AMERICAN HEALTH CONSULTANTS®

Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 20 Years

INSIDE

APRIL 1999

VOL. 23, NO. 4 (pages 41-52)

American Health Consultants® is A Medical Economics Company

Cut your costs and reduce your stress: Select appropriate patients for SDS

Insurer reports guidelines reduce average claims from $78,477 to $5,207

It's the scenario that every same-day surgery manager wants to avoid: A patient has ambulatory surgery, experiences problems in the postoperative recovery — problems that should have been identified before surgery — and has to be admitted to the hospital.

"It's very cost inefficient and stressful for everyone involved," says **Andrew M. Green**, MD, chief of anesthesiology at Carroll County General Hospital and medical director at Dixon Surgery Center, both in Westminster, MD.

And that's not the only problem. When an inappropriate patient is selected for an approach such as the laparoscopic technique, litigation can result, says **Pam Lockowitz**, president of MMI Risk Management Resources in Deerfield, IL. MMI insures health care organizations and offers risk management products and services.

"In looking at the details of these cases, we sometimes see patients who were selected had other issues that should have been dealt with. So, one, they are appropriate candidates for the laparoscopic approach, or two, they are appropriate for the outpatient setting," Lockowitz says.

MMI has worked with the ambulatory surgery clients it insures to develop patient evaluation and selection criteria that have resulted in a

EXECUTIVE SUMMARY

As more patients move to the outpatient setting, providers and insurance companies are concerned about selecting appropriate patients and procedures for the outpatient setting.

- A preoperative assessment tool can alert providers to medical conditions that need consultations in order to be optimized before surgery.
- Insurance companies are developing processes that help reduce liability; one reports its clients have minimized rates of unplanned returns to surgery within 48 hours and injuries to organs resulting from endoscopic surgery.

.06% rate of unplanned returns to surgery within 48 hours and a .17% rate of injuries to organs resulting from the use of an endoscope during surgery. These figures compare with a .54% rate of unplanned returns to surgery within 48 hours of inpatient surgery and a .54% rate of injuries to organs resulting from the use of an endoscope during inpatient surgery.

Clients who use MMI's perioperative guidelines to match patients to the appropriate care setting and surgical technique have reduced average cost per malpractice claim from $78,477 to $5,207, according to company reports.

"If a patient for some reason is dissatisfied with the outcome and sues, providers can generally stand behind having followed a good set of practice guidelines and meeting standards of care," Lockowitz says.

More than likely, providers can have the case dismissed or will win the verdict, she says. "They may only have to pay the cost of defense," Lockowitz adds.

Don't simply look at ASA class or procedure

Despite liability concerns, it's no longer necessary to limit outpatient surgery based on the American Society of Anesthesiologists (ASA) classification or type of procedure, Green says. But he adds this caveat: "as long as you have an ability to screen for high-risk patients . . . as long as there's a screening process to rule out patients who might need more intensive medical follow-up in the hospital in the perioperative period, despite having surgery that most people can have and go home the same day."

For example, a patient with stable congestive heart failure can undergo outpatient surgery, but someone who has a more severe case of heart failure and is more unstable might need a longer period for observation after surgery, he says.

A good nursing and medical assessment that includes surgeons, nursing, and anesthesia staff is critical for identifying such patients, says **Jane Kusler-Jensen**, RN, CNOR, nurse manager at Surgicenter of Greater Milwaukee.

Surgicenter conducts a "health survey" that questions patients about aspirin use, blood thinner use, latex allergies, previous anesthesia problems, history of asthma, and TB symptoms. For pediatric patients, the survey covers issues such as exposure to chickenpox. Some patients are given simple instructions, such as stop using aspirin; others undergo additional lab work to determine bleeding times, for example. Still others might need clearance from their surgeons or primary care physician, Kusler-Jensen says.

Green's surgery center also looks for red flags based on a preadmission screening process, which he adapted from one he helped develop at Yale University. Patients are called and asked a series of questions. **(See PAT Phone Interview form, p. 43.)** A subset of questions identifies patients at risk for anesthesia difficulties with airway management, cardiopulmonary problems, or bleeding problems, for example. **(See conditions on the form that are indented.)** Any patient who responds positively in these areas is asked to come to the center for an interview with an anesthesiologist.

After conducting a history and physical, the anesthesiologist determines if further consultations are needed or whether discussions with the primary care physician are warranted. For example, patients might need to be optimized on their medications for conditions such as asthma or hypertension.

By performing the assessment one to two weeks before surgery, there is time to maximize the patient's medical condition, Green says. The surgery program can work with consultants via fax, phone, or e-mail. "The main point isn't to try to get patients not to have same-day surgery," he emphasizes.

Providers aren't the only ones finding ways to identify potential problems in same-day surgery before they start. Insurance companies also are developing guidelines for selecting appropriate patients and approaches.

MMI examines malpractice cases and examines

(Continued on page 44)

COMING IN FUTURE MONTHS

- Controversy over use of trocar tip shields
- First surgical correction of vision that is reversible
- Cost-saving tips from your peers
- Assembling a Y2K rapid-response OR team for Dec. 31
- Critical path reduces costs, LOS in outpatient

The AMBULATORY CARE CENTER at the RICHARD N. DIXON BUILDING

PAT PHONE INTERVIEW

Best time & day to contact patient if a phone visit: _____

May the patient be called at work? Yes (phone) _____ No _____

Name _____ Nickname _____ Occupation _____

Home Phone _____ Other Phone _____

Family Doctor/Address _____

Surgeon _____ Procedure _____

List all medications (include over-the-counter drugs) you currently take. Include dose and frequency.

Name of Drug	Dose	Frequency

List all allergies to food, medications, and/or rubber/latex products:

_____

_____

_____

List all operations you have had (operation/date):

_____

_____

_____

_____

Check the box only if you have had any of the following:	Comments
☐ Have you had any serious or life-threatening illness in the past?	
☐ Have you had problems with anesthesia, other than nausea or vomiting?	
☐ Difficult intubation?	
☐ Malignant hyperthermia?	
☐ Prolonged hospital stay due to anesthesia?	
☐ Has a family member ever had problems with anesthesia other than nausea or vomiting?	
☐ Difficult intubation?	
☐ Malignant hyperthermia?	
☐ Prolonged hospital stay due to anesthesia?	
☐ Have you had chest pressure, pain on exertion, or severe shortness of breath with exertion?	
☐ Unstable — frequency/duration	
awake from sleep	
☐ Have you had asthma or other problems with your breathing?	
☐ recent (3 months) hospitalization or intubation, or prednisone use	
☐ Have you had any problems with your heart or circulation?	
☐ aortic valve disease (stenosis)	
☐ recent CHF within 1 month	
☐ MI within 6 months	
☐ Have you ever had an abnormal chest X-ray?	
☐ pneumonia within 1 month	
☐ Have you ever had diabetes/high blood sugar?	
☐ hospitalized for glucose control within 1 month	
☐ Have you ever had ulcers, a hiatal hernia, or frequent heartburn?	
☐ Have you had seizure disorder, stroke, or other neurologic problems?	
☐ stroke within 1 month	
☐ recent onset of seizures within 6 months or change in freq/treatment	
☐ Do you bleed easily? Frequently take aspirin or aspirin-like medication?	
☐ history of von Willebrand disease?	
☐ hemophilia	
☐ h/o bleeding after surgery	
☐ Are you more than 50 pounds overweight?	
☐ morbid obese	
☐ sleep apnea	
☐ Do you smoke a pack or more of cigarettes per day?	

Source: Dixon Surgery Center, Westminster, MD.

SOURCES

For more information on ensuring appropriate patients and procedures in same-day surgery, contact:

- **Andrew M. Green**, MD, 906 G Washington Road, Westminster, MD 21157. Telephone: (410) 871-6109. E-mail: agreen@ccgh.com.
- **Jane Kusler-Jensen**, RN, CNOR, Nurse Manager, Surgicenter of Greater Milwaukee, 3223 S. 103rd St., Milwaukee, WI 53227. Telephone: (414) 328-5800. Fax: (414) 328-5805. E-mail: jkusler@execpc.com.
- **Paula Wheeler**, Manager, Corporate Communications, MMI Companies, 540 Lake Cook Road, Deerfield, IL 60015-5290. Telephone: (847) 374-2498. Fax: (847) 940-7294. E-mail: pwheeler@mminet.com. Web: www.mmicompanies.com.

areas of potential problems for health care providers, including same-day surgery programs. For example, MMI has developed preoperative guidelines for endoscopic procedures. The guidelines indicate that patients with certain conditions should be evaluated on an individual basis as to whether they are more appropriate for an open procedure or the endoscopic approach, Lockowitz says. The list includes ASA classification 4 or higher, congestive heart failure, chronic ventilator dependency, and pregnancy.

"That is the guideline, that given those conditions, you could run into trouble," she says.

Documenting the rationale is critical for providers who decide to proceed with the endoscopic approach on such patients, Lockowitz emphasizes. "What we're saying is that this should be a very thoughtful practice."

Guidelines alone aren't enough

Keep in mind that policies, procedures, and guidelines alone aren't sufficient, experts emphasize. Lockowitz points to an incident at Beth Israel Medical Center in New York City in which investigators say a patient died after surgeons made gross medical errors and a salesman performed part of what should have been a routine procedure. **(For more information, see *Same-Day Surgery*, February 1999, p. 19.)**

Beth Israel probably had protocols in place for issues that were critical to this case, such as training on new equipment, fluid overload, and informed consent, Lockowitz says. "It comes down to: Do providers get comfortable and take short cuts here and there?" she asks.

Companies such as MMI help same-day surgery managers remember that there are reasons for the safety nets, she says.

"Don't get too comfortable," Lockowitz warns. Help your staff remember that precautions in the inpatient suite shouldn't be lost as procedures are moved to the outpatient setting, particularly since many of these cases involve general anesthesia. "If you don't get their attention in the first place and change behavior, you don't achieve what you want, which is to improve patient care," she says.

Screening is critical to ensuring quality patient care, Kusler-Jensen emphasizes. "We owe it to ourselves and to our patients to give the best care possible, and if we can prepare on the front end, we'll do a better job in the long run." ■

Cut thermal injuries with education, inspections

There is no doubt that laparoscopic surgery is a growing component of day surgery programs. In fact, an informal study performed by the Society of Laparoendoscopic Surgeons in Miami projects that laparoscopy will account for an estimated 40% of urology procedures, 50% of general surgery procedures, and 70% of gynecology procedures performed in the United States by the year 2000.[1]

Of all the surgeons performing laparoscopic procedures, 86% report that they use monopolar electrosurgery for cutting and coagulation during the surgery.[2]

Along with the increased use of electrosurgical tools during laparoscopic surgery comes an increased risk of thermal injuries to patients, says **D. Stephen Robins**, MD, president of Communicore, a Friday Harbor, WA-based medical communications company that promotes the use of technology.

The medical malpractice risk is significant. At a 1995 meeting of the Society of Laparoendoscopic Surgeons, 13% of the members surveyed said that they currently had one or more malpractice cases in litigation.[2] Because of the serious complications that are a result of thermal injury such as bowel perforation, peritonitis, or hemorrhage, the

EXECUTIVE SUMMARY

The increased use of electrosurgical tools during laparoscopic procedures has increased the risk of inadvertent thermal injuries to patients. Guidelines for patient safety that were recently published in the *Journal of the Society of Laparoendoscopic Surgeons* **(see guidelines, inserted in this issue)** point out several actions to promote safety:

- Educate physicians as to the biophysics of electrosurgery so that they are better able to evaluate the risks associated with procedures.
- Improve credentialing requirements for surgeons who use electrosurgical tools during laparoscopy.
- Develop stringent biomedical and staff inspection guidelines for electrosurgical equipment.
- Use active electrode monitoring technology to eliminate thermal injuries caused by insulation breakdown and stray electric currents.

jury awards in malpractice cases have been high, ranging from several hundred thousand dollars to $2 million. As a result, some insurers have raised malpractice rates by 15% to 20% for surgeons who use electrosurgical techniques.[3] Some attorneys say that surgeons, surgery centers, and hospitals may be targeted not only for the surgical errors but also for choosing equipment that allows stray current to injure a patient.[4]

Robins' organization put together a Consortium on Electrosurgical Safety During Laparoscopy that included patients who received thermal injuries during laparoscopic surgery, physicians, attorneys, insurers, and nurses. "Whenever you have a problem that can only be solved by a change of behavior, it is important to include all groups that are affected by the issues," Robins says.

Physicians haven't received safety training

A key result of the consortium's efforts is a list of principles and guidelines to help ensure patient safety. **(See electrosurgical safety guidelines, inserted in this issue.)** The guidelines address several issues, but the lack of training in electrosurgical safety for physicians was a surprise to him, says Robins.

"Potential dangers in electrosurgery are not well-recognized by surgeons because they haven't received training in laparoscopic electrosurgery," he says.

It is important for surgeons to learn how electricity is conducted and which voltage levels are appropriate for laparoscopic surgery, says **Andrew I. Brill**, MD, professor of obstetrics and gynecology and director of gynecologic endoscopy at the University of Illinois at Chicago.

Managers should develop and implement protocols that address not only visual inspection but also the voltage output of the equipment, Robins says. Making sure that regular inspections of the equipment are performed by the nursing staff as well as biomedical personnel is critical, as is purchasing equipment with appropriate safety features, he adds.

"Manufacturers can be very helpful in developing inspection guidelines, but it is up to the surgery program manager to make sure the equipment is regularly checked," Robins says.

Three types of injuries

It is important for day surgery program managers to be aware of the types of injuries that can occur and what they can do to prevent them. Thermal injuries that can occur during laparoscopic electrosurgery fall into these three categories:

❒ **Direct coupling.**

Also referred to as "pilot error," direct coupling occurs when the active electrode touches or arcs to another metal instrument. The electricity then travels through the second instrument and possibly to nearby tissue.

❒ **Capacitive coupling.**

Stray electrical current can travel through the insulation of an active electrode to any surrounding conductor, such as a metal trocar sheath. If the conductor (i.e. the trocar sheath) is not touching the abdominal wall, the electric current cannot reach the return electrode and will cause a thermal burn. Conductive material is not limited to metal, Brill points out. Blood also can conduct electricity, so if there is blood in the surgical field, the electric current can travel to another area, he explains.

❒ **Insulation failure.**

Constant sterilization and use of the equipment can cause the insulation that covers the shaft of the electrode to erode. The most dangerous cracks in insulation are the smaller, almost microscopic breaks, says Brill. These small cracks concentrate the current and are more likely to create significant injuries, he explains.

Remote electrode monitoring (REM), the use of a split conductive surface patient return electrode

SOURCES

For more information on laparoscopic electrosurgical safety, contact:

- **D. Stephen Robins**, MD, President, Communicore, P.O. Box 2389, Friday Harbor, WA 98250. Telephone: (360) 378-4248. Fax: (360) 378-4841. E-mail: srobins@communicore.com.
- **Andrew I. Brill**, MD, Professor, Obstetrics and Gynecology, University of Illinois at Chicago, 820 S. Wood St., Chicago, IL 60612. Telephone: (312) 996-9618. Fax: (312) 996-4238. E-mail: abrill@uic.edu.

For more information about active electrode monitoring equipment, contact:

- **Vicki Barnett**, Director of Surgical Services, Northside Hospital, 1000 Johnson Ferry Road, Atlanta, GA 30342-1611. Telephone: (404) 851-6504. Fax: (404) 851-6799.
- **Eileen Banman**, Sales/Marketing Coordinator, ElectroScope, 4828 Sterling Drive, Boulder, CO 80301. Telephone: (800) 998-0986, ext. 133 or (303) 444-2600. Fax: (303) 444-2693. E-mail: ebanman@electroscope.com. Web: www.electroscope.com.

that measures impedance between patient tissue, and the return electrode can reduce the risk of capacitive coupling. However, the best technological solution is active electrode monitoring (AEM), says Brill.

AEM is a technology that uses a combination of extra electrical shielding and an electronic current monitor to prevent burns due to insulation breakdown and capacitive coupling. The shielding is conductive and is connected directly to the return electrode of the electrosurgical unit, which allows the current to flow harmlessly back to the return electrode. If the amount of stray energy reaches a dangerous level, the current is shut off and an alarm sounds.

Northside Hospital in Atlanta began using active electrode monitoring in operating rooms that were designated specifically for laparoscopic procedures a few years ago.

"Now, AEM is the standard of care for all of our electrosurgical procedures, including our newly opened day surgery center," says **Vicki Barnett** RN, MSN, CNOR, director of surgical services.

There are capital and disposable costs associated with the technology, but the extra cost per case is covered by the payers her facility contracts with, says Barnett. The equipment was purchased from ElectroScope, a Boulder, CO-based company that is currently the only manufacturer of AEM laparoscopic equipment. While purchasing prices can vary among surgery centers depending on the specific agreements, an AEM system costs approximately $6,285, says **Eileen Banman**, sales / marketing coordinator for ElectroScope. This system includes a monitoring unit, cables, electrode shields for use with unshielded 5-mm electrodes, and 5-mm shielded electrodes with integrated shielding within the insulation.

"I am a supporter of AEM because whatever initial costs are incurred are small when you consider the cost of unintentionally burning a patient during surgery," she says.

References

1. Wetter PA. Trends study. Presented at Society of Laparoendoscopic Surgeons Annual Meeting. Seattle; June 1994.
2. Tucker RD. Laparoscopic electrosurgical injuries: Survey results and their implications. *Surg Laparosc Endosc* 1995; 5:311-317.
3. Harrell GJ, Kopps DR. Minimizing patient risk during laparoscopic electrosurgery. *AORN J* 1998; 67:1,194-1,205.
4. Laparoscopy seen as 'hotbed for malpractice.' *Laparoscopic Surgery Update* 1994; 2:121-123. ■

Same-Day Surgery Manager

Here's two new services for your SDS program

By **Stephen W. Earnhart**, MS
President and CEO
Earnhart & Associates
Dallas

At Earnhart & Associates, we are always looking for new ideas and procedures to enhance our bottom line — as we should. However, sometimes the ideas dry up, and we need to become a bit more creative.

Let's look at some new things we have been doing and see if they might work for you.

• **A surgery center within a surgery center: The esthetic plastic surgery center.**

Plastic surgeons, for the most part, shun the average surgery center because they think it doesn't meet the needs of their clientele's image. (I said, "average." Your center is perfect and beautiful; this is directed to other people's centers.)

Unfortunately they are often right. As much as we like to think that our center is pleasing to the eye, if you look closely, most do not live up to the average (again, notice the word "average") operating suite in most plastic surgeons' offices.

In my travels and meetings, I have been in many of these. They are ornate, lavish, and tastefully done. They are complete with *The New Yorker* magazine, attractive receptionists, and multicolor brochures. From somewhere there is a light source, although I can rarely find a lamp or overhead fluorescent lighting. And the music; where do they get this soothing music? And where the heck is the radio?

Now, those of us who have been in the industry for more than three months know that much of what the administrator does in dealing with plastic surgeons is to try to negotiate a reasonable facility fee from them that at least covers the cost of the sutures they use. Not an easy task. Obviously, the surgeons want the facility fee as low as possible, so their global fees are competitive with their peers. That will probably always be an issue; however, the cash upfront reimbursement is looking more attractive. To attract more esthetic procedures to our facilities, we have been creating a new image for these patients.

Creating an attractive atmosphere

Essentially, we are creating a new entrance to the surgery center — a distinctly different entrance from the main door. Often, this will be off on another part of the building or a different corridor. The signage will read "Esthetic Surgery Center" and will have, usually, the name of the surgeon operating that day on the door. Depending upon the number of plastic surgeons you have, this may or may not work for you.

Once the patient enters that door, there is a small, but highly appointed waiting area. The size is usually 120 square feet. There is a window for the receptionist to register the patient. You can use your own select staff member here, or you can have the surgeon bring over their own. Beyond the door, there is a single changing area that can double as the phase-two recovery area. Again, you need to evaluate the numbers of patients you are going to accommodate during the day. From this point, the patients share the general population operating rooms and phase-one recovery.

Will it work for you? I don't know. Clearly, before you would consider the expense, which isn't that much, you would want a commitment from the surgeons on potential new volume.

• **Kidney stone lithotripsy or fragmenting of kidney stone (CPT code 50590).**

This procedure is on the list to be approved for Medicare reimbursement for surgery centers by the Health Care Financing Administration with the implementation of the new ambulatory payment classifications (APCs). This procedure holds a lot of promise for new and existing facilities. The proposed reimbursement from Medicare is $2,107. We'll have to wait and see if that holds up.

In the meantime, strong consideration should be given, especially for new construction, for adding this service. For the majority of facilities, a mobile machine will be required — a fixed site probably doesn't make much sense. However, there is new equipment out there now that doesn't require a truck.

Most providers use the mobile 18-wheeler truck, which requires a specially constructed "pad" in the parking lot for the large truck to pull up and make water and electrical connection. The average price for the construction of the pad, overhang, hook-ups, construction of a door into the surgery center, etc. is about $25,000 (assuming you have no other construction issues). The services, there are several in the United States, usually have the staff and all the equipment to perform the procedures and usually schedule time once or twice a month, depending upon your schedule and number of patients.

The fee for the truck, machine, staff, and supplies can exceed $1,000 patient — but there is very little incremental cost involved beyond that fee. This is also a great way to get the urologist involved in the facility. Keep your eye on this new opportunity. To research companies, perform a search for "mobile lithotripsy" on the Internet.

(Editor's note: Earnhart can be reached at Earnhart and Associates, 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: surgery@onramp.net. World Wide Web: http://www.earnhart.com.) ■

GUEST COLUMN

An overview of 1999 CPT code changes

By **Rita A. Scichilone**, MHSA, RRA, CCS, CCS-P
Professional Management Midwest
Omaha, NE

It's that time of year when revised CPT code books have rolled off the presses and health care organizations gear up for changes in coding and reimbursement processing of patient services.

The 1999 version of CPT contains additions, deletions, and revised to code descriptions.

Two new appendices were added to show which codes are considered "add-on codes" (Appendix E) and which codes are exempt from modifier -51 use (Appendix F). **(For ordering information, see resource box, below right.)**

Add-on codes cannot stand alone since they are intended to be additional, rather than primary, procedures. For example, the first one on the list is CPT code 11101, now marked with a plus symbol and a description of "each separate/additional lesion (list separately in addition to code for primary procedure)." The primary procedure in this case is 1110 — Biopsy of skin, subcutaneous tissue, and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion.

As you can see, code 11101 would not stand alone. It would only be used when more than one biopsy of the skin was performed. Modifier -51 would not be appended since, by definition, it is an add-on code. To make sure coders understand, the manual provides instructions to "use 11101 in conjunction with code 11100."

Many of the revised descriptions in the 1999 version of CPT include similar language to clarify when you should report additional codes separately. Last July, Medicare implemented the use of hospital-specific modifiers. Two of the modifiers, -52 and -53, had descriptions from the Health Care Financing Administration (HCFA) that were at variance from the CPT definition.

The 1999 version of CPT makes it easier to distinguish hospital-reported modifiers by creating a special section titled Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use. It is interesting to note that two modifiers were created so the CPT definitions can remain constant. Modifiers -73 and -74 have been added to CPT with the HCFA definitions. The new language follows:

- **-73 Discontinued Outpatient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block[s], or general).

Under these circumstances, the intended service that is prepared for, but canceled, can be reported by the usual procedure number and the addition of modifier -73 or by use of the separate five-digit modifier 09973. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

For physician reporting of a discontinued procedure, see modifier -53.

- **-74 Discontinued Outpatient Hospital/ ASC Procedure After the Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block[s], or general) or after the procedure was started (incision made, intubation started, scope inserted, etc).

Under these circumstances, the intended service that is started but terminated can be reported by the usual procedure number and the addition of modifier -74 or by use of the separate five-digit

RESOURCE

The CPT 1999 Professional Edition may be ordered from the American Medical Association, Order Department, P.O. Box 7046, Dover, DE 19903-7046. Telephone: (800) 621-8335. Fax: (312) 464-5600. World Wide Web: www.ama-assn.org. Cost for the spiral-bound edition is $54.95 for members, and $64.95 for nonmembers. The three-ring binder costs $59.95 for members and $72.95 for nonmembers.

modifier 09974. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

Modifier -53 does not appear in this listing; it is now restricted to physician use only. Modifier -52 for reduced services is listed as a hospital modifier. The language in 1999 CPT follows:

- **-52 Reduced Services:** Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier -52.

Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or canceled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers -73 and -74.

It is not clear under which circumstances modifier -52 would be used since HCFA regulations include anesthesia as the determining factor for reduced services. It could be assumed that hospitals would use these modifiers only on occasions when services were reduced and the use of anesthesia would not apply, such as radiology. It should be noted that the use of five digits to communicate modifiers is not permitted for HCFA patients. The directive requires use of the two-digit modifiers appended to the CPT codes on the UB-92.

For the first time in CPT history, HCPCS modifiers have been added to Appendix A in the ASC/Hospital section. This is a list of the approved national modifiers required by HCFA for reporting after July 1, 1998. This is not a complete list, since only hospital modifiers are included, rather than the full set used by other types of health care providers.

The most recent draft of the revised Evaluation and Management (E&M) Documentation Guidelines is available on the American Medical Association's World Wide Web site: www.ama-assn.org. These guidelines may be used by hospital outpatient departments or hospitals in the ambulatory payment classification (APC) system to determine appropriate levels of E&M code selection and corresponding payment.

These documentation guidelines are not applicable to the Preventive Medicine Services, Critical Care, or Neonatal Intensive Care codes. Any format for documenting history (including preprinted history forms completed by the patient and reviewed by the physician) is acceptable. The chief complaint and reason for the encounter requirements are not applicable to inpatient hospital services. Definitions of chief complaint, reason for encounter, and brief/extended history of present illness have been added.

Some health information management professionals involved in current auditing for documentation to support coding levels believe the revised documentation guidelines will be easier to apply than the current ones.

At this point, no date of implementation or application for these guidelines for audit by Medicare has been offered. Currently, the 1995 or 1997 guidelines are used, whichever most benefits the health care provider. ■

Reader Question

What role can LPNs play in the recovery room?

An administrator of a freestanding surgery center in Florida hired a bright, licensed practical nurse (LPN) with experience working in a local hospital's critical care unit. The LPN was eager to help the RNs on staff, and the administrator knew they needed assistance in the recovery room. But when the administrator contacted state authorities and trade associations for directions on what LPNs can and cannot do in the

EXECUTIVE SUMMARY

State rule makers and industry associations have not reached a consensus on the role licensed practical nurses (LPNs) should play in the post-anesthesia care unit.

- States and associations do agree that LPNs can assist registered nurses in the second-stage recovery room, but confirm by checking your state regulations.
- Administrators and managers should request their state's scope of practice for LPNs from their state boards of nursing.

recovery room, she got bogged down by legal definitions of nursing that failed to offer any practical guidance.

So what is the answer?

While experts agree that LPNs can play a supporting role in the progressive, or second-stage, recovery room, they aren't in unison on the LPN's place in the post-anesthesia care unit (PACU), or first-stage recovery room. In fact, some think there is no real place for LPNs in the PACU at all.

"An LPN in a PACU is not a good match," says **Susan Kizirian**, RN, BSN, MBA, executive director of the Southeastern Urological Center in Tallahassee, FL. "The PACU is a high-tech area where you are constantly assessing patients' cardiopulmonary functions as they wake up from general anesthesia. And during the 30 minutes or so that patients are in the PACU, this assessment can only be conducted by a registered nurse, not an LPN."

States define the boundaries

Kizirian says most states prohibit ambulatory surgery centers from using LPNs in any area that requires assessment, and most areas in surgery centers demand some kind of assessment skill. For example, RNs should have the primary responsibility for giving patients discharge instructions, she says.

A registered nurse is trained and educated to assess patient care, while an LPN is not, says **Deborah G. Spratt**, RN, MPA, CNOR, CNAA, chairwoman of the Ambulatory Surgery Specialty Assembly of the Association of Operating Room Nurses (AORN) in Denver.

"The difference is that as registered nurses review documentation and speak to patients, they assess the patients' level of understanding and how ready they are to receive the instructions," says Spratt, nurse manager in the OR at Strong Memorial Hospital in Rochester, NY, and former clinical director of a New York surgery center.

Registered nurses assess whether patients have someone to care for them at home, and they assess the patients' levels of pain, nausea, and vomiting, she says. "If patients are nauseated, the RN can tell the LPN to give them medication. Later, the RN will assess whether the medication worked to treat the nausea."

Providing support to RNs and patients

Others insist that stating LPNs offer little value in the PACU is not accurate or realistic, given recent nursing shortages and the fact that LPNs have worked for more than 35 years in recovery rooms at hospitals. For example, the American Society of Perianesthesia Nurses (ASPAN) of Thorofare, NJ, and the Orlando-based Florida Hospital Association say LPNs can be helpful in the PACU — they just have to be under the supervision of an RN.

"Depending on the state and the institution, some LPNs can do limited care [in the PACU], such as checking blood pressure and giving meds," says **Cathy Allman**, RN, MSN, vice president of the Florida Hospital Association's Center for Nursing.

Despite these differing opinions, the experts seem to agree that LPNs can support RNs by taking over some of the technical aspects of patient care in the second-stage recovery room. LPNs can draw blood, change dressings, take vital signs, and report on blood loss or urine output. In Florida and some other states, LPNs also can administer IV medications if they are certified to do so. Registered nurses don't have to be in the same room at all times as the LPN, but they do need to be in the vicinity.

Because there's no industry consensus on the issue, experts suggest that managers and administrators who are unsure about LPNs' scope of practice contact their state board of nursing and review their facility licensing regulations to see what the statutes dictate. ■

SOURCES

For more information on LPNs in the recovery room, contact:

- **Cathy Allman**, RN, MSN, Vice President, Center for Nursing, Florida Hospital Association, 307 Park Lake Circle, Orlando, FL 32803. Fax: (407) 423-4648.
- **Deborah G. Spratt**, RN, MPA, CNOR, CNAA, Nurse Manager, Operating Room, Strong Memorial Hospital, University of Rochester Medical Center, 601 Elmwood Ave., Box 624, Rochester, NY 14642. Telephone: (716) 275-9618. Fax: (716) 273-1078. E-mail: dspratt@smhor.urmc.rochester.edu.
- **Susan Kizirian**, RN, BSN, MBA, Executive Director, Southeastern Urological Center, 2000 Center Point Blvd., Tallahassee, FL 32308. Telephone: (850) 309-0500. Fax: (850) 309-0404. E-mail: seuc@aol.com.

ACCREDITATION TIP

When surveyor seeks info that's not in the standards

It's one of the most popular questions among same-day surgery programs being accredited: What do you do when your surveyor asks for something that's not required in the standards? Many managers worry that questioning the surveyor will have a negative impact on the survey results. At the same time, managers can be frustrated over some surveyors' lack of flexibility. Here are some tips for dealing with this dilemma:

• **Ask, "Where is that requirement in the standards?"**

"When they say, 'I want to see X, Y, Z,' you ask them 'Where is it in the manual?'" suggests **Ann Kobs**, MS, RN, former director of the department of standards and current sentinel event specialist for the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. "They probably can't find it, so they're dead in the water right there."

Don't be afraid to ask questions

Or, Kobs advises, ask whether the request is a personal preference of the surveyor. "Ask that question," she says. "You're paying for it, for heaven's sake."

• **Provide information on your way of meeting the standard.**

Most surveyors apply standards based on their own framework. But that doesn't mean they are prejudiced against an alternative method, says **Beth Derby**, RN, MBA, a surveyor for the Accreditation Association of Ambulatory Health Care (AAAHC) in Skokie, IL, and executive vice president for Health Resources International (HRI) in West Hartford, CT.

If a surveyor asks for a written policy, for example, but you don't have one, feel free to show how you meet the standard in question, Derby suggests.

"As long as [managers] can adequately make their case, I think most surveyors are able to step outside their box and appreciate that a facility is in compliance, regardless of whether the tools are somewhat different from the experience of the surveyors," she says.

AAAHC tries to have surveyors with backgrounds similar to the facility being surveyed, Derby says. However, if you work in a surgery center and your surveyors come from a traditional hospital background, they might need more information from the facility on how to meet a particular standard. As an example, on the issue of medical staff members attending medical staff meetings, a center may offer smaller subspecialty group meetings as an alternative, given that mandatory attendance several times a year may not be feasible.

• **If all else fails, complain.**

There is a team leader among Joint Commission surveyors, Kobs points out. "If you can't settle it with the surveyor, go to the team leader," she suggests. "If the rambunctious one is the team leader, call us at Joint Commission."

Derby agrees that you should complain to the chairperson of the surveying group first and feel free to contact the accrediting organization

Same-Day Surgery® (ISSN 0190-5066) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Same-Day Surgery**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $459. Approximately 20 nursing contact hours, $509; Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $367 per year; 10 to 20 additional copies, $275 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $77 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing. Provider Number CEP 10864.

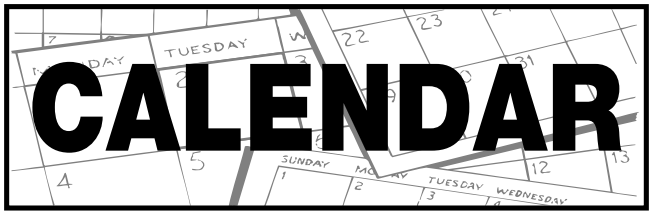
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Park Morgan**, (404) 262-5460, (park.morgan@medec.com).
Managing Editor: **Joy Daughtery Dickinson**, (912) 377-8044, (joy.daughtery@medec.com).
Production Editor: **Ann Duncan**.

Editorial Questions

Questions or comments? Call **Park Morgan** (404) 262-5460.

directly if your concerns are not addressed. Another option is to defend your position when you receive the draft report from the accreditation home office, she suggests. You can respond with supporting documentation that supports your position.

Don't avoid complaining because you're concerned about a negative impact on the survey, Kobs emphasizes. "I'm here to tell you if we don't hear about these surveyors, you get the same people back," she says. "It's just like your place. Nobody says anything. Guess what? They're still around, unfortunately." ■



• **Third International Congress on Ambulatory Surgery** — April 25-28, Venice, Italy. Contact: Organizing Secretariat, Key Congress, Via dei Tadi, 21-35139 Padua (Italy). Telephone: 39 049 659330. Fax: 39 049 8763081. E-mail: key cong@protec.it. Web: http://www.daysur venice.com.

• **1999 Ambulatory and Home Health Care Annual Meeting** — April 28-30, Chicago. Contact: Society for Ambulatory Care Professionals, One N. Franklin, Chicago, IL 60606. Telephone: (312) 422-3900. Fax: (312) 422-4577. World Wide Web: http://www.sacp-net.org.

• **Federated Ambulatory Surgery Association (FASA) Annual Meeting** — May 13-15, Orlando, FL. Contact: Sarah Silberstein, Administrator, FASA, 700 N. Fairfax St., Suite 306, Alexandria, VA 22314. Telephone: (703) 836-8808. Fax: (703) 549-0976. Web: www.fasa.org. ■

CE objectives

[For details on obtaining CE contact hours through Same-Day Surgery, *contact: Customer Service, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. Web: http://www.ahcpub.com.]*

After reading each issue of *Same-Day Surgery*, the reader will be able to do the following:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management.

• Describe how those issues affect nursing service delivery or management of a facility. **(See "Cut thermal injuries with education, inspections," p. 44 and "Here's two new services for your SDS program," p. 46.)**

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. **(See "What role can LPNs play in the recovery room?" p. 49.)** ■