ACG GI Practice Toolbox

Adding Anesthesia Services as an Ancillary Service to your Practice or ASC

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INTRODUCTION:

Many gastrointestinal (GI) practices with ambulatory surgical centers (ASC) have benefited from the addition of anesthesia providers as an ancillary service. Many groups report that incorporating anesthesia directly to their GI practice or ASC increases efficiency, results in improved quality of care and increases revenue. Adding this ancillary service, however, requires a careful examination of the rules and regulations dictated by the Centers for Medicare and Medicaid Services (CMS) and of your state. These rules and regulations along with the goals of your practice will guide the adoption of the best business model for this addition. This ACG Toolbox review provides a general guide for practices interested in adding anesthesia providers to your GI practice.

TOPIC OVERVIEW:

Moderate sedation, under the direction of the endoscopist, has been the gold standard for sedating patients undergoing endoscopic procedures for decades. The ideal medications should have a rapid onset and short duration of action to maintain patient comfort and hemodynamic stability during the procedure.[1] The medications should not carry the risk of major side effects. Although short-acting opiates and benzodiazepines have been the mainstay of sedation for decades, recent years have seen a rapid shift to the use of Propofol.

Anesthesia using Propofol has several advantages over traditional conscious sedation. The onset of effect of propofol is extremely rapid, while the duration of effect is very brief at between 4 and 8 minutes.[2] A meta-analysis showed that using propofol alone allowed a more rapid initiation of sedation (2 vs 6-8.5 minutes) and a shorter recovery time (15 vs 50-55 minutes) compared to benzodiazepines-based regimens.[2] The shift to this method of sedation has been dramatic. Between 2001 and 2015 the use of anesthesia professionals for routine screening colonoscopy increased from 11% to 50%.[3,4] Factors driving his increase include patient preference, increased use of narcotics in the community, and the race for increased efficiency in the ambulatory setting. As demands of ASC procedures increase and reimbursements decrease many gastroenterology practices have added anesthesia services to

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their practice. Anesthesia professionals are varied experience in sedation for endoscopy and may require time to become an effective and efficient member of your care team.

Anesthesia Directed Sedation (ADS) and non-anesthesiologist-administered (NAAP) or physician-directed propofol sedation (PDPS) require that a trained professional administer and manage the sedation of the patient. American Society of Gastrointestinal Endoscopy (ASGE) guidelines is another resource to review the practice of sedation for endoscopy.[5] It is important to review and consider individual state laws concerning the administration of propofol and whether trained personnel other than anesthesiologists may do so. Rules stemming from state medical practice and/or nurse practice laws have specific training requirements for who may administer sedation, as well recommendations for the supervising physician. Some states allow a trained registered nurse (RN) to administer this medication, while others require an anesthesia-trained professional. There may be state rules mandating the exclusion of any nursing responsibilities other than sedating and monitoring the patient during the procedure.

Choosing an Anesthesia Service Model for your Practice:

Several models for incorporating anesthesia services are described below. It is fundamental to realize that the federal Anti-Kickback Statute (AKS) risk varies among these models. As a result, it is crucial to consult with your lawyer about which one of these models best suits your ASC while in compliance with the federal and state laws.

1. Fee-For-Services/Independent Contractor Model. This model carries the lowest AKS risk. The anesthesia professionals independently provide services at the ASC and bill the payor directly for their services.

2. Employment of Anesthesia Professionals by Your Group Model. With this model, your group would hire or contract with anesthesia professionals. The ASC will then contract with your group to provide anesthesia services at the center. This will turn your group into a multi-specialty group.

3. ASC-Direct Employment Model. In this model, the ASC directly employs anesthesia professionals and bills for their services.

4. Per-Diem Independent Contractor Model. Using this model, the ASC contracts with the anesthesia professional to provide services. In this case, the ASC bills for the services and then pay the provider in the form of a pre-determined fee on a per-diem basis.

5. Employment of Anesthesia Providers by Creating a New Group Practice. Under this model a new practice is created as a single-specialty anesthesia group practice, owned by non-anesthesiologist physicians.

6. Company Model. Under this model, the group will establish and own a separate anesthesia company (with or without a separate anesthesia professional). The anesthesia company then

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employs or independently contracts with anesthesia professionals to provide anesthesia services to the ASC. To comply with AKS the company's profits return to the owners in proportion to their ownership interest and not in a way that rewards referrals.

CONCLUSION:

This toolbox article briefly describes several business models for adding anesthesia as an ancillary service to your practice or ASC. Adding this service requires careful consideration of your practice needs and goals as well as the laws in your state. We strongly encourage close consultation with an experienced healthcare attorney throughout the process. Many gastroenterology practices have successfully used one of these to improve the efficiency of care and increase revenue.

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