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Have checks and balances in place, or open the door for embezzlement

$178,000 stolen from surgery center gets attention of managers

The administrative manager of a surgery center had been asking to have access to the banking account, but the business manager said that the center was "maxed out on users" and he couldn't give her access. Later, when a vendor needed a check, the business manager maintained that the check had been cut; however, the administrative manager couldn't see that it was cashed.

She asked the medical director, who did have access to the center's banking account, to pull it up on the computer. She noticed the account had a negative balance a few weeks previously. She started to poke around, and she looked at the credit card withdrawals.

"The first think I clicked on was vacation purchases," said the administrative manager, who requested anonymity for herself and her center. When she looked back at the credit card purchases for the previous six months, she discovered shopping sprees to a video game store, payments for home cable and cell phone bills, and even a personal ad on Yahoo.

"I went into his office and confronted him," she said. When she showed him the first questionable charge, he said he must have pulled

EXECUTIVE SUMMARY

Embezzlement can happen when facilities lack checks and balances or outside review.

- No single person should collect cash, enter charges, or enter payments and make adjustments.
- Use outside accountants or another firm to perform a monthly or quarterly financial review.
- Note that patient refunds are an area ripe for embezzlement.
- Carry insurance for embezzlement, perform criminal and credit background checks on employees, and put a spending limit on no more than $5,000 on corporate credit cards.

out the wrong credit card. However, the business manager became visibly uncomfortable. "I knew I had him, but I needed proof," the administrative manager says.

The subsequent investigation indicated 45 wire transfers totaling $71,243.25 into the employee's personal account, plus shopping sprees and cash withdrawals. The administrative manager called the police that night to file a report. After the staff spent five days pulling proof, including receipts with his signature, the business manager was arrested. He is charged with embezzling more than $178,000 from his employer's accounts. In the meantime, the surgery center is receiving legal bills totaling tens of thousands.

"We know we're not going to get paid back, because most of the items he bought are already used," she said.

Losing money isn't the only reason to avoid financial crimes such as embezzlement and identity theft. "Red-flag" rules from the Federal Trade Commission (FTC) that will take effect Nov. 1 require covered facilities to have programs that can detect, prevent, and mitigate medical identity theft. **[A policy on "Red Flags Rule Compliance" is enclosed with the online version of this issue. For assistance, contact customer service at customer service@ahcmedia.com or (800) 688-2421.]**

Warning signs of embezzlement can include cash deposits that are lower than projected net revenues, says **Stuart Katz**, FACHE, CASC, executive director of Tucson (AZ) Orthopaedic Surgery Center. Or "a patient or several call and ask why they are still being billed when they 'have paid the darn bill!'" he says.

Other warning signs? The employees ask off from work a lot, they become withdrawn, or "you catch them in lies," says **Beverly A. Kirchner**, RN, BSN, CNOR, CASC, president of Genesee Associates in Dallas, which develops, manages, and consults with freestanding surgery centers.

What procedures can help avoid embezzlement? "Everybody should be checking everybody else," says the administrative manager of the center where money was embezzled.

Catherine M. Weaver, CASC, CMPE, CHFA, senior manager and a member of the health care team at Somerset CPAs in Indianapolis, says in health care, there can be the problem of "allowing a long-time employee responsibility in too many areas and not providing oversight or checks and balances. Many identified embezzlers have been long-time, trusted employees," she reports.

One common mistake, according to **Mandi M. Clossey**, CPA, manager and a member of the health care team at Somerset CPAs, is "allowing kindness and friendship to get in the way of managing and questioning employees when something doesn't feel right."

No single person should collect cash, enter charges, or enter payments and make adjustments, she warns. "If this segregation is not possible with a lean staff, then approvals and retrospective reviews should be conducted by management," Weaver says.

Katz says, "People can be cross-trained to do

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Warning Signs of Embezzlement

- **Change in an employee's work habits.** An employee that formerly did basic tasks is suddenly willing to work extra hours or take on more tasks.
- **Change in an employee's spending habits.** An employee suddenly starts to accumulate several new items (clothing, jewelry, etc.) that are not normal for him or her.
- **Patterns of cash draw shortages.** An employee might be stealing from the drawer.
- **Unusual bad debt write-offs.** They could be covering up a fraudulent scheme.
- **A decline in cash or credit encounters.** This drop could indicate that some sales are not being recorded.
- **Bounced business checks.** Bounced checks could indicate that funds are being taken out of your bank account.
- **Inventory shortages.** These shortages might indicate fictitious purchases are being recorded, sales of supplies are not being recorded, or an employee is stealing inventory.

Source: Somerset CPAs, Indianapolis.

many functions, but they should never be allowed to do more than one portion of the revenue cycle in a day." At his center, one staff member does all of the coding and billing, and another does all of the posting. Another staff member opens the mail, makes deposits, and copies about five members of the staff with the information.

"Our accounting staff then reconciles the postings to the deposit on a daily basis," Katz says. The chances for embezzlement? Not zero, "but by separating the functions of the business office to several people, the risk is minimized," he says.

Duties also are separated at facilities managed by Genesee Associates. A receptionist or office assistant opens all mail and makes deposits, Kirchner says. "Administrators check the deposit slip, review it against handwritten deposit receipts and the check log," which they initial, she says. The check log goes to collectors, along with explanations of benefits (EOBs) attached, she says. "Collectors key in payments and make sure we were paid correctly," Kirchner says. "If not, we start the appeal process immediately."

Once all payments have been confirmed, the check log goes to the business manager, she says. She records cash payments into the general ledger/accounting system, Kirchner says. "She never touches live cash," she says. "She pays the bills. She reconciles the bank statements at the end of the month."

One more tip from Clossey: "Make sure employees responsible for ordering supplies are not the same ones responsible for receiving them or paying for them."

The administrative manager at the center that suffered embezzlement advises others to use accountants or another outside company to review the financial books on a monthly or quarterly basis. Others suggest that all account statements (both electronic and hard copy) be sent to two individuals to avoid tampering with statements.

Have a CPA firm conduct an internal control review that will identify any areas of weakness and provide recommendations for corrective action, Clossey says. Accountants also compare the budget to the actual finances and investigate significant variances, she says.

Kirchner says, "The bottom line is that at the end of the month, you want an independent accountant that does a full review, which costs about $600 a month."

The accountants can review all cash and all financial reports before they are presented to the board or to the partners. Their role is to verify that the cash is matching and to confirm what was spent, Kirchner says. They also conduct random audits and ensure policies and procedures were followed, he says. "If not, they give us a report so we can follow through with PI [performance improvement]," Kirchner says. **(For more on embezzlement, see list of warning signs, left, and tips, below. For more information, see "My top suggestions to avoid fraud, theft in your program," *Same-Day Surgery*, February 2007, p. 23.)** ■

10 pieces of advice to stop embezzlers

Patient refunds are a prime area targeted by embezzlers, warns **Beverly A. Kirchner**, RN, BSN, CNOR, CASC, president of Genesee Associates in Dallas, which develops, manages, and consults with freestanding surgery centers. One surgery center that Kirchner heard about had a policy of having two people sign checks and double-check them. However, a business office manager and administrator collaborated to embezzle patient refund checks, she says.

"They were cutting patient refund checks to imaginary patients and depositing them in their personal account," Kirchner says.

As a result, Kirchner's facilities use a policy for refunds that requires a collector to identify the need for a refund. A form is completed, and all relevant data are attached. **(A copy of the policy is included in a business manual excerpt with the online issue of *Same-Day Surgery.)*** "That goes to the business manager, who goes into system, reviews all that data to confirm it, and signs off on it," Kirchner says. The form and data then go to the administrator, who also confirms and approves them. The business office manager cuts the refund check. The refund check comes to the administrator, who signs and mails it. The refund files are kept in the administrator's office in a locked cabinet, Kirchner says.

Consider these additionally suggestions:

• **Carry crime insurance for embezzlement.** For about $1,000 a year, you can obtain a million dollars' worth of coverage, Kirchner says. "It's a very good investment," she adds.

• **Perform criminal and credit background checks on employees.** "A background check will highlight prior convictions the person may have," says **Mandi M. Clossey**, CPA, manager and a member of the health care team at Somerset CPAs, Indianapolis. "A credit check will help you identify the indebtedness of an individual. Someone struggling to pay their bills due to debt-related issues might be more eager to steal."

Kirchner says, "We do criminal background check on every employee — state, local, and federal background checks."

• **Put a spending limit on credit cards.**

In California, a business office manager furnished her entire house with furniture using a credit card from her facility, Kirchner says. "We caught it, because she couldn't produce the receipt."

Set a spending limit of no more than $5,000, and audit the limit, she advises.

• **Have a company policy that requires employees to take vacations.** "Employees may be less likely to attempt fraudulent behavior if they think it will be uncovered while they are off duty," Clossey says.

• **Use a lockbox for petty cash.**

• **Bond employees who handle cash.**

• **Limit the endorsement of checks to one or two responsible officials.** Do not use rubber stamp signatures.

• **Checks received should be marked with a restrictive endorsement such as "for deposit only" marked on the check immediately upon receipt.**

• **Follow up on unexpected transactions and unusual amounts.** ■

Are you ready to conduct surgery on celebrities?

Don't wait until they are at the door to prepare

What do the following famous people have in common? Jill Biden, Pope Benedict XVI, Ozzy Osbourne, and The Dixie Chicks.

The answer: All have undergone outpatient surgery, sometimes unexpectedly when running into health issues while traveling.

All outpatient surgery providers must be prepared to handle a famous person having a procedure at their facilities, sometimes on short notice. Some hospitals choose to treat celebrities with injuries in the outpatient surgery area so they are away from unwanted media who might be trying to enter the emergency department or main hospital.

There are steps you can take now to ensure you are ready for treating a celebrity:

• **Notify your media officer.**

The George Washington University Hospital in Washington, DC, has performed outpatient surgery on several VIPs, including former first lady Laura Bush and former vice president Dick Cheney. "We will always notify our public information officer that there is such a person coming into the facility," says **Kimberly Russo**, MS, chief operating officer. "If they're getting inquiries, they know whether to get a release signed," she says. "As with any patient, we need authorization."

EXECUTIVE SUMMARY

Outpatient programs should be prepared to conduct surgery on a celebrity, sometimes without advance warning.

- Have staff sign confidentiality agreements, and provide privacy training at least annually. Monitor privacy of patients' records.
- Notify your media officer and security when a celebrity is scheduled.
- Allow VIPs to enter and exit the facility privately and to be treated without interruption while in your facility.

Heather B. Oldham, communications manager at George Washington, says, "Without a signed consent, we do not even confirm that this person is a patient."

• Ensure that staff members liable to be "star-struck" aren't caring for VIPs.

Consider carefully who is assigned to care for a celebrity, Russo advises. "We know if there is any individual might be star-struck, or might not be able to handle that individual, they're not assigned to that case," she says. "You have to depend on your managers, the middle management, to make those proper judgment calls."

• Provide private entry and exit.

Mount Sinai Medical Center in New York City designates a room for VIPs who come in for outpatient surgery, says **Suzanne Cushnie**, RN, clinical nurse manager, day of surgery, pretesting, and phase 2 area. The hospital has performed outpatient surgery on people including Gov. David A Paterson. Highly recognizable VIPs are brought directly into a designated room, where all care is provided. This setup allows them to bypass the admitting area. Additionally, one elevator can be designated for the VIP while the other elevator is closed down temporarily when the VIP is entering or exiting the facility, Cushnie says.

In Beverly Hills, CA, the Rodeo Drive Plastic Surgery center, which caters to celebrities, built a hidden back entrance that allows patients to enter and exit the facility away from the paparazzi. Additionally, the center spaces out consultations and patients so celebrities have privacy, says **Megan Levant**, surgery center administrator and privacy officer.

• Consider whether to use an alias for VIPs.

Russo recommends using an alias "to eliminate the ability to track patients in our care that are of interest." However, it should be the patient's choice, she says. "We always recommend it as a way of protecting them from persons or the media being able to contact them through the switchboard," she says.

However, aliases can have a downside, says **Mark Mayo**, corporate director of ASC Operations for Magna Health Systems in Chicago and executive director of the Surgery Center Association of Illinois. For example, records need to follow the patient should additional care or a transfer be required, and aliases could be used illegally for multiple prescription drugs under multiple names, with no backup checks in place, he says.

Others point out that the medical record is a legal document. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs a patient's privacy, points out **Stuart Katz**, FACHE, CASC, executive director of Tuscon (AZ) Orthopaedic Surgery Center. "Why go to all the cloak-and-dagger routine?" he says.

• Use additional security measures as needed.

At George Washington, levels of security depend on the VIP, but they sometimes include performing bag checks and identification checks for people entering patient care areas, Russo says.

Facilities typically notify their security staff that a VIP is having a procedure, sources say. Cushnie says, "Once they know they're coming, and we tell them, 'This is when they'll arrive,' they meet them at the entrance and escort them in, and stay with them along with their private security," she says.

• Ensure staff maintain the patient's privacy.

Typically, facilities have staff sign a confidentiality statement when they're hired. **[See agreement and a statement on confidential information included with the online issue of *Same-Day Surgery*. Contact customer service for assistance at (800) 688-2421 or customerservice@ahcmedia.com.]** Additionally, at Tucson Orthopaedic Surgery Center, "at least once a year, we go over all of the rules with the staff at a meeting for that purpose," says Katz. "The penalty for a breach is immediate termination."

When a celebrity musician is coming in for a procedure, Cushnie reminds her staff that they aren't allowed to crowd the patient or ask for any information. "I remind them: You're a professional, and this is a professional environment," she says. Cushnie also reminds them of federal privacy regulations.

Keep in mind that your per diem staff also need training on patient privacy and need to sign a confidentiality agreement, Levant adds.

• Ensure privacy of medical record.

Ensure the patient records can be accessed only be designated staff and that those staff can access only that part of the record needed for a particular job, Mayo says. "Registration should not have access to clinical chart for example, and dietary does not need to know the patient's home address or Social Security number," he says.

These concerns can be best addressed through limited access, Mayo says. "HIPAA requires this anyway, but many system administrators are weak in monitoring the security levels or in looking for potential inappropriate access tracking until after an incident occurs," he says.

At George Washington, special security features have been installed to eliminate inappropriate

access, and the chief information officer has a policy on monitoring internal access to medical records, Russo says.

Oldham says, "Our primary concern for all patients is to deliver excellent medical care, while protecting their privacy. Most times celebrity patients visit the hospital, the media and public never know they were here." **(For information on HIPAA changes, see story, below.)** ■

HIPAA requirements, penalties increased

According to the Ambulatory Surgery Center Association, the economic stimulus package passed by Congress earlier this year included several changes to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) involving privacy of patient information:

- The penalty for violations increased from $100 per penalty to $1,000 per penalty. The maximum penalty is $100,000. If the violation involves willful neglect, the violation per penalty is $100 to $1,000, and the maximum penalty is $100,000.
- When an unauthorized disclosure occurs, facilities have a greater obligation to alert patients and the government. Unless the information was "secured," facilities will be required to notify those who protected health information was involved. The Centers for Medicare & Medicaid Services (CMS) issued guidance this spring that said information must be encrypted or destroyed to be considered "secured." In some circumstances, facilities must notify the federal government and the media about the unauthorized disclosure.
- Patients can prevent providers from giving information to payers about services for which the patient pays directly. This change will require modification of some contracts, the ASC Association points out.
- Facilities that use electronic medical records (EMR) will be required to provide patients, upon request, with a list of all disclosures made through the use of an EMR for the prior three years. The implementation date for this provision depends on when the Department of Health and Human Services issues rules, but the earliest implementation date will be Jan. 1, 2011. Most of the other changes go into effect in 2010; however, increased penalties for violations have been in effect since Feb. 17, 2009.
- On Feb. 17, 2010, facilities using EMRs will be required to provide individuals a copy of their record electronically, upon request. Facilities can charge for the labor costs. ■

Ensuring no retained items is a shared responsibility

A woman goes in for an abdominal hysterectomy, bilateral salpingo-oophorectomy and omentectomy. Subsequent pain, nausea, and vomiting lead to medical attention and hospitalization, but the cause isn't identified.[1] One month after the surgery, a CT scan finds a lap sponge from the surgery, which had been miscounted by the nurses, court documents said. Now the woman is claiming negligence and suing the hospital for her injuries, the costs of the suit, and "all other relief justified in the premises," according to court documents.

According to the latest statistics from The Joint Commission, retained surgical objects are the fourth most common sentinel event. So, what can you do to avoid it? A lot, according to sources interviewed by *Same-Day Surgery.*

First, recognize that the count is not the responsibility of any one member of the OR team, says **Donald W. Moorman**, MD, associate surgeon in chief at Beth Israel Deaconess Medical Center in Boston. Moorman, along with Charlotte Guglielmi, RN, BSN, MA, CNOR, perioperative nurse specialist, Beth Israel Deaconess, spoke at the recent Perioperative Safety Symposium: Improving, Enhancing & Sustaining Positive Patient Outcomes sponsored by Joint Commission Resources (JCR) and the Council on Surgical and Perioperative Safety.

"Our current hospital's policy reflects multiple individuals engaged in the reconciliation process," Moorman says.

The circulating nurse prints a checklist to ensure no elements of the process are forgotten, he says. The attending surgeon signs the checklist after all of the surgical counts are reconciled. Radiologists join surgeons in reading X-rays to search for any missing objects. Everyone, including the anesthesiologist, remains in the OR until the outcome of any missing objects is determined.

The policy has been in place for more than a year, Moorman says. "We haven't had any unintentionally retained objects over that time," he says.

Because the checklist is a separate documentation process, it offers an added bonus, Moorman says. "It's extremely helpful in being able to go back after fact, look at a series of events, and determine if we have important system issues to repair," he says.

For example, additional education might be needed, Guglielmi says. "It gives us specific data to be able to analyze our near misses and our reconciled counts," she says.

Preventing retained sponges is a joint and shared responsibility, agrees **Verna C. Gibbs**, MD, professor of clinical surgery, University of California, San Francisco, staff surgeon, San Francisco VA Medical Center, and director of NoThing Left Behind, a national surgical patient safety project to prevent retained surgical items (www.nothingleftbehind.org). Gibbs also spoke at the perioperative safety symposium.

Surgeons should use only radio-opaque items and perform a methodical wound examination before closing in every case, Gibbs says. It's important that they don't simply "swish or sweep," she says. Surgeons should strive to see and touch during the exploration whenever possible, Gibbs says. They should look and feel in the recesses of the wound and examine under fatty protuberances and soft-tissue appendages, she adds.

Nurses should focus on accounting for surgical items rather than simply "counting them," Gibbs says. Radiologists and technicians are responsible for film quality and timely review of any X-rays, she says. The anesthesiologists should take responsibility to manage 4X4 sponges and to coordinate the anesthetic reversal with the surgical team members to ensure they already have accounted for all surgical items, she says.

Administrators are responsible for providing risk management and resources, as well as ensuring patient disclosure, Gibbs says. They can conduct a root cause analysis of missing objects, she says. Resources include adequate radiology support to ensure any X-rays are timely, Gibbs says. In terms of disclosure, "the patients have a right to know when something happens to them," she says. "Administrators need to provide disclosure guidelines." **(For more tips, see article, right. For needle-specific advice, see story, p. 92.)**

Reference

1. Smith A. Woman claims Lutheran Hospital left sponge in her after surgery. *The News-Sentinel* July 18, 2009. Accessed at www.news-sentinel.com/apps/pbcs.dll/article?AID=/20090718/NEWS/907180312. ■

Tips for reducing retained surgical items

Current practices for counting sponges have a 10%-15% error rate, says **Verna C. Gibbs**, MD, professor of clinical surgery, University of California, San Francisco (UCSF), staff surgeon, San Francisco VA Medical Center, and director of NoThing Left Behind, a national surgical patient safety project to prevent retained surgical items (www.nothing leftbehind.org). Gibbs spoke at the recent Perioperative Safety Symposium: Improving, Enhancing & Sustaining Positive Patient Outcomes sponsored by Joint Commission Resources (JCR) and the Council on Surgical and Perioperative Safety.

Retained sponge cases have occurred when low numbers of sponges — fewer than 20 — have been used, Gibbs says. Even more amazing: 80% of retained sponges occur in the setting of a correct count, she says. There are many factors, including variable counting processes; frequent confirmation bias between the scrub and circulator, especially if one of the nurses or techs is older and respected; and loss of situational awareness that causes staff to miss events that occur outside of the scrub's or circulator's control, Gibbs says. Also, normalization of deviance is a factor, she says.

Gibbs says providers should ask a different question at the end of each case: Where are the sponges? They should change the focus away from simply counting to a system that requires accounting in order to prove there are no sponges left in the patient. The system should be standardized, verifiable, low-cost, transparent, and systemized, she says.

Two choices are computer-assisted sponge counting and the Sponge ACCOUNTing System (SAS). With a computer-assisted system, sponges pass under the reader and are counted in at the beginning of case and then counted out at the end of the case. The Safety-Sponge System is a computer-assisted sponge counting system from SurgiCount Medical in Temecula, CA (www.surgicountmedical.com). **(A copy of guidelines for Gibbs' Sponge ACCOUNTing System is enclosed with the online issue of *Same-Day Surgery*.)** With the SAS, nurses use a standardized process to put sponges in hanging plastic folders and document the counts on a wall-mounted dry erase board in every OR. The folders vary in price from 30 to 60 cents each, Gibbs says.

Surgeons perform a methodical wound exam in every case and before leaving the OR. They verify with the nurses that *all* the sponges (used and unused) are in the holders. The surgeon and the nurse cross-verify the holders at the end of each case as a team.

Use SAS for low and medium cases

SAS should be standard for routine low and medium (10-49 sponges) sponge count cases, Gibbs says. In hospitals and surgery centers with cardiac minimally invasive cases, and lots of complexity or change, evaluate the radiofrequency (RF) wand as an adjunct to SAS, and switch to RF-tagged sponges, Gibbs advises.

Consider these additional suggestions:

• **The most common retained instrument is a malleable retractor**, Gibbs says. In addition to performing a methodical wound exam, which should reveal instruments left in the wound, she recommends you use a Glassman FISH viscera retainer to keep the bowel away. You also can bore a hole in end of a malleable retractor, and put a chain on it, Gibbs advises.

• **Consider a mandatory X-ray in lieu of an instrument count**, Gibbs says. This policy is especially useful in orthopedic surgery, but to be effective, the X-ray must be read in the OR, she says.

• **Consider modified instrument trays, especially for orthopedic surgery**, Gibbs says.

• **Reduce the number of instruments when possible.** "If you have 100, you have to count to 100," Gibbs says, "so if you reduce the number of instruments, you're less likely to have a retained instrument."

• **Use a common language between all OR team members for items such as radio-opaque objects.**

• **Radiofrequency options include an RFID bucket** (SmartSponge System from ClearCount Medical, www.clearcount.com) **and the RF Surgical Detection System** (RF Surgical, www.rfsurg.com). An RFID system counts sponges extremely fast and detects sponges, Gibbs says. The system is expensive, and the greatest advantage is in large (more than 50) sponge count cases. The RF surgical wand doesn't count sponges, but it is useful to detect sponges and find any missing ones before the patient leaves the OR.

In conclusion, adopt a standardized, verifiable system, measure frequently, and give immediate feedback, Gibbs advises. "Consistency yield excellence," she says. ■

How to avoid retained needles

Develop a rationale needle management plan to decrease miscounts and prevent lost needles, says **Verna C. Gibbs**, MD, professor of clinical surgery, University of California, San Francisco, staff surgeon, San Francisco VA Medical Center, and director of NoThing Left Behind, a national surgical patient safety project to prevent retained surgical items (www.nothingleftbehind. org). Gibbs spoke at the recent Perioperative Safety Symposium: Improving, Enhancing & Sustaining Positive Patient Outcomes sponsored by Joint Commission Resources (JCR) and the Council on Surgical and Perioperative Safety.

Consider her suggestions:

• Determine a size cutoff at a point where plain film X-rays won't be taken for a lost needle. She recommends needles less than 15 mm.

• Keep numbers of needles on back table low (less than 20). Use needle counter boxes.

• Separate small from large (greater than 15 mm) needles.

• If a miscount occurs: look for needle, then:

— If a large needle (greater than 15 mm), get an X-ray.

— If it's a small needle, don't get an X-ray. It's unlikely you will see a needle on the X-ray. It's unlikely you will be able to find it, and it's unlikely to result in injury.

• Document the incorrect needle count and decisions if the needle isn't found.

• Disclose the missing needle to the patient.

If there are remaining questions, obtain a CT scan, Gibbs says. "It will demonstrate all retained items," she says. ■

Electronic credentialing might offer benefits

Every manager wants to believe that the credentialing process has properly vetted all the organization's health care professionals to ensure that they are qualified and have no known criminal record. But that is not always the case. Too often, managers get a phone call alerting them that one of their staff or physicians has a problem that did not show up in the credentialing process.

The reason for some problematic employees and physicians slipping through the system often comes down to the administrative burden of doing a thorough background check, suggests **Matthew Haddad**, president and CEO of Medversant Technologies, a company in Los Angeles that offers credentialing and other services for providers. Although managers understand the need for researching the background of any and all employees, credentialing can be a long, expensive, and grueling process, he says.

In the time when most methods are moving from paper to digital, the credentialing process is no different, and managers might want to consider a more modern version of credentialing than the systems that have been in place for years. Along with several other companies and nonprofits, Medversant offers a software tool that ensures information on all health care providers is centralized, up-to-the-minute, and accessible to appropriate parties, therefore enhancing patient safety and the quality of care.

The old way of credentialing involves gathering a great deal of information, usually on paper, about the individual and then trying to confirm much of it yourself. Health care providers in recent years have moved more and more toward utilizing electronic databases and other computer resources, but Haddad says there still are many that could automate the process much more.

"What has traditionally been a mostly manual process turns into an electronic process that is faster, but at the same time offers better, more reliable information," he says. "Even though most hospitals have some sort of software in use, the software acts like a filing cabinet for the information, so that you still have to go find the data, print it out or copy it to another location, and use multiple sources for a report."

Electronic credentialing software, such as that offered by Medversant, actually does much of that work for the provider, rather than simply acting as a storage site for the data, Haddad says. "So, when you need to check various third-party sources to find information on an individual, the system automatically does that rather than a staff person having to go to each of those third-party resources and manually checking them," he says, "and it does that continuously. The system checks that information as often as those outside databases update, and you could never have enough staff to do that manually."

That constant updating provides a nearly real-time snapshot of the individual's information rather than relying on what might be outdated and incomplete information retrieved by hand at the beginning of the credentialing process, Haddad says.

Automating the credentialing process allows large health care organizations to move their credentials data from paper files to a more useful type of information, says **Anthony D. Begando**, founder and CEO of Tenon Consulting Solutions, a health care consulting company based in Alpharetta, GA, that has used electronic credentialing on behalf of its health care clients. "Automated credentialing provides organizations with a detailed inventory of the clinical skills across their enterprise," he says. "Automated credentialing substantially reduces the administrative burden placed on providers and greatly improves compliance."

In addition to services such as those offered by Haddad's company, Begando recommends the Universal Provider Datasource (UPD) offered by CAQH, a Washington, DC, nonprofit alliance of health plans and trade associations. *(Editor's note: For more information on the UPD, go to www.caqh.org/ucd.php.)* The UPD allows managers to leverage existing provider credentials information and electronically monitor hundreds of sources of sanctions data for providers.

Begando says moving to an automated credentialing environment allows for centralization of credentialing activities across an entire enterprise while preserving local privileging and board review processes. By participating in an electronic credentialing system such as the UPD, providers benefit from an improved credentialing process that yields more reliable information, and they also encourage a more cooperative relationship among providers, he says. For example, his system prompts for a new license before the current license expires, he says.

Haddad says some malpractice insurers have indicated that they might offer discounts for using electronic credentialing. "They're talking about offering discounts in the range of 8% to

SOURCES

For more information on electronic credentialing, contact:

- **Anthony D. Begando**, Founder and CEO, Tenon Consulting Solutions, Alpharetta, GA. Phone: (678) 990-0417. Web: www.tenonconsulting.com.
- **Matthew Haddad**, President and CEO, Medervsant Technologies, Los Angeles. Phone: (213) 291-6139. Web: www.medversant.com.

10%," he says. "They see benefits in terms of the provider being better able to screen out potential sources of liability down the road, so they see it as cost-effective to offer the discount to their customers who use a service like this." ■

Most women would choose surgical profession again

Most women surgeons would choose their careers again, although many would favor more options for part-time or other alternative work schedules, according to a report in the July issue of *Archives of Surgery*.

Over the past three decades, women have increased their presence in the surgical field, according to the article. "In the medical field, a career in surgery has significant lifestyle implications: the profession is associated with high degrees of patient acuity, significant on-call responsibility and irregular work hours, all requiring a significant commitment of personal time," the authors wrote. "The extent to which the surgical workplace has evolved to accommodate women and their role in family life is unknown to the public, in general, and to the upcoming generation of women physicians, in particular."

To assess professional and personal situations, perceptions and challenges for male and female surgeons, **Kathrin M. Troppmann**, MD, of the University of California Davis Medical Center, Sacramento, and colleagues mailed a questionnaire to all surgeons board-certified in 1988, 1992, 1996, 2000, or 2004. Of 3,507 surgeons, 895 (25.5%) responded, of whom 178 (20.3%) were women and 698 (79.7% were men).

Among the surgeons who responded:

• General surgery was the most common specialty among both sexes (39.3% of women and 46.7% of men); more women than men specialized in breast surgery (20.2% vs. 1.3%) and fewer specialized in vascular surgery (2.9% vs. 10.3%), but essentially there were no other sex differences in subspecialties.

• Most women (82.5%) and men (77.5%) would choose surgery as a profession again, and 83.5% of women and 61.3% of men would recommend surgery as a career choice to women.

• Men worked a median (midpoint) of 65 hours a week, compared with 60 for women.

• More women (8.5%) than men (3.2%) had ever worked part-time as a clinical surgeon, and women were less likely to disagree with the statement that more part-time work opportunities should be available for surgeons (33.3% vs. 55.5%).

• Women were significantly less likely than men to have a spouse who did not work outside the home (9.4% vs. 56.3%).

• Women surgeons also were less likely than men to have children (63.8% vs. 91.3%), as were surgeons of the younger generation (board-certified in 2000 or 2004); more women than men surgeons had children later in life, after entering surgical practice (62.4% vs. 32%).

• More women than men reported that maternity leave was important (67.8% vs. 30.8%) and that child care should be available at work (86.5% vs. 69.7%).

"In conclusion, most women surgeons would choose the surgical profession again. This highly positive perception should be pointed out to women considering a surgical career," the authors conclude. "To foster realistic expectations among medical students, the rewarding and challenging aspects of the surgical profession must be pointed out. Finally, our study results suggest that maximizing recruitment and retention of women surgeons will include giving serious consideration to alternative work schedules and optimization of maternity leave and child care opportunities."

Many of the findings also would apply to female anesthesiologists, Troppmann says. "Based on the anesthesiologists that I know that are women, it can be every bit as challenging," she says. ■

Same-Day Surgery Manager

Readers are riled over doc/employee column

By **Stephen W. Earnhart**, MS
CEO
Earnhart & Associates
Austin, TX

Looks like I struck a nerve with the column on physicians as employees **("Meet your new**

employee: Dr. Smith, surgeon," ***Same-Day Surgery,*** **July 2009)**. Let me share a few of the responses:

Question: As a busy member of the medical staff at our freestanding surgery center, I take offense at your suggestion that many subspecialists will one day be employees of the local hospital. The reason we developed our center was to get away from the "mother ship" and start our own center. That was 12 years ago, and none of the original investors has ever looked back. Short of a nationalized health system, I cannot think of anything more prosperous. You really should watch what you say, because you can plant seeds into the minds of younger surgeons.

Answer: Hospitals already employ groups such as anesthesia, radiology, hospitalists, and primary care providers, so it isn't a stretch to see hospitals trying to bring in subspecialists that they can influence and control referral patterns to the hospital. With a shortage of surgeons coming, the bigger players might try to control the market.

Question: Kudos on your article about subspecialists as employees. My group was hired by the one of our local hospitals about a year ago, much to the aghast of our fellow surgeons who essentially satirized (sic) us. It was exactly as your article described. I was worried before, not knowing what to expect, but wow! We love it! We even got a bonus at the end of the year. To my fellow surgeons: Listen to the offers that are out there. If you don't take it, others will, and the referral patterns will shift!

Answer: No response required.

Question: Can anesthesia personnel become employees? If they can and do become employees under my department, can I fire them? That would be so worth it! (Submitted by OR department head).

Answer: Actually, there are a number of employed anesthesia personnel across the country. As a department head, I guess you can fire them, but you would need to build a case for why.

Question: I am considering just what your last column suggested, but am nervous about it. As a professional, I am concerned about a loss of status amongst my peers and the staff at the hospital. I fear that if this trend develops or continues as you suggest, we will be in the same class as nurses and anesthesia and will not be looked upon as professionals.

Answer: You should be so lucky as to be in their "class."

Question: As a surgeon/employee of our local health system for about seven months now, I find that I have lost much of my eagerness to stay late or bust my butt seeing patients. My contract with my employer requires a level of "production" that is very easily obtained during normal working hours. If I am slacking off after only seven months, what is going to happen if everyone becomes employees and starts acting like me?

Answer: We are going to become like Canada, the United Kingdom, Australia, etc. But we are getting close to that anyway, aren't we? Like these other countries, we will have a two-tier system of health care delivery. One for those with insurance and access to a bloated, overburdened quagmire of services, and one for those with means who are willing to pay cash for good service. Right now, we are in the middle someplace.

(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart @earnhart.com. Web: www.earnhart.com.) ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answers listed in the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Latest tactic from payers, and how you should respond
- Tips on complying with patient safety goal on infection control
- What you should do now to prepare for health care reform
- Improve surgery outcomes — Your peers share benchmarks

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

9. What are warning signs that an employee is embezzling, according to Beverly A. Kirchner, RN, BSN, CNOR, CASC?
A. The employees ask off from work a lot.
B. The employees are withdrawn.
C. You catch them in lies.
D. All of the above

10. Which of the following is true of background checks on employees, according to Mandi M. Clossey, CPA?
A. You should perform criminal checks on all employees.
B. You should perform credit checks on all employees.
C. You should perform criminal and credit checks on all employees.
D. You should perform criminal and credit checks on business office employees.

11. At George Washington University Hospital, what is true considering media releases of VIP patients?
A. Only the fact that the person is a patient is released.
B. Only the facts that the person is a patient and the type of procedure are released.
C. Without a consent, the hospital will not even confirm that this person is a patient.

12. What is the policy on retained objects at Beth Israel Deaconess Medical Center?
A. Everyone, including the anesthesiologist, remains in the OR until the outcome of any missing objects is determined.
B. The nurses remain in the OR until the outcome of any missing objects is determined.
C. The nurses and the surgeon remain in the OR until the outcome of any missing objects is determined.

Answers: 9. D; 10. C; 11. C; 12. A.

_____ Surgery Center
Red Flags Rule Compliance
(Part of HIPAA Compliance)
Effective Nov. 1, 2009

Purpose: Identity theft prevention and detection and Red Flags Rule compliance.

It is the policy of _____ Surgery Center referred to as the "The Practice" in this document, to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how The Practice will (1) identify, (2) detect and (3) respond to "red flags". A "red flag" as defined by this policy includes a pattern, practice, or specific account or record activity that indicates possible identity theft.

It is the policy of The Practice that this identify theft prevention and detection and Red Flags Rule compliance program is approved by The Practice's Executive Committee President as of Nov. 1, 2009, and that the policy is reviewed and approved no less than annually.

It is the policy of The Practice that the Compliance Committee is assigned the responsibility of implementing and maintaining the Red Flags Rule requirements. Furthermore, it is the policy of The Practice that this group will provide sufficient resources and authority to fulfill these responsibilities. At a minimum, it is the policy of The Practice that there will be one individual designated as the privacy official.

It is the policy of The Practice that, pursuant to the existing HIPAA Security Rule, appropriate physical, administrative and technical safeguards will be in place to reasonably safeguard protected health information and sensitive information related to patient identity from any intentional or unintentional use or disclosure.

It is the policy of The Practice that its business associates must be contractually bound to protect sensitive patient information to the same degree as set forth in this policy. It is also the policy of The Practice that business associates who violate their agreement will be dealt with first by an attempt to correct the problem, and if that fails by termination of the agreement and discontinuation of services by the business associate.

It is the policy of The Practice that all members of the workforce have been trained by the Nov. 1, 2009, compliance date on the policies and procedures governing compliance with the Red Flags Rule. It is also the policy of The Practice that new members of our workforce receive training on these matters within a reasonable time after they have joined the workforce. It is the policy of The Practice to provide training should any policy or procedure related to the Red Flags Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is the policy of The Practice that training will be documented, indicating participants, date and subject matter.

Procedures

A. Identify Red Flags.

In the course of caring for patients, The Practice may encounter inconsistent or suspicious documents, information or activity that may signal identity theft. The Practice identifies the following as potential red flags, and this policy includes procedures describing how to detect and respond to these red flags below:

1. .A complaint or question from a patient based on the patient's receipt of:
    a. A bill for another individual;
    b. A bill for a product or service that the patient denies receiving;
    c. A bill from a health care provider that the patient never patronized; and
    d. A notice of insurance benefits (EOB) for health care services never received.
2. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient.
3. A complaint or question from a patient about the receipt of a collection notice from a bill collector.
4. A patient or health insurer report that coverage for legitimate hospital stays is denied because insurance benefits have been depleted or a lifetime cap has been reached.
5. A complaint or question from a patient about information added to a credit report by a health care provider or health insurer.
6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.
7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.
8. A notice or inquiry from an insurance fraud investigator for a private health insurer or a law enforcement agency, including but not limited to a Medicare or Medicaid fraud agency.

B. Detect Red Flags.

The Practice's staff will be alert for discrepancies in documents and patient information that suggest risk of identity theft or fraud. The Practice will verify patient identity, address and insurance coverage each visit at patient registration/check-in.

1. When a patient calls to request an appointment, the patient will be asked to bring the following at the time of the appointment:
    a. Driver's license or other photo ID;
    b. Current health insurance card; and
    c. Utility bill or other correspondence showing current residence if the photo ID does not show the patient's current address. If the patient is a minor, the patient's parent or guardian should bring the information listed above.

2. When the patient arrives for the appointment, the patient will be asked to produce the information listed above.
3. If the patient has not completed the registration form within the last six months, the receptionist will verify all current information on file, and, if appropriate, update the information.
4. Staff should be alert for the possibility of identity theft in the following situations:
    a. The photograph on a driver's license or other photo ID submitted by the patient does not resemble the patient.
    b. The patient submits a driver's license, insurance card, or other identifying information that appears to be altered or forged.
    c. Information on one form of identification the patient submitted is inconsistent with information on another form of identification or with information already in the practice's records.
    d. An address or telephone number is discovered to be incorrect, non-existent or fictitious.
    e. The patient fails to provide identifying information or documents.
    f. The patient's signature does not match a signature in the practice's record.
    g. The information the patient provided is the same information in the practice's records provided by another individual.

C. Respond to Red Flags.

If an employee of The Practice detects fraudulent activity or if a patient claims to be a victim of identity theft, The Practice will respond to and investigate the situation. If the fraudulent activity involves protect health information (PHI) covered under the HIPAA security standards, The Practice will also apply its existing HIPAA security policies and procedures to the response.

1. If potentially fraudulent activity (a red flag) is detected by an employee of The Practice, the employee should gather all documentation and report the incident immediately to their supervisor or someone from the management team.
2. The supervisor will determine whether the activity is fraudulent or authentic, and notify the compliance officer.
3. If the activity is determined to be fraudulent, then The Practice should take immediate action. Actions may include:
    a. Cancel the transaction;
    b. Notify appropriate law enforcement;
    c. Notify the affected patient;
    d. Notify affected provider; and
    e. Assess impact to the practice.

Page 4……

If a patient claims to be a victim of identity theft:

1. The patient should be encouraged to file a police report for identity theft if he/she has not done so already.
2. The patient should be encouraged to complete the ID Theft Affidavit developed by the FTC, along with supporting documentation.
3. The Practice will compare the patient's documentation with personal information in the practice's records.
4. If following investigation, it appears that the patient has been a victim of identity theft, the Practice will promptly consider what further remedial act/notifications may be needed under the circumstances.
5. The provider will review the affected patient's medical record to confirm whether documentation was made in the patient's medical record that resulted in inaccurate information in the record. If inaccuracies due to identity theft exist, a notation should be made in the record to indicate identity theft.
5. The practice medical records staff will determine whether any other records and/or ancillary service providers are linked to inaccurate information. Any additional files containing information relevant to identity theft will be removed and appropriate action taken. The patient is responsible for contacting ancillary service providers.
6. If following investigation, it does not appear that the patient has been a victim of identity theft, The Practice will take whatever action it deems appropriate.

_____
Director of Nursing

_____
Executive Director

_____
Medical Director

I have read this document and understand its intent, and my responsibility.

_____	_____	_____
Printed Name	Employee Signature	Date

Source: Tucson (AZ) Orthopaedic Surgery Center.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: TABLE OF CONTENTS	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

IX. BILLING

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: A. SYSTEM DESCRIPTION - BILLING	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

The Office Assistant will retrieve all Op Reports from the computer daily. Op Reports will be attached immediately in patient's chart. The Coder will request the Office Assistant to send Intra-Op records every Friday for all cases who do not have Op Report.

Face sheets are printed at the Surgery Center for the next day patient(s) each afternoon. The Receptionist verifies the patient information for collecting co-pays, deductibles and self-pay amounts. If the Receptionist notes there is special billing information, a need for Promissory Note prior invoice balance to be collected, Letter Of Protection (LOP) forms to be signed, he/she will prepare the correct form and place in chart.

G. Verify the insurance company's name and address to which the claim is to be sent.

H. Verify if the insurance company requires a special claim form from the employer or employee. If a claim form is needed, be sure the patient is aware they need to bring the form on day of surgery. Place a note in the Vision System that a special claim form is needed to bill.

I. If the dependent is over 18 years old, and in school, ask if you need to send proof of full time student status with the claim. If answer is yes, place a note in the Vision System that proof of full time student status must accompany claim. Notify patient of the need for proof of full time student status. Ask that this proof be brought to the Surgery Center the day of surgery.

J. Get the full name of the person verifying the insurance information. Put name in notes in the Vision System. Put extension number of person verifying the insurance information in the notes in the Vision System.

K. Make sure all workers compensation cases are verified. Do not accept Physician's Office verification. Make sure you have a "date of injury". Be sure the date of injury and full name of the person you verified the case with is entered in the Vision System notes. Remember the claim will be rejected without date of injury. Try to obtain the name and address of the actual insurance carrier, not just the employer.

L. When verifying secondary insurance on Medicare patients, be sure and ask if we have assignment of benefits, will they pay us, the provider, or if they only pay the patient. If they pay directly to the patient, then the co-pay should be collected on the day of surgery. Put a note on the Vision System concerning the payment.

M. Calculate the estimated amount of money that the patient should bring on the day of surgery. Notify patient and place note in Vision System.

N. Send "Admission Economic Impact" letter to the patient confirming conversation with patient about insurance benefits, estimated deductible, and co-pay due on date of service.

O. If the patient refuses to pay any co-insurance prior to surgery, it will be the decision of the Administrator at the Center to determine if the surgery is to be cancelled or remain scheduled. A form showing the Administrator's approval will be signed by the Administrator or their designee and sent to the billing department.

P. If a specific managed care contract states that a co-payment should not be charged until an EOB is received, this will be honored and the co-payment will not be collected the day of surgery.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: C. INSURANCE WORKSHEET PROCESS – DETERMINING PATIENT PROCEDURE CHARGES	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

Insurance Worksheet Process

CPT Code / Estimate Charges

1. Identify all CPT code(s) for procedure(s) scheduled.
2. Identify price for each CPT code scheduled.
3. Place CPT codes in order on form based on most expensive to the least expensive.
4. When placing CPT codes – first code is at 100%, second code should be at 50% of billed charges, third, fourth, etc. should be at 25% of billed charges.
5. Add up all CPT code charges to obtain total estimated charges for procedure(s) scheduled.

In Network Benefits

1. Place estimated charges on first line titled estimated charges.
2. Place amount of deductible not met by patient as identified by insurance company on second line.
3. Subtract deductible not met from estimated charges and place amount on line three.
4. Identify co-pay percentage on line four. Multiply Total from line three with percentage of line four.
5. Put percentage patient is estimated to owe in co-pay on line five.
6. On line six, put estimated charge for procedure(s). This amount is on line one.
7. On line seven, put Total due from patient. This amount will include deductible and co-pay added together. Subtract line seven, total due from patient, from line six, estimated charges, to obtain line eight, estimated amount from insurance.

Out of Network Benefits

1. Place estimated charges on first line titled estimated charges.
2. Place amount of deductible not met by patient as identified by insurance company on second line.
3. Subtract deductible not met from estimated charges and place amount on line three.
4. Identify co-pay percentage on line four. Multiply Total from line three with percentage of line four..
5. Put percentage patient is estimated to owe in co-pay on line five.
6. On line six, put estimated charge for procedure(s). This amount is on line one.

7. On line seven, put Total due from patient. This amount will include deductible and co-pay added together. Subtract line seven, total due from patient, from line six, estimated charges, to obtain line eight, estimated amount from insurance.

Accepting In-Network Benefits

1. Line one, put estimated amount of insurance payment for out of network benefits. This number is on line eight of Out of Network Benefits section.
2. On line two, place in Network deductible due from patient. This number is found on line two of In Network Benefits section.
3. On line three, place co-pay due from patient found on line five under In Network Benefits.
4. Add line one, two and three to obtain estimated payment for the procedure. If estimated payment is less than 75% of total estimated charges found on line five of Insurance Worksheet, you **must obtain approval** to schedule the procedure(s) from the Administrator. Review worksheet with the Administrator. Obtain the Administrator's initials on Insurance Worksheet when approved

Medicare Scheduling Process

1. Determine CPT Code(s) for procedure(s) posted. Check the CPT Code Book or ask Coder if CPT code(s) are allowed to be performed in ambulatory surgery center.
2. If CPT code(s) are not allowed to be performed in surgery center, call Administrator. Review code(s) not allowed. Obtain permission to proceed with scheduling process or to notify physician of the situation and cancel case.
3. If CPT code(s) are allowed in an ambulatory surgery center, follow process of determining the amount of co-pay the patient will owe.
4. To determine amount patient will owe, you must refer to the CPT code pricing allowed by HCFA (Medicare). Do not use our standard pricing by CPT code for HCFA (Medicare) patients.
5. Follow Insurance Worksheet process to complete process.
6. Call patient and discuss the amount you estimate him/her to owe. Send letter to patient confirming conversation.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: D. INSURANCE WORKSHEET	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

INSURANCE VERIFICATION FORM

Tax ID #: 33-1127725

Patient's Name: _____ D.O.B.: _____

Procedure: _____

Physician: _____

DOS: _____

INSURANCE INFORMATION

Ins Company: _____ Phone #: _____

Claims Addrs: _____

_____

IND PPO POS HMO

Other: _____

ID#: _____ Group# _____

Policy Holder: _____ Relationship: _____

Effective Date: _____

IN-NETWORK BENEFITS	OUT OF-NETWORK BENEFITS
Procedure Copay: $_____ or Ded:$_____ Met:$_____ Coins:_____ OOP: $_____ (__ Plus Ded)	Procedure Copay: $_____ or Ded:$_____ Met:$_____ Coins:_____ OOP: $_____ (__ Plus Ded)

OOP Met: $_____	OOP Met: $_____
Precert Required: Yes or No	Referral Required: Yes or No
Precert Phone #: _____	Deposit Required: Yes or No
Procedure Auth #: _____	Pre-Existing Clause: Yes or No
2nd Opinion Required: Yes or No	
Filing Limit: _____ LTM: $_____	Filing Limit: _____ LTM: $_____
Notes: _____	Notes: _____
_____	_____
Spoke To: _____	Verified By: _____

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: E. SCHEDULER COMPETENCY TEST: INSURANCE ESTIMATIONS	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

Scheduler Competency Test on Insurance Estimation

Scenario One

Dr. S. has scheduled an EGD and colonoscopy.

The In Network Benefits are:	**Deductible**	**$ 250.00**
	Co-Pay	**20%**
	Max OOP	**$1500.00**
The Out of Network Benefits are:	**Deductible**	**$1000.00**
	Co-pay	**50%**
	Max OOP	**$5000.00**

Can we do this case?

Scenario Two

Dr. H. has scheduled a dx arthroscopy with a possible ACL.

The In Network Benefits are:	**Deductible**	**$ 500.00**
	Co-pay	**10%**
	Max OOP	**$1500.00**
The Out of Network Benefits are:	**Deductible**	**$1000.00**
	Co-pay	**30%**
	Max OOP	**$2500.00**

Can we do the dx arthroscopy?
Can we do the ACL?
Can we bill for both cases?

Scenario Three

Dr. G. has posted a lap vag hysterectomy.

The patient has Medicare.	**Deductible**	**$ 100.00**
	Co-pay	**20%**

Can we do this case?

Scenario Four

Dr. B. has scheduled a laparoscopic Carpal Tunnel Release.

In Network Benefits are:	**Deductible**	**$ 100.00**
	Co-pay	**10%**
	Max OOP	**$2000.00**
Out of Network Benefits are:	**None**	

Can we do this case?

Scenario Five

Dr. P. has scheduled a BMT and tonsillectomy under age 12.

The In Network Benefits are:	**Deductible**	**$ 500.00 - $300.00 has been met**
	Co-pay	**20%**
	Max OOP	**$2000.00**
Out of Network Benefits are:	**Deductible**	**$1000.00 - $600.00 has been met**
	Co-pay	**50%**
	Max OOP	**$5000.00 - has been met**

Can we do this case?

CPT Codes and Prices

	CPT Code	**Price**
EGD → Dx	43235	$1800.00
Colonoscopy Dx	45378	$1800.00
Dx Arthroscopy →	4500	$1200.00
ACL	6625	$7500.00
Lap Vag Hyst	58550	$5700.00
Endoscopic Carpal Tunnel Release	29848	$3000.00
BMT	6 9436-50	$1200.00
Tonsillectomy under 12	42820	$1800.00

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: **F.SCHEDULER/PATIENT CONVERSATION**	**ISSUED: OCT 2007** **REVISED: NOV 2007**	**NUMBER:**

Good morning/good afternoon. My name is _____ calling from Legacy Surgery Center of Frisco to discuss the surgery you have scheduled to be performed in our center by Dr. _____ on ___(date)____ at ___(time)___.

I have contacted your insurance company and need to inform you of the following benefits you have with your insurance company.

- Pre-existing information
- Need for second opinion or not
- Deductible due upon admission to the center
- Estimated amount of co-pay due upon admission to the center. Really stress that the co-pay is only an estimate.
- Inform patient if they need to bring any special forms for us to be able to process their claim and insurance card.
- Inform patient if they need proof of being a full time student.
- If a Medicare patient and they have secondary insurance, review their benefits and how they or we will be paid (Patient, Provider, Surgery Center).
- Review a second time amount due from patient at time of service.
- Your insurance company does not provide coverage for this procedure or supplies needed (implant). You will be responsible for the cost of _____.

If patient claims they cannot pay amount due at time of service, offer a Promissory Note. The note is to be for ninety (90) days only. They must make a payment at time of service. If the arrangements do not meet the patient's needs, have them talk to the Administrator concerning what will meet their needs and the organization's needs.

If a Medicare patient cannot make a payment on date of service, inform them we will bill after we have filed his/her Medicare. The Collector will work with the Medicare patient on any amount due after their surgery.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: G. ECONOMIC IMPACT LETTER PROCESS	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

1. The scheduler will send an Economic Impact Letter to every patient scheduled for surgery.

2. The Economic Impact Letter will be mailed after the insurance has been verified and the scheduler has spoken to the patient concerning his/her financial obligation for his/her surgical procedure(s).

3. A copy of the letter will be scanned into the EMR, Amkai Charts, under 'Other Documents'

4. **There are several versions of the letter, be sure and send the correct version.**

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: **H. ECONOMIC IMPACT LETTER PRIOR TO ADMISSION**	**ISSUED: OCT 2007** **REVISED: OCT 2007**	**NUMBER:**

Date Line

Patient Address

Dear

We are pleased to inform you of the way we handle patient financial responsibility in our surgery center.

The Business Office hours are from 6:00 a.m. until 5:00 p.m. Monday through Friday. Feel free to call us any time during these hours if you have a question concerning your **estimated** bill for the procedure(s) you have scheduled on Date at Time.

Noting today's economic conditions we feel certain that you understand and appreciate the necessary for us to be diligent in our collection policies and procedures.

You will be financially responsible for your deductible and **estimated co-pay $**_____.
This amount is due and payable at the time services are rendered. In the event insurance rejects the claim, or benefits are less than expected, you will be required to pay the balance in full, or make appropriate arrangements for payment.

Please feel free to call 972-712-4800 and discuss these policies with us if you feel you are adversely affected. We wish to maintain "The Personal Touch" in our professional relationships and hope to serve you well with the best surgical care available.

Sincerely,

Scheduling Coordinator

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: I. PROMISSORY NOTE PROCEDURE	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

1. Should it be determined at the Surgery Center by the Scheduler that a Promissory Note is needed, the Scheduler will complete the note and give it to the Administrator for approval. All blanks will be completed. The patient will be required to sign prior to surgery.

2. Should a patient unexpectedly present with inadequate funds to pay his/her agreed upon balance due, a decision must be made by the Administrator as to whether a Promissory Note is written and signed or case is canceled.

3. Documentation of a Promissory Note being accepted must be entered into the Vision System. **A copy of the Promissory Note is scanned onto the EMR with other billing information.**

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: **J. ECONOMIC IMPACT LETTER WITH PROMISSORY NOTE**	**ISSUED: OCT 2007** **REVISED: OCT 2007**	**NUMBER:**

Date Line

Patient Address

Dear

We are pleased to inform you of the way we handle patient financial responsibility in our surgery center.

The Business Office hours are from 6:00 a.m. until 5:00 p.m. Monday through Friday. Feel free to call us any time during these hours if you have a question concerning your **estimated** bill for the procedure(s) you have scheduled on (Date) at (Time) .

Noting today's economic conditions we feel certain that you understand and appreciate the necessary for us to be diligent in our collection policies and procedures.

You will be financially responsible for your deductible and **estimated co-pay $ _____**.
This amount is due and payable at the time services are rendered. In the event insurance rejects the claim, or benefits are less than expected, you will be required to pay the balance in full, or make appropriate arrangements for payment.

Please feel free to call 972-712-4800 and discuss these policies with us if you feel you are adversely affected. We wish to maintain "The Personal Touch" in our professional relationships and hope to serve you well with the best surgical care available.

Sincerely,

Scheduling Coordinator

Legacy Surgery Center of Frisco
Promissory Note

(We, I)_____and _____as

RESPONSIBLE (party/parties) for _____**PROMISE** to **PAY**

LEGACY SURGERY CENTER for the use of the facilities on ____/____/____.

My **ESTIMATED** financial responsibility is $_____. Following my down payment of $_____. Payments will be made on a monthly basis with all payments due on the _____ of the month, beginning _____.

TERMS ARE AS FOLLOWS:

PAYMENT #1:_____**DUE:** _____

PAYMENT #2:_____**DUE:** _____

PAYMENT #3_____**DUE:** _____

It is fully understood that the above financial responsibility is only an estimate based on the procedure(s) scheduled. If additional procedures are performed, this amount will increase. If the amount increases, you will be notified in writing by the Business Office. In the event of non-payment by the insurance company, the responsible party/parties will be responsible for the entire balance of the account. If we have to take legal action to collect the balance all legal fees will be charged to the party/parties named in the agreement. It is further agreed that in event of any and every change in address and/or employment that the Surgery Center will be notified immediately.

FIRST GUARANTOR	**SECOND GUARANTOR**
STREET ADDRESS	**STREET ADDRESS**
CITY, STATE, ZIP CODE	**CITY, STATE, ZIP CODE**

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: K. ASSIGNMENT OF PROCEEDS CLAIM PROCESS	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

Purpose:

Every patient must sing a face sheet which assigns insurance benefits to the center. If the patient is suing for benefits due to any injury, an Assignment of Proceeds Claim Form must be completed & signed.

Policy:

1. If an attorney is involved in the payment for a patient receiving treatment at the surgery center an Assignment of Proceeds claim form must be completed and signed by all parties involved.

2. The form is scanned into the patient's EMR.

3. The original form is shredded once scanning is completed & verified in EMR.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: **L. ASSIGNMENT OF PROCEEDS CLAIM FORM**	**ISSUED: OCT 2007** **REVISED: OCT 2007**	**NUMBER:**

DATE: _____ Patient MRN#:_____

ESTIMATED FEE Amount:_____

PATIENT NAME: _____

ASSIGNMENT OF BENEFIT AGREEMENT:

I certify that the legal information provided is correct, complete. I authorized my attorney, _____to secure or release information relating to this claim. I understand that I am **financially responsible** for any amount unpaid by this assignment. In consideration of surgical services rendered to my dependent or me as named above.

ATTORNEY OF RECORD AGREEMENT:

The undersigned, being attorney of record for the above patient, does hereby agree to observe all of the terms above, and agrees to withhold such sum from any settlement or judgment, and to pay over such funds as may be necessary to discharge the obligation.

I further agree that in the event that my client, the above named patient, secures other counsel in connection with any action instituted by him/her on the account of the injuries for which he was treated, I shall inform such new counsel of this agreement, and secure his consent thereto.

Dated this _____ Day of _____, _____.

_____
ATTORNEY SIGNATURE

ADDRESS: _____

PHONE NUMBER: _____

CONTACT PERSON: _____

PAYMENT AGREEMENT:

I understand and accept financial responsibility for payment of all accounts with the Surgery Center. The legal settlement may pay all, part, or none of my account(s) and I am responsible to see all accounts are completely paid. Payment in full is expected within 45 days from you following the date of denied payment from legal settlements.

Dated this _____ Day of _____, _____.

_____
PATIENT/GUARANTOR SIGNATURE

SIGNATURE
WITNESSE BY: _____

DEPOSIT REQUIRED: _____

DEPOSIT COLLECTED: _____

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: **M. INSURANCE ONLY REQUEST PROCESS**	**ISSUED: OCT 2007** **REVISED: NOV 2007**	**NUMBER:**

1. A physician must be the one to request that the surgery center accept insurance only on his patient being scheduled.

2. The Scheduler will fax the physician's office a "Hardship" form. The physician will complete the form and return to the center.

3. The Scheduler will review the form for understanding of request. The Scheduler will sign the form and forward the document to Business Office Coder for coding and pricing. The Business Office Coder will complete and forward to Administrator for final approval.

4. Original form is scanned in patient's EMR.

5. The Scheduler will transcribe information from Hardship Form to patient's notes in Vision.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: N. STANDARDIZED CODING SYSTEMS FOR BILLING	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

POLICY:

The Surgery Center utilizes standard coding and billing systems, which include Indenix CPT and ICD - 9 Coding Resources. With the ability of the Vision's Outpatient Billing System Program, date entered during the billing process becomes part of the system's "Memory", and provides an accurate, reliable and on-going building of a coding reference library.

The Surgery Center maintains and utilizes current and outdated versions of the above CPT and ICD resources. This allows the Center to remain current on charges in the coding and billing standards for the community.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: O. CHARGE ENTRY PROCESS	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

1. The Surgery Center's Office Assistant attaches patient label to charge entry form.

2. The "Special Instructions" area is provided for any special claims filing instructions such as "Employee Claim Form Needed", implants, special splints and lab work. This area must be completed at the Surgery Center. Any forms needed for filing must be sent to the Billing/Coding Coordinator.

3. The Billing/Coding Coordinator completes procedure lines.

4. The Surgery Center's Office Assistant circles EKG if one was done in the Surgery Center.

5. The Office Assistant writes under "Special Instructions" all implants used on the patient. The Office Assistant needs to attach a copy of invoice or invoices if they have it for the implants. The Office Assistant must forward a copy of the invoice for implants when received if not available at time of billing. If invoice is not available when Charge Entry Form is completed, a copy of the PO must be attached.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: P. DETERMINE BAD DEBT	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

1. Patient due accounts are considered Bad Debt after forty-five (45) days of first statement being mailed with no response from patient. The Collector will send a serious delinquent letter to the patient after forty-five (45) days during Hopper Time. Hopper Time to be defined as 10th through 13th and 27th through 30th of each month. The serious delinquent letter will be mailed from the Business Office to arrive at the patient's address during these dates. If no response in ten (10) days from patient, the account will be placed with our attorney, small claims court or Bad Debt write-off Report and sent to the Administrator for approval.

   To determine Bad Debt Write Off, attorney or Small Claims Court:
   - any account $99.99 and under is to be written off with Administrator's approval.
   - any account greater than $100.00 is to be sent to TRW after receiving Administrator's approval.
   - any account greater than $500.00 is sent to Small Claims Court
   - any account greater than $1,000.00 is turned over to our attorney

2. Insurance due accounts are to be considered Bad Debt at forty-five (45) days of first claim form being mailed with no response from the insurance company. The Collector will contact the insurance company at forty-five (45) days. The Collector will follow up with the insurance company every ten (10) days until claim is paid. The Collector will speak to a supervisor concerning the claim. The conversation, including the full name of the person you are speaking to, will be recorded in the Vision notes. The Collector will follow up on the day the insurance company claimed we would receive payment if payment has not been received. When the insurance claim becomes ninety (90) days old and is not paid, the Administrator or Business Office Manager will call the insurance company and speak to a supervisor. If the issue cannot be resolved that day, then a report will go to the Administrator for him/her to follow up and the patient will be billed for the full amount owed.

3. The Collector will send all information requested by the insurance company the day it is requested. Send information via fax to responsible party at the insurance company and verify information received. A note will be placed in the system under the patient's account number in Vision concerning all activity on the account.

4. The organization will not hesitate to file a complaint with the Texas Insurance Commission concerning any claim that is not paid within 120 days of the first claim being mailed. The organization will not hesitate to charge the insurance company interest on the money due as specified by law.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: Q. BAD DEBT REPORTING	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

1. The Collector will run a query the third Thursday of each month.

2. The 3rd Friday morning of each month, the Collector will begin research on all accounts greater than ninety (90) days. The Collector will review the accounts in great detail.

3. A written report will be generated and given to the Business Office Manager for review. The written report will include, but not be limited to the following information:
   a. Age of account (DOS)
   b. Patient name
   c. Surgeon's name
   d. Surgery Center name
   e. Who was contacted and response
   f. How many times the patient or third party payer has been contacted.
   g. Problem if one can be identified.

4. The BOM will contact the Administrator for each account that he/she has a question about.

5. The Administrator will receive a written report once a month concerning amounts to be sent to the attorney, small claims court or Written Off to Bad Debt.

6. The Administrator will review and sign forms approving turning the patient over to the attorney, small claims court or Writing Off Account.

7. The Administrator will return forms to the Collector within two working days after receiving forms from the Collector.

8. The Collector will adjust the accounts as soon as the reports are approved.

9. The Collector will notify patient of intent to send account to the attorney or small claims court.

10. The Collector will turn all patients approved over to the attorney or small claims court.

11. The Collector will notify the patient of the action taken with his/her account.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: R. PAID IN FULL ACCOUNTS	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

The 15th of each month the Collector will create list of all paid in full accounts for the Surgery Center along with the complete financial file. The Office Assistant will mark and pull all paid in full accounts and file per protocol of the Medical Records Policy and Procedure.

Once a quarter, a complete list will be compiled for the Surgery Center. This will allow the Office Assistant to double check files for accuracy.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: S. PATIENT REFUNDS	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

1. The Collector will research all accounts with a credit balance from the daily deposit. Should the Collector find that a refund to a patient is warranted, he/she will provide the information to the Patient and Business Office Manager. The BOM will review the account for accuracy. The BOM will review the system to assure no accounts are missed and that the patient does not have an outstanding balance from a previous surgery.

2. The Collector will send the approved documentation on refunds to the BOM for approval. The BOM will process the refund check.

3. The BOM will forward check and documentation from patient refund to the Administrator. The Administrator will approve or deny refund. If approved, the Administrator will sign and mail check. The Administrator will keep all documentation on refunds in a locked file in alphabetical order by month.

4. If Administrator denies refund, the documentation is returned to Collector for review and clarification. Process to begin again for approval if Collector feels patient is owed a refund.

5. If the patient is not located within a year for the refund, the refund is turned over to the state as demanded by law.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: T. COLLECTION PROCESS	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

COLLECTION PROCESS:

1. Coding/Billing Coordinator will place copies of UB04 and/or CMS1500 forms in an electronic tickler file on day twenty one, (3) days after bill is mailed.
   Example: Bill is sent on the 4th – UB04 is placed in tickler file for follow-up on the 7th.

2. Collector will check tickler file for the day. He/she will call on each claim in the tickler file for the day. The Collector will note in system information obtained.
   Example: Claim in process, claim paid, claim not received.

3. Re-submit claim if insurance company reports they have not received claim.

4. Move tickler information to 14 days after first call and then on 14th day, make a 2nd follow-up call.

   Example: Call was made on 18th, move to 1st of the next month. Continue with step 2 to 4 until claim is paid. Ask for help at 45 days if not paid.

5. If insurance company says check is cut and mailed, place information in tickler file 7 days from date of call or day they say we will receive check. Follow-up with insurance company if check has not been received. Continue follow-up until account is paid.

6. Work aged accounts. Pick an aged category each week and work the accounts. Place follow-up notes in tickler file.

Aged account categories: Current, 31-60 days, 61-90 days, 91-120 days, 121-150 days, 151-180 days, 181 days and over.

Management will pick at least one aged account category each month and review. The findings from the review will be discussed with Collector.

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: U. HARDSHIP WRITE OFF PROCESS	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

Hardship Write-off Process

1. The Collector will identify a patient during her collection process that simply cannot afford to pay outstanding balance due the Center.
2. Once the Collector has identified the patient who potentially qualifies as a "Hardship Write-off", he/she sends the letter designed to accompany the Hardship Write-off for to the patient for completion.
3. The Collector documents this process in the patient's notes.
4. When the form is returned, the Collector reviews and confirms the patient is qualified for a Hardship Write-off.
5. If the patient qualifies, the form is forwarded to the Business Office Manager for approval.
6. If the Business Office Manager agrees with the Collector's assessment, the form is then signed and forwarded to the Administrator for review and signature.
7. If the Administrator agrees with the Business Office Manager, the form is then signed and forwarded to the collector.
8. The Collector will write-off the outstanding balance on the account when he/she receives completed form.
9. The Collector sends a copy of form and a statement showing zero balance to patient. The original is scanned into the EMR with patient's billing information.

* Hardship Write-off Form is found under 'Forms' tab in this Business Office Manual*

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: V. CRITERIA FOR HARDSHIP WRITE OFF	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

Criteria for Hardship Write-off

Criteria to include, but not limited to, the following:

- Fixed income with living expenses within $100.00 of income
- Income per month is under $1,000.00
- Long term illness with large medical debt
- Out of a job
- Disability on fixed income

* Hardship Write-off Form is found under 'Forms' tab in this Business Office Manual*

LEGACY SURGERY CENTER	IX. BILLING	
SUBJECT: W. CASH PAY PATIENTS PROCESS	ISSUED: OCT 2007 REVISED: NOV 2007	NUMBER:

1. The Scheduler will identify a patient with no insurance coverage.
2. The Scheduler will review the Charge Master to obtain pricing for the planned procedures.
3. The Scheduler will notify the patient of the price. The Scheduler can set up a payment plan with the patient. The plan is not to exceed six months unless extended time is approved by the Administrator.
4. A self -pay contract is signed with the patient, the patient must pay at least $100.00 for day of service.
5. The self-pay contract is scanned into the chart & attached to billing information. The patient is to receive a copy of the contract.
6. The Biller adjusts the balance to the agreed amount once the claim is produced. The patient is sent a statement immediately.
7. Determining the self-pay price:
    a. There is a fee schedule for cosmetic/plastic cases. The fee schedule will be followed.
    b. If the case does not involve any endoscopic or arthroscopic equipment, the price is 40% of the CPT Code price in the system (Charge Master).
    c. If the case does involve endoscopic or arthroscopic equipment, the price is 45% the CPT Code price in the system.
    d. If there are more than one CPT Codes, the following will apply:
        i. Determine cash CPT Code price for each procedure.
        ii. The highest CPT Code is billed at full cash price.
        iii. The second CPT Code is billed at 50% of the cash price.
        iv. The third CPT Code, etc.... is billed at 25% of the cash price.
8. Any questions are to be directed to the Administrator.

LEGACY SURGERY CENTER	X. CQI PLAN	
SUBJECT: TABLE OF CONTENTS	ISSUED: OCT 2007 REVISED: OCT 2007	NUMBER:

X. CQI PLAN

Source: Beverly A. Kirchner, RN, BSN, CNOR, CASC, President, Genesee Associates, Dallas.

_____ SURGERY CENTER

Confidentiality/Security Agreement
For Employees

_____ Surgery Center strongly believes in the balance of protecting patient information and privacy, while allowing its employees access to the information they need to successfully do their jobs. Security and confidentiality are part of everyone's job. Read each item carefully and ask questions if you need clarification.

Overall Confidentiality

1. I will treat all patient, physician, employee, and business information (i.e. medical, social, financial and emotional) acquired during the course of my work as strictly confidential (only to be discussed in private with appropriate individuals who need to know), whether on duty or off.
2. I will not release or disclose confidential information, unless my job requires it, and then only in accordance with Surgery Center policies.
3. I will access confidential information only on patients whose information I need in order to do my job, and understand that retrieving/viewing/printing information (computerized or paper) on other patients such as friends, relatives, neighbors, celebrities, or co-workers is a breach of confidentiality and can result in immediate termination and legal action.
4. I understand that access to a system is a privilege, and at no time am I authorized to use my system for other than its intended use or for my own personal gains or the gains of others.
5. I will appropriately dispose of confidential information and reports. I will never discard confidential patient identifying information in the regular trash (unless it has been shredded).

Confidentiality/Security Agreement

Computer System Security, as applicable

1. I will use only my password; I understand that my initials (my electronic signature) will be attached to each transaction that I input into the system. I am legally responsible for the accuracy of the information I input into the system as well as on the paper record. All inquiries, data entries, and orders performed using my password are permanently recorded.
2. I will not allow anyone to access a system by using my password. I will keep my password in confidence and will not disclose the password to anyone other than the System Administrator.
3. I will not attempt to use a password other than my own, nor will I attempt to gain access to any unauthorized system.
4. If I leave my workstation for any reason, I will exit my system so no unauthorized person may access confidential information or enter information under my password. I will make sure the paper record is not left open and unattended in areas where unauthorized people may view it.
5. If I have reason to believe that the confidentiality of my or another's password has been broken, I will notify my supervisor immediately.
6. I will not misuse or attempt to alter the computer system in any way. Only Center-approved and officially-licensed software may be added to the Surgery Center computers. All software installs must be handled through the Business Office Manager.
7. I understand that a violation of computer security is considered a violation of the Surgery Center Personnel Rules on confidential information and is subject to disciplinary action, including immediate discharge. Violation of any component of this Agreement may result in termination of my association with the Surgery Center or legal action.
8. I further understand that my password will be deleted from the system as soon as I terminate my association with _____ Surgery Center.
9. I will ask my supervisor for clarification if there are any items I do not understand before signing this Agreement. My signature below acknowledges that I have read and understand this Agreement and realize that it is a condition of my employment/association with _____ Surgery Center. I may request a copy of this signed Agreement.

_____ _____

Signature Date

_____

Name (Please print)

Source: Tucson (AZ) Orthopaedic Surgery Center.

Employee Manual: Confidential Information.

Confidential Information

In the course of employment with _____ *Surgery Center*, employees may have access to proprietary and other confidential information regarding business activity. This information should be used only in the course of work.

Contact between patients and surgery center personnel is privileged and highly confidential. It is your responsibility to hold any information concerning patients and members of our medical staff in absolute confidence. We are providing a valuable and personal service to our customers, and their privacy is our obligation and responsibility.

Any employee violating the stated Privacy Practices of _____ *Surgery Center* will be subject to disciplinary action as well as possible criminal and civil penalties per the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Source: Tucson (AZ) Orthopaedic Surgery Center.

Sponge ACCOUNTing System
Use of Plastic Hanging Sponge-Holders and a Dry Erase Board

This process involves the use of plastic hanging blue-backed sponge-holders which each contain 5 pouches. Each pouch has a thin center-divider which separates each pouch into 2 pockets. One sponge should be placed in each pocket. One sponge per pocket, 2 pockets per pouch and 5 pouches per holder means that each holder can accommodate 10 sponges. We recommend that each holder always be set up to hold 10 sponges be they laparotomy pads or raytex and different types of sponges should not be mixed within one holder. The sponge holders are held on racks mounted to IV poles. Each rack can usually accommodate 10 sponge holders (5 on each side) which is 100 sponges! A wall-mounted dry erase board to record operative information and the IN counts should be easily visible in each room. This process should be standardized for use throughout all operating rooms on every case that uses sponges.

The single most important element in the use of the hanging sponge-holders is to make sure that "the final count" is taken when ALL the sponges that have been opened during the case (used and unused) have been placed in the holders. The surgeon and nurse can then visually verify "SHOW ME" that all sponges have been accounted for and none remain in the patient.

1. Use sponge holders for laps and raytex on all cases that require a sponge count.
2. Hang the holders on the special racks attached to designated IV poles. Use a separate holder for each sponge type e.g. one for laps, one for raytex.
3. Used sponges coming from the operative field should be placed into a CLEAR plastic bag-lined receptacle (e.g. kick buckets or ring stands).
4. Take each used sponge from the receptacle. Make sure you have only one sponge. Open it up to its full length and then fold it up into an oval. Place one (1) sponge per pocket; two (2) sponges per pouch; ten (10) sponges per counter.
5. Put the first sponge in the LAST pocket in the bottom of the holder. Load the holder horizontally from the bottom row to the top row, filling first the bottom two pockets and continuing upwards. This process (going from the bottom to the top) will make visual determination of the filled holder easier to see from the OR table.
6. Place the folded sponge inside the pocket with the blue tag or blue stripe visible. The blue stripe must be visible because this is what differentiates a sponge with a radiographic marker from a dressing sponge. When viewing the holder note the blue stripe not the white sponge. Place another sponge in the other pocket in the other side of the pouch. Periodically throughout the case put the used sponges in the holder.
7. At the time of the final count, ALL sponges MUST be in the sponge holders and the final verification must be taken by two people viewing the sponge holders.
8. Keep a running total of the sponges added to the surgical field on the dry erase board using the same format that is used to count needles. The last number should always be the total number of sponges currently on the field.
9. At a permanent change of relief, the number of sponges in the holders should be physically reviewed using visual and audible communication between the circulating nurses changing positions before the relieved nurse departs the OR.
10. Sponge holders should remain hanging in their racks from the IV poles or they may be placed in CLEAR plastic bags if the IV poles become overloaded. However, the final count must have visual confirmation of all sponges in the holders to ensure that each holder is fully loaded with 10 sponges.

Verna C. Gibbs M.D. January 2009

Sponge ACCOUNTing System
Methodical Wound Examination

1. A methodical exploration of the operative wound must be conducted prior to closure in every operation. The space to be closed must be carefully examined. Special focus should be given to closure of a cavity within a cavity (i.e., heart, major vessel, stomach, bladder, uterus, and vagina). Surgeons should strive to **see and touch** during the exploration whenever possible; reliance on only one element of sensory perception is insufficient. The surgeon should visually and manually make every effort to assure that no unintended surgical items have been left in body cavities. The general process is to look and feel in the recesses of the wound and examine under fatty protuberances and soft-tissue appendages.

2. Unless clinically contraindicated for a specific patient, the following steps should be taken for procedures performed in the abdomen or pelvis. These steps should be performed before removing stationary or table mounted retractors.
    a. Examine all four quadrants of the abdomen with attention to:
        i. Lifting the transverse colon
        ii. Checking above/around the liver and above/around the spleen
        iii. Examining within and between loops of bowel
        iv. Inspecting anywhere a retractor or retractor blades were placed
    b. Examine the pelvis
        i. Look behind the bladder, uterus (if present) and around the upper rectum.
    c. The vagina should be examined if it was entered or explored as part of the procedure.

3. Unless clinically contraindicated for a specific patient, the following general steps should be taken for procedures performed in the mediastinum or thorax.
    a. In a mediastinal procedure, if the mediastinal pleura were opened, examine the ipsilateral pleural cavity.
    b. In a cardiac procedure, elevate the apex of the heart and examine the retrocardiac space. Examine the transverse sinus to the right and left of the aorta and pulmonary artery.
    c. In a thoracic procedure, examine the thoracic cavity with attention to the thoracic apex and base of the lungs, paravertebral sulcus, and inferior recesses of the diaphragm. Place a hand or finger behind the lung and palpate from apex to base.

4. If the surgeon is informed of a missing object by the circulating nurse, while the OR staff are looking for the surgical item, the surgeon should stop closing the wound and repeat the methodical wound examination.

Verna C. Gibbs M.D. January 2009

Sponge ACCOUNTing System
Guidelines for Intra-operative Radiographs

On occasion, an incorrect count is obtained and under these circumstances or when indicated by OR policy an intra-operative radiograph is required.

A written request for a "STAT image for foreign body detection" will be generated by the circulating nurse in a specific operating room under the name of the attending surgeon listed in the operation record as being responsible for the conduct of the operation.

The request will specify:

1. The name of the attending surgeon,
2. The kind or type of foreign body being looked for. Sponge, needle, name of instrument, other item. If a sponge is the missing item specify the type e.g. lap pad, raytex, towel
3. The OR room number and the telephone number for that room
4. The name of the circulating nurse or designated person in room to receive call back information
5. The nurse will note on the written request the time the request was submitted
6. Upon receiving the request a radiology technologist will take a radiograph of the appropriate site as requested by OR personnel. This should be accomplished expeditiously, but the elapsed time should never exceed twenty minutes. The technologist will note time request received and time radiograph taken on the request slip. Nurse will initial (in agreement) time of request.

The technologist taking the radiograph will call ahead to alert the radiologist on duty that a wet read to r/o foreign body is needed from a specific OR. The technologist will notify the radiologist by phone when imaging has been completed, and note the time the radiologist was notified that the study is available for viewing. The technologist should remain on the phone with the radiologist in case additional views are required.

The technologist will return to the OR to take a hard-copy film to the OR if requested by the peri-operative care personnel in the OR or if requested to take additional views

The radiologist on duty will review the film or the digital images of the radiographs and will call the specified OR with the results of their examination or with a request for additional views to be obtained. This should be accomplished expeditiously. The elapsed time should never be greater than twenty minutes. In the event that the radiologist on duty should require additional assistance or consultation to establish a diagnosis, the OR should be notified that such a secondary review is underway.

The person who answers the phone in the operating room and receives the results must be a member of the operating team – nurse, surgeon or anesthesiologist. The results must have "read back" confirmation and the findings documented in the operative record.

The radiologist will dictate the report following verbal transmission of the findings. The name and identifying number of the individual to whom the information was provided must be on the report or if "read back" was provided, indicate as such. The radiologist will note the time the information was transmitted.

Performance audits can be conducted to determine if timeliness guidelines have been met.

Verna C. Gibbs M.D. January 2009

Sponge ACCOUNTing System
Guidelines for the Anesthesia Provider

Preoperatively

When making purchasing decisions, try to choose sponges, instruments, and other devices that are visually distinct from those used in the surgical field. Any equipment that is left in the patient, even temporarily, should have a radiopaque component to permit identification with radiographs. Use a trash receptacle that is visually distinct from any used for the surgical field. Do not discard anesthesia related equipment into "kick buckets" or other surgical receptacles, and don't allow surgical equipment to be discarded into the anesthesia trash.

Do not borrow equipment such as scissors or sponges from the surgical field. Be sure to remove any equipment used for anesthesia procedures from the operating table before the operation starts. Clamps and needles used for central line placement, for example, need to be carefully collected and cleared from the field. Make sure that "the count is correct" for your own procedures.

Intra-operatively

If any items fall from the surgical field, be sure to inform the surgical team, including the circulator, immediately. Dropped items need to be promptly returned or discarded to ensure that they are properly accounted for.

If you assist the scrub team by retrieving items such as extra sutures or sponges for the instrument table, promptly inform the circulator of exactly what was opened. Opening extra equipment without properly adding them to the count will certainly lead to a discrepancy at the end of the procedure.

Postoperatively

Help foster team cooperation by actively asking near the end of the procedure if the appropriate counting procedures have been done. Try not to disturb the nursing staff while they are counting unless absolutely necessary. “Take a Pause for the Gauze.” Completion of the proper accounting practices is the responsibility of the entire operative team.

If the patient is stable, do not perform irreversible actions such as neuromuscular blockade reversal or extubation until the final count is complete.

Carefully check any discarded drapes or blankets for hidden instruments or sponges. Also, make sure that throat packs, bite blocks, and other such devices are removed from the oropharynx at the appropriate time.

In the Event of a Miscount

If the count reveals a discrepancy, help the operative team by keeping the patient safely anesthetized, if possible. Do not allow avoidable anesthetic issues to pressure the team to perform a less than diligent search. Assist the surgical team when possible, but remain vigilant about the patient's condition, especially since the rest of the team may be distracted by the accounting procedures. If the patient's medical condition is too unstable to warrant further delay, clearly communicate this to the surgeon so that a reasoned decision can be made weighing the risks of a retained item versus the benefits of ending the anesthetic.

Verna C. Gibbs M.D. January 2009

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