



## President's Message

by **Craig L. Muetterties, MD**

My winter message mentioned the recent interactions between physician anesthesiologists and nurse anesthetists that were initiated by both the ASA and AANA last year. I have been encouraged by the willingness of both groups to do this since all that we do is "about the patient", as ASA Past President Roger Litwiller, MD states whenever he speaks on this topic.

About six months ago, Dr. Litwiller let me know that he had been asked to address the Pennsylvania Association of Nurse Anesthetists at their annual meeting in Hershey this spring. I was encouraged by the initiative taken by this organization and asked Roger if he thought it would be OK if I attended as a "fly on the wall" to offer my support of his work. My reply came from the PANA coordinator for the event. Diana Davidson, CRNA invited me to not only attend Dr. Litwiller's lecture but also to participate as a presenter at the meeting!

I can speak for both Dr. Litwiller and myself and say that we were received with warm greetings from PANA's board of directors and enthusiastic responses to our presentations. I was given

the opportunity to speak on the topic of my choice at the meeting and chose "Management of the Geriatric Patient" as my topic. This topic is important to anesthesia providers in Pennsylvania since Pennsylvania is one of 9 states with over 1,000,000 citizens over 65 and 8% of these people live below the poverty line. This number places Pennsylvania as the state with the second highest percentage of citizens who are 65 years of age or older. Older patients are seen with increasing frequency in settings where they will be subjected to general anesthetics of short duration for procedures in gastroenterology and electrophysiology suites. Geriatric issues are great examples of topics where the two organizations can find consensus.

The publication of the joint statement on the safe use of propofol in unintubated patients by both organizations is an example of how this relationship can work. Patients across America face a potential danger from physicians who are willing to perform their procedure while medically directing a registered nurse-- they may find themselves caring for a

patient in the middle of a general anesthetic that neither caregiver is trained to manage. It is in areas like this that our organizations can begin to work together for maximum effectiveness.

Any healthy relationship between our organizations will be focused on topics that will be focused on patient care. I firmly believe that this relationship should avoid any issues that are political in nature. This will eliminate any item that is raised unilaterally by either organization. PSA has given the Professional Relations Committee, chaired by Joseph Answine of Harrisburg, the responsibility to represent your society in this venture. I need your prayers for success in this and I applaud the Pennsylvania Association of Nurse Anesthetists for their willingness to open the door with us to this process in Pennsylvania.

**Your PSA  
Pennsylvania  
Legislative  
Directory  
is Enclosed  
2005-2006  
(good for 2006!)**



## Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

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# ASA 2005 Legislative Conference

by Paul J. Schaner, M.D., District Director

The ASA held its Annual Legislative Conference May 2-4 at the JW Marriott in Washington, DC. The conference was attended by 397 ASA members, which included 26 resident members. The resident attendance has fortunately steadily increased. This conference should be a part of resident education. The leaders of tomorrow must be also skilled in legislative methodology. This activity is key for the legislative agenda of the society's members. The dedication of the attendees to learn the issues and lobby their senators and representatives is demanding and time consuming. This is time away from home, family and income. This is a necessary function that is required at the state and national level. I applaud the participants and the Washington staff responsible for the conference. Ronald Szabat, J.D., LL.M. as the new Director of the ASA Washington Office has made a seamless transition. The able Manuel Bonilla of the Washington Office continues his flawless performance and input to ASAPAC.

The Pennsylvania members who attended included the following: Richard P. Albertson, M.D., Edward H. Dench, M.D., Robert F. Early, Jr., M.D., Joseph W. Galassi, M.D., Donald Martin, M.D., Craig Muetterties, M.D., Steven W. Neely, M.D., Richard P. O'Flynn, M.D., Carol E. Rose, M.D., Paul J. Schaner, M.D., Stephen R. Strelec, M.D., Erin A. Sullivan, M.D., Joseph F. Talarico, M.D., Alec Tisdall, M.D. (Resident), Benjamin D. Unger, M.D. (Resident) and Patrick J. Vlahos, D.O.

The formal program featured a spectrum of distinguished speakers knowledgeable on pending legislative issues of concern for members of the ASA. Mr. Doug Badger, Deputy Assistant to the



President's Office of Legislative Affairs addressed the conference. He is a key advisor to President Bush. The members of congress who also addressed the conference included the following: The Honorable Jim DeMint(R-SC) from the Special Committee on Aging, the Honorable Richard E. Neal(D-MA) from the Committee on the Budget, The Honorable Tom Price, M.D.(R-GA) Member Committee on Education and Workforce, the Honorable Nancy L. Johnson(R-CT) Chair Committee on Ways and Means, Subcommittee on Health, The Honorable Frank Pallone, Jr.(D-NJ) Committee on Energy and Commerce, Subcommittee on Health, The Honorable Benjamin L. Cardin(D-MD) Member on Ways and Means, and The Honorable Jim Ramstad(R-MN) Member Committee on Ways and Means, Subcommittee on Health. These



individuals gave background information on current issues. Various position papers on the key issues for the coming year were distributed prior to the conference for review at home and key issues were reviewed in depth by the Washington staff during the conference. Ms. Patricia A. Clark gave a great presentation for strategies for communicating effectively with Congress effectively using attending conferees in various scenarios on stage. This

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# Workers' Compensation Reimbursement: Prompt Payment and Related Rules

By now everyone should be reaping the benefits of the Society's successful effort to increase the anesthesia conversion factor used in the Workers' Compensation system, which took effect in December of 2004. But in

addition to getting better reimbursement for treating injured workers, you are also entitled to relatively prompt payment.

The basic rule under both the Workers' Compensation Act and the Department of Labor and Industry regulations

is that providers are entitled to payment within 30 days of the insurer's receipt of a clean claim. In practical terms, this has resulted in the "36 day rule", adding 3 days for mail service to and from the provider's and insurer's offices. The interest on a late-paid bill, or portion of a bill, is at an above-market rate of 10%. When there is a dispute as to a portion of treatment, payment is due on all non-disputed care.

Payment, however, is not as straight-forward as with Medicare or private insurance in general, and is more akin to the process with patients injured in motor vehicle accidents. First, the insurer can dispute the reasonableness or necessity of the treatment. In

this respect, the anesthesiologist is the passive victim of the challenge to the surgeon's decision on medical necessity. Indeed, you can argue that the anesthesia is always necessary, even if the surgery was not. Second, the insurer can also argue that the injury requiring the care was not the result of a work-related injury. In either event, the Workers' Compensation process will decide the issue, generally without any involvement from the anesthesiologist, and if it rules that the care is reasonable or the injury is work-related, interest is due from the 36th day following receipt of the bill. If the injury and care aren't work-related but were necessary, the patient or his other insurer, which s/he hopefully has, can and should be billed.

The process of an insurer's challenge to the reasonableness or necessity of treatment generally operates through a utilization review organization. A UR organization is to issue a written report within 30 days of a request. A provider who disagrees with the UR result can challenge that decision via a Petition for Review asking the Worker's Compensation Bureau to review the matter administratively. The provider must do so within 30 days of the UR decision or within 90 days after the original billing date, which is first. The regulations list required documentation. The Bureau is to provide its administrative decision within 30 days of receipt of the documents.

**The basic rule under both the Workers' Compensation Act and the Department of Labor and Industry regulations is that providers are entitled to payment within 30 days of the insurer's receipt of a clean claim.**

That decision too can be challenged via an application for fee review. This is a more formal review, with a hearing before an administrative hearing officer. The hearing is less formal than a court proceeding, with lawyers permitted but not required. Finally, dissatisfied parties can appeal that decision to Commonwealth Court. One such case, with lawyers and on the related topic of "self referrals", made it all the way to the Pennsylvania Supreme Court.

For more information on this subject, feel free to contact Bob Hoffman at [rhoffman@wolfblock.com](mailto:rhoffman@wolfblock.com) or (717) 237-7182. Mr. Hoffman is a partner in WolfBlock's Health Law Practice, Harrisburg office.



## ASA 2005 Legislative Conference

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was utilized to make the visits on the Hill effective as possible.

A few topics of concern in the lobbying effort included the following: Medicare Physician Reimbursement Update and importantly, correction of the sustainable growth rate (SGR) formula which is the cause for the annual problem, parity for Medicare Anesthesia reimbursement and for teaching reimbursement of residents, Medical Litigation Reform, Patient Safety to include voluntary confidential reporting of medical errors, and physician antitrust reform for a fairer playing field to deal with third party payers.

Your delegation made a special lobbying effort with Senator Rick Santorum to address the issue of parity for Medicare teaching reimbursement of residents. The Senator responded and wrote in support of this request. While it does not guarantee it will come to be, without the effort it would never happen. The future of the specialty depends upon the teaching and education of the anesthesiologists of tomorrow.

A highlight of the conference was the presentation of



Robert F. Early, MD (President-Elect), W. Alec Tisdall, MD (President of Resident Component), and Joseph Talerico, DO (PSA Alternate Delegate) in front of the capitol in Washington, DC, during visits with members of Congress on May 4, 2005.

the Excellence in Government Award to Ervin Moss, M.D. of New Jersey for his exemplary contributions to the medical specialty of Anesthesiology and its practitioners and their patients. Dr. Moss has been a tireless worker for patient safety and a model for physician political action. He is the poster child for a physician political activist. A similar award was given to The Honorable Bill Frist, M.D. Congratulations to both who

exemplify the quintessential physician in government.

I invite members of the Pennsylvania Society to attend the conference next year in Washington. I also ask you to reserve Monday, October 17, 2005 for the PSA state legislative reception in Harrisburg. The reception for our state legislators is from 6:00 – 8:00 pm with a pre-reception dinner and briefing at 4:30 pm. This reception is key to our success in the coming year in Pennsylvania. **BE THERE!** If you ever thought, why doesn't somebody do something about it.....you are somebody..... **BE THERE.**



## Your Medical Specialty Needs You This Year – Your Time, Your Effort, Your Money

by **John P. Milliron, Esquire**

The PSA is having a Legislative Reception on Monday, October 17, at the Harrisburg Hilton. Ten years ago over 150 of our members attended. Two years ago when we last held the event, fewer than fifty of our members were there. There are always many of you who just cannot get

away because of schedules. But there are surely more than 50 out of 1250 of us in the state that don't have conflicts!

There is a registration form in the newsletter. Please return it today and plan to attend the Reception on October 17. We will be sending specific information

on directions and format later this month. This one-on-one setting with legislators is a critical part of our success.

Your elected representatives remember when you take the time to come to Harrisburg to

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# Heal Thyself

Once Seen as Risky, One

Group Of Doctors Changes Its Ways

Anesthesiologists Now Offer Model of How to Improve Safety, Lower Premiums

Surgeons Are Following Suit

by Joseph T. Hallinan, Tuesday, June 21, 2005, Wall Street Journal



The rising cost of medical-malpractice insurance has hit many doctors, especially surgeons and obstetricians. But one specialty has largely shielded itself:

Anesthesiologists pay less for malpractice insurance today, in constant dollars, than they did 20 years ago. That's mainly because some anesthesiologists chose a path many doctors in other specialties did not. Rather than pushing for laws that would protect them against patient lawsuits, these anesthesiologists focused on improving patient safety. Their theory: Less harm to patients would mean fewer lawsuits.

Over the past two decades, anesthesiologists have advocated the use of devices that alert doctors to potentially fatal problems in the operating room. They have helped develop computer-

ized mannequins that simulate real-life surgical crises. And they have pressed for procedures that protect unconscious patients from potential carbon-monoxide poisoning.

All this has helped save lives. Over the past two decades, patient deaths due to anesthesia have declined to one death per 200,000 to 300,000 cases from one for every 5,000 cases, according to studies compiled by the Institute of Medicine, an arm of the National Academies, a leading scientific advisory body.

Malpractice payments involving the nation's 30,000 anesthesiologists are down, too, and anesthesiologists typically pay some of the smallest malpractice premiums around. That's a huge change from when they were considered among the riskiest doctors to insure. Nationwide, the average annual premium for anesthesiologists is less than \$21,000, according to a survey by the American Society of Anesthesiologists. An obstetrician might pay 10 times that amount, Medical Liability Monitor, an industry newsletter, reports.

In some areas, anesthesiologists can now buy malpractice insurance for as little as \$4,300 a year, although premiums ranged as high as more than

\$56,000, according to the ASA. The ASA survey gave no general explanation for the disparity but did note that premiums were higher for anesthesiologists who had been sued before and for those who perform higher-risk procedures.

A 1999 report by the Institute of Medicine noted that "few professional societies or groups have demonstrated a visible commitment to reducing errors in health care and improving patient safety." It identified one exception: anesthesiologists.

"If there were any specialty where you said, 'Show me who has done anything right,' I would point to the anesthesiologists," says Neil Kochenour, medical director at the University of Utah Hospitals and Clinics. "They have really made some inroads and some impact."

Medical errors are a leading cause of death in the U.S., killing between 44,000 and 98,000 Americans each year, according to various studies.

Medical-malpractice insurance rates for some specialties, such as obstetrics and general surgery, have risen in some areas, especially in the past few years, as insurers have reported higher paid losses. The insur-

ance industry and many doctors groups have blamed greedy plaintiff's lawyers and capricious juries for those losses. As a remedy, insurers and many medical organizations have pushed for legislation that caps damage awards and lawyers' fees. Most states have enacted some form of tort reform.

Many anesthesiologists also support legislative moves to rein in malpractice suits. "Even though we've controlled costs, it's still a big issue for our membership," says Karen B. Domino, chair of the ASA's committee on professional liability.

But overall, anesthesiologists have put more emphasis on improving safety. And now, some doctors in other fields are praising them for choosing a different response. Noting the success achieved by anesthesiologists, other doctors — notably surgeons — have aimed more at improving treatment methods. "There's a lot of room for us to do a better job and decrease liability, not just for patient safety but to reduce liability [premiums]," says F. Dean Griffen, a surgeon in Shreveport, La., who heads the patient-safety and professional-liability committee for the American College of Surgeons. That professional group recently launched a study of cases modeled on one that helped anesthesiologists recognize some of their shortcomings years ago.

For most of its 160-year history, anesthesiology, the practice of rendering a patient unconscious or insensitive to pain, has been fraught with danger. As recently as 30 years ago, doctors in the U.S. still made patients unconscious by administering ether and other flammable gasses. On rare occasions, static electricity

# Commentary

by Ed Dench, MD

Past President Pennsylvania Medical Society

Past President Pennsylvania Society of Anesthesiologists

Delegate American Society of Anesthesiologists

The accompanying Wall Street Journal article lauds anesthesiologists for improving safety and consequently lowering our malpractice premiums.



The article gives an accurate account of the many ways anesthesiologists have been leaders in patient safety. We need to emphasize that it was anesthesiologists

that made the difference in both discovery of common mistakes and the education of the anesthesia community of these mistakes. Indeed, we should be proud of our commitment to patients and to our improvements in practice. However, we should remain cautious towards the flattery of this media attention, as they suggest a suspicious means and motivation for patient safety. In particular the article suggests that our improvements in safety are in response to litigation. In reality, our 100 years of efforts towards safety have been made not because of, but in spite of the tort system. Most tort cases are sealed and little if anything is ever learned to help avoid mistakes. Only after great effort were we able to see closed claims and make use of 10 year old data.

The premise of the article (promulgated by the Plaintiff bar) is that there would be no malpractice crisis if we physicians just stop making mistakes. There is no mention of many frivolous lawsuits or that physicians win in 80% of cases that go to court. It fails to report the fact that

anesthesiologists' malpractice premiums in PA have doubled in 5 years and in PA we pay double the rate paid in California where tort reform occurred in 1975. It was the anesthesiologists in California that lead the charge for tort reform and without their efforts it would not have passed. Clearly anesthesiologists through studying closed claims have reduced the risks of mishaps occurring. Lawsuit abuse, however, has increasingly created an environment that silences physician discussion of mistakes out of fear of legal reprisal. The legal system does not improve quality of care but instead maximizes income to attorneys (plaintiff and defense) and compensates those injured in a sporadic fashion. Open frank discussion of bad outcomes whether a suit is filed or not will improve quality of care. There is a need for state or national peer review that allows us to learn without reprisals and biases. That is exactly what the review panel did when they looked at the closed claim data. Specialists should evaluate their specialty to improve quality.

No physician wants or sets out to make a mistake. We all want to learn from others but it is the legal system, not the good physicians in this country that impedes our ability to improve. It is great to be praised but we must continue to fight for tort reform (or for a totally different system) so that we can continue to improve care for our patients and continue our leadership role in patient safety.

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sparked explosions. Less rarely, patients asphyxiated during surgery because their breathing tubes mistakenly became disconnected.

In 1982, the ABC news program "20/20" aired a piece on anesthesia-related deaths. "It was a devastating indictment of anesthesia," recalls Ellison C. Pierce Jr., a retired professor of anesthesiology at Harvard Medical School who is considered by many to be the father of the modern anesthesia-safety movement.

Around the same time, anesthesiologists were getting hit by their second wave of big malpractice-insurance premium increas-

es in a decade. The specialty was then considered among the riskiest to insure, and premiums were often two to three times as high as those other doctors paid. Casey Blitt, a 63-year-old Tucson, Ariz., anesthesiologist who has long been active on patient-safety issues, says his insurance soared to \$50,000 a year from \$20,000 or less. Dr. Pierce says anesthesiologists were "terrified," and anxious to do something.

Dr. Pierce at the time was president of the American Society of Anesthesiologists. In 1985, that group provided \$100,000 to launch the Anesthesia Patient Safety Foundation. The new foundation was unusual in medicine: a stand-alone organization solely devoted to patient safety. Working closely with the larger ASA, from which it still receives about \$400,000 a year, the foundation galvanized safety research and improvement.

Unlike most other medical groups, the foundation admitted as members not only doctors but nurses, insurers and even companies that make products used by anesthesiologists. Industry's participation initially caused angst over whether the foundation was designed merely to sell machines. But over the years, that concern dissipated, Dr. Pierce says, as company money helped the organization fund important research.

One advance was the development of high-tech mannequins that allow anesthesiologists to practice responses to allergic reactions and other life-threatening situations. Anesthesiologists say the mannequins have

also allowed them to become more proficient at performing an emergency procedure akin to a tracheotomy that involves slitting open a clogged airway -- something a doctor can't practice on live patients.

Twenty years ago, little was known about people injured or killed during anesthesia. No U.S. database existed, so anesthesiologists set out to create one. They decided to collect information from insurers on closed malpractice claims, those in which insurers had made a payment or otherwise disposed of the complaint.

Most insurers hesitated to cooperate at first, saying they were worried about patient privacy. One company finally agreed: St. Paul Fire & Marine Insurance Co. in Minnesota said it was concerned about heavy losses it had suffered from anesthesia-related injuries and was eager for anesthesiologists to review claims. Soon, other insurers followed suit.

Anesthesiologists left their practices for days at a time to pore over closed insurance claims. The information they collected was fed into a computer at the University of Washington to create an overall picture of how anesthesia accidents tend to occur. It "was a humbling experience," recalls Russell T. Wall, an anesthesiology professor at Georgetown University School of Medicine in Washington, D.C. To date, more than 6,400 claims have been analyzed.

In part by analyzing claims, the anesthesiologists were able to document the extent to which



## PSA Legislative Reception

Monday, October 17, 2005

Briefing, Dinner and Reception

Harrisburg Hilton and Towers

See newsletter insert

for RSVP information

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patients were dying because of a simple mistake: Anesthesiologists were inserting the patient's breathing tube down the wrong pipe. Rather than putting it down the trachea, which leads to the lungs, they were accidentally inserting it down the esophagus, which leads to the stomach. The problem was, there was no way to determine quickly whether the tube was in the right pipe. Patients often simply turned blue or their blood turned dark. By then, it was usually too late to save them.

The research contributed to two innovations that between them would all but eliminate death and injury from "intubation" errors. One, known as pulse oximetry, measures the oxygen level in the patient's blood stream by means of a device that clips onto the patient's finger. The other, capnography, measures carbon dioxide in a patient's expelled breath, which helps doctors determine at a glance that a patient is breathing properly.

At the time, though, the new technologies had a drawback, Dr. Pierce says: "It was very hard to get hospitals to buy pulse oximeters and capnographs," he says. When they were introduced in the 1980s, the two devices together cost about \$10,000, according to several anesthesiologists.

That's where the safety foundation came in. In 1986, at the urging of the foundation, anesthesiologists made the use of pulse oximetry part of the ASA's basic standards for anesthesia care. A bit later, they added capnography.

Failing to adhere to ASA recommendations can expose hospitals to malpractice liability. By 1990, says Dr. Pierce, almost

all American hospitals had pulse oximeters and capnographs.

That change has been accompanied by other less obvious improvements. During surgery, a patient's body temperature can fall as room-temperature intravenous fluids are infused into the blood. This cooling can cause tissue to die and make the body vulnerable to infection. The safety foundation funded research on the problem in the 1990s, and now care is taken to keep patients warm during surgery, often with specially made blankets that can be heated. Blood and fluid warmers are also used.

Anesthesiologists also have become much better at preventing patient exposure to carbon monoxide. The potentially deadly gas can be an unintended byproduct of the process of cleansing a patient's exhaled breath of carbon dioxide before the air is recycled back to the patient's lungs. One simple way to guard against this problem is to make sure that absorbent material in anesthesia machines that filters the recycled air remains moist.

In 1994, the newsletter of the anesthesiologists' foundation documented cases in which patients were exposed to high levels of carbon monoxide during surgery on Mondays, presumably after absorbents had spent the weekend drying out. The organization recommended replacing the absorbent material on Monday mornings and several other changes. These are now standard practice, and rates of carbon-monoxide exposure have fallen dramatically.

Anesthesiologists are now focused on alarm bells. Modern anesthesia machines come equipped with audible alarms that sound when certain thresholds, such as oxygen levels, are crossed. But the alarms irritate many surgeons, so some anesthesiologists have turned them off. The foundation has documented 26 alarm-related malpractice claims between 1970 and 2002, or a little more than one a year. Of those, more than 20 resulted in either death or brain damage.

The foundation is pushing to adopt a formal standard that prohibits anesthesiologists from disabling the alarms. "I would not fly on an airplane if the pilot announced all the alarms were being turned off," says Robert K. Stoelting, the foundation's current president. "Our patients deserve the same safety net."

Dr. Stoelting, a retired chair of the anesthesiology department at the Indiana University School of Medicine, runs the foundation from suburban Indianapolis. He has a two-person administrative staff and a relatively modest \$1 million annual budget.

As anesthesia fatalities have dropped, so has the percentage of total malpractice suits filed against anesthesiologists. In 1972, according to a recent study by Public Citizen, a consumer-advocacy group in Washington, D.C., anesthesiologists accounted for 7.9% of all medical-malpractice claims, double the proportion of physicians who practiced anesthesiology. Between 1985 and 2001, anesthesiologists accounted for only 3.8% of all

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claims, roughly comparable to the percentage of doctors who were anesthesiologists.

The size of payments from successful malpractice suits against anesthesiologists also has declined. According to the American Society of Anesthesiologists, the median payment during the 1970s was \$332,280. By the 1990s, it had dropped 46%, to \$179,010. These amounts are in 2005 dollars and are the most recent figures available.

Claims for serious injuries have become less frequent. In the 1970s, according to the ASA, more than half of anesthesia-malpractice claims involved death or permanent brain injury. In the 1990s, that fell to less than one-third of claims.

Malpractice rates for anesthesiologists have gradually fallen, the ASA says. This year, the average annual premium is \$20,572, compared with \$32,620 in inflation-adjusted dollars in 1985. That's a decrease of 37%

over 20 years. Malpractice rates are generally set at the beginning of the year.

Anesthesiologists still make mistakes and aren't immune to recent moves in insurance rates. Their annual inflation-adjusted premiums have climbed 24% since 2002, when they had dipped to an average of \$16,559. Insurers say that overall malpractice rates have risen by that amount or more for other specialties during the same period, but reliable nationwide figures aren't publicly available. As is done in other specialties, anesthesiologists accused of disciplinary problems are referred to state licensing agencies.

Other specialties have noticed how the anesthesiologists have fared. Dr. Griffen of the College of Surgeons says that more surgeons have begun to see a connection between improving patient safety and lowering malpractice premiums. The college's closed-claims study so

far involves about 350 cases, and the group hopes it will grow to 500 this year.

At the University of Utah Hospitals and Clinics, Dr. Kochevour says his institution has tried to emulate the anesthesiologists by concentrating more on identifying systemic errors and less on individual blame. But these efforts run headlong into thinking drummed into physicians since medical school, he says. "I don't think physicians are very good systems thinkers, by and large," he says. Many, especially surgeons, prize their independence, he says, and that makes it hard to achieve the kind of cooperation necessary to reduce errors.

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## Your Medical Specialty Needs You This Year

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meet them. This year more than 300 nurse anesthetists visited Harrisburg — and lobbied effectively. Hundreds of CRNA's come to the Capital every year and plead their cause. We can, and must, do better.

There are two bills in the Legislature — one in the House and one in the Senate. Both of these pieces of legislation would eliminate all physician supervision of CRNA's and replace it with the term "cooperation." The term

would be defined at a later date by the Board of Nursing. You must be here to talk to your legislator and explain to them — in person — why supervision is a critical component of patient care. We can't do it for you. You are the constituent and only you have the credibility necessary for us to win this battle for patient safety.

Also enclosed in this issue of the Sentinel is your copy of the PSA Legislative Directory. It contains important information on

phone numbers, addresses and committee assignments of your local legislators. Keep it close by for easy reference to contact your representative and senator.

Finally — don't forget your contribution by personal check to Z-Pac. Every anesthesiologist should send his/her contribution directly to Paul Schaner, M.D., 133 N. Heide Lane, McMurray, PA. 15317. None of us are too busy for that!

# Anesthesiologist-Ambulatory Surgery Center Arrangements

Ms. Carol Grelecki, WolfBlock Health Law Practice Group

Compensation or remuneration arrangements between anesthesia providers and ambulatory surgery centers (“ASCs”) have become quite prevalent. However, these arrangements do have the potential for abuse. Bearing this in mind, this article explores the most common forms of ASC-provider arrangements, applicable law and regulations, as well as key examples of suspect arrangements. Anesthesiologists confronted with these types of arrangements should seek the advice of knowledgeable counsel on the particulars presented and should not rely on these general comments.

## Applicable Law

The Federal Anti-Kickback Statute (“Anti-Kickback Statute”) prohibits the offer or receipt of any remuneration, including the solicitation or acceptance of remuneration, in exchange for the referral of services paid for by the federal health care programs. For the purposes of the Anti-Kickback Statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Moreover, the Anti-Kickback Statute has been broadly construed to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. Under the Anti-Kickback Statute, violators are subject to fines, imprisonment, and additional penalties under the Civil Monetary Penalty Law. Program exclusion usually results as well.

However, the Office of the Inspector General has published “safe harbor” regulations that define practices that are not considered violations of the Anti-Kickback Statute because they are unlikely to result in fraud or abuse. The “safe harbors” set forth specific conditions that, if met, assure entities involved of not being prosecuted or sanctioned for the arrangement qualifying for the “safe harbor.” Strict compliance with each element of the “safe harbor” regulation is required to obtain “safe harbor” protection.

**In light of the referral relationship between anesthesia providers and the physician owners of ASCs, it is prudent to structure the arrangements between anesthesia providers and ASCs to meet the requirements of a “safe harbor” to avoid scrutiny under the Anti-Kickback Statute.**

There are several “safe harbors” that may be applicable to proposed ASC-anesthesia provider arrangements, covering (1) rental of space by the ASC to the anesthesia provider; (2) rental of equipment, again by the ASC to the anesthesia provider; and (3) personal services and management contracts, in which the ASC performs certain tasks for the anesthesia provider. The “safe harbors” governing these contracts generally share com-

mon requirements including, but not limited to, the following: (i) the arrangement is in writing and signed; (ii) the agreement specifies all of the services/premises/equipment to be provided or leased; (iii) if the agreement is intended to provide for services/premises/equipment on less than a full-time basis, the agreement specifies the exact schedule and cost per interval; (iv) the agreement does not include services/premises/equipment that exceed the legitimate business needs of the parties; (v) compensation is set in advance and at fair market value; (vi) the term is for a period of one year; and (vii) the agreement is commercially reasonable. Items (iv) (v), and (vi) focus on the economics of the transaction and are designed to insure that the anesthesia provider is not, in effect, offering remuneration to the ASC to permit the anesthesia provider to practice there. From the perspective of anesthesia providers, the safe harbors help respond to pressure that may be put on them to enter into contracts that favor the ASC at the expense of the provider.

Note, compliance with a “safe harbor” exception, while certainly prudent, is not required. Arrangements that do not meet



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# Anesthesiologist-Ambulatory Surgery Center Arrangements

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safe harbor criteria only violate the Anti-Kickback Statute if the parties intend to provide remuneration in return for referrals. There may sometimes be legitimate reason that an arrangement between an anesthesiologist and an ASC cannot meet the “safe harbor requirements. In that event, it is essential, at a minimum, that the arrangement be established based on fair market value in an arm’s length transaction, not influenced by the value or volume of referrals or potential referrals between the parties and not adjusted to take into account the anesthesia provider’s proximity to a referral source. This will help to avoid an inference that the arrangement is intended to induce referrals between the parties.

## Typical ASC-Anesthesia Provider Arrangements

Typically, ASC-anesthesia provider remuneration arrangements fall into three categories: (1) the traditional fee-for-service model; (2) the employment/independent contractor model; and (3) the anesthesia company model. All three can implicate the Anti-Kickback Statute.

### Fee-for-service model

The fee-for-service model is the most common form of ASC-anesthesia provider arrangement. Here, the ASC hires an anesthesia provider to perform all required anesthesia services and the anesthesia provider directly bills and collects for those services. The only remuneration

or compensation arrangement between the ASC and the anesthesia provider is the provider’s lease of space and services from the ASC. The anesthesia provider does not have an ownership interest in the ASC, the ASC does not compensate the anesthesia provider for services performed, and the ASC does not bill and/or collect for services performed by the anesthesia provider.

Although the fee-for-service model has the least regulatory risk, the ASC can manipulate the legality of the arrangement by, for example, requiring the anesthesia provider to pay more than fair market value for space, equipment and/or personnel lease arrangements. These excess payments could be perceived as a kickback in exchange for the right to provide anesthesia services.

### Employment/independent contractor model.

Under the employment/independent contractor model the ASC directly employs the anesthesia provider. The ASC pays the anesthesia provider a salary and in exchange the anesthesia provider assigns to the ASC the anesthesiologist’s right to bill and collect for professional services performed. Alternatively, the anesthesia provider may directly bill and collect for anesthesia services and then turn over the collections to the ASC in exchange for a guaranteed salary. This model may implicate the Anti-Kickback Statute if the anesthesia provider assigns the right to full payment for services provided in exchange for a guaranteed salary, even if less than the anticipated reimbursement.

This assignment can be viewed as being in exchange for anesthesia referrals made by the ASC.

In addition, Medicare and some third party payors may deny claims by an ASC that include both facility and professional anesthesia services.

### Anesthesia company model.

One of the newest forms of ASC-provider arrangement involves an ASC setting up a separate anesthesia company that has the same ownership as the ASC. In this model, the anesthesia company employs anesthesia providers to perform anesthesia services at the ASC. Reimbursement in this model works this way: (a) the ASC bills for facility fees; (b) the anesthesia company bills for anesthesia services; and (c) the anesthesia company’s profits are distributed to its owners. As in the employment/independent contractor model discussed above, the anesthesia provider’s assignment to the anesthesia company of the right to full payment for services in exchange for a lesser amount in the form of a guaranteed salary may implicate the Anti-Kickback Statute.

## Suspect Arrangements

As a general rule, anesthesia providers should be wary of the following suspect arrangements:

- Paying rent to an ASC for space that is not commercially reasonable and/or other than fair market value.
- Any requirement that the anesthesia provider turn over a percentage of collections to the ASC.

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- Buying equipment, drugs and/or supplies on behalf of the ASC without being reimbursed by the ASC.
- Hiring the ASC to provide services for payment that does not reflect fair market value of the transaction.
- Any requirement that the anesthesia provider buy an ownership interest in the ASC for an amount per share in excess of other owners.
- Contracts contingent on referrals and/or making loans to the ASC.
- Entering into any financial arrangement with an ASC without trying to comply with a safe harbor or, at a minimum, without pricing the transaction(s) at fair market value.
- An ASC's demand to transform a fee-for-service arrangement into an anesthesia company model arrangement with the same group of anesthesia providers.

Anesthesia providers should consult knowledgeable counsel prior to entering into any of the above or any other suspect arrangement.

For more information on this subject, feel free to contact Carol Grelecki at [cgrelecki@wolfblock.com](mailto:cgrelecki@wolfblock.com) or (973) 228-5700, or Bob Hoffman at [rhoffman@wolfblock.com](mailto:rhoffman@wolfblock.com) or (717) 237-7182. Mr. Hoffman is a partner in WolfBlock's Health Law Practice, Harrisburg office. Ms. Grelecki is counsel in WolfBlock's Health Law Practice, Roseland office.

# CAC Report

by Joseph West, MD, CAC Representative

At the June 9, 2005 HGSA CAC (Carrier Advisory Committee) meeting, CERT was again discussed. Anesthesiology again is doing well in the review process. The one source of errors for us was operative diagnosis not matching operative procedure.

In addition, the indications, limitations documentation, and utilization guidelines for SI joint injections were approved as follows:

## Indications

SI joint injection will be considered medically reasonable and necessary in the following circumstances:

1. For diagnostic indications, to inject contrast media into the joint for evaluation of the integrity (or lack thereof) of articular cartilage and morphologic features of the joint space and capsule.
2. For therapeutic indications, to inject an anesthetic and/or steroid to block the joint for immediate and potentially lasting pain relief.

SI joint injections are performed under fluoroscopic guidance to ensure optimal access to the joint.

The differential diagnosis of SI joint pain requires a detailed history and thorough physical exam. Imaging with radiographs, MRI, bone scans, and CT scans do not consistently differentiate symptomatic from asymptomatic individuals.

When sacroiliac joint dysfunction is present in conjunction with other primary pain generators (such as lumbar radiculitis

secondary to degenerative disc disease or lumbar facet arthropathy secondary to lumbar facet arthritis), treatment should first address the non-sacroiliac joint pain generators, as SI joint dysfunction may resolve once these pain generators have been successfully treated. If there is residual sacroiliac joint pain, it may be appropriate to perform SI joint injections to address the remaining pain.

## Limitations

If documentation in the medical record substantiates that the injections are not effective, further injections would not be medically necessary.

This Carrier has determined that providing an SI joint injection to the same patient on the same day as an initial lumbar epidural (62311), transforaminal epidural (64483, 64484) or lumbar facet joint (64475, 64476) injection is considered not medically reasonable and necessary.

## Coverage Topic

Doctor office visits.

## CPT/HCPCS Codes

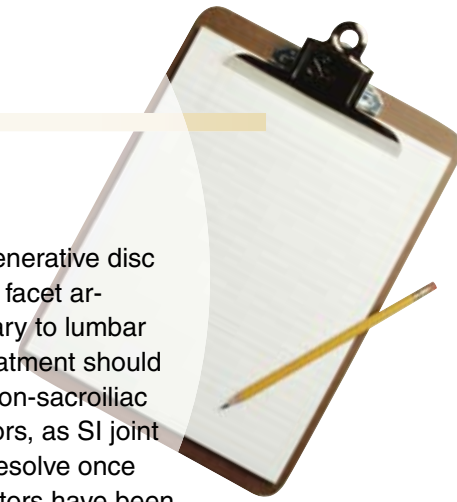
27096

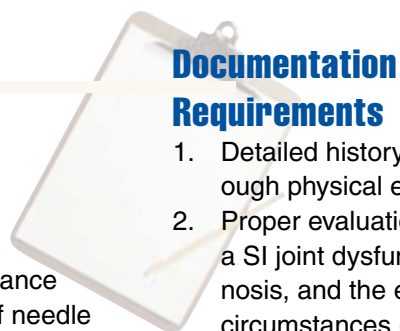
Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid

73542

Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation

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## Documentation Requirements

1. Detailed history and thorough physical examination.
2. Proper evaluation leading to a SI joint dysfunction diagnosis, and the extenuating circumstances (i.e. level of pain, interruption of activities of daily living), must be clearly documented.
3. Notation that if the SI joint pain is secondary to another primary source of pain treatment of the primary source has been performed prior to the initiation of the SI joint injection.
4. Identification of the affected muscle(s), fascia and/or ligaments and the site of each injection noted.
5. Indication that noninvasive treatments (i.e. rest, physical therapy, NSAIDs, etc.) have been tried and were unsuccessful, or contraindicated.
6. Drugs injected and the dosage of the drug.
7. For subsequent treatments with SI joint injections, the documentation in the medical record must show the benefits received from the prior set(s) of injections.
8. The medical record must be available to the carrier upon request.

## Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Patients who have gained no symptom relief or functional improvement after two injections should not proceed with additional injections because a subsequent positive outcome is low.

Evidence-based practice guidelines indicate the following descriptions of the frequency of SI joint injections:

1. In the diagnostic or stabilization phase, a patient may receive injections at intervals of no sooner than 1 week or, preferably, 2 weeks.
2. In the treatment of therapeutic phase (after the stabilization is completed), the suggested frequency would be 2 months or longer between each injection, provided that at least 50% relief is obtained for 6 weeks.
3. If the neutral blockade is applied for different regions, it may be performed at intervals of no sooner than 1 week or, preferably, 2 weeks for most types of blocks. The therapeutic frequency may remain at 2 months for each region. It is further suggested that all regions be treated at the same time, provided all procedures are performed safely.
4. In the diagnostic or stabilization phase, the suggested number of injections would be limited to no more than 4 times per year.
5. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 6 times for local anesthetic and steroid blocks within a period of 1 year.

76005

Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction

## ICD-9 Codes That Support Medical Necessity

720.0

Ankylosing spondylitis

720.2

Sacroiliitis, not elsewhere classified

724.6

Disorders of sacrum

846.0-846.9

Sprains and strains of sacroiliac region

## ICD-9 Codes that DO NOT Support Medical Necessity

Any ICD-9 code not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.



# Welcome New Members

## **PSA Active Members**

Howard Alster, MD  
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## 2005 Mcare Assessment Abatement

### Application Process

The Health Care Provider Retention Program is providing eligible health care providers financial relief in the form of an abatement of the Mcare assessment for policy year 2005. To get started, you will first need to complete the electronic online application found at their website: [www.mcare.state.pa.us](http://www.mcare.state.pa.us)

All documents must be received  
by February 15, 2006.

Watch for Next Issue in the Fall of 2005



**Sentinel**

Pennsylvania Society of Anesthesiologists Newsletter