



Understanding the Business of Anesthesia

Here's a look at the options available to you in choosing a model for the delivery of anesthesia services.

Anesthesiologists and nurse anesthetists won't just magically appear in your surgery center when you wheel in your first patient. Like every other member of your OR staff, you must recruit your anesthesia providers. First, though, you must decide two things.

- The form of an anesthesia arrangement that makes sense for your facility: independent contractors, employees, partners, members of a locum tenens organization or part of a nearby hospital-based group; and
- whether you'll use the services of anesthesiologists, nurse anesthetists or both to administer anesthesia. Keep in mind that anesthesiologists and CRNAs earn the same in many areas of the country.

The independent contractor

Arguably, ambulatory surgery centers with independent contractor anesthesiologists have the best of all worlds. The independent contractor anesthesiologist is a physician who can offer the most flex-

ibility in clinical independence, prescription writing services and pain management services (if subspecialty trained and qualified). This individual — or group of individuals — is also maximally incentivized to promote your business. The independent contractor is fiscally aligned with the surgeon and the facility in that he makes a living by doing cases. If cases aren't properly screened, there is a high cancellation rate, or patients aren't absolutely satisfied with their clinical care

and customer service, the anesthesiologist loses alongside his surgeon colleague, facility administrator and owner(s). Of course, the anesthesia provider could well be a CRNA and, in states

where CRNAs have independent practice status — and where operating surgeons accept this arrangement — this is an option to consider. Many successful facilities have independent contractor anesthesia groups that are comprised of anesthesiologists and nurse anesthetists working together in a care-group model.

How you'll compensate them. Independent contractors usually bill for their own services. Because the anesthesia supplies are considered covered by the facility fee, these providers have a revenue-neutral effect on the ASC bottom line. Sometimes, surgery centers will pay one physician a stipend ranging from \$60,000 to \$150,000 a year to also act as the medical director of the facility and handle such additional administrative and medical tasks as credentialing and quality assurance.

The hospital group

The hospital group model is simply a variation on the independent contractor arrangement. In this scenario, often through the goodwill generated by anesthesiologists or CRNAs with surgeons at nearby hospitals, the anesthesia providers arrange to have designated individuals (or a team of rotating providers) cover the operating rooms at a free-standing surgery center.

How you'll compensate them. The fiscal model is often identical to that of the independent contractor model. An important note: It behooves the surgery and the independent/hospital group providers to make sure that all parties participate in the same insurance contracts. It makes for unhappy patients when an anesthesiologist does not participate with the plan and the patient gets a hefty, unexpected bill.

The employee model

In the employee model, you'll negotiate contracts with nurses or physicians to provide anesthesia to your facility's patients for a given salary plus benefits. This model is particularly suited to extremely



busy and efficient surgery centers, as it's possible to generate profit above and beyond what the employee costs. The downside to this model: For new, underutilized operating rooms, the anesthesia provider may become (and be seen as) a financial drain on an up-and-coming organization.

In my experience and estimation, the added built-in incentive of the independent contractor (it is only human nature to work just a bit harder when that work is the only form of one's income) and the added savings to start-up facilities more than offset any revenues lost years down the line when an ASC becomes very busy.

Hopefully, you'll have the foresight to construct independent-contractor, hospital-based or employee contracts that reward loyalty and contributions to the long-term success of your surgery center.

The trick in designing your new surgical center is ensuring that your patients receive the safest anesthesia possible from the most qualified providers.

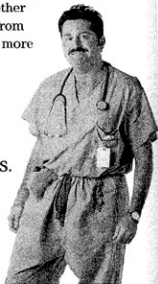
How you'll compensate them. An employer-employee contract with terms for salary and benefits. Salaries could range from \$120,000 per year per anesthesia provider for a less-than-busy facility or one operating only a few days per week, to \$300,000 per year per provider for a busy center.

The locum tenens model

Locum tenens physicians and nurses are traveling providers arranged through contracts with compa-

nies that act as schedulers and middlemen. With the anesthesia provider shortage, this model has grown in popularity in recent years. Some say that no matter how skilled and well-liked a traveling anesthesiologist or CRNA may be, there is no substitute for the familiarity, consistency and camaraderie of a long-term, permanent face in the operating room. No surgeon, operating room nurse, technician or administrator wants to look up at the head of the operating table and wonder whom the provider du jour will be.

How you'll compensate them. A contract outlining pay, overtime and travel expenses for the daily or weekly guarantee of an anesthesia provider. The locum tenens provider (whether CRNA or physician) could cost from \$850 for a short day to \$1,400 or more



for a long day. Most locum tenens companies will negotiate better daily or weekly rates for long-term contracts.

The partner model

The partner model may not be suitable for every anesthesia provider or ambulatory surgery center. In addition, the concept of partner may not be economically or practically feasible for many start-up facilities. But rewarding an independent contractor or employee with the potential to buy into the surgical facility can be a win-win proposition. People want to be included — even in taking risks — and they often perform at their best when they know that they, too, have a stake in the success of their organization.

How you'll compensate them. There are many variations of the partnership theme, running the gamut from original

Anesthesiologist or CRNA?

Everyone understands what anesthesia providers do, right? They provide IV sedation, regional blocks and general anesthesia. There's also the medical management and supervision of patients in the perioperative arena. You can choose either an anesthesiologist or a CRNA.

Anesthesiologists	Nurse anesthetists (CRNAs)
<ul style="list-style-type: none"> • four years of residency training • medical school • board-certified physicians 	<ul style="list-style-type: none"> • nursing school • specialty training • certified registered nurse anesthetists

Who Pays for Anesthesia Supplies and Drugs?

It's ill-advised for surgical centers to attempt to recoup drug and supply costs from anesthesia providers. The government can interpret this as a form of kickback. Here's why:

- The government and all insurance companies consider the money paid to facilities for the facility fee to include surgical and anesthesia supplies, and
- surgeons, physician-owners and administrators could bid anesthesia providers against each other to see

joint ventures to contractual options evaluated several years into an independent or employee contractual relationship.

Are you anesthesia-ready?

A word of caution: don't become overly obsessed with how much an anesthesiologist or nurse anesthetist will drain from the bottom line. There will be no more important position in your center than your anesthesiologist or CRNA. Yes, surgeons will refer patients to your facility, but the anesthesia patients receive will be — in most cases — their biggest risk.

Some have referred to anesthesia as controlled poison or the art of the near-overdose. However you think of anesthesia, the fact is that patients decide on having surgery first, and then anesthesia becomes a necessary evil. The trick in designing your new surgical center is ensuring that your patients receive the safest anesthesia possible from the most qualified providers — and that they request your facility next time because their anesthetic experience was superior.

who'll pad the facility bottom line the most in exchange for the exclusive right to give anesthesia in the facility.

If your facility's goal is to profit from anesthesia, structure your operations around an employee model. In this model, you must openly solicit in some form for your desired position(s) and see who'll take the job for the required hours, pay and benefits.

An added word of caution: I strongly urge facilities where there are high-

volume cosmetic/cash-pay cases to be on the lookout for unusual arrangements between surgeon and anesthesia provider. Some surgeons may be under the false pretense that since no third party is involved in the payment of services that no one is looking to the movement of cash between patient, surgeon and anesthesia. There's no gray area: The IRS requires that you disclose earned income.

— Adam F. Dorin, MD, MBA

In choosing a model for the delivery of anesthesia services in your facility, there will be many issues to consider — from the number of ORs and type of business plan to surgeon preference. Only you will know which option will be best

for your new surgical center. Choose wisely. OSM

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