American Society of Anesthesiologists

PRACTICE MANAGEMENT

Starting Out:

A Practice Management Guide for Anesthesiology Residents

PRACTICE MANAGEMENT

Starting Out: A Practice Management Guide for Anesthesiology Residents

Prepared for
the American Society of Anesthesiologists
by Judith Jurin Semo, Esq.
Squire, Sanders & Dempsey L.L.P.

American Society of Anesthesiologists

520 N. Northwest Highway
Park Ridge, IL 60068-2573
(847) 825-5586
mail@asahq.org
www.asahq.org

5M108LC

Starting Out:
A Practice Management Guide for Anesthesiology Residents

published by
the American Society of Anesthesiologists.

ASA Executive Office
520 N. Northwest Highway
Park Ridge, IL 60068-2573
(847) 825-5586

ASA Washington Office
1101 Vermont Ave., N.W., Suite 606
Washington, DC 20005
(202) 289-2222

TABLE OF CONTENTS

PREFACE

As business considerations and government regulation have increasingly become intertwined with medical practice, anesthesiologists leaving clinical residency programs and embarking on their careers increasingly have felt ill-equipped to handle the nonclinical aspects of their new careers. This guide is intended to provide practical advice concerning the legal and regulatory aspects of practice to anesthesiology residents and anesthesiologists who are just starting out in their practice.

This manual was principally prepared by Judith Jurin Semo, Esq., of the law firm Squire, Sanders & Dempsey L.L.P., in Washington, D.C., which serves as legal counsel to the American Society of Anesthesiologists (ASA), in consultation with the ASA Committee on Practice Management. Marcelle M. Willock, M.D., M.B.A., prepared the chapter on professionalism; Arnold J. Berry, M.D., M.P.H., Chair of the ASA Committee on Occupational Health, prepared the chapter on substance abuse; and Sorin J. Brull, M.D., an adjunct member of the Committee on Quality Improvement, prepared much of the first part of the chapter on credentialing. Ms. Semo's colleague, Samuel Black, prepared much of the text of chapter IV on retirement and tax planning. The manual reflects the firm's comments and views on legal issues, and the views of ASA members on practical issues facing anesthesiologists as they enter practice. The manual does not represent a statement of ASA policy or requirements.

Recommendations regarding the topics covered in this guide do not constitute legal advice. ASA members should consult with their legal counsel, business managers, accountants and other consultants concerning specific legal and business questions.

I. INTRODUCTION

The transition to practice from residency, with its focus on clinical issues, can be rocky, particularly if the move is to private practice. In place of the attention on patient care in the academic setting, day-to-day practice is marked by many different issues that compete for an anesthesiologist's attention. Although caring for patients is foremost, an anesthesiologist is expected to deal with the business end of clinical practice. For many physicians entering practice, the increasing emphasis on contracts, business matters and legal issues can be frustrating, both because it detracts from the efforts placed on clinical practice and because, as entry-level physicians, they are not prepared to deal with business issues when they complete residency.

This monograph is designed to provide practical guidance to anesthesiology residents about practice management issues that generally are not covered in residency programs, but which are essential for them to understand. It may also serve as a useful reference for practicing anesthesiologists.

A. HOW THIS GUIDE IS ORGANIZED

The guide is organized into nine substantive chapters that address specific areas of interest to physicians beginning their professional careers. Where possible, information is organized into chart form in the "*At a Glance*" boxes, and key points in a discussion appear in text boxes for additional emphasis. For ease of reference, the anesthesiology group is referred to as the "Group," and the hospital at which the Group practices is referred to as the "Hospital." ***A detailed glossary of acronyms, abbreviations and terminology appears as Appendix A***. It is organized both by topic area and alphabetically.

B. ASA AND OTHER RESOURCES

A number of ASA publications address the topics covered in this guide in greater detail. Specifically, *Contracting Issues: A Primer for Anesthesiologists* (1999) addresses numerous issues involved in negotiating the wide variety of contracts that anesthesiologists may encounter, including agreements used to form anesthesiology practices; agreements negotiated within a practice, such as employment agreements and shareholder agreements; and agreements with outside entities, such as hospitals, billing companies, and software companies. That publication includes a **forms supplement** on the ASA Web site that contains a variety of sample agreements. *Contracts for Anesthesiology Care: A Handbook for Anesthesiologists* (rev. 1994) contains a more detailed discussion of hospital contracting issues. *Managed Care Contracting: Considerations for Anesthesiologists* (1996) discusses managed care contracting provisions and strategy, *Calculating Anesthesia Capitation Rates* (1996) addresses capitation issues and *Managed Care Reimbursement Mechanisms: A Guide for Anesthesiologists* (1994) provides useful information on how to evaluate a variety of compensation methodologies, including flat fee/fee schedule payment and capitation rates. Finally, *Compliance with Medicare and Other Payor Billing Requirements* (1997) provides an overview of anesthesia billing compliance issues. ASA members should consult those six ASA publications for additional information regarding those topics.

Additional resources on specific topics are listed in the "***Resource reference***" boxes.

II. PATIENT CARE AND PROFESSIONALISM

As physicians, your proper focus is on the patient and achieving the best possible outcome in each case. As members of businesses, your emphasis may shift to providing clinical care in the most cost-effective manner and to the business and legal issues of an academic and/or private practice in anesthesiology. But those latter emphases should not compromise the central focus on the best interests of the patient and the delivery of high-quality anesthesiology care. Legal obligations tend to be framed in terms of minimum standards of care. Ethical and moral obligations focus instead on what is right. You should aim for a high standard of moral and ethical behavior with patients and within the profession.

Both the "Principles of Medical Ethics of the American Medical Association" (AMA) and the ASA "Guidelines for the Ethical Practice of Anesthesiology" emphasize the physician's overriding obligation to place the patient's interest foremost. Pronounced concern is developing in the medical community that the complexities of modern society in general and the variety of pressures on physicians in particular, including the increasing penetration and demands of managed care and the shrinking resources available to support health care for all, have shifted attention away from professionalism and the essential values and obligations of physicians.

Resource reference

The ASA "Guidelines for the Ethical Practice of Anesthesiology"

(Continued on next column)

(Continued from previous column)

outline the professional responsibilities of anesthesiologists. The AMA "Principles of Medical Ethics" are reproduced as part of those ASA guidelines. All ASA standards, guidelines and statements appear on the ASA Web site <www.asahq.org/Standards/homepage.html> and are reproduced in the white pages at the back of the ASA *Directory of Members*.

Professionalism is a set of values, attitudes and behaviors that focus on commitment to service. Among the core attitudes and behaviors expected of medical professionals are integrity, availability, accountability and altruism. In practice, these values should result in honesty in one's dealings with patients and others; respect and compassion for patients; respect for families, colleagues and coworkers; effective communication; and the ability and willingness to accept responsibility. Maintaining appropriate, timely, and legible medical records and adhering to rules and regulations of health care facilities and licensing authorities are also required. You must assure ongoing competence by performing self-assessment and maintaining your knowledge and skills up-to-date. While not everyone is involved in teaching students and residents, the word "doctor" connotes "teacher," and thus you are expected to be willing to instruct your patients, coworkers and others as needed. If you choose an academic career, you must recognize the obligation to the university and its functions of teaching and research. Not everyone in the modern academic medical center will be able to do research, but

collaborating and supporting colleagues, as well as recognizing their contributions, are essential to the well-functioning department. Another duty of academic faculty members is to serve as good role models for students and residents and, in time, to become mentors to them and to junior faculty.

Lastly, how you conduct yourself within and outside of the professional organization reflects on you, your employer, your organization and the profession. Your conduct in the clinical setting needs to be patient-focused. Negative attitudes and behaviors — be they clinical, personal or interpersonal — must be confronted and changed for the integrity of the individual, the department and the institution. Engaging in personal phone calls in the operating room, surfing the Web or attending to other matters during patient care is not what is expected. Some anesthesiologists may feel that no one sees their street clothes when they come to work and therefore they need not dress professionally. Colleagues and other staff do see you and, although clothes do not "make" the person, they can unmake the person. You need to pay attention to how you dress in going to work, seeing patients, and participating in hospital events. While a good knowledge of resources — both institutional and personal — is needed, an impression of "greediness" is detrimental to all concerned.

As a member of a business, your duties also involve being a good citizen of the medical community and serving that community, be it at the local level in the department, hospital or other health care setting, or in your professional group or organizations at a regional or national level, e.g., civic organization, medical society or ASA. Interaction with knowledgeable colleagues at other institutions can enhance your knowledge and skills, can help to disseminate information about anesthesiology and can help to provide a broad range of input to national organizations that establish standards of care. Your participation in these activities also will benefit your Group, as it will enable you to bring back a wide range of information to your Group.

Your professionalism will benefit not only your patients but also your own standing among your peers and professional organizations.

In summary, responsibility for patients and placing the needs of the patient first; honesty and integrity in dealings with patients and colleagues; commitment to colleagues; and accepting responsibility for one's actions are core values of professionalism. Some physicians speak of a sense of assault that derives from governmental enforcement efforts and societal attitudes that assume that physicians are out to defraud payors rather than to heal patients. Your challenge as you enter practice will be to balance the demands of day-to-day practice and the increasing intrusion of legal and business considerations into the practice of anesthesiology, yet to maintain these essential professional values.

III. WHAT'S WHAT: STATUTES, LAWS AND REGULATIONS

A. FEDERAL LAW

1. Constitution. As the foundation of the legal system in the United States, the United States Constitution provides the framework for the relationships (i) among the three branches of the federal government – the Executive, the Legislative and the Judicial; (ii) among the states; (iii) between the states and the federal government; and (iv) between individuals and both the federal and state governments.

2. Statutes. On the federal level, proposed legislation is introduced in either chamber of Congress – the House or the Senate. It is referred to one or more committees with jurisdiction over the subject matter, where hearings are held and the public has a chance to be heard. It then is considered by the full chamber with opportunity for debate. If it is passed, it then is referred to the other chamber, where the committee and full chamber processes are repeated.

Any conflicts between the versions passed by the House and the Senate are resolved in a conference committee consisting of representatives from both chambers, and the final version of the legislation is sent back to each chamber for passage. If passed by both chambers, the legislation is sent to the President for signature. If the President declines to sign the bill (exercising the veto power), Congress may override the veto by a two-thirds vote.

Once enacted, statutes are incorporated into the United States Code, which is a compendium of all United States statutory law. Statutes often are written in broad language that is subject to interpretation. The Sherman Antitrust Act, by way of example, prohibits "contracts in restraint of trade." It is the job of the Executive and Judicial Branches to interpret the laws – through the rulemaking process in the Executive Branch and through court decisions in the Judicial Branch. Ultimately, it is the role of the Executive Branch to administer the laws.

3. Regulations (or rules).

a. *In general*. Congress may delegate power to Executive Branch agencies to develop regulations, also known as rules, that provide greater detail regarding how the law will be interpreted and enforced. Federal rules have the force and effect of law and often are the source of the practical restrictions on private sector activity.

In the Medicare context, the Social Security Act establishes the Medicare program that provides payment for medical services provided to senior citizens. The regulations promulgated by the Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS) define the conditions for payment for anesthesiology services to Medicare patients.

b. *Rulemaking and the administrative process*. Administrative or Executive Branch agencies act in two fundamental capacities: as lawmakers and as adjudicators. The procedural requirements applicable to an administrative agency depend upon whether the action being taken is "legislative," affecting a broad range of persons, or "adjudicatory," affecting a particular group of people. The distinction can be difficult to make.

In order to promote uniformity and open-

ness in the rulemaking process, Congress passed the Federal Administrative Procedure Act, which is the primary source of federal administrative agency law. Agencies seeking to issue regulations implementing legislation usually must publish a Notice of Proposed Rulemaking (NPRM) and afford the public an opportunity for notice and comment. In general, a sixty-day comment period is required. In adopting final regulations, the agency must respond to the comments that were filed and explain why it is adopting or rejecting the positions advocated in the comments. Agency regulations are subject to review in the courts. The standard of review is whether the rule is "arbitrary and capricious." On most substantive matters, the courts defer to the expertise of the agency.

Agency notices, including NPRMs and final rules, are published in a daily publication known as the *Federal Register*. It often is useful to consult the *Federal Register* version of a final rule to review the *preamble*, which is the agency's explanation of the need for the rule and its reasoning in adopting the rule. An agency's section-by-section analysis of the regulation and explanation of its intentions in either adopting, rejecting or modifying a proposed position can provide valuable guidance regarding how the rule is intended to apply in practice. Once final regulations are adopted, they are published in the Code of Federal Regulations (CFR), which is updated annually. The CFR typically contains only the text of the rule without the preamble or other explanatory material.

4. Federal versus state regulation and preemption. Most governmental power is concurrent, belonging both to the states and the federal government. Under our federal system, federal law takes precedence over conflicting state law. In particular, a federal statute or regulation supersedes any state or local action that *actually conflicts* with the federal rule. The same principle holds true if the state or local law *interferes with achievement of a federal objective*. Even if a state or local law does not conflict with federal law or objectives, it *may be invalid if Congress appears to intend to "occupy" the entire field*, thus precluding *any* state or local regulation. If the federal law does not expressly provide that it preempts state law, the courts will consider several factors in determining whether state law is preempted: the *comprehensiveness of the federal law* – the less a federal law leaves uncovered, the more likely a finding of preemption – and *whether a federal statute creates an agency to enforce the law*, in which case all matters arguably in the agency's jurisdiction are generally deemed to be preempted.

Resource reference

Many federal resources are available on the Internet. Information about pending and enacted legislation, including committee reports, is available at <thomas.loc.gov/>. Federal agency regulations may be retrieved through the CFR online at <www.access.gpo.gov/nara/cfr/index.html>. Federal agency notices published in the *Federal Register* are available at ww.access.gpo.gov/su_docs/aces/aces140.html>.

B. STATE LAW

1. In general. State legislatures follow much the same procedure as Congress in enacting legislation.

Resource reference

Many state Web sites have links to their state codes, regulations and decisions as well as other material. State Web addresses generally have the word "state," followed by the postal abbreviation for the state, followed by "us" (e.g., <www.state.az.us>).

2. Conflict of laws. In some cases, as when a dispute involves parties from more than

one state, a court is faced with the question of what law should be applied to the case — a question that generally is known as conflict of laws. The law of the site of the transaction giving rise to the dispute is generally the law that is applied. Parties many times will try to avoid a conflict of laws question by specifying in a contract which state law will apply to interpretation of the agreement.

C. COMMON LAW AND CASE LAW (JUDICIAL DECISIONS)

Common law refers to a body of legal precedents developed over centuries by judges. In a sense, common law is "unwritten" law, in contrast to statutory law enacted by legislatures. Frequently, the term is used to refer the body of English law on which American law is based. Many principles of common law are collected in a series of publications prepared by the American Law Institute titled *Restatement of the Law*, including *Restatement (Second) of the Law of Contracts* and *Restatement (Second) of Torts*. The purpose of the *Restatements* is to provide a gathering of the nonstatutory, general law of the United States.

Case law, or jurisprudence, refers to the collection of published court decisions that are used in ruling on disputes. Although the decisions reached in court cases are not found in statutes, they often have much the same effect as statutory laws because the principles represented in the decisions provide legal rules that are used in judging conduct and disputes.

D. "PRIVATE" LAWS AND CONTRACTS

A contract is an exchange of enforceable promises and can be viewed as private law that governs the relationship between parties to the contract. A contract can impose more stringent rules than federal or state law otherwise would impose. So long as a contract does not violate law or public policy and represents a *mutual* exchange of "consideration" or value, it will be enforced. See chapter on Contracts, beginning on page 41.

E. ETHICS

Strictly speaking, ethical rules are not legally binding. The values that ethical rules embody, and the moral obligations associated with those rules, however, should be a part of the code of conduct of physicians. See discussion of Professionalism, Chapter II, pages 3-4.

IV. PROFESSIONAL LIABILITY ISSUES

A. AN INTRODUCTION TO TORT LIABILITY AND MALPRACTICE

1. In general. Professional, or malpractice, liability refers to the potential liability associated with providing clinical services to patients. In the event of an adverse outcome, the essential question is whether or not the adverse outcome was simply an anticipated risk associated with the procedure, or whether it was caused by the failure of the physician to exercise due care in providing services.

There are two grounds for finding the physician liable: 1) failure to explain the risks of the anesthesia and to obtain informed consent and 2) failure to exercise due care in providing services, either due to negligence (the more likely possibility) or to intentional wrongdoing. A third potential basis of liability – violating a specific statutory duty – can result in both clinical and criminal liability, depending upon the specific law involved. If the risk was anticipated and the physician obtained informed consent from the patient to proceed notwithstanding the risk, then the patient is understood to have assumed the risk. Accordingly, the patient cannot later contend that he or she did not appreciate the risk. Judging the second basis for liability, whether the physician exercised due care and was not negligent, underlies most malpractice cases that are litigated. Both sides call upon experts to explain the standards in the industry or profession and to explain how the defendant either deviated from those standards (plaintiff's perspective) or adhered to them (the defendant's position).

a. *Practice standards*. What standards are used? As a general rule, prevailing community standards apply, although many aspects of anesthesiology care may be subject to national standards of care. Examples of the types of issues that may vary by community are whether it is expected (or standard) to have in-house anesthesiology coverage for surgical and obstetric cases, or whether it is expected or required that an anesthesiologist will medically direct a nurse anesthetist or anesthesiologist's assistant. Some of these issues may be determined by state law, Hospital policies, or rules and regulations of the department of anesthesiology. There would be little grounds on which to challenge application of those authorities to a malpractice case.

Anesthesiologists, like all physicians, should be versed in the standards of the professional organizations in their particular fields. The should be familiar with general ASA standards relating to what steps are included in preoperative, intraoperative, and postoperative care, or standards of medical subspecialty associations in subspecialty areas such as obstetric anesthesia, critical care anesthesia, pediatric anesthesia and chronic pain management. (See the **Resource reference** box on page 3 for information on locating ASA standards, guidelines and statements.) In the event of conflicting opinions of experts, a judge or jury is likely to pay close attention to those professional association standards.

b. *Burden of proof*. The "burden of proof" and the related presumptions drawn from the evidence presented can be important in resolving a claim of negligence. Presumptions regarding whether a party has satisfied the burden of proof can shift back and forth in a case, depending upon the nature of the claim and the

evidence presented. The burden of proof generally is on a plaintiff to prove the allegations of wrongdoing asserted in the "complaint," the document the plaintiff files to begin a lawsuit that outlines the basis for the plaintiff's action. The plaintiff must establish both the facts that occurred as well as the theory of liability, which in a malpractice case is that the defendant failed to adhere to the applicable standards and that such failure caused the injury to the plaintiff.

Once the plaintiff has made that showing, the plaintiff has satisfied the initial burden and is entitled to a presumption that the defendant was negligent. The defendant then must demonstrate why that showing is inaccurate or why the plaintiff has failed to establish a claim or, more accurately, a claim upon which relief may be granted. The defendant's case may involve the assertion of *defenses*, legal grounds that will shield the defendant from liability. Among the types of defenses that may be asserted are lack of causation (that even given the facts and standards as stated, the injury was caused by another action or force) or an affirmative defense (e.g., that the action is time-barred by the statute of limitations). The burden of proof is on the defendant to establish any affirmative defenses asserted. If the defendant successfully counters the plaintiff's case or establishes an affirmative defense, the presumption shifts to the defendant, who is entitled to a finding that the defendant was not negligent.

These determinations regarding what facts have or have not been established are for the finder of fact to make. The plaintiff is entitled to request a trial by jury, and plaintiffs in malpractice cases almost always seek jury trials. If the plaintiff does not request a trial by jury, a judge will determine the facts.

Does a physician's failure to pass the board certification examination have any bearing on the physician's ability to provide services in accordance with applicable professional stan-

(Continued on next column)

(Continued from previous column)

dards? Several courts have considered whether a physician's failure to pass board certification examinations or lack of board certification may be admitted into evidence in a medical malpractice case against the physician. Courts generally have ruled that evidence of the physician's lack of board certification is admissible, but that evidence regarding failed board examinations is not admissible.

Courts have rejected evidence of a physician's failure of board certification exams where the physician actually passed the exams by the time of the medical services that gave rise to the lawsuit.

c. *Administrative screening processes.* Some states have an administrative procedure, such as a medical malpractice review board, that plaintiffs must pursue before filing suit in court. Such procedures serve as screening mechanisms to preclude frivolous or unfounded claims from being tried in court.

2. Individual liability, vicarious liability and "respondeat superior." It probably will not come as any surprise that individuals are responsible for their own actions, whether work-related or not. Individuals also can be responsible for the actions of others, based on several different theories of "agency." In the most extreme case, under a doctrine known as "captain of the ship," a surgeon is deemed to be in control of all persons assisting, regardless of the nature of their tasks, even if they are not the surgeon's employees. Typically, this doctrine has been used in cases against surgeons, rather than in cases against other physicians. The "captain of the ship" doctrine is based on the theory that the surgeon has the absolute right of control of all personnel in the operating room, but it has fallen into disfavor.

Increasingly in medical malpractice cases, courts look to whether a non-employee assistant can be said to have become the "borrowed servant" of the defendant physician. Courts review the facts to determine *whether the physi-*

cian possessed, and exercised, the right to control the actions of the assisting person, whether a nurse anesthetist or other nonphysician employee. Liability is more likely when the physician has the right to control the actions of those persons.

If you work in an anesthesia care team setting, you should understand that you can, and are likely to be, held responsible for the actions of nurse anesthetists or other individuals assisting in a case, whether those individuals are Group or Hospital employees. If the nurse anesthetist or other assisting individual is a Group employee, liability can be imposed under the theory of "respondeat superior," under which the "master" – here, the physician – is responsible for the negligence of the "servant," when the servant is engaged in performing the master's work.

> The fact that a nonphysician assisting in a case is not an employee will not shield a supervising physician from liability. Liability is virtually assured if the assistant is an employee and the actions in question were within the scope of the individual's responsibility.

3. Types of legal relationships.

a. *Employer-employee*. The hallmark of the employment relationship is the ability of the employer to control the actions of the employee. Employers are liable for the actions of the employee that are within the employee's scope of duties. An employer Group would be liable for the clinical malpractice of an employee physician or for improper claims submitted based on insufficient documentation by an employee physician. In contrast, the Group would be unlikely to be found responsible for the wrongful actions of an employee physician taken outside the work context.

b. *Agent*. "Agents" are individuals or companies that have a business relationship with the "principal," the person who is being represented. Ideally, the scope of the relationship will be described in a contract, and the agency relationship will be "express." The scope of the relationship may also be defined by business practice. In the absence of a written agreement, it can be unclear whether the agent is acting on behalf of the principal. If an agency relationship exists in those circumstances, it is said to be an "implied agency." A principal is responsible for the authorized actions of the agent – those duties that the agent performs for the principal. The question that arises is whether the agent had authority, or apparent authority, to act on behalf of the principal.

c. *Independent contractor*. An independent contractor is a person hired to perform a specific task or set of services. An independent contractor differs from an agent in that the independent contractor is not acting on behalf of the person retaining the contractor's services. The person who retains the contractor's services generally is not legally responsible for the contractor's actions, because the hiring person does not have the right to oversee the way in which the contractor performs the specified duties. A person may be responsible for negligence in retaining an independent contractor that would be based on harm the independent contractor causes that is proximately related to the failure to investigate adequately the contractor's qualifications. When a Group retains a "locum tenens" physician to fill in for a former employee physician until a new physician can be hired, the temporary physician usually is an independent contractor.

d. *Deciding who's who*. The relationship between a Group and a physician can be difficult to determine. The substance of the relationship, not the labels that the parties attach to it, governs the determination. The *level of control* that the Group exercises over the physician will determine whether the physician is an employee or independent contractor. Just because a Group does not withhold taxes on a physician does not mean the physician will not be found to be an employee of the Group for tax purposes. Nor does calling a physician an independent contractor insulate the Group from potential liability for the physician's actions.

Resource reference

The ASA publication *Contracting Issues: A Primer for Anesthesiologists* (1999) contains a chart (page 48) listing the 20 factors that the Internal Revenue Service (IRS) examines to determine whether or not an employment relationship exists.

4. Attorney's fees. Each party bears its own attorney's fees and out-of-pocket expenses in litigation unless the statute on which the plaintiff's claim is predicated authorizes the award of attorney's fees to the successful plaintiff, or unless the parties have a contractual agreement providing for one party to bear the legal fees. By statute, attorney's fees may be awarded to the plaintiff in antitrust, False Claims Act and various employment discrimination actions, to name just a few.

B. LIABILITY AND MALPRACTICE INSURANCE

1. In general. As a resident, you did not need to be concerned with purchasing liability insurance; your residency program was responsible for obtaining insurance coverage for your practice. When you leave residency or change professional affiliation, you need to understand the type of insurance coverage you are purchasing and what exactly is covered. Probably the most important lessons to be learned from this discussion are that professional liability policies differ substantially and that *the least expensive policy you are offered may be more expensive in the long run*.

2. "Occurrence" versus "claims-made" coverage. Two general types of liability insurance are marketed – "occurrence" and "claims-made." An *"occurrence"* policy provides coverage for the clinical services you provide during the time that the insurance coverage is in effect *no matter when a claim relating to those services is asserted*. In contrast, a *"claims-made"* policy provides coverage for claims asserted during the time period that the liability policy is in effect. *Once the claims-made policy expires or coverage terminates, you have no insurance protection* for clinical services provided under that policy, unless you purchase what is known as "tail" coverage from the company that issued the policy that is about to expire or terminate, or unless you purchase "nose" coverage from the new carrier that will be writing your next professional liability policy. (A "modified" claims-made policy operates differently; see discussion in subsection B.3.)

A "tail" policy provides coverage for claims relating to the medical services you provided during the time the insurance policy was in effect. "Tail" policies typically provide coverage back to the "retroactive" date: the date on which you first were covered by a claims-made policy. Another factor affecting the necessary duration of the tail coverage for clinical services is the statute of limitations in your state. State tort liability statutes of limitation can vary. In addition, the time limit often is "tolled" or delayed until "discovery" of the allegedly wrongful act, if the plaintiff-patient would not reasonably have had knowledge of the injury until the later time. In the case of minors (the age of majority depends upon state law), the statute of limitations may be even longer.

3. "Pure" and "modified" claims-made policies. In some areas of the country, including Illinois and Maryland, carriers offer a so-called "pure" claims-made policy. Pure claims-made coverage is the coverage described above: You are not covered against claims brought against you unless your policy is in effect or you have purchased tail coverage. The problem that occurs is when you know of an incident that may lead to the filing of a claim. During that interim period between the occurrence of an adverse incident and the filing of the claim, you may be locked in with your current carrier because it will be difficult for you to obtain coverage from another claims-made carrier that will ask about your prior history before agreeing to insure you.

In contrast, under a *modified claims-made* policy, *reporting an adverse incident* that could

lead to the filing of a claim *triggers protection for life for any claims resulting from the reported incident*. If you are in the position where you need or wish to change liability carriers, and you know of an adverse incident but no claim has yet been filed, you will have more flexibility in changing carriers, because a new carrier will not be responsible for covering the liability associated with the reported adverse incident. It still is necessary to purchase tail coverage with modified claims-made protection for unreported incidents. Modified claims-made coverage is more widely available than is pure claims-made coverage.

4. Comparing the cost of coverage.

a. *Comparing different types of policies*. An occurrence policy often is preferable, if available, because it insures you against liability for clinical services regardless of when the claim is asserted. With the advent of modified claims-made coverage, the difference between occurrence coverage and claims-made coverage is less pronounced. The cost of an occurrence-based policy cannot be compared with the often less expensive claims-made policy alone. A more accurate comparison is the cost of the occurrence policy in comparison with the cost of the claims-made policy and the tail coverage.

b. *How are premiums calculated?* Before deciding upon any policy, make sure you have in writing the projected cost of the premiums for at least the first five years. Often you cannot obtain fixed premium prices beyond the first year and must rely instead on projected premiums; fixed premiums are more desirable, if they are available. Some companies may offer you a very low rate for the first year or two out, and why not? As a brand-new physician (from a liability perspective, your residency training program generally covers any potential liability associated with your actions while a resident), you represent a very low risk for the insurer. You do not want to sign with an insurer that offers attractive low rates in years one, and possibly two and three, but compensates for those low rates with much higher rates in subsequent years. The *"mature" rate* is the rate you will live with as a practical matter, not the introductory reduced rate.

If the insurer is quoting a rate that is a percentage discount, or perhaps a decreasing discount, off the standard premium, you need to determine whether the discount is applied to a stable amount or an increasing amount each year.

To some extent, liability insurers rely on the fact that physicians tend not to make changes in their liability carriers. With all of the business and practice management demands on physicians who often simply want to practice medicine, physicians may not have as a top priority which liability carrier will offer them lower rates or other more favorable terms (e.g., cost of tail coverage or representation and cooperation in malpractice cases).

Despite the focus of this discussion on financial issues, probably the most important issue in the choice of liability carriers is *how fast the carrier will move to settle, rather than to litigate*, malpractice cases. The cost of litigation is high, and a carrier may want to settle cases in which the plaintiff's claim is not particularly strong, rather than incur the substantial costs of litigating a case through trial and possibly appeal. Any settlement made in a malpractice case is *reportable to the National Practitioner Data Bank.* If you think a patient's claim is weak, you do not want to be represented by a liability carrier that wants to settle the case.

c. *How is the cost of tail coverage calculated?*

i. *In general*. How does the carrier calculate the cost of tail coverage, and what will tail coverage cost? Tail coverage often is expressed either as a percentage of the expiring year's premium (e.g., 120 to 220 percent of the expiring year's or the "mature" year's premium, whichever is greater). If you change carriers when you are three years out of residency, and the carrier charges you a percentage of the "mature" rate, you will pay substantially more for the same tail coverage than if the carrier

charged a percentage of the expiring year's premium. In that case, you may want to explore the cost of "nose" coverage – coverage for the same time period – from the "new" carrier that will be writing your new malpractice policy.

ii. *What is the portability of coverage?* Some liability insurers do not charge for tail coverage if you leave one position and continue to practice in the same state and obtain coverage from the same carrier. The problem occurs when you change companies or if you practice elsewhere. If the insurer is a national company, the in-state limitation on the benefit might not apply.

In some cases, an employer (often the former employer) will require you to obtain tail coverage even if the carrier says it is not necessary because that former employer will not have any way of knowing whether you subsequently change liability carriers or move out of state. Some hospital-anesthesiology group agreements require the Group to guarantee that each anesthesiologist who leaves the Group will obtain tail coverage, in which case the Group will have no flexibility to authorize an exception to the requirement.

iii. *Free "retirement" tails*. Some insurers offer a free retirement tail. Although retirement and the related circumstances discussed in this section may seem remote when you first begin to practice, you still should consider these issues. Are there limitations on the availability of the free tail upon retirement, such as a minimum number of years that you need to be insured with the carrier, a minimum number of years you must have practiced or an age limit? If the liability carrier offers a free retirement tail for individuals who are at least 55 years old and have been insured by the carrier for at least ten years, the free retirement tail will not be free if you decide to retire from practice at age 54.

5. Who is your agent and how does the agent's compensation affect the agent's advice? If you use an insurance agent, make certain you understand with whom you are speaking, how the agent is compensated, what financial incentives the agent has and how those incentives may affect the advice the agent gives you. So-called "independent" agents may appear to be more objective than "captive" agents who are employed by a liability carrier, but you may need additional information to make that determination. Is the independent agent bringing you all available options to consider, or are there some insurance products for which the agent is not compensated and therefore will not discuss with you? Is the agent paid more by one carrier than another, which could lead the agent to be less than objective about which product best suits your needs? These all are questions to ask before, not after, the fact.

6. Statutory limitations on damages. Another factor determining the cost of liability coverage is the existence of any statutory "cap" or limitation on tort liability in malpractice cases. Generally, those caps limit the amount of punitive damages that a judge or jury may award to a designated dollar amount. The limitation usually will not cover actual damages, which represent the costs the plaintiff patient incurs in correcting or dealing with the injury. A statutory cap on punitive damages directly affects the level of risk the liability carrier takes in insuring a physician, and rates for malpractice coverage often will reflect such a cap by providing a lower rate for the same limits of coverage as would be charged in a state without such a cap. The fact that a state passes legislation limiting tort liability does not necessarily end the liability debate; a court may find the legislation to violate the state constitution.

Resource reference

The American Medical Association <www.ama-assn.org> and the American Tort Reform Association <www.atra.org/atra> may provide additional information regarding tort reform and limitations on liability in particular states.

7. Policy limits. The so-called "limits" on the policy – the dollar limits on the amount of

coverage being provided – will be determined by factors such as the dollar limits required by the Medical Staff bylaws of the facility at which you practice, whether your state has any fund for compensation of victims (e.g., the Wisconsin Patients Compensation Fund), the agreement between your employer and the facility at which it provides services and the requirements of participation agreements with different payors. In some cases, managed care organizations (MCOs) may require higher limits of coverage than the Group has obtained.

8. Determining the scope of coverage.

a. *Moonlighting*. Even if your new employer provides insurance coverage, you need to understand the type of coverage provided. The scope of the coverage is particularly important if you plan to moonlight, or to provide clinical services on behalf of someone other than your employer. Depending upon how the policy is worded, you may not have coverage for services provided outside of the Group.

b. *Administrative and quasi-clinical services*. If you participate in quality assurance, peer review or similar activities as part of your responsibilities under an agreement with an employer anesthesiology practice or a hospital or ambulatory surgical center (ASC), or if you make recommendations regarding personnel employed by others (e.g., OR or PACU personnel), you need to determine whether your liability policy provides coverage for potential liability associated with those activities or whether additional coverage is required.

c. *Volunteer and professional association activities*. Many physicians become involved in the activities of professional medical associations and subspecialty associations. Whether you will need separate liability coverage for those activities will depend upon your level of involvement, the nature of your activities, the scope of coverage under your primary malpractice policy and the coverage, if any, provided by the association. Some professional organizations provide insurance coverage for their officers and directors through separate "director and officer" (or D&O) policies. Others may agree to "indemnify" (i.e., to pay all costs associated with) association representatives (a broader term that would include committee members) against liability associated with actions they take, provided that those actions are within the scope of their authority as association representatives.

> Understand when you need coverage and obtain it before a specific need arises.

9. Exclusions. You should understand what risks and liabilities are *not* covered by your professional liability policy. Sometimes the activities involving the greatest amount of risk are excluded from coverage. In understanding the scope of the "exclusions," it is important to understand how key terminology is defined.

a. *"Contractually assumed" liability*. One matter that frequently is excluded from coverage is "contractually assumed" liability, or the liability that a physician would not otherwise have but assumes solely by virtue of a contract. "Indemnification" or "hold harmless" agreements are examples of contractually assumed liability. Common indemnification clauses in agreements with hospitals or MCOs call for the Group to "hold the other party harmless," i.e., to pay all costs and expenses, associated with claims relating to the anesthesiology and pain management services Group anesthesiologists provide. Absent the indemnification clause, each party would bear its own legal fees and expenses and, if found liable, would pay for its share of the judgment. An indemnification provision *transfers* responsibility for payment to the party agreeing to the indemnification. Because the indemnification provision goes beyond what the law otherwise would impose, it is known as "contractually assumed" liability. This type of risk generally is *excluded* from coverage under professional liability policies. See discussion of indemnification in Chapter VII, section A.6, pages 44-45.

b. *"Riders."* If a risk is excluded from coverage, it may be possible to obtain coverage for the risk by paying an additional premium for a "rider"(sometimes referred to as an "endorsement"), an addition to the policy covering a particular contingency. For example, if a liability policy expressly provides that it does not cover contractually assumed liability (such as the liability associated with an indemnification clause) or liability resulting from antitrust claims, the liability carrier might agree to cover such liability through issuing a rider in exchange for an additional premium.

> Understand the cost of a rider before agreeing to a contractual obligation. If you obtain your own malpractice coverage, it is advisable to have a contact at the carrier who will provide written responses to your coverage questions.

10. Asset protection insurance. You may want to consider obtaining asset protection insurance to cover the risk that your malpractice coverage does not provide full protection. The need for this additional type of coverage will depend upon whether state law limits punitive damages in malpractice cases, the trend of jury verdicts in malpractice cases in the jurisdiction and the nature of the patient population and the general level of health and preventive care the average patient in the community receives. These risk factors then can be intelligently balanced against the cost of the additional coverage.

C. COMPARING AND SELECTING A MALPRACTICE CARRIER

What is the *nature of the carrier's business*? Does the carrier underwrite all types of commercial risks or does it limit its business to medical malpractice? What is its *underwriting philosophy*? Does it cover any physician who applies and is willing to pay for a policy or is it more selective in covering physicians? Review carefully the policy the company is offering and consider having an independent, knowledgeable consultant review it. *Who owns* the company and *who manages* the company also are important questions.

Depending upon your employment setting, you may not have the option to select a liability carrier; you may be insured by whatever carrier your employer selects. If, however, you are purchasing your own liability coverage, you should call different carriers and ask them what questions you should consider in purchasing coverage. Those companies that are more forthcoming about the issues you should be considering, and that are willing to compare their product with competing policies to help you to assess what coverage is most cost-effective for you, may well be the carriers to consider.

You should check with other sources of information to learn as much as possible about the carrier, its operations, the level of dissatisfaction of other insureds and its financial stability. There are a variety of sources of publicly available information, including the state insurance commissioner. Run a search on a database of newspapers and insurance publications (e.g., the LEXIS®-NEXIS® service) or a corporate/financial on-line service (e.g., Dun & Bradstreet) to learn more about what articles are being written about the company. Consult with the state or county medical association to learn if it has any experience with the company. Once you start exploring the company, you may identify additional sources of information.

D. OTHER INSURANCE COVERAGE

1. General liability insurance. Some agreements with hospitals or with MCOs require anesthesiologists to maintain general liability insurance, which covers liability associated with ownership or operation of physical facilities. Most anesthesiologists do not maintain general liability coverage unless they own a chronic pain clinic and own or operate the facility. Beware of this type of requirement in agreements.

2. Disability insurance. To someone just

starting out in professional practice, it may seem odd to address disability insurance that provides protection in the event you are unable to work. Because no one plans to become disabled, disability sometimes is viewed as a less likely occurrence and disability insurance may therefore be a lower priority.

> As is true with other forms of insurance, it is important to acknowledge the underlying reason for purchasing disability insurance: peace of mind. If you have a family or financial obligations to others, you need to consider how those obligations will be met if you are unable to work. Many professionals have inadequate long-term disability insurance and discover their need for it when it is too late.

a. *Questions to ask*. Review any disability policies carefully to identify *how disability is defined, when benefits will be payable, what exclusions from coverage* are listed, and *how long benefits will be payable*. How is partial disability handled? How are disagreements resolved, such as a dispute between the insured's physician and the carrier's physician as to whether the insured is disabled? Is the opinion of the carrier's physician dispositive? Does disability mean inability to practice as an anesthesiologist or inability to practice medicine? Will your carrier deem you to be qualified to practice medicine even if you cannot practice anesthesiology and need to complete another residency? Are benefits discontinued after a set period of time or after a set amount has been paid?

b. *Types of policies*. Insurers offer two types of disability coverage: short-term coverage, which often is payable immediately but for a shorter period of time, and long-term coverage, which covers extended disability conditions and is payable over a longer period of time. The specifics of coverage will be addressed in the policy, which will be important to review carefully. Understand the coverage you are obtaining and consider whether it will meet your needs. Ideally, you will want to have both types of disability coverage but the combined cost may lead you to balance the cost and benefits of the different types of coverage.

c. *Tax considerations*. Consider the "pay now or pay later" tax consequences associated with how the premiums are paid. Premiums paid with pre-tax dollars may be attractive initially but any benefits paid out will be subject to federal income tax. In contrast, if you pay the premiums on the disability policy with after-tax dollars, the benefits payable under the policy are *not* subject to federal income tax.

3. Errors and omissions (E&O) insurance. In the last several years, some insurers have started to offer various forms of E&O policies to protect physicians against liability for billing errors and Medicare fraud and abuse. Although it is necessary to review the policy for the precise scope of coverage, this new form of insurance generally will cover the legal and litigation expenses associated with a government investigation or a private payor audit. It may also cover resulting fines and penalties. An E&O policy typically will not protect you against having to refund any overpayment (for this purpose, overpayment means the amount paid on the claim, not the difference between the amount paid and the amount to which you would have been entitled had you billed correctly), but fines and penalties, along with defense costs, may be much more significant than the actual dollar amount of the overpayment. The federal False Claims Act provides for civil penalties of between $5,500 and $11,000 (adjusted for inflation for violations occurring after 9/29/99), and the Civil Monetary Penalties provisions of the Medicare statute provide for $10,000 in civil fines, for each false claim *plus* triple the amount of the claim. In other words, a single $300 erroneous claim could result in $11,900 in liability ($11,000 penalty, plus three times $300). As long as the billing errors underlying the claim are truly not intentional but result from "reckless disregard" or "deliberate ignorance" at worst, the statutory penalties –

$11,900 – should be covered by a good E&O policy.

Standard D&O liability, malpractice or even E&O policies generally will not cover Medicare fraud and abuse *fines* or *audit expenses*. D&O policies typically exclude losses based on punitive damages, liquidated damages, criminal or civil fines, sanctions, taxes and the multiplied portion of any damages award subject to doubling or trebling. Malpractice insurance generally covers personal injury, property damage or employee benefits liability arising from the policy holder's professional medical activities. These areas do not encompass reviews or investigations by private or governmental insurance programs or the fines and penalties resulting from investigations.

Companies offering health care billing E&O insurance generally require as a condition of coverage that the policyholder Group have in place a written compliance plan that satisfies their guidelines. Most carriers will base coverage determinations and prices upon a review of the practice's compliance history as well as the amount of the deductible, if any. Audits or investigations that are known to the Group at the time it applies for coverage are excluded from coverage, much like "prior existing conditions" are not covered in most health insurance policies. The lesson here is that once you know of a problem, it is probably too late to obtain the E&O coverage you need.

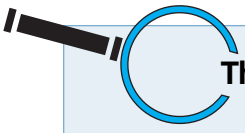
E&O policies are generally written on a claims-made basis. If you terminate coverage or leave the Group holding an E&O policy and want to protect yourself against liability arising out of any billings submitted during the term of the policy, you will need to ensure that you purchase tail coverage.

It bears repeating that *you should know the quality of the carrier and fully understand the terms of the policy you are considering*. Does the policy cover only the costs of an investigation? What is the dollar limit of the policy? Will it cover the costs of a "shadow" audit (an audit you commission to assess the validity of a government auditor's conclusions) and patient record reviews, which may be an important element of a defense strategy? Do you have the option to increase the defense limits?

4. Health insurance. If the employer pays the premiums for health insurance, proceeds from health insurance are excludable to the extent they are i) amounts paid directly or indirectly to the employee as reimbursements for medical care, or ii) payments (or reimbursements) of expenses incurred for medical care of the employee (or the employee's spouse or dependents). Because these two types of payments are the ones that typically are made under a health insurance policy, the issues regarding the tax implications of who purchases the insurance coverage and whether pre- or after-tax dollars are used are less pronounced in the case of health insurance than in the case of disability insurance.

E. THE NATIONAL PRACTITIONER DATA BANK AND REPORTABLE ACTIONS

1. In general. In 1986, Congress passed the Health Care Quality Improvement Act, which established the National Practitioner Data Bank (Data Bank). The principal purpose of the Data Bank is to facilitate a comprehensive review of professional credentials. Since it became effective in 1990, the Data Bank has maintained records of licensure, clinical privileges, professional society membership and Drug Enforcement Agency (DEA) actions taken against health care practitioners and malpractice payments made for their benefit. Medicare/Medicaid exclusion reports were added to the Data Bank under an agreement with HCFA and the Office of Inspector General (OIG) and are now disclosed to queriers along with malpractice payments and adverse action reports. Information must be reported regarding physicians, dentists and other health care practitioners who are licensed or otherwise authorized under state law to provide health care services.



The National Practitioner Data Bank *At a Glance*

Who must report:

- Medical malpractice payors must report to the Data Bank and the appropriate State Licensing Board within 30 days of a payment.
- Hospitals, other health care entities and professional societies must report to the Data Bank and State Licensing Boards within 15 days of an "adverse action."
- State Licensing Boards are responsible for reporting to the Data Bank within 30 days of the adverse licensure action.

Who may query:

- Hospitals must query when a practitioner first applies for privileges and, thereafter, every two years on practitioners who are Medical Staff members or who hold clinical privileges.
- Other health care entities, including professional societies, may query when entering an employment or affiliation relationship with a practitioner or in conjunction with professional review activities.
- State licensing boards may query at any time.
- Health care practitioners may self-query at any time.
- Plaintiffs' attorneys may query under certain circumstances.

Note: *Medical malpractice payors may not query at any time.*

Reporting requirements

Who must report:	***What must be reported:***
Medical Malpractice Payors	Payment resulting from a written claim or judgment.
State Licensing Boards	Licensure disciplinary action based on reasons related to professional competence or conduct.
Hospitals & Other Health Care Entities	Professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period longer than 30 days; or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation.
Professional Societies	Professional review action, based on reasons relating to professional competence or conduct, adversely affecting membership.

2. Types of reports

a. *Initial Report.* The initial report is the first record of a medical malpractice payment or adverse action submitted to and processed by the Data Bank. The reporting entity submits the report to the Data Bank electronically and prints and mails a copy of the report to the appropriate state licensing board. An initial report

is the current version of the report until a correction, void or revision to action is submitted. When the Data Bank processes an initial report, a report verification is sent electronically to the reporting entity, and a notification of a report in the Data Bank is mailed to the subject practitioner. If you receive such a notification, you should review the information to ensure that it is correct.

b. *Correction, void previous report, revision to action*. A correction is a change that supersedes the contents of the current version of a report. In contrast, a void is the retraction of a report in its entirety that results in removal of the report from the practitioner's disclosable record. A revision to action is a new action that modifies an adverse action previously reported. Revisions to action include reversal of a professional review action or reinstatement of a license, clinical privileges or professional society membership. A correction is distinct from a revision to action in that a *correction overwrites* the initial report whereas a *revision* is treated as *an addendum* to the initial report.

c. *The dispute process*. A practitioner who disagrees with a Data Bank report about him or her may dispute either the factual accuracy of the information in a report or whether a report was submitted in accordance with the Data Bank's reporting requirements, including the eligibility of an entity to report to the Data Bank. The dispute process is not an avenue to protest settlement of a medical malpractice claim or to dispute the propriety of or basis for an adverse action. If a practitioner believes that information in a report is factually inaccurate or should not have been reported (e.g., a suspension of clinical privileges for 30 days or ineligibility of the reporting entity), the practitioner must attempt to resolve the disagreement directly with the reporting entity. Changes to a report may be submitted only by the reporting entity. Notification of a dispute is included with a report when it is released to future queriers and is sent to all queriers who previously received the report. If the reporting entity declines to change the report or takes no action, the subject practitioner may request that the Secretary of HHS review the disputed report.

d. *Determining the reportability of actions*. Sometimes the reportability of a particular action is not clear. If an impaired physician who is a member of a hospital Medical Staff has been repeatedly encouraged to enter a rehabilitation program but continues to disregard the hospital's advice and offers of assistance, no reportable action occurs. If, in contrast, an authorized hospital official, such as the CEO or Department Chair, directs the physician to give up clinical privileges and enter a rehabilitation program or face investigation relating to possible professional incompetence or improper professional conduct, the surrender of clinical privileges is reportable to the Data Bank.

Examples of Reportable Actions

The following adverse licensure actions, when related to the professional competence or professional conduct of a physician or dentist, must be reported to the Data Bank:

- Denial of an initial application for clinical privileges or granting of more limited privileges than those requested if the denial or limitation of privileges is the result of a professional review action and is related to the practitioner's professional competence or conduct;
- Denial of an application for license renewal;
- Surrender of clinical privileges in exchange for not undergoing an investigation;
- Reciprocal licensure disciplinary action taken by a State Board against a licensee or applicant for licensure renewal based upon a licensure disciplinary action related to the practitioner's professional

(Continued on next page)

(Continued from previous page)

competence or professional conduct taken by another State Board;
- Fines and other monetary sanctions accompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation or surrender; and
- Involuntary entry by an impaired practitioner into a rehabilitation program if the entry is required by a professional review action, is based on the practitioner's competence or professional conduct and adversely affects the practitioner's clinical privileges for more than 30 days.

Examples of Nonreportable Actions

The following adverse licensure actions should *not* be reported to the Data Bank:
- Denial of an initial application for license;
- Fines and other monetary sanctions unaccompanied by other licensure action, such as revocation, suspension, censure, reprimand, probation or surrender;
- A settlement agreement that imposes monitoring of a practitioner for a specific period of time, unless such monitoring constitutes a restriction of the practitioner's license or is considered to be a reprimand;
- A licensure disciplinary action that is imposed with a "stay" pending completion of specific programs or actions;
- Voluntary relinquishment of a physician's license for personal reasons not related to his or her professional competence or professional conduct (e.g., retirement) ;
- Licensure actions taken against nonphysician, nondentist health care practitioners; or
- Voluntary entrance of an impaired practitioner into a rehabilitation program *if* no professional review action was taken *and* the practitioner did not relinquish clinical privileges.

Resource reference

The Health Resources and Services Administration within HHS maintains extensive information regarding the Data Bank on its Web site at <www.hrsa.dhhs.gov/bhpr/dqa/factshts/fsnpdb.htm#4>.

F. RISK MANAGEMENT ISSUES

1. Defining risk management. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines risk management activities to refer to clinical and administrative activities that facilities undertake to identify, evaluate and reduce the risk of injury to patients, staff and visitors, and the risk of loss to the organization itself. A risk is an exposure to the chance of injury or financial loss. Financial losses may be based on patient injuries, the billing of clinical and other services provided to patients, regulatory compliance issues and enforcement or internal business disputes. Loss also may be nonfinancial in nature (e.g., loss of goodwill). Although the focus of risk management programs typically is on injuries to patients and the claims they might file, it also encompasses injuries to hospital employees and others, including physicians, who provide services. With its focus on minimizing risk of injury to patients, risk management is part of the quality assurance program of any facility.

The most direct form of risk management is evidenced in the Medical Staff application process as the Hospital reviews an applicant's qualifications to ensure that the physician has the necessary clinical skills to perform the scope of practice that the requested privileges would permit. Toward that end, hospitals and other facilities increasingly are demanding that members of their Medical Staff be board-certified or board-eligible. Studies do not necessarily support the premise that board certification has a cause and effect relationship on the quality of medical care delivered. Negligence in the

provision of clinical services is as much a function of poor judgment as it is lack of clinical skills.

If, in the course of participating in Hospital risk management activities, you comment on the performance of other physicians or Hospital employees, you may incur liability in connection with any negative comments you make regarding the job performance of others, particularly if they are disciplined or terminated on the basis of your evaluation. If you are joining a group of anesthesiologists, ask whether they have negotiated for financial protection from the Hospital or other facility to cover potential liability in connection with their participation in these and other risk management activities. See discussion of indemnification issues, Chapter VII, section A.6, pages 44-45.

2. The risk management process. If there is an adverse event, the Hospital's risk management team will assume responsibility to coordinate the process. The risk manager is likely to bring in legal counsel in order to protect conversations from discovery (the stage of litigation where each party can learn about the other's case by requesting documents and taking depositions of key players).

> It is important to bear in mind that the Hospital's legal counsel will represent the Hospital, not you or your Group. Ask your Group how it deals with risk management issues and what procedures have been established to address that situation. Will the Group provide counsel for meetings regarding an incident? Do Hospital rules allow separate counsel for the Group (or for the individual physician) to attend those meetings? You may want to retain separate counsel to assess your possible exposure and to ensure that your interests are being protected.

The Hospital's and the Group's professional liability carriers also will need to be notified. You should exercise caution in preparing any summaries of events, as they could be subject to discovery. It is best if any summaries are prepared in the context of attorney-client discussions in order to enhance the legal protection that may be available against discovery.

You and your employer will need to consider, in consultation with legal counsel, how to handle the bill for your professional fee. Billing the patient for the services may not be wise from a patient relations perspective, but writing off the bill may raise other fraud and abuse compliance issues (see Chapter X, sections D.2.c. and D.5 (pages 86-87).

Be prepared for the significant stress that may be involved in the aftermath of an adverse event and obtain help if needed.

3. Amending medical records. A frequent question in this context is what changes, if any, may be made to a medical record after an adverse event has occurred. You first need to consult any rules that your Hospital (or other facility) may have on the subject as well as any policies that your Group may have adopted. As a general rule, do not alter existing documentation or notes or backdate any entries. It may be possible to add information in the form of an addendum or other authorized means provided that such information is clearly designated as new information and the date of the addition is noted. You should consider the need for additional documentation, and whether it relates to clinical management of the patient, before deciding to add information.

4. Contractual obligations to report incidents. Buried in the mounds of paper that constitute your managed care agreements, may well be language requiring you to notify the MCO of any adverse event, even if a claim has not been filed and even if the case did not involve an MCO member. Failing to comply with these reporting requirements would constitute a breach of the agreement and could lead to termination. Whether that potential is problematic depends upon whether you are under practical or legal pressure (e.g., due to your relationship with the Hospital or a contractual obligation) to participate with the MCO in question.

G. INFORMED CONSENT

Resource reference

The ASA *Manual for Anesthesia Department Organization and Management* contains a chapter on informed consent which includes copies of anesthesia informed consent statements.

1. What must be disclosed. The informed consent process is intended to help patients understand what will happen to them during the course of the medical care they receive and to give them realistic expectations of their care. It is the legal recognition of the patient's right to personal autonomy in decisions regarding medical treatment. State law governs the nature of the information that must be provided to the patient. In general, the information must be sufficient to allow the patient to understand the risks and benefits of a recommended treatment prior to giving consent for the treatment. Two standards have been used to judge whether adequate information has been provided to the patient.

a. *What a reasonably prudent physician in the community would disclose*. Traditionally, informed consent has been based on what a reasonable physician with similar training in the same community would tell a patient about a procedure and the risks of injury associated with the procedure. The risks to be disclosed would be the probable risks.

b. *What a reasonable person in the patient's position would want to know*. More recently, the standard requires the physician to disclose information that a reasonable person under the same circumstances would have wanted to know in making a decision regarding undergoing the treatment. Under this standard, the test for determining whether a particular risk must be disclosed is its *materiality to the patient's decision*. Part of the consent process is also acknowledging the uncertainty of the outcome, so that unexpected outcomes are not a complete surprise.

Under this standard, a physician need not disclose risks of which the average person is aware or risks that do not bear on the patient's decision. A more subjective variation of this standard would require that a patient be informed of all information that rational people would want to know, as well as anything else that might affect the patient's personal decision, including religious or cultural beliefs.

2. In writing. Written consent signed by the patient is presumed to be valid but that presumption may be rebutted upon proof that the consent was obtained through fraud, deception or misrepresentation. Note that state law may contain specific consent requirements for specific medical conditions. Your state medical association and even your liability carrier should be able to provide you with more information regarding informed consent requirements in your state. If a patient decides to pursue litigation, good documentation of the informed consent will be an important element of your defense.

Ideally, anesthesiologists meet with their patients in advance of the day of surgery to discuss the options for anesthesia, the risks involved and the patient's questions. Informed consent can be obtained at that time. In practice, however, informed consent for surgical anesthesia often is obtained in the brief meeting between the anesthesiologist and patient immediately prior to surgery. Do not rely on the surgeon or attending physician to obtain informed consent for anesthesia. If you do so, you may find that the information disclosed was insufficient.

3. Problems in obtaining informed consent.

a. *Premedicated patients and patients in severe pain*. If you are first meeting with the patient immediately prior to surgery, the medical condition of the otherwise competent patient may raise questions about the patient's ability to give informed consent. The premedicated patient, the laboring patient and the patient under stress are examples of such patients.

The question is ultimately whether the patient demonstrates the capacity to understand his or her situation, as well as the proposed care, its risks, benefits and alternatives.

b. *Patients with some limitation on cognitive function*. Patients with known mental illness, organic brain disease or known diminished mental capacity are capable of participating in the informed consent process, but expert consultation may be needed to determine whether the patient is capable of understanding the risks and options and making a decision regarding them.

c. *Incompetent patients and emergency situations*. If a patient is legally incompetent to consent (e.g., the patient is a minor or has a mental incapacity), the parent or guardian must be informed and must consent to treatment on behalf of the patient. Emergency situations generally are recognized as exceptions to the requirement for informed consent and consent for the treatment is implied. To qualify as an emergency, you must determine that the patient's condition poses a threat to the patient's life or health and that a delay in treatment would be harmful. You should document in the patient's record the nature of the surgical treatment, the nature and magnitude of the risk to the patient's life or health, the immediacy of the risk to the patient and, if applicable, the efforts to seek informed consent.

4. Do-not-resuscitate (DNR) orders. Many states recognize the right of patients to determine in advance that they do not want to receive emergency treatment to restart their heart or breathing. A DNR order authorizes health care providers to withhold resuscitation measures. DNR orders are designed for individuals suffering from serious, possibly life-threatening medical conditions and persons in the final stages of a terminal illness who are certain that they do not want to receive emergency treatment. Depending upon state law, legal guardians may be authorized to communicate informed health care decisions on behalf of a patient who is unable to communicate these decisions due to a physical incapacity or illness. States or hospitals may have varying policies regarding different measures to be taken based on the stage of illness or whether the patient is in partial, rather than full, respiratory or cardiac arrest.

DNR orders can be revoked in several ways, including verbally instructing emergency responders to disregard a DNR order. A patient can revoke a DNR order at any time, regardless of his or her mental or physical condition. Due to the variation in DNR order policies from state to state and from hospital to hospital, you should make sure to consult your Medical Staff policies and state regulations regarding when, how and by whom DNR orders may be either invoked (implemented) or revoked.

Resource reference

Consult the ASA "Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives that Limit Treatment."

5. Advance directives. In contrast to a DNR order, an advance directive simply expresses a person's desires in the event of a future illness. An advance directive tells physicians the type of care to administer if that particular patient becomes unable to make medical decisions.

Advance directives are generally short, uncomplicated documents that come in a variety of forms. For example, you may encounter formal attorney-drafted documents, standard form advance directives or more informal patient-drafted documents. You should be aware of your Medical Staff policy and state regulations on the implementation and validity of advance directives.

V. CREDENTIALING AND MEDICAL STAFF RELATIONS

A. CREDENTIALING AND PEER REVIEW

1. Overview of the credentialing process. The credentialing process refers to the process for reviewing the professional criteria for membership on the Medical Staff of a hospital or ASC and for clinical privileges to practice at the facility. Verifying a physician's credentials is an integral part of any facility's (or insurance carrier's) privilege-granting and risk management process. It not only helps to insure that credentials presented in an application are valid, it also serves as an initial screening mechanism for quality in a health care delivery setting. JCAHO guidelines identify four core criteria essential to establishing and maintaining a qualified and competent Medical Staff: a) current licensure, b) relevant training or experience, c) current competence and d) ability to perform the privileges requested.

Current licensure is verified at the time of initial appointment and upon renewal of privileges either by confirming the license with the primary source or viewing the applicant's current license or registration. *Confirmation of relevant training* also is done through primary source verification whenever possible and includes reviewing letters from residency and fellowship programs. If you have just completed training in a residency or fellowship program, you may establish relevant training through a letter from the program director. If Board certification in anesthesiology is required, the Hospital will consult the Official Directory of Board Certified Medical Specialists published by the American Board of Medical Specialists. For residents and fellows, *current competence and ability to perform privileges requested* will be confirmed by the director of the training program. In the case of a physician seeking reappointment, renewal or revision of privileges, current competence is determined by the results of peer recommendations and department recommendations, as well as performance improvement activities, if applicable. The ability to perform privileges requested is confirmed in a renewal or reappointment application by approval of the department chairman (or the chief of staff in a nondepartmentalized hospital).

Credentialing also has a preventive element. By confirming the qualifications of physicians and their ability to perform clinical procedures, the goal is to minimize the potential for adverse outcomes. The following credentials are among those that typically are reviewed:

- Medical education, including postgraduate internships, residencies and fellowships;
- Licensure from each state in which a license has been or is currently held, including any history of discipline or sanction. The Federation of State Medical Boards (FSMB) maintains a database of these sanctions and often serves as a secondary verification source of state information. (Physicians have a right to obtain a copy of the FSMB profile one time annually without charge.);
- Board certification;
- DEA certificate status;
- Existing and previous hospital admitting and outpatient treatment privileges, including a delineation of procedure-specific privileges and a history of priv-

ilege suspension of 30 days or greater in length;
- Professional liability insurance claim history and current limits and terms of coverage;
- National Practitioner Data Bank entries on malpractice actions and settlements;
- Medicare, Medicaid or other federal program sanctions;
- Work history, including dates of service and contact information; and
- Personal and/or professional references.

Traditionally, credentialing has been done by state medical boards, hospitals, ASCs and individual insurance carriers. More recently, private centralized credentialing organizations and state medical board credentialing services have gained popularity in light of the rapid growth of managed care plans and increasing provider participation in a wide range of plans.

Original source documents must be provided directly to the credentialing organization. Documentation from the applicant typically is not acceptable. One common element of most applications is the peer reference requirement in which a physician with a professional association with another physician is requested to provide an opinion regarding competence and ability to interact with other physicians and with patients.

MCOs, employers, malpractice carriers and regulatory agencies seek outcome data and incorporate that information into their credentialing and marketing efforts. Some states, such as Florida and Massachusetts, now make credentialing information available to the public.

Some facilities have developed a "Delegated Credentialing" authority by which a managed care entity agrees to accept the facility's credentialing packet as complete. This process allows the physician to proceed directly to the Credentials Committee for approval in place of having to verify all original sources. The process typically reduces the credentialing period from 90 days down to approximately 30 days.

Resource reference

The following organizations can provide more information:

American Board of Medical Specialties
(847) 491-9091, <www.certifieddoctor.org>

American Medical Association
(312) 464-5000, <www.ama-assn.org>

Federation of State Medical Boards
(817) 868-4000, <www.fsmb.org>

National Practitioner Data Bank
(800) 767-6732, <www.hrsa.dhhs.gov/bhpr/dqa/factshts/fsnpdb.htm#4>.

2. Economic credentialing. Economic credentialing refers to the process of making decisions regarding the appointment or reappointment of physicians, or the delineation of privileges, based upon economic considerations unrelated to the quality of care or professional competence of the applicant. Such economic criteria include the cost-effectiveness of the physician's treatment of patients or the number of patients the physician refers to the hospital or other facility. Although economic factors are somewhat less applicable to anesthesiologists, hospitals still may engage in some degree of economic credentialing, looking at factors such as the size of a Group's chronic pain practice and the number of cases to be performed at the Hospital or the Group's practice at competing facilities. Economic credentialing often occurs in a subtle, rather than an overt, fashion and while inconsistent with a focus on quality of care, may be difficult to challenge - absent some favorable state law barring reliance on economic factors in granting privileges or Medical Staff bylaws prohibiting consideration of economic factors.

Resource reference

Consult the ASA "Statement on Economic Credentialing."

3. Peer review. The clinical services that all Medical Staff members provide in the Hospital are reviewed periodically, usually in the form of peer review by the Hospital medical board. The reviews may include consideration of deaths, unimproved cases, infectious complications, errors in diagnosis and results of treatment from selected cases currently in the Hospital, selected cases discharged since the last meeting of the Hospital medical board, analysis of clinical reports from each Hospital clinical department and reports of Medical and Dental Staff committees.

4. Medical Staff issues. As a member of the Medical Staff, you are likely to become involved in a variety of Medical Staff activities. Generally speaking, the Medical Staff activities that have a greater competitive impact on fellow Medical Staff colleagues are the ones that are likely to carry a greater potential for liability. In particular, Medical Staff activities such as peer review or credentialing have a greater potential to adversely affect a physician's ability to practice. When reviewing professional opportunities, you may want to consider the possibility that such activities may involve potential liability and to consider whether the Medical Staff bylaws of the Hospital or the terms of the Group's agreement with the Hospital provide for liability protection – in the form of financial or insurance coverage – for such potential activities.

5. Confidentiality. All medical information is confidential. The need for confidentiality stems from the sensitive and potentially stigmatizing nature of personal medical information. Physicians and their employees should be aware of the pertinent state and federal laws governing release of information and should understand that any release of information – whether verbally or in writing – is subject to restriction. The increasing use of computers in the storage, retrieval and transmission of data provides new opportunities and challenges to maintaining control over confidential information.

In December 2000, acting pursuant to the mandate in the 1996 Health Insurance Portability and Accountability Act (HIPAA), HHS issued final regulations that prohibit "covered entities" from using or disclosing individually identifiable health information except as authorized by the patient or as expressly permitted by the rule. The rule bars the use and disclosure of protected health information without written patient consent for purposes of health care treatment, payment and operations (e.g., quality assurance, utilization review and credentialing). Disclosure for certain national priority activities such as public health and law enforcement is permitted without patient authorization. Covered entities include health care providers who transmit health information electronically and health plans. Among other things, the regulation subjects physicians' "business associates," a term that covers billing companies, to similar restrictions by requiring that physicians have written contracts with their business associates to assure that the business associates will safeguard protected health information. Compliance with the final regulations is required by April 2003.

6. Utilization review. Utilization review refers to the design, quantitative assessment and systematic improvement of patient care delivery systems. Most utilization review efforts help to establish medical necessity by progressing through a three-tiered review process. The first tier consists of a clinical review of the patient's clinical history, including laboratory and other reports. This information often clearly establishes the medical necessity and the reasonableness of the treatment plan proposed. Licensed clinical personnel (e.g., nurses) often perform these reviews under physician supervision. If medical necessity for the proposed treatment is not established at the tier-one level, a physician reviews the plan of treatment and the nurse's recommendation for action before deciding on approval or disapproval of the request. In some cases, this peer review can be accomplished using a nonphysician (e.g., a physical therapist may render a decision on a

physical therapy treatment). If the clinical review and peer review processes have failed to establish the medical necessity, the issue can be addressed during an appeals process in which both parties present the clinical evidence to clinical peers who are board-certified in the same specialty and who typically work in the same specialty as the treating provider.

Because of the nature of clinical care, these processes must be accomplished in a narrow time frame of a few days. While retrospective reviews are useful in gathering data and in trending issues, concurrent review of the proposed care is an essential element in all utilization review efforts whether they are conducted internally to reduce the length of stay or externally to benchmark one physician or practice against a large array of physicians or practices.

7. Challenging denial of privileges. Your ability to challenge a denial of privileges will depend upon the facts surrounding the denial. Challenges to credentialing decisions generally are based on one of several grounds:

- Breach of contract, alleging that the hospital action in denying or curtailing of privileges violates Hospital or Medical Staff bylaws requirements;
- Violation of due process rights; and
- Violation of specific statutes such as federal antidiscrimination or antitrust laws.

The success of these challenges depends in the first instance on whether the facts demonstrate that the claimed wrong occurred. If a Hospital fails to follow its own bylaws in deciding not to grant privileges, its action may be successfully challenged although the procedural defect is fairly easy to remedy. In order to establish a due process violation, a plaintiff physician would need to establish that the Hospital was a public or quasi-public entity that owed the plaintiff due process. Under the U.S. Constitution, the federal and state governments are restricted from taking property without affording individuals "due process;" private entities generally are not subject to due process restrictions unless their actions are found to constitute "state action." Accordingly, a due process claim asserted against a private hospital is unlikely to be successful. Finally, whether a disappointed physician could establish that the Hospital engaged in unlawful discrimination – on the basis of race, gender, national origin, disability, age or some other impermissible ground – would depend upon the facts surrounding the adverse action.

Many challenges to credentialing decisions, including in particular the denial of Medical Staff privileges, have been based on claimed violations of federal and state antitrust laws, with the plaintiff physicians claiming that their exclusion from the Hospital constitutes an illegal restraint of trade or, less frequently, an attempt to monopolize a market. Court decisions in these cases often relate to proving elements of antitrust claims, such as the existence of market power or concerted action (e.g., disputes over issues such as whether a Hospital and its Medical Staff were separate entities that could "conspire" with each other or whether the Hospital's actions "affected commerce" sufficiently to meet the jurisdictional standard in federal antitrust law). Courts generally have reviewed antitrust challenges to credentialing decisions using a "rule of reason" analysis that has allowed hospitals to offer legitimate considerations for their decisions. A successful antitrust challenge to a credentialing decision would require a rather exceptional set of facts.

The increasing prevalence of exclusive contracts for medical services, including anesthesiology services, has made it more difficult to challenge hospital decisions denying Medical Staff privileges to physicians who first apply for privileges but who are not part of the Group holding the exclusive contract. This situation is to be distinguished from challenges by physicians who hold Medical Staff privileges but who are excluded from practicing at a Hospital when the Hospital grants an exclusive contract to another physician or physician group. This topic is discussed in the context of hospital-anesthesiology group contracts in Chapter VII, section C.1, page 52.

State law may provide additional protections to physicians against adverse credentialing decisions by hospitals and other facilities. Several such laws are referenced in the table below. Any physician adversely affected by a credentialing decision should consider the availability of state law protection.

B. NONPHYSICIAN HEALTH PRACTITIONERS

1. Scope of practice. The authority for physician and nonphysician health professionals to practice their professions is set by state law. State law defines the qualifications required to be licensed and the permitted *scope of practice* of different health professionals – the types of services that different health practitioners may provide. For physicians, the grant of authority to practice medicine often is broadly framed. The scope of practice for nonphysician health care professionals, including anesthesiologist assistants and nurse anesthetists, may be more circumscribed in the specific services that such professionals may provide. Anesthesiologist assistants (who are physician assistants) and nurse anesthetists (who are registered nurses) both have specialized training in anesthesia and anesthetic techniques.

Nurse anesthetists are authorized to practice in all 50 states and the District of Columbia, while anesthesiology assistants are only authorized to practice in a few states, such as Georgia. State law varies markedly as to the level of supervision or direction required for practice with anesthesiology assistants and nurse anesthetists. The definition of what constitutes supervision or direction also may differ from one state to the next. Similarly, state law is not uniform with regard to the rights, if any, of nonphysicians to prescribe controlled substances.

Resource reference

The ASA Office of Governmental Affairs (202/289-2222) has more detailed information regarding the education, training, scope of practice and prescriptive authority of nonphysician health practitioners. The state component society of anesthesiologists may also have additional information regarding these issues.

Physician-Friendly State Laws

Florida (Fla. Stat. Ann. § 395.0191(4))	Protects the right of the Medical Staff of a licensed facility to review all applications for appointment and reappointment to the Medical Staff.
Illinois (210 Ill. Comp. Stat. 85/10.4)	Provides for a fair hearing to physicians whose privileges have been terminated or reduced as a result of the award of an exclusive contract.
Texas (Tex. Health & Safety § 241.1015)	Prohibits hospitals from refusing to grant or renew staff privileges on the basis of a physician's provision of services at a different hospital.
Tennessee (Tenn. Code Ann. § 68-11-227)	Prohibits hospitals from requiring hospital-based physicians to pay for the use of medical equipment and restricts the ability of hospitals to tie clinical privileges to a contract absent a separately executed agreement to terminate clinical privileges.

State law defines the scope of permissible activity of licensed health care providers. Hospitals and other health care facilities may not grant more expansive authority, but they may adopt more restrictive requirements regarding clinical practice by nonphysician health practitioners within their institutions. Anesthesiology practices similarly may limit the scope of practice of their nonphysician employees.

> ***A cautionary note*:** At least one court has ruled that anesthesiologists and nurse anesthetists compete with each other in the provision of anesthesia services. (Although a similar ruling has not been issued relating to anesthesiologist assistants, readers should assume that the same caution applies to them.) An employer (here, the anesthesiologist) may establish limits on the actions that an employee (the nurse anesthetist) may take. Outside the scope of employment, greater caution should be exercised before taking action (including engaging in clinically focused activities such as the adoption of practice protocols) that could restrict the ability of non-Group-employed nurse anesthetists to practice. If you are in a position to take action that could adversely affect the ability of a nonphysician anesthesia provider to exercise the full range of legally permissible practices, you should consult with counsel in advance to minimize potential liability under the antitrust laws.
>
> This cautionary note ***does not*** apply to legitimate approaches to legislative or other governmental authorities. Such activity is protected under the antitrust laws under what is known as the *Noerr-Pennington* doctrine.

2. The anesthesia care team. Nurse anesthetists and anesthesiologist assistants are an integral part of many anesthesiology practices. Under the medical direction of anesthesiologists, nurse anesthetists and anesthesiologist assistants can provide quality care in a cost-effective manner. With the increase in managed care market share and the corresponding decrease in payment, nurse anesthetists and anesthesiologist assistant services may assist in controlling costs while ensuring the delivery of quality services in cases in which normal events do not require constant attendance by an anesthesiologist.

Maintaining a productive, mutually beneficial working relationship with nurse anesthetists and anesthesiologist assistants in a practice is critical to the long-term success of the practice. If an anesthesiology practice employs nurse anesthetists and anesthesiologist assistants, nurse anesthetist and anesthesiologist assistant relations must be a central consideration in wage determinations, benefit package changes and scheduling.

VI. BUSINESS, TAX AND RETIREMENT PLANNING FOR THE SELF-EMPLOYED

A. PROFESSIONAL PRACTICE AND STARTING OUT

1. Introduction. The extent of business planning that you will need to do depends largely on the type of practice and professional setting you are entering. If you join an established anesthesiology practice, the legal structure of the entity and many associated decisions will already have been made. If, in contrast, you will be practicing as a solo practitioner or as a member of an anesthesiology department, but independently of other anesthesiologists on staff, you will need to address business planning matters.

2. Type of entity/form of organization and associated tax considerations. It is unlikely that you will want to practice as a solo practitioner in your capacity as an individual physician. Liability considerations, specifically unlimited personal liability for medical malpractice and other business obligations, will lead you to a legal entity structure, such as a professional corporation or a limited liability company (LLC). Both types of entities offer a limitation on personal liability. They differ in terms of structure, taxation and regulatory requirements (see summary table below). The decision as to which entity is best will depend upon the state's professional corporation and LLC laws and your personal circumstances and objectives. You should consult with counsel and your tax advisor in making this decision.

Types of Business Structures *At a Glance*

Type of Entity	Advantages	Disadvantages
C corporation (a corporation that has not elected Subchapter S status)	Limited liability (liability limited to extent of capital contribution). As an established type of entity, corporations offer greater predictability of result in the event of dispute and litigation.	Double taxation (taxation at both the entity and shareholder level). More specific structural and operational requirements than for an LLC.

(Table continued on following page)

Types of Business Structures at a Glance (cont.)

Type of Entity	Advantages	Disadvantages
S corporation	Limited liability. No double taxation.	Restrictions on structure (number and nature of share-holders, only one class of stock).
Limited liability company	Limited liability. No double taxation. Flexibility to structure and operate as desired (e.g., can make disproportionate distributions of income to members without regard to members' ownership interests).	"Phantom" income (realizing income even though it has not been distributed). Cannot offer tax-free fringe benefits to members. As a relatively new type of entity, LLCs offer less predictability of result in event of dispute and litigation.

Resource reference

See further discussion of this topic in *Contracting Issues: A Primer for Anesthesiologists (*pages 19-23).

3. Licenses needed.

a. *State medical license*. If you will be working in a state other than the one in which you are practicing or practiced as a resident, you will need to apply for a medical license from the new state. Processing times can differ, so you should apply early to minimize potential delays.

b. *DEA number*. Under the authority of the Controlled Substances Act, the DEA, a unit of the United States Department of Justice, registers all persons who handle controlled substances. Legitimate handlers of controlled drugs include manufacturers, hospitals, pharmacies, practitioners and researchers. The goal of controls is to ensure the ready availability of "controlled substances" for medical use while preventing their distribution for illicit sale and abuse.

c. *Medicare provider number*. You will need to enroll with the Medicare carrier for the geographic area in which you will be working. The general enrollment form, Form 855 (blue), was revised effective in 1998 and is significantly more complex than was the prior form. Be sure to sign the form and to include a notarized copy of your medical license to ensure timely processing of your application.

Even if you already are enrolled in the Medicare program, you will need to complete Form 855R, Individual Reassignment of Benefits (green), if the Group will be billing for your services. This same form is used to *enroll* a new physician Group in order to list all Group members/partners rendering services within the Group/partnership setting or to *update* the status of a Group (e.g., to delete physicians or to assign a physician to a new practice location). Information changes (e.g., changes to a physician's or Group's name, mailing address or telephone number) are reported using Form 855C, Change of Information (pink).

Effective September 1999, applicants must disclose their Social Security Number (SSN) and/or Employer Identification Number (EIN),

as well as those of other persons and organizations associated with the applicant, in the form HCFA 855. Even when you are working under a Group's tax identification number, your SSN is required for you to receive a Unique Physician Identification Number (UPIN).

d. *Electronic submission of claims to Medicare*. Completing the HCFA-855 does not automatically authorize you to transmit electronic claims to Medicare. You will need to complete the Electronic Data Interchange (EDI) enrollment form in order to submit your claims electronically.

B. RETIREMENT AND BENEFITS PLANNING

1. Introduction. As a resident, you may think that you are too young to be making plans for retirement. In today's economy, however, it may well take a portfolio of several million dollars to ensure a comfortable retirement. It is never too early, and you are never too young, to start saving for that goal. Accordingly, this discussion will cover *the three common sources of retirement income: a) an employer's (or self-employed person's) "qualified" retirement plans, b) your personal savings and c) Social Security*. This discussion will also touch on some of the major tax aspects of these three components of retirement savings.

2. Definitions.

a. *Contribution*. An amount paid by the employer, the employee or a self-employed individual to a retirement plan.

b. *Participant*. An employee (or self-employed person) who satisfies any eligibility requirements under his or her employer's retirement plan and subsequently participates in the plan.

c. *Beneficiary*. The individual (or individuals) or entities that a participant designates to receive his or her benefit under a retirement plan in the event of the participant's death. If no beneficiary is designated by the participant, the plan may automatically distribute the participant's benefit to his or her spouse (or, if there is no spouse, to other family members).

d. *Vesting*. The process, under a retirement plan by which a participant attains a nonforfeitable right to his or her benefit under the plan.

e. *Defined benefit plan*. A retirement plan in which an employer promises to pay participants a certain benefit amount upon retirement. The amount of the benefit is determined by a formula. The formula may calculate benefits based on a percentage of a participant's annual compensation and years of service, or may provide for a flat benefit (e.g., a certain benefit amount regardless of compensation or years of service). Pension benefits under a defined benefit plan are not dependent on investment performance. Rather, the employer is obligated to contribute enough to the plan to pay for the promised benefits. In general, a defined benefit plan more heavily favors older or longer-serving employees as a result of the manner in which benefits accrue.

f. *Defined contribution plan*. In a defined contribution plan, a separate account is established for each participant. Employer contributions, which are determined based on a formula under the plan, are periodically credited to each account. Participant accounts are further adjusted to reflect the plan's investment performance. Thus, investment performance has a direct impact on the amount of the participant's total benefit. The employer may make contributions to the plan, and, in the case of a 401(k) plan, a participant may make before-tax contributions to the plan. This type of contribution by a participant is advantageous because it reduces the participant's gross income and allows for tax-free earnings under the plan. (See subsection 3.a.iii below for further discussion of 401(k) plans.)

g. *Qualified plan*. A retirement plan that has been formally determined by the IRS to meet certain requirements under the Internal Revenue Code (the Code), with the result that properly calculated contributions are deductible in the computation of an employer's or self-em-

ployed person's taxable income and are excludable from the taxable income of the participant. In addition, the investment returns of a qualified plan are not subject to current taxation, and the benefits paid out from the plan are eligible for special (beneficial) income tax treatment.

h. *Rollover*. The process of transferring a vested account balance from one qualified plan or individual retirement account (IRA) to another qualified plan or IRA.

3. The first component of retirement planning: Qualified retirement plans and arrangements.

a. *Types of employer-provided plans commonly offered*. Employers in the anesthesia field today commonly offer two different types of qualified plans, both of which are defined contribution plans. The first is a money purchase pension plan. The second is a combination of a profit sharing plan and a 401(k) plan. It is difficult to say whether one type is more prevalent than the other. Whatever plan is offered, *you should always maximize your contributions and those of your employer to all of the retirement plans offered by your employer*.

i. *Money-purchase pension plans*. A money purchase pension plan is a defined contribution plan in which the employer has a fixed obligation to make contributions. Typically, contributions will be based on a certain percentage of an employee's compensation. The funds contributed to a money purchase pension plan will be credited to each participant's separate account, and adjustments will be made to each account based on the plan's investment performance.

ii. *Profit-sharing plans*. A profit-sharing plan is a defined contribution plan in which the employer makes a contribution to the plan based on a formula in the plan. This contribution can be, but is not required to be, made from the profits of the employer and is usually determined on an annual basis. Often there is no mandatory employer contribution under a profit sharing plan. Rather, the employer typically retains discretion whether to make a contribution to the plan for any particular year. As in the case of a money purchase pension plan, funds contributed to a profit sharing plan are credited to each participant's separate account and adjustments are made to each account based on the plan's investment performance.

iii. *401(k) plans*. A 401(k) plan is one under which a participant may elect to make before-tax contributions to the plan. This is accomplished by a participant entering into a salary reduction agreement with the employer wherein the employer reduces the participant's compensation by the amount of the participant's 401(k) plan contribution. The IRS places limits on the amount of compensation that can be contributed to a 401(k) plan. For 1999, the maximum amount that may be contributed in before-tax contributions is $10,000. Also, there are other restrictions that may affect highly compensated employees. You will need to check with your employer to find out if these will apply to you. Often under a 401(k) plan an employer will "match" a participant's before-tax contribution. A participant also may be able to contribute after-tax amounts to a 401(k) plan (although after-tax contributions will not reduce taxable compensation, they will accrue earnings on a tax-free basis). A participant's account under a 401(k) plan is adjusted for investment performance.

b. *Limited ability to negotiate pension issues*. Can you negotiate the terms of these plans as part of your employment negotiations? The answer generally is no. Employers are not likely to amend a plan, which requires a filing with the IRS, to accommodate a new physician employee. But you can evaluate the retirement plan benefits offered by a particular employer and, if you are in the position of having more than one employment offer, compare the plans that are offered.

c. *Comparing pension and benefit plans*. Whether you have one employment offer or more than one, it is logical to ask about the terms of retirement plans. A convenient way for an employer to respond may be to give you one or more "summary plan descriptions," lay-

language documents circulated to all employees describing the principal features of each qualified plan. The following discussion identifies the questions you should consider as you review any description of a qualified plan.

i. *When does a new employee become a participant*? Common entry dates are after six or 12 months' employment or on the first January 1 or July 1 after such an anniversary. From your perspective, the sooner you can participate, the better.

ii. *When does a participant vest in the plan*? In some cases, an employer may require a participant to complete a certain number of years of service to be vested in any employer contributions under the plan (you are always 100 percent vested in your before-tax contributions under a 401(k) plan). In general, the law allows an employer to established a vesting schedule of up to seven years if contributions are partially vested each year following the second year of service, or up to five years if contributions are not vested at all until completion of the fifth year of service. Some employers offer immediate 100 percent vesting of employer contributions. Because vesting schedules vary from plan to plan, it is important to ask about this issue.

iii. *What are the contribution terms*? What is the formula for the employer's contributions? Is the employer's contribution mandatory or discretionary? If discretionary, how often in the past has the employer contributed to the plan? What is the formula for employee contributions? What are the maximum contributions the employer and the employee may make under each plan?

iv. *Does the plan accept rollovers*? If you have a balance in a rollover IRA or in a prior qualified plan, that plan is required to allow you to make a rollover out of it. Will the new employer's plan accept the rollover?

v. *Can you self-manage your account*? In other words, can you choose how that account will be invested? Who is the vendor that provides the investment choices? What is the range of investment options available?

vi. *Can you borrow or make other in-service withdrawals from the plan*? What are the terms of any such borrowing or withdrawals?

d. *General points: SEP or SIMPLE plans*. Money purchase pension plans, profit sharing plans and 401(k) plans have complex nondiscrimination and "anti-top heavy" rules required by federal law. These rules require employers who make contributions for the benefit of highly paid individuals, such as physicians, to make proportionate contributions for the benefit of less highly paid employees such as nurses, secretaries, and receptionists. (For purposes of the nondiscrimination rules, generally, an employee who makes more than $80,000/year is deemed to be highly paid. Under this definition, physicians and most nurse anesthetists or anesthesiologist assistants employed by anesthesiology groups would be highly compensated employees.) The nondiscrimination rules also limit the contributions that may be made for the benefit of highly paid individuals. These rules can cause the plans to be very expensive to maintain while limiting the amount of benefits that can be provided to principals.

For this reason, many employers have opted out of these more complex plans and have chosen to establish SEP or SIMPLE plans. Under a SEP arrangement, an employer makes a contribution according to a formula under the plan (although the contribution may be discretionary) on a nondiscriminatory basis to all covered employees. These contributions are then funneled to IRAs maintained for the individual employees. The employer may take a deduction for its contribution of up to 15 percent of the compensation of its employees. The maximum contribution to any single participant's IRA is $30,000.

Under a SIMPLE plan (short for "Savings Incentive Match Plan for Employees"), an IRA is likewise used as a funding vehicle. Employers are generally required to make contributions of 2 percent of compensation to each IRA, and employees may make before-tax contributions. Certain restrictions apply. For example, an employer may have no more than 100 employees

(but may elect for this purpose to take into account only those employees who received at least $5,000 of compensation from the employer for the preceding year). The plan must meet certain vesting, participation, administrative and salary reduction requirements. Contributions are likely to be smaller under a SEP or a SIMPLE plan, but these plans leave more after-tax income for private savings.

e. *Nonqualified plans.* In addition to (or in lieu of) one or more qualified retirement plans, an employer may establish one or more nonqualified plans. These plans generally are not subject to the various nondiscrimination restrictions affecting qualified plans. Therefore, under these plans the employer is able to contribute more to highly compensated employees. Nonqualified plans take various forms. The employer may impose vesting, distribution and other restrictions. Contributions under these plans may be in the form of employer securities. It is important to remember that unlike contributions under qualified plans, contributions made on your behalf to nonqualified plans generally are not protected from the rights of the creditors of the employer. In the event that your employer goes bankrupt or experiences other credit difficulties, your benefit (even if vested) is not guaranteed under a nonqualified plan.

f. *Whatever the plan, maximize contributions. Take whatever steps are needed to contribute and to make sure your employer contributes the maximum amount possible each year to all of your employer's retirement plans.* Even if you do not have the ready cash to make the maximum contribution, it is worth taking out a short-term loan to do so by the deadline as long as you know you will be able to pay the loan back within a few months. A better approach is to *have your maximum contribution withheld from your regular paycheck.* Many physicians have found that even these maximum amounts of retirement savings obtainable through qualified plans are not enough. But by making the maximum contribution to all employer-offered plans, you will achieve at least the greatest tax efficiencies.

g. *Retirement plan arrangements for the self-employed anesthesiologist.* If you are going to be self-employed, bear in mind that you may be able to create a professional corporation, become an employee of your own corporation and set up any of the employer-provided plans described above. If you are self-employed and are not in a position to set up a professional corporation, but instead will practice in a partnership or proprietorship, you will have a somewhat different choice of retirement plan arrangements. *As a self-employed physician, you should follow the rule set forth above and maximize your contributions to all qualified plan arrangements each year.*

i. *"Keogh" plans.* The best-known qualified plan approach for self-employed physicians is a "Keogh" plan arrangement, which can take the form of a package of two plans, such as a money purchase pension plan and a profit sharing plan, or a money purchase pension plan and a 401(k) plan. Both plans are defined contribution plans. A Keogh plan is simply a pension or profit-sharing plan that is tailored to operate in a partnership or proprietorship setting, with somewhat different contribution limits than apply in a corporate setting because earned income is computed differently.

ii. *SEP or SIMPLE plans.* If you will not be a participant in a Keogh arrangement, you could establish a SEP or a SIMPLE plan. These plans are described in subsection 3.d, page 34. Depending on various rules, you may be able to make contributions both to a SIMPLE plan and to a Roth IRA (see subsection 4.b, page 36) in the same year.

iii. *How to establish these plans.* You can set up any of these arrangements or plans with the standard-form documents offered by an investment firm. An investment firm will often provide the documents at no cost if you place the plan funds under their management. Be sure, however, that you follow all of the IRS rules with respect to the filings for and maintenance of the plan. If you establish one of these plans, you as the plan sponsor would be responsible for ensuring that each plan complies

with the law. Even if your investment firm is at fault for not following IRS requirements, the IRS will penalize the plan sponsor. If the IRS disqualifies a retirement plan for failure to adhere to IRS rules, the employer will lose all deductions taken under the plan, and all contributions made to the plan will become taxable to participants.

4. The second component of retirement planning: personal savings.

a. *In general*. Since many physicians have found that relying only on qualified retirement plans is not enough, you will want to consider a program of personal savings as well.

i. *How much should you save?* A logical first question is how much you should save. You may want to consider discussing this question with a financial consultant. You may be best off with a consultant who is compensated primarily from offering advice on an hourly basis, rather than selling financial products, in order to reduce the consultant's bias in favor of any one kind of investment product. Your discussion should focus on the amount of income you will need in retirement.

ii. *How much risk should you take?* The discussion will also cover the levels of risk or volatility, risk of loss of principal and risk of inflation with which you would be comfortable as an investor. This will indicate what portions of your portfolio ought to be in what kinds of investments — such as bonds, U.S. equities and foreign equities — and what would be the logical yield of your investment portfolio. This will help the consultant calculate what you need to be saving to achieve your desired level of retirement income. As you become more skilled at investment management, you may be able to do this kind of calculation yourself using the Internet.

iii. *Investment return*. The return on your investments depends in part on whether the return is tax-free, tax-deferred or taxable. Obviously you will want to minimize taxes on your portfolio. This suggests that you may want, especially in your early professional years, to keep the bonds portion (except tax-free bonds) of your investments in the tax-protected (qualified plan) part of your portfolio.

b. *IRA Savings. Your first savings and investment priority, after maximizing all contributions to your employer's or your self-employment qualified plans, should be contributions to IRAs.* All employee and self-employed physicians have at least one IRA savings option available each year. You may, depending on the kinds of tax-qualified plans you have and depending on your earned income, invest personally (that is, outside the employment or self-employment context) in Roth IRAs, regular IRAs or non-deductible IRAs. Contributions to a Roth IRA are non-deductible, but there is no tax on a Roth IRA's investment income and there is no tax on most distributions (such as retirement distributions). Contributions to a regular IRA are deductible, and there is no tax on a regular IRA's investment income but there is tax on distributions. Contributions to a non-deductible IRA are not deductible, but there is no tax on a non-deductible IRA's investment income and the tax on distributions is slightly less than in the case of a regular IRA. In any event, the maximum amount you can contribute each year to these types of IRAs combined is $2,000 (up to $2,000 more if contributions are made for your spouse). This amount may seem small, but IRA balances have a way of increasing rapidly. You should arrange for regular withholding, or automatic debiting of your checking account, to make sure that these contributions are made.

Subject to certain other rules, you can convert your existing regular IRA, or part of it, to a Roth IRA if your "adjusted gross income" is not more than $100,000 (same figure for a couple). The amount you convert, however, is taxable income in the year of conversion.

In future years, look for all these limits to increase and the various rules applicable to these kinds of IRAs to become more flexible.

You should maximize your contribution and those of your spouse to all available retirement IRAs. Keeping records of your IRA contribu-

tions is important. This is a good reason to keep your federal income tax returns and Forms W–2 indefinitely.

c. *Non-IRA Savings*. Beyond these IRA amounts, the next part of your retirement investments may well consist of taxable securities. You should arrange for regular withholding, or automatic debiting of your checking account, to make sure that you are adding to your investment portfolio regularly.

To further minimize your tax burden, you can invest in mutual funds that are "tax managed." These are funds the management of which takes into account the investors' likely tax consequences on sales, so the funds aim for longer holding periods, at balancing sales at a gain with sales at a loss, and at calculating the timing of sales in such a way as to reduce tax burdens. You can further reduce your tax burdens on this part of your portfolio by lengthening your holding periods, generally investing for the long term, considering equities that emphasize appreciation instead of dividends, and investing in tax-free bonds.

A tax-deferred annuity is an investment product linked to a life insurance policy so that the investment income is tax-deferred. Whether this is a sensible investment for you is a question best answered by an unbiased investment consultant. If it does appear that this is a reasonable idea for you, you should ask whether the product fits into your investment approach, the quality of the investment assets offered, the amounts of any related fees and loads, the extent you can manage the investments, the track record of the product, the reputation of the company offering it and of the portfolio managers, and the quality of the local investment professional (if any) representing the company with whom you would be working.

Turning to life insurance, typically, an unmarried physician with no children needs relatively little life insurance, a married physician with children needs life insurance in the seven-figure range, and a physician with a large liquid net worth needs perhaps less life insurance, since liquid net worth can substitute for insurance coverage. Again, in considering life insurance, you need to ask whether the product is appropriate for you, investigate the track record of the company and the quality of its local representatives, and consider whether your premiums are fixed or could rise, whether you can borrow against any equity and the terms of that borrowing.

5. The third component of retirement planning: Social Security. Although Social Security benefits typically will not be a large part of the retirement income of a physician starting out today in private practice, it is nevertheless appropriate to have an understanding of the program. Contributions to Social Security are based on current Social Security tax rates as applied to the "wage base" or the self-employment income base. Both of these base amounts increase from year to year depending on the cost of living. In general, of the contributions relating to you during your working career, one-half are taxable when contributed. On the other end, Social Security pension distributions are taxable income. It is useful occasionally to check the Social Security Administration's records relating to your contributions to be sure they are accurate, and that is another good reason to retain your income tax returns and your Forms W-2 indefinitely. You could think of Social Security as an investment in a better-than-AAA debt instrument with a variable but low yield. At this time, you cannot choose how your accumulating contributions are invested but that could change if federal law is amended.

6. Estate planning. As part of your retirement planning, you will want to consult with an estate planning attorney. Estate and probate laws differ from state to state so you should make sure that the attorney you use is an expert on the law that applies to you. You should ask the attorney to review the advantages and disadvantages of the various options available to you, such as the choice between a will and a "pourover will" coupled with a revo-

cable trust; the latter is an approach to avoid probate. Asset protection – including consideration of your professional liability coverage, the cost of paying for tail coverage (assuming you are not eligible for a free retirement tail) in comparison with the cost of the probate process and whether the probate process will shield your estate from potential unmatured malpractice claims – is an appropriate topic for discussion as part of the estate planning analysis.

C. OBTAINING FINANCING FOR YOUR PRACTICE: LOAN AGREEMENTS

1. In general. If you are joining an existing practice or working for an employer, you probably will not need to obtain financing. If you are establishing your own practice, however, you may need to obtain financing to start up a new practice to cover any potential cash flow shortfalls that may occur until you realize revenue. Even if your practice is responsible for securing such a loan, you may be affected by the conditions of such a loan depending upon the conditions of your employment agreement. Therefore, you should evaluate the loan's terms in conjunction with the terms of your employment contract or recruitment agreement in order to determine whether the loan is compatible with your practice needs.

2. Types of loans. Your practice would most likely opt to obtain standard financing through a bank or similar institution. These standard loans are comparable with any type of bank loan. If you will be practicing in a rural or otherwise remote location, your practice may be able to obtain recruitment assistance loans from a local hospital. These loans contain forgiveness provisions in exchange for a commitment to practice in the community for a certain period of time. Regardless of what type of loan you or your Group chooses to secure, there are several issues of importance in evaluating whether a particular loan is compatible with your practice needs.

3. Questions you need to ask when evaluating the terms of a standard loan.

a. *Do you need to co-sign the agreement?* Even if your practice is taking out the loan, you still may be obligated to co-sign the agreement. If you sign the loan agreement in your individual capacity, you assume individual liability, which means that the lender can reach your personal assets in the event of a default.

b. *What is the interest rate of the loan?* What is the rate of interest on the loan and will it change over the course of the agreement? Is there a cap or limit on the potential increase in the rate (e.g., a percentage above prime, beyond which the rate cannot increase during the term of the loan agreement)?

c. *What are the repayment terms of the loan?* These issues are crucial to your assessment of the loan agreement. You should assess whether you can meet the financial expectations of the loan's conditions. For example, it might not make sense if your practice were required to pay a substantial percentage of the principal during the first few months of the loan repayment. Generally, a lender can offer you a line of credit with a balloon payment that may be a preferable type of loan depending upon your projected cash flow.

d. *What obligations and liabilities would you have?* If your practice will be taking out a loan, the bank will deal with your practice separately rather than either directly or indirectly with you. Regardless, if the practice is taking out a loan on your behalf, you may be subject to certain obligations or liabilities pursuant to provisions in your employment contract. Therefore, even if you are not required to sign the loan agreement, you need to review your employment contract and the loan agreement to identify any such obligations. For example, your employment contract may have a clause making you liable for the loan repayment if you leave the practice within a certain time period.

e. *What security does the lender require?* You should determine, for example, whether the lender would require attaching a security interest in your receivables as a condition of the

loan. Such a requirement could potentially cause additional cash flow problems if you are starting your own practice or could be in conflict with your employment contract with an existing practice.

f. *What covenants are attached to the loan?* There could be instances in which you might breach the covenants at the outset of the loan agreement due to provisions in your contract. You need to assess how these covenants could affect your practice and you should review your employment contract to see such covenants are consistent with it.

In determining whether a particular loan is compatible with your practice, you need to review any prospective loan agreement in tandem with your employment contract to make sure that their terms are consistent with one another. In this assessment, you should view these agreements as if they were rolled into one transaction. It may be advisable to have your attorney or accountant on hand to review any provisions that you might find questionable.

D. GETTING HELP – HOW TO LOCATE/EVALUATE CONSULTANTS

1. Overview. It is important to surround yourself with knowledgeable consultants. When starting out, you will need accounting and legal advisors who can help you establish your practice, evaluate employment and business opportunities and provide basic tax planning. If you join an established anesthesiology group, the Group may have a practice manager, benefits firm or consultant to serve as a resource. As physicians face increased pressure to deal with business issues, they tend to be less likely to operate as sole practitioners. But if you choose that mode of practice, you may have greater need for support.

2. Need for experienced consultants. Finding consultants who have the qualifications to meet your needs can be difficult. A time-tested way to locate consultants is to ask colleagues for names of consultants they have used and then to ask those consultants for references and to check those references. You want to find consultants who have experience dealing with the type of issues you are facing. An attorney who specializes in real estate transactions is unlikely to be the person to help you negotiate a managed care agreement or to address Medicare billing questions.

3. Resources. Other resources include state and national professional associations. ASA and state component societies can suggest names of consultants in particular fields. The ASA Washington office maintains a list of attorneys and consultants around the country who are familiar with the variety of contracts that anesthesiologists encounter, including hospital, employment and managed care agreements.

Your state and local medical societies also may have suggestions. Medical subspecialty associations may be able to suggest consultants. If the association does not maintain a list of consultants, ask the association for the names of its attorneys and consultants who may be able to recommend competent colleagues. Professional associations in related fields, including the Anesthesia Administration Assembly and Medical Group Management Association, may also provide a valuable resource. Finally, look at the authors of articles on issues of interest and contact the authors for additional information. As persons with experience in a particular field, they may have a wide range of contacts in areas of interest to you.

Resource reference

The AMA web site <www.ama-assn.org/ethic/state.htm> lists contact information for all state medical associations; the ASA Web site lists contact information for state component societies of anesthesiologists <www.asahq.org/asarc/statecomp.html>.

4. Contract review services. State and local medical associations provide a variety of

contract review services. In some states, state medical association attorneys will review physician employment or managed care agreements for a set fee and will provide a written analysis of the legal and practical problems in the contract. These contract analysis services often are available to nonmembers for a higher fee, which may be of interest if your state association does not offer this service. For significant payors in the market, local medical associations may have existing analyses of each payor's basic participation agreement.

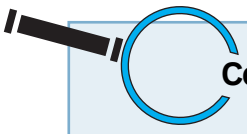
5. What things cost. Lawyers and other consultants generally charge for their services on an hourly basis. An employment or MCO participation agreement may be five pages or 30 pages, which makes it difficult to speak in terms of any average range of fees. The range of actual fees will depend upon factors such as the lawyer's experience and location. An attorney may be able to provide an estimate of fees in advance or, somewhat less commonly, may agree to a set fee for the work.

The more organized you are, the more efficient your attorney can be. If you want to have a contract reviewed, assemble all related documents (such as any sample agreement you were given), any correspondence (including e-mail communication) relating to the contract and any prior versions of the agreement. Read the agreement carefully yourself and mark any language that you do not understand or to which you object. If the agreement refers to any attachments, make sure you have them (or have requested them) before giving the document to an attorney to review. Make a list of the relevant facts to review with your attorney, including any specific questions you have. For example, if you are considering an employment agreement, make sure your lawyer knows if you already are moonlighting and wish to continue moonlighting after taking the permanent position. Make a list of any items addressed during your meetings with a potential employer, but which do not appear in the agreement. This preparation can save time when your attorney reviews the document.

VII. CONTRACTING ISSUES

Chapter highlight: A contract becomes critical when a relationship breaks down or simply comes to an end because it contains the blueprint for such matters as how fast the other party can terminate the deal, what rights you will have upon termination and what restrictions the other party will be able to enforce after the relationship ends.

The ASA publication titled *Contracting Issues: A Primer for Anesthesiologists* addresses contracting strategy and specific contracting issues in extensive detail. **Consult that publication and the accompanying forms supplement for more specific information**. Managed care contracting is covered in *Managed Care Contracting: Considerations for Anesthesiologists,* also published by ASA.



Contracting Basics *At a Glance*

- ✔ How long will the agreement be in effect?
- ✔ What options do you have to terminate?
- ✔ How fast and on what grounds can the other party terminate?
- ✔ If you are to be paid, how quickly will you be paid, and are there any remedies (e.g., interest or a higher rate of payment) if the other party is late in paying?
- ✔ What obligations, if any, will you have after the agreement ends?

A. ISSUES COMMON TO ALL AGREEMENTS

1. If it is important, make sure it is in the contract. If you were promised something during your discussion, make sure the promise is included in the written contract. *If it's not in the contract, it's not enforceable*. Included in the "boilerplate" (the general provisions often found at the end of an agreement) of most agreements is language stating that the written agreement supersedes all prior agreements between the parties and reflects the entire agreement between the parties.

Background note: Most agreements that you will encounter will be written agreements, and the preceding discussion applies to the circumstance in which the parties reduce their understanding to writing. In that case, it is essential that all elements of the agreement be reflected in the document.

An agreement does not have to be in writing to be enforceable. Some oral agreements are binding, particularly if one party has reasonably relied on the oral agreement or promise to that party's detriment. There are limitations on the enforceability of oral agreements that will vary from state to state.

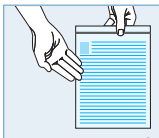
2. If it is important, make sure it survives termination of the agreement. If a provision will be important *after* the relationship ends (e.g., access to medical records), make sure the contract provides that the obligation survives termination of the agreement.

3. Pay careful attention to the definitions. If words are defined in the contract, *they only mean what they are defined to mean*. A contract is an understanding between the parties. The parties are free to define words however they choose. Do not assume that terms have their standard definition.

An especially important definition in contracts that anesthesiologists face is ***how is the word "anesthesiology" defined and, in particular, does it include pain management?*** This definition can have enormous practical consequences for an anesthesiology practice. An exclusive contract for anesthesiology services that covers only surgical anesthesiology services is a far different item from one that covers all anesthesiology and acute and chronic pain management services. In the context of managed care contracts, a Group with an active chronic pain practice needs to understand the scope of services to which the negotiated price will apply.

4. What is the term, or duration, of the agreement? The *term of the agreement is only as long as the period for notice of termination*. Even if the agreement states that it is to continue for one or two years, if it is subject to termination on 30, 60 or 90 days' notice, it is only a 30, 60 or 90-day agreement.

Is the agreement automatically renewable? Automatic renewal means that the agreement continues in force without any action by either party. If the agreement renews and you are to receive compensation, you will want an escalator clause to adjust your compensation in subsequent years.



Sample language: Automatic renewal (employment agreement)

Unless terminated earlier pursuant to the provisions of this Agreement, the term of this Agreement shall commence as of January 1, 2000 ("Commencement Date"), and shall continue through December 31, 2000, and shall automatically be renewed for successive one-year periods upon the terms and conditions hereinafter set forth unless written notice is given by Employer to Employee at least sixty (60) days prior to the expiration of the initial term or any renewal term that this Agreement shall not be renewed, in which case the Agreement shall terminate at the expiration of the initial term or renewal term as the case may be.

Concerns: If salary is a fixed amount, rather than formula-based, you will want to provide for an increase in compensation in subsequent years. A separate concern is that only the Employer has the right to block automatic termination of the agreement. Depending upon other provisions authorizing you to terminate, you will want a mutual right to block automatic renewal of the agreement.

5. Termination.

a. *Termination without cause can be a powerful tool against you*. Can the other party terminate the contract *without* cause? Without cause, or "no-cause," termination means precisely that: the other party can terminate for no reason – or no stated reason. If so, how much notice will you have and will that be enough time to relocate?

Sample language: Termination Without Cause (employment agreement)

Either party may terminate this Agreement, without stated cause, upon sixty (60) days' notice.

Concerns: The Group has an unrestricted ability to terminate you with only 60 days' notice. In addition, the notice is not required to be in writing, which could lead to questions as to whether notice actually had been served.

Advantages: The ability to terminate is *mutual* so that both parties have the same right.

This discussion of contract terminology and protective provisions could end right here, without reviewing other contractual issues. Termination without cause is a powerful remedy because it allows a party to terminate the agreement without any reason, provided that it gives the required advance notice. The termination without cause provision allows a party to bypass the "for-cause" grounds for termination and to avoid any claims for wrongful termination, because the other party does not need to prove that you did anything wrong in order to terminate the relationship. *That means that the other party holds the cards, no matter what the issue and no matter what the agreement provides*. If tensions develop in the relationship, the other party – whether an employer anesthesiology Group or the Hospital – can call it quits well before the stated end date of the agreement. Note, however, that if you are the employer, you would want to have the ability to terminate an employment relationship without cause, in order to avoid claims of wrongful termination.

But a termination without cause provision is commonly included in employment agreements and other contracts and you may be unsuccessful in having it eliminated. Your main protection will be *time* – the notice period before the other party may terminate. *Negotiate for the longest possible notice period* (30 days is relatively short, 90 days is common and 180 days is rather long in an employment agreement with a physician coming out of residency). But bear in mind that the longer the notice period to exercise the termination without cause provision, the more likely the other party is to rely on the more subjective grounds for for-cause termination if the other party truly wants to terminate the relationship quickly.

A counterbalancing consideration is that the notice period for termination is likely to be mutual: The longer the notice the other party must give you, the longer the notice you must give the other party if you are the one terminating the relationship. This mutuality is a result of custom and negotiating posture, not legal requirements. If you become truly unhappy with a relationship (e.g., an employment relationship or an agreement with an MCO), a longer notice period may be difficult for you to honor.

The type of agreement may affect the desirability of a termination-without-cause provision. In contrast to employment agreements and contracts with hospitals, in which termination-without-cause provisions can be problematic, it may well be in your interest to have the ability to terminate a relationship with an MCO without cause. If the MCO is sluggish in paying, is slow in credentialing physicians or otherwise is causing difficulties in the relationship, although not technically in breach of the agreement, you would want the ability to terminate the relationship without having to prove that the MCO breached a specific provision in the agreement.

b. *With cause, and how subjective are the grounds for termination?* Under what circumstances can the other party terminate the agreement for cause, and will you be afforded a chance to rectify the claimed breach? For-cause termination generally results in immediate termination. How subjective are the grounds for for-cause termination? If the grounds are subjective and the decision-making power to determine whether a breach has occurred rests with the other party, the supposedly for-cause termination begins to resemble without-cause termination.

Sample language: Termination With Cause (employment agreement)

This Agreement shall terminate prior to the date set forth in Paragraph 3 above [the Term of the Agreement] or on the expiration date of any extension thereof upon the occurrence of any of the following events:

…Upon the Employee engaging in any conduct substantially harmful to the Employer's business or business reputation.

Concerns: The standard for breach is subjective, and the determination whether the standard has been satisfied is entirely in the Employer's discretion.

In the employment context, if the Group may only terminate the agreement for cause, you may want to ask for a *periodic evaluation* of your performance in order to provide a basis to demonstrate satisfactory performance and to minimize the likelihood of the Group claiming unsatisfactory performance. If the Group may terminate the contract without cause, this type of provision is less significant, as the Group can always access the without-cause option to end the relationship.

c. *Are the performance standards subjective?* Review performance requirements for subjective standards that may be easily breached.

Sample language: Subjective Performance Standard (employment context):

Physician shall remain satisfactory to the President of the Corporation, as determined by the President in his/her sole discretion, in the performance of any and all duties performed pursuant to this Agreement and in his/her personal and professional conduct.

Physician shall not engage in any personal or professional conduct which, in the reasonable determination of Employer, does or may materially adversely affect the image or standing of Employer.

Concerns: The performance standard is very subjective and the determination whether the standard has been satisfied is entirely in the Employer's discretion. In most employment agreements, material breach of any provision of the Agreement — such as this vague standard — would be grounds for "for-cause" termination, which generally is immediate.

d. "*Notice and cure.*" A "notice and cure" provision requires the other party to provide you (or both parties to provide each other) with notice of a breach and allows you a fixed period of time to "cure" or fix the problem or to take steps to begin to remedy the problem. If the for-cause termination clause does not contain this provision, you should ask for one.

The issue that often arises in notice and cure situations is the adequacy of the breaching party's effort to fix the problem. If the non-breaching party truly wants to terminate the relationship or to exert pressure on the breaching party, it may not be an objective judge of the suitability of the breaching party's efforts to cure. For that reason, you may want to provide that *an independent third party* will review the adequacy of the breaching party's efforts to fix the problem.

e. *Mutual ability to terminate.* Make sure that any termination provisions are mutual so that you have an opportunity to terminate the agreement if you are unhappy. If the ability to terminate is one-sided, you may be tied to the agreement until it expires at the end of the term.

Sample language: One-Sided Termination Provision (employment agreement)

Employer may terminate this Agreement, with or without cause, on 60 days' written notice to Employee.

6. Do not agree to indemnify the other party. Any language that provides that you will "indemnify" or "hold another party harmless" from any and all costs that the other party incurs as a result of some circumstance should be closely examined and, if possible, deleted. Indemnification clauses can be (and usually are) drafted broadly to cover all costs that the other party incurs as a result of the actions identified (e.g., all services you provide, even if you provide clinically appropriate services). *Most professional liability policies do not cover contractually assumed liability.* If the other party insists upon an indemnification clause, you should 1) obtain a rider to your liability policy to cover the indemnification agreement and 2) include language in the agreement limiting the extent of your liability to such amounts as actually are paid under your policy.

In contrast, you will want the other party to indemnify you against liability stemming from any administrative or nonclinical services you

provide under an agreement (e.g., service on Hospital or MCO committees). The other party either can include you under its liability policy or compensate you for the cost of a rider to your malpractice policy to cover this additional potential liability. In any event, you should confirm whether your own professional liability policy covers nonclinical services.

Another circumstance in which you may want to request indemnification is if the other party insists on the right to direct you not to hire or to cease using an individual anesthesiologist or nurse anesthetist. In that event, you would want a written statement from the other party explaining the basis for any such directive as well as indemnification in the event the excluded individual files suit alleging wrongful discrimination or termination.

7. Any amendments to the agreement should be in writing and signed by both parties. If changes are not made in writing, the opportunity for misunderstanding as to the precise nature of amendment increases. Managed care agreements often provide that the MCO can amend the agreement upon written notice to the physician. *If the other party can change the agreement, you are wasting your time negotiating*.

If the parties want to make minor handwritten changes to an agreement, each revision should be initialed by both parties in order to signify their agreement with the revision. Handwritten notations to an agreement can be confusing absent evidence of assent to the changes.

8. Attachments.

a. *Make sure attachments are actually attached*. Review all documents referred to in the agreement (e.g., attachments, policies or manuals). If the agreement provides that a document is attached, make sure it is attached.

b. *Make sure important attachments are "incorporated by reference" into the agreement*. Simply referring to an external document without incorporating it by reference into the agreement can lead to ambiguity in interpreting an agreement. If an external document is important (e.g., a compensation formula), make sure that it is made part of the agreement and is binding on both parties by "incorporating it by reference" into the agreement.

9. Notices in writing. All references in the agreement to notice (e.g., of alleged breach, termination or other matters) should be in writing to avoid any question as to whether notice in fact was given.

10. Assignment. Ideally, an agreement should provide that neither party may "assign" (or transfer) its rights or obligations under the agreement without the express written consent of the other party. It is not uncommon for hospitals, MCOs and even anesthesiology practices to try to reserve the right to assign their obligations. If an assignment occurs, you may be working for a very different entity. This area is one in which the obligations often are not mutual. Parties negotiating with physicians for clinical or administrative services generally try to restrict the ability of the physician or the Group from assigning its obligations while preserving the right to transfer their obligations. At a minimum, you will want to negotiate for advance written notice of any assignment by the other party and a right on your part to terminate the agreement. In that way, if you do not want to continue the contractual relationship with the new "assignee," you will have an option to end the relationship. You also will want language making the contract binding on all assignees or successors in interest in the event that you do not want to terminate the agreement.

11. Standard of care. Do not agree to provide the "highest" level of care or other superlative description of the standard of care. You may unwittingly be binding yourself to a higher level of care than the law otherwise would require.

12. Access to records. In most agreements, particularly employment agreements and agreements with hospitals, you will want to make sure that the other side will provide you with access to the medical records relating to the clinical services you provide during the agreement. Watch for limits on the circumstances under which you will have access, burdensome requirements relating to the advance notice you must provide or open-ended provisions relating to your paying for copies of the records.

13. Governing law and venue. Some locations are proximate to several different states or jurisdictions. State law may differ on issues such as the enforceability of restrictive covenants. It can be important to specify in the agreement which state's law will govern any disputes. In addition, some contracts identify a location where disputes will be resolved ("venue" for resolution of disputes). Make sure that the location specified is not inconvenient for you.

14. Dispute resolution. As traditional litigation becomes protracted and costly, parties increasingly are agreeing to alternative dispute resolution (ADR) mechanisms. Is a dispute resolution procedure specified? If so, who bears the cost – the party invoking the procedure or the party who succeeds? Must the parties meet to try to resolve their differences prior to invoking the dispute resolution procedure? Is the procedure *binding* so that the parties are precluded from pursuing traditional litigation?

It is hard to generalize whether a dispute resolution procedure is good or bad. The answer will depend largely on the answers to the questions posed in the preceding paragraph.

Resource reference

See discussion of dispute resolution clauses in *Contracting Issues: A Primer for Anesthesiologists* (pages 41-42).

15. Any blank spaces? Make sure any blank spaces in the agreement are filled in prior to execution.

B. EMPLOYMENT AGREEMENTS

1. General considerations.

a. *What does an agreement accomplish?* An agreement serves the useful purpose of focusing the parties on whether they actually have reached agreement on the terms of employment. Establishing the details of the relationship can minimize the potential for misunderstandings – time commitment, call responsibility, compensation, outside employment, termination and restrictions after employment. The agreement serves as a written record of the deal, which can be important down the road as time passes, memories fade and leadership in the Group changes.

b. *Is the agreement a good idea?* Does the contract reflect what was discussed during the interview? What types of restrictions does the agreement impose? How fast can the Group terminate the agreement? And what happens when the relationship is over? Does the agreement bar you from practicing at the Hospital (or other facilities) where the Group practices or does it broadly limit you from practicing in a designated geographic area? Depending upon the baggage in the agreement, you may be better off without an agreement.

c. *Negotiating strategy*. As a resident or entry-level physician, you may feel that you have relatively little bargaining power and that the chances of accomplishing what you want through negotiation are slim. However trite it sounds, you will not know unless you try. Your success will depend upon several factors, many of which are out of your control, but some of which are in your control.

- *Read through the agreement and sort out what issues are most problematic*.
  - ➡ Read through the contract yourself. Make a copy of the agreement, mark any provisions you do not understand and ask for clarification.

Do not rely on others to identify issues of concern to you.

- ➡ Get a second opinion. Ask a colleague to review the agreement and see what issues or problems the colleague identifies. Sometimes a fresh eye can spot issues that you missed.
- ➡ Be careful in reading, and make certain that you review the definitions. *Defined terms mean what they are defined to mean in the agreement*; do not assume that their ordinary meanings apply.

- Assume that the contract is negotiable and ask for what you want up front. You often have less bargaining power as an employee than as a prospective employee.
- *Do not be overly aggressive in discussing your concerns with the agreement.* Stay calm and focused when discussing your concerns with the agreement.
- *How much is truly negotiable and how much is based on the Group's agreement with the Hospital?* If the Group's agreement with the Hospital has adverse provisions (e.g., termination without cause on short notice or a covenant not to compete), those are certain to be reflected in the employment agreements with physicians and they will not be negotiable. They may be completely objectionable, but if the Group has no flexibility on those points, why waste time?
- *Be selective in identifying your priorities.* If the concern is with a policy that broadly affects all Group employees (e.g., moonlighting or vacation), the Group is far less likely to agree to modifications. Focus on the issues that you have the greatest chance to change, unless the point is of overriding importance to you.
- Do not sign under pressure. Feel comfortable with the agreement before you sign, or at least determine that you have negotiated each provision that is negotiable.

d. *Revising the agreement.* So how do you go about negotiating an agreement, and who should do the negotiating? Absent special considerations, you may well be your own best advocate. Bringing in an outside person to negotiate portions of the agreement is not necessary *unless* you feel uncomfortable. A reasonable alternative may be to review the agreement with an outside adviser, but to conduct your own negotiations. If you are dealing directly with a Group physician in negotiating the agreement, the process may be more manageable than if the Group delegates the contracting process to a nonphysician manager.

The process of revising the agreement can be straightforward. First, make a copy of the agreement so you always have a "clean" copy available. Take the copy of the agreement and edit it in the manner desired. If a provision is wholly unacceptable, delete it. If the provision is acceptable in most circumstances, add a "proviso," a clause that carves out an exception to the general statement (*"provided that this section [insert the section number] shall not apply in the event that [identify the circumstances] . . ."*). If a section is ambiguous, edit it to meet your understanding. In general, you are better off suggesting the language you want rather than simply raising the issue and allowing the Group's counsel to revise the agreement. Marking directly on the agreement allows the Group to see the particular problems you have identified. Make sure to keep a copy of whatever document you finally give to the Group.

If you are uncomfortable revising the agreement yourself or if you have questions about what certain provisions mean, consider consulting counsel. Remember to locate counsel experienced in reviewing employment agreements, preferably agreements in the health care industry.

e. *So what is important?* On a day-to-day basis the employment agreement generally has little impact, as scheduling and case demands

will dictate your duties. As noted above, the employment agreement becomes critical when the employment relationship breaks down or comes to an end. The next section will review the chief areas to consider in an employment agreement.

2. Common contract terminology.

a. *Post-termination restrictions.* If the relationship does not work out, the post-termination limitations on your practice are the provisions that will most significantly restrict your options, possibly even forcing you to relocate.

i. *"Tying" or "clean sweep" provision.*

Sample language: "Tying" or "clean sweep" provision

The Medical Staff appointment and/or clinical privileges of the Employee at the Hospital and at any facility where the Employer provides professional services shall terminate concurrently with the termination or expiration of this Agreement, notwithstanding any provisions of the Hospital or Medical Staff Bylaws relating to notice, hearing, appellate review and/or other rights generally provided to members of the Medical Staff prior to adverse action in respect to Medical Staff appointment and privileges, all of which provisions and rights are hereby expressly waived. The Employee acknowledges that inclusion of this provision is required by the terms of the Hospital Agreement. Any and all such terminations of the Employee's Medical Staff membership and clinical privileges shall be deemed to have been through voluntary resignation.

Tying the continuation of your clinical privileges to the contract (e.g., requiring you to resign your clinical privileges at the Hospital or other facility upon termination of your employment agreement with the Group) means that you no longer can practice at the Hospital once your employment terminates. This restriction is significant, but if the Group has an exclusive contract with the Hospital (or hospitals), you will be shut out of the Hospital without regard to what your employment agreement provides. You also need to determine whether the Group's agreement with the Hospital mandates inclusion of this language in your employment agreement. Many hospitals require that physician groups include this type of provision in their employment agreements in order to minimize the possibility that competing groups of anesthesiologists will try to provide services in the Hospital.

Because of these practical considerations, a tying provision, while important, may drop in relative importance with other negotiating priorities. See the related discussion in Chapter VII, section C.1, page 52.

ii. *Covenant not to compete*. A covenant, or agreement, not to compete with the Group (also known as a restrictive covenant) is an agreement on your part not to practice in a designated geographic area for a specified period of time. A noncompete clause can severely restrict your options if your employment terminates and is likely to be a key negotiating priority. The enforceability of restrictive covenants depends upon state law, but in most states they are enforceable if they are reasonable in geographic scope and time (two years probably is enforceable; five years may not be). This type of provision is one that you should work to eliminate or narrow, particularly if you will be practicing surgical anesthesia rather than pain management.

Some hospitals, concerned about the potential diversion of their patient population to competing ASCs and physicians' offices, restrict the ability of contracted anesthesiologists from providing clinical anesthesia or administrative services (e.g., medical director services) at area facilities. The anesthesiology groups, in turn, must obtain parallel agreements from their employee or contracted physicians. If the Group has this type of restriction in its agreement with the Hospital, it will not have the ability to modify this restriction in its employment agreements.

b. *Clear delineation of responsibilities and time commitment.* How clearly are your responsibilities outlined? Will you have exposure to the full range of cases? If the Group pro-

vides services at more than one location, where will you be assigned? If the Group covers an ASC, you will want to be certain that you rotate through the main ORs to maintain your skills.

If the position is part-time, how is part-time status defined? Are weekends and evenings handled in proportion to the part-time status?

Sample language: Delineation of duties; part-time status

For purposes of this Agreement, the term "part-time" shall mean that the Employee shall render the services set forth herein to the Employer for three-fifths (3/5) of a full-time position, provided, however, that a) if another physician employee is on vacation, the Employee shall provide full-time coverage for that physician employee, and b) the Employee may be required to take more than three-fifths (3/5) of the call on weekends during the term of this Agreement.

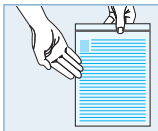
Concerns: Although the agreement is nominally part-time, the Employer has reserved an open-ended ability to require the Employee to fill in on a full-time basis for colleagues who are on vacation. In addition, the Employee's weekend call responsibilities are not proportional to the three-fifths part-time status.

How are scheduling and call coverage addressed? Will you take more call than other physicians in the Group? Will you have lower priority in scheduling? If you have lowest priority in the schedule and compensation is based in whole or in part on productivity, you are likely to be disadvantaged. Does the agreement allow you to delegate call to someone else? What is the response time when you are on call? Finally, does the employment agreement contain a residency requirement related to the call requirement?

c. *Compensation (salary and benefits)*.

i. *Salary*. Compensation obviously is important, but it should not be the key issue. Is the level of your compensation clear? Will you receive a bonus and on what basis, or is the *award* of a bonus entirely within the Group's discretion? Is the *amount* of a bonus based upon a formula or is it also within the Group's discretion? Who keeps any outside income you earn (e.g., honoraria, expert witness fees)? Beyond your own compensation, it also is important to understand how the "partners" (who more likely are shareholders rather than partners) are compensated – not the level of compensation, but the methodology. Do they receive equal compensation, or is compensation productivity-based? How is productivity measured, and is nonclinical time included in the mix? Is the risk of the payor mix blended (e.g., do the physicians receive the actual collections from the cases they perform, or is the money pooled and then the average unit value calculated)? This last point is important, because if the funds are not pooled, it can lead to competition for cases and tension within the Group.

Understand *when* your compensation is payable. If compensation is expressed as a lump-sum amount, the contract should state that that amount is payable in equal installments. If your income will be based on a percentage of the Group's net income, make sure you understand how "net" is defined. What expenses are deducted from the Group's gross income to arrive at net income? In general, you should be wary of complicated formulae used to determine your income. The Group will be in control of the calculations, and it will be difficult for you to predict your level of income. If you have no choice, consider two protections: retain the ability to require an accounting to determine accuracy of calculations, and provide a base level below which your income cannot go (*"provided that in no case shall Employee's annual salary be less than $[amount]"*).



Sample language: Compensation before revision:

Employer will pay Employee one hundred twenty-five thousand dollars ($125,000) per year.

(Continued on next page)

(Continued from previous page)

After revision:

Employer will pay Employee one hundred twenty-five thousand dollars ($125,000) per year to be paid in equal semimonthly installments on the 15th and 30th day of each month, beginning with the first month in which Employee provides services to Employer.

ii. *Fringe benefits*. The type and scope of fringe benefits can be a significant component of compensation and deserve attention. If the benefits are vaguely described (e.g., "such benefits as Employer provides to all employees"), the benefits are subject to change. Make sure you understand the *extent of employee contribution* to benefits. Although disability may seem a long way off, disability coverage is important and you should understand how "disability" is defined, when benefits are payable (is there a waiting period?), how long they are payable and whether the benefits will be taxable. What type of pension plan is offered? What is the vesting period and what are the eligibility rules for contribution?

As discussed above in the section regarding insurance coverage (see Chapter IV, section D.2.c, page 16, and D.4, page 17), you should consider the tax consequences associated with paying premiums with before-tax versus after-tax dollars.

d. *Opportunity for advancement*. The future often is not addressed in an employment agreement and for good reason. From the Group's perspective, it does not want to be tied down to a commitment of advancement to a relative stranger. Even if an agreement purports to address shareholder status or the time frame to consideration, recognize the limitations of the Group's commitment. *Its promise to advance you terminates along with the agreement* (unless the clause expressly provides that it survives termination). The Group's historical practice and the experience of the younger physicians in the Group may be the best practical source of information regarding what the future will hold.

If the agreement addresses advancement, examine how specific the commitments are. Is the Group agreeing that you will become a shareholder or an equal shareholder with the same voting and compensation as other shareholders? An agreement to become a shareholder may not be what it seems if the Group has different classes of shareholders with different voting and different dividend rights. Has the Group addressed a buy-in (i.e., an amount you will be obligated to pay to "buy into" the Group)? That amount may be addressed in the shareholders' agreement, which may be amended before you are eligible for advancement. Also, what is the basis of the buy-in? If the Group practices only at one hospital and has an exclusive contract with the Hospital that is terminable without cause on relatively short notice, and if the contract ties the clinical privileges of Group members to the agreement, the buy-in should reflect the relatively precarious nature of the Group's position.

In negotiating provisions in this area, be mindful of the impression you are making and balance the importance of specificity on these issues with the potential for creating an adverse impression.

e. *Liability insurance*. In most employment situations, the employer purchases the malpractice coverage for the employee physician. Check whether the cost of the coverage is deducted from your compensation or is otherwise charged to you. What type of coverage will be purchased – "claims-made" or "occurrence"? (See discussion of liability insurance in Chapter IV, section B, beginning on page 11.) If the coverage is "claims-made," are you required to purchase tail coverage? How much will that tail coverage cost, and is the Group reserving the right to deduct the cost of tail coverage from your final pay check? What about so-called "nose" coverage for your practice prior to coming to the Group? If your only practice has been as part of the residency program, nose coverage is unlikely to be required.

Suggestion: If you are required to purchase tail coverage, you may want to limit the circumstances in which that obligation applies by providing that the Group must purchase tail coverage if it exercises its option to terminate the agreement without cause. That provision may serve as a practical limitation on the otherwise unlimited ability of the Group to terminate you without cause (if such a provision is included in the agreement).

f. *What do you know about the Group?* An employment relationship is one of the most important relationships you will have. Make sure you know what you're getting into before you sign the agreement.

- Does the Group have a contract with the Hospital or other facilities at which it practices? What is the nature of that agreement?

Issue: It is important for you to know about the Group's agreement with the Hospital, but how do you get a copy? Most Groups will be reluctant to share a copy of their agreement with a prospective employee. You may need to settle for asking questions regarding the nature of the agreement. The most important issues are 1) how long has the agreement been in effect and when does it expire; 2) is it terminable without cause and, if so, on how much notice; 3) are privileges tied to the agreement; and 4) does it restrict the Group from providing services at other facilities?

As a reality check, you also will want to know the general history of the Group's relationship with the Hospital, including how long the Group has been providing services at the Hospital, with or without an agreement, and whether there have been particular problems with the Hospital over specific issues.

Another useful source of information is the Hospital's relationship with other hospital-based physicians. Have there been issues with other departments and how have those issues been resolved?

- Does the Group have a reputation for hiring physicians and turning them over after a short period?
- *What is the relationship among Group members*? Is the Group collegial, or are there feuding factions?
- Does the Group practice in a care team mode? What is the typical medical direction ratio? Are you comfortable practicing in that environment? What is the relationship between Group members and the nurse anesthetists? Does the Group employ the nurse anesthetists and has it always done so, or did the Hospital employ them at one point? Were there any issues or problems when the Group assumed responsibility for employing the nurse anesthetists?
- Does the Group have a knowledgeable practice manager and sophisticated information management systems?
- Has the Group focused on billing compliance issues?
- Has the income of Group members gone down in recent years and, if so, why?

These issues are by no means a complete list of all points to consider, but they all are ones that you should understand before you agree to join. Careful checking in the first instance can save unhappy discoveries later.

g. *Corporate practice of medicine*. A few states, notably California, Texas, Ohio and Colorado, follow a rule known as the "corporate practice of medicine" that prohibits corporations from employing physicians. The concern underlying this doctrine is based on public policy: Corporate involvement in the practice of medicine would commercialize the profession and threaten physician autonomy. The rationale is that physicians would not be free to exercise their professional judgment if they were required to answer to nonphysician corporate employers as their first allegiance would be to the corporation, not to the patient. By way of example, the corporate practice of medicine doctrine would prohibit HMO, hospital or other health care corporations from employing physicians.

In some states other than California, Texas, Ohio and Colorado, vestiges of the corporate practice of medicine doctrine still survive in

some form. Even in states recognizing this doctrine, enforcement has been lax and this doctrine tends to be more of a relic than a current restriction. Almost every state allows the practice of medicine by corporations that are limited to individuals who are licensed practitioners. The law also usually permits the practice by HMOs and, in some instances, nonprofit corporations.

In summary, the precise law governing the corporate practice of medicine will vary from state to state. Although the reach of the corporate practice of medicine doctrine is somewhat limited, its existence is still worth noting.

h. *Conclusion*. Make sure you understand the deal you are getting before you sign, not when problems have arisen and you are assessing your options. Even if you make only moderate progress in negotiating adverse provisions in the agreement, understanding the dynamics of how the agreement can operate if tensions develop can empower you to select your course of action more wisely.

Resource reference

See additional discussion of employment agreements in *Contracting Issues: A Primer for Anesthesiologists* (pages 37-47).

C. CONTRACTS WITH HOSPITALS AND AMBULATORY SURGICAL CENTERS.

Resource reference

This subject is addressed in detail in Part Three, Section I of *Contracting Issues: A Primer for Anesthesiologists* (pages 57- 69).

1. Medical staff membership and clinical privileges issues. A "clean sweep" or other clause that ties a physician's privileges to the existence of the agreement and provides for automatic termination of those privileges upon termination of the agreement is a common, but distinctly disadvantageous, provision. A legitimate question is what the Hospital can do in the absence of that language.

In general, ousted physicians have had little meaningful legal recourse when the hospitals at which they have practiced have entered into exclusive contracts with other providers. Courts tend to defer to the decision of a hospital to "close" a department and enter into an exclusive agreement with a group of physicians, even if existing physicians on staff are forced out by that decision, so long as the decision is a business, or administrative, decision. Even when a hospital is transitioning from an "open" department to a "closed" department, courts often conclude that the right to a hearing under the Medical Staff bylaws is not triggered unless the exclusion of a physician is based upon concerns with the particular physician's performance or conduct.

It is extremely rare for courts to grant relief to excluded physicians. If they do, there often are unique facts supporting the grant of relief or there is a helpful state law (e.g., Florida law requires the Medical Staff to review all applications for appointment and reappointment to the Medical Staff and provides for a right to a hearing; see page 28). Moreover, it may be harder to obtain relief when the excluded physicians have themselves previously been the beneficiaries of an exclusive contract. In some cases, courts have ruled that the excluded physician is entitled to a hearing. Such a hearing is of limited utility, however, when the Hospital makes an administrative decision to contract with another physician group.

Thus, even in the absence of language "tying" the clinical privileges of Group physicians to the contract, a hospital generally is able to do much the same thing – enter into an exclusive arrangement with another group and force out Group anesthesiologists. Given the generally unfavorable case law, you may wonder why you should not simply concede this issue and focus on other important issues in a draft agreement. *It is important to understand*

the decided shift in power that occurs in favor of the Hospital if a Group agrees to inclusion of tying language. No matter how favorable other contractual provisions may be, if the Hospital asks the Group to take action – e.g., to sign a particular managed care agreement or to provide an additional anesthesiologist to staff an underutilized operating room – and the Group objects, the Group will always be under pressure to yield to the Hospital's request, or to risk the possibility that the Group will be displaced upon termination of the agreement.

Beware of seemingly innocuous language that does not tie the clinical privileges of Group members to the agreement but which may limit their ability to challenge a Hospital's entry into an exclusive agreement with another group (e.g., "upon termination of the agreement, *the Group acknowledges the Hospital's ability to enter into an exclusive contract with another anesthesiology group")*. While apparently merely a restatement of the obvious, this language can undercut the ability of the Group to challenge a subsequent exclusive contract arrangement. When excluded physicians are unable to exercise their clinical privileges as a result of an exclusive contract between a hospital and another physician group, the theory underlying the claim of the excluded physicians for relief is that they had the *expectation* of continuing to be able to provide services at the Hospital and that the exclusive agreement with the other group interferes with that expectation and *deprives Group physicians of a legitimate property right*.

The language under discussion would bar Group physicians from making such an argument – whether framed as a claim for denial of due process, violation of a federal Constitutional right or a state constitutional right or other interference with business expectation – by acknowledging that they can be displaced upon termination of the agreement. Once you acknowledge that you can be displaced, you can hardly claim later that you never expected that contingency to occur. Thus, although the proposed language does not "tie" the clinical privileges of Group physicians to the contract, it has much the same effect.

Once a Group "gives" on the privileges issue, the Group will have to live with that position in all future negotiations. It will be difficult, if not impossible, for the Group to negotiate for deletion of the language. Where possible and consistent with other negotiating priorities, the Group is best advised to preserve its independence by not agreeing to inclusion of "tying" or other similar language.

2. Requests for proposal.

a. *In general*. Hospitals and ASCs are increasingly using the mechanism of a request for proposal (RFP) or similar competitive bidding process to solicit proposals for coverage of their anesthesiology needs. Whereas use of RFPs once was reserved for staffing of new facilities, it increasingly is being used for coverage of existing facilities. Issuance of an RFP often signals problems in the relationship between the existing anesthesiology Group and the Hospital or ASC administration. Even in the case of a new facility being opened by an established hospital, a Hospital's use of an RFP rather than inviting its existing Group to provide services is usually not a positive indication.

b. *The "nonconforming bid" strategy*. Hospitals and ASCs sometimes use the RFP process as a means to bypass the negotiation process. The RFP will contain either a list of contractual terms or an agreement for services to which the responding party must agree in its proposal. A more sinister permutation of this strategy is to deem all proposals not containing an unqualified agreement to all contractual terms nonresponsive and therefore not subject to consideration. This procedure collapses what would otherwise be a contract negotiation into a requirement that the proposals submitted agree to all terms set forth in the RFP. The consequence for objecting to any one element of the RFP or proposing to modify a requirement is that the Group's entire proposal is deemed nonresponsive and therefore is not con-

sidered. By including problematic provisions, including ones relating to tying clinical privileges to the contract, restricting the Group's practice at other facilities, and requiring the Group to sign participation agreements with any payor the Hospital designates, the Hospital avoids negotiations on difficult issues.

c. *Responding to an RFP*. In the absence of a requirement that bidders agree to all points in the RFP, the Group will have some flexibility to structure its proposal. In order to prepare a winning proposal, the Group will need to try to distinguish its services from those of competing bidders. To do so, the proposal may need to go beyond the requirements set forth in the RFP.

i. *Substantive suggestions*.

A. *Summarize salient features of the proposal at the outset*. The Group may want to consider a brief summary at the outset that identifies key advantages or features of its proposal.

B. *Highlight additional credentials*. In describing the Group's qualifications, the proposal should identify any special qualifications of Group anesthesiologists, such as fellowship training in anesthesiology subspecialties and Board certification in specialties other than anesthesiology.

C. *Discuss proposals to improve operations*. If the Group is already providing services at the facility, it should consider including a section regarding its ideas to improve operation of the anesthesiology department. It should identify operational and coverage goals, highlighting the services that it will offer. If the Group can identify ways in which it can assist the Hospital or ASC to save money, it should include those ideas (e.g., reducing turnover time of ORs or working with the pharmacy department to ensure precise accounting for and billing of all drugs).

ii. *Procedural suggestions*. If the RFP sets forth specific requirements, the Group should respond point-by-point in a manner that makes clear that all mandated responses are included. Any required attachments should be clearly labeled as part of the proposal. Finally, the Group should identify a contact person for the proposal, along with telephone and beeper numbers, to allow the Hospital or ASC to follow up with questions.

iii. *The proposal as a marketing document*. A proposal responding to an RFP is a form of marketing document and should be structured as one. It should be prepared in a manner that makes it as readable as possible, with important text emphasized to allow for quick review of the document. If the Group is willing to provide service that goes beyond the requirements in the RFP, such as in-house coverage of particular units or services, those features of the proposal should be highlighted for emphasis.

iv. *Professional assistance or review is advisable*. The Group should consider obtaining professional assistance in preparing its response, or at a minimum to review and critique its response, particularly if the opportunity is a critically important one for the Group.

D. CONTRACTING WITH MANAGED CARE ORGANIZATIONS (MCOS)

Managed care contracting has become an important part of most anesthesiology practices. As hospitals and ASCs face decreasing inpatient volume and compete for patient populations, they look to their hospital-based physicians to join with them in participating with MCOs. You need to understand which provisions in managed care contracts can have the greatest impact on your practice, so that you can negotiate the best managed care agreements possible.

Resource reference

This subject is addressed in detail in the ASA publications titled *Managed Care Contracting: Considerations for Anesthesiologists and Calculating Anesthesia Capitation Rates.*

An MCO may propose compensation

(Continued on next page)

(Continued from previous page)

based upon the Medicare resource-based relative value scale (RBRVS) or a Hospital may propose to use the Medicare physician fee schedule as a basis for building a package price arrangement. The RBRVS has undervalued anesthesiology services since its inception. A monograph titled *Medicare & Anesthesia Reimbursement Methods: Why the Medicare Fee Schedule Is the Wrong Benchmark for Commercial Anesthesia Payments* (1998), which is available in booklet and electronic (slide) formats from the ASA Publications Department, contains numerous arguments against use of the RBRVS as a benchmark for compensation for anesthesiology services.

E. AN INTRODUCTION TO ANTITRUST LAW

Federal and state antitrust laws are designed to promote competition in the provision of goods and services, including medical services. Antitrust law is designed to preserve the free-market system by prohibiting activities – such as price fixing among competitors or concerted boycotts against competitors – the purpose or effect of which is to restrain free trade. Both the federal government and private parties have used the antitrust laws to challenge business arrangements between physicians and others, including exclusive contracts between hospitals and physicians and physician integration efforts. Accordingly, it is important for physicians to understand how the antitrust laws may apply to their practices.

Resource reference

This subject is addressed in detail in the ASA publication titled *Managed Care Contracting: Considerations for Anesthesiologists (*pages 65-72).

F. CONTRACTS WITH OUTSIDE MEDICAL BILLING SERVICES

Physicians have two choices to collect compensation for their professional services: hire their own employees to prepare and submit bills or retain an outside billing company. Agreements with outside (or third-party) billing companies are important from both a practical perspective, because physicians want to collect all of the compensation to which they are entitled, and a legal viewpoint, because the federal government is concerned that outside billing agents may try to falsify claims for services in an effort to increase reimbursement. The OIG's *Compliance Program Guidance for Third-Party Medical Billing Companies* requires that the responsibilities of the billing company and the physician be formalized in a written contract that identifies which functions are shared responsibilities and which functions are the sole responsibility of one of the parties.

Resource reference

This subject is addressed in detail in the ASA publication titled *Contracting Issues: A Primer for Anesthesiologists (*pages 73-77).

VIII. SUBSTANCE ABUSE

A. GENERAL INFORMATION

1. Nature of the disease. Chemical dependence is one form of impairment that may occur in anesthesiologists and other physicians. It presents risks to the public, the physician, the family, the Hospital and the professional colleagues of the physician. It is a chronic, relapsing disease that affects individuals in all social strata and in all walks of life. Although it occurs no more frequently among physicians than it does in the general public, chemical dependence is particularly noticeable when it occurs in professionals. For an addiction to develop, there must be a drug that is readily available and an urge to use that drug. The *urge* is genetic and behavioral in origin; *availability* is situational. To become an addict, the physician must have an inherent susceptibility to the disease and must be able to obtain drugs. Drug type and availability are usually dictated by the physician's medical specialty.

2. Progression of the disease. The disease is progressive, with the speed of onset depending upon the "drug of choice." While addiction to alcohol may take decades to become apparent, addiction to potent opioids frequently becomes apparent within weeks. Unless the disease is recognized and treated appropriately, it will result in social, psychological and physical harm to the abuser, and may end in death.

3. Incidence. Although there are no precise data regarding the prevalence of dependence on alcohol and other drugs in anesthesiologists, recent survey data indicate that in anesthesiology training programs in the United States, the disease appears at a rate of about 0.5 percent per year in all personnel in those programs (*ASA Survey of Chemical Dependence in Anesthesiology Training Programs in the United States: 1986-1995*. Analysis of those data and preparation of a report are in progress). As yet, there are no similar data for anesthesiologists in private practice. Both the survey data and reports from treatment centers have clearly shown that the potent opioids, *fentanyl* and *sufentanil*, are the drugs most frequently abused by anesthesiologists, making up about 70 percent of cases. Alcohol and cocaine each accounted for about 10 percent of the cases, while the remainder were divided nearly evenly among several other drugs, including benzodiazepines, potent inhalation agents, nitrous oxide, sodium thiopental, lidocaine and propofol.

4. Detection. Early detection is usually difficult since the signs and symptoms of dependency are frequently quite subtle until the later stages of addiction have developed. Identification is also hampered by the overwhelming *denial* of the disease, not only by the addict but also by colleagues and family members. Self-reporting is unusual, in large part because of denial and also due to the fear of losing one's job, one's license to practice medicine and the respect of others. See Tables 1 and 2, beginning next page.

5. Addiction. *Addiction* is the *overwhelming compulsion to use drugs in spite of adverse consequences*. It is a chronic, progressive disease that results in loss of control of one's life. Unless it is recognized and treated skillfully, addiction will result in disability and

will often end with death. Physical dependence frequently develops but is not present in all drug addictions.

Drug abuse involves the *inappropriate use of drugs* (including alcohol), but is not accompanied by the uncontrolled compulsion seen with addictions. The person who is arrested for driving under the influence of alcohol, who realizes the transgression and is able to avoid further incidents, has *abused* the drug. In contrast, the person who irrationally blames the arrest on outside influences such as the officer's career goals, and who continues drinking uncontrollably, is addicted.

Table 1: What to Look for Inside the Hospital

1. Addicts sign out ever-increasing quantities of narcotics.
2. Addicts frequently have unusual changes in behavior, such as wide mood swings, periods of depression, anger and irritability alternating with periods of euphoria.
3. Charting may become increasingly sloppy and unreadable.
4. Addicts often sign out narcotics in inappropriately high doses for the operation being performed.
5. They refuse lunch and coffee relief.
6. Addicts like to work alone in order to use anesthetic techniques without narcotics, falsify records and divert drugs for personal use.
7. They volunteer for extra cases, often where large amounts of narcotics are available (e.g., cardiac cases).
8. They frequently relieve others.
9. They are often at the hospital when off duty, staying close to their drug supply to prevent withdrawal.
10. They volunteer frequently for extra call.
11. They are often difficult to find between cases, taking short naps after using.
12. Addicted anesthesia personnel may insist on personally administering narcotics in the recover room.
13. Addicts make frequent requests for bathroom relief. This is usually where they use drugs.
14. Addicts may wear long-sleeved gowns to hide needle tracks and also to combat the subjective feeling of cold they experience when using narcotics.
15. Narcotic addicts often have pinpoint pupils.
16. An addict's patients may come into the recovery room complaining of pain out of proportion to the amount of narcotic charted on the anesthesia record.
17. Weight loss and pale skin are also common signs of addiction.
18. Addicts may be seen injecting drugs.
19. Untreated addicts are found comatose.
20. Undetected addicts are found dead.

Table 2: What to Look for Outside the Hospital

1. Addiction is a disease of loneliness and isolation. Addicts quickly withdraw from family, friends and leisure activities.
2. Addicts have unusual changes in behavior, including wide mood swings, periods of depression, anger and irritability alternating with periods of euphoria.

(Continued on next page)

(Continued from previous page)

3. Unexplained over-spending, legal problems (such as DWIs), gambling, extramarital affairs and increased problems at work are commonly seen in addicts.
4. An obvious physical sign of alcoholism is the frequent smell of alcohol on the breath.
5. Domestic strife, fights and arguments may increase in number and intensity.
6. Sexual drive may significantly decrease.
7. Children may develop behavioral problems.
8. Some addicts frequently change jobs over a period of several years in an attempt to find a "geographic cure" for their disease or to hide it from coworkers.
9. Addicts need to be near their drug source. For a health care professional, this means long hours at the hospital even when off duty. For alcoholics, it means calling in sick to work. Alcoholics may disappear without explanation to bars or hiding places to drink secretly.
10. Addicts may suddenly develop the habit of locking themselves in the bathroom or other rooms while they are using drugs.
11. Addicts frequently hide pills, syringes or alcohol bottles around the house.
12. Persons who inject drugs may leave bloody swabs and syringes containing blood-tinged liquid in conspicuous places.
13. Addicts may display evidence of withdrawal, especially diaphoresis (sweating) and tremors.
14. Narcotic addicts often have pinpoint pupils.
15. Weight loss and pale skin are also common signs of addiction.
16. Addicts may be seen injecting drugs.
17. Tragically, some addicts are found comatose or dead before any of these signs have been recognized by others.

[Tables 1 & 2 are adapted from Farley, WJ & Arnold, WP: Videotape: Unmasking Addiction: Chemical Dependency in Anesthesiology (1991). Produced by Davids Productions, Parsippany, NJ, and funded by Janssen Pharmaceutical, Piscataway, NJ.)]

B. GATHERING INFORMATION AND REPORTING THE FINDINGS

1. The information-gathering process. The presence of behavioral changes suggestive of chemical dependence raises a suspicion, but should never be construed as conclusive proof of drug abuse. When the disease is suspected, however, it is important that the possibility be investigated in an expeditious, but caring and confidential manner.

Suspicion of a drug problem should be reported, but it is crucial that it be reported to the proper person or committee. Depending upon the particular institution, the appropriate channel may be the Physician Well-Being Committee or similar committee of the state medical society, a peer assistance committee, the department's chair, a direct supervisor or other relevant individual. It should be the responsibility of this person to investigate confidentially the available information and to seek corroborating documentation. The investigation may involve interviews with associates, colleagues, family members, friends and others acquainted with the person in question as well as a review of anesthetic and pharmacy records.

For the protection of the suspected addict, it is important not to go directly to police or other authority whose prime charge is to prosecute. Anyone who has diverted controlled drugs for personal use has legally committed a felony and is subject to criminal prosecution. At the same time, this individual is acutely ill and is

urgently in need of treatment. Prosecution may be in the addict's future, but treatment should be the primary intent of the initial investigation.

2. Potential legal issues. Laws regarding chemical dependence in physicians vary from state to state. Some require that all cases of chemical dependence in physicians be reported, some mandate reporting abuse of all drugs except alcohol and others have no statutory requirement to report impaired physicians at all. Laws that demand reporting directly to regulatory boards rather than to advocacy committees may tend to cripple the activities of committees whose goal is to assist the ill physician. As a result, unless the aim of the board is advocacy, few physicians in these states will receive the needed medical care. Although impairment is not primarily a legal issue, if questions arise regarding specific methods of management, it is imperative for those concerned to contact the medical society in the state of record.

Hospitals, medical staffs and individual physicians have occasionally been found negligent for failure to monitor or restrict the privileges of an impaired physician. To be aware of and yet to ignore chemical dependence may result in legal liability. That is the basis of the "snitch law" that is enforced in some states. If reasonable care is taken to see that an impaired physician is identified and treated in accordance with accepted medical practice, liability, other than possible imputed liability for any malpractice engaged in by the impaired physician, is generally reduced or eliminated.

In most states, legislation provides immunity from liability to members of a professional society or Medical Staff committee whose purpose is to review the quality of medical services. Persons who give information to such committees are also usually granted immunity, providing they believe the information is true, they are not reporting it with malice and they discuss it only with the committee.

C. RETURN TO WORK

Whether a recovering anesthesiologist should return to the practice of anesthesiology is a hotly debated topic for which there are no firm answers. The attitudes of departmental colleagues, surgeons, other members of the Medical Staff and the administrators of the Hospital play a major role. If these individuals are unwilling to accept the recovering physician and the stipulations outlined in the aftercare contract, then the likelihood of successful return will be slim. On the other hand, if they have a basic understanding of the disease of addiction and are amenable to gradual return to work in keeping with the contract, then the outcome in most cases will be positive.

The potential for successful return to work may be in part related to the drug of abuse. Preliminary analysis of data obtained in the ASA *Survey of Chemical Dependence in Anesthesiology Training Programs In the United States: 1986-1995* indicate that only about 50 percent of physicians with a history of fentanyl abuse returned to the specialty following treatment. Of those who returned, nearly half were terminated either voluntarily or involuntarily. In that group, the apparent relapse rate was nearly 20 percent per year over a maximum period of 18 months. In contrast, for those who abused nonopioid drugs, the relapse rate was about 4 percent per year. These figures must be regarded with caution since they do not take into account the length and type of treatment, the willingness of the department to accept the individual and other factors that are felt to be important to long-term recovery.

Resource reference

If the Hospital or the Group decides not to permit the recovering anesthesiologist to return to practice *solely* on the basis of the physician's history of addiction, either may be vulnerable to legal action by the anesthesiologist for illegal discrimination on the basis of disability. See discussion of the Americans with Disabilities Act in *Contracting Issues: A Primer for Anesthesiologists* (pages 42-43).

The American Board of Anesthesiology's (ABA) Policy on Alcoholism and Substance Abuse

The following ABA policy (6.01) applies to candidates in the certification process.

"The Americans with Disabilities Act (ADA) protects individuals with a history of alcoholism or substance abuse who are not currently abusing alcohol or using drugs illegally. The ABA supports the intent of the ADA.

The ABA will admit qualified applicants and candidates with a history of alcoholism to its examination system and to examination if, in response to its inquiries, the ABA receives acceptable documentation that they do not currently pose a direct threat to the health and safety of others.

The ABA will admit qualified applicants and candidates with a history of illegal use of drugs to its examination system and to examination if, in response to its inquiries, the ABA receives acceptable documentation that they are not currently engaged in the illegal use of drugs.

After a candidate with a history of alcoholism or illegal use of drugs satisfies the examination requirements for certification, the ABA will determine whether it should defer awarding its certification to the candidate for a period of time to avoid certifying a candidate who poses a direct threat to the health and safety of others. If the ABA determines that deferral of the candidate's certification is appropriate because the candidate does currently pose a threat to the health and safety of others, the ABA will assess the specific circumstances of the candidate's history of alcoholism or illegal use of drugs to determine when the candidate should write the Board to request issuance of its certification."

Source: The American Board of Anesthesiology. Booklet of Information. December 1998.

D. WHERE TO GO FOR HELP

Nearly every state medical society has a program for the identification and management of chemically dependent physicians. Most will provide assistance with confidential investigation, intervention, treatment referral and aftercare monitoring and will advocate for the recovering physician in matters of interest to the state board of medicine. A telephone call to the medical society in your state will begin this important process.

Resource reference

The telephone number for the ASA's Hotline on Chemical Dependence is 847-825-5586. It is printed at the bottom of the inside cover of every edition of the *ASA Newsletter*. With attention to strict confidentiality, personnel will provide callers with the appropriate telephone numbers for their locality and if possible will offer the name of a confidential consultant who can provide additional information and resources.

IX. PAYMENT FOR SERVICES, THE MEDICARE PROGRAM AND OTHER GOVERNMENTAL PROGRAMS

THE ASA RELATIVE VALUE GUIDE (RVG)

1. The origin of the ASA RVG. The origin of the ASA relative value guide (or RVG) can be traced to the post-World War II years when anesthesiology was still a new specialty and insurers approached ASA seeking to have some consistency be brought to the many billing methods used by anesthesiologists. The system that evolved, which has been modified in many ways, accounts for two primary elements: 1) the anesthetic risk and difficulty of the procedure, which are reflected in the "basic" (often referred to as "base") units, and 2) the time for the surgical procedure, which is not under the anesthesiologist's control. Over time, unit values ("modifier" units) were added to account for the patient's *physical status* and *qualifying circumstances* that present additional risk factors and significantly affect the nature of the anesthetic service provided. The physical status modifiers provide compensation for the additional difficulty presented by a patient with severe systemic disease; the qualifying circumstances modifiers account for the patient's age, as well as for specific conditions such as hypothermia and controlled hypotension.

In 1970, the RVG was modified from a system based on surgical procedures to one based on anatomical systems and regions. The purposes of the revision were several: 1) make the RVG less voluminous, 2) simplify billing by grouping many procedures together and 3) separate anesthetic from surgical procedures.

2. The current RVG. In the recent editions of the ASA RVG, each anesthesia code is assigned a basic unit value that accounts for the difficulty of physician work involved in each anesthetic procedure. Currently, there are approximately 250 anesthesia codes. The basic units vary from a low of three units for anesthesia for simpler anesthetic procedures to a high of 30 units for anesthesia for transplant procedures.

Anesthesia Payment
At a Glance

(Base units + time units + modifier units) x Conversion Factor = Charge

(Note that payment will not necessarily correspond to your charge)

The conversion factor is the dollars and cents multiplier (e.g., $34.50) by which the sum of the base, time and modifier units is multiplied to calculate the charge for anesthesiology services.

The ASA RVG is not the only relative value guide available. Other companies, including St. Anthony's (which now publishes the "McGraw-Hill" RVG), publish relative value guides. Anesthesiologists in general and ASA members in particular are not required to use the ASA RVG. In fact, an anesthesiologist is free to exercise personal judgment and to develop a separate RVG or to charge for professional services using another methodology. The ASA RVG is, however, widely accepted, which provides a certain degree of credibility. If you choose to use another relative value guide, you may wish to confirm that the base units allocated for the services you most commonly provide

are adequate. Beware of efforts by managed care organizations to use proprietary relative value guide systems that they have developed that they will not share with you and which may undervalue the difficulty of the anesthesiology services you provide.

Finally, it bears mention that the ASA RVG represents a "fee-for-service" payment methodology. Some managed care payors, and indeed some anesthesiology groups, are moving to different payment methodologies that may rely in part on the ASA RVG (e.g., flat fee payment for particular anesthesiology services, with the flat fee based on the Group's average number of base, time and modifier units for the procedure), or may be entirely independent of a fee-for-service methodology (e.g., capitation, which provides a fixed payment, often expressed in terms of a fee "per member, per month" that does not vary in proportion to the actual volume of services provided).

Resource reference

For more information on these methodologies and how to evaluate the level of payment realized, see the ASA publications titled *Calculating Anesthesia Capitation Rates* (1996) and *Managed Care Reimbursement Mechanisms: A Guide for Anesthesiologists* (1994).

a. *What is included in a basic, or base, unit*? The basic unit reflects the value of all usual physician anesthesiology services except the time actually spent in anesthesia care and modifying factors. Specifically, the basic unit value includes usual preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care and interpretation of noninvasive monitoring such as ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry readings.

b. *Time units*. Time units are added to the basic value and modifying units. Anesthesia time starts when the physician begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the physician is no longer in personal attendance, which is when the patient may safely be placed under postoperative care. This definition *excludes* time spent by the anesthesiologist with the patient both before and after the perioperative period for the purpose of preoperative evaluation and usual required postoperative visits and notes. This care is included in the basic units.

i. *Medicare*. For purposes of Medicare, time units are defined as 15-minute increments involving the "continuous actual presence" of the anesthesiologist or nurse anesthetist. Under current policy, fractions of time units are rounded to the nearest tenth of a unit.

ii. *Non-Medicare and commercial payors*. The ASA RVG refers to time units being calculated "as customary in the local area." Anesthesiologists and payors use time units of differing sizes to calculate reimbursement. Anesthesiologists typically use either a ten-minute or 15-minute time unit. The limitation on establishing a time unit is a practical one – what will a payor accept? Some payors look to Medicare and use 15-minute time units, but others measure time in increments that may vary from five minutes to 30 minutes. Payors also handle fractions of units in different ways, so it is important to understand how you will be compensated for those partial units. Some payors will pay a full unit for any portion of a time unit; this was the original Medicare methodology for payment for fractions of time units. Other payors set a threshold (e.g., five or seven minutes) below which no payment is made for time and above which a full unit is paid, even if the time is less than 15 minutes.

When entering into any contractual arrangement, make certain you understand how time will be calculated. What is the *size* of the time unit (expressed in minutes), how are *fractions* of time compensated, and how is anesthesia time *defined?*

c. *Modifier units*. Modifier units take into account the physical status of the patient and qualifying circumstances that significantly impact on the character of the anesthetic service provided. The physical status modifiers range from a unit value of one for a patient with severe systemic disease to a unit value of three for a moribund patient who is not expected to survive without surgery. The qualifying circumstances modifiers range from a unit value of one for a patient who is under one year or over 70 years to a unit value of five for anesthesia complicated by utilization of controlled hypotension or total body hypothermia. Other modifiers pertaining to unusual services are subject to individual consideration.

Medicare does not compensate physicians for modifier units. Private insurers vary in the degree to which they will accept modifier units.

d. *Ancillary services*. A number of the CPT-4 codes that anesthesiologists routinely bill – including placement of arterial lines, central venous catheters and Swan Ganz catheters, and performance of various nerve blocks – are included in the ASA RVG. They have been assigned basic unit values but have no time component. HCFA, however, pays for them as surgical procedures and not under the ASA RVG.

e. *Multiple procedures*. If the anesthesiologist is involved in multiple anesthesia services for the same patient during the same operative session, payment is made according to i) the basic unit associated with the anesthesia procedure having the highest basic unit value and ii) the anesthesia time that encompasses the multiple procedures. HCFA has incorporated this methodology for multiple procedures.

B. AN INTRODUCTION TO MEDICARE

1. In general. The federal Medicare program compensates beneficiaries, hospitals, physicians and other classes of providers for covered services. The program is divided into two parts: Part A covers inpatient hospitalization, skilled nursing facility, hospice and home health agency care. Part B covers services and goods provided by physicians and certain other categories of health practitioners. HCFA (renamed CMS in June 2001) is the federal agency within HHS responsible for administering the Medicare program. HCFA obtains claims processing services from contractors known as "intermediaries" under Part A and "carriers" under Part B. Intermediaries and carriers generally are private insurance companies that serve as federal government contractors.

Medicare beneficiaries include eligible persons ages 65 and older, and certain disabled persons without regard to age.

2. Reimbursement.

a. *Reimbursement of hospitals*. Until 1983, the standard Medicare reimbursement for hospitals and other Part A providers was based on the lower of the costs of, or charges for, services. Beginning in fiscal year 1984, hospitals began to receive payment for Part A services under a prospective payment system based on "diagnosis-related groups" (or DRGs) of illnesses. Each patient condition is classified into a DRG, to which HCFA has assigned a numerical weight representing the relative hospital resources necessary to treat the average case in that DRG. Payment is based on that weight times the sum of labor-related and nonlabor-related standardized amounts.

b. *Reimbursement of physicians*.

i. *Pre-1992 "reasonable charge" reimbursement*. Until 1992, physicians were reimbursed on a "reasonable charge" basis. The reasonable charge could not exceed the lesser of the actual charge or the customary charge in the locality (which was keyed at the 75th percentile of all customary charges) and was subject to the Medicare Maximum Allowable Actual Charge (MAAC).

ii. *Physician fee schedule*. In 1992, Medicare began to reimburse physicians on the basis of a national physician fee schedule that is based on an RBRVS system. Under the physician fee schedule that is updated each year, physicians are reimbursed on the basis of relative value units (RVUs) and a conversion

Medicare Reimbursement *At a Glance*

Sum of:	Relative value* for work + Relative value* for practice expenses + Relative value* for professional liability insurance
Multiplied by:	Conversion factor
Equals:	PAYMENT

***Note:** Each relative value is adjusted using a geographic practice cost index (GPCI) for that particular relative value.

factor, using the formula in the ***At a Glance*** box above. In developing the fee schedule, Congress mandated that anesthesia services be reimbursed under a method different from that applied to other physician services. Anesthesia is the only medical specialty reimbursed for *time* under the physician fee schedule; reimbursement is based on the 1988 ASA RVG, with minor modifications.

HCFA updates the three resources that constitute the "value" of the relative value unit — work required, practice expense, and malpractice insurance expense — each year and publishes the fee schedule tables containing those revised values in the *Federal Register*. For calendar year 2000, those relative weights for anesthesiology services were: work value — 73.59 percent; practice expense — 19.55 percent; and malpractice expense — 6.86 percent.

Effective in 1998, Congress directed that Medicare use a single conversion factor for all physician services except anesthesia services. In 2000, the single conversion factor for all physician services (except anesthesia) was $36.61, and the anesthesia conversion factor was $17.77. HCFA makes annual adjustments to the physician fee schedule, including the anesthesia conversion factor, based largely on inflation with adjustments for budget neutrality.

iii. *Coverage policies, including medical necessity requirement.* Certain kinds of medical services, such as routine physical checkups, are categorically excluded from Medicare coverage. Services that are not categorically excluded may only be reimbursed when they are reasonable and necessary.

At the time a physician provides a service, it may not be certain as to whether Medicare will regard the service as reasonable and necessary. For that reason, Medicare includes a provision for an "Advance Beneficiary Notice" (ABN), which advises the beneficiary that Medicare may not pay for the service. If the patient agrees to pay from the patient's own funds if Medicare does not, and if Medicare subsequently denies payment, the doctor may bill the patient directly. A physician is not required to obtain an ABN from the Medicare beneficiary, but if the physician does not obtain an ABN, the physician cannot bill the patient directly after Medicare denies payment.

Anesthesiologists often rely on the Hospital at which they practice or on the attending physician to obtain an ABN from a Medicare beneficiary. Relying on the forms obtained by others does not provide assurance that the language is sufficiently specific to provide adequate notice to the patient that Medicare may not pay for the anesthesia associated with the procedure and that the beneficiary will be responsible for that fee. You are best advised to review the ABN form on which you and your Group are relying to assure it meets your needs and allows you to bill Medicare patients for services for which Medicare denies payment.

3. Participation in Medicare. Participation in Medicare is different from enrollment in

Medicare. Enrollment refers to the process of becoming eligible to receive payment under the Medicare program (see Chapter VI, section A.3.c, page 31). Participation in Medicare refers to execution of a Medicare Participating Physician Agreement, under which the physician agrees to "accept assignment." Accepting assignment refers to an agreement on the part of participating physicians to accept the Medicare allowable, which the beneficiary assigns to the physician, as payment in full for the physician's services. A participating physician may only bill the Medicare beneficiary for the 20 percent copayment and deductible. The physician agrees to absorb the difference between the physician's standard fee and the Medicare allowable. In calendar year 2000, the average Medicare conversion factor for anesthesiology services was $17.77. Actual conversion factors varied somewhat by locality from a low in 2000 of $15.79 in South Dakota (and $14.50 in Puerto Rico) to high of $21.01 in the Manhattan area of New York. The conversion factor for anesthesiologists and nurse anesthetists is the same.

The limiting charge applies even when Medicare is a secondary payor and the physician is billing another insurer. Physicians who bill in excess of the limiting charge and whose violations exceed $300 will receive a warning notice from the carrier and will be subject to intensified monitoring. Persistent violations are referred to the OIG. Penalties include assessments of double the overcharges, civil monetary penalties of up to $10,000 per violation and/or exclusion from the program for five years. In addition, physicians must complete and submit the claim form for nonassigned claims without charge. Physicians who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions administered by the OIG, which include fines of $2,000 per violation and exclusion from the program.

4. "Private Contracting"

a. *Two-year bar on Medicare participation*. The Balanced Budget Act of 1997 allows physicians to treat Medicare patients outside of the Medicare program (i.e., to charge Medicare patients their standard rates) if

Participation in Medicare *At a Glance*

Issue	Participating Physician	Nonparticipating Physician
Who receives the funds?	Medicare pays the physician 80 percent of the allowable fee; the physician bills the patient for the 20 percent copayment.	Medicare pays the 80 percent of the allowable fee directly to the patient; the physician must bill the patient for the 80 percent as well as the 20 percent copayment.
How much is payable?	Medicare pays 5 percent more to participating physicians.	Medicare pays 5 percent less to nonparticipating physicians, even if a nonparticipating physician accepts assignment on a particular claim.
How much can be charged?	Limited to the Medicare "allowable."	May charge up to the "limiting charge," which is 115 percent of the lower nonparticipating fee schedule payment (i.e., 109.25 percent higher than the allowable charge).

the physicians agree not to bill Medicare for any patient for two years. The provision is known as the "private contracting" provision because it regulates physicians who seek to privately contract with Medicare patients. Any physician who enters into such a private contract must execute an affidavit stating that the physician will not submit any claim under Medicare for any service to any Medicare beneficiary, and will not receive any Medicare reimbursement, for a two-year period beginning on the date the affidavit is signed. A physician who enters into a private contract with even a single patient is barred from submitting a claim to Medicare for any patient for a two-year period. Although the private contracting provision and the heavy penalty imposed on physicians who go outside the Medicare system have caused consternation, a legal challenge to the law was rejected.

b. *Cautionary note.* This discussion of private contracting is included for general informational purposes. Medicare represents a significant payor for most anesthesiology practices and, as a practical matter, most anesthesiologists do not have a realistic option not to submit claims to Medicare. In many cases, participation in Medicare is mandated by the hospitals or other facilities at which anesthesiologists provide services.

5. Who is eligible to be paid: Medicare reassignment rules. The Medicare statute provides for payment for services to be made to the beneficiary who receives services or, through assignment, to the physician or other person who provides the service. Payment generally will not be made to anyone else under a "reassignment" (an assignment by the physician to someone else), except to the extent an exception specifically authorizes the reassignment. The exceptions to this general rule are limited in nature and include the physician's employer, a health care delivery system or a reciprocal coverage arrangement.

a. *Requirements for locum tenens and reciprocal coverage arrangements*. The locum tenens and reciprocal coverage exceptions both are intended to cover arrangements in which one physician substitutes for another. The primary difference between them relates to the way in which the substitute physician is paid. Under the locum tenens exception, the regular physician pays for the locum tenens' services on a per diem or similar fee-for-time basis, whereas in reciprocal coverage arrangements, the physicians provide services for each other on an occasional reciprocal basis. In both cases, payment may be made to the regular physician (or the Group) if the services furnished by the second physician are provided to patients of the first physician and if all of the following conditions are satisfied: 1) the first physician is unavailable to provide the services; 2) the services are furnished pursuant to an arrangement that i) is informal and reciprocal *or* ii) involves *per diem* or other fee-for-time compensation; 3) "the services are not provided by the second physician over a continuous period of more than 60 days"; and 4) the claim form submitted to the carrier includes the second physician's unique identifier and indicates that the claim meets these requirements. Nonphysician suppliers may reassign benefits under conditions similar to those that apply to physicians.

The reciprocal coverage exception does not apply to substitution arrangements among physicians in the same medical Group where claims are submitted in the name of the Group (in contrast, Group physicians who bill in their own names generally are treated as independent physicians for purposes of these exceptions). The term "regular physician" includes a physician who has left the Group and for whom the Group has hired the locum tenens physician as a replacement.

One frequently encountered obstacle to the use of these exceptions to the reassignment rule is the requirement that "[t]he substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days." This period continues without interruption on days on which no covered visit services are provided on behalf of the

regular physician or are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

b. *Independent contractors*. In many cases, the authorized exceptions do *not* authorize a Group to bill for the services of independent contractor physicians. In contrast, payment for the services of nurse anesthetists and anesthesiologist assistants may be made to a Group that has an employment *or* an independent contractor relationship with the nurse anesthetist or anesthesiologist assistant.

Resource references

The Medicare reassignment rules, including the subject of payments to agents and lockbox accounts, are discussed in *Contracting Issues: A Primer for Anesthesiologists (*pages 49-50).

C. MEDICARE RULES GOVERNING NURSE ANESTHETIST AND ANESTHESIA CARE TEAM PAYMENT

The table below summarizes current Medicare payment policies.

A nurse anesthetist who performs a case on a nonmedically directed basis receives 100 percent of the Medicare allowance, the same as an anesthesiologist who personally performs a case. Nurse anesthetists are required, however, to participate in Medicare and thus may not balance bill up to the limiting charge.

D. MEDICAID PAYMENT

Although Medicaid may sometimes be lumped with Medicare in discussions of payment, Medicaid is a very different program and the rules regarding coverage and payment can differ significantly from Medicare rules (see table, next page). Medicaid is a state program for medical care for the indigent that is partially

HCFA Payment Policy *At a Glance*

Personal Performance	Medical Direction	Medical Supervision
Anesthesiologist performs the entire anesthesia service alone,	The physician directs qualified individuals in one to four concurrent cases (non-Medicare cases are counted for this purpose; even an overlap of one minute counts as a concurrent case), *and*	The anesthesiologist medically supervises more than four concurrent anesthesia procedures (non-Medicare cases are counted for this purpose; even an overlap of one minute counts as a concurrent case), *or*
The anesthesiologist satisfies the requirements for a teaching physician and works with an intern or resident,	Must meet the seven steps of medical direction and not perform other services other than one of the six exceptions to the rule of no other services.	The anesthesiologist fails to meet all seven steps of medical direction (e.g., leaves the OR suite for more than a brief period).

(Continued on next page)

HCFA Payment Policy *At a Glance (cont.)*		
The physician and the nurse anesthetist or anesthesiologist assistant are involved in a single case and the services of each are found to be medically necessary, *or* The physician is continuously involved in a single case involving a student nurse anesthetist.		
PAYMENT **Personal Performance**	**PAYMENT** **Medical Direction**	**PAYMENT** **Medical Supervision**
Anesthesiologist receives 100 percent of the Medicare allowance.	Anesthesiologist receives 50 percent of the Medicare allowance; nurse anesthetist or anesthesiologist assistant receives 50 percent.	Anesthesiologist receives 3 base units as compensation for preoperative services, plus 1 unit if present for induction; nurse anesthetist or anesthesiologist assistant receives 50 percent of the Medicare allowance. Whether the payment to the anesthesiologist equals or comes close to 50 percent of the Medicare allowance depends upon the complexity and length of the procedure. In relatively short cases with a low number of base units, the supervision rate may approximate the medical direction rate, which is 50 percent of the Medicare allowance.

federally funded. Upon approval of a "state plan," a state is entitled to federal matching funds (known as "federal financial participation," or FFP) for state Medicaid expenditures which vary as a percentage of the state's expenditures based upon the state's per capita income. States have flexibility in establishing eligibility requirements for Medicaid programs, although federal rules require Medicaid coverage for the "categorically needy," a group which generally includes low-income pregnant women and children.

Medicaid payment policies for anesthesiology services vary by state and do not necessarily correspond to Medicare policies. Physicians need to understand what services their state Medicaid program will cover (e.g., the Pennsylvania Medicaid program will reimburse anesthesiologists for personally performed and medically directed services, but not for medically supervised services).

Medicare vs. Medicaid *At a Glance*

Topic	Medicare	Medicaid
Purpose	Health insurance for persons 65 and older and for limited categories of persons under 65 who are entitled to Medicare (e.g., due to disability).	Health assistance for persons of any age.
Administration	Administered through insurance companies under contract to the government to process Medicare claims.	Administered by the federal government through state and local governments following federal and state guidelines.
Regulation	Medicare regulations are the same in all states.	Medicaid regulations vary from state to state.
Financing	Financed by monthly premiums paid by the beneficiary and by payroll tax deductions.	Financed by federal, state and county tax dollars.
Eligibility	Age 65 and over – eligibility based on Social Security or Railroad Retirement. Under 65 – eligibility based on disability. Kidney dialysis – eligibility at any age.	Eligibility based on financial need.
Beneficiary payment	Beneficiary responsible for paying deductibles, coinsurance or copayments and Part B premiums.	Can help pay Medicaid deductible, coinsurance or copayment and premiums.
Covered benefits	Hospital and medical benefits; preventive care and long-term care benefits are limited.	Comprehensive benefits: hospital, preventive care, long-term care and other items not covered under Medicare such as dental work, prescriptions, transportation, eyeglasses and hearing aids.

E. WORKERS' COMPENSATION

1. Purpose. Workers' compensation is intended to compensate employees and their dependents for lost income and reasonable medical expenses for death, injury or occupational disease caused by their employment. Except for claims against an employer for intentional acts that cause injury, the provisions of the state workers' compensation act usually provide the sole source of compensation and related benefits for an occupational injury or disease.

2. Coverage and general administrative information. All employers, public or private, who have entered into an employer-employee

relationship are subject to workers' compensation. Responsibility within state government for workers' compensation matters will depend upon the state. Generally, employers must participate in the state fund or obtain permission to self-insure; private insurance coverage typically is not permitted. Employers who can demonstrate sufficient financial and administrative ability to meet all of the obligations imposed by the workers' compensation law may be granted permission to self-insure. There is no difference in the amount of compensation or benefits that are due the injured employee under a self-insured plan.

Employers who participate in the state fund are assessed premiums based upon their payroll. Group ratings for employers in the same industry and retrospective rating plans are available.

Any injury caused by external accidental means or accidental in character and result received during the course of and arising out of the employee's employment is compensable under state workers' compensation laws. An injury need not be the result of a sudden mishap in order to qualify for coverage. A pre-existing condition may also be compensable in whole or in part if it is aggravated or substantially accelerated by employment.

State law sets a time limit (two years from the date of injury in some states) on filing claims for workers' compensation benefits. The time period may be extended under certain circumstances. Once a claim is filed, the state agency issues an order allowing or disallowing the claim and the employer has a time period to appeal.

In some states, claims are managed by MCOs. In those cases, the MCO is responsible for addressing medical management issues such as whether a particular service is covered or is medically necessary.

The benefits payable to claimants include temporary total compensation, permanent partial disability awards, temporary partial compensation, wage loss compensation, permanent total disability benefits, death benefits and medical benefits.

The state fund pays medical bills for allowed conditions in a claim against employers that participate in the state workers' compensation fund. Self-insured employers must pay the medical expenses directly. The agencies administering workers' compensation programs generally have maximum fee schedules governing payment for medical services.

Workers' compensation is separate from the requirements of the federal ADA, and the fact that an employee is awarded workers' compensation benefits does not necessarily establish that the employee is protected by the ADA. The definition of disability under state workers' compensation laws may differ from the definition under the ADA. The ADA prohibits employers from discriminating against "qualified individuals with disabilities." Not all injured employees are protected by the ADA. An injured employee is protected by the ADA if the individual is able to perform the essential functions of the job.

X. AVOIDING "FRAUD AND ABUSE" LIABILITY: BILLING COMPLIANCE

A. OVERVIEW OF BILLING COMPLIANCE ISSUES

1. In general. As a resident, your focus most likely is on clinical issues and patient care. Residency programs typically do not educate residents about the business aspects of practice or the specifics of governmental and private payor billing requirements. Perhaps you think that you will not encounter billing compliance problems so long as you provide good patient care and are not out to "cheat the system." This approach is seemingly compelling and logical, but it is wrong. *You do not need to intend to cheat the system to incur substantial financial liability for bills you (or others) submit for your services, especially if the patient was a Medicare, Medicaid or other federal program beneficiary.*

This chapter will provide an overview of the laws and standards on which enforcement actions are based and a review of basic Medicare billing requirements as they apply to anesthesiology and pain management services, including billing issues that commonly arise in day-to-day practice. These topics are discussed in greater detail in the ASA monograph titled *Compliance with Medicare and Other Payor Billing Requirements* (1997).

2. What are billing requirements, and what is billing compliance? The term "billing requirements" refers to the conditions that different "payors," or companies that pay for health care services, establish for payment for services. Among payors, the Medicare program generally contains the most specific requirements to bill for anesthesiology services, and Medicare represents a significant payor for most anesthesiology practices. Medicaid requirements differ from state to state, although in general they tend to incorporate many of the Medicare rules. Some private payors incorporate Medicare standards into their participation agreements as a basis for payment. For all of these reasons, it is important for you to understand Medicare rules and how sometimes simple changes in your practice can help you avoid noncompliance.

3. Why is billing compliance important? As recently as several years ago, enforcement officials focused on egregious billing practices and most physicians were primarily concerned with the collection rate and performance of their billing staff or outside billing company. The University of Pennsylvania's $30 million settlement with the federal government served as a wake-up call to the health care industry, reminding it that the federal government expects physicians to know the billing rules that apply to their practices and that it will hold physicians accountable for their failure to comply strictly with those rules.

For anesthesiology residents and anesthesiologists, the sobering news is that the OIG has targeted anesthesiology billing as a priority in its enforcement efforts. Billing for anesthesiology services is enormously complex, which makes it easy to make mistakes. *First*, the fact that anesthesiologists, unlike most physicians, bill for the *time* associated with their professional service leads to scrutiny to ensure that time charged is accurate time, not rounded time. *Second*, anesthesiologists often practice in a care team mode, with nurse anesthetists as

well as with residents. Billing Medicare for medically directed services requires careful adherence to specific rules that are subject to interpretation. *Moreover*, day-to-day practice situations – in which anesthesiologists or other care team providers may substitute for each other during a case, cases may change from personally performed to medically directed mid-case, or delays may occur between the time the anesthesiologist begins to prepare the patient for anesthesia and the case begins – do not fit neatly into the rules.

It is important to bear in mind that the burden is on *you* as the physician to know the billing rules and to determine how to bill for services correctly. As physicians, you will bear ultimate responsibility for claims submitted in your name, no matter who prepares the claims (the Group's employees or an outside billing company), even if you do not have actual knowledge regarding how a particular claim is coded.

4. Accurate billing is a team effort. Physicians commonly believe that their role is to provide clinical services and it is the job of their billing staff – whether employees or a contracted outside billing service – to figure out how to bill for those services. This approach is workable if you provide sufficient information to identify the service provided and to demonstrate the medical necessity (where needed; e.g., postoperative pain epidurals and monitored anesthesia care [MAC] for certain procedures) for the service. Too often, however, the billing staff has insufficient or conflicting information regarding the specific services that were provided. The potential for inaccurate claims (which are false claims in the eyes of government prosecutors) increases if you do not document your services completely or are uncooper-

Billing References *At a Glance*

Every compliance library should have copies of the following basic reference materials:

- HCFA regulations governing billing Medicare for anesthesiology services;
- Excerpts from the *Medicare Part B Carriers Manual* (MCM) governing billing Medicare for anesthesiology services;
- Anesthesiology billing policies from the Medicare carrier for the state or region;
- The current year's (not an outdated) relative value guide (RVG) used to bill for services, whether the RVG is published by ASA or another organization;
- The current edition of *Current Procedural Terminology*™ (CPT), currently CPT-4, published by AMA;
- The current edition of the *ICD•9•CM* (International Classification of Diseases, 9th revision);
- The current edition of the ASA *CROSSWALK*™, which is a systematic listing of all AMA CPT-4 codes except pathology, with appropriate anesthesiology CPT-4 codes;
- The *Correct Coding Initiative*, including the chapter on anesthesia services and updates;
- The ASA monograph titled *Compliance with Medicare and Other Payor Billing Requirements* (1997); and
- *ASA NEWSLETTER* articles on Medicare billing issues and payment policy (check the ASA Web site, <www.asahq.org/Washington/Pract_Mgmt_Rpts.html> for a listing of relevant articles published in back issues).

Commercial publications also may be useful in staying current regarding new developments. The *Anesthesia Answer Book*, published by UCG, Rockville, Maryland (888-287-2223), is one such publication (this identification is solely informational and should not be interpreted as an endorsement).

ative in responding to questions and requests for more information from billing personnel.

It is important to consider whether the way in which information is transmitted to billing staff (internal or external) may predetermine the coding decisions. Specifically, if you check off services on a billing slip or superbill that includes CPT™ codes, in many cases you may be instructing the billing staff to code the services in a particular manner.

Physicians often fail to appreciate that their billing staffs are wholly reliant on the information the physicians provide. When an anesthesiologist marks anesthesia start and end times, the billing staff has little way to verify the accuracy of that information. The billing staff is aware of problems only when it is presented with inconsistent information – such as when an anesthesiologist appears in two different locations (e.g., a surgery center and an operating room suite) at the same time because a substitution of anesthesiologists was not marked, or when a billing slip indicates that an invasive monitoring line was placed and the anesthesia record does not reflect that such a line was inserted (assuming the billing staff has the anesthesia record to review).

Providing billing personnel with complete information and encouraging them to ask questions not only will promote compliance with billing rules, but also may expedite the billing process by minimizing delays to clarify ambiguous information. This latter point bears repetition: *if billing personnel are discouraged from asking questions or are ignored, potential issues are not investigated and the potential for repeated billing mistakes increases.*

5. What information should you give to your billing staff? *Billing slips or superbills cannot and do not replace the anesthesia record*. The practice of using billing slips or superbills *alone* to bill for anesthesiology services is dangerous. Although convenient, the check-offs and shortcuts that are the essential elements of the billing slip can lead to inaccurate coding. *If your billing staff does not bill from the anesthesia record based upon the services actually documented, it is billing blindly*. The documentation supporting a claim submitted for payment must appear in the patient's medical record, not in an extraneous document.

6. Should you do your billing yourself or contract with an outside service? The in-house versus outsourcing issue is obviously an extremely important practical question, but one which does not have a common answer. Actually, the *answer relates to the level of resources a practice invests in its billing component*. If a Group is able to provide its billing staff with sufficient time and resources to stay current on changes in billing rules and to take the time required to pursue questions and to bill properly, then a Group may decide to have its own employees bill for services. The more varied the types of clinical services provided (e.g., chronic pain and critical care) and the more frequently a Group bills evaluation and management (E&M) services, the more time the billing staff will need to ensure the accuracy of the claims.

Another important issue is the independence of billing staff members and their ability to question billing decisions. Internal billing personnel may feel that their jobs are on the line if they tell the Group that a bill cannot be submitted because there is inadequate documentation (e.g., medical direction or the level E&M code to be billed). On the other hand, outside billing services also may be reluctant to raise billing concerns for fear of losing a client practice. This issue underscores the need to *deal with a company that is financially solvent* so that it is not unduly dependent upon any one particular client practice.

If the Group has an external contracted billing service, it must make sure that the service has the expertise necessary and is willing to invest the time required to do the billing properly, in addition to being willing to pursue collections vigorously. Many billing services want to bill off a superbill or billing slip. That approach is acceptable so long as the billing service is willing to *check the anesthesia record*

to ensure that all information on the billing slip actually has been documented on the anesthesia record.

Yet another issue with outside billing services is the often-inconsistent performance of different offices of the same company. A national company with a good reputation may have inexperienced staff in a particular office, which will lead to unacceptable results. In addition, a smaller office will be substantially and adversely affected by staff turnover, whereas a larger office may have more trained personnel to apply to an account. The turnover problem also is an issue for internal Group-employed billing staff, particularly if only one person is coding services.

In many academic practices, the billing operation has been shifted in the past several years from a departmental function to a centralized billing office in an effort to increase compliance with billing rules. For anesthesiologists, the concern is whether the centralized billing office personnel have experience in billing for anesthesiology services and are preparing bills accurately.

7. Enforcement and potential sanctions. Some physicians view the recent emphasis on compliance as needlessly exaggerated. Those who have been in practice for many years point to the fact that they have not been audited in the past. Others rely on the fact that their claims have been paid as evidence of the lack of any problem. Still others claim that the Medicare rules are hopelessly complex and unrealistic and assert that they cannot possibly learn all of the intricacies or comply with all of the requirements. Besides, they comment, how will the government ever discover an error amidst the millions of claims submitted?

Although there is always an element of uncertainty regarding whether improper claims will be discovered, the possibility of discovery is far greater than it was previously. *First*, the federal government has been funding increased enforcement efforts, believing that recoveries (through settlements and prosecutions) are an important way to combat and deter improper billing. *Second*, there is a powerful incentive for private parties – such as disgruntled employees and former employees – to become whistleblowers. Depending upon several factors, a whistleblower can recover between 15 and 30 percent of the proceeds (or settlement amount) in a False Claims Act lawsuit. If an employee chooses not to file a *qui tam* (or whistleblower) lawsuit, the employee can simply call the Medicare carrier or OIG to report concerns. HCFA has instructed carriers to refer complaints from employees or former employees immediately to the Office of Investigations, which is the unit within the OIG staffed with professional criminal investigators and which is charged with all HHS criminal investigations, including Medicare fraud. *Finally*, Medicare carriers are carefully examining claims, using both sophisticated computer screens and detailed post-payment audits, to identify improper claims.

The sanctions for submitting false (i.e., wrong) claims are daunting and include both criminal and civil penalties as well as exclusion from the Medicare and Medicaid programs. The federal False Claims Act civil penalties include treble the amount of the claim plus up to $11,000 *per claim* (increased from $10,000 for inflation for violations occurring after 9/29/99). Stated otherwise, an improperly submitted claim for $450 for medical direction services can translate into a civil penalty of $12,350 (3 times $450 + $11,000). *The government does not have to establish specific intent to defraud* and it is *no defense that the Group provided other reimbursable services* or that *it did not have actual knowledge that the claims were false*. The prohibition is against filing claims for services that the person knows or *should know* were not provided as claimed and it is enough if the person acts in deliberate ignorance of the truth or falsity of the information. See Chapter IV, section D.3, pages 16-17.

Moreover, the government need not identify each claim that is erroneous. It is allowed to review a sampling of claims, determine an error

rate and *extrapolate an error rate over a multi-year period*. This methodology was used in the case of the University of Pennsylvania $30 million settlement, in which the government reviewed 100 claims and extrapolated the results over a six-year period.

Criminal sanctions for "knowingly and willfully" making false statements in claims include up to five years' imprisonment, fines of $25,000 for each false claim and automatic exclusion from the Medicare and Medicaid programs. For most anesthesiology practices, exclusion from Medicare and Medicaid is a practical bar to practice because most hospitals and other facilities at which anesthesiologists provide services require that the anesthesiologists be eligible to participate in Medicare and Medicaid. In civil cases, exclusion is "permissive," which means that the government can exercise discretion in determining whether to exclude a physician from the Medicare and Medicaid programs.

Thus far, the discussion has focused on potential liability in connection with billing *governmental* payors. Physician practices also face potential criminal liability for making false statements in claims submitted to *private* payors as well. Penalties include fines and imprisonment for up to 10 years, with stiffer penalties for more serious offenses.

B. OVERVIEW OF MEDICARE ANESTHESIA BILLING RULES

Resource references

This subject is addressed in detail in Chapter III of the ASA publication titled *Compliance with Medicare and Other Payor Billing Requirements* (pages 13-30).

1. Personally performed services. For purposes of Medicare billing, an anesthesiologist is considered to be *personally performing* the anesthetic procedure in any of the following four circumstances:

- the anesthesiologist performs the entire anesthesia service alone;
- the anesthesiologist is continuously involved in a single case with a nurse anesthetist or anesthesiologist assistant and the services of each are found to be medically necessary;
- the anesthesiologist performs a case with an intern or resident and meets the requirements for teaching physicians in anesthesia cases; or
- the anesthesiologist is continuously involved in a single case involving a student nurse anesthetist.

a. *Continuous presence*. In cases in which the anesthesiologist is providing services alone or is considered to be personally performing a case (other than when working with an intern or resident), the anesthesiologist must be continuously present in the operating room or anesthetizing area from induction to safe transfer of patient care to the post anesthesia care unit or ICU personnel. If the anesthesiologist needs to leave the operating room or anesthetizing area for any reason, whether for a brief period of time (e.g., for personal privileges such as brief restroom visits or to get equipment needed for the procedure) or for a longer period, the anesthesiologist must transfer care of the patient to another anesthesiologist in the same group practice who has no patient care responsibilities at the time. The transfer of care must be documented in the anesthetic record.

In the case of an intern or resident, the teaching physician-anesthesiologist must be present during all critical or key portions of the procedure, including induction and emergence. The teaching physician's presence is not required during the preoperative exam or postoperative care. Anesthesiologists in academic practice are well-advised not to rely on this "teaching" rule, because if they assume responsibility for a second case during any portion of the teaching case, even a brief overlap of a minute, the medical direction rules, which require the anesthesiologist to perform the preop-

erative exam and to provide postoperative care, will apply.

b. *Prohibition on performing other services*. An anesthesiologist who is personally performing a case or procedure is fully occupied with that procedure and cannot medically direct other cases at the same time or provide services to other patients. Although this rule appears to be straightforward, questions arise in practice. For example, an anesthesiologist who is inserting invasive monitoring lines or a postoperative pain epidural is considered to be personally performing the procedure and therefore should not have other patient care responsibilities, such as medical direction of a concurrent case, at the same time. An anesthesiologist who is medically directing concurrent cases cannot provide a break for a nurse anesthetist, because the anesthesiologist would be personally performing that case and would "break" medical direction of the other concurrent case or cases.

Similarly, teaching physicians cannot perform services involving other patients during the period the intern or resident is furnishing services in the single case.

c. *Two-provider cases: When one-on-one cases are deemed to be personally performed*. Effective January 1, 1998, when an anesthesiologist works on one case with a nurse anesthetist or anesthesiologist assistant, the case is considered to be medically directed and Medicare allocates the payment equally between the medically directing anesthesiologist and the nurse anesthetist. Generally, when both providers are involved in a single anesthesia service, Medicare will *not* pay a full allowance for each provider *unless* documentation is submitted showing that it was *medically necessary for both the anesthesiologist and the nurse anesthetist to be involved in the procedure*. When this medical necessity requirement is satisfied, the anesthesiologist is considered to be personally performing the case and must satisfy the continuous presence requirement. You should document any unusual circumstances (e.g., trauma cases, ruptured aneurysm cases, unstable surgical patients who require massive blood transfusions or patients undergoing surgery for major body burns) that may justify additional compensation.

2. Medical direction.

a. *Seven steps of medical direction*. In order to bill Medicare for medical direction services, an anesthesiologist must perform *all seven steps of medical direction*: 1) performing the preanesthetic examination, 2) prescribing the anesthetic plan, 3) personally participating in the most demanding portions of the case (including induction and emergence where applicable), 4) ensuring that any procedures the anesthesiologist does not perform are performed by a qualified individual (see subsection f, below), 5) monitoring at frequent intervals, 6) remaining physically present and immediately available and 7) providing indicated post-anesthetic care. The seven steps are based on the ASA "Guidelines for the Ethical Practice of Anesthesiology," which HCFA used to define the nature of the anesthesiologist's participation in a medically directed case. ***You must personally perform* all *of these portions of a case in order to bill for medical direction services***. These requirements are subject to interpretation and satisfying them can be difficult in practice, particularly if the operating schedule is busy.

b. *Interpreting the "immediate availability" requirement*. The requirement to remain physically present and available for immediate diagnosis and treatment of emergencies has two components: *remaining immediately available in both geographic* and *practical terms*. Within each facility in which it provides services, an anesthesiology practice must assess what locations satisfy the immediate availability requirement. From a practical perspective, if you are medically directing a case, you must be able to drop the task at hand and respond forthwith to exigent circumstances.

c. *Prohibition on providing additional services and exceptions to the rule*. The practical aspect of immediate availability reflects the *Medicare restriction on performing additional services to other patients while medically di-*

recting one or more concurrent cases. This rule means that if you are medically directing one or more cases, you cannot insert invasive monitoring lines or administer a pain epidural or a block for a cataract procedure on a patient in the holding area. Despite this restriction, Medicare recognizes six services that you may perform while medically directing one or more concurrent cases: a) addressing an emergency of short duration in the immediate area; b) administering a labor epidural, c) periodic (not continuous) monitoring of an obstetric patient, d) receiving patients entering the operating suite for the next surgery, e) checking or discharging patients in the recovery room and f) handling scheduling matters.

*These exceptions do **not** dispense with the medical direction requirements*. Accordingly, among other requirements, you must continue to remain immediately available and to monitor the medically directed cases at frequent intervals. If the labor and delivery area is not geographically immediately available to the operating suite, the labor epidural exception will *not* authorize you to perform a labor epidural several floors away. The practical strategy is to have another anesthesiologist assume responsibility for medically directing your concurrent cases.

The scope of the six exceptions is subject to interpretation. What is an emergency of short duration? Medicare has not defined what "short" means, although it must be evaluated in the context of the cases you are medically directing. This issue is one that a practice can address in its compliance plan. As a guideline, an emergency that consumes 15 or more minutes of time (or 10 minutes for those practices using 10-minute units) is unlikely to qualify as an emergency of short duration.

- ***Billing rules are separate from clinical considerations.*** Just because it may be clinically acceptable to engage in certain activities

(Continued on next column)

(Continued from previous column)

while medically directing cases does not authorize performance of those activities for billing purposes.

- ***HCFA may revise the medical direction rules.*** ASA has been in discussions with HCFA over the past several years to try to clarify the anesthesia billing rules. ASA is hopeful that HCFA will adopt modifications relating to the medical direction rules that will be helpful to anesthesiologists, although such changes are not likely to be in effect before 2002. The potential for change serves as a reminder that it is necessary to stay abreast of changes in HCFA and local carrier interpretations of Medicare billing rules.

d. *Providing relief breaks*. One area that creates practical problems for many practices is the practice of providing breaks, both to nurse anesthetists and to anesthesiologists. Under Medicare billing rules, *a nurse anesthetist cannot relieve an anesthesiologist* regardless whether the anesthesiologist is personally performing a case or medically directing one or more cases. Billing Medicare for services in these situations can be difficult, as carriers routinely reject multiple claims for the same case. Similarly, *an anesthesiologist who is medically directing concurrent cases cannot relieve a nurse anesthetist*. An anesthesiologist doing so would be personally performing the newly assumed case, and an anesthesiologist cannot personally perform and medically direct at the same time. The simplest policy is for anesthesiologists to relieve other anesthesiologists and for nurse anesthetists to relieve nurse anesthetists.

Medicare rules permit anesthesiologists within a group practice to *share medical direction responsibilities* within a case, ***provided*** that the *anesthesia record documents the time at which medical direction responsibility was transferred and identifies which anesthesiologist performed which particular services*. In

these instances, the claim should be submitted in the name of the anesthesiologist who spends the greatest amount of time providing services to the patient. Medicare has not formally recognized sharing of duties among nurse anesthetists, although the same principles (documenting the time and the services provided) would appear to apply.

e. *Defining "concurrent" cases*. For purposes of the Medicare program, concurrency is determined on the basis of other cases occurring at the same time, even if those cases do *not* involve Medicare patients. Any overlap of time – even as brief as one minute – will render cases concurrent, even if the vast majority of time on a particular case was spent on the one case alone.

f. *Whom can you medically direct?* Anesthesiologists sometimes wonder whether medical direction rules apply when a holding area nurse or circulating nurse monitors a patient during a period in which the nurse anesthetist and anesthesiologist are temporarily involved elsewhere, such as when there is a delay in starting a case. No, they do not, because those nurses are not "qualified individuals" for purposes of the medical direction rules. The following individuals are qualified individuals who may be medically directed: anesthesiologist assistants (if they are licensed under state law), certified registered nurse anesthetists, interns and residents. The medical direction rules apply to student nurse anesthetists only if the physician directs no more than two concurrent cases. A medical student cannot be medically directed.

3. Calculating time.

a. *Continuous, actual presence*. For purposes of Medicare, time involves the "*continuous, actual presence*" of the anesthesiologist or medically directed qualified provider. If there is a break in the anesthesiologist's or nurse anesthetist's attendance to the patient, as may occur when a surgical procedure is delayed after the patient is prepared for anesthesia, anesthesia time stops and resumes when the physician or nurse anesthetist once again is in continuous presence with the patient.

b. *Discontinuous segments of anesthesia time*. Effective in 2000, HCFA rules expressly allow anesthesiologists to *aggregate* discontinuous segments of anesthesia time, *provided* that the anesthesia time and the monitoring of the patient within each block of time are continuous. It also would be necessary to have careful documentation of the start and end times of any separate segments of anesthesia time.

c. *One patient at a time*. In some ambulatory care settings, it is not uncommon for several patients to be blocked close in time so that more than one patient is under an anesthetic at the same time. Although it may be clinically acceptable to monitor several patients concurrently, the government has taken the position that a physician who is personally performing a case or a nurse anesthetist cannot be in "continuous actual presence" for more than one patient at a time. Billing for anesthesia time for more than one patient at a time can lead to civil and even criminal liability.

Although the principle that an anesthesiologist who is personally performing a case or a nurse anesthetist may not provide services to more than one patient at a time may appear obvious, problems can occur if the documentation indicates that the anesthesiologist or nurse anesthetist was providing services in two cases at the same time. This situation may occur if clocks in different locations (e.g., the different operating rooms and the PACU) are not synchronized or, in the case of a nurse anesthetist, if the medically directing anesthesiologist begins to prepare the next patient for surgery when the nurse anesthetist is taking the first patient to the PACU.

d. *Anesthesia start and stop times*. Anesthesia time begins when the anesthesiologist or medically-directed nurse anesthetist begins to prepare the patient for anesthesia care. Time spent in the preoperative examination is *not* anesthesia time. If a nurse anesthetist is beginning to prepare the patient for anesthesia, the medically directing anesthesiologist must be

immediately available in order for anesthesia time to begin. Anesthesia time ends when the anesthesiologist or medically directed nurse anesthetist no longer is in personal attendance, which is when the patient may be safely transferred for post-operative care. In the case of the medically-directed nurse anesthetist, anesthesia time ends if the anesthesiologist no longer is immediately available, as may happen when the nurse anesthetist transports the patient to a postanesthesia care unit or ICU that is on a different floor or otherwise is distant from the operating suite.

e. *Actual time*. Medicare requires that claims be submitted for actual, not rounded, time. ***Do not round time to the nearest five minutes or add time units to the surgical time to account for the time taken to prepare the patient for anesthesia or to transport the patient to the PACU***. Doing so can lead to substantial civil penalty and even criminal liability.

4. Services subject to greater scrutiny for medical necessity and proper classification.

a. *Monitored anesthesia care*.

i. *Definition*. MAC involves the intraoperative monitoring by an anesthesiologist, or nurse anesthetist under the medical direction of a physician, of the patient's vital physiological signs in anticipation of the need to administer general anesthesia, sedatives or other medications, or the development of adverse reaction to the surgical procedure. The physician must provide, or medically direct, the following services in order for the service to be reimbursable under Medicare: a) intraoperative monitoring of the patient's vital signs, b) performing a preanesthetic examination and evaluation, c) prescribing the anesthesia care required, d) administering any necessary oral or parenteral medications (e.g., sedatives, narcotics, or hypnotics) and e) providing indicated postoperative anesthesia care.

Medicare pays the same amount for MAC as for general anesthesia. In submitting claims, however, MAC cases must be designated as MAC cases through the use of the "QS" modifier. In 1999, the use of two additional modifiers – one designating light sedation (G8) and one indicating deep sedation (G9) – began, although carriers are not required to use these additional modifiers and not all carriers have adopted them.

ii. *Distinguishing between MAC and general anesthesia*. Sometimes it is not clear when a MAC case ends and a general anesthetic begins. Some anesthesiologists take the position that if a patient loses consciousness for any period of time, the case should be billed as a general anesthetic. That interpretation is overly aggressive. While it is a matter of clinical judgment, a more appropriate approach to distinguish between MAC and general anesthesia is to make the distinction on the basis of whether the patient maintains an airway and responds to verbal stimuli. Such cases should be designated as MAC cases. General anesthesia is commonly defined as cases in which the patient loses airway reflexes and becomes unresponsive to stimuli. If the patient is conscious during all but a brief portion of the procedure, the case should be designated as a MAC case. It is up to individual practices to define the length of the brief period (e.g., under 60 seconds) in the absence of guidance from the carrier.

Resource reference

The ASA "Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia" (approved in 1999) describes conscious sedation, deep sedation and general anesthesia and may be of assistance in this task.

iii. *Time*. MAC cases can be short and, in some settings, you may have several patients who are undergoing MAC at the same time. Anesthesia time generally begins when you begin to prepare the patient for anesthesia and ends when the patient can be safely transferred for postoperative care. But if you have several MAC patients and are in continuous presence

with those patients at the same time, you are personally performing cases and may not "count" time for multiple patients together. Instead, time on MAC cases is the actual time spent with each particular patient (note that this calculation necessarily requires careful documentation of each segment of time spent with each patient).

iv. *Medical necessity*. A key issue associated with MAC is the medical necessity of providing MAC and whether the operating physician could provide sedation. The designation of MAC cases through use of the QS modifier facilitates Medicare scrutiny of MAC claims. You should understand which specific procedures and medical conditions your local carriers will recognize as requiring MAC. See discussion of the national model MAC policy on page 22 of the ASA *Compliance* manual.

Some carriers have determined that they will not pay for MAC for specific procedures. An example is the determination of Empire, the Medicare carrier for part of New York State, that it will not pay for MAC for endoscopies. You should determine whether your carrier has adopted, modified or rejected the model policy. If you provide MAC for a surgical procedure other than one for which the carrier routinely would accept as requiring MAC, you are well-advised to document the medical necessity for MAC, including obtaining a written request for MAC from the surgeon.

v. *Documentation*. You should clearly document the medical necessity for performing MAC in the anesthesia record. Your Medicare carrier may require that ICD-9 diagnosis codes be submitted with the claim to support the medical necessity for MAC, particularly in the case of procedures the carrier has designated as usually not requiring MAC. The anesthesia record must contain documentation of the patient's vital physiological signs (oxygenation, ventilation, blood pressure and pulse) during the procedure and the administration of oral or parenteral medications as needed. Finally, a copy of a history and physical examination must be available for review upon request by the carrier.

b. *Acute pain management services*. Medicare takes the position that the global payment to the surgeon covers the provision of postoperative pain services. Claims submitted by anesthesiologists for postoperative pain services are subject to closer review – either on the initial request for payment or in post-payment audits – for medical necessity. Medical necessity for your involvement must be documented in the patient's record through use of appropriate ICD-9 diagnosis codes or other information demonstrating the need for your involvement. The best documentation is a written request from the surgeon identifying why your services are needed. Alternatively (and less desirably), the surgeon should write a request for your services for postoperative pain in the patient's medical record. At a minimum, you should document the surgeon's oral request.

In addition to documenting medical necessity, it is important to document that the acute pain service is separate from the surgical anesthesia service. If a nerve block is performed or epidural catheter is inserted for postoperative pain, make certain that the anesthesia record indicates that the block or epidural was performed *solely* for postoperative pain and not as the means of administering the anesthetic for the surgical procedure. If you use the epidural catheter intraoperatively to supplement another mode of anesthesia, you may not bill for the postoperative pain epidural.

Medicare will not reimburse anesthesiologists for patient-controlled analgesia (PCA) services, although other payors may (it is useful to address payment for postoperative pain services in managed care agreements to ensure agreement on payment for these services). Some carriers allow an anesthesiologist who initiates PCA in the PACU to include the initial set-up time in the anesthesia time reported.

c. *Chronic pain management services*.

i. *Coding: Use of E&M and surgical procedure codes*. Unlike traditional anesthesiology services which are billed on the basis of time, chronic pain services are billed using E&M and

surgical procedure codes. E&M codes require face-to-face contact with the patient and present special documentation concerns because they may be billed at different levels. Classification of E&M services and payment depend primarily upon three factors: *the history, the examination and the level of medical decision making involved*. Because the level of the E&M service is dependent on several key components, performance and documentation of each component is important.

ii. *Documentation*. HCFA and the AMA issued documentation guidelines for E&M services that outline with specificity how the component parts are to be documented. Until revised guidelines are issued, physicians may use either the 1995 or the 1997 guidelines.

The history must include documentation of some or all of the chief complaint, the history of present illness, the review of systems and the past, family and/or social history. Documentation of the examination must identify the affected body area(s) or organ system(s) examined with detailed requirements as to the elements that must be performed in order to qualify the level of exam as 1) problem focused, 2) expanded problem focused, 3) detailed or 4) comprehensive. The complexity of medical decision making depends upon the number of possible diagnoses and/or the number of management options that must be considered, the amount or complexity of medical records, diagnostic tests and other information to be reviewed, and the risk of significant complications, morbidity and mortality. *Documentation must reflect these considerations*.

Several Medicare carriers have specific documentation requirements for *chronic* pain procedures — including requirements to substantiate the diagnosis, justify the medical necessity of a particular treatment and identify the plan of treatment — that should be consulted. Some carriers require that the patient's history and physical, as well as documentation of the patient's response to the pain procedure, be available for review by the carrier. These rules reflect an underlying concern about the possibility for abuse in the provision of pain management services, which underscores the importance of being scrupulous in documenting the chronic pain management services.

d. *Consultation versus a visit*. Consultations are paid at a higher rate than are visits, making them a target for review in postpayment audits.

i. *Definition of a consultation*. In order to qualify as a consultation, another *physician* must have made a *written request* for the anesthesiologist's services, and the consultation must include *a history, examination and a written report filed with the patient's record* maintained by the attending physician who requested the consultation. Claims for consultations must include a diagnosis. If the request for the consulting physician's services is not in writing, the requirements are not met. Standing orders in the medical record for consultations or telephone requests are insufficient. A request from a nonphysician allied health practitioner also does not meet the requirements to bill for a consultation. If the consulting physician does not prepare a written report that is sent to the referring physician, a consultation cannot be billed.

ii. *Distinguishing visits from consultations*. A consultation is distinguished from a visit because the requesting physician is seeking the opinion or advice of the consulting physician regarding evaluation or management of a specific problem. If care of the patient is transferred to the consulting physician, the service is a visit, not a consultation. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral. In shorthand terms, a *consultation* is a request to "*evaluate and report back*," whereas a *visit* is a request to "*evaluate and treat*."

iii. *Consultation followed by treatment*. A consulting anesthesiologist may provide services to a patient during a consultation and bill for the consultation, provided that a transfer of care did not occur. The anesthesiologist should document why the services are being provided

and how the services meet the patient's immediate need. If the referring physician transfers complete responsibility of treatment — either orally or in writing — at the time of the request for consultation or referral, the service must be billed as a visit, not as a consultation. Subsequent visits to manage a portion or all of the patient's condition are billed as visits — either established patient office visit or subsequent hospital care, depending on the setting.

iv. *"New" versus "established" patient.* In making the visit/consultation distinction, it also is important to bear in mind the definitions of "new" and "established" patient. A new patient is one who has not received any professional services from the physician or another Group physician of the same specialty within the past three years. All anesthesiology Group members, including chronic pain specialists, are treated as physicians of the same specialty for purposes of making the new/established patient distinction. For practical purposes, that means that a chronic pain patient who is sent for a consultation to a Group pain physician will be considered to be an established patient if another Group anesthesiologist administered anesthesia to the patient within the previous three years in an unrelated surgical procedure.

e. *Critical care.* See ASA *Compliance with Medicare and Other Payor Billing Requirements* (pages 25-26).

i. *General definition.* The AMA CPT™ 2000 defines critical care in the following manner:

> A critical illness or injury acutely impairs one or more vital organ systems such that the patient's survival is jeopardized. The care of such patients involves decision making of high complexity to assess, manipulate and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, postoperative complications, overwhelming infection, or other vital system functions to treat single or multiple vital organ system failure or to prevent further deterioration.

The code usage is determined by the *patient's condition, not by the physician's service.* The need for full attention – the need to monitor the patient's condition closely and to adjust therapy accordingly – distinguishes critical care services. You cannot provide services to any other patient during the same period of time.

ii. *Documentation issues.* If you provide critical care services, you must document the *care given* and include *narrative documentation or ICD-9 diagnosis codes* that support the conclusion that the patient is critically ill. Because critical care coding depends upon the time, you must record the *time spent* with the critically ill patient in the patient's medical record. Time includes time spent in activities directly related to the individual patient's care, including time spent at the patient's immediate bedside or elsewhere on the floor or unit. Time spent in activities that occur outside the unit or off the floor (e.g., telephone calls) do not qualify as critical care services because you are not immediately available to the patient.

iii. *Is payment bundled into payment to the surgeon?* In post-surgical Medicare cases, treatment of *anticipated post-operative complications* is the responsibility of the surgeon, and payment for the service is included in the global surgical payment to the surgeon, which covers a ninety-day period following surgery. In order for anesthesiologists to be eligible for payment, either a) the medical condition requiring critical care services should be independent of the medical condition that required the surgical intervention, or b) the surgeon must transfer care to you (and appropriate modifiers indicating the transfer must be used). It is essential that the medical necessity of your services be documented in the patient's record, through inclusion of *diagnosis codes* that identify that the patient's critical condition is separate from the diagnosis that led to the surgical intervention. If medical necessity is in doubt, it is wise to use one of the higher levels of subsequent inpatient codes, rather than the critical care codes.

iv. *Critical care and the teaching physician*. The teaching physician must be present for the period of time for which any critical care services are billed. Time spent by the resident in the absence of the teaching physician and time spent teaching *cannot* be billed by the teaching physician as critical care.

5. "Bundling" of services and "black box edits." For billing purposes, Medicare and private carriers have "bundled" payment for certain ancillary services that are deemed to be part of the primary procedure into payment for the primary procedure (e.g., the preoperative examination and insertion of I.V. lines are bundled into the anesthetic service and may not be separately billed).

In an effort to cut down on inappropriate billing, HCFA contracted with one of its Part B carriers, AdminaStar Federal, to prepare a "rebundling" manual identifying pairs of CPT-4 codes that cannot be billed together. This effort, and the policy manual accompanying the listing of code pairs, is known as the Correct Coding Initiative (CCI). The so-called "black box edits" are the secret third-party payment rules that result in claim denials based on the particular code or combination of codes submitted. Commercial insurers use software incorporating their own edits to cut costs and have resisted physicians' efforts to learn what may and may not be billed together on the ground that the software algorithms are "proprietary" or trade secrets. HCFA no longer is using commercial black box edits to the software that carriers use to reimburse physicians.

C. DOCUMENTATION

1. Documentation strategies. So how do you document that you did what you know you did? It is useful to envision a complete stranger, unversed in medical practice and unknowledgeable about anesthesiology practice, reviewing anesthesia records from the cases in which you are involved. That person must be able to judge from the anesthesia records whether you have complied with the Medicare or other payor billing rules. An auditor also will have all other documents and records relating to the case to compare with the anesthesia record, including the circulating nurse's notes, the operating room log and the charge slip (if any).

What type of documentation is enough to avoid problems? At the time you are completing an anesthesia record, your expectation is that you are recording the care provided to the patient, not that you are preparing a record to be used in your defense. But you need to recognize that you may need to rely on any medical record you prepare to support your claim for payment in a postpayment audit and possibly to defend yourself in a legal proceeding.

2. General guidelines. The patient's medical record needs to reflect the services that were provided, both to document the care provided and to support a claim for payment. It is advisable to avoid using check-offs and initials alone, which are not informative for indicating presence during a procedure, and instead to make narrative notations to document services provided.

a. *Personally performed cases*. In personally performed cases, you are performing the case without assistance and should document monitoring of the patient's vital signs and explain any unanticipated reactions or changes in vital signs during the procedures. Any invasive monitoring services should be documented as to the location where the monitor was placed.

b. *Medical direction cases*. ***The anesthesiologist must document compliance with medical direction requirements***. Effective January 1999, HCFA rules expressly require the anesthesiologist to document in this manner:

> The physician alone inclusively documents in the patient's record that the conditions [for medical direction] have been satisfied, specifically documenting that he or she performed the preanesthetic exam and evaluation, provided the indicated postanesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

The medical record also must indicate that the medically directing anesthesiologist complied with the other medical direction requirements, which include frequent monitoring and remaining physically present and immediately available through the case.

This requirement does not preclude nurse anesthetists from assisting in the documentation provided that you comply with this rule. Many anesthesiologists, however, rely on nurse anesthetists to document the care provided. Such a practice fails to comply with the requirement that you, the anesthesiologist, document compliance with medical direction requirements. In addition, if you do not check the documentation, you have no assurance that the anesthesia start and stop times listed are accurate or that the services are being properly documented. In medical supervision cases, either the Group anesthesiologist or nurse anesthetist may participate in the documentation.

Anesthesiology practices that use "global" documentation statements (summary statements that you have provided the required services) must make certain that their global statements conform to these requirements and that it is the anesthesiologist who writes the statement. Global statements are better than no documentation, but they are not the preferred way to document services, particularly if physicians sign them without considering whether in fact they actually have performed all of the services referenced in the statement. Ultimately, the documentation in the anesthesia record must reflect the services that were provided and must adequately describe the nature of your involvement in medically directed cases to support the claim for payment.

3. Documentation style. The best documentation consists of written notations identifying the services performed and the time that they were performed. ***Notes written in your individual style are the best format***, rather than a preapproved, more general statement that does not reflect the services provided as accurately. When documenting medical direction services, Group anesthesiologists should comment on each step of medical direction, even if in a summary fashion (e.g., "Induction – smooth").

4. Elements to be documented. The ASA protocol titled "Documentation of Anesthesia Care" provides guidelines for documenting anesthesia services. ASA suggests that anesthesia care be documented to reflect the three general components of anesthesia care - preanesthesia, perianesthesia and postanesthesia services. Documentation of the preanesthetic evaluation should include the patient's medical, anesthesia and medication history; the results of an appropriate physical examination; review of objective diagnostic data; the ASA physical status; and the formulation of an anesthetic plan and discussion of the plan with the patient and/or responsible adult.

The ASA protocol states that documentation of the perianesthesia period should include a time-based record of intraoperative events, including an immediate review prior to initiation of anesthetic procedures of the patient's condition and a check of equipment; monitoring of the patient's vital signs; the amounts of all drugs and agents used and the times given; the types and amounts of all intravenous fluids used, including blood and blood products, and the times administered; the technique(s) used; significant or unusual events during the anesthesia period; and the status of the patient at the conclusion of the anesthesia. In the post-anesthesia period, documentation should reflect the patient's condition on admission and discharge from the PACU, including a time-based record of vital signs and level of consciousness; all drugs administered and their dosages; the type and amounts of intravenous fluids administered; unusual events, including complications; and postanesthesia visits.

Sample documentation strategies are discussed in ASA's *Compliance with Medicare and Other Payor Billing Requirements* (page 20).

5. Timing of documentation. Documentation of services should occur *as contempora-*

neously as possible with the time when the services are provided. Depending upon the condition of each patient under the anesthesiologist's care and the anesthesiologist's need to respond to emergency situations, it may be necessary for the anesthesiologist to document some of the services provided after they occur. In such cases, the time of the entry should be noted, the time differential should be as minimal as possible (no more than a few hours) and the reason for the delay noted. Such late documentation should be reserved for unusual circumstances and cases in which the anesthesia services were routine. In those cases, it may be sufficient for the anesthesiologist to use a "global" compliance statement that represents that the anesthesiologist performed all elements of service necessary.

6. Documentation in cases involving "intraoperative handoffs." If more than one Group anesthesiologist provides medical direction during a case, Group anesthesiologists must identify in the anesthesia record the time when the new anesthesiologist became involved in the care of the patient and which anesthesiologist performed which services. Specifically, the following information must be recorded in the anesthesia record: i) the transfer of care, ii) the time the transfer occurred, iii) the names of all health care providers involved, and iv) which anesthesiologist provided which services. The same requirement applies to Group nurse anesthetists when one nurse anesthetist relieves another during a case.

This exception allowing more than one anesthesiologist to participate in a case applies *only* to anesthesiologists who practice together in the *same group practice*. If more than one group provides services at a facility, or if anesthesiologists are practicing independently, they may not relieve one another in personally performed or medically directed cases (or if they do, they may not bill Medicare for their services; the ability to bill other payors would depend upon each payor's specific rules).

7. Compliance programs

Resource reference

This subject is addressed in detail in Chapter VI of the ASA publication titled *Compliance with Medicare and Other Payor Billing Requirements* (pages 37-39).

In September 2000, the OIG issued Compliance Program Guidance for Individual and Small Group Physician Practices <www.dhhs.gov/progorg/oig/modcomp/webcpg.txt>, which should be considered in developing a compliance program. The OIG also has issued compliance program guidance for a variety of organizations, including hospitals and third-party billing companies that also may provide ideas. The OIG compliance guidance is available at the OIG Web site <www.dhhs.gov/progorg/oig/modcomp/index.htm>.

The sample compliance plan in the ASA Practice Management monograph *Compliance with Medicare and Other Payor Billing Requirements* also may serve as a resource. The sample plan needs to be tailored to address the areas of greatest risk for a particular group and to identify any particular requirements imposed by the local Medicare Part B carrier.

The Practice Management column in the December 1999 issue of the *ASA NEWSLETTER* addresses practical issues in approaching compliance plan development.

D. OVERVIEW OF FRAUD AND ABUSE LAWS

Resource reference

This subject is addressed in detail in Chapter II of the ASA publication titled *Compliance with Medicare and Other Payor Billing Requirements* (pages 2-11).

1. False claims. The submission of false claims to the federal government is prohibited by several different statutes. A "false" claim includes a claim that does not conform to

Medicare (or other government program) requirements for payment. Substantial compliance with Medicare billing requirements will not preclude a determination that a claim is false and that a physician is liable for civil or even criminal penalties.

2. Antikickback statute.

a. *In general*. The Medicare and Medicaid Patient and Program Protection Act of 1987, commonly known as the antikickback law, is a criminal statute that bars the *knowing and willful* solicitation or receipt of any *remuneration* "in return for" i) referring a patient or ii) purchasing or otherwise arranging for an item or service for which payment may be made under Medicare, other federal health plans or Medicaid. It also prohibits the offer or payment of remuneration *to induce* a person to refer patients.

b. *Agreements with hospitals*. The following arrangements with hospitals are among other situations that raise potential kickback concerns, particularly if the hospital is conditioning the award of an exclusive contract on the physicians' willingness to provide the services without compensation:

- a hospital's requirement that the Group provide substantial administrative and quasi-clinical services without compensation, or with below-market compensation;
- a requirement that the Group cover "inefficient" anesthetizing locations (e.g., MRI or lithotripsy) where cases are not necessarily scheduled in an efficient manner, which results in the Group allocating one anesthesiologist to cover that area for the day;
- a demand that the Group provide in-house coverage for unprofitable services, such as a requirement that the Group provide an anesthesiologist (or nurse anesthetist) in-house for a particular service (e.g., obstetric or trauma coverage), where the collections do not cover the cost of providing the service; or
- a Hospital's insistence that it control global or package payments or, indeed, other managed care arrangements, which would give the Hospital control over the amount it would pay the Group for its professional services.

The greater the pressure the Hospital exerts on the Group to accept these or other conditions that economically disadvantage the Group and benefit the Hospital, and the more the Hospital sets acceptance of these economically disadvantageous terms as a condition – implied or express – of awarding an exclusive contract, the more the Hospital's insistence on these terms approaches a kickback.

c. *Professional courtesy discounts*. Any discount — including professional courtesy discounts extended in private third-party payor cases — to any physician or staff member (or a member of the physician's or staff member's family) who is in a position to refer patients covered by Medicare, Medicaid, CHAMPUS or other federally sponsored health insurance programs should be reviewed for compliance with the antikickback law. See ASA's *Compliance with Medicare and Other Payor Billing Requirements* (page 9).

d. *Investments in ASCs*. When physicians invest in ASCs, the federal government's concern is whether the financial return the physicians receive represents compensation for referrals to the facility and, therefore, could cause them to refer patients without medical necessity. In November 1999, the OIG issued a "safe harbor" rule governing investments in ASCs that outlines the conditions under which the government would not pursue enforcement action. These guidelines include a requirement that investment interests be offered on terms not related to the volume or value of referrals and, in the case of multispecialty ASCs, establish a "one-third/one-third" test: at least one-third of the physician's clinical practice income be derived from procedures that can be performed only in a hospital or ASC and that the

physician perform at least one-third of the procedures requiring a hospital or ASC at the particular ASC in which the physician is investing. The Practice Management column in the February 2000 issue of the *ASA NEWSLETTER* addresses this safe harbor in greater detail.

3. Stark self-referral prohibitions. The Stark II self-referral prohibitions bar physicians from referring Medicare patients for a list of *designated health services* if the referring physician or an immediate family member has a financial relationship through ownership or compensation with the provider of the services. Anesthesiology services are not included in the list of designated health services, so that the federal self-referral prohibition generally does not apply to anesthesiologists. You should consider the scope of any state self-referral law in connection with any investment in a facility or service to which you might refer patients.

4. Health care fraud and abuse and private payors. The expansion of federal anti-fraud provisions to cover *private* health care plans is perhaps the most significant change effected by HIPAA. See ASA's *Compliance with Medicare and Other Payor Billing Requirements* (pages 10-11).

5. Professional courtesy discounts. The practice of granting professional courtesy discounts – both in Medicare and private payor cases – is problematic in a number of respects and may result in false statements liability, potential kickbacks, violations of the HIPAA prohibition on providing "remuneration" to Medicare and Medicaid beneficiaries, breaches of MCO participation agreements and violation of parallel state laws. See ASA's *Compliance with Medicare and Other Payor Billing Requirements* (pages 27-28).

CHAPTER XI. CONCLUSION

This monograph represents only an introduction to the business aspects of the practice of medicine. The need for you to become involved in the business end of your practice is likely to increase as governmental and private payors push for better deals, hospitals and ASCs position themselves to be in the most favorable competitive posture, and different types of service providers (e.g., billing services and software developers) vie for your business. Carefully constructed legal documents can provide important protections for you and your Group, just as poorly conceived agreements can tie you or your Group to an unhappy relationship.

You can best protect your interests by taking an active role in monitoring the health of your practice. Understanding the myriad rules that regulate medical practice and payment for services provides the necessary foundation against which to assess the vigor of your practice, as well as an understanding of the business environment. These tools, in turn, will help you identify potential problems at an early stage. The more educated you become, the better you will be able to recognize when you need professional assistance in dealing with a challenge and the more likely you will be to obtain assistance sufficiently early in the process so that the positions of the parties have not hardened.

Properly prepared, you can be your own best advocate. By learning what tasks can be delegated to others and when it is important to be in the forefront, you can free yourself to focus on the patient care that you have spent so many years training to provide.

APPENDIX A: GLOSSARY AND INDEX OF ACRONYMS, ABBREVIATIONS AND TERMINOLOGY

A. ORGANIZED BY TOPIC AREA

1. ABBREVIATIONS USED IN THE TEXT OR COMMONLY USED

ASC — Ambulatory surgical center.

CFR — Code of Federal Regulations.

"Claims-made" policy — An insurance policy that provides coverage for claims asserted during the time period the liability policy is in effect. Once the policy expires or terminates, insurance protection stops. Physicians generally purchase a "tail" policy to cover liability during the otherwise uncovered period.

"Clean sweep" — A contractual provision that ties a physician's privileges to the existence of the agreement and provides that the privileges of Group physicians automatically will terminate upon termination or expiration of the agreement for any reason.

CPT™ — [Physicians'] *Current Procedural Terminology*, currently in the Fourth Edition, published by the American Medical Association, which lists descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

CROSSWALK™ — An ASA publication which is a systematic listing of all AMA CPT-4 codes, except pathology, with appropriate anesthesia CPT-4 codes.

DNR order — Do-not-resuscitate order.

E&M code — Evaluation and management code.

FFS — Fee-for-service method of reimbursement.

ICD or ICD-9 — International Classification of Diseases, 9th Revision. A comprehensive listing of diagnosis codes used to describe the diagnosis, symptom, complaint, condition or problem; used for clinical and billing purposes.

"Occurrence" policy — An insurance policy that provides coverage for claims relating to clinical services provided during the time the insurance coverage is in effect, no matter when a claim relating to those services is asserted.

PACU — Postanesthesia care unit or recovery room.

PCP — Primary care physician.

RFP — Request for proposal.

RRC — The Residency Review Committee for Anesthesiology that establishes program requirements for residency education in anesthesiology. The RRC and the Accreditation Council for Graduate Medical Education ("ACGME") accredit residency programs that meet the RRC requirements.

RUC — The AMA/Specialty Society Relative Value Update Committee.

RVG — Relative value guide.

2. BUSINESS/LEGAL TERMINOLOGY

ADR — Alternative dispute resolution.

C corporation — A corporation that has not elected Subchapter S status.

the Code — The Internal Revenue Code.

Economic credentialing — Credentialing a physician based upon the physician's impact on the hospital's bottom line, rather than the quality of care the physician provides, in determining whether to grant or deny privileges.

EIN — Employer identification number (the tax identifying number assigned to entities, analogous to the Social Security number issued to individuals).

IRA — Individual retirement account.

LLC — Limited liability company.

LLP — Limited liability partnership.

MCO — Managed care organization.

Relator — "Whistleblower." In the context of the False Claims Act, the private person with knowledge of false claims or fraud who brings a lawsuit in his/her own name and in the name of the United States.

Rider — A supplement to an insurance policy that covers a risk that otherwise is excluded from coverage under the policy.

S corporation — A corporation that has elected "Subchapter S" status under the Internal Revenue Code.

SIMPLE plan — Savings Incentive Match Plan for Employees.

SSN — Social Security Number.

Subchapter S status — An election under federal tax laws that provides for "pass-through" taxation as a partnership with profits and losses attributed to the members, rather than to the entity.

Qui tam action — An action brought by an informer under a statute, such as the federal False Claims Act, that establishes a penalty for the commission (or omission) of a certain act, and provides that part of any recovery is to go to the person bringing the action, with the remainder going to the state. *Qui tam* is an abbreviation of a longer Latin phrase that in full means: "Who sues on behalf of the King as well as for himself."

3. FEDERAL LAWS AND FEDERAL PROGRAMS

ADA — Americans with Disabilities Act.

CHAMPUS — Civilian Health and Medical Program of the Uniformed Services.

COBRA — Consolidated Omnibus Budget Reconciliation Act. COBRA provides for an employee or an employee's spouse or dependents to elect up to 18 months of continued group health coverage at their own expense in the event of termination of employment other than for gross misconduct, retirement or reduction in hours.

EMTALA — Emergency Medical Treatment and Active Labor Act. EMTALA is a federal statute that prohibits the refusal of services or transfer of patients prior to screening and stabilization.

FICA — Federal Insurance Contribution Act, which establishes the requirement of employer and employee contributions to the Social Security system.

FUTA — Federal Unemployment Tax Act.

HIPAA — Health Insurance Portability and Accountability Act.

TEFRA — Tax Equity and Fiscal Responsibility Act (1982). HCFA issued the medical direction rules under authority of TEFRA.

4. FEDERAL AGENCIES AND AGENCY ABBREVIATIONS

CMS — Centers for Medicare & Medicare Services (previously known as HCFA).

DEA — Drug Enforcement Administration.

DOJ — Department of Justice.

HCFA — Health Care Financing Administration, a unit of the Department of Health and Human Services. HCFA is responsible for administering the Medicare program. Effective June 14, 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

HHS — the Department of Health and Human Services.

IRS — Internal Revenue Service.

NLRB — National Labor Relations Board.

NPRM — Notice of Proposed Rulemaking.

OIG — Office of Inspector General within the Department of Health and Human Services.

OSHA — Occupational Safety and Health Administration.

5. MEDICARE & MEDICAID TERMINOLOGY

ABN — Advance Beneficiary Notice, a form that advises the beneficiary that Medicare may not pay for the service.

"Accept assignment" — An agreement on the part of the participating physician to accept the Medicare or Medicaid allowable, which the beneficiary (the patient) assigns to the physician, as payment in full for the physician's services.

"Black box" edits — The secret third-party payment rules that result in claim denials based on the particular code or combination of codes submitted.

Bundling — The practice by Medicare and some private carriers of including payment for certain covered services within the payment for the primary procedure or service rather than reimbursing separately for those covered services.

CAC — Carrier advisory committee.

CCI — The Correct Coding Initiative, a manual prepared for HCFA that lists those pairs of CPT-4 codes that cannot be billed together.

CF — Conversion factor. In the Medicare context, the CF is set by HCFA. In the non-Medicare context, physicians are free to establish their own CFs.

DRG — Diagnosis-related group (the basis for payments to hospitals and other providers under Medicare Part A).

EDI — Electronic data interchange.

EOMB — Explanation of Medicare Part B benefits.

Form 855 — Medicare Part B provider enrollment form.

FFP — The federal financial participation for the Medicaid program that consists of the federal matching funds for state Medicaid expenditures.

GAF — Geographic adjustment factor.

Limiting charge — A limitation on the amount that nonphysicians may charge Medicare beneficiaries. The limiting charge is 115 percent of the lower nonparticipating fee schedule payment (i.e., 109.25 percent higher than the allowable charge).

MAAC — Maximum Allowable Actual Charge.

MCM — Medicare Part B Carriers Manual.

MEI — Medicare Economic Index.

MFS — Medicare Fee Schedule.

PPS — Prospective payment system that is the basis on which Medicare compensates hospitals.

RBRVS — Resource-Based Relative Value Scale (the methodology underlying the Medicare Physician Fee Schedule).

RVU — Relative value unit.

Unbundling — The practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced rate.

UPIN — Unique Provider Identification Number.

6. PRIVATE ORGANIZATIONS

AAA — Anesthesia Administration Assembly, a unit of the Medical Group Management Association.

AANA — American Association of Nurse Anesthetists.

ABA — American Board of Anesthesiology.

ABMS — American Board of Medical Specialists.

AMA — American Medical Association.

ASA — American Society of Anesthesiologists.

FSMB — Federation of State Medical Boards.

JCAHO — Joint Commission on Accreditation of Healthcare Organizations.

MGMA — Medical Group Management Association.

NCQA — National Committee of Quality Assurance. NCQA accredits managed care organizations.

B. ORGANIZED ALPHABETICALLY

ADR — Alternative dispute resolution.

AAA — Anesthesia Administration Assembly, a unit of the Medical Group Management Association.

AANA — American Association of Nurse Anesthetists.

ABA — American Board of Anesthesiology.

ABMS — American Board of Medical Specialists.

ABN — Advance Beneficiary Notice, a form that advises the beneficiary that Medicare may not pay for the service.

"Accept assignment" — An agreement on the part of the participating physician to accept the Medicare or Medicaid allowable, which the beneficiary (the patient) assigns to the physician, as payment in full for the physician's services.

ADA — Americans with Disabilities Act.

AMA — American Medical Association.

ASA — American Society of Anesthesiologists.

ASC — Ambulatory surgical center.

"Black box" edits — The secret third-party payment rules that result in claim denials based on the particular code or combination of codes submitted.

Bundling — The practice by Medicare and some private carriers of including payment for certain covered services within the payment for the primary procedure or service rather than reimbursing separately for those covered services.

C corporation — A corporation that has not elected Subchapter S status.

CAC — Carrier advisory committee.

CCI — The Correct Coding Initiative, a manual prepared for HCFA that lists those pairs of CPT-4 codes that cannot be billed together.

CF — Conversion factor. In the Medicare context, the CF is set by HCFA. In the non-Medicare context, physicians are free to establish their own CFs.

CFR — Code of Federal Regulations.

CHAMPUS — Civilian Health and Medical Program of the Uniformed Services.

"Claims-made" policy — An insurance policy that provides coverage for claims asserted during the time period that the liability policy is in effect. Once the policy expires or terminates, insurance protection stops. Physicians generally purchase a "tail" policy to cover liability during the otherwise uncovered period.

"Clean sweep" — A contractual provision that ties a physician's privileges to the existence of the agreement and provides that the privileges of Group physicians automatically will terminate upon expiration of the agreement for any reason.

CMS — Centers for Medicare & Medicare Services (previously known as HCFA).

COBRA — Consolidated Omnibus Budget Reconciliation Act.

the Code — The Internal Revenue Code.

CPT™ — [Physicians'] *Current Procedural Terminology*, currently in the Fourth Edition, published by the American Medical Association, which lists descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

CROSSWALK™ — An ASA publication that is a systematic listing of all AMA CPT-4 codes except pathology with appropriate anesthesia CPT-4 codes.

DEA — Drug Enforcement Administration.

DNR order — Do-not-resuscitate order.

DOJ — United States Department of Justice.

DRG — Diagnosis-related group (the basis for payments to hospitals and other providers under Medicare Part A).

Economic credentialing — Credentialing a physician based upon the physician's impact on the hospital's bottom line, rather than the quality of care the physician provides, in determining whether to grant or deny privileges.

EDI — Electronic data interchange.

EIN — Employer identification number (the tax identifying number assigned to entities,

analogous to the Social Security number issued to individuals).

E&M code — Evaluation and management code.

EMTALA — Emergency Medical Treatment and Active Labor Act. EMTALA is a federal statute that prohibits the refusal of services or transfer of patients prior to screening and stabilization.

EOMB — Explanation of Medicare Part B benefits.

FFP — The federal financial participation for the Medicaid program that consists of the federal matching funds for state Medicaid expenditures.

FFS — Fee-for-service method of reimbursement.

FICA — Federal Insurance Contribution Act, which establishes the requirement of employer and employee contributions to the Social Security system.

Form 855 — Medicare Part B provider enrollment form.

FSMB — Federation of State Medical Boards.

FUTA — Federal Unemployment Tax Act.

GAF — Geographic adjustment factor.

HCFA — Health Care Financing Administration, a unit of the Department of Health and Human Services. HCFA is responsible for administering the Medicare program. Effective June 14, 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS).

HHS — The United States Department of Health and Human Services.

HIPAA — Health Insurance Portability and Accountability Act.

ICD or ICD-9 — International Classification of Diseases, 9th Revision. A comprehensive listing of diagnosis codes used to describe the diagnosis, symptom, complaint, condition or problem; used for clinical and billing purposes.

IRA — Individual retirement account.

IRS — Internal Revenue Service.

JCAHO — Joint Commission on Accreditation of Healthcare Organizations.

Limiting charge — A limitation on the amount that nonphysicians may charge Medicare beneficiaries. The limiting charge is 115 percent of the lower nonparticipating fee schedule payment (i.e., 109.25 percent higher than the allowable charge).

LLC — Limited liability company.

LLP — Limited liability partnership.

MAAC — Maximum Allowable Actual Charge.

MCM — Medicare Part B Carriers Manual.

MCO — Managed care organization.

MEI — Medicare Economic Index.

MFS — Medicare Fee Schedule.

MGMA — Medical Group Management Association.

NLRB — National Labor Relations Board.

NCQA — National Committee for Quality Assurance. NCQA accredits managed care organizations.

NPRM — Notice of Proposed Rulemaking.

"Occurrence" policy — An insurance policy that provides coverage for claims relating to clinical services provided during the time the insurance coverage is in effect, no matter when a claim relating to those services is asserted.

OIG — Office of Inspector General within the Department of Health and Human Services.

OSHA — Occupational Safety and Health Administration.

PACU — Postanesthesia care unit or recovery room.

PCP — Primary care physician.

PPS — Prospective payment system.

***Qui tam* action** — An action brought by an informer under a statute, such as the federal False Claims Act, that establishes a penalty for the commission (or omission) of a certain act, and provides that part of any recovery is to go to the person bringing the action, with the remainder going to the state. *Qui tam* is an abbreviation of a longer Latin phrase that in full means: "Who sues on behalf of the King as well as for himself."

RBRVS — Resource-Based Relative Value Scale (the methodology underlying the Medicare Physician Fee Schedule).

Relator — "Whistleblower." In the context of the False Claims Act, the private person with knowledge of false claims or fraud who brings a lawsuit in his/her own name and in the name of the United States.

RFP — Request for proposal.

RUC — The AMA/Specialty Society Relative Value Update Committee.

RVG — Relative value guide.

S corporation — A corporation that has elected "Subchapter S" status under the Internal Revenue Code.

SIMPLE plan — Savings Incentive Match Plan for Employees.

SSN — Social Security number.

Subchapter S status — An election under federal tax laws that provides for "pass-through" taxation as a partnership with profits and losses attributed to the members rather than to the entity.

TEFRA — Tax Equity and Fiscal Responsibility Act (1982).

Unbundling — The practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together and therefore at a reduced rate.

UPIN — Unique Physician Identification Number.