When negotiating a contract with your anesthesia group, you'll spend considerable time discussing such usual sticking points as compensation, length of contract and how to handle unused OR time. But other, less-apparent issues are as important, chief among them: Does your agreement comply with the federal anti-kickback statute and its regulations?

ASCs must be particularly mindful of their relationships with anesthesia providers regarding staffing, billing and referral relationships. Similarly, anesthesia groups can level the playing field against ASC owners during contract negotiations and protect against one-sided arrangements if they understand the governing laws and regulations. This article examines 3 types of joint-venture arrangements between ASCs and anesthesia groups and considers the level of legal risk associated with each model.

Traditional fee-for-service model. An anesthesia group contracts directly with an ASC to provide anesthesia services on a fee-for-service basis. The anesthesia group directly bills payors for the professional fees and is responsible for its collections. This model — used by 73% of respondents to a 2004 Outpatient Surgery Magazine survey — carries little regulatory risk because there's typically no direct financial relationship between the ASC and anesthesia group.

Employment model. An ASC directly hires the anesthesia provider, paying his salary and fringe benefits, and bills patients' payors for professional fees and facility services. Only 26% of the Outpatient Surgery survey respondents reported using the employment model. Unlike the traditional fee-for-service model, the ASC can profit directly from anesthesia services, and this may provide a financial incentive for ASC investors. If the compensation package for anesthesiologists is held in check, a well-run ASC can obtain a larger profit margin for its investors, though the anesthesiologists might not share in the upside.

Company model. Under the company model, the most controversial of the 3 arrangements, the ASC forms a company to administer anesthesia services. The revenues from the facility fees and professional fees (less the compensation paid to anesthesiologists) are divided among ASC owners. The American Society of Anesthesiologists recently expressed concern that the company model is being used more
frequently. In a March 19, 2009, letter to the HHS Office of Inspector General, the ASA warned that the company model was "likely to result in corruption of professional judgment." In the fee-for-service model, the anesthesia group exercises its own judgment to determine whether anesthesia is necessary for a particular procedure. In the company model, ASCs have a financial incentive to administer anesthesia as often as possible, and the overuse of unnecessary anesthesia services could occur. The ASA has asked the OIG to issue a special advisory bulletin discussing the company model and issues for ASC owners and anesthesiologists to consider.

Anti-kickback concerns
The federal anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. The anti-kickback statute prohibits a quid pro quo relationship in a healthcare transaction that uses federal dollars. There are certain safe harbor protections that can be used to ensure a business arrangement is appropriate.

Generally, if the anesthesia group pays the ASC for using space or equipment, federal anti-kickback concerns may be raised. There are anti-kickback safe harbor protections relating to leasing space and equipment. For example, if the lease is for fair market value set forth in a written document and is commercially reasonable, the arrangement could qualify for safe harbor protection.

Because of the anti-kickback statute, the federal government is concerned with arrangements that are not arm's-length, meaning that the arrangement isn't consistent with the marketplace and with commercially reasonable terms and conditions between multiple parties. For example, red flags may be raised if an anesthesia group contracts for a fixed revenue basis and is asked or required to forfeit a portion of profit back to an ASC in exchange for an exclusive contract. Concerns may also be raised if, in order to secure a contract, an anesthesia group is required to pay the costs of supplies or pharmaceuticals that normally should be provided by the ASC. Though these might seem like small concessions in exchange for the financial security of a contract, each of these scenarios raises anti-kickback issues.

Every ASC and anesthesia provider contractual relationship that potentially implicates the anti-kickback statute should be structured to comply with the relevant safe harbor provisions. An arrangement that doesn't meet each element of a safe harbor doesn't make the arrangement illegal unless the government proves the requisite intent, but it does raise the level of risk.

Making fee arrangements
Here are 2 issues ASC owners and anesthesia practice groups must consider when drafting contracts.

• Clarity in each of the contractual terms. Identifying the hours that an anesthesia provider is expected to be physically available to provide services in the ASC is
essential because that has a correlation to the payment provided to the anesthesia provider, particularly in the employment model and the company model. For example, a relevant issue is whether the anesthesia provider is paid an hourly rate or a per diem rate. It's important that the remuneration be at fair market value. The amount paid as fair market value in a large urban area may not be the same as what is paid in a rural community. Having an independent pay consultant confirm the compensation structure provides an extra level of protection should a governmental authority question the arrangement.

- How will you handle unused OR time? Will the anesthesia provider be paid for being available even if no clinical services are being provided? This is important for economic and legal reasons. If the anesthesia provider's compensation is withheld or reduced for unused operating room time, this shifts control over total compensation to the ASC, since an anesthesia provider providing intraoperative care has no control over the flow of patients into an ASC. The resulting offset can translate to the anesthesia provider not being paid fair market value, particularly if the anesthesia provider isn't able to secure and provide anesthesia work at alternative locations while making himself or herself or colleagues available upon request at the ASC.

As the 08-08 opinion addressed (see "What Does the OIG Tell Us?"), defining the scope and expected commitment of an anesthesia provider's administrative duties is important. Time costs money. Administrative arrangements need to be separate from clinical arrangements. Ensuring the payments for administrative efforts are fair market value in an arm's-length transaction is essential. Phantom administrative time payments are as troublesome as no hourly or discounted payment for legitimate, quantifiable administrative duties. The OIG hasn't issued opinions regarding what constitutes fair market value for administrative services.

Balancing risk with reward
ASCs and anesthesia service providers can enter into business arrangements that are mutually beneficial, but each should be careful when negotiating arrangements, including the fee details. The role of potential referral relationships and financial gain resulting from these opportunities must be understood and addressed. Many situations that could yield a greater financial reward for ASCs or anesthesia providers also carry more legal risk.

*Reprinted with permission of Outpatient Surgery Magazine.*