American Society of Anesthesiologists

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March 19, 2009

Inspector General Daniel R. Levinson
Office of Inspector General
United States Department of Health and Human Services
Room 5541 Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Levinson,

The American Society of Anesthesiologists (ASA), representing over 43,000 members, has received increasingly frequent concerns from its members regarding an economic model that potentially violates the Federal anti-kickback provisions of the Social Security Act (the Act) (section 1128B), and/or the prohibition of self-referrals of the Act (section 1877). The ASA respectfully requests the Office of Inspector General to issue a Special Advisory Bulletin on the economic model ("company model") described below.

The overwhelming majority of anesthesiologists are organized as independent group practices that contract with hospitals, ambulatory surgical centers (ASCs) or other outpatient providers to provide anesthesia services. The anesthesiology groups vary in terms of size and areas of practice and can include some or all of the following individuals: anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs).

Typically the anesthesia group operates under a traditional fee-for service model, whereby the group provides some or all anesthesia services at a particular facility or office. Under this model, the anesthesia group exercises independent clinical judgment, operates relatively independently, and directly bills and collects for the services it provides. Other than perhaps leasing space, equipment and/or administrative personnel services from the facility or office, there is usually no compensation agreement between the group and the facility or office.

A limited number of anesthesia providers operate under an employment model whereby the facility directly pays the anesthesia providers a salary. In exchange for the salary, the anesthesia provider either assigns billing and collecting for professional fees to the facility or handles billing himself/herself and then turns over collections to the facility.

A third model, the "company model", has grown in popularity in various areas of the country and is the impetus for this letter. Trade press articles increasingly note the popularity of this model among ASCs (e.g., *Can Surgery Centers Profit from Anesthesia?* Outpatient Surgery, April 2004[1], and *Five Ways Your ASC Can Profit from Anesthesia Services,* SurgiStrategies, May 2005[2]). Under the "company model", a physician-owned facility, such as an ASC, establishes and incorporates a separate anesthesia company under the same ownership as the facility. The anesthesia company employs anesthesia providers and exists to provide anesthesia services to the facility. The establishment of the separate corporation allows for billing of facility fees and anesthesia services fees, which is usually handled through the same billing/administrative company. After the anesthesia providers' salaries, billing expenses and other costs are extracted, the anesthesia company's profits are distributed back to the owners of the facility. Some estimate these distributed profits as 40% or higher of the anesthesia fees. In most cases, the fees paid to the anesthesia providers are less than they could earn if they billed independently.

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[1] http://www.outpatientsurgery.net/2004/04/can_surgery_centers_profit_anesthesia.php

[2] http://www.surgistrategies.com/articles/business_finance_and_law/558_551slaw.html

As health care dollars become increasingly scarce, health care facilities are looking to areas, including anesthesia services, to enhance their profitability. The "company model" is gaining traction across the country and is especially prevalent with endoscopy centers owned by gastroenterologists. We have learned of gastroenterologists establishing or proposing the company model in a number of states, including Tennessee, Florida, Pennsylvania, Oklahoma and North Carolina. Coupled with the increasing prevalence of the "company model" are additional demands upon anesthesia providers to pay remuneration for services beyond what they actually receive, including non-clinical supplies, scrubs, locker room and lunch room use, and full-time administrative office staff despite providing services for only part of a work week. We feel that these requests constitute kickbacks.

The Office of Inspector General has previously stated its concerns in regard to joint ventures:

> *Distributions from the joint venture may be disguised remuneration paid in return for referrals. Like any kickback scheme, such arrangements can lead to overutilization of services, increased costs for federal health care programs, corruption of professional judgment, and unfair competition.*

All of these stated concerns exist with the "company model" described above. First, the model will result in overutilization of anesthesia services. Under the fee-for-service model, the anesthesia group provides anesthesia services to the facility, but exercises independent clinical judgment. Often the contract between the facility and anesthesia group specifies select procedures in which anesthesia services will be provided (*e.g.*, in the case of endoscopy, those patients in which moderate sedation is not appropriate). Patient care and safety are optimized as patients only receive medically appropriate services, and costs to the health care system are minimized. However, under the "company model" the facility owners, who also own the anesthesia company and have a stake in the anesthesia profits, have an incentive to increase utilization of anesthesia services, and thus, increase costs to the system and federal health care programs. Some of our members report that at least one endoscopy center in Florida has increased its anesthesia utilization to nearly 100% now that it has transitioned to the "company model". Commercial health insurers have begun expressing concern about the utilization rates of facilities operating under this model. The incentive clearly exists, and we estimate that all practices operating under the company model will experience the same incentive.

Given the increased opportunity for profits from anesthesia services, the "company model" is likely to result in corruption of professional judgment. In the example of the endoscopy center, a gastroenterologist performs the procedure as a physician and owner of both the center and the anesthesia company. He/she will receive income from the performance of the procedure, facility fee and administration of anesthesia. Now that he/she has a stake in the game in regard to anesthesia services, it does not take a leap of logic for one to surmise that he/she could pressure anesthesia providers, who are employees of his/her company, to administer anesthesia or administer a deeper level of anesthesia to patients who might be able to tolerate the procedure without such anesthesia services. The resulting increase in referrals for anesthesia services could amount to a violation of the self-referral laws. More important, they could have a detrimental impact on patient safety and quality of care.

Finally, the "company model" requires anesthesia providers to pass back to the facility a substantial portion of the fees for the services they provide to patients. As previously stated, some have estimated 40% of the anesthesia fee is distributed to the physician owners of the facility. Further, anesthesia groups cannot economically compete with such a model unless they are willing to provide a similar illegal kickback to the facility.

While we recognize this situation may disproportionately impact anesthesiologists because we are one of the only traditional "hospital-based" specialists who provide services at ASCs and other physician offices, we believe this model or a derivative thereof could be applied to other hospital-based specialists. Therefore, the potential impact could be quite substantial.

Given the fact that several anesthesiology group practices have seen their contracts terminated for failing to agree to the company model, and out of concern for patient safety and quality of care, we respectfully request the Office of Inspector General to issue a Special Advisory Bulletin clarifying the merits, implications and legality of the company model described.

If you need any additional information from ASA, please contact Chip Amoe, JD, MPA, Assistant Director of Federal Affairs, or Jason Byrd, JD, Associate Director of Practice Management and Quality Initiatives, at (202) 289-2222.

Sincerely,

Roger A. Moore M.D

Roger A. Moore, M.D.
President