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Medicare surveys change under new Conditions for Coverage

Ambulatory surgery centers (ASCs) undergoing Medicare accreditation surveys under the new Conditions for Coverage (CfCs) that took effect in May 2009, are reporting that the surveys are longer than in the past, have more surveyors, and put a much stronger emphasis on infection control.

At North Shore Surgical Center in Lincolnwood, IL, a recent survey took three days, although it originally was scheduled for two, says **Kim Zidonis**, RN, administrator. "There was so much information that they needed input on, it took a whole additional day," she says.

The Centers for Medicare & Medicaid Services (CMS) has just approved a process change for ambulatory surveys seeking deemed status from The Joint Commission (TJC), according to **Michael Kulczycki**, MBA, executive director of ambulatory care accreditation at TJC. TJC will "sample" closed patient records and credentialing/privileging files of surgeons on staff, Kulczycki says. "This is critical in passing along to TJC customers the 'efficiencies' of this process vs. relying on state survey processes in which they may allocate two, three, or four additional days of survey activity," he says.

Another change to the Medicare surveys under the new CfCs is that instead of one surveyor, there are two or three, says **Monica Daniel**, principal with AXIOM Integrated Services, a Chicago-based consulting group for

EXECUTIVE SUMMARY

You will need to make some significant changes to be prepared for accreditation surveys under the new Medicare Conditions for Coverage (CfCs).

- Expect a longer survey with more surveyors.
- Infection control is a significant focus. Make sure you know your equipment, and verify that staff members are following your policies and procedures.
- Have a list of multidose medications and the average number for patients per vial or container.
- At least one patient will be traced from arrival to discharge.

ambulatory health care organizations. Their primary focus is infection control, especially sterilizers, Zidonis reports. **[A "Checklist for Medicare Survey — Infection Control (Excerpt) is enclosed with the online issue of *Same-Day Surgery.*" For information on how to access, contact customer service at (800) 688-2421 or customerservice@ahcmedia.com.]** The surveyors are using the new infection control worksheet, she says. **(*Same-Day Surgery* ran a copy of the draft survey in the online version of the March 2009 issue with the story "Centers come under tighter scrutiny for infection control practices," p. 21.)** One surveyor must complete the form, but it includes input from the survey team, says **Michon Villanueva**, assistant director of accreditation services for the Accreditation Association for Ambulatory Health Care (AAAHC). The form is completed based on direct observation and interviews with the staff. Instead of talking with administrators, surveyors will "ask the appropriate individual as to how they perform their task," says Villanueva, who spoke about accreditation to the most recent meeting of the Texas Ambulatory Surgery Center Society.

Quality data, education are two focuses

The Medicare surveys formerly were policy- and procedure-driven, Daniel says. "Now it's gearing into a lot of leadership, education, as well as still looking at policies and procedures and how it correlates, but also looking hard at quality data," she says. Specific items examined include how infection control relates to your quality; how your program educates staff, physicians, and any outside staff; and how you incorporate infection control into education.

At North Shore, surveyors hit on the topic of infection control "very, very hard," Daniel says. Now, she says, surveyors will ask, "What are your quality indicators for infection control, and how are you monitoring them and how are they reported to the board?"

Zidonis said she had to educate surveyors on the difference between steam sterilizers, liquid sterilizers, and gas sterilizers. "There was a lot of time training the inspectors, in a sense," she says. The surveyors wanted to ensure the center was following manufacturers' instructions for the sterilizers, Zidonis says.

Consider putting all of your infection control information into one binder as a one-stop shop, says Daniel, who said they provide this service for their clients.

"When you sit in front of a surveyor, and they say, 'Tell me about your infection control program,' you think, 'Where do I start?'" she says. "If you can show them what your infection control program encompasses, it makes it easier for surveyors. If you make it easy for them, they'll be out of your center faster." **(For specific advice on the infection control part of the survey, see p. 27.)**

Here are additional survey changes:

- **Multidose medications.**

Surveyors will want a list of all multidose medications at your facility, Daniel warns. They want

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the names of the medications and the average number for patients per vial or container, she says.

"If you have number of multidose medications, and list isn't completely ready, staff can be caught off guard, because that's a lot of calculations for lots of medications," Daniel says. Have a complete list of medications and any product inserts ready for surveyors, she advises.

- **Tracers.**

Observing a procedure wasn't previously required for a Medicare survey, says Villanueva. "The new survey protocol outlines the expectation that the surveyor that observes the procedure is there from pre-op to post-op, and follows the patient throughout," she says.

At least one procedure will be selected, and it should be one that isn't expected to exceed 90 minutes, Villanueva says. Surveyors will be looking at "not just what happens with the patient, but all staff activity," she says. For example, they will determine whether staff members are following appropriate sterile techniques and whether they are adhering to policies and procedures, Villanueva says. In addition to infection control, other areas that will be examined include the physical environment, medication administration, assessment of anesthesia and procedure risk, pre-op update assessment of changes from the history & physical, provision of surgical and anesthesia services, the post-surgical assessment, recovery, and discharge orders.

For example, surveyors want to ensure all patients are discharged in the company of a responsible adult, except those patients exempted by the attending physician, according to a memo sent by AXIOM to its clients.[1] AXIOM recommends that you review your policies for those patients who don't mandate a ride home. The regulations state "exemptions must be specific to individual patients, not blanket exemptions to a whole class of patients," according to AXIOM. Ensure that each patient has a discharge order, signed by the physician who performed the surgery or procedure, it advised.

In terms of anesthesia services, surveyors will look at your use of certified registered nurse anesthetists (CRNAs) and their supervision, AXIOM said. If CRNAs or other allied health professionals are used, identify who has been granted authority for supervision, it advised. Ensure this information is documented in the privileges, AXIOM said.

Another change from past surveys is that managers formerly told members of their staff to respond only to what the surveyor is asking for, Daniel says. Now, surveyors are asking vague questions, and staff members should go through the answer in a detailed manner to ensure it's complete, Zidonis says.

"I suggest knowing everything step by step so you can give a good and complete answer," she says. "Make sure the staff understands it as well." **(For steps to prepare for a survey, see story, below. Also see story on how patient rights are handled, p. 28.)**

Reference

1. AXIOM Consulting Group. *Memorandum: CMS Conditions for Coverage 2009 — Updated 10/14/09*. Issued Oct. 23, 2009. ■

Here are steps to prepare for accreditation survey

When preparing for your accreditation survey under the new Medicare Conditions for Coverage (CfCs), consider the survey to be an "open-book test," says **Michon Villanueva**, assistant director of accreditation services for the Accreditation Association for Ambulatory Health Care (AAAHC).

"I'm simply stressing to surgery centers that they have the ability to look at exactly what the state agencies and accrediting agencies are tasked to do, because they can look at the interpretive guidelines," Villanueva says. "It's an opportunity to educate themselves. Everything is out there to prepare for a Medicare survey."

For your survey, you'll need a list of surgeries from the past six months, says **Michael Kulczycki**, MBA, executive director of ambulatory care accreditation at The Joint Commission. You should have a list of cases in the past 12 months in which any patients were transferred to a hospital or the patient died, he says.

Have all documents related to your infection control program including, for example, a description of the program, policies and procedures, and surveillance data, he says.

Make sure you know your infection control equipment, and ensure the manufacturers' guidelines are followed in your policy, as well as your day-to-day practice, says **Kim Zidonis**, RN, administrator at North Shore Surgical Center in Lincolnwood, IL, which recently was surveyed.

Monica Daniel, principal with AXIOM

Integrated Services, a Chicago-based consulting group for ambulatory health care organizations, says, "I can't reiterate it enough. You may think you know what staff is doing," Daniel says. For example, you've had a protocol for doing sterilizer testing in place, but you find that staff aren't following that protocol. Check with staff and verify what they're doing, she says.

Daniel has seen programs that had a change of personnel, and practices that were not in the policies and procedures were carried on by a new staff person. "So you might have known two months ago that everything was in place, but now there's a new person, and there's a state survey, and you say, 'We've always been doing leak test every day,' and all of a sudden they're not doing it," she says. ■

Patient rights handled differently from the past

When North Shore Surgical Center in Lincolnwood, IL, was surveyed recently under the new Medicare Conditions for Coverage (CfCs), the patient tracer was handled differently than in past surveys, says **Kim Zidonis**, RN, administrator.

Zidonis reports that during her survey, the surveyors were there when the patient checked in and checked to ensure the patient had received the center's bill of rights prior to coming in, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) agreement and advance directives.

In a memo to its clients, AXIOM Integrated Services, a Chicago-based consulting group for ambulatory health care organizations, wrote that organizations should send the patient rights, which should incorporate all of the components outlined in the CfC, to the patients when they're scheduled.[1]

You might want to incorporate the patient rights into a "physician marketing packet" and ask the physician to provide this information to the patient when scheduled for surgery, AXIOM advised. Also, you can post the patient rights on your web site for patients to retrieve, it wrote.

AXIOM noted that the patient rights must be provided in a language and manner that the patient can understand, so this requirement might mean you need to translate the forms.

It wrote that providing the patient this notice for the first time on the day that the surgical procedure is scheduled to occur is not acceptable, unless:

- the referral to the ASC is made on that same date;
- the referring physician indicates, in writing, that this is medically necessary for the patient to have surgery on the same day, and that surgery in an ASC setting is suitable for the patient. The Centers for Medicare & Medicaid Services (CMS) would consider "medically necessary" to be emergency cases or when the patient's health/safety would be jeopardized if the surgery were performed one day later, according to AXIOM.

Reference

1. AXIOM Integrated Services. *Memorandum: CMS Conditions for Coverage 2009 — Updated 10/14/09.* Issued Oct. 23, 2009. ■

Joint Commission focuses on the operating room

When Mendocino Coast Hospital in Fort Bragg, CA, recently underwent its accreditation survey by The Joint Commission, the biggest surprise was the scrutiny on and large amount of time spent in the operating room in the surgery area vs. the nurses' floor, says **Susan Bivins**, RN, the director of quality and risk management.

"I really thought it would be the other way around," she says. "I think [the surveyor used to be] an OR nurse and felt very comfortable there." The nurse spent a significant amount of time in the GI lab and watched an ophthalmology surgery. She looked for timeouts and site verification, Bivins recalls.

"Looking at our operating room really surprised me, because it's always an area that's usually so well run and nonproblematic that they usually do a pass-through of the outpatient department and on to the acute floor," she says. "Although [the surveyor] didn't find many things wrong in the area, she did spend a lot of time there. That was quite a surprise and I kept thinking, 'She's shorting all the other departments.'"

The OR did not come out of the process unscathed. The physicians had been resisting marking the surgical site, and the hospital was cited, Bivins says. "And fortunately, our chief of staff was there, heard the citation, heard the discussion, understands the problems, and will make it happen," she says. "Now it's made believers out of them, and we will be changing that." Bivins expects

SOURCE

For more information about surveys by The Joint Commission, contact:

- **Susan Bivins**, RN, Director of Quality and Risk Management, Mendocino Coast Hospital in Fort Bragg, CA. E-mail: sbivins@mcdh.net.

to have more clout when she goes to the medical staff in the future to say a change is required.

The surveyor also reviewed the post-op notes on patients returning to the nurses' floor from outpatient surgery. She cited the facility for "not documenting the fact that we educated the patient on what to expect," including informing them of such things as the site would be marked, two forms of identification would be checked, and that the patient should notify the nurse if he or she experienced pain, fever, or other adverse events, Bivins says.

Now, the outpatient surgery pre-op form will include a box that signifies the patient has been educated. For inpatients, the box will be on the post-op checklist, she says.

Additionally, an engineer came the first day to review the life safety standards. The surveyor was complimentary but the hospital was cited twice, Bivins says. One was for clutter in the hallways.

"We had a gurney in the hallway, and we had the COWs [computers on wheels] in the hallway. [The surveyor] went by with his 8-foot tape measure to make sure the egress was 8 feet, and it wasn't," Bivins says. She points to the difficulty of trying to find places to store things and questions about where to put the carts when the nurse is with a patient and leaves it at the door. The hospital now has designated storage areas on both ends of the hallway where the carts will be stored. **(For more information about problems and accolades during the survey, see below.)** ■

Surveyor examines recredentialing process

When Mendocino Coast Hospital in Fort Bragg, CA, recently underwent its accreditation survey by The Joint Commission, there was a hard lesson learned.

The medical staff coordinator who works on the recredentialing process "was under the opinion from previous surveys that as long as the final reappointment approval fell within the month of the two years previous, it was OK, which meant that if the board meeting met at the end of the month for the final approval, then that would be approved," says **Susan Bivins**, RN, director of quality and risk management at Mendocino Coast.

During the survey, the coordinator learned that the recredentialing had to be before 24 months exactly. "The surveyor actually called back to The Joint Commission to clarify that" when the medical staff coordinator said she'd been told it had to be within the month of the previous date, Bivins says. The surveyor said it had to be before 24 months.

"So, we missed the whole group of our department of medicine; a whole big group of them missed the reappointment date by three days," Bivins says. "But it's an easy fix, she says. "We'll just move everything up a month," she says.

Where they received compliments

Surveyors were complimentary of the hospital's work on the ongoing professional practice evaluation (OPPE) and the focused professional practice evaluation (FPPE). Bivins says the surveyor commented those areas have been a problem for many providers.

Another compliment went to Mendocino's medication reconciliation process, another tough spot for most providers. "We have a really good program," Bivins says. Bivins credits the success to the pharmacy department, which championed the program. The surveyor took with her copies of the medication reconciliation form.

Bivins says they have strong policies in place for monitoring and labeling look-alike, sound-alike, high-alert drugs, as well as disposing of narcotics such as fentanyl patches, which the surveyor commented was one of the strongest she'd seen. "We log the drug in, and it goes to a special receptacle, so it's checked there, and there's no concern of someone getting a hold of it and siphoning out the drugs or disposing of them in the regular trash," Bivins explains.

The surveyor also was impressed with the sample medication storage in the health clinic. Bivins says when the hospital took the clinic over, there were drug samples everywhere. And it was "a hard sell" to change that, but again the pharmacy department took charge.

Surveyors also complimented the hospital's

use of healing techniques such as guided imagery CDs for surgeries. Its anticoagulation clinic also received a good mark.

The surveyor did spend a lot of time on infection control and hand hygiene surveying, Bivins says. The hospital had started surveying hand hygiene observance in July, but had not compiled the results yet or had enough data to aggregate and report on, she says. The surveyor cited them for "not having gone to the next level of taking the results and really looking at what we're doing. So, we just need to tighten that up, but we had a good process in place," Bivins says. ■

New standard of care in SSI prevention

Move to chlorhexidine-alcohol patient prep expected

The clear conclusion of a recently published study is preoperative cleansing of the patient's skin with chlorhexidine-alcohol is hands-down better to cleansing with povidone-iodine for preventing surgical-site infection after clean-contaminated surgery.[1] Now it gets interesting.

For starters, povidone iodine is used as the skin prep in almost three-quarters of all surgeries, with chlorhexidine alcohol the choice for only about 10% of operations to cleanse patient skin. Costs — for the solutions and materials, not for the later surgical-site infections (SSIs) — are a clear factor in that unbalanced proportion. However, the nature of the clinical trial means the results can be widely extrapolated to other settings, says lead author **Rabih O. Darouiche**, MD, lead author and director of the Center for Prostheses Infection, Baylor College of Medicine in Houston. In short, it's a game changer.

"Overall, we saw a 41% reduction" in SSIs, he reports. "I cannot think of any confounding variable that essentially would change the potential efficacy of a certain antiseptic preparation in one city vs. another or one hospital vs. another. This is a really easy — a practical, quick, and very powerful approach. I really see no barriers that could limit the implementation of this approach on a national basis."

Since 2002, the Centers for Disease Control and Prevention has recommended chlorhexidine-alcohol for skin cleansing of the insertion site for vascular catheters. However, the CDC has not issued a similar recommendation for skin cleansing at surgical sites, citing a lack of clinical evidence. Until now. Published in *The New England Journal of Medicine*, Darouiche's study is expected to lead to new CDC recommendations for surgical-site prep to prevent endogenous infections from patient flora.

Talking to AHC Media, publisher of *Same-Day Surgery*, the day the clinical trial results were published, Darouiche observed, "Many experts of the field think these results should be able to switch the standard of care from povidone-iodine to chlorhexidine-alcohol for preoperative skin cleaning."

One of them is veteran health care epidemiologist **Richard Wenzel**, MD, professor and chairman of the department of internal medicine at the Medical College of Virginia in Richmond, who wrote an accompanying editorial on the study.[2]

"The switch to a different skin prep would be at some additional cost, but it is very small compared with preventing 40% of surgical-site infections," Wenzel tells AHC Media. "And this is not an extra procedure. There is no opportunity costs in other words for the surgeon, he or she is already going to do a prep, and they are just changing the materials. It's absolutely remarkable."

Breaking down the cost factors

The cost of the applicator that contains the chlorhexidine and alcohol is about $6 — roughly twice as much as the iodophor product, Darouiche explained.

"On average, we applied two applicators that contained chlorhexidine-alcohol on the skin of an individual patient in the study, so for each patient who received chlorhexidine-alcohol an additional cost of $9 was incurred," he adds. "This study showed that you would have to apply chlorhexidine-alcohol rather that povidone-iodine in 17 patients in order to prevent one case of surgical-site infection. So, 17 patients times $9 is $153. That pales in comparison to how much money you can save by preventing the onset of surgical-site infection, which we know can cost anywhere from a few thousands of dollars to tens of thousands of dollars."

The Darouiche clinical trial randomly assigned adults undergoing clean-contaminated surgery in six hospitals to preoperative skin preparation with chlorhexidine-alcohol scrub or povidone-iodine scrub and paint. Enrolled patients were randomly assigned in a 1:1 ratio to have the skin at the surgical site preoperatively scrubbed with an applicator that contained 2% chlorhexidine gluconate and 70% isopropyl alcohol or preoperatively scrubbed

and then painted with an aqueous solution of 10% povidone-iodine. The primary outcome was any surgical-site infection within 30 days after surgery.

A total of 849 subjects (409 in the chlorhexidine-alcohol group and 440 in the povidone-iodine group) qualified for the intention-to-treat analysis. The overall rate of surgical-site infection was significantly lower in the chlorhexidine-alcohol group than in the povidone-iodine group (9.5% vs. 16.1%). Chlorhexidine-alcohol was significantly more protective than povidone-iodine against both superficial incisional infections (4.2% vs. 8.6%) and deep incisional infections (1% vs. 3%) — but not against organ-space infections (4.4% vs. 4.5%).

"Actually we never anticipated that this would reduce the rate of organ-space infection," Darouiche explains. "Most incision infections are caused by organisms that reside on the patient's skin. That's why we anticipated that the chlorhexidine alcohol would significantly reduce the rate of incisional infections, but the skin antiseptics are not expected to find the way below the incisional area and prevent infection in deep organs and spaces."

Moreover, efficacy of infection prevention was not dependent on the organism, meaning MRSA, and all its attendant costs, is as likely to die on the patient's skin as any other bug. Culture of the surgical site in 60 of 61 infected patients yielded growth of organisms (a total of 107 isolates) and similar proportions of infected patients in the two study groups. Gram-positive aerobic bacteria (63 isolates) outnumbered gram-negative aerobic bacteria (25 isolates) by a factor of 2.5, with 38% of cultures polymicrobial.

"The protection by chlorhexidine-alcohol was essentially the same across different groups of organisms," Darouiche emphasizes.

The 41% reduction in SSI risk is comparable to a 49% reduction in the risk of vascular catheter-related bloodstream infection in a meta-analysis that showed the superiority of skin disinfection with chlorhexidine-based solutions vs. 10% povidone-iodine.[3] Although both the antiseptic preparations studied possess broad-spectrum antimicrobial activity, the superior clinical protection provided by chlorhexidine-alcohol is probably related to its more rapid action, persistent activity despite exposure to bodily fluids, and residual effect, Darouiche hypothesizes. As a result, some infections that might have been seeded from the patients' flora during the procedure are prevented. Since two-thirds of surgical-site infections are confined to the incision, optimizing skin antisepsis before surgery could result in a significant clinical benefit and immense cost savings, he emphasizes.

"Personally, I think better patient care is the primary outcome, and everything else is secondary to that," Darouiche says.

References

1. Darouiche RO, Wall MJ, Itani K, et al. Chlorhexidine-alcohol vs. povidone-iodine for surgical-site antisepsis. *New Eng J Med* 2009; 362:18-26.
2. Wenzel, R. Minimizing surgical-site infections. Editorial. *New Eng J Med* 2009; 362:75-77.
3. Chaiyakunapruk N, Veenstra DL, Lipsky BA, et al. Chlorhexidine compared with povidone-iodine solution for vascular catheter-site care: A meta-analysis. *Ann Intern Med* 2002; 136:792-801. ■

Start planning now for transition to ICD-10

The ICD-10-CM code set is scheduled to replace ICD-9-CM, the current U.S. diagnostic code set, on Oct. 1, 2013. While that date is in the far future, you should prepare now, coding experts warn.

"The planning stages for how to train staff should be in mind now," says **Stephanie Ellis**, RN, CPC, owner and president of Ellis Medical Consulting, a Brentwood, TN-based consulting firm surveying ambulatory surgery facilities and physician practices for coding and compliance. Ellis spoke at a recent ASC Coding Seminar sponsored by the Ambulatory Surgery Center Association.

You will need to provide significant education and training for physicians, coders, billers, and other health care staff to fully implement this major coding change, Ellis says. However, there is no need for coders to begin training immediately, she says. "Once ICD-10 is implemented, certified coders holding a credential with AAPC [the American Academy of Professional Coders] will have two years to pass an open-book, online proficiency test on ICD 10, which they must do to keep their coding certification," Ellis explains.

In many ways, ICD-10-CM is similar to ICD-9-CM, she notes. For example, the guidelines, conventions, rules, and organization of the codes are alike, Ellis says. "Coders, billers, and providers who are currently qualified to use ICD-9-CM codes should be able to make the transition to ICD-10 coding," she says. **(For a comparison of the two systems, see graphic, p. 32.)**

There is one deadline that providers need to

Comparison of ICD-9-CM and ICD-10-CM

Issue	ICD-9-CM	ICD-10-CM
Volume of codes	Approximately 13,600	Approximately 120,000
Composition of codes	Mostly numeric, with E and V codes alphanumeric. Valid codes of three, four, or five digits.	All codes are alphanumeric, beginning with a letter and with a mix of numbers and letters thereafter. Valid codes may have three, four, five, six, or seven digits.
Duplication of code sets	Currently, only ICD-9-CM codes are required. No mapping is necessary.	For a period of up to two years, systems will need to access both ICD-9-CM and ICD-10-CM codes, as we transition from ICD-9-CM to ICD-10-CM. Mapping will be necessary so that equivalent codes can be found for issues of disease tracking, medical necessity edits, and outcomes studies.

Source: American Academy of Procedural Coders, Salt Lake City.

prepare for now, says **Cristina Bentin,** CCS-P, CPC-H, CMA, principal for Coding Compliance Management, a Baton Rouge, LA-based health care consulting company specializing in the markets of ambulatory surgery centers and surgical hospitals with emphasis on coding support, reimbursement, and training. "Ambulatory surgery providers should be aware that before ICD-10-CM/PCS can be utilized, systems need to first undergo system upgrades for HIPAA ASC [Accredited Standards Committee] X12 version 5010 transactions of which the Level 1 internal testing compliance deadline is Dec. 31, 2010," Bentin says. "Level 1 compliance is achieved when a covered entity can demonstrably create and receive compliant transactions."

While outpatient surgery providers don't need to panic, another item they need to examine early is the system used for coding and billing claims, Ellis says. "They need to check with their system vendor and be sure they will be doing whatever they need to do so that they will be ready to handle the change to ICD-10 in a timely manner," she says.

Providers should check with the clearinghouse they use for claims about the same issue, Ellis says. "They need to make sure that any coding software they use will be prepared in enough time to be usable with cross-coding tables for converting diagnosis and/or procedures in words to codes and ICD-9 codes to ICD-10 codes," she says.

Providers should check with their largest payers about dates of when they will expect their codes on claims to be filed using ICD-10 codes as well, Ellis points out. "Provider billing systems should have the capability to file claims with both ICD-9 and ICD-10 codes when the changeover first occurs, because not all payers will observe the same 'going live' date to accept ICD-10 codes," particularly Medicaid programs, who frequently are years behind any changes to codes due to budget issues, she warns.

For up to two years, systems will need to access ICD-9-CM and ICD-10-CM codes, as providers transition from one system to the other. Mapping will be necessary to find equivalent codes for purposes of disease tracking, medical necessity edits, and outcomes studies.

There's much preparation needed, Bentin says. "Many ambulatory surgery [providers] are overwhelmed at the thought of converting to ICD-10," she says. However, there are multiple resources, including the American Health Information Management Association (www.AHIMA.org), she says. **(See additional resources, p. 33.)** "Education is the biggest challenge for the facility," Bentin says. "Coders should begin familiarizing themselves with ICD-10 now rather than later." **For a list of benefits of the new system, see p. 33.)** ■

RESOURCES

- **For general ICD-10 information**, go to www.cms.hhs.gov/ICD10.
- **For more information on the ICD-10 code set**, go to www.who.int/classifications/icd/en.
- **For ICD-10-CM coding system, mappings, and guidelines**, go to www.cdc.gov/nchs/icd.htm.

What's the reason for a new diagnosis system?

CMS predicts fewer rejected claims

The United States is implementing ICD-10 because the ICD-9-CM has several problems, primarily that it is out of room for expansion, says **Stephanie Ellis**, RN, CPC, owner and president of Ellis Medical Consulting, a Brentwood, TN-based consulting firm surveying ambulatory surgery facilities and physician practices for coding and compliance.

"Medical science keeps making new discoveries, and there are no numbers to assign these diagnoses," she says. "The more detailed ICD-10 codes will help streamline claims submissions by making claims much easier for payers to understand."

ICD-10-CM increases the number of codes from about 13,000 codes in the ICD-9-CM for diagnoses to 68,000 ICD-10-CM codes. The ICD-10-CM codes are up to seven characters in an alpha-numeric system.

The Centers for Medicare & Medicaid Services (CMS) lists the long-term benefits of ICD-10-CM to be:

— ICD-10 codes can better accommodate new procedures. An estimated 1% of all procedures each year are new.

— There are expected to be fewer improper and rejected claims using ICD-10.

— ICD-10 offers improved disease management.

— ICD-10 offers an improvement in disease monitoring worldwide, because most other countries already are using ICD-10-CM codes. ■

Same-Day Surgery Manager

Addressing fragmentation of surgical services

By **Stephen W. Earnhart**, MS
CEO
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Inpatient surgery is on the fifth floor. L&D is on the third floor. The GI center is near the ED in the first floor. The outpatient surgery center is on two. The lithotripsy is in a trailer in the parking lot. The heart center is in the medical office building across the street. The spine center is down the hall. Whew! The oncology center is . . . somewhere. The breast center is to the right of the elevators, fourth floor, in the new pavilion, over near the duck pond, on Bleecker Street.

Be honest: How close am I?

Where are we going with this? Is it any wonder we are having health care reform shoved down our throats? Is it any wonder that anesthesia is throwing its arms in the air trying to figure out how to cover all these locations? Consider the plight of the poor patient who has to find an operating room location based upon body part. It is silly and is out of control.

How did we get so fragmented? I am a great proponent of separating inpatient from outpatient. They are completely different classes of patients with differing needs and outcome expectations, and the facility and staff need to respond accordingly. The others? I think this industry needs some better architects and stronger, more intelligent thinking in the space planning department.

Ever live in a cheap apartment? I mean the kind where you can hear your neighbor using the bathroom? I have. Know why? Those buildings are built with "straight-line" plumbing to cut costs. All the bathrooms, kitchens, etc., are on one vertical line. We don't have to be that cheap, but it wouldn't hurt to lean a little closer to it than we are.

Most hospitals have a "strategic planning department." Ask to be a part of that group. They won't like it and will resent you and laugh behind your back — but hey, why not? So many times, new facilities are erected with little or no input from the staff. Get involved in your own hospital and start asking questions. If you have no idea what to ask, just ask this one question and everyone will think you are a

genius. The question? *"Why?" Why are we doing this? Why haven't you checked this? Why are the costs so high? Why? Why? Why?*

Surgery centers: Wipe that smirk off your face. Look around. There are eye centers, GI centers, ortho, ENT, spine, plastic, yada, yada, yada! If I had the resources, I would roll up all the small for-profit surgery centers in AnyTown, USA, into one large center. I would eliminate all the passive investors, make ownership in the centers meaningful to the surgeons, and make them rock and roll! All these mom-and-pop surgery centers only fragment the population, and most just eke out a living or are not profitable at all. (Yes, I know your center is wonderful and profitable and not at all like those I am writing about.)

It drives me crazy to audit a small ASC that is doing everything right, but just doesn't have enough cases to justify its existence. But if you took two of those centers and combined them. . . . Oh, what potential! (Too much ego for most to overcome, but it makes for a nice dream.)

With health care reform lumbering down the road, something is going to change. Reimbursement is going to go down. Surgeon fees are going to be reduced. The quality of care is going to be affected. What a wonderful opportunity to do something right! *(Earnhart & Associates is a consulting firm specializing in all aspects of outpatient surgery development and management. Contact Earnhart at 13492 Research Blvd., Suite 120-258, Austin, TX 78750-2254. E-mail: searnhart@earnhart.com. Web: www.earnhart.com. Tweet address: Earnhart_EAI.)* ■

After 5 'never' events, observer, taping required

Rhode Island Hospital, the teaching hospital for Brown University's Alpert Medical School in Providence, is facing unprecedented sanctions from the state health department after its fifth wrong-site surgery since 2007.

The health department responded to the fifth wrong-site surgery by not only imposing a $150,000 fine, but also imposing requirements intended to prevent a sixth from happening. A compliance order from the department requires Rhode Island Hospital to assign a clinical employee who is not part of the surgical team to observe all surgeries at the hospital for at least one year. That person will monitor whether doctors are marking the site to be operated on and taking a timeout before operating to ensure they're operating on the proper body part.

The order also requires the surgeon to be involved in marking the surgical site. The state also gave the hospital 45 days to install video and audio recording equipment in all its operating rooms. The cameras do not have to record every surgery, but each doctor must be taped performing surgery at least twice every year. The hospital can decide whether to tell surgeons when the cameras are recording, but it will obtain permission from patients or their families.

In a press conference regarding the sanctions, state health director **David Gifford**, MD, MPH, said he had never heard of such requirements, but that they were necessary in this case. "Clearly, there's a culture of making mistakes; so, if they're hesitant to have someone to look over their shoulder, that says to me that we're doing the right thing," he said.

Repeated never events should prompt a review of the hospital's culture, says **Georgene Saliba**, RN, HRM, CPHRM, FASHRM, administrator for claims and risk management at Lehigh Valley Hospital & Health Network in Allentown, PA, and the 2009 president of the American Society for Healthcare Risk Management (ASHRM). Saliba wonders what the string of errors might suggest regarding the culture at Rhode Island Hospital, particularly whether patient safety protocols are truly valued vs. being seen as just window dressing, and whether staff feel empowered to speak up.

"We have the Universal Protocol, and we can use the aviation model with the checklists, but people have to be engaged in the checklists," she says. "We can give them the tools and the processes, but they have to actually do it. They can't just go through the motions."

Saliba says she is particularly troubled by the reports that there was no timeout before the fifth wrong-site surgery, because the timeout is the final opportunity for identifying any errors. "That's the last time you can catch something that might have been missed at 16 other steps along the way," she says. "You absolutely cannot skip this final, crucial step, where you have a last chance to catch a problem before it becomes a serious, possibly tragic mistake. You should have a culture in which no one in that OR would ever allow you to skip that step, a culture in which you'd have a chorus of voices piping up to stop that procedure, because you didn't do a timeout."

Most never events are tied to a breakdown in

SOURCES

For more information on wrong-site surgery, contact:
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communication, Saliba says.

"We have to be a team. Without that team approach, there will be a break in process, and errors will occur," she says. "And you have to have a culture with a 'stop-the-line' mentality, where people will speak up even if the surgeon is the biggest surgeon who brings in the most revenue. Even if he huffs and puffs and blows your house down, you have to be willing to stop that procedure."

The negative publicity from not just one never event, but a string of incidents, can be crippling, says **Don Hannaford**, senior vice president of Levick Strategic Communications, in Washington, DC, who has extensive experience as a crisis management counselor for health care providers. In this respect, he says, Rhode Island hospital is doing the right thing by publicly acknowledging the incident and not trying to make excuses.

The best approach is to admit that it happened. You never increase the patient's comfort that it is unlikely to happen in the future if you don't acknowledge something that clearly happened in the past, Hannaford says.

The hospital also must go along with the state's corrective action with no complaints, he advises. "Rhode Island Hospital has to take their medicine, with the video cameras and the other requirements. And they have to tell their doctors to shut up and stop acting like whining brats who don't want Big Brother looking over their shoulders. They deserve to have Big Brother looking over their shoulders because they [made significant errors] five times in two years," Hannaford says.

The unusual and extensive sanctions actually can work in the hospital's favor, he says. After such an egregious error, it is not enough to say that you already had the right policies and procedures in place and admit that you did not follow them. To make amends and promote confidence, the provider must take additional steps beyond whatever precautions already were in place, even if those existing precautions should have been adequate.

The only exception would be if the hospital were willing to fire the one person who violated policy, Hannaford says. But that would only work when the error can be pinned on an individual, and the incident happened once. After five never events, even the general public gets the idea that there is some sort of systemic problem.

"You must do something more to show that there is heightened attention," he says. "That could be an extra step, an additional person, some additional measure. You can't just say you had all the right policies in place and you didn't follow them, but you promise you will next time. That doesn't inspire confidence in anybody." **[The fifth wrong-site surgery originally was covered in *Same-Day Surgery Weekly Alert*, Nov. 6, 2009. To subscribe to this free weekly ezine, contact customer service at (800) 688-2421 or customerservice@ahcmedia.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 **June** 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

- How to save thousands on paper and printing costs
- A surprising choice for a marketer pays off
- Billing tips for ambulatory surgery
- Using retired nurses as nonclinical volunteers

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 abbreviation(s) should you beware of on a patient's insurance care because it is a/they are reimbursement rate-limiting plan(s), according to Catherine A. Meredith, RN, CASC, vice president of finance for Ambulatory Surgical Centers of America?
A. MNRP
B. NAP
C. FAC
D. All of the above

10. During its accreditation survey by The Joint Commission, Mendocino Coast Hospital was cited the facility for "not documenting the fact that we educated the patient on what to expect," according to Susan Bivins, RN, director of quality and risk management. What are patients to be informed about, according to Bivins?
A. The site would be marked.
B. Two forms of identification would be checked.
C. The patient should notify the nurse if he or she experienced pain, fever, or other adverse events.
D. All of the above

11. During Mendocino Coast Hospital's accreditation survey, what did the medical staff coordinator learn about the recredentialing process?
A. As long as the final reappointment approval fell within the month of the two years previous, that was sufficient, which meant that if the board meeting met at the end of the month for the final approval, then that would be approved.
B. The recredentialing had to be before 24 months exactly.
C. Neither A nor B.

12. A recently published study found that preoperative cleansing of the patient's skin with chlorhexidine-alcohol was superior to cleansing with povidone-iodine for preventing surgical-site infections. Overall, what percentage of SSI reduction was reported in the clinical trail for the chlorhexidine alcohol group?
A. 17%
B. 25%
C. 41%
D. 60%

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

Checklist for Medicare Survey — Infection Control (Excerpt)

- ☐ Does the organization have an explicit infection control program?
- ☐ Does the organization follow nationally recognized infection control guidelines? And, is there documentation that shows the organization considered these when creating the infection control program?
- ☐ Does the organization have a "licensed healthcare professional" qualified through training in infection control and designated to direct the program? The infection control officer should be a licensed individual, and have ongoing education (online education, seminars, etc) to show proof of training. **UPDATE:** Note, in the regulations it does not state that the individual must be "licensed", yet in the Infection Control Survey document that will be utilized by the surveyors, it references this point. It is up to the organization how they want to interpret, but we would recommend having someone with a "license" in this position.
- ☐ Does the organization have a system to actively identify infections related to procedures, and is there supporting documentation to confirm this tracking? In most centers, surgeons are queried postoperatively regarding infections. The list of patients and letters returned by the surgeons should be kept on file.
- ☐ Does the organization have a policy/procedure in place to comply with the state notifiable disease reporting? Centers should have their State Infectious Disease reporting requirements printed and on site, as well as a policy that says you will follow these regulations.
- ☐ Do staff members — **including medical staff** — receive infection control training? How often? What method? Upon orientation ALL staff should receive some sort of education on infection control/prevention. Medical staff as well as LIP/allied health should also receive an orientation and show education/review on infection control. Annually — all staff should also go through education/inservicing on infection control.

INJECTION PRACTICES IN INFECTION CONTROL

Medications that are pre-drawn are labeled with:

- ☐ a. time of draw;
- ☐ b. initials of the person drawing;
- ☐ c. medication name;
- ☐ d. strength; and
- ☐ e. expiration date or time.

- ☐ Single-dose vials are used for only one patient.
- ☐ Multidose injectable medications are used for only one patient. If not, then they will look for the following:
- ☐ a. rubber septum on a multidose vial used for more than one patient is disinfected with alcohol prior to each entry
- ☐ b. when used for more than one patient are dated when they are first opened and discarded within 28 days of opening or according to manufacturer's recommendations, whichever comes first.
- ☐ c. When used for more than one patient are not stored or accessed in the immediate areas where direct patient contact occurs.

SINGLE-USE DEVICES, STERILIZATION, AND HIGH-LEVEL DISINFECTION

- ☐ If single-use devices are reprocessed, you must verify that they are "approved by the FDA for reprocessing," and "reprocessed by an FDA approved reprocessor."
- ☐ Items are pre-cleaned according to manufacturer's instructions or evidence-based guidelines prior to sterilization.
- ☐ Items that go under high-level disinfection are allowed to dry before use.
- ☐ Following high-level disinfection, items are stored in a designated clean area in a manner to prevent contamination.

ENVIRONMENTAL INFECTION CONTROL

- ☐ Operating rooms are cleaned and disinfected after each surgical or invasive procedure using an EPA-registered disinfectant.
- ☐ Operating rooms are terminally cleaned daily.

(Continued on page 2)

POINT-OF-CARE DEVICES (e.g., Glucometers)

☐ A new single-use, auto-disabling lancing device is used for each patient.

☐ The glucometer is not used on more than one patient unless the manufacturer's instructions indicate this is permissible, meaning that you can show it is for "institutional use/professional."

☐ The glucometer is cleaned and disinfected after EVERY use. How do you document this?

Source: AXIOM Integrated Services, Chicago.