage," Ringo Blog (last visited November 18, 2022)
[3] Business Wire, A Berkshire Hathaway Company, November 15, 2023

Continued on page 4

Anesthesia Stipend Requests

Continued from page 3

c) **Practice Financial Data:** Additionally, since most anesthesia stipends are driven by the amount of patient revenue a practice generates, the facility will likely request financial reports depicting revenue cycle results. These billing reports should illustrate the effectiveness of billing operations. As such, it is good practice for the group's business leadership to monitor billing activity monthly with its revenue cycle management (RCM) company. Key metrics a facility may review when considering its stipend support include Net Collection Rate, Days in AR, Percentage of AR >90 or 120 days, and Bad Debt percent. As such, it is essential the group maintains a close working relationship with the manager of its RCM operation to keep their finger on the financial pulse of the practice and be prepared to discuss it during stipend talks.

d) **Managed Care Contracts:** Crucial here is to ensure the anesthesia group proactively maintains its managed care contracts. One best practice is to maintain a managed care contract matrix including all key terms and conditions of each payer contract in one location, such as a working spreadsheet. This would include contractual unit, flat fee and modifier reimbursement, renewal dates, timely filing deadlines and annual escalators, to name the most key. It is paramount to always be aware of renewal dates and work with your RCM company's managed care expert, so renegotiations begin in ample time prior to the renewal date. This ensures a lapse does not occur, thus forgoing a contractual reimbursement increase in the present year but also for future years, since unit increases are typically a percentage increase applied to the then-current rate. It is also critical to have a sense of market anesthesia unit rates and to strive to meet or exceed that level. The group's RCM company will often deploy a managed care expert to help the group achieve favorable managed care contracts and demonstrate that to the hospital.

e) **Inclusion of Performance Metrics into the Stipend Arrangement.** This is a common component and often required for continued financial assistance. These measures are typically operational, or quality in nature. Examples may include: (1) patient experience results via surveys, (2) quality measurements, which are often satisfied via reporting MIPS quality measures, (3) anesthesia-related case cancellations or on-time case starts, especially the first case of the day.

3) **The Subsidy Evaluation and Request** Drawing upon the components discussed in the paragraphs above, the group should prepare its own assessment, typically with the assistance of their own consultant (whom may be at an arm's reach within the group's RCM company). This approach starts the negotiation at the level of financial support determined necessary by the group for continued viability, utilizing actual practice expense and revenue data via its own due diligence, then shared with the facility and methodically walking through the step-by-step process supporting the request.

This process should involve the following:

1) Financial Practice Assessment
   a. An analysis of expected revenue (applying contractual payer rates) vs. actual for the same period, utilizing actual payer & case mix experience. This validates the group is achieving its revenue potential, or close to it.

2) Anesthesia Coverage Staffing Model
   a. Establish expected staffing, considering number of anesthetizing locations and hours of operation for each, work schedule of anesthesia providers and the call demands of the facility. Depending on the situation, it may be prudent to run multiple staffing models, (e.g., personally performed vs. varying physician/ CRNA/AA ratios of medical direction).
   b. Apply market-based compensation packages to the providers and other operating overhead.

3) Determine appropriate subsidy range based on results of above.
   a. Note, this may include multiple scenarios, yielding multiple subsidy ranges. For instance, Scenario #1 may be an "as-is" stipend arrangement. However, if it is deemed OR utilization can be improved without a decrease in case volume, via decreasing daily ORs or alteration in hours, a Scenario #2 may involve an alternate lower subsidy range based on fewer ORs and, hence, fewer anesthesia provider FTEs.

While requesting a stipend or increased financial support may not be welcome news to facility administrators in this current environment, we have experienced facility receptiveness as the anesthesia shortage is acutely felt by all parties. This shortage directly impacts OR revenue and, hence, facility bottom line. Moreover, these administrators are likely aware of recent public accounts of health systems across the U.S. making sweeping changes in their anesthesia department staffing in an attempt to reduce costs, only to find themselves in a predicament once the terminated group departs. In severe cases, these administrators have seen the majority of cases cancelled when the transition is made, in some cases accepting only emergency and OB patients in the short term due to lack of anesthesia providers. With industry evidence for additional financial support to anesthesia groups mounting, and health systems realizing the necessity of anesthesia stipend arrangements to sustain OR case revenue, it is incumbent upon anesthesia groups to build its case with empirical data to support its stipend request to their facility leadership.

DAVID J. PLATT, MPA

David J. Platt, MPA serves as Senior Vice President for the Coronis Health anesthesia division, responsible for revenue cycle management of Coronis anesthesia clients. He has worked exclusively in the anesthesia industry assisting group practices of all employment structures in providing RCM and practice management services for the last 20+ years, also facilitating beneficial relationships between facilities and anesthesia groups. Dave holds a Master of Public Administration (MPA) degree, with certification in Health Care Administration, from West Virginia University. He can be reached at **David.Platt@CoronisHealth.com**.

Enhancing Anesthesiology Practices: The Benefits of *AnesthesiaGo*

BY MICHAEL BRONSON, MD
Mission Viejo Anesthesia Consultants, Inc., Mission Viejo, CA

In the fast-paced world of healthcare, efficiency and accuracy are paramount. For anesthesiologists tasked with creating and managing complex schedules, coordinating patient care and ensuring safety during surgeries, every minute counts. Enter *AnesthesiaGo*—a revolutionary software solution designed to streamline and optimize anesthesiology practices. From scheduling to reporting, this innovative platform offers an array of tools to modernize the scheduling and management of anesthesia groups.

A HISTORY

As a busy anesthesiologist in a growing group, I became aware of an all-too common issue: the struggle to find the time to maintain the paperwork associated with daily patient care. At the end of each workday, which consisted of caring for patients, my management work would just be beginning. In order to prepare the daily schedule for the following day, I'd be in the OR poring over a stack of papers that had a list of all of our cases across the different sites for the next day, a list of the call order and a pencil.

To make the next day flow smoothly, I then had to spend time manually assigning an anesthesiologist to each case, making sure: (a) they were credentialed at those locations, (b) had the specialty requirements (cardiac, pediatric, regional, etc.), and (c) weren't already scheduled somewhere else, among many other considerations. This process usually took over an hour and care had to be taken to eliminate errors like double-bookings, scheduling staff to a case at a time they don't service or forgetting to schedule someone's cases altogether. Frequently, the process of correcting the mistakes created more mistakes, leading to more time spent and a lot of confusion the night before.

It didn't take long doing it this way to look for a more modern approach to the daily scheduling process. These struggles led me to search for a solution. When one didn't exist, I put together a team of computer programmers and data scientists to develop a mechanized process for OR scheduling. We fine-tuned various iterations until we came up with a system that met our needs. We called it *AnesthesiaGo*. This program has been a tremendous time saver for us. We have been using it since 2018. PerfectServe acquired the platform in 2021. It is used across the country and internationally, as well.

I share this article as an attempt to assure others in our specialty who are struggling with scheduling issues that there is an answer, and this is how our group at Mission Viejo Anesthesia Consultants worked to solve it.

TIME SAVINGS IN SCHEDULING

One of the most significant advantages of *AnesthesiaGo* is the time saved in creating schedules. Traditionally, scheduling can be a time-consuming and cumbersome task, often prone to human error and miscommunication. With *AnesthesiaGo's* intuitive interface and automated features, scheduling becomes a breeze. The software takes into account various factors such as call order, specialty requirements, surgeon and anesthesiologist preferences, as well as inter-site travel time where applicable. The system also allows for the aggregate scheduling of hospital and non-hospital sites by integrating with the EMR for case retrieval or allowing for manual inputting in non-EMR settings. This not only saves valuable time for anesthesiologists, but

also ensures that all scheduling conflicts are minimized, leading to smoother operations and improved patient outcomes.

Once all of the cases and personnel are in the system, the application will generate a suggested schedule based on each group's rules. The user will then have the opportunity to make any edits by dragging and dropping cases to other providers, if desired. If undesired conflicts are manually created, the user will be alerted to those potential errors.

EFFICIENCY IN SCHEDULE MANAGEMENT

Beyond simply creating schedules, *AnesthesiaGo* enhances efficiency in schedule management. The software allows for easy updates and modifications, accommodating last-minute changes or unforeseen circumstances with ease.

Anesthesiologists can quickly adjust schedules, reassign tasks or add new cases without disrupting the workflow. This flexibility is invaluable in a dynamic healthcare environment where adaptability is key. Those practices already using a monthly call scheduling program like LightningBolt can have each day's providers automatically pushed into the *AnesthesiaGo* platform for daily schedule creation. In turn, once the *AnesthesiaGo* schedule is created, those individual schedules are pushed back into the LightningBolt phone app.

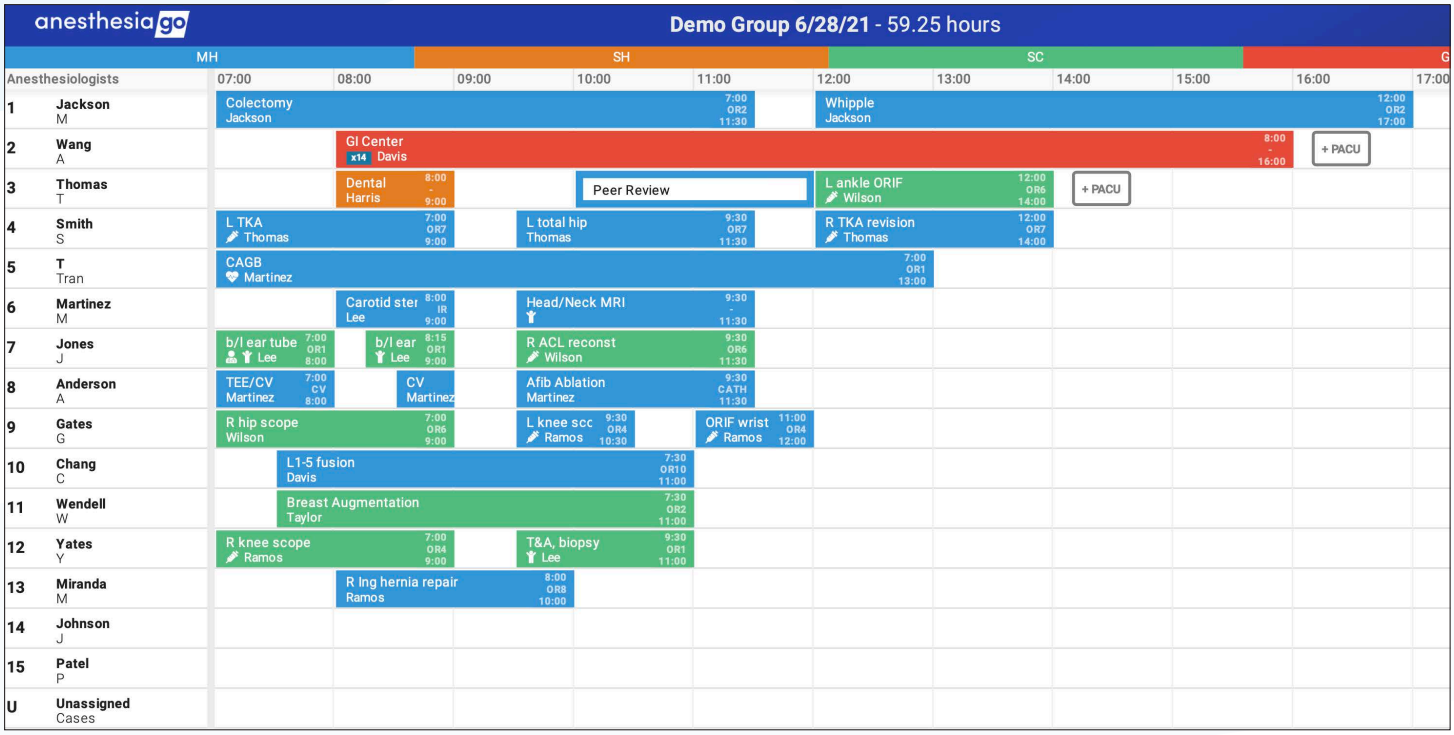
COLOR-CODED BOARD RUNNER REPORTS

Many years ago, if I was the "board runner" the next day, I used to spend 15-20 minutes each night scribbling a map of where everyone was going to be the next day so I could identify potential conflicts, overlaps or gaps where I could accommodate an add-on.

With *AnesthesiaGo*, once the schedule is made, I (and my group members) now immediately receive a color-coded board runner report. These reports offer a visual representation of the schedule, highlighting critical information I used to try to ascertain with pen and paper. I have also discovered that our gauge of "being busy" has gone from a subjective sense to seeing the actual hours of the group's aggregate case times each day, a more objective measure of workload.

VALUE TO DATA, REPORTING, AND ANALYTICS

AnesthesiaGo not only facilitates day-to-day operations, but also provides valuable insights through data, reporting and analytics. By saving data as schedules are created, the software offers a comprehensive view of anesthesiology practices, going as granular as into each anesthesiologist's individual statistics or as wide as a view



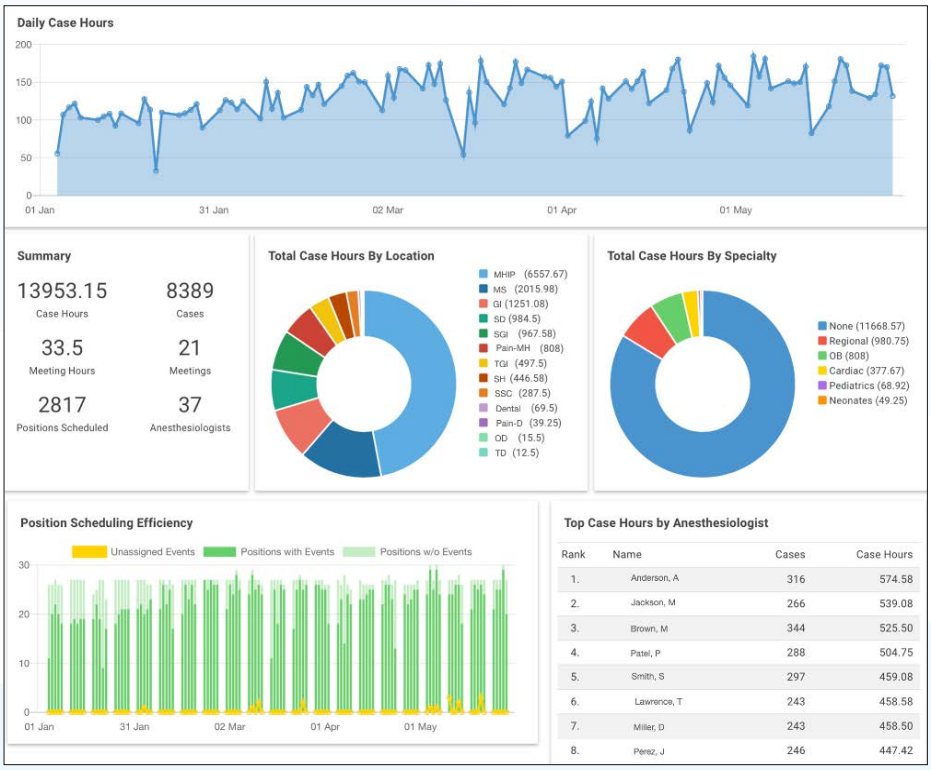
Continued on page 8

Enhancing Anesthesiology Practices

Continued from page 7

of the group's caseload at each location. The application can assess data across specialties and can show workforce utilization information, allowing groups to be more intentional with how many providers to schedule each day. Anesthesiologists can analyze trends, identify areas for improvement and make data-driven decisions to optimize performance and enhance patient care. Moreover, robust reporting capabilities allow for easy retrieval of information from past schedules.

AnesthesiaGo represents a paradigm shift in anesthesiology practices, offering a host of benefits for the busy anesthesia provider. From time savings in scheduling to efficiency in schedule management, from color-coded board runner reports to valuable data insights, this innovative software empowers anesthesiologists to deliver optimal care while maximizing operational efficiency.



As healthcare continues to evolve, solutions like *AnesthesiaGo* play a crucial role in driving excellence in patient care and clinical outcomes.

MICHAEL BRONSON, MD

Michael Bronson, MD is a UC-San Diego trained and board-certified anesthesiologist working in Orange County, California. Aside from his role as a full-time physician, he has built and scaled multiple healthcare businesses and currently serves as the CEO of the Wellness Clinic of Orange County (therapeutic infusions for mood and pain disorders). He co-founded and served as the CEO for *AnesthesiaGo* (scheduling software for anesthesiologists) prior to its acquisition by PerfectServe in 2021. He serves in various leadership roles within his private practice group, notably on the Board of Directors as well as the Orthopedic and Neurosurgical Service Line Director. At the hospital level he has served on a number of committees with experience on a Multidisciplinary Peer Review team and as a member of the Medical Executive Board. Dr. Bronson also functions as an advisor and consultant to various software and medical device companies that seek his expertise and opinion at various stages of development. Prior to gaining experience in business development, as a Chief Resident at UCSD he worked closely with world renown anesthesiologist, Jonathon Benumof, and authored several chapters in his textbook, Clinical Anesthesiology.

In his free time Dr. Bronson enjoys spending time with his wife and three children, cooking, reading, traveling, picnics at the beach and attending sporting events. He can be reached at **michaelpbronson@gmail.com**.

Five Key Anesthesia Metrics

BY JODY LOCKE, MA
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Five years in, the long-term effects of the COVID-19 pandemic are still present in our industry. Ever since the second quarter of 2021—when surgical case volume dropped precipitously—most anesthesia providers have been asking the same two questions: when would things return to normal, and what would normal look like? Now that we are already in 2024, we have a much better perspective on the impact of the pandemic and the state of the specialty.

To identify the most significant trends, we reviewed the data from 12 Coronis Health anesthesia clients from across the country. Practice data for activity from January through October was compiled for 2022 and 2023. Surgical and obstetric data included case counts, units billed, collections and payor mix. Because the intent was to identify trends, the data represented postings by month, based on date of entry (DOE). The sample represented 591,737 surgical and obstetric (OB) cases from 2022 and 637,263 total cases from 2023, which we determined to be meaningful and representative. The objective was to identify trends that would be useful in assessing broad indications and potential concerns.

Our analysis has focused on five key management metrics that all anesthesia practices should be tracking as they plan for the future. These metrics define the current economic realities of the specialty.

TABLE 1: PERCENTAGE CHANGE IN OBSTETRIC VS. SURGICAL CASE VOLUME

	Obstetric Case Volume Changes	Surgical Case Volume Changes
Practice 1	7%	21%
Practice 2	7%	6%
Practice 3	-12%	2%
Practice 4	32%	16%
Practice 5	1%	17%
Practice 6	-1%	-9%
Practice 7	-5%	1%
Practice 8	0%	3%
Practice 9	0%	10%
Practice 10	1%	8%
Practice 11	0%	16%
Practice 12	-6%	8%
Overall	0%	8%

1. Percentage change in case volume
2. Percentage change in acuity of case (units per surgical case)
3. Percentage change in DOE collections (OR versus OB)
4. Yield per unit (surgical cases)
5. Yield per hour

OVERALL PRODUCTION TRENDS

As a practical matter, it is always useful to distinguish surgical from obstetric activity. There are many compelling reasons for this. Surgical cases typically represent the majority of practice activity and the most significant percentage of practice revenue. Most payer contracts are based on the surgical payment model, where payment represents a per-unit payment for base and time units. Obstetric care is often the most challenging aspect of practice economics. It is not uncommon for the obstetric population to have a much higher rate of Medicaid patients, which usually results in much less revenue per shift. Most practices typically develop two distinct staffing models.

The good news is that most practices experienced a significant increase in overall surgical case volume from 2022 to 2023. As indicated in Table 1, the average growth rate of this sample was eight percent while obstetric case volume

Continued on page 10

Five Key Anesthesia Metrics

Continued from page 9

remained essentially flat. As Table 1 indicates, some practices experienced a significant growth in surgical volume. While it is true that most hospitals saw an increase in case volume from one year to the next, the bulk of this increase came as a result of the addition of new venues. The largest practices aggressively pursued surgery centers.

ACUITY OF CARE

While it is true that most anesthesia providers tend to measure their production in cases performed, this is not exactly the best way to measure the economic potential of the practice. Anesthesia is unique in relying on base and time units to determine payment. Because of these changes in the acuity of care, the average units billed per case can have a significant impact on the overall revenue potential of the practice.

The migration from inpatient surgical venues to outpatient venues—especially those dedicated to endoscopy—can gradually erode the billing potential. Although the drop in average units per case may appear small, the overall impact can be significant.

Conventional wisdom has held that there is an inverse relationship between the average units per case and the payer mix. In other words, inpatient facilities with a higher Medicare population tend to generate more units per case, but the average yield per unit is less. The notion that payment for cases performed in an outpatient facility nets more per unit is not always true, as will be explored below.

NET COLLECTIONS

Obviously, what matters most to every practice is the amount of money collected. Table 3 indicates the percentage change in Date of Entry (DOE) collections from 2022 to 2023. Most practices have an expectation of what should be deposited each month. When collections reach or exceed this number, they are happy. When it falls short, they want to know why. It is a common paradigm. Based on the past few years, most practices are ecstatic to see total collections represent a seven percent increase.

When it comes to assessing the impact of strong collections, we are at an interesting juncture. The impact of the COVID-19 pandemic was dramatic and was still being felt to some extent into 2022. Positive collection trends this year raise hopes that this growth is the new normal. Let us hope this is the case, but history tells us that the future is never guaranteed.

TABLE 2: CHANGES IN AVERAGE UNITS PER CASE

	Average 2022 units per surgical case	Average 2023 units per surgical case	Percentage change
Practice 1	11.94	11.57	-3.10%
Practice 2	12.96	12.99	0.25%
Practice 3	13.05	12.83	-1.69%
Practice 4	10.16	9.99	-1.64%
Practice 5	12.18	11.66	-4.23%
Practice 6	10.40	11.18	7.49%
Practice 7	10.42	10.49	0.63%
Practice 8	8.92	9.07	1.70%
Practice 9	9.70	9.46	-2.43%
Practice 10	12.53	12.50	-0.27%
Practice 11	12.47	12.27	-1.63%
Practice 12	14.27	13.68	-4.11%
Overall	11.30	11.19	-0.98%

YIELD PER SURGICAL UNIT

The amount a practice collects per surgical unit is a function of the practice's payer mix. In general terms, providers understand that public payer units (Medicare, Medicaid, Workers' Compensation, Champus and VA) are significantly discounted. At $20 or so per unit, the Medicare rate is often less than 25 percent of the average commercial contract rate. One way to monitor the impact of public payer rates is to track payer mix.

The good news is that the overall average of public payers for this sample of

TABLE 3: PERCENTAGE CHANGE IN DATE OF ENTRY (DOE) COLLECTIONS

	OB DOE Collections	Surgical DOE Collections	Overall Impact
Practice 1	7.7%	9.5%	9.3%
Practice 2	6.5%	5.8%	5.9%
Practice 3	-25.7%	-12.9%	-15.3%
Practice 4	85.4%	23.2%	27.5%
Practice 5	-4.9%	5.7%	3.3%
Practice 6	-1.1%	-0.7%	-0.8%
Practice 7	-0.1%	6.4%	6.1%
Practice 8	-8.1%	4.8%	4.4%
Practice 9	3.8%	9.0%	8.4%
Practice 10	3.4%	5.6%	5.3%
Practice 11	-2.4%	17.6%	15.3%
Practice 12	3.4%	10.8%	9.9%
Overall	2.8%	7.6%	7.1%

practices has not changed from 2022 to 2023 as shown in the table below. We find that 48 percent of surgical units are getting billed to public payers in both years. This is a significant percentage. The problem is that this does not tell the whole story.

The bad news is that a practice really needs to generate 50 ASA units per location day at a rate of $40 per unit to generate enough revenue to cover the cost of providers at current market rates. As Table 5 clearly indicates, only two practices meet this requirement of a net yield of $40 per unit (Practice 9 and Practice 10). The others must rely on hospital support to cover their costs.

Three factors have led to the need for financial support from facilities: the impact of public payers, inefficient operating room utilization and the increasing cost of anesthesiologists and CRNAs. As the market becomes increasingly competitive, many practices have either sold out to larger entities or become hospital employees. This information is a critical component of an effective management strategy.

TABLE 4: PAYOR SOURCE PER SURGICAL UNIT

2022												
Payor	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5	Practice 6	Practice 7	Practice 8	Practice 9	Practice 10	Practice 11	Practice 12
Medicare	14%	17%	17%	22%	18%	22%	45%	47%	21%	23%	23%	21%
Medicare Hmo	19%	12%	8%	13%	6%	9%	0%	0%	13%	12%	9%	8%
Medicaid	2%	1%	6%	1%	2%	1%	16%	12%	1%	6%	1%	1%
Medicaid HMO	20%	5%	27%	13%	6%	9%	0%	0%	12%	1%	11%	10%
Veterans	0%	0%	2%	1%	0%	0%	0%	0%	0%	0%	0%	0%
Tricare/Champus	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Grand Total	55%	35%	60%	50%	32%	41%	61%	59%	47%	42%	44%	40%
2023												
Payor	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5	Practice 6	Practice 7	Practice 8	Practice 9	Practice 10	Practice 11	Practice 12
Medicare	13%	16%	18%	19%	18%	23%	45%	47%	21%	23%	19%	19%
Medicare Hmo	20%	13%	7%	16%	12%	15%	0%	0%	14%	13%	8%	8%
Medicaid	2%	1%	4%	1%	1%	1%	16%	12%	1%	6%	2%	2%
Medicaid HMO	21%	5%	22%	14%	6%	9%	0%	0%	11%	1%	10%	10%
Veterans	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%
Tricare/Champus	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Grand Total	56%	35%	53%	51%	37%	48%	61%	59%	47%	43%	39%	39%
Comparison 2022 Vs 2023												
Payor	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5	Practice 6	Practice 7	Practice 8	Practice 9	Practice 10	Practice 11	Practice 12
Medicare	-1%	-1%	1%	-3%	0%	1%	0%	0%	0%	0%	-4%	-2%
Medicare Hmo	1%	1%	-1%	3%	6%	6%	0%	0%	1%	1%	-1%	0%
Medicaid	0%	0%	-2%	0%	-1%	0%	0%	0%	0%	0%	1%	1%
Medicaid HMO	1%	0%	-5%	1%	0%	0%	0%	0%	-1%	0%	-1%	0%
Veterans	0%	0%	-1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Tricare/Champus	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Grand Total	1%	0%	-7%	1%	5%	7%	0%	0%	0%	1%	-5%	-1%

Continued on page 12

Five Key Anesthesia Metrics

Continued from page 11

TABLE 5: CHANGE IN SURGICAL YIELD			
	2022 Surgical Yield	2023 Surgical Yield	Net Change
Practice 1	$32.15	$29.98	-$2.17
Practice 2	$36.25	$35.97	-$0.28
Practice 3	$27.02	$23.57	-$3.45
Practice 4	$29.39	$31.73	$2.34
Practice 5	$41.00	$38.62	-$2.38
Practice 6	$34.95	$35.30	$0.35
Practice 7	$20.91	$21.90	$0.99
Practice 8	$15.94	$15.88	-$0.06
Practice 9	$41.71	$42.27	$0.57
Practice 10	$45.25	$44.54	-$0.71
Practice 11	$30.66	$31.67	$1.01
Practice 12	$36.38	$38.77	$2.39
Overall	$32.06	$32.20	$0.14

PROFITABILITY – YIELD PER HOUR

Ultimately, the true value of management information comes down to profitability. As more and more practices have come to rely on hospital support to close the gap between the revenue generated from clinical activity and the cost of providing the care, the negotiation of subsidies requires a detailed understanding of the actual revenue potential of each venue. While most of the management information provided by billing staff is actual production data, which is not normalized, it is normalized metrics that allow for an objective comparison to market data. The yield per unit is one example of normalized data, but two other metrics tend to be more relevant and useful for determining profitability: the average yield per hour of care provided and the average yield per clinical day. For purposes of this discussion, the average yield per hour of care is relatively easy to calculate while the yield per clinical day requires detailed coverage information.

TABLE 6: AVERAGE YIELD PER HOUR OF CARE			
	2022	2023	Change
Practice 1	$272.81	$258.52	-5.2%
Practice 2	$390.63	$389.98	-0.2%
Practice 3	$218.94	$193.04	-11.8%
Practice 4	$252.98	$275.99	9.1%
Practice 5	$314.20	$302.24	-3.8%
Practice 6	$301.68	$289.54	-4.0%
Practice 7	$180.28	$187.69	4.1%
Practice 8	$154.29	$149.47	-3.1%
Practice 9	$368.44	$383.36	4.0%
Practice 10	$343.64	$340.67	-0.9%
Practice 11	$326.47	$342.17	4.8%
Practice 12	$379.72	$415.36	9.4%
Overall	$282.92	$286.27	1.2%

Looking at Table 6, $286.27 is the average yield per hour of care. In Chart 6 above, seven of the 12 practices yield more than the average. This number is a reasonable benchmark for purposes of assessing a practice's yield. From a staffing perspective, this means that each practice should strive to minimize the cost of care through a judicious use of physicians and CRNAs to target a reasonable cost given the payer mix and market for the practice.

CONCLUSIONS

For most practices, 2023 has been a good year. The key metrics are generally positive, although there are clearly some outliers. There is a saying that "a rising tide lifts all ships." There is a lot of truth to this. Strong surgical volume is typically a blessing. It is always better to have too many cases than not enough cases.

While the metrics are generally positive, they are not necessarily stellar. Payer mix is always a challenge. Given the national demographic trends, the Medicare population is growing. Americans over 80 are the fastest growing segment of the American population. Although the sample included here has not seen any dramatic increase in public payers, many practices have been seeing a one percent increase in their Medicare population per year. This is why it is so critical to monitor payer mix and the impact of Medicare and Medicaid over time.
It should also be noted that the number of anesthetizing locations continues to increase as cases move from traditional inpatient venues to outpatient facilities. The dramatic increase in the number of anesthetics for endoscopic cases can be profitable for many practices, but it definitely erodes the average units per case without necessarily increasing the yield per unit.

To avoid the need for financial subsidy from the facility, a practice should ideally generate 50 billable ASA units per location day at a rate of at least $40 per billed unit. The number-one challenge for most practices today is to generate enough revenue to recruit and retain an adequate team of qualified providers. The impact of discounted public payer rates and commercial plans that are becoming ever more reluctant in agreeing to rate increases is a universal challenge.

It is important to remember that good news today is not always good news tomorrow. As is true in the provision of anesthesia, vigilance is the key to success. One must always be monitoring the evolution of various factors to be able to plan for their ultimate impact.

JODY LOCKE, MA

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Another Transparency Obligation: The FinCEN Beneficial Ownership Information Reporting Requirements

BY KATHRYN HICKNER, ESQ.
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Many physician practices and healthcare businesses are facing a new set of federal transparency requirements that require action now. The U.S. Department of Treasury Financial Crimes Enforcement Network (FinCEN) **Beneficial Ownership Information Reporting Requirements** (the Rule), which was promulgated pursuant to the 2021 bipartisan Corporate Transparency Act, is intended to help curb illegal finance and other impermissible activity in the United States.

Healthcare stakeholders who are already experiencing burnout from operating in a heavily regulated industry and a punitive enforcement environment are not thrilled to add one more task to their administrative "to do" list. The good news is that the government has aimed to ensure that compliance is "**simple, secure and free of charge**." Also, stakeholders will be comforted by FinCEN's abundant **FAQs** and other helpful **materials**.

The goal of this article is to provide a basic overview of the Rule and address some commonly asked questions.

REPORTING COMPANIES AND EXEMPT ENTITIES

There are two types of reporting companies: "domestic reporting companies" and "foreign reporting companies." Domestic reporting companies include corporations, LLCs and other similar entities that are created by filing a document with a secretary of state or any similar state office. Foreign reporting companies include entities formed under foreign country laws that are registered to do business in the United States.

That being said, an entity that otherwise satisfies the definition of a reporting company does not need to report to FinCEN under the Rule if they satisfy one of the potential exceptions. There are twenty-three exceptions afforded. Briefly referenced, these exceptions are intended for the following entities: (a) securities reporting issuer, (b) governmental authority, (c) bank, (d) credit union, (e) depository institution holding company, (f) money services business, (g) broker or dealer in securities, (h) securities exchange or

clearing agency, (i) other Exchange Act registered entity, (j) investment company or investment adviser, (k) venture capital fund adviser, (l) insurance company, (m) state-licensed insurance producer, (n) Commodity Exchange Act registered entity, (o) accounting firm, (p) public utility, (q) financial market utility, (r) pooled investment vehicle, (s) tax-exempt entity, (t) entity assisting a tax-exempt entity, (u) large operating company, (v) subsidiary of certain exempt entities, and (w) inactive entity. In order to rely upon any of these exceptions, an entity must satisfy numerous specific requirements that are beyond the scope of this article.

The most relevant exceptions for many physician practices and other healthcare organizations are typically the *tax-exempt entity* and the *large operating company* exceptions. Broadly summarized and subject to some nuances, in order to satisfy the *large operating company* exceptions, the entity must employ more than 20 full-time employees in the United States, operate or have a physical presence in the United States and have filed a federal income tax or information return in the United States for the previous year demonstrating more than $5,000,000 in gross receipts or sales.

INFORMATION TO BE REPORTED

Each reporting entity must share basic information about itself (e.g., name and address). It must also share the following information about each beneficial owner: (a) name; (b) date of birth; (c) address; and (d) the identifying number and issuer from either a non-expired U.S. driver's license, a non-expired U.S. passport, or a non-expired identification document issued by a State (including a U.S. territory or possession), local government, or Indian tribe. If none of those documents exist, a non-expired foreign passport can be used. For purposes of this requirement, a "beneficial owner" is generally an individual who owns or controls at least 25 percent of a company or has substantial control over the company. In addition, companies created on or after January 1, 2024 must also submit information about company applicants. Generally speaking, "company applicants" are those individuals who file or are responsible for filing the company's formation document.

FinCEN has published helpful **guidance** that clarifies who is and who is not a "beneficial owner" or a "company applicant" and what type of information needs to be published about each individual.

Additional FinCEN **regulations** (sometimes referred to as the Access Rule) have been promulgated to protect the security of the information reported under the Rule. These regulations will become effective on February 20, 2024. These regulations are designed to protect the confidentiality of the information while also permitting law enforcement and national security agencies to use the information to address money laundering, terrorist financing, tax fraud and other illicit activity. In general, the regulations provide that the reported information can only be shared with governmental agencies, regulators financial institutions. Additional information about those safeguards can be found in FinCEN **guidance**.

TIMING REQUIREMENTS

All existing physician practices, healthcare businesses and others that are required to make a beneficial ownership report under the Rule will need to file their initial reports this year. FinCEN began accepting reports on January 1, 2024 and has published **guidance** on how to complete the process.

The deadline differs based upon when the entity was organized. For those that were in existence prior to January 1, 2024, they have a little more time before action is necessary—their deadline is January 1, 2025. For those companies that are organized or registered to do business during 2024, they must file a report within 90 days after receiving actual or public notice that the company has been created or registered. Those that are formed after January 1, 2025 will only have 30 days from actual or public notice that the company has been created or registered.

In the event that an entity was previously exempt from the reporting requirement but no longer qualifies for the exemption, the entity is required to make a report within 30 days of the date when the exemption is no longer satisfied.

Continued on page 16

Another Transparency Obligation

Continued from page 15

In the event that there is a change in information about a reporting company or its beneficial owners in a report filed under the Rule, the company must file an update within 30 days. However, reporting companies are not required to file updates to personal information about a company applicant.

Note that the reports do not need to be updated annually. Rather, once the initial report is submitted, subsequent updates are not required unless the information needs to be corrected or has changed.

REPERCUSSIONS OF NONCOMPLIANCE

In the event of willful failure to comply with the Rule's reporting requirements, the entity, senior officials and individuals who withhold information preventing a complete and accurate filing, may each be subject to civil and criminal penalties. For noncompliant entities, this could include civil penalties of up to $500 for each day that the violation continues, or criminal penalties including imprisonment for up to (2) two years and/or a fine of up to $10,000.

PRACTICAL TAKE-AWAYS

For those physician practices and other healthcare businesses that may need to comply, now is the time to reach out to your attorneys, CPAs and other advisors to assess whether your organization must comply and to obtain assistance doing so if necessary. Each entity may also want to review its governing documents to determine whether they adequately protect all involved in the event that a beneficial owner or company applicant is uncooperative with efforts to comply with the Rule. For those physician practices and other healthcare businesses that are in the process of selling their businesses, they should expect buyers to review compliance with the Rule during the diligence process.

BY KATHRYN HICKNER, ESQ.

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Mastering the Hybrid Workflow: A Symphony of Communication, Performance and Inclusivity

KAI WILLIAMS, MHRM
Chief Human Resources Officer, Coronis Health, Dallas, TX

The healthcare world is changing fast, and successful teams need to adapt. That means mastering the art of working together seamlessly, whether you're in the office, at home or somewhere in between. This guide is your roadmap to building a high-performing team in a hybrid environment, with a focus on clear communication, maximized performance and an inclusive culture.

COMMUNICATION HARMONY: NO MORE INFORMATION OVERLOAD

Ditch the scattered, confusing communication. Empower your team with pre-recorded briefings and case reviews they can access on their own terms. This fosters deeper understanding and engagement, setting the stage for a collaborative environment.

Think of it like a central platform where everyone's on the same page. A single platform for video calls, messaging and document sharing eliminates app-hopping chaos and keeps everyone in the loop, no matter where they are.

Moreover, communication isn't just about information flow. Virtual "huddle" sessions for complex cases bring your team together, boosting engagement and collaboration. Imagine everyone informed and involved, regardless of location.

PERFORMANCE PRECISION: FINE-TUNING INDIVIDUAL AND TEAM SUCCESS

Personalized goals and regular check-ins are like customized training plans, driving each team member and the entire group towards excellence. This feedback loop ensures everyone's aligned and moving in the right direction. However, the performance journey doesn't stop there. Keep your team at the forefront of healthcare advancements with targeted online courses and hands-on workshops. Continuous skill development is the hallmark of a high-performing team, always pushing the boundaries of what's possible.

Remember, well-being fuels everything. Set clear expectations and provide resources that support healthy work/life balance. A happy and healthy team is a productive and powerful team.

BUILDING A SUPPORTIVE CULTURE: EVERYONE ON THE SAME STAGE

Empathy-driven leadership sets the tone. Acknowledge challenges, create a safe space for open communication and let every member feel valued, heard and appreciated. Imagine a team where everyone feels connected and comfortable contributing, regardless of their location.

Location barriers? Not a problem. Virtual onboarding and team-building activities break down walls, seamlessly integrating new members and strengthening existing bonds. Picture a team where everyone feels part of the same unit, even when they're miles apart.

Don't forget to celebrate! Public recognition, even virtual, boosts morale, inspires confidence and reinforces a positive team culture. Let the appreciation wash over your team, fueling their motivation and dedication.

Harness the power of technology to orchestrate success across all aspects of your hybrid workflow:

- Communication & Collaboration: Microsoft Teams, Google Workspace, Slack
- Project Management: Asana, Trello, Monday.com
- Virtual Meeting: Zoom, Google Meet, Webex
- Performance & Engagement: Moodle, BambooHR, Peakon
- Well-being & Work/Life Balance: Headspace, Calendly, RescueTime
- Culture & Inclusion: BambooHR Onboarding, Donut, SHRM

Continued on page 18

Mastering the Hybrid Workflow

Continued from page 17

STAYING AHEAD OF THE CURVE: EMBRACING NEW TRENDS

AI-powered tools are like your tech-savvy assistants, streamlining processes and boosting productivity from scheduling to sentiment analysis. Let technology handle the mundane tasks while you focus on the bigger picture.

Immerse yourselves in the future with AR/VR. Imagine virtual meetings, training simulations and team-building exercises that transport your team to new worlds. These cutting-edge experiences can foster deeper engagement and collaboration.

Data is your guiding light. Optimize hybrid schedules and measure the impact on performance and well-being, using insights to make informed decisions. This data-driven approach ensures you're always moving in the right direction.

EVOLVING WORK MODELS: FINDING YOUR RHYTHM

The four-day workweek isn't just a buzzword. It's a chance to improve well-being and productivity while boosting retention. Demonstrate your commitment to a healthy work/life balance and watch your team thrive. While this model isn't for everyone, it's worth considering as another option in your team-building strategy.

Hybrid-first vs. office-first? The choice is yours. Choose between flexible workspaces or dedicated desks, aligning your work model with the preferences and needs of your team. Remember, a happy and productive team thrives in an environment that suits them best.

Micro-offices and co-working spaces can be the missing piece, providing greater flexibility and reducing commutes. Imagine a world where your team members can work comfortably and efficiently, close to home when needed and connected to the team when desired.

FOCUS ON EMPLOYEE EXPERIENCE: CRAFTING A SYMPHONY OF SATISFACTION

Forget one-size-fits-all schedules. Cater to individual preferences and family needs with personalized hybrid arrangements. This harmonious work/life balance ensures that your team's unique needs are met.

Navigating the hybrid workflow transcends mere checklists; it involves crafting a dynamic ensemble of collaboration, performance and inclusivity. By adopting these strategies and harnessing technology's prowess, you can cultivate a flourishing team poised for success in the ever-shifting healthcare terrain. Keep in mind that communication sets the melody, performance establishes the harmony and inclusivity dictates the rhythm. So, don your conductor's hat, lead your team with assurance and orchestrate a symphony of success in the business casual world of healthcare.

KAI WILLIAMS, MHRM

Kai Williams, MHRM, serves as chief human resources officer for Coronis Health. In that capacity, Ms. Williams, a seasoned HR professional, oversees all HR-related initiatives worldwide. Kai is an accomplished global human resources executive with a 20+ year record of proven success conceiving, leading, and executing HR initiatives. She has led teams in the US, India, Singapore, London, and Ireland. Kai is passionate about leadership development and is a member of the John Maxwell Certified Leadership team and a DISC consultant. Throughout her career, Kai has excelled as a trusted advisor and change agent in the finance, printing, manufacturing, marketing and technology industries. She has a diverse background across a variety of companies like Apex, Epsilon, RR Donnelley and Bank of America. Kai holds a Master of Human Resource Management degree from the University of Phoenix. She can be reached at **Kai.Williams@CoronisHealth.com**.

Sure, Dr. Chuck Was A Creep, But Did He Kill Your Facility Agreement . . . or Worse?

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

Staffing pressure, the inability to recruit and retain, is like a virus, infecting medical groups of many sorts and nearly all sizes.

Perhaps that's why the "Somewhere Group," an amalgam of hospital-based groups with a pretend name, one of which might just be a few miles from where you are now, overlooked Chuck's somewhat odd demeanor and the fact that he'd held three handfuls of practice positions over the past handful of years.

Soon, the complaints started coming in. "He stands way too close to me, sometimes inches from my face." "Chuck comes up behind me and touches my arms." "He brushes up against me."

Then, out of the not-so-blue, comes a lawsuit, publicized in the local paper, brought by a hospital volunteer, alleging civil assault: Chuck had used his finger to "draw" on the plaintiff to show where an incision had been made on a patient.

The story is picked up by television news, featuring interviews not only with the plaintiff but with hospital employees who decry that they've been complaining about creepy Chuck for months.

The hospital's CEO is having a meltdown. Chuck's got to go, and fast. The CEO calls Somewhere Group's leader and says he's exercising his rights under Somewhere's exclusive contract.

What might those rights be and is Somewhere itself on the chopping block?

SOME POTENTIAL PROVISIONS

The CEO is likely referring to a class of hospital contract provisions that consists of two sorts.

The first is generally found in the breach/termination section of the agreement. An example would be a provision that provides that, "Hospital may terminate this Agreement immediately upon a good faith determination by Hospital that a Provider has done something to cause material harm to the business reputation of Hospital."

The second is comprised of two elements.

The initial element might be found in a provision dealing with professional qualifications, such as one stating that, "Group shall ensure that no Provider engages in any conduct that is unethical, unprofessional or jeopardizes, or threatens to jeopardize, the health or safety of patients."

The other element is a standard provision that permits the hospital to terminate the agreement upon the group's breach; it would look something like this:

> *"Any party hereto may terminate this Agreement immediately if any other party breaches this Agreement and such breach is not cured within [some number of days]."*

TWO BIG PROBLEMS

The Chuck saga presents two contract drafting issues for medical groups to consider.

Continued on page 20

Sure, Dr. Chuck Was A Creep

Continued from page 19

The first is that the agreement attaches standards to particular providers but places the impact of their breach on the group. Chuck violates the terms, but the Somewhere Group pays the price.

When negotiating the agreement, Somewhere should have negotiated for language that specifies that if an individual provider breaches a qualification provision or if a breach relates to a specific provider's conduct, then the breach can be cured by removing the provider from the schedule or terminating his or her relationship with the group.

The second is that chucking Chuck from the schedule or from the group, *even if the group had successfully negotiated for the ability to cure by removing the "offending" provider*, will often draw a wrongful termination or similar lawsuit against the group. Consider, though, that the decision to chuck Chuck was really made by the hospital's CEO.

The solution to that quagmire is for groups to negotiate for an indemnification provision: If the hospital triggers the removal of a provider, the hospital indemnifies the group for any blowback from the provider.

Note that although the Chuck saga is far from uncommon, other triggers, such as a physician's exclusion from participation in federal healthcare programs or medical license issues or provisions giving a hospital administrator carte blanche to withdraw approval of any provider, can put the group into one or both of these predicaments.

In your own group's contract negotiations, hope for the best, but plan for the worst. That bit of planning might prevent your group from Somewhere's fate.

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Coding Conundrum for Labor Epidurals

BY KELLY DENNIS, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I
Perfect Office Solutions, Inc., Leesburg, FL

Coders often struggle with new or unique scenarios when it comes to reporting labor epidural services. It is important to communicate with your coders and billers to ensure compliant billing. For example, the following questions recently came through my inbox.

Question: Would it be appropriate to use code 01960 to code for a vaginal delivery under nitrous oxide?

Response: According to the Health Evidence Review Commission (HERC), "Nitrous oxide is a non-flammable, tasteless, odorless gas that is self-administered on demand by laboring women through a mouthpiece or facemask (Collins, Starr, Bishop, Baysiner, 2012; Klomp et al., 2012)." While you may find resources recommending reporting 01960, the American Society of Anesthesiologists® (ASA) has not changed their position from reporting an unlisted anesthesia code for nitrous oxide since 2016. Code 01960 does not apply since the patient did not receive "analgesia/anesthesia care" for the vaginal delivery. According to the ASA, a vaginal delivery under nitrous oxide should be reported with the unlisted code, 01999.

Coding tip! Unlisted codes require extra documentation. Include all relevant procedure notes and anesthesia records, as well as a listed code with a similar relative value. This helps the claims processor determine whether to allow and how much payment to allow!

Question: An epidural started on day one and ended on the third day. The patient labored for three days and did not deliver. The surgeon is billing 59856 due to fetal demise and that code crosses to an anesthesia code 01966, which is not the service we provided. Can I report 01967? The patient did not deliver vaginally, and I am not sure what ASA code to use for this since it was over 72 hours.

Response: Even though the surgeon is reporting 59856, which crosswalks to anesthesia code 01966, your code will not match the surgeon in this case. Your anesthesia provider placed an epidural catheter (code 01967), which does not require the patient to deliver. Per the code description, "*Neuraxial labor analgesia/anesthesia for **planned vaginal delivery** (this includes any repeat subarachnoid needle placement and*

Resources:
https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2016/01/coding-for-nitrous-oxide-for-labor-analgesia
https://www.oregon.gov/oha/HPA/DSI-HERC/EvidenceBasedReports/Nitrous%20Oxide%20for%20Labor%20Pain%20Mgmt.pdf

Continued on page 22

Coding Conundrum for Labor Epidurals

Continued from page 21

drug injection and/or any necessary replacement of an epidural catheter during labor." The code is for planned delivery and the patient labored for three days before surgical intervention. Since the labor epidural was used as the method of anesthesia, your dilemma is in reporting the time of 72 hours. If you follow one of the ASA's recommendations for billing, as noted in the resource provided, there will be a cap on the charge. You still report the date and time span as documented. Based on the unique circumstances, the payer may ask for documentation, and you want it to match the information being provided on the claim. Keep in mind the payer may also limit or restrict the amount of time spent for 01967.

Coding tip! Keep a close eye on your labor epidural charges and payments. Per the ASA, charges should "reasonably reflect the costs of providing labor anesthesia services as well as the intensity and time involved in performing and monitoring any neuraxial labor anesthesia service." Payments may vary based on flat rates or caps by some payers. Know what your payers expect in your geographical location!

Question: We use a care team approach. If the anesthesiologist and a second certified registered nurse anesthetist (CRNA) were not present for the epidural and did not document their presence at the Cesarean section (C-Section), I am not sure how to bill this. We look for documentation from the medical doctor (MD) for the pre-anesthesia evaluation, anesthesia plan, a post-anesthesia evaluation and attesting to presence in order to bill as medically directed for a labor and delivery case. If any one of these are not documented by the physician, do we bill for only the CRNA as medical direction was not met?

Response: Whether the labor epidural is one MD/CRNA care team and the C-Section is the same MD with a different CRNA or not, the medically directing anesthesiologist will document participation. They should have already performed a pre-anesthesia exam and evaluation and prescribed the plan for the epidural. These steps do not need to be

Resource:
https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/coding-and-billing-for-labor-epidurals

met again for the C-Section. This covers steps one and two (See Cigna resource linked at the end of this article).
Moving forward to a C-Section may be a demanding aspect of the case, depending on the circumstances, and the medically directing anesthesiologists may document his or her presence, as applicable. As epidural is a regional anesthesia, there is not an "induction" or "emergence" as with general anesthesia. Documenting presence and participation (such as present for placement of the epidural or placing the epidural catheter) would be true for both the epidural and C-Section, although case checks for an epidural are sporadic. Interestingly, the monitoring at frequent intervals indicates "general anesthetic" and this is not a general anesthesia. Clinical judgments are made by the medically directing anesthesiologist for each patient, and this covers steps three and five.

Steps four and six indicate that no specific documentation is required. These are a "given," meaning these steps are expected for every single patient under the care of the anesthesia care team.

Step seven will be related to both the epidural and the C-Section, as there is not an expectation these are separated for post-anesthesia care requirements. The anesthesia care team will transfer care of this patient to the PACU just once.

Coding tip! Each record should stand on its own for compliance purposes. If the steps of medical direction are not documented, payer guidance is referenced as Coronis understands policies differ. In any case, modifiers reported on the claim form should match the documentation! Otherwise, it may not be considered a "clean claim."

For full details on the CIGNA resources, please click **HERE**.

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Professional Events

DATE	EVENT	LOCATION	CONTACT INFO
June 7-9	Florida Society of Anesthesiologists 2024 Annual Meeting	The Breakers West Palm Beach, FL	https://www.fsahq.org/fsa-annual-meeting/
August 2-6	American Association of Nurse Anesthetists 2024 Annual Congress	San Diego Convention Center San Diego, CA	https://www.aana.com/premier-event/annual-congress/
September 5-8	Texas Society of Anesthesiologists 2024 Annual Conference	JW Marriott San Antonio Hill Country San Antonio, TX	https://tsa.org/
September 6-8	Michigan Society of Anesthesiologists 2024 Annual Conference	Park Place Hotel Traverse City, MI	https://mymsahq.org/annual-conference/#!form/ConfVendor
September 22-24	The Ohio Society of Anesthesiologists 85th Annual Meeting	Columbus Hilton at Easton Columbus, OH	https://osainc.org/events/
October 18 – 22	American Society of Anesthesiologists Annual Conference	Pennsylvania Convention Center Philadelphia, PA	https://www.asanet.org/2024-annual-meeting/

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