



GEORGIA
SOCIETY OF
ANESTHESIOLOGISTS, INC.

scope

Newsletter

Spring
2011



Timothy N. Beeson, MD

President 2011

Georgia Society of Interventional Pain Physicians which made passage of this important public health bill a legislative priority for four years as did GSA.

The Medicare Access to Rural Anesthesiology Act would change the way rural anesthesiologists are paid. Medicare typically pays physicians under Medicare Part B fee schedule. In the 1980s, a statutory exception was created by Congress to allow rural hospitals to use the more generous Part A funds to pay

ASA members. Owners of ambulatory surgical centers (ASCs) are not the only professionals seeking to share anesthesia fees. Anesthesia employee arrangements risk our clinical and practice independence. This is a very real threat to every anesthesiologist. For more information, seek out the 2011 ASA Conference on Practice Management podcast on the ASA website (www.asahq.org). For recently published legal guidance, go to "NEWS" at www.gsahq.org.

What's our CAUSE, where's our TIME?

In the last two months, the GSA has written letters and spoken to many politicians addressing Prompt Pay, Prescription Drug Monitoring Bill, Medicare Access to Rural Anesthesiology Act of 2011 and the "Company Model". All of these "events" have a significant impact on the practice of Anesthesia in our state.

The GSA sent to state lawmakers a Memorandum of Support for Prompt Pay legislation and many GSA members contacted their local legislators. Prompt Pay will require all third-party administrators to pay paper claims in 30 days, electronic claims in 15 days or address why they haven't done so. This would hold them to the same requirements as other insurance companies. Hospital based physicians are obligated by Federal law to care for any patient who presents at the hospital regardless of pay status. Many of these patients have government or no health care coverage causing significant cash flow problems and inducing payroll issues in our anesthesia departments. Congratulations to the Medical Association of Georgia and other specialty societies we joined to pass the bill in Atlanta.

The Prescription Drug Monitoring Bill, also known as the "pill mill" bill, calls for the establishment of a program to monitor the prescribing and dispensing of Schedule II, III, IV and V controlled substances which would be the pathway for establishing an Electronic Database Review Advisory Committee. This Committee could provide rules and regulations for prescriptive drug monitoring. This bill has been a legislative priority for our pain management specialty. Congrats to the

for anesthesia services. The payment arrangement allows small rural hospitals to induce certain anesthesia providers to provide anesthesia services at their facilities. This only applied to non-physician providers. This proposed new Act would include anesthesiologists so that rural facilities could recruit anesthesiologists to smaller communities.

Everybody is busy: family time, personal obligations and professional duties occupy your days and nights. Priorities and choices have to be made. Many choose to extend their services to our professional organizations to help in shaping the future of our given field. Others contribute to PAC organizations to enable us to open communications with

Public Policy UPDATE

The Company Model was first addressed by the ASA back in 2009 in a letter to the Office of Inspector General (OIG) expressing concerns that this model violated Federal laws. In 2010, the ASA requested the OIG to issue a Special Advisory Bulletin regarding this model. The last GSA meeting/newsletter introduced many to the "Company Model" and some of the ramifications it may have in our future. On February 18th ASAPAC Vital Signs invited all to submit comments to the OIG to develop regulations on Special Fraud Alerts. The GSA also put out the word the same day, including the deadline 2/28/2011. Specific details for emphasis and sample letters to the OIG were made available to all

policy makers. Our organizations send out opportunities for all of our membership to contribute by giving content and contact information dealing with key issues. Sample letters emphasizing the specific concerns regarding controversial topics are usually available. These services are underutilized. It is not difficult to respond to at least some of these "Urgent" emails. Our response may significantly influence the result. Please find the time to use these tools to help our elected and appointed officials make educated decisions. The future of the specialty is dependent on the participation of the membership. Phone calls and e-mails make a difference.

Editor's Corner

Kathryn Stack, MD, Chair, Communications Committee, Editor, *GSA scope*



We Should Do Better

I hope you are all well as spring has settled over Georgia. As I reflect back on another day at the office, I am disturbed by a situation I know each of you have also faced at one time or another. Every day, anesthesiologists balance between the extremes of "do everything possible" and "DNR"; many are even conscientious in pre-operative discussions with patients and families to discuss on an individual basis and settle somewhere in between. However, it is hard to assimilate "futile" and "one last desperate attempt" with "do no harm".

If there really was such an entity as an institutional death panel (admittedly, a carefully designed politically-polarizing term), would I ever have been providing general anesthesia for ERCP in an ASA Class 5 patient suffering from terminal metastatic cancer, acute and ongoing cardiac ischemia and impending respiratory failure presenting with a DNR

order recently revoked for this procedure? This family was so heartbroken, distressed and overwhelmed, that the decision to proceed with one last non-operative procedure to make Dad more comfortable was completely lost in the discussion and explanation of general anesthesia as life support and a possible terminal event, anesthesia as a further stress on the heart, and intubation rendering ventilator weaning difficult or impossible. After successful stent placement, relative hemodynamic stability, and an uneventful transfer to the ICU, the patient was unable to be weaned from the ventilator over the course of the next day. So, with a perfectly placed stent, the family chose to extubate Dad expeditiously and decelerate care. What happened to "do no harm"? I have to admit this case cost me a bit of sleep.

I cannot blame this emotionally stressed and distraught family for valiantly pursuing all avenues for Dad. Similarly, the patient's hospitalist was motivated to make Dad as comfortable as possible:

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The GSA Newsletter is published quarterly by the Georgia Society of Anesthesiologists, Inc. Opinions expressed in this publication do not necessarily reflect the official position of the Society. Direct correspondence to:

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Emory Residents focus on patient safety



Danika K. Little, MD (PGY-3)

Treasurer | GSA Resident Section

Residency is about developing and honing our medical knowledge and skills for the betterment of patient care. It is easy to get lost in the knowledge component: long hours of studying, reading, self-quizzing or even using simulators. However, medical knowledge is only one of the six ACGME core competencies. Recently, Emory anesthesia residents undertook group projects on another core competency – patient care – by researching, analyzing and presenting on various topics of patient safety including the following:

Transfer Of Care (TOC). A survey demonstrated a majority interest in a standardized format for TOC between anesthesia providers. Postoperative care plans (e.g. should the patient remain intubated, is a blood sugar check or x ray needed in PACU, analgesia) were found to be most often neglected in a TOC hand-off. Interestingly, although most respondents felt there was not a detriment to patient care, they were willing to work less predictable hours to minimize TOC in complex cases.

Massive Transfusion Protocols (MTP). Surprisingly, there currently is no MTP in place at Emory University Hospital (EUH) despite being a regional referral center. Research revealed MTP improves communication between the blood bank and practitioners and reduces mortality by administering component products in a ratio more closely resembling whole blood (best is 1:1 pRBCs to plasma) and by delivering and transfusing products more rapidly. MTP also reduces costs – even using Factor VII – as there is less redundancy, overall usage and waste in ordering, preparing and delivering blood products.

Single-Use Vials. To ascertain if Emory anesthesia practitioners followed CDC guidelines, a survey was conducted regarding aseptic techniques for IV injections. Because most respondents were unaware that a single use vial should be punctured once and discarded (rather than the stopper cleaned and a new needle used), this area was identified as needing improvement in technique to potentially reduce bloodstream infections.

Corneal Abrasions. Literature revealed that, although it is hard to determine the exact cause, approximately 80% of corneal abrasions are thought to be related to corneal drying due to air exposure rather than direct trauma. There are approximately 6.5 corneal abrasions per year at EUH, most occurring in patients in the supine position. Accordingly, it was advocated that patients' eyes always be taped shut.

Operating Room Fires. While not common, OR fires are devastating causes of patient morbidity and mortality. The three key components of the fire triad are oxidizer (O₂/N₂O), energy source (surgical laser/bovie) and fuel (patient hair/drapes). A presentation was made of case reports and laser-safe airway equipment to address this issue.

Failed Peripartum Spinal Anesthetics. Patients at Grady Memorial Hospital tend to be obese and have more medical co-morbidities, so failed spinals can be disastrous to securing airways for general anesthesia. The failure rate over the past year was found to be approximately 6% and, rather than related to resident experience, was due to the season – failure rate was three times higher during the warmer months. This suggests a correlation to the heat stability of the local anesthetic commonly used, bupivacaine.

While medical knowledge is paramount to physician training, another key element is patient care. These projects and presentations show that Emory residents are keeping patient-safety in mind.

Do Better ...continued from page 2

the endoscopist merely assessed the likelihood of successfully placing the stent, and the family had inevitably never been advised about the risk of general anesthesia in this dire situation until too late in the process when decisions had already been made, rationalized and solidified. However noble the motives, the specialty of medicine owes its patients and families more than this. Emotional support, education, better coordination of care and a bit of time to digest the consequences of these grave decisions is the responsibility of the institution of medicine. Death panel is merely a negatively-charged divisive term. A well-designed multi-disciplinary program readily available to patients and their families would empower most to make compassionate and ethical decisions after having the opportunity to digest all the pertinent information, ask questions and receive emotional support. Fiscal responsibility would unassumingly and inconspicuously follow along. We should be able to do better for Dad.

Perspective

At GHSU

ABC

always be careful



Vikas Kumar, MD | CA-2

President-elect | GSA Resident Section

Out of this nettle, danger, we pluck this flower, safety.

- William Shakespeare

Anesthetizing patients for surgery has always been compared to flying a jet. The 2010 annual meeting of the American Society of Anesthesiologists featured Jeff Skiles, the co-pilot of the "Miracle on the Hudson." He drew parallels between the training and preparedness of pilots and anesthesiologists. In both professions, there is no room for error.

Our specialty has become much safer because of advanced monitors, better medications and better equipment. We have organizations such as the ASA, Anesthesia Patient Safety Foundation (APSF), Anesthesia Quality Institute (AQI), National Anesthesia Clinical Outcome Registry (NACOR) and The Joint Commission which provide guidance to practicing anesthesiologists to ensure patient safety.

Indeed, anesthesiology was the first medical specialty to champion patient safety as a specific focus with the founding of the APSF in 1985. Its sole mission is to raise awareness of patient safety issues and offer many clinical safety tools. In 1986, the ASA became the first medical specialty to adopt standards of care for its members. AQI's goal is to improve efficiency and outcomes and can be a primary source of information for quality improvement in clinical practice. NACOR collects and assesses data from millions of cases from institutions and practice groups. With this valuable information, we can measure our progress, make improvements and evaluate ourselves again.

The Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), works to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. Recently, The Joint Commission visited our hospital and imparted some recommendations. They suggest proper labeling of syringes including drug name, strength, date, time, initial and expiration date if needed. The drug carts should be secured to prevent unauthorized access, especially after hours. All patients going for surgery should have pre and post operative evaluation within 48 hours of surgery. They should be reevaluated immediately before induction and this means assessing vital signs, airway and response to any pre procedure medications. As anesthesiologists, one particular recommendation, there should be no pre-labeled syringes, is not pragmatic. ASA and APSF argue that pre-labeled syringes may help to reduce drug administration errors and improve efficiency in operating rooms and during traumas and emergencies. They asked for a further review on these recommendations. As anesthesiologists, we always walk a fine line between efficiency and patient safety.

Nothing is more important than being well prepared. This applies to all practical aspects of life, and anesthesia is no exception. Throughout training, we have programmed many check-lists in our gray matter and the lists keep getting longer with experience. Even in today's world of smart phones and tablets, with several anesthesia applications in hand, nothing can replace a well-trained and well-prepared anesthesiologist. Vigilance is still the most important factor in patient safety as it was 100 years ago. It is better to be safe than sorry.

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CRNAs
Medical Students

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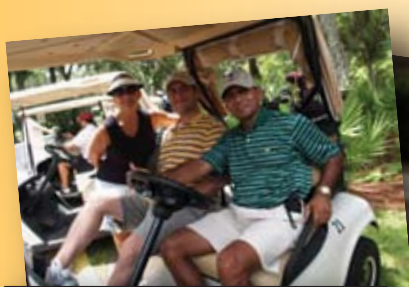
BASICS AT THE BEACH - SUMMER MEETING

Offering 10 CME Hours... Register at www.gsahq.org

For the first time in GSA history we have the special honor of having the ASA jointly sponsor our summer event. This new pilot relationship with ASA's education department will help us increase our focus on the educational needs and objectives of GSA members and enhance our marketing to a broader audience.

Content for Basics at the Beach is based on your feedback in educational surveys and post-meeting evaluations over the last few years. The educational focus will update attendee knowledge on some of the basics of anesthesia as well as snapshot the future of anesthesia in the clinical setting.

An Enriching Family Experience Along Georgia's Golden Isles...



Activity Agenda/Schedule

Saturday July 23, 2011

6:00a	Exhibitor Setup
6:15-7:15a	Breakfast with Dr. Andy Harris (Member of Congress)
6:30-7:20a	Registration/Breakfast with Exhibitors
7:20-7:30a	Welcome, GSA President
	Introductions, Summer Meeting Activities Directors
7:30-8:10a	Dr. Mark Warner – ASA Update John Thorner, JD, CAE
8:10-8:50a	Dr. Mark Warner – Perioperative Neuropathies, Blindness & Positioning Problems
8:50-9:30a	Dr. Robert Morales – Imaging of the Airway & Clinical Correlation, Part 1
9:30-9:40a	Questions and Answers
9:40-10:10a	Break with Exhibitors and Posters Session
	Resident Section Meeting
10:10-11:10a	Dr. Lena Sun – Neurotoxicity and Anesthesia
11:10-11:20a	Questions and Answers
11:20-12:00p	Dr. Andy Harris – Washington Update
12:00a-12:40p	Tina Frey – ACLS Update
12:40-12:45p	Questions and Answers
12:45p	Adjourn

Sunday July 24, 2011

6:45-8:00a	Registration/Breakfast with Exhibitors
7:00-7:30a	General Business Meeting for GSA Members
7:30-7:40a	Announcements – Introductions GSA President
7:40-8:20a	Dr. Ahsan Qadeer – URIs in Kids, When to Proceed with Anesthesia
8:20-9:00a	Dr. Roman Sniecinski – Intraoperative TEE
9:00-9:30a	Break with Exhibitors
9:30-10:10a	Dr. Darlene Mashman – Malignant Hyperthermia: An Update
10:10-10:50a	Dr. Darlene Mashman – Malignant Hyperthermia: Is Your Team Ready?
10:50-11:30a	Dr. Arnold Berry – MOCA Update
11:30a-12:10p	Dr. Robert Morales -- Imaging of the Airway and Clinical Correlation, Part 2
12:10-12:25p	Questions and Answers
12:25p	Adjourn



BASICS AT THE BEACH - SUMMER MEETING

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Faculty Disclosure/Resolution of conflicts of interest:

The American Society of Anesthesiologists and The Georgia Society of Anesthesiologists adhere to ACCME Essential Areas, Standards, and Policies regarding industry support of continuing medical education. Disclosure of the planning committee and faculty's commercial relationships will be made known at the activity. Speakers are required to openly disclose any limitations of data and/or any discussion of any off-label, experimental, or investigational uses of drugs or devices in their presentations. In accordance with the ACCME Standards for Commercial Support of CME, the American Society of Anesthesiologists will implement mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.

Commercial Support Statement:

This CME activity is supported by educational grants. A complete list of supporters will be published in the course syllabus.

Accreditation Statement:

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of American Society of Anesthesiologists and The Georgia Society of Anesthesiologists. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation:

The American Society of Anesthesiologists designates this live activity for a maximum of 10 AMA PRA Category 1 Credit(s)[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Darlene Mashman, MD

Children's Healthcare of Atlanta at Egleston Hospital

- Malignant Hyperthermia Update
- Learning Objectives:
 - Recognize two early signs of Malignant Hyperthermia
 - Identify two diseases associated with Malignant Hyperthermia
 - Describe one current diagnostic test for patients and families who have experienced Malignant Hyperthermia
- Creating a Mock Malignant Hyperthermia Code
- Learning Objectives:
 - Name two obstacles to setting up a mock malignant hyperthermia code or drill at participant's own institution
 - Be able to examine the deficiencies in participant's own hospital in relation to preparedness for malignant hyperthermia event

Lena Sun, MD

Columbia University

- Neurotoxicity and Anesthesia
- Learning Objectives:
 - Identify three anesthetic agents known to cause deleterious effects in developing animal brains.
 - Identify three changes seen in animal brains seen in current research examining neurotoxicity of anesthesia

Arnold Berry, MD

VP for Scientific Affairs, ASA

- Emory University
- Maintenance of Certification in Anesthesia (MOCA) Update
- Learning Objectives:
 - Describe four current requirements for Anesthesiology Maintenance of Certification
 - Learn and be able to formulate a plan for their own maintenance of certification

Ahsan Qadeer, MD

Georgia Health Sciences University

- Upper Respiratory Tract Infections in Children: When to Proceed and Anesthetic Management
- Learning Objectives:
 - Identify two potential anesthetic risks and complications of pediatric patients with URIs
 - Identify two findings seen in patients with URIs for whom surgery should be canceled or delayed
 - Optimize anesthetic planning and management of patients with URIs undergoing anesthesia and surgery

Special Needs Statement:

The Georgia Society of Anesthesiologists is committed to making its activities accessible to all individuals. If you are in need of an accommodation, please do not hesitate to call and/or submit a description of your needs in writing in order to receive service.

Mark Warner, MD

President, ASA - Mayo Clinic, Rochester, MN

- Perioperative Neuropathies, Blindness and Positioning Problems
- Learning Objectives:
 - Be able to describe three principles of positioning patients
 - Learn the etiologies of perioperative neuropathies
 - Restate three examples of patient positioning problems

Robert Morales, MD

University of Maryland

- Imaging of the Airway and Clinical Correlation
- Learning Objectives:
 - ID two types of scans that can be utilized to evaluate a patient's airway with radiologic imaging
 - Name two radiologic imaging findings that may predict difficult laryngoscopy and intubation

Roman Sniecinski, MD

Emory University

- Intraoperative TEE
- Learning Objectives:
 - Identify four anatomic structures seen on TEE
 - Recognize three indications for TEE
 - Name two potential complications of TEE.

Tina Frey, BSN

Children's Healthcare of Atlanta

- Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life
- Learning Objectives:
 - Recite two changes in ACLS/BLS/PALS
 - Understand why such changes occurred

Andy Harris, MD

U.S. Congressman

- Washington, D.C. Legislation Update
- Learning Objectives:
 - Discuss the current changes in legislation that will affect the practice of anesthesiology
 - Name two changes in the current healthcare law that are scheduled to go into effect in 2012
 - Identify two changes that H.R. 4872 make to the Patient Protection and Affordable Care Act

Register at www.gsahq.org

Cancellation Policy:

Cancellations and/or changes in registration or participation in all or any portion of the meeting must be received at GSA headquarters by Monday, July 18, 2011, to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after Monday, July 18. The cancellation policy and late registration fee will be strictly enforced.

Contact information for registration: Heather Atha, GSA Member Services Manager: 404.249.9178 | heather.atha@politics.org

GHSU Alumni Reception at GSA Summer Meeting



C. Alvin Head, MD

Professor & Chair | Anesthesia & Perioperative Medicine

75th Anniversary

Hundreds of anesthesiology residents and pain medicine fellows have walked through our doors since our beginnings in 1937. We will be celebrating our 75th anniversary in 2012, and we've started to hold alumni receptions to get back in touch with our alumni, update everyone on what we've been doing as a department and let everyone know how we plan to celebrate this great milestone.

So far, we've held receptions in Atlanta, Augusta, Gainesville and Macon. We are planning more in North Carolina, Florida and elsewhere. We hope you'll join us at The Frederica House for our GSA reception on Saturday, July 23, at 6pm. Hope to see you there!

You've probably heard that the Medical College of Georgia is now Georgia Health Sciences University, a name change that is long overdue and reflects how much our institution has grown. In addition to medical students, we have been training allied health, dentistry, graduate and nursing students for quite some time. Thankfully, our beloved MCG name hasn't gone away, as the School of Medicine is now Medical College of Georgia.

Look for the latest in our newsletter, department webpage and our new Facebook page which we created just for our 75th anniversary called "Anesthesiology 75 Years at MCG at GHSU." Granted, it's a bit long, but we thought it would help to have all the important words in our name. You can find a link to it at our GHSU homepage, www.georgiahealth.edu/som/anes.

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Financial Arrangements Between Anesthesiologists, Ambulatory Surgery Centers and Gastroenterologists

Charles H. Newman, Esq., and Matthew J. Levy, Esq.
Kern Augustine Conroy & Schoppmann, P.C.

Editor's note: This article is published with the expressed consent of the New York State Society of Anesthesiologists and was published in the NYSSA Sphere, Spring 2011, Volume 63 Number 1. GSA does not give legal advice; this article is not intended to be legal advice. Readers who have further questions should contact an attorney.

Ambulatory surgery centers ("ASCs"), particularly those whose physicians specialize in gastroenterology and endoscopy ("GI"), have been placing increasing pressure on anesthesiologists to enter into various financial arrangements that would allow the ASC or its owners to share in the income received by the anesthesiologists who provide anesthesiology services at the ASC. These arrangements take a variety of forms; however, they all have one element in common: the ASC and/or the surgeons who own the ASC, who are in a position to refer business to the anesthesiologists, are seeking to share in the revenue generated by the anesthesiologists, who are the beneficiaries of such referrals. Therefore, any arrangement must be analyzed in the context of the general prohibitions in both New York and federal law against kickbacks and fee-splitting, sometimes referred to herein as the "anti-kickback laws," particularly given the severe consequences of violating these laws.

I. Summary of Anti-Kickback Laws

A. Federal Anti-Kickback Statute

The federal anti-kickback statute provides, in pertinent part:

- (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind —
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program ... shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

In addition to the criminal penalties described above, violation of the federal anti-kickback statute can result in civil penalties and exclusion from participation in Medicare and Medicaid.

B. Third-Party Payor Agreements

Furthermore, many private third-party payor contracts contain provisions that allow the third-party payor to deny payment for any service rendered at a time when the provider was not in compliance with all applicable laws. Thus, violation of the federal anti-kickback law can result in significant loss of reimbursement, or claims for recovery of reimbursements previously paid, not only with respect to Medicare and Medicaid but also with respect to private third-party payors.

C. New York Anti-Kickback and Fee-Splitting Laws

In addition to the federal prohibitions and penalties described above, New York state law prohibits (i) "Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or in connection with the performance of professional services," and fee-splitting other than with a partner, employee, associate or subcontractor. The fee-splitting prohibition specifically includes arrangements for furnishing space, facilities, equipment or personnel services where the payment is based on a percentage of income or receipts.

D. Federal Safe Harbor Regulations

Applicable regulations of the Department of Health and Human Services include a series of "safe harbors," which describe certain financial arrangements that will not be treated as a criminal offense or serve as the basis for exclusion from Medicare and Medicaid. In general, arrangements that satisfy a safe harbor will also be acceptable under the New York laws cited above. Although arrangements that do not satisfy a safe harbor do not automatically constitute a violation of the anti-kickback laws, such arrangements will be subject to scrutiny by the Office of Inspector General ("OIG") and

other regulatory authorities to determine whether, in fact, at least one purpose of the arrangement was to provide remuneration to induce referrals.

In light of the significant criminal and civil penalties that may be assessed for violation of the anti-kickback laws, every effort should be made to structure an arrangement to satisfy the requirements of a safe harbor. If the safe harbor cannot be satisfied, each arrangement must be carefully analyzed on a case-by-case basis to assess the risk that the arrangement will be found to violate the anti-kickback laws.

E. OIG Special Advisory Bulletin on Contractual Joint Ventures

The OIG issued a Special Advisory Bulletin in April 2003 concerning Contractual Joint Ventures (the "Advisory Bulletin"), in which the OIG identifies suspect features of contractual joint ventures that would lead it to view them as violating the anti-kickback law. For purposes of the Advisory Bulletin, "joint ventures" are defined very broadly to include "any common enterprise with mutual economic benefit." The Advisory Bulletin also cautions that even where particular contractual arrangements meet the technical requirements of a safe harbor, the overall joint venture may still violate the anti-kickback law. Given this broad definition, any analysis of any of the business arrangements discussed in this article must take the OIG's joint venture analysis into account.

Among the characteristics that could indicate a prohibited arrangement, as described in the Advisory Bulletin, are the following:

- **New Line of Business.** One party is seeking to expand into a new line of business that can be provided to the first party's existing patient base.
- **Captive Referral Base.** The new venture is serving the owner's existing patient base, rather than expanding into an area that would allow it to serve an additional patient base.

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Advocacy

Away from the bedside, crowding the table



Steve Walsh, MD

GSA President-Elect | MAG Treasurer

Two words I use every day with most every patient. They are powerful words; I feel privileged to use them. The words are "safety" and "comfort." As anesthesiologists we observe significant patient anxiety every day. We can tell patients that it will be safe. We can tell them they will be comfortable. With these words of reassurance we watch anxiety dissipate. This is a source of great satisfaction. This is a core value of anesthesiology practice. This is what gets me out of bed every day.

I fear that our core practice value may be in jeopardy. With ever rising healthcare costs there are many who seek opportunity to replace, infringe or make more difficult what we as anesthesiologists do. The ironic thing about this challenge is that in order for us to stay at the bedside we also need to use our talents away from the bedside. We need to participate in health-

care policy -- be it local, state, or national. One of the ways GSA members can participate is through attending the ASA Legislative Conference.

Recently, twenty-two GSA members left the bedside to use their talents at the 2011 ASA Legislative Conference. The conference allows participants to hear state issues from anesthesiologists across the country. Our national organization spoke on the 2011 key federal legislative issues of fair payment, empowering patients, expanding patient access, easing drug shortage, and the surgical home. Following the presentations, our GSA registrants, under the organization of Executive Secretary Jet Toney, broke out into four teams to take the message to our Senate and Congressional representatives.

Our team spoke on the inequity of Medicare payments to anesthesiologists compared to all other medical specialties. Under our nation's current fiscal challenge a rate increase is unrealistic; rather legislators were asked to exclude anesthesiologists from cuts required from the SGR volume and cost growth formula.

Several legislators were unfamiliar with the drug shortage threat that is all too familiar with us. We helped them understand the potential consequence of comprise. What we ask is that an urgent evaluation be made by appropriate

agencies and if necessary policies created to ensure a reliable manufacturing and distribution of critically necessary and routine medications.

Lastly, we addressed the potential of improved quality and reduced cost through a Medicare "surgical home" demonstration project. The ASA white paper outlined why this is important: "Surgical care is associated with 65% of all hospital expenses. Unfortunately, thousands of patients suffer surgical complications including death. Anesthesiologists, recognized by the Institute of Medicine as leaders of safety, are in a unique position to coordinate efforts in the surgical continuum of pre-, intra-, and post-surgical care."

All three of these concerns are so vital for anesthesiologists and the care of their patients. We can participate in both stabilizing our current system and redesigning the future system.

I will always remember a colleague who told me about a meeting she attended. It was a think-tank meeting of nationally known speakers. They presented on various topics of social issues. One of the topics was titled "Healthcare in 2025". Out of all the panelists that participated not one was a medical doctor. This must change. Not only do we need a seat at the table, we all need to crowd around the table.

Financial ...continued from page 10

- Remuneration for Referrals. The practical effect of the arrangement, viewed in its entirety, is to allow one party (the GI physician or ASC) to bill for services that were previously being provided and billed by another party (the anesthesiologists) and to be compensated in a manner that takes into account the volume and value of business generated between the parties.

The principals enunciated in the Advisory Bulletin were reiterated by the OIG in the "OIG Supplemental Compliance Program for Hospitals" (the "SCP").

With this backdrop, we will now look at a few business models that have been considered, bearing in mind that each of these models is susceptible to numerous variations in details.

II. Business Models

While there are an infinite variety of arrangements that can be created, the possible structures can be divided into five basic types, each of which entails risks and benefits. This article attempts to highlight some of the relative risks and benefits of each type of arrangement. However, it is merely an introductory article for purposes of drawing attention to the issues involved and does not constitute an endorsement or condemnation of any particular transaction.

A. Service Agreement Model

Under the "Service Agreement Model," an ASC will enter into an agreement with an anesthesiologist or anesthesiology group whereby the ASC will provide office space, equipment, and/or administrative support services to the anesthesiology group in

exchange for a fee. As noted above, to satisfy New York law, the fee paid to the ASC cannot be determined as a percentage of revenues. This model implicates three safe harbor rules: space rental, equipment rental, and personal services and management contracts. The primary requirements common to each of these safe harbor regulations are:

1. The agreement must be in writing.
2. The written agreement must cover all of the space, equipment, and/or services involved.
3. If the arrangement is less than full time, the intervals of use or periods of service must be specified in advance in the agreement between the parties.

For the complete version, go to "scope the news" at www.gsahq.org.

GSA members walk Capitol Hill



Washington, D.C., Cannon House Office Bldg. – U.S. Representative (Dr.) Tom Price, R-GA 6 (center), met with GSA members (l-r) Dr. Gaurav Patel, Dr. Keith Robinson, Dr. Jim Beatty and Dr. Tom West

Washington, DC -- Earlier this month, more than 20 GSA members joined more than 400 Anesthesiologists, resident physicians, AAs and state component staff/lobbyists at the annual ASA Legislative Conference in the nation's Capital. Foremost on the tongues of GSA members who invested time and shoe leather in visiting the offices of Georgia's 13 Members of Congress and two U.S. Senators was advocacy for federal action to eliminate vital drug shortages and against future physician payment cuts in Medicare/Medicaid.

Four teams consisting of GSA members met with members of Congress and/or specific health Legislative Assistants to advocate for patients and physicians on ASA's four current major federal policy initiatives:

1) Drug Shortages (S. 296 "Preserving Access to Life-Saving Medications Act")

Since 2006, the number of identified new drug shortages has tripled. Drug shortages can be caused by several factors, one of which is the FDA's oversight of drug manufacturers. S. 296 would increase the FDA's authority over manufacturers to mandate notification before withdrawal from a market.

2) Prevent Medicare Service & Payment Cuts / Hold Anesthesiology Harmless (H.R. 452 "Medicare Decisions Accountability Act" & S. 668 "Health Care Bureaucrats Elimination Act")

Medicare payment rates for anesthesia are palpable, and could get worse as the Independent Payment Advisory Board (IPAB) gains authority to make reductions in Part B payments. Anesthesia payments are also unduly impacted by the manner in which the Medicare sustainable growth rate (SGR) is applied. Where anesthesiology services are not driving the volume or growth in Medicare expenditures, they are cut at the same rate as services leading to increase costs. H.R. 452 and S. 668 would repeal IPAB.

3) Expand Access to Anesthesiology Medical Care Support "Pass Through" Legislation (H.R. 1044 "Medicare Access to Rural Anesthesiology")

Rural areas have a hard time retaining anesthesiologists due to low Medicare Part B payments and low patient volume. In the 1980s, legislation designed to combat declining access to services allowed rural hospitals a better arrangement by using Medicare Part A

as a pass through to contract with non-physician anesthesia providers. H.R. would allow rural hospitals to contract with anesthesiologists using pass-through funds.

4) Empower Patients—More Information for Smarter Health Care Choices (H.R. 451 "Health Care Truth and Transparency Act")

Health care provider-related advertisements, marketing and degree titles are notoriously ambiguous and lead to unnecessary patient confusion. H.R. 451 would provide enhanced transparency requirements regarding medical care delivery and, in fact, should save money. The legislation, sponsored by Georgia Rep. David Scott, D-GA 13, is timely given the granting of Doctor of Nursing (PhD Nursing) degrees.



Stephen Anderson, MD

Resident | GHSU/MCG

Seen behind policy curtain

As a CA-1 at the Medical College of Georgia, I have an extraordinary amount to learn about the field of anesthesia. Perfecting procedural skills and learning drug mechanisms is enough to keep any first-year resident busy for seemingly endless hours. But this week, I had the opportunity to learn about an aspect of our field not taught in a textbook or in an operating room.

At the 2011 ASA Legislative Conference in Washington, DC, we discussed many of the issues that will affect our field in the years to come. As the federal government debates how to reform healthcare as a whole, I learned from many of the medical and legislative experts exactly how we will

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For more information on ASA's federal advocacy, go to...

<http://www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities.aspx>

State Issues and Advances

The 2011 Session of the Georgia General Assembly adjourned sine die on April 14. GSA's lobbying team and Society leaders worked closely with the Medical Association of Georgia, other medical specialty societies and affiliated organizations to pass two major initiatives which have been on the GSA Advocacy Goals list for more than two years.

The General Assembly adopted legislation to empower law enforcement and professional licensing boards to identify, prosecute and **shut down "pill mills"** where legal drugs are illegally and abusively prescribed and/or dispensed (SB 36). The legislation creates an electronic database to monitor and review the dispensing of controlled substances. The measure is designed to combat prescription drug abuse and "doctor shopping." Sponsors: Sen. Buddy Carter, R-Savannah and Rep. Tom Weldon, R-Ringgold. The legislation has been a GSA priority for four years.

Passage of this legislation follows GSA's primary role in encouraging the state Composite Medical Board to adopt "Guidelines for Pain Management" in January 2008 after a series of legislative stakeholder meetings held statewide to promote adoption. The combination of new safeguards on illegal prescribing of narcotics and other schedule II drugs and the 2008 "Guidelines for Pain Management" are two spokes in a public policy wheel to clarify proper administration of pain management for the protection of patients.

Also adopted after three years of coalition effort was HB 167 by Rep. Steve Davis, R-McDonough, which expands Georgia's **prompt pay statute** without an ERISA exemption to third party administrators (TPAs). The bill would require TPAs to pay paper claims in 30 days and electronic claims in 15 days or address why they haven't done so within the same timeframe. TPAs which fail to comply with the statute on less than 95 percent of the claims during a quarter would be subject to interest payments totaling 12 percent of the amount due. Congratulations to the Medical Association of Georgia for its leadership on this legislation over the past three years.

For more information on state legislation, go to www.legis.state.ga.us or contact... Dr. Mark Huffman, GSA Government Affairs Chair, at mmhuffman@comcast.net.

State Advocacy Scorecard

Report

- **"Pill Mill" enforcement – SB 36 creates a database to track & identify illegal prescribing/dispensing of legal drugs.** ✓ Passed
- **Third-Party Prompt Pay – HB 167 requires TPAs to abide by state's prompt pay statute.** ✓ Passed
- **Office Based Surgery/Anesthesia Guidelines – GSA is working with the Georgia Composite Medical Board to write guidelines for anesthesia & surgery in a physician's office.** ▶ In Progress
- **Payer Advocacy – GSA is working with MAG & other specialty societies to create a more effective third-party payer advocacy program to assist members.** ▶ In Progress
- **Medicaid Payment Issues – GSA has joined with other medical societies to advocate for much-needed corrections & clarifications to state Medicaid physician payment problems.** ▶ In Progress

Pain Management & OBS Guidelines: Two spokes in the public policy wheel... for patient protection.



Mark Huffman, MD
Chair | Government Affairs

Curtain ...continued from page 12

fit into this restructured model and be financially compensated as Medicare ever expands in the face of trillion dollar federal deficits. Another issue that has generated much concern across the country is the the alarming incidence of drug shortages. This is an issue that may be more applicable on a resident level since we are constantly changing our anesthetic plan based on drug availability; and often times, we are forced to use drugs that are suboptimal for a given situation.

As a former Capitol Hill legislative staffer, I have seen behind the proverbial curtain as to how policy is shaped. I have been lobbied by many interest groups from all over the state and country. We have great resources at the state and federal level that are lobbying on our behalf to ensure that anesthesia is not lost in the shuffle as medicine continues to evolve. Becoming actively involved in the governmental affairs aspect of our field by attending meetings, writing letters, or contributing financially is a great way to preserve our interests not only for the present but for years to come.

Put tools in lobbyists' toolbox



James E. "Jet" Toney

Executive Secretary | Lead Lobbyist

A professional lobbyist's stock in trade is equal parts information and integrity. On your behalf, GSA's lobbying team imparts information to elected and appointed decision makers in a concerted effort to positively impact public policy in health-care, insurance, liability and payment. Integrity is a daily requirement; without trust, lawmakers and staff give no value to one's information.

A lobbyist's toolbox is filled with methods and activities which enhance our ability to influence the making and administration of public policy and laws. These tools operate most effectively, however, when they are well-lubricated by the grease of political contributions. This lubrication is so important to our work that your contributions are a critical element in GSA's public affairs strategy.

Bottom line, if you want your advocates to be good at influencing the making of laws and regulation, give generously to your professional political action committees (PACs).

Well-funded PACs equip the mother organizations to move swiftly and efficiently in the political world and, ultimately, in the world of government decisions. GSA-PAC and ASA-PAC are two outstanding examples of political funds which have made substantial contributions to policy leaders and state and federal movers and shakers. If you have contributed to GSA-PAC and ASA-PAC this year you have helped equip your lobbyists to do their work in the very unique world of politics and government.

The following GSA members have contributed to GSA-PAC since November 1, 2010 through May 6, 2011:

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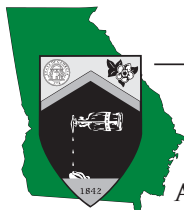
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GSA PAC Report

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Number of Contributors	180	220	209	206	247	253	215	250	220	291	322	249	189
Interest Income	\$3,014	\$4,946	\$2,532	\$282	\$694	\$1,458	\$764	\$2,941	\$3,169	\$2,509	\$255	\$61	\$4
Political Contributions	\$5,650	\$42,000	\$33,100	\$78,600	\$24,500	\$47,250	\$5,850	\$55,750	\$15,000	\$62,600	\$39,700	\$97,485	\$500
Fund Balance Year End	\$50,239	50,444	\$55,246	\$23,144	\$52,227	\$45,845	\$58,295	\$39,301	\$58,186	\$60,130	\$79,249	\$30,410	\$27,453



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