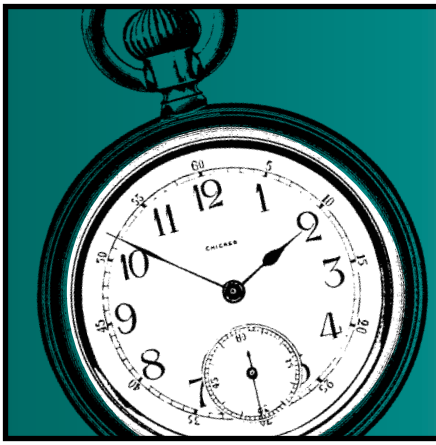

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IN THIS ISSUE

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Anesthetists tout post-op nerve blocks, but who's going to pay?

Surgeons are slow to accept, but data show reduced length of stay

It's a technique that offers better pain control, reduced length of stay, and fewer unplanned admissions, according to anesthesiologists and research data. So what's the controversy with nerve blocks?

"Insurers don't want to pay for anything new," says **Girish P. Joshi**, MD, MB, BS, FFARCSI, professor of anesthesiology and pain management at the University of Texas Southwestern Medical Center at Dallas. "The key now is to try to get insurance to realize the importance of it."

Some providers are reporting denial rates that approach 20% to 25%. And sometimes, resistance comes from within the outpatient surgery program. The reimbursement does not cover the drugs or the pump, which is charged separately, says **Jennifer R. Greger**, MD, with Greater Houston Anesthesia. When providing a block, anesthesiologists cannot bill for the time, she says. Medicare will cover nerve blocks, but the reimbursement rate is about $18 a unit, she says. HMOs' reimbursement has to do with the contract price, and that amount typically is about $40 a unit in Texas, Greger notes.

EXECUTIVE SUMMARY

Anesthesiologists push the benefits of postoperative nerve blocks, including better pain control, reduced length of stay, and fewer unplanned admissions. However, surgeons sometimes are reticent to offer the procedures, and insurers don't always pay.

- Nerve blocks require anesthesiologists' time, additional equipment, training, patient education, staff education, and surgeon education.
- Provide documentation to insurers, including the surgeon's request and separate progress notes, and use modifier -59.
- Anesthesiologists should continually review regional anesthesia resources and the current literature to determine which procedures warrant this technique.

With the continuous nerve blocks, there is a cost for the pump ($200 to $300) plus the catheter kit (about $25), says **Alan P. Marco**, MD, MMM, associate professor and chairman of the department of anesthesiology at the Medical College of Ohio in Toledo.

The cost of a single-injection needle, not including other equipment (such as a nerve stimulator) or drugs, is approximately $15, says **Brian A. Williams**, MD, MBA, associate professor of anesthesiology at the University of Pittsburgh.

A lot of surgeons don't understand nerve blocks, Greger says. Surgeons think it will delay their cases, she points out. "Most of the time, that's not true at all," she says. "It doesn't delay it because you can get it done ahead of time."

In fact, peripheral blocks have been demonstrated to be more effective and provide better patient-reported outcomes than using strictly opioid-based postoperative analgesia,[1-8] Williams says. Nerve blocks can be placed before surgery and coadministered with a total intravenous anesthetic technique (consisting of propofol), he explains. These are associated with lower doses of opioids during and after surgery.

"There's no unplanned admission for vomiting from narcotics," Greger says.

Patients express a high priority for avoiding nausea and vomiting, Williams notes. "Interviewed patients would spend $48 of $100 allotted to avoid nausea, vomiting, and gagging, and would spend $17 of this $100 to avoid pain.[9] I believe that it is time for anesthesiologists to understand these patient preferences to avoid these avoidable side effects, and these preferences should have priority in everyday outpatient practice."

In outpatient surgery, many anesthesia providers give patients volatile gas anesthetics with or without nerve blocks as part of the anesthetic plan, he explains. "Many have been doing this for years, because that is all that was available for years." However, in painful outpatient orthopedic surgery, gas anesthesia has been associated with an unplanned hospital admission as frequently as 17% of cases with no nerve blocks, and in 7% of cases with nerve blocks,[10] Williams says.

Gas anesthesia causes nausea and vomiting for about eight hours or so after surgery, he says. Propofol prevents nausea and vomiting for about four to six hours after surgery, Williams adds. "So I block the nerves that are likely to produce pain for more than eight hours despite a routine dose of an anti-inflammatory drug, use propofol exclusively during surgery to render the patient comfortable and/or unresponsive, and after surgery instruct patients to take prescribed opioids as needed for breakthrough pain despite the block, or when the block starts to wear off," he says.

Regional anesthesia patients with propofol can bypass the post-anesthesia care unit (PACU) almost 90% of the time, whereas gas anesthesia patients without block probably will be eligible for PACU bypass less than 10% of the time, if at

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all, Williams says. With continuous nerve blocks, shoulder surgery patients can go home the same day instead of having to stay overnight for pain control, Joshi says.

And that's not the only advantage. "There's a quicker return to activities of daily living," he maintains.

Nerve blocks are not without caveats. For example, some practitioners are uncomfortable sending patients home with nerve blocks because of the risk of injury with an injection, or with continuous nerve blocks, the risk of infection, Marco explains.

Nerve damage is rare, between 0.02% and 0.4%, depending on the study, Williams says.

Also, some providers are concerned that patients could go home with a numb limb, injure it, and not realize it. "There is some risk there," Marco says. "But I think the benefit of better pain control and the benefits of avoiding narcotics and side effects put the balance in favor of nerve blocks."

Other caveats include:

• Practitioners may be resistant.

Nerve blocks are labor-intensive and require an anesthesiologist's effort perhaps four to five times beyond the time the anesthesiologist would usually spend in immediate proximity of a patient if he or she was medically directing two to four operating rooms, Williams says.

Some surgeons don't consider their procedures to be painful and may forbid pain management interventions, he adds. Also, the overall process of patient flow from arrival to discharge requires some re-engineering to ensure that the nerve block techniques happen without creating delays in the system, he explains. "Nerve blocks take time, and require additional equipment, disposables, and pharmacy products," says Williams, who adds that nerve stimulators are one required investment. "That doesn't even account for necessary training, patient education, staff education, and surgeon education."

• Training is important.

Simply attending a one-to-two-day meeting on regional anesthesia techniques does not immediately render one a regionalist, Williams emphasizes. "In order to develop and maintain skills, I believe that regional techniques should be part of routine practice, with perhaps 10 procedures [blocks] per week or so for a practitioner," he says. "If a practitioner is just newly adding block procedures to his/her practice, it may be difficult to meaningfully develop and maintain the necessary skills if one is only performing one to five blocks per month."

SOURCE AND RESOURCES

For more on postoperative nerve blocks, contact:

- **Jennifer R. Greger**, MD, Greater Houston Anesthesia.
- **Girish P. Joshi**, MD, MB, BS, FFARCSI, Professor of Anesthesiology and Pain Management, University of Texas Southwestern Medical Center at Dallas. E-mail: girish.joshi@utsouthwestern.edu.
- **Brian A. Williams**, MD, MBA, University of Pittsburgh Medical Center/South Side Hospital, 2000 Mary St., Suite 341, Pittsburgh, PA 15203.

For more on regional anesthetic techniques, contact:

- **New York School of Regional Anesthesia.** Web: www.NYSORA.com. Click on "clinical applications" for information including "nerve block techniques for use in outpatients" and "postoperative pain management." Click on "techniques" for information on various regional anesthetic techniques. Click on "what's new" for a list of scientific meetings and educational text.

For information on peripheral nerve blocks and pain management, go to:

- **www.regionalblock.com.** The site is maintained by Jacques Chelly, MD, PhD, Professor and Vice Chairman of Clinical Research, Department of Anesthesiology, University of Pittsburgh School of Medicine; and Director of Orthopaedic Anesthesia and Acute Pain Services, University of Pittsburgh Medical Center, Shadyside Hospital.
- **uianesthesia.com/rasci/.** This web site is provided by the Regional Anesthesia Study Center of Iowa, University of Iowa Health Care, Iowa City. Click on "movies and descriptions of blocks" for movies and discussions of different single-injection and continuous nerve blocks.

Other providers, such as Joshi, say 20-40 procedures a year is enough to be proficient.

It is useful to have a proctor for the first couple of procedures to become familiar with the kits you're using and small differences in the procedure, such as threading catheters, Marco says.

• Expect resistance from insurers.

Many insurers carve out pharmacy benefits or don't have it. If the postoperative analgesia regimen is oral narcotics, patients go to a pharmacy and have a prescription filled. But with a nerve block, the physician submits a bill, and insurers must deal with it, Marco points out.

Some providers follow the policy described in the October 2001 issue of *CPT Assistant*: If these procedures "are performed in conjunction with

general anesthesia to provide postoperative analgesia, they are separate and distinct procedures and are reported in addition to the anesthesia code."[11]

Separate documentation for nerve blocks is critical for payer approval, Greger says. Ensure the surgeon requests postoperative pain management, she says. Include separate progress notes that document what you did, Greger advises. Also, use modifier -59 to indicate that it's a separately identifiable service, she suggests.

• **Stay updated on new research.**

Anesthesiologists should do continual reviews of regional anesthesia resources and the current literature, Williams advises.

The review of current literature is important because that will help the practitioner determine which procedures warrant invasive regional anesthesia procedures, and which do not, he says.

"If a complication were to occur on a nerve block patient undergoing a surgical procedure that had not been previously reported with using nerve block analgesia, or a procedure in which nerve blocks had not been shown to be of any particular benefit — e.g., minimally invasive diagnostic knee arthroscopy, then this complication may be difficult to justify or defend after the fact," Williams says. "Caution and proper patient selection are truly essential and important steps."

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Surgery clinics targeted in national investigation

FBI: Patients recruited for unnecessary surgery

The FBI has raided three southern California surgery clinics as part of an investigation into a health care fraud scheme in which patients were recruited from 48 states to have unnecessary surgeries. This scheme stands out from others in that patients actually underwent surgical procedures, including colonoscopy with no preparation and adult circumcision. "Using data analysis, our joint efforts with [the National Health Care Anti-Fraud Association] have connected the dots between the surgery centers and insurance providers and shown that the scam is deeply entrenched and operating nationwide," the FBI said.[1]

The investigation involves dozens of surgery clinics and more than 100 health care providers, mostly in southern California, according to investigators.[2] At press time, indictments were expected.

EXECUTIVE SUMMARY

An investigation into a "rent-a-patient" scheme has targeted three southern California surgery centers and patients from 48 states. To avoid even the appearance of fraud:

- Work with the payer to ensure you are using the correct code.
- Investigate if you have a large number of patients traveling extended distances for services that are readily available in other areas.
- Know what goes on in your center on weekends.

In the "rent-a-patient" scheme, recruiters are alleged to find and pay people to undergo procedures that they don't need, says **Bill Mahon**, president of the National Health Care Anti-fraud Association in Washington, DC. These procedures include hernia repairs where there is no hernia and palmar hyperhidrosis (sweaty palm surgery). Some centers were billing seven to 10 times the customary rate, Mahon says.

"For colonoscopy, which typically is about $2,500, the typical bills ranged from $15,000 to $20,000 or more," he says. Palmar hyperhidrosis is the big-ticket item; normally, those procedures costs $6,000 to $10,000 at the most, he says. "The typical [fraudulent] bill is from $60,000-$70,000," he says. The bill for one 25-minute procedure was $73,600, of which $59,000 was billed as surgical supplies; that claim was not paid, he says. The condition of having sweaty palms is rare, and surgery is typically a last resort, Mahon adds.

In the alleged scheme, recruiters are paid to entice co-workers or others to have surgery, Mahon says. In some cases, advertisements were run on fliers or in ethnic newspapers with free numbers to call for free cosmetic surgery or other procedures, with free airfare and hotel included. Many of the patients are low-income workers and often are immigrants. Some are offered a percent of the profits from the scheme, which also is shared with the recruiters and the physicians. "Outside the center, they are being coached by recruiters on what symptoms to describe to surgeons, then undergo procedures," he explains.

Health care claims for unnecessary surgeries may total $500 million in recent years.[1] The scheme typically involves large self-insured employers with somewhat generous benefits or traditional indemnity health plans that allow employees to go to out-of-network health care providers. Some policies don't demand reasonable and customary reimbursement, which means insurers must foot the entire bill unless they can prove it was fraud.

To avoid even the appearance of fraud, consider these suggestions:

• **Use the correct code.** The largest area of health care fraud involves misrepresentation of actual services provided, says **Byron Hollis**, national anti-fraud director of the Blue Cross Blue Shield Assoc. Some providers select codes based on the codes' reimbursement, he says. "There's a CPT code that, if you stretch the imagination, might have something to do with the procedure actually performed; that's the code illegitimate providers use."

If you have a gray area of coding, work with your insurance company to ensure you're using a recognized code, he advises. "That will reduce the scrutiny that any specific claim is given."

• **Be alert to patients coming from outside your geographic area.** If you notice a large percentage of patients coming from geographic areas that necessitate extended trips or air travel, review those cases closely, Hollis advises. "There could be legitimate reasons for that." However, if you consistently see patients traveling long distances for services that are readily available in the rest of the country, or patients are offered inducements to travel long distances to have services readily available elsewhere, consider that a red flag, he adds.

• **Take note of unusual claims or surgeries.** When providers bill seven to 10 times the customary and reasonable rates, those claims stand out, Mahon says. If you notice an unusual number of procedures, such as palmar hyperhidrosis, determine if the physician has spent sufficient time to ensure other therapies have been tried. "Or has he spent a cursory five to 10 minutes doing an examination, then said, 'We'll do surgery'?" he asks.

Also, be alert to any physicians who are performing a significant number of procedures on Saturdays and Sundays, he says. Surgeries typically were scheduled on those days in the rent-a-patient scheme, Mahon says. If you allow other surgeons to use your facility on weekends, don't assume they will be legitimate, Mahon says.

"If you're concerned about what is going on in your center on weekends, look at it with your own eyes," he suggests. Determine if there is a significant amount of pedestrian traffic or people congregated around your center who may be telling other people what to do, Mahon advises.

The insurance payment system is built on trust between patients and providers, and between providers and insurers, Hollis adds. "When things go bad, it's because someone violates that trust," he notes.

SOURCE

- **Bill Mahon**, President, National Health Care Anti-Fraud Association, Washington, DC. E-mail: fraud@nhcaa.org.

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Less pain for outpatient knee replacement

New technique does not cut the quadriceps muscle

EXECUTIVE SUMMARY

A new technique that doesn't affect the quadriceps muscle during a total knee replacement enables patients to go home the same day of their surgery and to experience a shorter recovery period.

- Surgeons performing minimally invasive knee replacements say that 40% of all knee replacements will be performed in this manner in the next five years.
- Same-day surgery managers and medical directors should look for specialized training in the procedure before credentialing the surgeon.
- In spite of the benefits of less pain and quicker recovery, there are no data on long-term effectiveness of the procedure.

Although technological advances are responsible for the movement of many surgical procedures from the inpatient to the outpatient setting, sometimes the switch relies more upon the surgeon's technique rather than the actual equipment.

"The main reason knee replacement patients experienced a great deal of pain and a slow recovery in a traditional knee replacement is that the quadriceps muscle is cut to give the surgeon access to the knee," says **Richard Berger**, MD, an orthopedic surgeon in Chicago who is performing knee replacements on a same-day surgery basis. "There was a need for instruments that enable minimally invasive surgery in knees, but the major change is the surgeon's approach," he says.

As with most procedures that move to the outpatient setting, the difference in recovery time between a traditional knee replacement and a minimally invasive knee replacement is substantial, points out Berger. Recovery from traditional knee surgery requires three to five days in the hospital and another five to seven days in a secondary care facility such as a rehabilitation center or a nursing home before the patient goes home, he says.

Although the cost of the implants and the tools is comparable to those used in traditional surgery, the shortened length of stay and the reduced need for lengthy therapy decreases the overall cost of the procedure, he adds. Recovery of function also is significantly faster, Berger notes. "Once a patient can go up and down stairs, get in and out of bed on his or her own, and get in and out of a chair, the patient is sent home.

At this time, all of his outpatient knee replacement procedures are scheduled as first case of the day, so the patient spends a few hours in recovery, has lunch, goes to physical therapy, and then is discharged to home in the afternoon using crutches or a cane for support. "Within three to four days, they are walking on their own," Berger says. Patients undergoing traditional knee replacement surgery reach this point in three to four weeks after going home, he adds.

Patients undergoing the minimally invasive surgery are 90% recovered in three weeks, as compared to traditional surgery recovery time of three to four months, Berger adds. Because the patient doesn't experience the same level of pain with the minimally invasive surgery, most patients are able to drive in six to seven days because they no longer need pain medication, he says.

Alfred J. Tria, MD, an orthopedic surgeon at The Institute for Advanced Orthopaedic Study, a division of The Orthopaedic Center of New Jersey in Somerset, pioneered the minimally invasive method but does keep his patients in the hospital for one night. "At the present time, only about 30% of my patients can undergo the procedure," he says. "I limit it to patients less than 80 years of age, under 225 pounds, with minimal deformity of the knee, with osteoarthritis, and with no previous major open-knee operations."

While there only are a few surgeons performing minimally invasive knee replacement at this time, Tria expects the popularity of the procedure to grow. "We believe the minimally invasive technique will account for 40% of all total knee replacements in the next five years," Tria explains. "The technique has no disadvantages, as long as surgeons are properly trained to avoid complications."

Berger contends credentialing for this procedure should require procedure-specific training. "This is not a simple procedure for a surgeon and does require special instruction," he says.

Zimmer, the Warsaw, IN-based manufacturer of the instruments, offers a two-day course at which the surgeons can practice on a cadaveric knee, he says. **(For contact information, see resource box, p. 67.)** In addition to the course, surgeons must scrub with one of the surgeons involved in the design of the equipment before Zimmer will release the instruments to them, adds Tria.

The minimally invasive knee replacement was

SOURCES AND RESOURCE

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For information on minimally invasive instruments and training for total knee replacement contact:

- **Zimmer**, 1800 W. Center St., Warsaw, IN 46581-0708. Phone: (800) 613-6131 or (574) 267-6131. Fax: (574) 372-4988. E-mail: info@ zimmer.com. Web: www.zimmer.com. Click on "medical professional." For training information, then choose "medical education calendar."

not discussed by the National Institutes of Health Consensus Panel on Total Knee Replacement because the approach is too new to assess its effectiveness, says **E. Anthony Rankin**, MD, chief of orthopaedic surgery at Providence Hospital in Washington, DC, and chair of the consensus panel. In addition to the need for additional training, there also is a disadvantage due to the lack of a track record regarding longevity of the results and the short length of time in which surgeons have had to evaluate patient-based outcomes, he adds.

However, "there is an appeal for this technique, both for surgeons and patients, based on its newness and promise of shorter recovery time," he adds. ■

Liposuction cases are safe, according to study

National guidelines, patient education important

The recent action by the Florida Board of Medicine to restrict liposuction and abdominoplasty procedures in an office setting may call the safety of liposuction into question. **(For more information on the Florida action, see "After 8 patient deaths, FL moratorium announced," *Same-Day Surgery*, April 2004, p. 46.)**

However, the latest liposuction study reports a complication rate of only 3% for 331 cases performed in office-based settings included in the study, according to the Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement (IQI) in Wilmette, IL.

The combination of adherence to national clinical practice guidelines, careful patient preoperative evaluations, and diligent monitoring during the procedure contribute to a low complication rate, says **Sheila Ferguson**, director of the Surgical Suite for Dermatology Associates of Atlanta, which participated in the study. "I'm surprised to see more patients requesting liposuction and wanting the procedure to be performed in a matter of days," she explains.

Patients usually have to wait a few weeks after the initial consultation for several reasons, including a busy surgery schedule as well as the facility's insistence on complete lab work-ups and medical clearance from the patient's family doctor if there are any medical problems, says Ferguson. "We also want the patient to have time to think about the procedure, to make sure they have read all the material we give them, to give them time to ask questions, and to ensure that they are making a fully informed decision," she adds.

The range of supranatant fat and fluid extracted in the study cases ranged from 10 ml to 13,700 ml, with a median of 2,075 ml and an average of 2,620 ml. In 12% of cases, more than 5,000 ml of fluid was extracted. Guidelines from the American Society of Plastic Surgeons (ASPS) in Arlington Heights, IL, recommend the procedure be performed inpatient if more than 5,000 ml is extracted. The American Academy of Dermatology (AAD) in Schaumburg, IL, and the American Society for Dermatologic Surgery in Rolling Meadows, IL, recommend that

EXECUTIVE SUMMARY

Among the results reported in the latest liposuction study produced by the Institute for Quality Improvement is a complication rate of only 3% for 331 cases included in the study. Adherence to national guidelines, diligent monitoring during cases, and patient education contribute to this low rate, according to one participant.

- 89% of patients who recalled their procedure reported a comfort rating of "1" or "2" on a scale of 1 to 5, with 1 representing no pain.
- Prophylactic antibiotics were administered in 92% of the cases.
- 94% of the patients contacted six months after the procedure rated their decision to undergo liposuction as positive.

SOURCE AND RESOURCE

For more information, contact:

- **Sheila Ferguson**, Director, Surgical Suite for Dermatology Associates of Atlanta, 5555 Peachtree Dunwoody Road N.E., Atlanta, GA 30342. Phone: (404) 256-4457, ext. 239.

Copies of the liposuction study are available for $50 each plus shipping charges, which range from $12 to $35. To order, contact:

- **Institute for Quality Improvement**, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091-2992. Phone: (847) 853-6060. To order on-line, go to www.aaahciqi.org, and scroll down to "Liposuction with Sedation, Regional, and/or General Anesthesia."

no liposuction be performed if more than 5,000 ml of aspirate is required, regardless of location.

Study participants reported a lidocaine dose range from 0-66 mg/kg, with a median of 26 mg/kg and an average of 25 mg/kg. Clinical practice guidelines from the AAD cite 55 mg/kg as a safe limit, while the more conservative guidelines of the ASPS recommend a maximum of 35 mg/kg total lidocaine dose.

Ferguson says postoperative pain is not a problem for her patients. "We give them prescriptions for a minimum number of pain pills, and we've only had one patient ask for a refill in the past several years," she explains.

Her facility provides a significant amount of preoperative education, and staff tell patients to start their medication as soon as they eat so that when the anesthesia wears off, they won't feel pain, Ferguson says. "We also tell them to expect soreness as they heal." Because the patients aren't surprised by the soreness during recovery, they don't panic and think that it is a symptom of a complication or the beginning of pain, she explains.

Patients also aren't complaining of pain during the procedure. Of the 98% of patients who responded to a one-week postoperative survey, 61% recalled their procedures, and 89% reported an intraoperative comfort rating of "1" (66%) or "2" (23%) on a scale of 1 to 5, with "1" equal to no discomfort.

There was only one aspect of the study's findings that surprised Ferguson. "We only use intravenous sedation, and I did not know that general anesthesia still was being used by some surgeons," she says.

Of the 38% of cases where the type of anesthesia was listed and for which there were more than 10 cases, the following types of anesthesia were used:

- intravenous: 31%;
- intramuscular: 21%;
- laryngeal mask airway (LMA): 7%;
- LMA/other general: 3%.

Ferguson's facility also administers prophylactic antibiotics for each case, as did 92% of the study participants.

"The types of antibiotics used for which there were more than three cases were cefazolin (53%), cephalexin (41%), and ampicillin (6%), says **Naomi Kuznets**, PhD, director of IQI.

A large number of patients included in the study were happy with the procedure: 94% of the patients contacted six months after the procedure rated their decision to undergo liposuction as positive, and 89% reported high levels of satisfaction with the procedure.

"I did not have one patient who I contacted after the study say that they regretted their decision," Ferguson adds. "They were all pleased with the lack of pain during and after the procedure, and with their results." ■

Same-Day Surgery Manager

Why are some surgeons returning to hospitals?

By **Stephen W. Earnhart**, MS
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Austin, TX

As this industry continues to expand and reach new levels of acceptance and opportunities, the need for quality surgeons utilizing our programs grows with it.

I remember vividly the days of going around to the surgeons' offices, hoping to catch them in a weak moment, and convincing them that they "need to try our surgery center for just one case."

I told them if we didn't live up to the hype, we would leave them alone. Shock of all shocks, we are doing that again. There is a situation happening that many of you may not be aware of: Surgeons are going back to the hospitals to

perform their ambulatory surgery cases!

"What?" you say. "How can this be? We are so cool!" As cool as dedicated ambulatory surgery centers (ASCs) are, "the times they are a changing." While many hospitals are joint venturing surgery centers with surgeons and continue to expand, there are some hospitals that refuse to join the party. They are holding fast to providing very efficient, cost-effective service to the end user. With so many ASCs in diverse markets across the country, posting of cases at the local hospital can be far easier than at the busy ASC.

However, the inability of hospitals to share equity with the surgeons will continue to plague them. That's unfortunate, in a way, because many hospitals are trying to correct past mistakes and become more user-friendly. With a significant number of surgery centers boasting 25% to 200% returns on their investment, it is unlikely that the high-volume surgeon will forgo that opportunity just to post cases faster.

Chances are, these big cutters will migrate and develop their own center before they go back. But to the newer surgeons without cash to invest and/or not enough cases to be attractive to the for-profit sector, they are finding comfort in the not-for-profit hospital sector. And they are finding a kinder, gentler hospital in which to work.

Several hospitals are changing rapidly the way they conduct themselves with their surgeons. Many are adopting the lifestyle of the for-profit sector without the sharing of revenue with their surgeons. "Attention to detail" is the new war cry of the not-for-profit hospital industry. Changing personnel, benchmarking, throwing out antiquated thinking and concepts, thinking before acting, listening to what works, exploring other options, lowering their egos — these actions are making hospitals a potential viable new opportunity for surgeons. Suddenly hospitals have become the new underdog, and Americans love the underdog.

The concept of a surgery center on every street corner is not as popular as it was once. What goes around comes around, and I see a curve ahead in the road. ASCs need to focus on customer service and market to the surgeons.

Time and time again, I hear the surgeons complaining to me about how their surgery center has become more difficult to work in. They say there are too many cliques or the centers are too focused on money; they are catering too much to one specialty or surgeon; turnaround time is getting longer and longer; or staff are not as receptive to changes as they once were. In an industry that is 100% dependent upon the surgeon using the facility, more attention needs to be focused on the core business and not the other "business."

What we starting doing 20-plus years ago was a good thing. It worked then, and it still does; but the paradigms are shifting. Watch what is happening in the industry. One of those changes is that hospitals are waking up and regrouping. I always have maintained one of the reasons surgery centers are so strong is because there is a robust community hospital in town. With surgical volumes increasing every year, there is ample business for both. This is just a heads up that our surgeons are always going to be looking for efficient, user-friendly environments. Don't get too hung up on the idea that it always is going to be you.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management.

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CMS describes HIPAA authorization form

The Centers for Medicare & Medicaid Services (CMS) offers a preview of a privacy authorization form that includes the core elements and necessary statements required in the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

CMS is developing a standard authorization form for Medicare beneficiaries to use to authorize CMS to release personal health information to a third party. Although the form will not be available for several months, the program memorandum offers a guide to the elements necessary for a valid privacy authorization. The core elements of a valid authorization must contain at least the following elements:

- Description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.
- Name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure.
- Name or other specific identification of the person(s) or class of persons, to whom the covered entity may make the requested use or disclosure.

• Description of each purpose of the requested use or disclosure. The statement, "at the request of the individual" is a sufficient description of the purpose when the beneficiary initiates the authorization and does not, or elects not to, provide a statement of the purpose.

• Expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure.

• Signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual also must be provided. Although the HIPAA Privacy Rule only requires a description of the representative's authority to act for the individual, CMS is requiring that documentation showing their authority, such as a power of attorney, be attached to the authorization.

The memorandum also includes examples of wording that may be used to place an individual on notice that he or she can revoke the authorization and the process that must be followed to revoke authorization. The program memorandum can be accessed at: www.cms.gov/manuals/pm_trans/AB03147.pdf. ■

HIPAA Q & A

Are there privacy concerns with off-site workers?

[Editor's note: This column addresses specific questions related to Health Insurance Portability and Accountability Act (HIPAA) implementation. The cautions listed below apply not only to employees working at remote locations, but also to off-site, third-party independent contractors such as a transcription service.]

Question: If an employee works out of his or her home, either full-time or part-time (e.g. during maternity leave, on weekends or evenings, or as part of telecommuting job description), do the HIPAA security regulations apply? If so, how do we ensure compliance?

Answer: If the employee is working at home with electronic protected health information (EPHI), the security regulations apply, according to **Robert W. Markette Jr**., an Indianapolis attorney. Compliance will depend upon a number of factors:

• Does the employee access EPHI remotely?

• Does the employee maintain EPHI on the home personal computer (PC)?

• Who in the home can access the PC?

• How is EPHI stored and retrieved?

"If the employee is accessing EPHI remotely, I would recommend at least evaluating the security of EPHI in transit," says Markette. "If you have concerns about the security of that transmission, you might consider steps to increase the security."

There are numerous technologies that could work in this environment, and each entity will need to assess the risks and determine what is needed for an appropriate operating procedure, he adds.

You also may want to establish password-protected access if other people have access to the employee's computer. **(For information about setting up passwords, see HIPAA Q&A, *Same-Day Surgery*, February 2004, p. 16.)** ■

OIG: Reduce payment for intraocular lenses

Recommendation won't take affect now

The Department of Health and Human Services' Office of Inspector General (OIG) has reported that the $150 Medicare payment for intraocular lenses (IOLs) is more than the cost of IOLs to surgery centers. OIG recommends that the Medicare payment be reduced in a manner that consider the different types and costs of IOLs.

Overall, IOL cost averaged $90.30 per lens, the report says. The highest cost IOL, made of soft acrylic, averaged $125 per lens. The most frequently used IOL, made of silicone, averaged $69 per lens. The lowest cost IOL, made of polymethyl methacrylate (PMMA) averaged $39 per lens.

The Centers for Medicare & Medicaid Services (CMS) will consider this recommendation as it designs a new payment system for surgery centers. CMS is required to implement a revised payment system by Jan. 1, 2008. This report will not change payments for IOLs in the immediate future.

A free copy of the report is available through the Federated Ambulatory Surgery Association. Go to www.fasa.org. Under "What's New at FASA," click on "OIG Releases IOL Report," then "Read the IOL Report." ■

Task force to address ASCs, specialty hospitals

The American Hospital Association (AHA) has formed a new task force to address the challenges from the growth of physician-owned specialty hospitals and other limited service providers, including ambulatory surgery centers (ASCs).

The Task Force on Delivery System Fragmentation succeeds an earlier AHA task force that investigated niche provider issues and helped lead Congress to place an 18-month moratorium on development of new specialty hospitals. **(For more information, see *Same-Day Surgery*, January 2004, p. 4.)** William Petasnick, president and CEO of Froedtert and Community Health in Milwaukee, will chair the group.

According to an AHA issue paper on limited-service providers obtained by *Same-Day Surgery*, the AHA's priorities are:

• Extend the 18-month moratorium to allow Congress to consider and act on studies related to limited-service providers.

• Limit further physician self-referral.

• Require physicians to disclose the nature of any financial interest they have in a health care-related entity to which they refer patients.

• Require comparable federal quality standards and mechanisms for enforcing them where there are similar clinical practices occurring in inpatient, outpatient, and specialty service settings (such as ASCs).

• Require a formal transfer agreement for ASCs and specialty hospitals that don't have a full-time emergency department.

"The AHA has appointed a task force to assess the current environment and consider how these recommended actions should be expanded to address escalating growth in limited-service providers and ways in which community hospitals and physicians can work together to meet all the needs of their communities," the issue paper said. ■

Hemostatic agent leads to 110 adverse events

Since 1996, the Food and Drug Administration (FDA) has received reports of more than 110 adverse events related to absorbable hemostatic agents, including 11 that resulted in paralysis or other neural deficits.

The device is used to promote coagulation and stop internal bleeding during surgical procedures.

Review the device label, especially the contraindications, warnings, and precautions, suggests the FDA's Center for Devices and Radiological Health (CDRH). If you use an absorbable hemostatic agent on or near bony or neural spaces:

• Use the minimum amount necessary to achieve hemostasis.

• Remove as much of the agent as possible after hemostasis is achieved.

This will reduce the likelihood of neural and other soft tissue damage from swelling of the absorbable hemostatic agent, and/or migration and swelling of fragments of the agent, according to the CDRH. For more information, see the notice at www.fda.gov/cdrh/safety/040204-hemostatics.html.

CDRH encourages providers to report adverse events related to absorbable hemostatic agents, even if they don't meet the requirements for mandatory reporting.

You can report these directly to the device manufacturer. You also can report to MedWatch, the FDA's voluntary reporting program.

You may submit reports to MedWatch by phone at (800) FDA-1088; by fax at (800) FDA-0178; by mail to MedWatch, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857-9787; or on-line at www.fda.gov/medwatch/report.htm. ■

COMING IN FUTURE MONTHS

■ How long is too long? Debate over limiting outpatient surgery

■ Traditional vs. laparoscopic approach examined

■ New procedure cuts recovery time in half

■ Should patients with complex medical conditions have outpatient surgery?

■ How to handle an unannounced survey — Getting ready for January

CE/CME objectives

After reading this issue of *Same-Day Surgery*, readers will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *"Surgery clinics targeted in national investigation"* in this issue.
- Describe how those issues affect clinical service delivery or management of a facility (See *"Anesthetists tout post-op nerve blocks, but who's going to pay?" "Less pain for outpatient knee replacement,"* and *"Liposuction cases are safe, according to study.")*
- Cite practical solutions to problems or integrate information into your daily practices, according to advice from nationally recognized ambulatory surgery experts.

CE/CME answers

21. A **22. C** **23. B** **24. D**

CE/CME *questions*

21. Regional anesthesia patients with propofol can bypass PACU almost 90% of the time, whereas gas anesthesia patients without block probably will be eligible for PACU bypass how often, according to Brian A. Williams, MD, MBA, associate professor of anesthesiology at the University of Pittsburgh?
    A. less than 10% of the time, if at all
    B. less than 15% of the time, if at all
    C. less than 20% of the time, if at all
    D. less than 25% of the time, if at all
22. In the "rent-a-patient" scheme, on which days were surgeries typically scheduled?
    A. on Mondays and Fridays, to accommodate patient's travel
    B. on Fridays, when centers tend to be busiest
    C. on Saturdays and Sundays
    D. on holidays
23. Patients undergoing minimally invasive knee replacement surgery will be 90% recovered in what time frame, according to Richard Berger, MD, an orthopedic surgeon?
    A. two weeks
    B. three weeks
    C. four weeks
    D. five weeks
24. What is one reason for the low complication rate reported in the latest liposuction study produced by the Institute for Quality Improvement, according to Sheila Ferguson, director of the Surgical Suite for Dermatology Associates of Atlanta?
    A. new medications
    B. fewer patients asking for the procedure
    C. more staff members in the operating room
    D. adherence to national clinical practice guidelines

CE/CME instructions

Physicians and nurses participate in this CE/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 this 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. ■