Comunique
VOLUME 25, ISSUE 3
SUMMER 2020
ANESTHESIA BUSINESS CONSULTANTS

Who Really Owns Your Anesthesia Group?

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

Walmart is famous for its slogan "Save Money. Live Better."

It's no surprise that the slogan is aimed at the customer.

But have you ever wondered about the supplier?

There is a tremendous analogy here for medical groups of all stripes and for anesthesiology groups in particular.

Lower Prices. Every Day.

From the inception of its business, Walmart employed a low-price strategy. And, it's certainly no trade secret that the way Walmart *sells* at low prices is to *buy* at even lower prices—in fact, at the lowest prices.

To get those lowest prices, Walmart is willing, and quite able, to buy in very large quantities. And, therein lies the twist, the twist tie, if you will, for its suppliers, and, by analogy, you will see, for you.

Manufacturers, as they began selling to Walmart, craved the large distribution the chain offered. They'd assess how much Walmart would buy, and look at how many stores Walmart would put their product in. In order to get access to the Walmart business and the tremendous distribution, the manufacturers would then sell to Walmart at reduced prices—in fact, at their lowest prices.

As a result of capturing Walmart's business, many suppliers thought they

Continued on page 4

➤ INSIDE THIS ISSUE:

Anesthesia Business Consultants is proud to be a

MiraMed Quality Payment Program
CMS-APPROVED Qualified Registry

Anesthesia Quality Institute
PREFERRED VENDOR

AICPA SOC

Coronavirus: A Game-Changing Event

Just when we thought we had seen it all and successfully managed innumerable practice management challenges, along comes a virus so insidious and so contagious that every aspect of the economy will be affected. Americans have been laid off in record numbers. Surgical case volumes have dropped precipitously. Once well-managed anesthesia practices are scrambling to cobble together a strategy for survival. As your business partners, we are exploring all options and will be updating you with our research and insights. This collection of articles is just a small sample of the wisdom of our eminently qualified industry experts.

Kate Hickner, Esq. discusses one of the most interesting policy developments to come out of this crisis: new guidelines for telemedicine. While it is not entirely clear how this will impact anesthesia providers, these new guidelines are sure to be a preview of coming developments. Clearly, treatment paradigms are going to change.

Will Latham draws our attention to the importance of group governance in a very interesting discussion of some of the most common governance problems groups face. He shares the insights of his years of experience managing all manner of practices. His piece consists of many very practical suggestions for today's practices.

Mark Weiss, JD poses a very intriguing question: who really owns your anesthesia group? However valuable your contract at a given facility, he submits that, in many ways, groups have sold out to the facilities they serve. Is it any wonder that so many practices have decided to sell their practices? It is a very thought-provoking piece.

One of our ever-loyal contributors, Kelly Dennis, presents some interesting thoughts with regard to the potential of an audit and the specific requirements of medical direction. It is hard to imagine that payers will be turning to audits in the current environment and yet audits tend to peak when money is short. This is a timely reminder.

ABC's own Kendall Lutz sheds some light on one of the most fundamental questions in anesthesia: is it better to be a generalist or a specialist? His piece on boutique anesthesia practices raises some interesting questions about the value of focusing on a niche or boutique market.

Michael Bronson, MD of Mission Viejo Anesthesia Consultants and our own Jody Locke provide a fascinating profile of a ketamine clinic in southern California. This is a line of business that many practices are considering but few, as yet, are pursuing. We believe this is a very timely and relevant case study for your review.

Who knows how long the current crisis will last and what its lasting impact will be on the specialty of anesthesia. The rate of infection continues to rise and, despite government intervention, it is entirely unclear how most practices will survive the economic implications of the current environment. Just know that we are all in this together. Your success is our success.

With best wishes,

Tony Mira
President and CEO

Internal Audits: Process and Frequency

Kelly D. Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I
Perfect Office Solutions, Inc., Leesburg, FL

Many practices are too busy with day-to-day work to keep track of how often they should conduct internal audits. However, if your practice has a compliance plan, it generally outlines the required audit frequency. Do you know what your compliance plan requires?

If your anesthesiology practice is still using the compliance plan outline published in September 1997 by the American Society of Anesthesiologists™ in *Compliance With Medicare and Other Payor Billing Requirements,* your practice is required to review pre-submissions (claims reviewed *before* filing to the insurance carrier) on a quarterly basis, and post-submission (claims reviewed *after* filing to the insurance carrier) at regular intervals, such as semi-annually. You may also want to consider updating your compliance plan to ensure it meets current standards.

How to Prepare for Audit

Having anesthesia records available as you start your internal audit will make the review process easier. If anesthesia records are not available, you should obtain them from the hospital's medical records department.

An internal audit is simply an objective review of the anesthesia services billed to monitor the accuracy and suitability of claims. It should be performed by a qualified employee—such as the office administrator, manager, a certified coder (*other* than the employee who coded the services), the compliance officer, a physician or a combination of staff members.

Each practice determines the number of charges or percentage of claims to be reviewed for each provider. It also

determines how to make appropriate corrections and, depending on the internal audit results and compliance plan requirements (when applicable), whether to contact legal counsel. Although the standard compliance plan requires the practice to discuss all claims monitoring with legal counsel, the practice may modify the plan to require legal counsel consultation only during *external* audits.

A simple pre-submission review should compare the codes and modifiers billed with the documentation on file. Because the auditor reviews this information before submitting the claim, corrections are made during the review process, and corrective actions are taken and conveyed to staff. For example, a review determined the coder mistook "TKA" for a total knee arthroscopy (01400, base value - 4), rather than a total knee arthroplasty (01402, base value - 7). The practice must take several corrective steps:

1. Change code, if applicable. Make certain what procedure was performed as different clinical staff may be using different acronyms;
2. Ensure acronyms in your practice are clearly defined; and
3. Request a report of 01400 and 01402 claims filed to verify accuracy. Choose your time frame based on payer policy and timely filing requirements, such as one year or 90 days.

A post-submission review is more complex and should include a review from the time the claim is entered all the way through resolution. Choose a date within the past six months; and, in addition to checking codes and modifiers used, review payment processes to ensure correct payments were received and appropriate adjustments were taken. Each practice should know exactly what payment to expect from each payer. Medicare pays by location and the amount is standard; other payers may be contracted using various amounts and time calculation techniques, so a matrix of expected reimbursement is helpful. At the very least, a form listing annual expected amounts is necessary.

Continued on page 5

Who Really Owns Your Anesthesia Group?

Continued from page 1

had reached the promised land. Their sales shot up. Sure, margins on those sales were slim, but the quantities were stupendous. But that was just the start.

Once Walmart became a bigger and bigger and even biggest part of a supplier's business, Walmart continued putting the pressure on. They knew that the supplier was so dependent upon Walmart for their huge volume and reach, that they could push *even harder* for *really* low prices, and then for *really* lower prices, and then for *really* lowest prices.

In a very real sense, far beyond the colloquial, many manufacturers became "owned" by Walmart. The twist ties that bound them to Walmart got tighter and tighter. Their margins were on a starvation diet, but quantities were super-sized. And, if they lost the giant chain's distribution, the shock of the resulting excess capacity might pull them under.

Are You a Metaphorical Walmart Supplier?

If you're the leader of an anesthesia group, it's often much the same story. That is, if you've allowed your business to become dependent upon a single hospital or even a single system of hospitals.

If that's the case, then who really owns your group? Is it really you and your partners? Or, in essence, does the hospital or the system "own" your group in the same way that Walmart "owns" the suppliers who've become dependent upon their business?

At the extreme end of the continuum, if the hospital or system administrator were to tell you that they've decided that it's in their best interest that, as of a month from next Tuesday, all anesthesia services will be provided by Best PowerPoint Anesthesia Group or through the anesthesia department of Nearby Giant University, so you'd better go cut employment deals, what other viable alternative would you have? Likely, none.

Short of that doomsday event (but one that happens more often than you might imagine), the same dynamic plays out whenever a hospital makes a demand on a dependent group. From "we're cutting your stipend" to "we want you to expand coverage," what choice do you have other than to say "yes"? The alternative, of course, whether spoken or understood, is that you'll soon be an "ex-vendor."

Should you attempt to sell your group, if you've become that dependent on one large source of business, what sort of a discount will the buyer demand due to your huge, "baked in" fragility?

The real question is, have you, in essence, given away the ownership of your practice entity by falling into the "Walmart" trap?

Do you and your fellow physician "owners" really own what you think you own?

Mark F. Weiss, JD is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He is also the co-founder of a healthcare mergers and acquisitions advisory firm, Steering Advisors. He can be reached by email at markweiss@advisorylawgroup.com or at markweiss@steeringadvisors.com.