



## PRESIDENT'S MESSAGE

# We Need Your Help to Affect Change

by Steven W. Neeley, M.D., President

Once again, I urge all of us to become involved with medicine and the constant battle to keep the practice of anesthesiology vibrant and appreciated by the public and our state and federal lawmakers.

Many of our PSA Board members recently attended the American Society of Anesthesiologists' Legislative Conference in Washington, D.C. The climate was definitely abuzz on both sides of the aisle about the recently passed health care legislation.

One side saw the need for changes to the bill and the other basically wanted to start over. I was impressed that both parties understood the particular issue facing anesthesia. They have even recognized the term "33 percent Medicare problem" – that is that Medicare only reimburses about 33 percent for anesthesia services when compared to commercial third party payers. Other specialties are reimbursed at approximately 80 percent of commercial payers.

This inequity will be even further compounded when the new



health care plan begins to force more companies and patients to government-run options (Medicare and Medicaid). This will eventually lead to access problems for our patients, either by some decrease in providers or facilities not accepting these payments and, therefore, negatively impacting our patients' safety.

It will eventually put in doubt the viability of our specialty. At this same time, decreased payments from and more patients in Medicare will further impair the abilities of our hospitals to subsidize anesthesia services. These combined effects could be devastating to anesthesiology.

This sounds very bleak, and well it could be. So what can we do about it? Well, the good news is that our ASA lobby in Washington, D.C., has been doing a wonderful job with educating our federal legislators on the issues. We must follow up with our personal congressman/woman and senators with a visit, phone call and/or e-mail to reinforce these ideas and urge a fix to the "33 percent problem."

If we all do this, our voices will be hard to ignore. If we just "leave to our PSA leadership," those few voices will resonate that our Society as a whole does not care, and the devastating effects of this health care bill will be a reality.

We need to continue to educate our representatives and their aides and let them know we all care about the future of our specialty and medicine as a whole. This may be the most important election season we ever face and we can't just remain on the sideline.

I don't think we need to worry ourselves with which party is in control of what, but whoever is in office needs to know that we

# Summer 2010



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PENNSYLVANIA  
society of  
ANESTHESIOLOGISTS

### Sentinel

Pennsylvania Society of  
Anesthesiologists Newsletter

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# Breaking Down the Business of Anesthesia

by Joseph F. Answine, M.D., Assistant Secretary Treasurer, Pennsylvania Society of Anesthesiologists; Fred Rosetty, Practice Administrator and Chief Operating Officer, Riverside Anesthesia Associates, Ltd.; and Kevin Slenker, M.D., President of Anesthesia Associates of Lancaster, Ltd.

During most doctors' undergraduate and medical education, understanding the business side of the industry is the furthest thing from their mind. They want to be a doctor, help people, and somehow miraculously it would come with a paycheck.

Most go through their residency years expecting to compile significant debt. But that is OK because, the thinking goes, all the debt would go away and their ignorance to the financial side won't be a factor.

However, in today's world of being a doctor and anesthesiologist, the initial payout is larger, the debt is huge, overhead isn't shrinking to say the least with malpractice premiums at the top of the list, and reimbursement is dwindling with projections of becoming significantly worse. In a private anesthesia group, many times the physicians in the group are too busy to realize when they have reached a critical mass and the need has arisen to hire a professional businessperson to take over the day-to-day management of the practice.

The most successful private practice anesthesia groups have a highly functional and symbiotic relationship between the physician CEO and the layperson practice administrator, executive director or chief operating officer.

Private anesthesia groups all have differing needs due to market demographics, payer markets, clinical needs of the facilities they cover and internal group dynamics. However, a seasoned practice administrator can work collaboratively with the group's physician CEO, board of directors and/or executive committee to improve three important underlying busi-

ness dynamics: payer contracting process, governance/strategic planning and managing the billing process.

The billing process can be managed either internally with an in-house staff or externally by working with a competent and established anesthesia billing company.

Both the Medical Group Management Association (**Physician Compensation and Production Survey and Cost Survey for Single Specialty Practices**) and the ASA (**Fee Survey**) have compiled statistics and metrics that can be successfully used to negotiate and benchmark payer contracts. Most payer contracts can be broken down into three or four different components: surgical anesthesia, obstetrical anesthesia, non-anesthesia procedures (TEE monitoring, insertion of Swan Ganz catheters, insertion of Arterial lines, etc.) and chronic pain management.

Many anesthesia groups focus exclusively on negotiating a fair market value for the anesthesia unit conversion factor at the expense of factoring in how the remaining two or three components can dilute the overall expected value of the contract. Obstetrical anesthesia (labor epidurals, caesarian sections) claims can easily be underpaid or denied by payers because of the varying methodologies for billing anesthesia services for labor epidurals.

Units for epidural insertion, infusion time, units for anesthesiologist face-to-face time with the patient and units for removal of the epidural catheter may all be partially reduced or denied entirely depending on each payer's claim processing system ability.



For simplicity and improving the effectiveness of post payment monitoring, some anesthesia groups have successfully negotiated global fees for obstetrical anesthesia, which removes several impediments in processing obstetrical anesthesia claims.

Careful attention should also be paid to payer fee schedule rates for non-anesthesia procedures and chronic pain management. Historically most of these procedures have been assigned units via the **ASA Relative Value Guide**; unfortunately, since Medicare and most commercial insurers' payment methodology is via a fee schedule unrelated to ASA units, most practices have abandoned the process of assigning ASA units to these procedures when managing their billing operations.

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# Legislative Update

by Joseph F. Talarico, D.O., President-Elect, Chair, Insurance and Legislation Committee

## Welcome New Members

### Active

Michael E. Bell, D.O.  
Monica A. Bolland, MD  
Roman Y. DeJesus, M.D.  
Aida M. El Barbary, M.D., Ph.D.  
Rajeev K. Garg, M.D.  
Aseem A. Gupta, M.D.  
Haeoh M. Jung, M.D.  
Sam W. Keller, M.D.  
Larry I. Kim, M.D.  
Melissa A. Lasota, M.D.  
Charles Mancuso, M.D.  
Daphne M. Pierre-Paul, M.D.  
Joseph V. Rodrigues, M.D.  
Devika Singh, M.D.  
Nasser J. Sonbolian, M.D.  
Michael A. Suvick, M.D.  
Mihaela Visoiu, M.D.  
Xianren Wu, M.D.

### Retired

Sonya Gladshstein, M.D.  
Nghì V. Nguyen, M.D.  
Usha G. Rao, M.D.

## Pennsylvania Issues

In July 2009, Marc Gergely (D-Allegheny) introduced House Bill 1866. Like HB 1274, a bill introduced in the last session that failed to make it out of the same committee handily, HB 1866 would amend the Nursing Practice Act to give professional status to CRNAs and define their scope of practice so as to, in effect, permit independent practice.

Two PSA members provided effective testimony at a hearing of the Pennsylvania House Professional Licensure Committee, and, for the time being, it does not appear as though HB 1866 will get to the House Floor for consideration. PSA, with the assistance of our legislative counsel staff consisting of John Milliron and Andy Goodman of Milliron Associates, and legal counsel Bob Hoffman of Eckert Seamans Cherin & Mellott, has been highly successful in educating legislators about the patient safety benefits of physician supervision of anesthesia. While PSA has preserved physician supervision of anesthesia to date, there are some concerns going forward.

Bills that would expand CRNA scope of practice have been repeatedly introduced in the Pennsylvania legislature, and there is no reason to assume that HB 1866 will be the final attempt to eliminate physician supervision. Most concerning is the fact that HB 1866 was co-sponsored by an inordinate number of freshman legislators.

The Pennsylvania legislature has undergone dramatic turnover in the past two elections, a trend that will likely continue. Because of this turnover,

freshman legislators often lack the background knowledge of patient safety in anesthesia. This information must be available to first-time legislators.

For this reason, it is essential that all PSA members contact their Pennsylvania representatives and senators, develop a relationship and contribute to their campaigns. In addition, contributions to Z-PAC, the Political Action Committee of the PSA, will enable us to continue to advocate for our profession.

We know that anesthesiology is the practice of medicine; it is incumbent upon all Pennsylvania anesthesiologists to ensure that our state legislators are aware of that fact as well.

For a more comprehensive review of Pennsylvania legislative issues refer to the PSA website legislative affairs section:

<http://www.psanes.org/Legislators/PAandNationalIssues/tabid/140/Default.aspx>

## Federal Issues

On May 11, the American Society of Anesthesiologists joined forces with 22 surgical societies in writing to U.S. House Speaker Nancy Pelosi. The letter strongly urged Congress to enact legislation that would stop the cuts in Medicare reimbursement to physicians, and create stability by providing increases in payments to physicians that reflect the ever-increasing cost of providing physician services.

To view the letter, go to the following link on the ASA web site:

<http://www.asahq.org/Washington/May-Leg-SurgSocietiesOpposeFreeze.pdf>

# Report from the ASA Board of Directors

by Donald E. Martin, M.D.

This March, the American Society of Anesthesiologists (ASA) Board of Directors approved statements on two issues of clinical importance to most anesthesiologists. Both were related to Joint Commission surveyors and their interpretation of Joint Commission standards:

## 1. Labeling medications used in Neuraxial Anesthesia

Currently, Joint Commission National Patient Safety Goals require labeling of syringes used to deliver medications in perioperative and other procedural settings, on or off a sterile field. This requirement has been interpreted by some surveyors as mandating the labeling of syringes used, as part of prepackaged sterile trays, to deliver spinal or epidural anesthesia.

Surveyors have made this interpretation in spite of the fact that these trays are opened and used immediately by a single individual performing an anesthetic. The Board expressed concerns regarding disruption of sterility, or introducing toxic substances, if each of the syringes used to draw up and administer spinal anesthetics needed to be labeled with tape or marker before use. Therefore, the ASA board approved the following statement:

“Labeling sterile syringes is not required when an anesthesiologist is performing a spinal or an epidural anesthetic under sterile conditions without any break in the process, the medications are immediately administered, and never out

of sight and control of the Anesthesiologist.”

This statement was supported by a focused review of the ASA Closed Claim Data Base through December 2008, showing that there were no cases of wrong medications placed into a sterile syringe during a neuraxial block. Therefore, the chances of administering the wrong medication would be extremely small when an anesthesiologist is performing a continuous procedure in which the medication is drawn up and immediately administered.

One of the assumptions made with this statement, however, is that pre-labeled syringes are not currently available on epidural and spinal anesthesia trays.

## 2. Infection control during tracheal intubation

Joint Commission standards for infection control and sterility have been interpreted during surveys as requiring that tracheal tubes and laryngoscopes be left in a sealed package until they are actually used. This practice would prevent the preparation of these items, or their testing for functionality, in advance of their actual use.

Further, a focused review of the ASA Closed Claim Data Base until 2008 showed that there were no cases of infection resulting from placement of an endotracheal tube or LMA. In addition, there were no claims for infections from dirty instruments used

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## What Training Qualifies a Non-Anesthesiologist to Administer Anesthesia?

Recent interpretive guidelines by the Centers for Medicare and Medicaid Services (CMS) appear to place responsibility on anesthesia departments to establish standards of anesthetic administration throughout their hospitals. Therefore, the New Mexico Society of Anesthesiologists has proposed the following five criteria to qualify other physicians and nurses to administer Anesthetics:

- Formal didactic education in anesthesia, including anatomy, physiology, and pharmacology.
- Supervised anesthesia training in a formal anesthesia training program consisting of a minimum of four months and 100 cases.
- Participation in lifelong education in the theory and practice of anesthesia.
- Involvement in quality improvement activities, reviewed periodically by anesthesia peers, to allow them to demonstrate competency in medical knowledge and the clinical practice of anesthesia.
- Privileges for any non-anesthesiologist to administer anesthesia would need to be approved by an ABA-certified anesthesiologist within that individual's health care system.

These criteria are undergoing discussion in many states, including Pennsylvania.

# Patient Safety Advisories for Anesthesiologists

From the Pennsylvania Patient Safety Authority

Available on the  
Clinical Updates Page  
of the  
PSA Website  
[www.psanes.org](http://www.psanes.org)

- “Preventing Wrong Site Surgery Project: Digging Deeper”
- “Beyond the Bundle: Reducing The Risk of Central Line Associated Bloodstream Infections”
- “Improving the Safety of the Blood Transfusion Process”

# PSA Members Help Address SGR, Transparency Issues at ASA Legislative Conference

by Donald E. Martin, M.D., and Joseph F. Talarico, D.O.

Pennsylvania was well represented at the ASA Annual Legislative Conference in Washington, D.C., this April. Twenty-one anesthesiologists from our state, including seven resident members representing four of our residency training programs, attended.

The topics discussed included:

- 1. “The 33 percent problem”** – ASA is urging that anesthesia services be re-evaluated as underpaid procedures by Kathleen Sebelius, the Secretary of Health and Human Services. This process will be conducted under the authority of the recently passed Patient Protection and Affordable Care Act, and is very similar to what our Society did in Pennsylvania to increase reimbursement for anesthesia services under the Workman’s Compensation Program. The Medicare fee schedule values anesthesiology services at 33 percent of usual and customary fees, as compared to the average of 80 percent for other specialties.
- 2. Medicare cuts** – In addition to advocating for the replacement of SGR with a more equitable formula, we urged legislators to overturn the 21 percent cut in Medicare reimbursement scheduled to take effect in May 2010. Since our meeting, legislation was enacted and signed into law that would delay this cut in reimbursement until the end of June. Needless to say, that is not good enough. We are maintaining a dialogue with our senators and representatives to achieve a permanent solution.



Members of the PSA Board of Directors and several PSA resident members pose for a picture in the U.S. Capitol Building. The statue is of Crawford Long, M.D., who was the first doctor to use an anesthetic. PSA members came to Washington, D.C., from April 25-28 for a board meeting and to attend the ASA Legislative Conference.

Pictured on the right side of the statue is Richard Month, M.D.; Joshua Atkins, M.D.; Joseph Galassi, M.D.; Donald Martin, M.D.; Patrick Vlahos, D.O.; Paul Schaner, M.D.; Craig Muetterties, M.D.

Pictured on the left side of the statue is Matthew Uhlenkott, M.D.; Mark Lischner, D.O.; Richard O’Flynn, M.D.; Teresa O’Flynn, M.D.; Arun Jayaraman, M.D.; Bhaskar Deb, M.D.; Steven Neeley, M.D.; Ryan Ball, M.D.; and Robert Early, M.D.

- 3. Truth and Transparency** – Use of the title “doctor” by non-physicians in the health care setting is at least confusing, and possibly deceptive, to patients. Therefore, ASA is advocating support for “Truth and Transparency Legislation” currently being introduced in the U.S. House of Representatives by Representatives Scott and Sullivan.
- 4. Rural Pass-Through** – Hospitals across the country, including at least three in Pennsylvania, qualify for the “Rural Pass-Through” for nurse anesthetists providing anesthesia services. The ASA is working to extend this pass-through to anesthesiologists, so that these hospitals with low volumes of procedures could reap the benefits of physician anesthesia services.

# Apathy Be Gone, Get Out the Vote

by Paul J. Schaner, M.D.

The passage of more than 2,000 pages of the health care bill has occurred. Speaker Pelosi's comment you will know what is in it when the bill is passed was classic. This typified the construction style of this massive legislation from behind closed doors with

deals cut for votes and a transparency as clear as a frosted window in mid February.

The process has painfully frosted many voters. It has left many numb and uncertain of the ultimate outcome of this legislation. What is certain is that many states question the constitutionality of the legislation.

The possibility of this bill reducing the deficit is as clear as the aforementioned window-pane. The placing of most of the uninsured on the Medicaid roles, which is unfunded, forces the financially strapped states to balance budgets in a bleak economic environment. Further, physician

reimbursement for Medicaid is worse than Medicare.

While coverage maybe there, what will be the access? In part the touted deficit cuts of this bill are predicated on Medicare physician cuts. Who will care for these patients if a 21 percent cut held in monthly limbo is permitted?

The flawed Sustainable Growth Rate (SGR) formula that triggers the physician Medicare payment cuts was to be corrected. It is not. For anesthesia this question of Medicare payment is super critical. The rest of medicine is reimbursed at 78-82 percent of the commercial rate. Anesthesia is at 33 percent of the commercial rate.

A widespread adoption of the Medicare payment schedule will be disastrous for the specialty of anesthesia. It is essential for us to strive to correct this inequity. The challenge will be to find the money in this immense sea of red ink. The will of Congress to do these cuts are historically unlikely. But the deficit grows daily, which will pressure cuts.

The bill establishes the Independent Payment Advisory Board (IPAB) that has the power to cut payments. This could make the correction of the SGR mute. Con-

gress does have the power to reign in the IPAB, but again it becomes a legislative effort to accomplish IPAB changes.

The early support of this bill by the American Medical Association is proving to be a disaster as many specialty physicians drop memberships. The AARP's support of the bill has also back lashed with members dwindling because of AARP's backing of the bill.

While the taxing of Americans begins now, it is four years prior to full implementation of benefits. This is a benefit that provides time to ardently work for change to this bill; it is a start not a finish.

The mid-term election results will be pivotal. The fate of medicine and indeed the nation will be determined by the outcome of the 2010 election. The bottom line is we must be vigilant and strive to be fully engaged in supporting and voting for the election of politicians dedicated to a fiscally responsible government and enact legislation that is open to input from the electorate.

A government of the people, for the people and by the people happens if voter apathy is gone and elected representatives represent their constituents.



## Board of Medicine — Quick Reminders

- The Board of Medicine Newsletter is now available by web access. This link will take you to the most recent issue of the Board Newsletter: <http://www.dos.state.pa.us/portal/server.pt/community/medicine/19103>
- License renewal information will come to you during the last quarter of this year, so be sure that the Board has your current address. Information on how to notify the Board of your new address is available on this page: [http://www.portal.state.pa.us/portal/server.pt/community/state\\_board\\_of\\_medicine/12512/licensure\\_information/599413](http://www.portal.state.pa.us/portal/server.pt/community/state_board_of_medicine/12512/licensure_information/599413)
- Be aware of the Board's CME requirements. Information on the requirement is available by going to the following link [http://www.portal.state.pa.us/portal/server.pt/community/state\\_board\\_of\\_medicine/12512/cme\\_requirements/572037](http://www.portal.state.pa.us/portal/server.pt/community/state_board_of_medicine/12512/cme_requirements/572037) then click on **(MD) Unrestricted License**.
- Audits of CME activity are done of a random 10 percent of all physicians; thus you should maintain your CME certificates thru the remainder of the next cycle.



P E N N S Y L V A N I A  
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A N E S T H E S I O L O G I S T S

## Doctors for Education

### PSA's Speakers Program Informs Physicians About Anesthesia

The Pennsylvania Society of Anesthesiologists (PSA) announces the launch of *Doctors for Education*, a new program dedicated to educating fellow anesthesiologists and medical staffs about a variety of anesthesia-related topics.

#### How it works

- Medical organizations/practices looking for a speaker must complete a Speaking Engagement Request Form (which can be found at [www.psanes.org](http://www.psanes.org)).
- After returning the completed speaking engagement form, a staff coordinator will establish contact with you once the speaker has been confirmed. Please allow 7-10 business days for speaker reservations to be confirmed.
- PSA member volunteers will share their knowledge and experience with your organization.
- An Evaluation Form will be provided to the organization contact at the conclusion of the event.

#### Topics

For the full list, visit the PSA website at [www.psanes.org](http://www.psanes.org).

#### Topics include:

##### Available in Berks and surrounding counties:

- Indications and Use of Laryngeal Mask Airways

##### Available in Centre and surrounding counties:

- Politics and Medicine
- What You Need to Know About Office-Based Anesthesia
- Tort Issues

##### Available in Philadelphia and surrounding counties:

- Jet Ventilation for Airway Procedures
- Total Intravenous Anesthesia
- Dexmedetomidine
- Anesthesia for "Awake" Airway Surgery
- Anesthesia for "Awake" Craniotomy
- Simulation In Anesthesia

## PRESIDENT'S MESSAGE

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are active politically and will help those who will further our anesthesia related issues.

Other issues facing anesthesia are perhaps secondary to the above. On both the state and federal levels we would like to push for legislation that will make the identification of health care providers to patients "transparent."

Our patients deserve to know the training of those caring for them, so non-physicians with doctorates do not identify themselves as "doctor" in a hospital setting without specifying they are not physicians. We all have experienced this in some fashion, and it is especially important for us in anesthesia.

Maybe these recent events will serve to awaken our specialty as a whole. We need to take this message to our

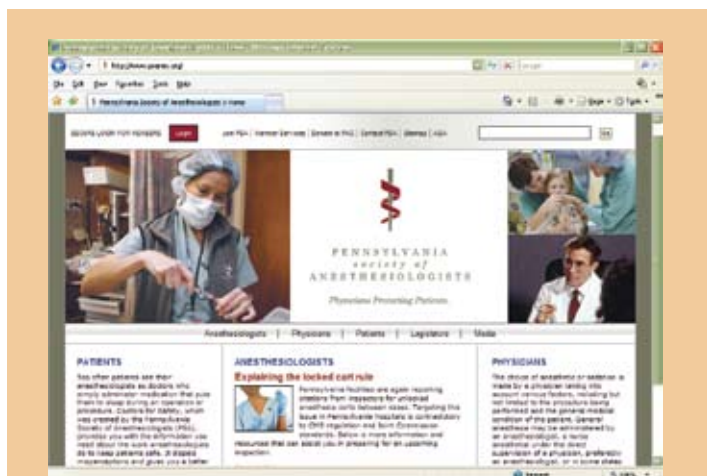
co-workers and get them involved with PSA and donating to our Political Action Committees, both Z-PAC (state PAC) and ASAPAC (national).

We need to be involved with candidates who support our anesthesia related issues. That means contributions as well as attending political events. Our lawmakers want to know us and associate with us. They want our help and ideas. They won't get them or get to know us if we leave it up to others to get involved.

We have started to contact some members in areas of the state who are underrepresented in PSA. If contacted, I hope your entire group will take it upon themselves to be that "key contact" for legislators in your area. Grassroots involvement in the political process will produce great changes. So accept the challenge to help.

I have used the phrase, "now, more than ever" in past messages and I think it applies even more. No matter what your past feelings have been about political involvement, we all definitely need each other now. First, contact and educate our representatives. Second, contribute to both to our state and national PACs and to individual candidates who support our issues. Educate the public about the importance of our specialty, and the public support our cause as well.

Don't be invisible. Make yourself and your job known to each of your patients. We can't afford to do nothing. Now, more than ever, please be involved.



## PSA Website Continues to Evolve

The new-look, user-friendly PSA website serves as a place for members to learn about the latest clinical information that affects your profession. It serves as a way to stay up to date on how the PSA is fighting to protect the interest of Pennsylvania anesthesiologists and their patients.

The PSA website is designed to educate patients, legislators and the media about the important role anesthesiologists play. There are also sections that remain exclusive for PSA members – but to get into those pages, you must register and set up your own username and password.

Members should have received a letter from the PSA's Harrisburg office in March with instructions on how to set up your personalized username and password. If you have not received such a letter, please e-mail us at [psa@pamedsoc.org](mailto:psa@pamedsoc.org) or call (717) 558-7750.

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## BREAKING DOWN THE BUSINESS OF ANESTHESIA

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Payer fee schedule rates should be converted into per ASA Relative Value unit rates to effectively monitor the effect of these items on the overall payer contract that is being negotiated. By maintaining this practice, which assigns relative value to all of the services that a typical anesthesia group provides, multiple payer contracts or terms can be compared to determine the most favorable arrangements.

The following example illustrates how a seemingly innocuous payer contract with a unit conversion factor of \$60 per unit can “net out” at significantly less money for the anesthesia group:

Item	Per Unit Reimbursement	% of Practice	Expected \$
Surgical Anesthesia	\$60.00	70%	\$42.00/unit
Obstetrical Anesthesia	\$40.00	20%	8.00/unit
Non-Anesthesia	\$25.00	5%	1.25/unit
Chronic Pain	\$25.00	5%	1.25/unit
<b>Total Contract Expected Per Unit</b>			<b>\$52.50/unit</b>

In this example, the dilutive effect of obstetrical anesthesia, non-anesthesia procedures and chronic pain management reduced

the overall expected reimbursement of the contract by \$7.50 per unit or 12.5 percent. Further significant dilution will occur when a payer’s policy is to split the anesthesia claim (reducing reimbursement to the attending anesthesiologist for medical direction of non-group employed nurse anesthetists). In the example above, if the anesthesia group medically directs 50 percent of the total surgical anesthetics, group reimbursement will be further reduced by \$21 per unit (\$60 per unit times 70 percent times 50 percent).

This is a simplistic example of how payers can dilute the value of an anesthesia contract without the anesthesia group knowing how and why the dilution occurs. Similarly, many anesthesiologists

do not have a good understanding of some of the internal processes and mechanics of the health insurers that pay their claims.

An important concept to understand when interacting with health insurance payers is the concept of ‘float’. Financial ‘float’ occurs when premiums are collected ‘up-front’ by payers and

invested until those premiums are paid out later as claims. The longer the payer holds onto the premium money collected, the more valuable the float becomes. In its essence, float is money and health insurance payers are conduits for investable cash.

Warren Buffett, whose holding company, Berkshire Hathaway, is one of the top 10 insurance companies in the world, described this concept wittily in “The Making of An American Capitalist:” “Initially, the morning mail brings in lots of cash and few claims. This state of affairs can produce a blissful, almost euphoric, feeling akin to that experienced by an innocent upon receipt of his first credit card.”

These examples serve to illustrate that sophisticated market forces are at work and can adversely affect the financial fortunes of anesthesiologists. I would encourage all anesthesiologists to devote as much time as possible to understanding some of these forces and to obtain business education either by working with experienced practice administrators, attending the ASA Practice Management Conference or registering for the ASA Certificate in Business Administration Program.

It is not enough just to provide a great clinical service in today’s marketplace. To those anesthesiologists who venture into private practice without a fundamental understanding of market forces, I will close with “Caveat emptor.”

## REPORT FROM THE ASA BOARD OF DIRECTORS

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for the tracheal intubations found.

For these reasons, and recognizing the limitations of closed claims data, the ASA Board adopted the following statement:

“All instruments used for intubation of the trachea (endotracheal tubes, LMA’s, laryngoscopes, fiber optic devices, stylets, forceps, or other airway devices) should be properly cleaned using standard methods for decontamination and high level disinfection between each patient use and stored in

a clean environment. Sterility is not required. Pre-packed endotracheal tubes can be opened, cuffs checked for any leaks, stylets placed for future use, cuff syringes attached, and placed back into the package. Data suggest that storage and subsequent use of such prepared endotracheal tubes is reasonable for up to 48 hours.”

# Physicians Receive Big Court Wins in Mcare Litigation

by Robert Hoffman, Esq., Eckert Seamans Cherin & Mellott, LLC

Physicians and hospitals have scored two big victories, together worth in the neighborhood of \$600 million, in their legal battle with the Commonwealth over the Mcare fund. Those victories, if upheld on appeal, should result in a substantial influx of funds into Mcare and thereafter Mcare rate relief for physicians.

The victories come in two related cases brought by the Medical Society and the Hospital and Healthsystem Association



of Pennsylvania. Both decisions were issued April 15 and the Commonwealth appealed both to the Pennsylvania Supreme Court.

The first case challenged the Commonwealth's underfunding of abatements given to physicians paying Mcare assessments during the period 2003-07. The Commonwealth granted abatements, of either 50 percent or 100 percent of the assessment amount, and was supposed to fund the abatements from a special fund set up for that

purpose, using a dedicated funding stream. It did not do so and the shortfall is somewhere between \$450 and \$615 million.

The Commonwealth argued that it had no obligation to fully fund abatements and, instead, had to provide only enough funds to keep Mcare solvent. One problem with the Commonwealth's position is that it resulted in physicians, rather than the Commonwealth, funding the abatements received by other physicians.

To make matters worse, the legislature, as part of the 2009 budget, took all the funds that were available for that purpose – \$708 million – and transferred them to the general fund.

The second case challenged the legislature's grab of \$100 million directly out of Mcare, again as part of the 2009 budget. These were monies that, in significant part, physicians had contributed and all of the funds were, by statute, dedicated for use in Mcare.

The Commonwealth took the position that it had created the Mcare fund, had contributed some funds to it, and could take what it wanted for other purposes.

Commonwealth Court rejected all of the Commonwealth's positions. The Court found that the Commonwealth had clear statutory obligations to fully fund abatements and to use all Mcare funds for Mcare purposes.

It then found that both of these rights were "vested," which means that subsequent legislative actions could not take them away. The Court then rejected a series of other Commonwealth defenses, including that physicians had

not been harmed by the funding shortfalls (despite a funding shortfall exceeding \$500 million) and that the Court had no place ruling on the issues because they arose in the context of a budget impasse.

As to the latter, the court wrote:

"The Commonwealth's arguments do not change the fact that this Court is required to administer justice in interpreting and applying the laws enacted by the General Assembly with respect to all matters brought before the Court for adjudication. Indeed, our system of government is designed to be one of checks and balances such that justice is ultimately the end result."

Some of what happens next is predictable, some not. As expected, the Commonwealth has appealed the rulings to the Pennsylvania Supreme Court. Doing so gave the Commonwealth an automatic stay of its obligation to comply with the Court's orders.

That means that physicians will receive no imminent relief and will, instead, have to await the Supreme Court's decision. The Supreme Court will likely hear argument in the case either late this year or early 2011, and decide the case within another six months.

What the Supreme Court will decide is anyone's guess. One encouraging sign is that Commonwealth Court heard the case twice and issued two opinions, with a total of eight judges participating in one or both decisions. Of those eight, only one sided with the Commonwealth.

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