SAME-DAY SURGERY

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FEBRUARY 2019 Vol. 43, No. 2; p. 13-24

INSIDE

RELIAS MEDIA

ASC Market Growth on Track for 2019 and Beyond

Surgery centers can expect steady growth in 2019 and beyond, according to the authors of a recent ambulatory surgery center (ASC) market report who predict 16% growth in outpatient procedure volumes through 2026.[1]

This growth largely is due to an expanding population of older patients who need surgery now or will soon, but it is supplemented by surgical procedures shifting from inpatient to outpatient settings, according to the 2018 Ambulatory Surgery Center Market Report by the Health Industry Distributors Association (HIDA).

"There's no question that there's a continual, gradual movement away from inpatient surgery and toward ambulatory surgery centers. It looks like the government is trying to change reimbursement, so there is more of an incentive to go to ASCs," says **Jeff Peters**, MBA, the CEO of Surgical Directions, a specialty healthcare consulting firm based in Chicago. "There typically is 2% growth per year, and we think that will continue," he predicts. Peters also believes there will be an end to regular growth in the proportion of ASCs owned by surgeons. Instead, most ASCs eventually will be affiliated with health systems. Original ASC owners are maturing, Peters notes, and their younger physician counterparts are less likely to want to buy out their ASCs.

"The market for opening new investor-owned ASCs is not rich," he explains. "This is because young physicians don't have as much interest in taking financial risk, and more and more young surgeons are being employed by hospitals and health systems."

No matter who owns ASCs, such facilities will continue to gain market share as major payers encourage this trend to save costs. For instance, recent changes by CMS have helped ASCs capture more market share. One such change involved CMS removing six procedures from its list of 1,700 inpatient-only procedures in 2018 and proposed two more removals for 2019. The procedures that may be performed on either an inpatient or outpatient basis now include knee replacements and gastric restrictive procedures. CMS evaluates surgical procedures annually

Financial Disclosure: Consulting Editor **Mark Mayo**, CASC, MS, reports he is a consultant for ASD Management. Editor **Jonathan Springston**, Editor **Jill Drachenberg**, Editorial Group Manager **Terrey L. Hatcher**, Author **Melinda Young**, Physician Editor **Steven A. Gunderson**, DO, FACA, DABA, CASC, Nurse Planner **Kay Ball**, RN, PhD, CNOR, FAAN, and Author **Stephen W. Earnhart**, RN, CRNA, MA, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

SAME-DAY SURGERY

Same-Day Surgery **(ISSN 0190-5066) is published monthly by Relias Learning, 111 Corning Road, Suite 250, Cary, NC 27518-9238. Periodicals postage paid at Cary, NC, and additional mailing offices. POSTMASTER: Send address changes to *Same-Day Surgery*, Relias Learning, 111 Corning Road, Suite 250, Cary, NC 27518-9238.**

GST Registration Number: R128870672.

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to see which should remain on the inpatient-only (IPO) list for Medicare/Medicaid reimbursement. The major factor in CMS' decisions is safety, says **Justin Waters**, manager, research and analytics, for HIDA.

"With improvements in medical technologies and surgical techniques, an increasing number of procedures are being removed from the IPO list," Waters says. "This shift generates increased volumes for ASCs."

For example, a HIDA survey of ASC providers revealed that 35% of respondents reported an increase in surgical volumes in 2017, while 57% anticipated an increase in 2018. "Increased surgical volumes correlate directly with higher ASC revenues," Waters adds.

HIDA's report predicts the ASC market will increase to $40 billion in 2020 from an estimated $36 billion in 2018. Primarily, ASC market share growth is influenced by changes in reimbursement and advancements in pain management and technology, Peters says. "Surgeons and patients have a better experience in ASCs as opposed to doing the same procedure in a hospital setting," he adds.

Lower outpatient surgery costs have contributed to ASC revenue growth. "This shift toward outpatient is expected to increase ASC volumes, thus generating higher profits," Waters says. "Surgeries performed in an outpatient setting avoid the hospital room charges and related costs associated with inpatient procedures."

Research revealed that hospital outpatient departments (HOPD) set procedural prices lower than the same procedure in an inpatient setting, but higher than prices at an ASC, Waters notes.

"By focusing solely on outpatient procedures and by specializing, ASCs are able to cut operational costs and thus offer reduced pricing," he says. "It is estimated that by 2026, patients will save ... on out-of-pocket spending as ASCs capture an increasing percentage of HOPD surgical volumes."

Another growth driver is the nation's aging population. "By 2020, the population of Americans ages 65-plus is projected to grow to 56.4 million, and it is expected to reach 98.2 million by 2060," Waters says. "In a study by the National Library of Medicine *(http://bit.ly/2LmlAw4)*, the average American was reported to spend $316,000 on medical expenses over a lifetime. However,

EXECUTIVE SUMMARY

Surgery center growth is on track to rise 16% through 2026, according to the 2018 Ambulatory Surgery Center Market Report by the Health Industry Distributors Association.

- Movement from inpatient surgeries to ambulatory surgery centers continues at a steady clip.
- Medicare removed knee replacement surgery from the inpatient-only list in 2018, which contributes to the ASC growth trend.
- Growth opportunities include orthopedic, spine, and prostate cancer procedures.

nearly half of spending occurred during senior years, 50-plus years."

With more people in need of healthcare and who can spend money on it, more procedures will shift to outpatient settings, causing increased volumes at ASCs, Waters predicts. Surgery centers that want to increase their own volumes and revenues in 2019 could focus on joints and spine procedures, Peters suggests.

"If you want to have a very profitable service, I would focus on prostate surgery. If you're the first one in the market, you will capture the market," Peters adds. "The centers doing ambulatory prostate surgery now are doing 10 a week and generating margins of 50%." ■

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INPATIENT-ONLY PROCEDURES REVISIONS

In 2018, CMS removed six procedures from its inpatient-only list, a change researchers say contributed to growth in the ASC market. These changes are described as:

- **CPT code 27447.** Arthroplasty, knee, condyle, and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty);
- **CPT code 43282.** Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh;
- **CPT code 43772.** Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only;
- **CPT code 43773.** Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only;
- **CPT code 43774.** Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components;
- **CPT code 55866.** Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing; includes robotic assistance, when performed. *(Learn much more about the 2018 changes at: http://bit.ly/2SJSb16.)*

For 2019, CMS has proposed removing two procedures from its inpatient-only list:

- **CPT code 31241.** Nasal/sinus endoscopy, surgical; with litigation of sphenopalatine artery;
- **CPT code 01402.** Anesthesia for open or surgical arthroscopic procedures of knee joint; total knee arthroplasty. *(Learn more at: http://bit.ly/2RYGvrx.)* ■

Breaking Down ASC Market Trends and Changes

An insider provides insight about the predictions and findings in HIDA's recent report

In an interview with *Same-Day Surgery*, **Justin Waters** provides insight about the predictions and findings in HIDA's recently published 2018 Ambulatory Surgery Center Market Report.

SDS: *The 2018 market report notes that more than half of outpatient surgeries are performed in an ASC setting now, up from 32% in 2005, with predictions pointing to more market-shifting to ASCs.*

What are the top five service lines that have experienced the largest patient volume increases in the ASC setting? Did your research offer any clues as to why these particular surgeries have shifted so rapidly to ASC settings?

Waters: Tracking the case volume by specialty, as a percent of total cases, the following added the greatest case volume growth from 2016 to 2017: gastroenterology, an increase of 25% to 29% of cases, [and] urology, an increase from 5% to 6% of cases. The remaining specialties decreased or remained the same as a share of total ASC cases.

While our research did not uncover a specific link between these specialties and their growth, urology cases are the fourth most profitable for ASCs. Gastroenterology is 11th. In our ASC provider survey, 48% of ASC [respondents] reported performing gastroenterology surgeries, and 38% [of respondents] reported performing urologic surgeries. Of those that do not currently perform surgeries in those specialties, 10% say they plan to provide gastro [by 2020], while 7% plan to provide urology.

SDS: *In the HIDA report, commercial payers were calculated to account for 64% of the ASC payer mix in 2017, followed by Medicare at 19%. Also, worker's compensation accounts for 10%, other pay is 8%, self-pay is 7%, and Medicaid at 6%.*

How has this division of the payer mix pie shifted over the past decade? For instance, was self-pay higher or lower in previous years? Have commercial insurance and Medicare also increased?

Waters: In 2016, commercial payers were estimated to be 52% of the ASC payer mix, Medicare 26%, Medicaid 6%, workers' compensation 8%, and self-pay 4%. In 2012, commercial payers [were] 57%, Medicare/Medicaid combined 30%, and workers' compensation 5%.[1,2]

SDS: *The report also revealed that ASC nurses earned an average of $35.93 per hour in 2017, less than the $37.13 rate of 2016. Is that decline a one-time decrease, or is this a continuation of a downward wage trend? To what do you attribute the decline?*

Waters: The overall trend in salaries is growth, and 2017 was a likely one-time shift. From 2011 to 2017, the average ASC nurse salary has increased from approximately $31 per hour to $36 per hour. We do not have data to definitively link this dip in wages to attempts to rein in operational expenses; however, our provider survey revealed that in 2017, labor was the largest expense for ASCs at 43% of the total. What may give insight into their thinking is that when speaking of supply chain strategies, ASC providers named "staying within budget" and "decreasing expenses" as top priorities.

SDS: *Noting increasing deductibles, the HIDA report suggested that price transparency is beneficial to ASCs. Would you please explain some of the reasons why ASCs should market their procedure prices to consumers?*

Waters: ASCs benefit from price transparency by having procedure prices that are often significantly lower than in an inpatient setting or a hospital outpatient department. Through ASC utilization, patients can reduce the overall cost and out-of-pocket costs for a procedure .... This makes ASCs highly competitive. In fact, a study by VMG Intellimarker revealed that when an ASC is added to a hospital service area, procedure rates for that hospital decline by an average of 500 per 10,000 Medicare beneficiaries. Advertising pricing would do more to shift this even further in favor of ASCs.[3,4] ■

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Peer Review Privilege Useful When ASCs Follow State Laws

The peer review requirements in an ASC's medical staff bylaws should mirror state law

Suppose a former patient sues an ASC and surgeon. The patient's attorney asks to see every peer review note related to the surgeon. Does the ASC have to turn over the peer review documentation?

Surgery center board members might think this type of information is protected automatically from legal discovery. However, if these board members rely on this assumption, they are wrong, according to **Thomas J. Stallings**, JD, partner at McGuireWoods in Richmond, VA. There is no federal peer review privilege, and each state sets different criteria for peer review privilege, he says. Thus, ASCs must follow their states' laws to ensure they enjoy this legally protected confidentiality when confronted with lawsuits.

"The general rule is that everything is fair game in a lawsuit," Stallings says. "You can ask the other side to give up their documents, and a privilege is an exception to that rule."

Peer review privilege works like attorney-client privilege: ASC peer review committees' minutes and other materials are protected from discovery in a lawsuit. But this is not an automatic privilege. There are prerequisites determined by the state. "In order to qualify for that privilege, you have to be structured in a particular way, and that depends on the state's law," Stallings explains.

For example, a state's law might specify what defines a peer review

committee. The law might dictate that the committee has to be responsible for one of several activities, which could include working to improve the quality of care or evaluating professional conduct, Stallings notes.

Peer review committee members can discuss and investigate problems and maintain privilege by following their states' requirements. However, these members cannot move the umbrella of privilege over the heads of other people or groups. For instance, risk managers typically do not enjoy legal privilege, Stallings says. If an ASC has a problem and asks a risk manager to investigate and address it, the risk manager's work and documentation likely are not covered by privilege.

"The mistake I see most often is people assume that every quality review is protected. It might be, but it's not always protected," Stallings cautions. "Knowing the rules of the road is a good management strategy so you understand what would be protected and what is not protected."

There are other steps ASC leaders can take to maintain their peer review privilege:

• **Be proactive.** "Don't wait until there's a fight over a certain set of documents to see if they're privileged or not. It might be too late," Stallings warns.

Instead, in the ASC's medical staff bylaws, include the same requirements for peer review privilege that are listed in state law. If the state specifies that the peer review committee must have a certain member composition and responsibilities, then the ASC should spell out these requirements in the bylaws, Stallings recommends.

Too often, ASCs use generic, off-the-shelf medical staff bylaws or they adopt bylaws from a local hospital. This is a mistake because ASC staff might not follow these generic bylaws. If the bylaws are not followed, a plaintiff attorney could argue that the ASC did not take the actions required under its own bylaws. The proactive ASC can argue before a judge that it has created bylaws that outline the state's requirements and that the facility followed these bylaws.

"If it goes before a judge, and the judge says, *'The law says you have to have a committee with this kind of membership and function,'* then the ASC can say, *'It's right here in our medical staff bylaws. We qualify for privilege, so we don't have to turn over the records,'"* Stallings says.

Surgery centers also should be proactive with addressing behaviors and practices that could result in lawsuits, Stallings suggests. If a physician is not following technique for a procedure, then this should be addressed by directing the doctor to learn from peers or take a course on the technique.

"Prevent something more significant from happening," Stallings says. "Don't let behavior fester or snowball. Address it early on. It takes a certain amount of will and direction from the governing body."

It also might require a surgery center to educate staff and physicians about medical staff bylaws and how to ensure they follow the rules. "It benefits the center and physicians to be proactive," Stallings says. "Whether the physician has behavioral or clinical issues, it's better to have that addressed and corrected before it spirals into something really bad."

• **Review and revise bylaws periodically.** "ASCs need to periodically review and revise, as appropriate, their medical staff bylaws," Stallings recommends. "The medical staff bylaws document is important and very dry. It might sit on a shelf and collect dust."

Surgery centers that have been using the local hospital's medical staff bylaws should come up with their own version.

"More often than not, I see surgery centers that copy the local hospital's medical staff bylaws," Stallings says. "That's a bad idea because hospitals are structured differently and have much larger medical staffs and more committees and layers."

A hospital with 200 doctors on the medical staff might need more committees. But a surgery center with 20 doctors does not need the same hierarchy, he notes. Plus, it is unlikely the surgery center is following the bylaws that were based on a hospital, which can lead to trouble.

"If there's a disconnect between your bylaws and your practice, then you either change the bylaws to fit your actual practice, or you modify your practice to fit the bylaws," Stallings says. "You don't want a disconnect to exist between bylaws and real-life practice." ■

EXECUTIVE SUMMARY

ASCs must follow state laws about peer review privilege to ensure they enjoy legally protected confidentiality when confronted with lawsuits.

- There is no federal peer review privilege; each state's rules are different.
- Not every quality review is protected under peer review privilege.
- If the state specifies that the peer review committee should include certain members and handle specific responsibilities, then the ASC should put these requirements in its bylaws.

Following These Coding Tips Could Decrease Payer Denials

Staff education and periodic spot audits are two keys to success

ASCs need coding expertise to support the entire revenue cycle management team from scheduling to collection.

Whether an ASC employers its own coders or contracts with an outside company, it is important to follow guidelines, educate staff, and provide oversight. ASCs also should stay up to date on coding changes, according to **Juanita Mendoza**, CPC, CASCC, coding services manager for Sovereign Healthcare.

"One of the things that always has been a hot topic is the difference between surveillance and screening," she says. "Previously, there wasn't any guidance on how to code a colonoscopy screening vs. surveillance. In our facilities, our coding is outsourced, but when we contract with them they have a facility coding information form that tells them what guidelines we want them to follow. I sent this information about surveillance colonoscopy to them, and I do periodic audits of their coding to be sure they follow this guidance."

Mendoza offers some advice to ASC leaders who are looking to ensure their facilities code accurately and receive optimal procedural reimbursement:

• **Educate physicians and staff.** When there is new guidance or a coding change, Mendoza gives coding staff a short PowerPoint presentation, hitting key points. "Then, I give them a handout with documentation examples, and I expound on it with them," she explains.

Educating physicians requires more explanation to help them understand why a word used a certain way could result in coding denials. "I don't believe that surgeons are aware of how their documentation is interpreted by a coder," Mendoza says. "This circles back to surveillance and screening. A screening is an exam that is done in a seemingly healthy patient to look for a disease. If the disease is found, then the patient can get treatment."

The key to screening is that the patient seemingly is well and shows no signs or symptoms of disease. If a patient has received a diagnosis screening, then there is a diagnosis code. This code is based on what the doctor wrote as the underlying issue or reason for the procedure.

"For example, with a screening colonoscopy, a doctor might note that the patient has rectal bleeding," Mendoza offers. "The fact that he or she included rectal bleeding is a sign/symptom. Now, it's no longer a screening because the patient had a sign/symptom of rectal bleeding."

But suppose the rectal bleeding was due to hemorrhoids or something else that is unrelated to the colonoscopy. In this case, the colonoscopy should be coded as a screening. The only reason it was not coded correctly is because of how the physician documented the case.

"Communicating this information to physicians is very important," Mendoza says. "If the bleeding is not pertinent to this episode of care, then don't document it."

If a surgeon sees a patient who reports rectal bleeding, the physician might feel compelled to be thorough and include that in the documentation. But doing so has repercussions. Mendoza suggests a better solution would be for the physician to tell the patient, *"I understand that, but you are here for your screening. If you continue to have rectal bleeding, then we'll see you in the office and take a look at that time."*

"I'm not saying the doctor shouldn't document it, but as far as this encounter goes, the patient is here for a screening. The clinic notes are up to the doctor, but the documentation needs to be clear that the reason for encounter is screening," Mendoza explains. "Sometimes, the doctor will say, *'screening and incidental rectal bleeding.'* The fact that the doctor calls it 'incidental' shows that it is not relevant to this episode of care."

• **Audit periodically and provide spot checks.** Best practices in

EXECUTIVE SUMMARY

Coding expertise in an ASC can help the facility maintain compliance with payers' rules and ensure proper staff education.

- Learn the difference between surveillance and screening in colonoscopies.
- Periodic audits of coding ensure that coders are following all guidelines.
- ASCs should educate physicians about how to ensure coding is accurate and results in optimal reimbursement.

oversight include periodic audits for coding compliance. "Third-party audits are a great way to go," Mendoza says. "Audits are not just for compliance purposes; they're also a learning tool. As an auditor, when I say something is wrong, I have to provide an official guidance."

Official guidance is not the auditor's opinion. It is based on, and cites, official sources. Some periodic audits are scheduled quarterly for compliance. Others can be spot checks, held whenever there is new education or new guidance, Mendoza says.

"We need to make sure the new guidance is being applied," she adds.

• **Compare pathological reports to diagnosis codes.** This advice works very well with colonoscopies, but also might be relevant to other procedures. For instance, a colonoscopy might reveal polyps. Some polyps, called adenomatous, potentially could transform into a malignancy. These are coded differently than polyps that will not transform into malignancy, Mendoza notes.

"A patient who has a history of adenomatous polyps is considered at high risk of colon cancer. This determines the intervals at which they are able to go in for surveillance," she explains.

A high-risk patient might need a colonoscopy screening every two years. A patient with no risk might be suitable for a colonoscopy every 10 years.

Here's how coding can affect the patient's care: Suppose the patient undergoes a colonoscopy. The physician discovers adenomatous polyps. The physician will tell the patient to return in a couple of years for another colonoscopy. But somehow, the physician's documentation does not include the word "adenomatous." In two years, the patient returns for a colonoscopy, undergoes the procedure, and the insurance company denies the claim because the coding did not indicate a need for a colonoscopy in less than 10 years.

Since colonoscopies and other major screenings are considered preventive services that payers are federally mandated to cover at no out-of-pocket costs to patients, there is a big financial cost to a patient whose colonoscopy is not covered because of the way it was coded.

> EDUCATING PHYSICIANS REQUIRES MORE EXPLANATION TO HELP THEM UNDERSTAND WHY A WORD USED A CERTAIN WAY COULD RESULT IN CODING DENIALS.

"If coders are not checking the pathology report, then they don't know there was a mistake," Mendoza says. "This is a challenge for ASCs because the physician has the patient's entire medical history in their report. All the ASC has is the documentation related to that particular encounter."

The solution is to check the pathological reports before assigning a diagnosis code for a polyp, Mendoza adds.

• **Track denial trends.** "We track denials because these create a problem with patient responsibility," Mendoza says.

For example, a patient may believe a service is preventive and will be covered 100%. However, if the documentation does not support this notion, then the procedure will not be processed as a preventive service.

"We'll have problems on the back end with the patient," Mendoza notes. "Sometimes, the claim is denied because the diagnosis code doesn't match up with the procedure code."

Anytime a denial is related to coding, Mendoza's team reviews the issue and tries to correct the problem. One time, the coding sent to the insurer was correct, but the claims still were not processed correctly, she says. The trend appeared to be a system problem because a review of the coding showed it to be correct. Still, the claims were not processed correctly, Mendoza recalls. When told of the error, the insurance company asked the organization to send all of its incorrect claims in bulk to be corrected. "They, hopefully, will make adjustments in their system so it would not continue to be a problem," Mendoza says.

• **Correct problems.** "Number one, documentation has to support the service," Mendoza says. "If something wasn't a diagnostic procedure, and the doctor mentioned it in error, then the coder has to generate a physician query, asking, *'Documentation says this. However, is it this or that?'"*

Another way to correct a coding issue is to direct the physician to dictate an addendum, correction, or additional note that clarifies the situation, Mendoza offers.

"The documentation has to support the service code and has to be clarified," she explains. "It can be fixed with additional documentation, or billers can turn around and submit a corrected claim." ■

The Challenges of Opening a Community's First ASC

Administrator offers tips for those considering a new facility or expanding an existing ASC

When Green Mountain Surgery Center opens in Colchester, VT, in the spring, it will become Vermont's first multispecialty ASC.

An independently owned facility that is governed by a board, Green Mountain successfully navigated the state's certificate of need (CON) process, sought Joint Commission accreditation, and started the survey process, according to **John Paoni**, administrator.

"We have to perform 10 procedures first. Once we pass the survey, we'll be fully operational," he says.

One of the reasons the Green Mountain's founders decided to open a surgery center in Vermont was because local wait times are long for some surgical procedures, Paoni says.

"There is a huge need to offer ambulatory outpatient surgery procedures in the state of Vermont," he says. "I stayed in a bed and breakfast for several months, and one person I stayed with said, *'I just scheduled a colonoscopy, and it was four months before I could get in.'"*

Like other ASCs nationwide, the new Green Mountain will offer a lower fee schedule than hospital inpatient and outpatient procedure fees, Paoni says.

"One of our prime missions is to deliver affordable healthcare to citizens of Vermont," Paoni says.

The Green Mountain facility will include four procedure rooms and two ORs. Even obtaining permission for two ORs was a challenge as the organization navigated the CON process, Paoni notes. The easy part has been finding surgeons interested in working in the ASC setting. "The doctor culture here is totally amazing," Paoni says. "They're very down to earth, and they want to work with you and are very open to suggestions and ideas."

In fact, the idea for opening the ASC came from surgeons who were tired of surgery waits at the hospital, he says.

> "IF I BROUGHT MY MOM HERE, HOW DO I WANT HER TO BE TREATED? HOW DO I WANT MY FACILITY TO BE PRESENTED?"

"The doctors got together and said, *'I'm getting bumped at the hospital. I go in to do a procedure, and I have to wait around until I can get in the OR, or if I finish the colonoscopy in 30 minutes instead of 40, they penalize me on my block time,'"* Paoni says.

Paoni has received numerous calls from physicians interested in hearing more about the new ASC. Physicians employed by health systems have expressed interest in becoming independent, he says.

"A lot of doctors are very dissatisfied with being employed because they lose control over many different areas of practice," Paoni says. "They're starting to pull back and become self-employed." Hiring nursing staff has been another challenge, although that also is going well, Paoni notes. Nurses interviewing at Green Mountain Surgery Center have been unfamiliar with how ASCs work differently than hospital ORs.

When interviewing nurses with specialization in gastrointestinal surgery or another type of surgery, Paoni explains that at an ASC, one nurse will learn pre-op, post-op, GI, ophthalmology, and every other area with the goal of becoming skilled at it all.

"When there's time, you will be asked to clean the waiting room chairs because that's how an ASC runs. Everyone jumps in and does everything," he says.

Nurses also must be well versed on ASC regulations, including infection control rules, as a separate infection control or compliance department will not exist at Green Mountain, he adds.

"The nurses we've interviewed so far have been very excited about the idea of learning more and not being stuck in one specialty all the time," Paoni says. "The hours are much more convenient for them. We run eight to five, Monday through Friday, with no on-call or nights or weekends, although we may do some Saturday procedures."

Paoni offers some advice for those who may be considering opening a new ASC or expanding an existing facility:

- **Know life safety requirements.**

"Make sure all fire-rated doors have the maximum allowable space on the bottom between the door

and the floor," Paoni says. "You need to know where the fire walls have fire-stopping insulation, which is a fire caulk applied inside the one-hour minimum fire barrier wall."

When a fire's temperature rises to 165 degrees, the wall material expands and completely fills the space inside the fire barrier wall, he adds. "Fire caulking is a big initiative, and it has to be done correctly."

• Prepare for emergencies and disasters.

Increasingly, ASCs must incorporate emergency preparedness into their building design, which includes active shooter and other terrorism events. "Our world changed [after] 9/11, and we all have learned to think differently," Paoni says. "I was at another ASC when there was an active shooting event down the road from the building, and we had to put the facility on lockdown."

What Paoni learned from that experience is that surgery centers often are not designed with this potential crisis in mind. ASCs can be made safer. "When we had an active shooting event, I had to post [employees] at the doors to let people in and out because we had to lock the doors," he says.

One possible structural solution would be to design the facility to lock easily when there is an active shooter event. The door system could use employee badges to gain entry. This could prevent a shooter from entering, and it could allow all employees and patients to stay away from the doors and potential harm.

"We need to be prepared for an active shooting event," Paoni says. "When you're building and designing a new surgery center, you have to take these things into consideration. It's all about the patients. At the end of the day, when you have greater patient outcomes, everything else falls into place."

• Follow federal rules.

ASCs must follow rules related to the Americans with Disabilities Act (ADA) for signage and design. For example, ADA-accessible countertops must be 28-34 inches high with at least 24 inches of space from the floor to the bottom of the counter to enable someone using a wheelchair to maneuver comfortably. Also, each door must be labeled with a Braille sign, Paoni says.

"You want your facility to be a shining example," Paoni says. "If I brought my mom here, how do I want her to be treated? How do I want my facility to be presented?"

Adhering to all infection control requirements also is very important.

• Focus on marketing.

"We have a website that will list all of the different types of services and procedures for the community," he says. "We want people to know we're here." Becoming the first multispecialty ASC in the state is advantageous.

"There has been a tremendous amount of publicity and news articles regarding the opening of Green Mountain Surgery Center," Paoni says. "The community is excited about this and is welcoming us."

• Emphasize quality assurance.

Since the Green Mountain ASC could test Vermont's uncharted regulatory waters, Paoni also anticipates greater scrutiny by state regulatory officials. This makes it imperative to institute a quality assurance program and to be accredited according to nationally recognized standards.

"We want to make sure we do everything by the book, follow the rules, and set up a great facility to take care of everybody the right way," he says.

(Editor's Note: In 2018, Vermont lawmakers crafted legislation that would define ASCs and outline rules for obtaining a license, maintaining records, following health department rules, and more. However, the bill remained stalled in committee throughout the year and its future is uncertain. Still, Paoni says the bill's status has not affected Green Mountain's planned opening. Read more about the legislation at: http://bit.ly/2BcHCwi.) ■

SDS Manager

How Cost-Effective Is Outsourcing?

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We all do it, some more than others. Some do it all the time, and others just a few times per month. After a while, you want to do it all the time, and that is when you open yourself up for disappointment.

When you first outsourced, it probably was housekeeping, laundry, human resources, or some other essential service that you did not want to deal with internally or that was too expensive. Other examples of outsourced services include billing, management, IT, contracting, credentialing, patient registration, website, social media, forms, anesthesia, medical records consultant, pharmacy, EMR, staffing, linen, gas sterilization, infection control consultants, payroll, human resources, housekeeping, and custom packs. Has it become that complicated? Perhaps for some facilities more than others. Everything lately seems to take too long, cost too much, or is just not available.

Should a facility bring all these services back in house again? Billing seems too complex now to return to an old model. I know many facilities still handle billing in house, but they seem to struggle. It is practically impossible to make a profit or just break even by hiring your own internal staff to handle anesthesia. Who wants the smell of detergent in the place or wants to spend valuable staff time reviewing medical records?

We have become so dependent on others to handle tasks we cannot or do not want to do that it might be tough bringing all these services back in house. But what does all this cost? What are we paying someone to check a patient's insurance deductible and out-of-pocket obligation? Is it a good deal or too expensive? One of the largest outsourcing tasks we handle is management services. After almost 30 years in business, I have observed that many who hire someone to manage their facilities for them do not need it. Conversely, many who have *not* hired someone to manage their facilities *should*. Similarly, billing is a complicated task and a big expense. Are you capable of doing this yourself? Or should someone else handle that service?

Start by meeting with your business office staff and identifying all the money going out the door for these services. There are lots of hidden costs with some of these services. It is important to turn over every stone and see what is hiding under there.

After calculating these costs, figure out what it would cost to handle services in house with your own staff. Most facilities are likely to discover many additional headaches and, in some cases, perhaps additional costs when it comes to bringing services back in house. The cost of software, personnel, training, and keeping up with the changes takes it way beyond the bandwidth that the average and even above-average facility can handle. The larger the facility, the more disparity exists. I have looked at this from every angle and cannot make the numbers work. If you take the time to run the numbers yourself, you will agree with me. The next time you want to complain about an outsourcing partner and think you can do it better yourself, back away and crunch the numbers. You might think twice before cancelling that contract. ■

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Earnhart & Associates can be reached at 5114 Balcones Woods Drive, Suite 307-203, Austin, TX 78759. Phone: (512) 297-7575. Fax: (512) 233-2979. Email: searnhart@earnhart.com. Web: www.earnhart.com.)

CMS Grants Medicare Reporting Exemptions to Disaster Areas

Medicare providers recently affected by earthquakes, wildfires, hurricanes, and flooding in the fall of 2018 were granted waivers by CMS. Regions struck by the Alaskan earthquake, Northern California areas devastated by wildfires, and North Carolina and South Carolina counties hit hard by hurricane/storm flooding all are exempt from certain CMS reporting and compliance requirements.

CMS issued a blanket waiver for the 2018 earthquake near Anchorage, AK. The waiver provides temporary emergency coverage of skilled nursing facility services without a qualifying hospital stay and expands the number of beds and length of stay in critical access hospitals.

The waiver also makes it easier for healthcare organizations to replace durable medical equipment that was lost, destroyed, or damaged in the earthquake disaster. *(Editor's Note: Learn much more about it online at: https://go.cms.gov/2LlhDaW.)*

ASCs and other healthcare organization affected by the California Camp Fire and other fires in the state in the fall of 2018 were granted waivers to sanctions and penalties from noncompliance with HIPAA privacy regulations, beginning in November 2018 *(https://go.cms.gov/2Eppumh)*.

ASCs that are located in one of 14 South Carolina counties and 27 North Carolina counties that were designated as a major disaster area by FEMA are exempt from the reporting requirement. Those facilities can direct their resources to patient care and building repairs *(Read more at: https://bit.ly/2EwtmCM)*. Also, ASCs and other healthcare organizations in places affected by Hurricane Florence were granted an exception to quality reporting, according to CMS. The agency continues updating the exception list to reflect the needs of healthcare organizations in other disaster zones. ASCs and other healthcare organizations that sustained some storm or disaster damage but are outside the FEMA-designated areas can request an exception to the reporting requirements. CMS will decide whether to provide these particular exemptions on a case-by-case basis.

For a copy of the CMS extraordinary circumstances exceptions request, including instructions about how to send the form, visit: http://bit.ly/2EBgyLk. ■

CME/CE OBJECTIVES

After reading *Same-Day Surgery,* the participant will be able to:

- identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care;
- identify how current issues in ambulatory surgery affect clinical and management practices;
- incorporate practical solutions to ambulatory surgery issues and concerns into daily practices.

COMING IN FUTURE MONTHS

- Handling sharps properly and providing infection control
- Creating a quality improvement process
- Providing value-based care that is profitable
- Improving inventory management through routine tasks

SAME-DAY SURGERY

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Log on to ReliasMedia.com then select My Account to take a post-test. *First-time users must register on the site.*

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CME/CE QUESTIONS

1. **According to a survey of ASCs conducted by the Health Industry Distributors Association (HIDA), 57% of respondents anticipated an increase in surgical volumes in 2018. What percentage of respondents reported an increase in surgical volumes in 2017?**

   a. 28%
   b. 35%
   c. 47%
   d. 61%

2. **HIDA's 2018 ASC Market Report revealed that service lines with the largest patient volume increases between 2016 and 2017 were:**

   a. spine and orthopedic.
   b. cosmetic and bariatrics.
   c. gastroenterology and urology.
   d. prostate and breast augmentation.

3. **Who governs ASCs' use of peer review privilege?**

   a. The federal government
   b. State governments
   c. CMS
   d. Local municipalities

4. **To ensure compliance with informed consent, ASC auditors can follow a checklist of questions regarding informed consent. Which of the following questions would be suitable for this checklist?**

   a. Is the physician's office informed consent listed on the chart?
   b. Was the patient asked if the surgeon discussed the surgery to be performed?
   c. Was the patient asked if the surgeon explained the procedure to the patient's satisfaction and understanding?
   d. All of the above