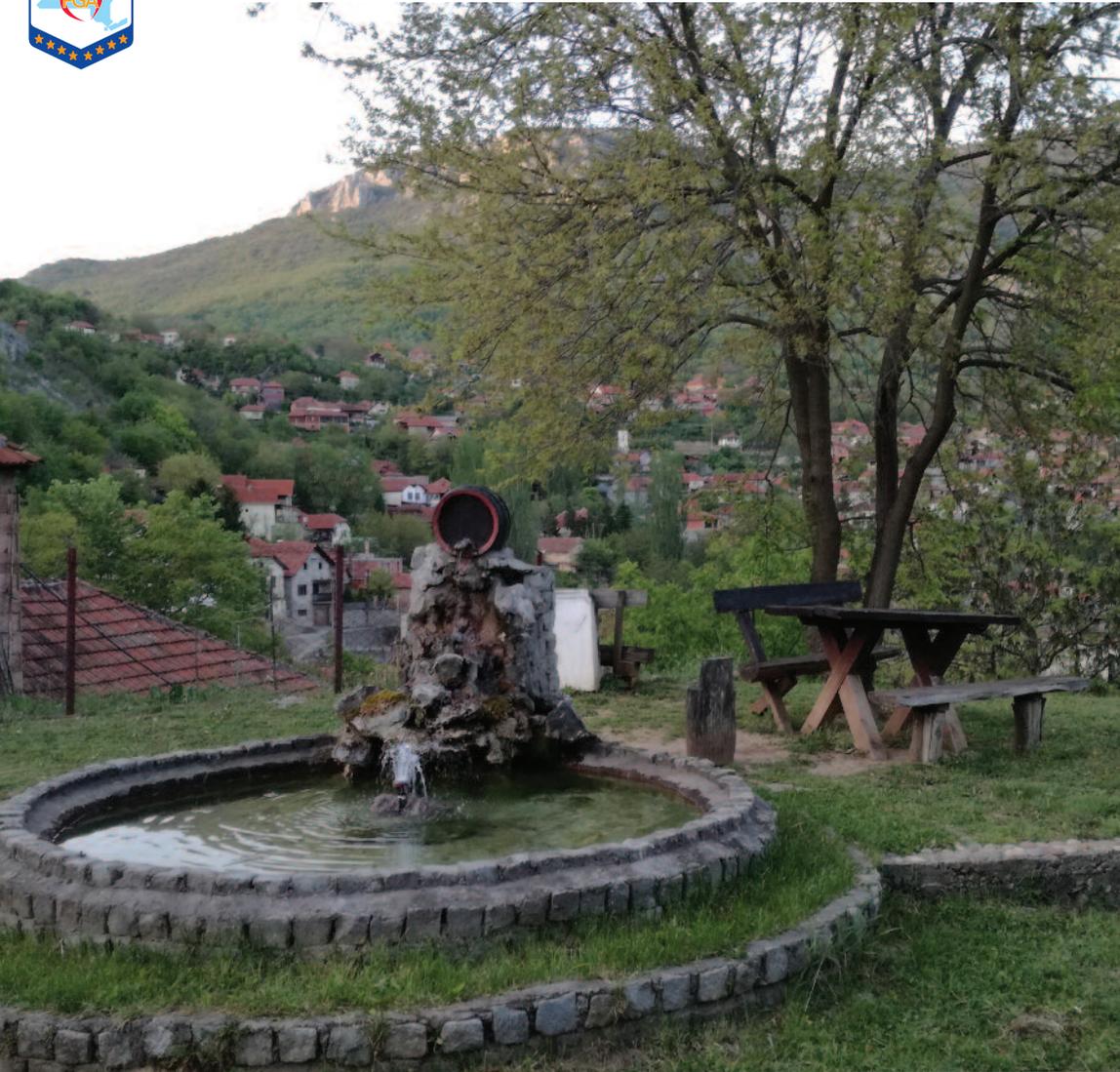


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A Journey to Serbia

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On the cover:
Sićevo village nearby Niš, Serbia

Cover photo courtesy of Michael Akerman, M.D.

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President's Message

Get to Know the NYSSA Staff

ROSE BERKUN, M.D.

The difference between success and failure is a great team. For many years, the New York State Society of Anesthesiologists (NYSSA) has been one of the most productive and successful state component societies within the American Society of Anesthesiologists. The PostGraduate Assembly (PGA), our annual educational meeting, is the third-largest anesthesia meeting in the world and is offered free to NYSSA members. Our legislative agenda is executed with precision and has been successful in preserving physician supervision of nurse anesthetists. The NYSSA's political action committee (NYAPAC) requires enormous data collection and strict compliance with government regulations.

I could not complete my year as NYSSA president without expressing deep gratitude to the people who work diligently behind the scenes and are vital to our organization. Every day NYSSA staff members work hard on behalf of the association's members, New York patients, and the profession of anesthesiology. I would like to pull the curtain up and introduce the dedicated staff members who are the backbone



(Left to right) NYSSA staff members MaryAnn Peck, Jacqueline Homan, Kathy Felicias, Stuart Hayman, Will Burdett, Kelly Mancusi and Lisa O'Neill

of the NYSSA. Below is a brief introduction to the voices you hear when you call the NYSSA office and the faces you see at the PGA:

Stuart Hayman

This is Stuart's 10th year as the executive director of the NYSSA and the manager of the PGA. Under Stuart's leadership, the NYSSA's finances and membership numbers have prospered, and the organization has celebrated numerous legislative victories.

Originally from Washington, D.C., Stuart is a proud U.S. Navy veteran. After his military service, he earned a bachelor's degree in accounting and a master's degree in administration, both from Maryland universities. Stuart's career in organized medicine began at the Montgomery County Medical Society in Maryland, where he spent 10 years as chief operating officer. In 1998, he moved to New York to become the executive director of the Westchester County Medical Society (WCMS) and the Westchester Academy of Medicine (WAM). While at WCMS he took on the management of the Bronx and Westchester chapters of the American Psychiatric Society.

Stuart works closely with the NYSSA's leadership to develop and prioritize strategic objectives, to direct and motivate staff, and to promote the organization's goals while supporting constructive change. These goals include:

Advocacy – Stuart works with leadership to develop legislative priorities, agendas and budgets. He collaborates with two external lobbying firms to achieve identified priorities and serves as a conduit between the consultants and leadership with regard to the political action committee. He coordinates member participation at state and national meetings and legislative conferences. He forms coalitions with associations on issues of mutual interest and acts as a liaison between the NYSSA and government agencies.

Communication – Under Stuart's leadership, the NYSSA transformed its communications programs, including print publications, website, and social media.

International Conference Management and Education – Stuart manages the PGA and the NYSSA's House of Delegates. He also ensures that the organization maintains ACCME accreditation.

Marketing – Stuart supervises the development and implementation of national and international marketing campaigns and forges international alliances.

Operations Management – Stuart oversees a multimillion-dollar budget and a staff of seven. He negotiated the profitable sale of the organization’s headquarters and the purchase of new office space. He created a 501(c)(3) foundation (AFNY) to facilitate the funding of an international anesthesia training program.

Lisa ONeill

Lisa joined the NYSSA staff in 2008 after seven years with the Westchester County Medical Society. Lisa is one of two assistant executive directors for the NYSSA and she is in charge of operations. She is currently working on her certification in association management. Lisa handles the accounting functions for the association and manages the NYAPAC contribution database. She is also responsible for the NYSSA and PGA social media platforms. In addition, Lisa assists the *Sphere* editor and graphic designer and she manages both the PGA and *Sphere* websites as well as the electronic letter from the president. Lisa is a graduate of Iona College, where she was a member of the women’s varsity rowing team. She recently moved to a waterfront townhouse on City Island in the Bronx.

Kelly Mancusi

Kelly is the second NYSSA assistant executive director and the director of events and education. Kelly is responsible for the planning and oversight of everything related to the PGA. She also manages membership and marketing, as well as corporate and intersociety relations. Kelly holds a master’s degree in business administration and is a certified meeting planner. She joined the NYSSA staff in late 2015 and hit the ground running by flying out to the ASA meeting in San Diego on her second day on the job. Kelly is a graduate of Iona College, where she was also a member of the women’s varsity rowing team. She lives in New Rochelle, New York, with her husband, two dogs and a cat.

Kathy Felicies

Kathy just celebrated her 37th anniversary with the NYSSA. She is affectionately known as the NYSSA’s “institutional knowledge.” Her title is executive secretary, but that doesn’t communicate the importance of her role. Kathy is responsible for coordinating the participation of more than

350 speakers at the PGA (including abstract submissions, disclosures, honorariums, etc.). Kathy also assists the House of Delegates speakers and the executive director with the reference committee reports. Additionally, she sells tickets for the workshops, mini-workshops and PBLDs while on-site at the PGA. After the PGA, Kathy prepares sales reports and other data for management and the PGA leadership.

MaryAnn Peck

MaryAnn has been working full time for the NYSSA since April 1994. Prior to working full time for the association, she worked in the office part time in the months leading up to the PGA and at the PGA. MaryAnn has a diverse set of responsibilities that include: membership billing and payment processing; PGA poster submissions and registrations; PGA registration and ticket sales; assisting the executive director with committee and officer reports (solicitation and formatting); and providing miscellaneous district support. She also answers the NYSSA phones. MaryAnn lives in Ozone Park, Queens, close to her large family, with whom she spends as much time as she can.

Will Burdett

Will has been with the NYSSA full time since 2003; prior to that he worked part time for the organization while completing his business degree at Adelphi University. Will serves as the exhibits and marketing manager and is responsible for the technical exhibits at the PGA; he also helps secure other sources of non-dues revenue. Will is responsible for managing the utilization of workshop equipment and in-kind support at the PGA, PGA general marketing, and the processing of new members. Will lives in Bayside, Queens. Many members may remember his mother, Pat, who worked for the NYSSA for more than 31 years and helped grow the PGA.

Jacqueline Homan

Jacky is the newest member of the staff, having joined the NYSSA in March 2017. Jacky's main duty is to support both the director of operations and the director of events. In this capacity, she monitors NYAPAC donations, maintains member profiles, assists with coordinating event space, and organizes meeting hotel reservations as well as food orders. Jacky also coordinates all of the legislative meetings for the NYSSA's delegation to the ASA Legislative Conference. Jacky is working toward her certification as a meeting planner. She recently received her bachelor's degree in marketing from LIU Post (Long Island University). ■



Editorial

The Value of Relationships

SAMIR KENDALE, M.D.

It's hard to believe that the year is almost over. It has been an eventful one, to say the least. We have received wonderful feedback on our wellness series in *Sphere*. Additionally, the Ad Hoc Committee on Women Physicians has been one of the most active committees in the NYSSA, affirming its relevance to our membership. As the many photographs in these issues of *Sphere* indicate, NYSSA leaders are constantly traveling to Albany and around the world to advocate for the specialty and share our important messages directly and in person.

Our patients come to us to care for them when they are at their most vulnerable; they put their trust in us to treat them in the safest manner possible. Many of our state and national advocacy efforts have been successful, but we must continue to make our voices heard to maintain safe care for our patients. A terrific opportunity to do so is during Physician Anesthesiologists Week, scheduled for January 28 through February 3, 2018. Mark your calendars! Here are five simple ideas of actions to take to demonstrate your pride in your specialty:

- 1) Change your social media graphics to the official Physician Anesthesiologists Week images, available on the ASA website (<http://www.asahq.org>). If you don't know how to do this, ask a social media savvy friend to help!
- 2) Share a story or thought about your life as an anesthesiologist with the hashtag #PhysAnesWk18.
- 3) Make sure you have made your PAC donations this year. Physician Anesthesiologists Week is a great reminder.
- 4) View the *Sphere* blog at <http://nyssasphere.weebly.com> and share your favorite articles with friends and family.
- 5) Follow and share messages from the NYSSA on any social media platform. In the coming year we aim to see growth in the NYSSA's digital presence, which can only happen with your help. This is a free and easy way to support our society and our specialty.

After reading this issue's feature article about Dr. Michael Akerman's exciting journey to Serbia, I came away with a few bits of wisdom. Just as we have seen from other stories about different forms of medical travel, there is great value in undertaking these excursions. This value, however, is not parasitic, in which those who receive assistance offer nothing in return. To the contrary, these medical mission trips result in symbiotic relationships. There is often a true reciprocity in these situations, with the apparent "givers" learning and growing just as much as those they are helping. This is, in fact, the best kind of relationship. Likewise, NYSSA members give time and money to the association with the expectation that we will continue to advocate for New York's anesthesiologists. It is a similar two-way street. That said, if you have ideas about how we can help you and/or our specialty, please reach out to us by attending a district meeting or the PGA, or contact us via email or through social media. The NYSSA should continue to be the voice of its members. ■

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From the Executive Director

The Year in Review

STUART A. HAYMAN, M.S.

As I begin my 10th year as the NYSSA's executive director, it is my pleasure to provide the membership with a brief synopsis of my annual report.

Your NYSSA staff continues to work hard to improve the organization's financial health, to update our technology, to expand our use of social media, to increase our membership numbers, and to support all NYSSA members. I am proud of our dynamic, skilled and effective staff and of our accomplishments this year.

Thanks to the continued dedication and support of our leadership and volunteers, we have come a long way from the organization I joined in 2008. We have retired nearly \$2 million of NYSSA debt and built up strong reserves. Today the NYSSA is one of the strongest medical associations in New York and the most accomplished component society of the ASA.

Below are just a few of our activities this past year. For a complete copy of my annual report, please email me at stuart@nyssa-pga.org.

Advocating for Our Members

One of the NYSSA's primary strategic goals is to advocate on behalf of all New York anesthesiologists on the issues and legislation that impact your ability to provide medical care. To that end, the NYSSA has worked with Charles Assini, Esq., legislative counsel, for 32-plus years, and the Albany lobby firm Reid, McNally & Savage for more than two decades. Both consultants have extensive knowledge of and insight into regulations and legislation in New York state. Over the years, these specialists have done an outstanding job of safeguarding the practice of anesthesiology and guiding the NYSSA through regulatory and legislative changes.

The NYSSA has also been fortunate to have a core group of volunteer leaders who dedicate enormous time and effort to the organization's legislative and regulatory goals. I wish to thank Rose Berkun, M.D., who has been very active attending multiple PAC fundraisers, legislative events,

and district meetings around the state. Others who deserve special recognition include: Andrew Rosenberg, M.D., past president; Government Relations Committee Chairman David Wlody, M.D.; Dr. Wlody's two assistants, Jon Gal, M.D., and Scott Plotkin, M.D.; and NYAPAC Chair Mike Simon, M.D. Additionally, the NYSSA's Executive Committee and the Board of Directors have given significant time to work on behalf of the members, the association, and the profession.

The NYSSA's PAC (NYAPAC) is one of the larger physician PACs in New York state. The PAC's success is dependent on the financial support of all NYSSA members. Every member is strongly encouraged to donate to NYAPAC so that the NYSSA can continue to make your voice heard in Albany and beyond.

In Albany, the leadership, consultants and staff work with the Medical Society of the State of New York (MSSNY) and other specialty societies to combat aggressive scope expansion bills and to shape other legislation. The single biggest issue the NYSSA deals with in Albany is the title legislation relating to scope of practice. This year, we were fortunate to receive a copy of the New York State Association of Nurse Anesthetists (NYSANA) memorandum in opposition to the safe anesthesia bills that the NYSSA supports (A.1829 Morelle/S.4422 DeFrancisco). The NYSANA position memorandum makes clear that the nurse anesthetists are intensifying their efforts to practice independently. For example, during the 2016/2017 legislative session, these efforts resulted in the consideration of title bills that were promoted as "only" creating the title of certified registered nurse anesthetist (CRNA) when, in fact, the **NYSSA's position was that these bills unequivocally created the obligation and the pathway for the Board of Nursing to define nurse anesthetist scope of practice, without guidance from the Legislature and beyond the jurisdiction of the Department of Health.** As a new legislative session approaches, the NYSSA's leadership, volunteers and staff will continue to monitor these and other legislative developments closely.

Other significant issues we worked on this year included:

- We assisted the NYSSA lobbyist with an online media education campaign.
- We began planning a patient safety education campaign to be launched in the spring of 2018.

- We worked with multiple members, attorneys and MSSNY on the issue of Medicaid fee splitting. This is a resurrected effort by the attorney general's office to fine physicians who pay their third-party billing companies a percentage of their billings. This is considered fee splitting by the AG.
- The NYSSA worked with MSSNY and specialty societies on an opposition letter to the state Legislature regarding changes to the healthcare budget bill that would enable the Health Care Modernization Team demonstration projects to override statutes and regulations and expand the scope of mid-level medical providers.

Providing for the Educational Needs of Our Members

The PGA is one of the oldest, largest, and most successful anesthesiology meetings in the world. It accounts for more than half of the staff's time annually. The PGA's continued success is directly attributable to the leadership of General Chair Richard Beers, M.D., and Scientific Programs Chair Audrée Bendo, M.D.

The PGA MOCA offerings this year will include credits for multiple educational programs. As in the past, attendees will be eligible for credits for patient safety, as well as MOCA part 2. For the first time, this year all the PGA workshops have been approved for MOCA credits for part 4 (via simulation instruction).

Accreditation is essential to the NYSSA and the PGA program. The reaccreditation process is scheduled for 2018 and the work has already begun. We are very fortunate to have Francine Yudkowitz, M.D., leading this effort once again.

This year we worked with a consultant to develop a new source of funding for the PGA via corporate and PGA supporters. We launched the new program in September and have been actively meeting with vendors. Additionally, I worked with Merck to secure financial support for the 2017 PGA.

Staff continues to work with Edmond Cohen, M.D., on the successful thoracic symposiums. This program is contingent on the Marriott having space outside of our contract. We also continue to offer the state-mandated infection control CME course on our website.

Educating the Public

- We provided information to the lieutenant governor and the commissioner of health as they developed activities to address the opioid crisis.
- We continued the joint New York State Fair effort with the Medical Society of the State of New York (MSSNY).
- We continued to work with the New York City Department of Health and Mental Hygiene on data collection and education relating to safe injection practices.

Advancing Our Mission

- We collaborated with state, national and international associations on education, socioeconomic issues, healthcare policy, and marketing opportunities. Organizations we have worked with include: the ASA, the ESA, the WFSA, and the Canadian Anesthesiologists' Society, as well as the ASA's state component societies and other New York medical and specialty societies. We have begun discussions regarding possible collaborations with the Brazilian Society of Anesthesiology and the Society of Anaesthesiology of Sao Paulo.
- The NYSSA's members were represented at MSSNY's House of Delegates meeting and a Council meeting, as well as various AMA meetings.

In conclusion, the above information is just a snapshot of my annual summary to the Board of Directors. This has been another productive and successful year for the organization. I thank you for your continued support and for the opportunity to represent the NYSSA as your staff leader. ■

Teaching Regional Anesthesia in Serbia

MICHAEL AKERMAN, M.D.

“To succeed, jump as quickly at opportunities as you do at conclusions.”

– Benjamin Franklin

Many Americans have a preconceived notion about Serbia. The events of the 1990s left an impression and influenced opinions about the country. My recent experience in Serbia differed greatly from my own expectations, and I feel extremely fortunate to have spent time there.

My journey began at a get-together in New York with some of my colleagues and friends. As the night was winding down, I mentioned to my Serbian friend that I would be very interested in visiting her home country and doing some anesthesia work there. Within two weeks, I was put in touch with Serbian native Dr. Ivan Velickovic,



Photo courtesy of Nada Pejčić, M.D.

Teaching an ultrasound course at the conference in Niš, Serbia

director of OB anesthesia at SUNY Downstate Medical Center, and I was booked for travel a few months later to Serbia.

The details of my trip started to come together. The first few days after my arrival, I would attend the “Eighth Annual Scientific Symposium in Anesthesiology and Intensive Care” conference in Niš, Serbia. The meeting organizer, Dr. Radmilo Jankovic, was kind enough to invite me to give a lecture and to co-lead an ultrasound workshop. During the remainder of the week I would then travel to the Serbian city of Leskovac to teach regional anesthesia at the local hospital.

Offering Patients a Better Hospital Experience

I arrived late on a Thursday night in Niš; within a few hours of my arrival I presented a workshop on regional anesthesia with Dr. Jinlei Li from Yale University. With the help of Dr. Nada Pejcić (our host and local expert), everything went smoothly. The workshop was divided

Photo courtesy of Nada Pejcić, M.D.



Teaching Dr. Zoran Marinković to perform ultrasound-guided truncal nerve blocks

into two sessions — morning and afternoon. We focused on upper extremity nerve blocks in the morning and lower extremity nerve blocks in the afternoon. The success of the workshop was evident from the enthusiasm of the participants. The level of interest was so high that we gladly stayed to answer questions. After the workshop I was free to enjoy the many lectures and parties that were organized as part of the conference. The last day of the conference I presented my lecture — “An Update on the TAP Block.” Overall, the conference was an exciting and very educational event, and I am honored to have been a part of it.

In the early morning on Monday, I met up with Dr. Pejcic and we drove to Leskovac Hospital, a beautiful drive south of Niš through fields, farmland and beautiful scenery. We spent the next four days together offering patients our services. In that short time, we performed 27 quadratus lumborum blocks (mostly post-cesarean section under general anesthesia), one combined spinal epidural for labor pain, and one peripheral nerve block for an orthopedic procedure on the lower extremity. Twenty-six of the 27 patients who received the QL block reported adequate post-operative pain control. The patient who received the CSE reported an excellent birthing experience and the patient having the orthopedic procedure reported no pain. It was an amazing feeling to be able to offer these patients a better hospital experience. The



**Dr. Nada Pejcic and Dr. Michael Akerman
with the ultrasound cart**

patients and the medical staff were very appreciative. The level of interest in and excitement about regional anesthesia was palpable.

I wanted to leave my colleagues in Serbia with something they could continue to do even in my absence. I met Dr. Pejcic at the PGA before I went to Serbia and we talked about my plans to visit for a few weeks prior to my arrival. We discussed regional anesthesia extensively and she was well prepared by the time I arrived. During those four days in Leskovac, I spent a lot of time teaching her the use of ultrasound technique and regional anesthesia concepts. By the fourth day, Dr. Pejcic was not only performing QL blocks independently, she was teaching her colleagues how to perform them as well. Since I returned to New York, we remain in contact and Dr. Pejcic has been continuing to offer regional anesthesia to her patients. She has performed more than 70 blocks (and has expanded

Photo courtesy of Michael Akerman, M.D.



Sićevo Gorge, river Nišava, hydroelectric power plant from 1931

her repertoire to include popliteal and adductor blocks) and has presented her work at a local conference. Dr. Pejcic's love of regional anesthesia, patient care and constant learning is something that I hope to emulate in my own practice.

My week in Serbia went as fast as it came. I met wonderful and hospitable people, people with warm hearts who have a strong connection to their history. They often take the time to sit and "have a drink" (normally coffee or tea) and enjoy each other's company. Dr. Pejcic and her husband made me feel welcome in a foreign country. Every night they had another trip planned. We drove on roads rarely traveled to get to the top of a mountain for unforgettable views, visited monasteries, tasted fresh spring water, and of course ate a lot. I also learned about the history of this region from the people themselves and visited places of historical significance such as

Photo courtesy of Nada Pejcic, M.D.



Monastery St. Petka, Sicevo village nearby Niš. Pictured, left to right, are Nebojša Pejcic, Dr. Neeti Sadana and Dr. Michael Akerman.

Skull Tower and Crveni Krst, a Holocaust concentration camp in Niš. This was a week I will cherish, and one that gave me much more than I gave in return. I appreciate my hosts inviting me into their home and treating me like family. I hope to plan more trips where I can work with my Serbian colleagues to provide exceptional patient care.

While people in the U.S. may be familiar with medical mission projects in Latin America or Sub-Saharan Africa, very few people know about the opportunities that exist to participate in these projects in Eastern Europe. I decided to go to Serbia because an opportunity presented itself. Ultimately, it was a decision that led to expanding my world view, meeting new people, and sharing what I know about anesthesia and acute pain with a dedicated group of professionals who hope to better serve their patients. ■

Michael Akerman, M.D., is an assistant professor in the Department of Anesthesiology at Weill Cornell Medicine in New York. He specializes in regional and thoracic anesthesia.

You Can Make a Difference



The Anesthesiology Foundation of New York (AFNY) is a 501(c)(3) nonprofit organization whose mission is to improve patient care around the world through education and research.

In keeping with its mission, **AFNY provides PGA-related scholarships** to the most enthusiastic and dedicated anesthesiologists from the developing world who wish to refine their delivery of safe, modern anesthetic care. During the past 24 years, more than 374 anesthesiologists representing 62 countries have enhanced their education and training thanks to the generosity of the NYSSA and its members.

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Scenes From the 2017 ASA Annual Meeting



(Left to right) Drs. Melinda Aquino, Ingrid Hollinger, Tracey Straker, Rose Berkun, Liz Mahoney and Vilma Joseph

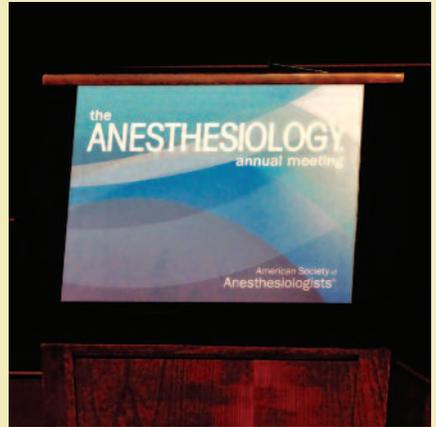


(Left to right) Dr. Lawrence Epstein, NYSSA Executive Director Stuart Hayman and Dr. Jonathan Gal



(Left to right) Drs. Karen Silbert, Rose Berkun, Ingrid Hollinger, Tal Levy and Linda Hertzberg

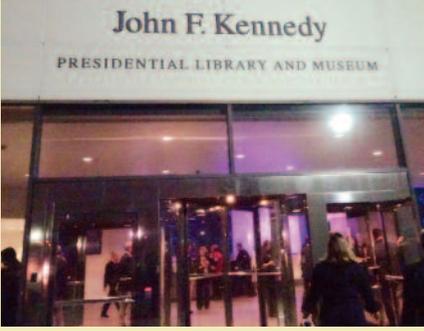
Opening Session and President's Reception



(Left to right) NYSSA Executive Director Stuart Hayman, ASA staff member Bob Wallace, and ASA CEO Paul Pomerantz



Dr. David Wlody



**Drs. Robert Lagasse, Rose Berkun,
Michael Simon and Lawrence Epstein**



Dr. Liz Mahoney and Thomas Mahoney



Drs. Jonathan Gal and David Bronheim



**NYSSA President Dr. Rose Berkun and
ASA President Dr. James Grant**



**Dr. Steven Schulman (left) with Dr.
Daniel Sajewski and Terry Sajewski**

New York Caucus

Drs. Rose Berkun and David Wlody



The New York Caucus

Technical Exhibits



PGA Technical Exhibit Chairman Dr. Paul Willoughby (seated, center) helps man the NYSSA booth.

Airway Workshop

NYSSA member Dr. Francis Stellaccio presents at an airway workshop.



NYSSA and CSA Reception



California Society of Anesthesiologists (CSA)
President Dr. Karen Silbert and NYSSA President
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Understanding Third-Party Payor Audits

MATHEW J. LEVY, ESQ., AND STACEY LIPITZ MARDER, ESQ.

It's a scenario that no physician wants to experience: After spending countless hours and an enormous amount of effort to get paid 50 or 60 cents on the dollar, a payor suddenly demands that some exorbitant amount of money be "repaid," or threatens not to pay the physician until documentation is reviewed. This article will explore the basis for third-party payor audits, including retrospective overpayment demands and prepayment audit reviews, as well as the steps involved in responding to these audits to achieve the most favorable results possible. Furthermore, we will explore how a physician can reduce his/her odds of being subject to an audit in the first place.

Understanding Retrospective Audits

Few things frustrate medical professionals more than the managed care company audit of the prior year's payor recoupments. The payor has reviewed as few as six charts, isolates what it interprets as a pattern of inappropriate billing, and then takes the amount involved and *extrapolates* that amount to extend over a randomly selected number of past years. The result? A "discrepancy" of several dollars quickly becomes a demand for several hundred thousand dollars or even millions of dollars. While couched by payors as a "retrospective audit" or a "probe review," many physicians have simply termed it an old-fashioned shakedown.

Understanding how these audits come about is a key first step in avoiding their potential effects. The triggering event in most cases is a simple computer analysis that identifies those physicians who are billing and/or coding differently than their supposed peers, labels those physicians as "outliers," and refers them for additional scrutiny. Oftentimes, the health plan or managed care company will then request a sampling of records from the physician, which are reviewed to determine whether the received documentation supports the billing submitted. This is the basis for the calculation of the potential overpayment demand.

Physicians must understand that even the smallest of amounts in dispute can generate extremely large demands for repayment. If a discrepancy is noted as a result of the computer review, that notation triggers "additional scrutiny" of the practice. While this method is neither statistically valid

nor based upon a truly random sample, even the smallest of discrepancies provides the reviewer with a simple method to demand exorbitant monies be “repaid” to the payor. The basic “repayment formula” is as follows:

$$\begin{aligned} &\text{Claimed Overpayment} \\ &\quad \times \\ &\quad \text{Rate of Code Usage} \\ &\quad \quad \times \\ &\quad \quad \underline{\text{Number of Years Enrolled}} \\ &\quad \quad \quad = \\ &\quad \quad \quad \text{DEMAND} \end{aligned}$$

Using this formula, a billing discrepancy of only \$2 can bring about an enormous demand. Example:

$$\begin{aligned} &\text{Claimed Overpayment - } \$2 \\ &\quad \times \\ &\text{Rate of Code Usage - 2,000 per year (eight per day, 40 per week)} \\ &\quad \times \\ &\quad \underline{\text{Number of Years Enrolled - 12}} \\ &\quad \quad \quad = \\ &\quad \quad \quad \text{DEMAND - } \$48,000 \end{aligned}$$

In the event that a health plan or managed care company determines that an overpayment demand is justified, the physician will receive written notification. The health plan or managed care company is obligated to inform the physician how it arrived at its calculation. The correspondence will also outline the physician’s appeal rights.

Responding to a Retrospective Medicare Audit

Being the subject of a third-party payor retrospective audit can be very daunting for a physician. In the event a physician receives notification of an alleged overpayment demand, he/she must submit an appeal showing why the demand should be reduced or removed.

With respect to a Medicare overpayment demand, the physician has 120 days from receipt of the demand to file a redetermination appeal. However, in order to prevent Medicare from beginning its recoupment efforts, the redetermination appeal must be filed within 30 days. It is important to note that interest on the balance allegedly owed continues to accrue even if an offset is delayed.

If the results of the initial redetermination appeal are unfavorable, the next level of appeal in connection with a Medicare overpayment demand is a reconsideration request, whereby a qualified independent contractor (QIC) reviews the appeal. Such an appeal must be filed within 180 days of receipt of the redetermination results.

If all other avenues of recourse are exhausted, the third level of appeal is the administrative law judge (ALJ) hearing. The ALJ hearing gives physicians an opportunity to present their case directly to an ALJ, who is independent of Medicare. This is often the first time that a physician can have his/her case presented to an unbiased party. Due to the increasing number of physicians who are subject to Medicare overpayment demands, there is currently a waiting period of more than two years before a physician can have a case heard before an ALJ.

The appeals process with respect to private carriers is not as exhaustive. There is generally only one level of appeal, which is typically outlined in the provider manual. Upon receipt of the results of the appeal, negotiations are held between the carrier and the attorney. Once a settlement amount is agreed upon, the parties will enter into a settlement agreement, which will outline the terms of the settlement.

During the appeals process, the areas generally targeted are documentation/coding and extrapolation. Specifically, with the assistance of coding and statistical experts, we prove that the documentation supported the code billed and that the extrapolation was not statistically valid. These arguments are utilized to decrease or, ideally, remove the alleged overpayment demand.

Understanding Prepay Audit Reviews

In today's healthcare climate, insurance companies are engaging in several tactics to make it more difficult for physicians to receive proper reimbursement. In addition to retrospective overpayment demands, insurance carriers are delaying payments and making it more difficult for physicians to get paid through prepayment audits. Being placed on a prepayment audit review is extremely frustrating for a physician, and can ultimately have a devastating impact on the operation of a practice.

When a physician has been placed on a prepayment audit review, each time the physician submits a claim, the claim is denied by the

insurance carrier and there is a request that the physician submit a copy of his/her medical records in order to support the claim. The prepayment audit review can involve a specific code billed or all codes billed. Once the insurance carrier receives the medical records requested, the records are reviewed to determine whether or not the claim should ultimately be paid.

Even if the claim is eventually paid, payment would not be made until approximately 90 to 120 days after the claim is submitted (as opposed to 30 or 45 days in the event the physician was not on prepayment review). This process can be very costly for a physician. In addition to the physician's staff spending countless hours preparing the medical records to be submitted to the insurance carrier, the delay in payment can have a significant impact on cash flow, as many physicians rely on reimbursement from insurance carriers to pay their employees and the day-to-day expenses of running their practices.

Insurance carriers, including Medicare, are investing heavily in billing software programs. These sophisticated programs compare a physician's billing habits with those of his/her peers in the same geographic location. To the extent that a physician's billing patterns differ from the insurance carrier's predetermined norms, the insurance carrier may place the physician on prepayment audit review before the carrier can justify payment.

In order to be removed from prepayment audit review, the physician must have his/her medical records reviewed and analyzed so that the payor can determine whether the physician's documentation supports the codes submitted. In the event that a physician's documentation does *not* justify the codes submitted, the physician must rectify such billing deficiencies going forward.

Once the medical records have been reviewed, the physician's healthcare team, including attorneys and coding experts, will contact and negotiate with the insurance carrier. In order to be removed from prepayment audit review, the physician must be in compliance with the insurance carrier's requirements regarding coding and documentation. If a physician is placed on prepayment audit review, it is recommended that the physician begin the removal process immediately in order to avoid being placed on prepayment audit review by other carriers as well. Since insurance carriers often enter into arrangements with third-party

contractors (who have relationships with other carriers) to review records, there is a good chance that the physician will be hit with multiple audits from other carriers if already on one carrier's radar.

Responding to a Visit From an Investigator

In addition to written requests for records, as the government and private payors continue to invest resources in combating fraud and abuse in the healthcare system, many practices are being faced with unexpected visits from investigators from the state and federal government, as well as private payors. These investigators represent entities such as Medicare, the Office of the Medicaid Inspector General (OMIG), and private insurance carriers. In the event one of these investigators decides to make a visit to a physician's office, it is imperative to understand how the physician and his/her staff should respond to ensure that the physician's interests are protected and that his/her exposure is limited.

If a physician or a member of his/her staff receives a knock at the door from an investigator, the first thing to do is check the investigator's identification and credentials, and make and retain a copy of the same. This information should be kept in a safe place for future reference.

Physicians must remember to live by the golden rule: NEVER speak to, or allow anyone in the office to speak to, any investigator! Although these investigators are often friendly, their intention is to obtain as much information from the physician and staff members as possible with respect to the practice. Other tactics often employed by investigators include intimidation and promises of leniency. It is especially important never to speak with an investigator without the physician's legal counsel present, as anything that is said to the investigator can and will be used against the physician.

In most instances, visiting investigators will make a request to obtain a copy of medical records and other documents kept by the practice. Staff members should be informed that they should not release any records without first speaking with the physician. It is best to either have the attorney provide the records directly at a later date or to set a time for the investigator to come back after hours to make the copies. In addition to controlling the information disclosed, this will limit office disruptions. Prior to turning over such information — specifically medical records — physicians also need to confirm that such disclosure is compliant with

HIPAA and state privacy rules and regulations, and that the appropriate authorizations have been obtained.

A visit from an investigator can be a daunting experience. Even the most informal, cursory contact by an investigator should prompt an immediate and well-coordinated reaction. It is important to be prepared and to inform staff ahead of time of the practice's protocols with respect to a visit from an investigator. There should be a written policy in place outlining the specific steps that the staff should take in such instances, including contacting legal counsel and providing medical records. These protocols are extremely important and can often mitigate an agency's findings.

How to Avoid a Third-Party Audit

To decrease the chance of being subject to a third-party audit, recognize that today's billing and coding systems dictate the need for specialized assistance. Physicians must ensure that their current billing practices are in compliance with their carriers' policies, and that their documentation adequately supports their billing claims. From simple pre-printed forms to digital transcription to an electronic medical record, ample resources exist to document the level of services rendered, justify their medical necessity, and preclude reviews by investigating authorities.

An annual review conducted by a certified coder can provide valuable insight into what areas are currently under scrutiny, what trends are developing with one's peers, and/or what can be done to keep a practice in strict compliance. Advice from any billing resource should be provided verbally (any written reports could be discoverable in any future legal proceedings) and should be provided directly to the physicians involved. Physicians who are willing to recognize that billing and coding in today's healthcare environment is very complex, and who obtain ongoing advice from specialists, will have taken an enormous first step in avoiding the potentially devastating impact of being the target of an audit. ■

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Legislative Update

CHARLES J. ASSINI, JR., ESQ.

As we prepare for the upcoming 2018 New York state legislative session, defeat of the nurse anesthetist title bill (Paulin/Gallivan A0442/S1385), which is supported by the New York State Association of Nurse Anesthetists (NYSANA), will be our top legislative priority. The following memorandum will be presented to lawmakers to underscore the significant deficiencies associated with this bill. The memorandum also underscores why it is difficult to explain the purpose of the nurse anesthetist title bill and the potential outcomes that would result from the passage of this legislation, as there are virtually no comparisons to be made with previous legislation that created a professional title without also defining the scope of practice of the healthcare professionals who were being granted such title.

Why the Paulin/Gallivan (A0442/S1385) Nurse Anesthetist Title Bill Should Have a Defined Scope of Practice to Protect Patients Undergoing Anesthesia

1. By failing to provide the scope of practice of a nurse anesthetist and not following the statutory framework that the Legislature created in 1971 (Chapter 987) and has used through 2016 (Chapter 497) to recognize professions, the nurse anesthetist title bill introduced by Paulin/Gallivan (A0442/S1385):
 - a. Fails to follow the entire regulatory framework governing the professions, which is predicated upon a defined scope of practice to ensure the profession is being practiced within the acceptable definition.¹
 - b. Impedes the ability of the Board of Regents and Office of the Professions to carry out their regulatory obligations with respect to the new profession of “certified registered nurse anesthetists,” including responding to complaints of unprofessional conduct and unauthorized acts by the professional.
 - c. Creates uncertainty between the New York State Education Department and the Department of Health with respect to the standard of

anesthesia care that physician anesthesiologists, operative physicians, and nurse anesthetists are required to follow with respect to Article 28 facilities.

d. Obviates the New York Legislature’s constitutional duty to protect and promote the welfare of New York’s citizens by failing to define the scope of practice of healthcare professionals (i.e., nurse anesthetists).² A matter of public concern is the administration of potentially lethal drugs to New York patients by a nurse anesthetist.

e. Creates ambiguity in the operating room, where the roles of the physician anesthesiologist, the operative physician, and the nurse anesthetist with respect to the administration of anesthesia require clarity because medical management decisions must be made in a matter of seconds to ensure the safety of patients undergoing surgery.

2. The enactment of the Paulin/Gallivan nurse anesthetist title bill (A0442/S1385):

a. Will, by necessity, create a pathway for the Board of Nursing, based upon broad regulatory authority provided under Article 130 of the education law, to proceed to define the nurse anesthetists’ scope of practice without guidance from the New York Legislature.

b. Will create ambiguity by incorporation of the provision that it will not permit “independent practice” of a nurse anesthetist.

For example, the creation of a collaborative relationship between a nurse anesthetist and another healthcare professional does not create “independent practice”; however, a collaborative relationship where the “collaborative healthcare provider” need not be immediately available contravenes the existing physician-led anesthesia care team standard of care. In fact, this is precisely what the Board of Nursing and NYSANA pursued in 2004; namely, to circumvent the Legislature, they attempted to create a “nurse practitioner in anesthesia” profession and eliminate the physician-led anesthesia care team model. The initiative was withdrawn because it would have jeopardized the well-being of patients undergoing anesthesia in New York state.

c. Will create a situation where, unlike any other recognized healthcare profession (with the exception of clinical nurse specialist) the Board of Nursing, not the Legislature, may define the scope of practice of

a healthcare professional without any input from the Board for Medicine, Department of Health, or professional medical societies.

NYSANA has made it clear, in the association's Memorandum in Opposition to the Morelle/DeFrancisco bill, that the NYSSA should have no role in defining a nurse anesthetist's scope of practice despite the fact that the predominate mode of the delivery of anesthesia care in New York state, the U.S., and within the Veterans Health Administration is through the physician-led anesthesia care team. As such, it is impossible to define the scope of practice of the nurse anesthetist without defining the supervisory responsibilities of the physician anesthesiologist. ■

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NOTES

1. All critical healthcare professions recognized by the New York Legislature, in accordance with the education law, Title VIII "The Professions," define the scope of practice of the profession. To obtain a copy of a chart summarizing the section of law and verifying that the scope of practice for these critical healthcare professions was defined when the title legislation was passed, please contact me. The title of clinical nurse specialist (CNS) does not contain a defined scope of practice; however, a CNS is a registered professional nurse, which has a defined scope, with certification as a clinical nurse specialist (specialty named in certificate), and a CNS does not administer potentially lethal drugs.

2. The New York State Constitution (Article XVII §3) identifies the protection and promotion of the health of the people of New York as matters of public concern. Certainly, the administration of potentially lethal drugs highly qualifies as a matter of public concern. More importantly, the New York State Constitution empowers the New York Legislature with the authority to make provisions to ensure those concerns are met. This was accomplished when the Legislature enacted Article 130 Title VIII "The Professions" in 1971 and created the uniform framework defining each profession then recognized and delegating the authority to the Board of Regents and commissioner of health to oversee and regulate the professions.

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Neonatal Respiratory Depression After Epidural Fentanyl

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NEW YORK MEDICAL COLLEGE/WESTCHESTER MEDICAL CENTER AND NEW
YORK MEDICAL COLLEGE/METROPOLITAN HOSPITAL CENTER

Introduction

The safety and efficacy of neuraxial analgesia for labor pain is well-studied.¹ Several options for neuraxial analgesia are available to the anesthesiologist, including placement of epidural catheter, combined spinal-epidural (CSE), single-shot spinal, or intrathecal catheter, with the selection of the method of analgesic delivery dependent on the clinical situation, practitioner preference, and experience. Epidural analgesia offers improved patient satisfaction and lower complication rates when compared to other analgesic techniques, such as remifentanyl patient-controlled analgesia or continuous midwifery support.^{2,3}

Local anesthetic is typically the medication of choice for neuraxial analgesia, with fast onset, easy titratability and relatively predictable duration of action. The addition of opioids to neuraxial analgesia allows for more effective onset of analgesia and potentially a decrease in motor blockade, as less local anesthetic is required to produce similar pain relief.⁴ Opioid neuraxial analgesia is associated with fewer opioid-related side effects than intravenous opioids; neonatal respiratory depression requiring reversal with naloxone has been described with patient-controlled analgesia with fentanyl.⁵ Neuraxial labor analgesia results in less systemic distribution of opioid with fewer effects on the neonate.⁶ Despite this, neonatal respiratory depression after administration of epidural opioid has been described in the literature. We present a case of neonatal depression after cesarean section with epidural anesthesia, with improvement of symptoms after administration of naloxone.

Case Presentation

The patient was a 26-year-old primigravid female at 41 weeks without significant past medical history or toxic habits and a BMI of 32.4 kg/m² who was admitted to the labor and delivery floor in active labor. She requested an epidural catheter for labor analgesia, and after obtaining

informed consent an epidural catheter was placed uneventfully. The patient was started on a bupivacaine 0.05% and fentanyl 2 mcg/mL infusion at 10 mL/h with good pain relief. The infusion was decreased to 7 mL/h after about three hours, when the patient reported numbness in bilateral lower extremities. These symptoms improved with the decreased rate. The patient labored uneventfully for about eight hours until she was planned for cesarean section due to nonreassuring fetal heart tracing.

To achieve surgical anesthesia for the cesarean section, the epidural catheter was bolused with 100 µg of fentanyl and a total of 20 mL of 2% lidocaine. The cesarean section proceeded without complication. One minute after delivery the neonate's APGAR score was noted to be 1 despite stimulation and suctioning. The neonate maintained oxygen saturations and heart rate, however respirations and activity did not improve. After receiving supplemental oxygen, naloxone 400 mcg was given via intramuscular injection. The neonate made rapid improvement in activity and APGAR score was noted to be 6 at five minutes postpartum, and 7 at 10 minutes. The neonate was transferred to intermediate care in the neonatal intensive care unit, and was found to be recovering well 24 hours later.

Discussion

A review of the anesthesiology literature yields only a handful of case reports of neonatal depression after administration of neuraxial opioids. A randomized controlled study by Porter et al. of 138 women with epidural anesthesia, randomized to receive bupivacaine vs. bupivacaine and fentanyl via infusion, showed no significant difference in any indices of neonatal respiration between the two groups. The mean dose of fentanyl for all patients in this study was 184 µg.⁷ However, the doses of fentanyl given to the parturients in Porter's study were given as an infusion only. In this case, the patient received a bolus dose of fentanyl prior to cesarean section. Kumar and Paes reported two cases of epidural respiratory depression after epidural analgesia for labor with normal vaginal delivery.⁸ In contrast to the findings of Porter et al., the patients received boluses of fentanyl after placement of the epidural catheter and a slow infusion thereafter, per institutional policy. Porter et al. did not note any correlation between fentanyl levels and indices of respiration in the newborn.

Owing to its lipophilicity, fentanyl diffuses freely from the epidural space into the systemic circulation, and can reach therapeutic plasma levels within 20 to 30 minutes. Several studies have shown plasma levels of

fentanyl of 2-3 ng/ml to be associated with clinically significant respiratory depression.⁹ Furthermore, maternal:fetal ratios of fentanyl concentrations measured after use of the drug have been reported as near 1:1.¹⁰ However, these patients received fentanyl in a slow epidural infusion, versus an infusion in addition to short-term bolus doses. The mother in this case did not exhibit clinically significant respiratory depression.

The results of these studies show no consistent association between fentanyl administration and respiratory depression in the newborn. This may imply a wide variation in drug concentration in the neonate due to individual variation. However, in the general literature and in our own experience, opioid administration during labor appears to be safe and efficacious in the vast majority of parturients. Much of the literature regarding opioid-induced respiratory depression in the newborn regards vaginal deliveries only; a larger-scale analysis of respiratory depression in cesarean section versus vaginal delivery may yield a difference in prevalence between the two.

Opioid-induced respiratory depression nonetheless should remain in the differential diagnosis during neonatal resuscitation. The neonate in this case responded well to a dose of naloxone and recovered well in the immediate postpartum period. Other causes of neonatal depression in the immediate postpartum period were less likely; no magnesium infusion was given, nor were any benzodiazepines or intravenous opioids administered. A prospective cohort study of 5,000 term non-anomalous neonates found risk factors including nulliparity, presence of meconium, pregestational diabetes, hypertension, obesity, maternal fever and cesarean section as risk factors for significant neonatal morbidity; in this case, only cesarean delivery and obesity were present.¹¹ Naloxone is not part of the majority of neonatal resuscitation algorithms, and is not recommended for regular administration in the immediate postnatal setting.¹² Our findings in this case, however, highlight the importance of communication between the anesthesiologist, obstetrician and pediatrician when epidural or intrathecal opioids are administered so that the possibility of opioid-induced respiratory depression remains in the differential diagnosis. ■

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