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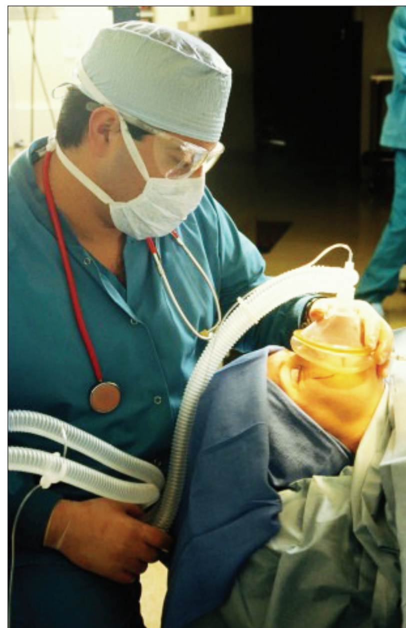
Can ASCs Share in Anesthesia Revenue?

A look at three ways that you can partner with your anesthesia providers.

If you're a physician-owner seeking to profit from anesthesia reimbursement, here's an overview of three joint-venture models that let you do just that. Each is unlike the traditional ASC-anesthesia arrangement, where the ASC bills for facility fees while anesthesia providers bill for services rendered.

1 Anesthesia services company. This model involves forming a new company to supply anesthesia services, either owned by the same physicians who own the ASC, in the same percentages, or by selected investors, provided the selection isn't rewarding the ASC's highest utilizers. Since the development, recruitment, management, and coding and billing associated with an anesthesia concession requires some business acumen, an anesthesia services company may also partly own the new company.

The new company, now the ASC's exclusive anesthesia provider, may charge a management fee for its administrative assistance. It will employ or contract with anesthesia providers, enroll in Medicare to bill for services and obtain all payor contracts. It will allocate the profits among its owners in accordance with the ownership breakdown.



IN THE LOOP Partnering with your anesthesia providers can boost your facility's bottom line.

In a variation of this model, the new company starts out wholly owned by the established anesthesia company with the condition that, after a limited period of time, the ASC's investors have the option to purchase all or part of the new company at a predetermined fair market value. The new company and the established company will then enter into a long-term management arrangement.

From a payment perspective, this model reduces the possibility that payors will deny claims or reimburse at a lesser level. From a regulatory perspective, however, the model shares certain elements of a "suspect contractual joint venture" under the federal Anti-kickback Statute. Recent guidance from the Office of Inspector General suggests that arrangements in which an existing supplier gives a referral source the opportunity to profit may be deemed sham arrangements and the profit opportunities deemed kickbacks. By setting up the arrangement to safe harbor the various financial arrangements, you can reduce, if not eliminate, the likelihood that this arrangement will be seen as suspect.

2 Group practice anesthesia. This model, in which the physicians' practice employs the anesthesia providers and bills for their services, is ideal for ASCs whose physician-investors are associated with a single group practice. A tremendous benefit is that you don't have to allocate the anesthesia profits to investors on a pro rata basis. You can distribute them with more flexibility, in a manner more closely reflecting each physician's relative productivity, since they're allocated through the group practice.

Another benefit of this model is the ease and speed with which you can implement it, since the group practice already has a Medicare number and payor contracts. Review those contracts to verify that the group practice will be reimbursed for the anesthesia services at the same rate that an anesthesia practice would. If it won't, the practice may want to form a new entity to employ and bill for anesthesia services, which will operate as a wholly-owned subsidiary of the practice.

This model shouldn't present significant regulatory issues, as anesthesia services are operated as a natural extension of the practice.

3 In-house provider. With this model, an ASC effectively shifts anesthesia services in-house by hiring providers as employees or retaining them as independent contractors. The anesthesia provider assigns the ASC the right to bill for and collect anesthesia fees.

There are two key advantages here. First, the ASC and its investors can administer and profit from anesthesia services the same way they have from the center's operations, lessening the likelihood for investor grievances that the anesthesia concession is being administered differently than the center's other workings. Second, the model might better position the ASC to offer its payors package pricing; that is, approach the payors with a package of two services (the facility and the anesthesia provider fees) that they'd otherwise have to pay separately.

This arrangement does come with cautions. It could implicate the Anti-kickback Statute if the anesthesia provider accepts a payment below fair market value in exchange for an exclusive source of anesthesia referrals. Some payors have expressed reluctance to process claims from ASCs that cover both facility and anesthesia services. It could also implicate states' fee-splitting laws or, if the ASC involves non-physician ownership, their corporate practice of medicine laws. **OSM**

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