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INSIDE

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Brace yourself: HCFA might be wrong in optimistic predictions for PPS rule

Faulty assumptions also used for ASC outpatient proposal, some say

Many same-day surgery experts initially were relieved to see the Health Care Financing Administration's (HCFA) estimation that the final regulation for the hospital outpatient prospective payment system (PPS) would lead to a 4.6% increase in outpatient payments, instead of a 5.7% reduction. All the hoopla over the projected impact had been exaggerated, some suggested. But now it appears the hoopla might be more accurate than HCFA.

Many experts now say that HCFA made a number of assumptions; the estimates probably are off; and it's unclear what impact the rule will have on hospital payments. In addition, some fear that "faulty assumptions" were present in the ambulatory surgery center (ASC) proposed PPS regulation and could cause problems with that final rule, scheduled for publication in November 2000 and implementation in April 2001.

In regard to the final hospital rule, "I never thought it was good news," says **Eric Zimmerman**, JD, associate with McDermott, Will, and

EXECUTIVE SUMMARY

Several experts are questioning the Health Care Financing Administration's (HCFA) estimate that hospital payments will increase 4.6% under the outpatient prospective payment system (PPS).

- HCFA is accused of making faulty assumptions — for example, that volumes will increase and providers will upcode.
- Those same assumptions were used for the proposed ambulatory surgery center (ASC) regulations, some charge. The final ASC rule is scheduled for publication in November 2000, and implementation is scheduled for April 2001.
- Delay of the July 1, 2000, implementation date for hospitals appears unlikely.
- In good news, HCFA is considering increasing outpatient PPS payments for more than 500 medical items.

Emery in Washington, DC.

HCFA made several assumptions, for example, that the outpatient claims collected by the agency to develop the PPS were correctly coded, he says.

"I think everyone agrees that hospitals have not correctly coded claims in the past because they haven't had an incentive to do so," he says. "It's hard to try to analyze what the impact is going to be, code by code and also in the aggregate, when you don't have a historical sense."

Consultants who have analyzed HCFA's assumptions for both the hospital-based rule and the proposed ASC regulation have come to different conclusions than the federal agency, Zimmerman points out. For example, The Lewin Group, a health care consulting company in Falls Church, VA, determined that under the ASC proposed rule, payment would decrease by 10%. In comparison, HCFA estimated that payment would decrease by 2%. "That's a pretty considerable difference," Zimmerman says, and adds that a 2% reduction is out of the question for high-volume procedures such as ophthalmology.

"I'm nervous that the same faulty assumptions are present here in hospital context too," he says.

In forming the hospital outpatient PPS, HCFA assumed that the new payment system would cause outpatient staff to start coding more completely, or when they had a choice between two codes, to upcode, says **Kevin Coleman**, senior scientist at The Lewin Group.

"They also assumed hospitals and other outpatient facilities that would be facing reductions in payment would try to offset those losses through volume growth," he says. In addition, HCFA assumed that with multiple procedures, some hospitals would submit separate claims for each procedure to maintain higher payments rather than submit the procedures on a single claim and face payment discounts. These assumptions are reflected in the final rule, Coleman says.

However, HCFA wasn't specific about how it arrived at these assumptions. For example, no one knows if there will be a volume offset, and no one knows if upcoding will occur and if it will occur rapidly, he adds.

When the Congressional Budget Office (CBO) looked at the differences between Medicare outpatient payments restored by the Balanced Budget Act and the Balanced Budget Refinement Act (BBRA), it estimated that between 2000 and 2004, $5.3 billion would be restored in payments to hospitals. "When we made our estimate, we could only come up with $4 billion," Coleman says.

"I'm not saying we're right and they're wrong," he says. "We're just not sure what HCFA and the CBO have done."

The bottom line: The impact of the BBRA probably is going to be somewhat smaller than HCFA predicted, he says. "It's difficult to assume how people will respond to a completely new payment system," Coleman adds.

Take HCFA's prediction "with a grain of salt," suggests **Deborah Williams**, senior associate director of policy for the American Hospital Association (AHA) in Washington, DC. "No one knows what's going to happen July 1," she says. "The payments could be more; they could be less; or HCFA could be about right." Keep in mind that HCFA is offering "transitional-corridor" payments until 2004. Medicare will pay hospitals a portion of any losses they would otherwise incur resulting from receiving smaller payment than under prior law.

"That affects the numbers," Williams says. "That's why the estimate is so high."

At Fairview-Southdale Hospital in Edina, MN, same-day surgery managers have been advised by their financial consultants, Cleveland-based IMRglobal-ORION, that they should expect a mixed response. "They know in some areas we'll probably be losing money, but they feel that if we follow the rules, there are areas for us to gain money, also," says **Sonia Barness**, RN, CNOR, same-day surgery nurse manager. **(See tips for same-day surgery managers, p. 67.)**

For example, same-day surgery programs will be reimbursed for multiple procedures, although the reimbursement will be discounted for the

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SOURCES

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second and subsequent procedures.

In good news from HCFA, the agency is considering increasing outpatient PPS payments for more than 500 medical items, according to an April 21 letter to the Washington, DC-based Health Industry Manufacturer's Association. In the letter, HCFA said the items would be considered for transitional pass-through payments, which would mean increased reimbursement for up to three years.

HCFA said that a significant number of catheters and items that patients don't take home with them probably would qualify for the increased payments. At press time, HCFA planned to post a revised list of approved items on its Web site (www.hcfa.gov). **(For good news on new intraocular lens technology, see story, p. 68.)**

Will July 1 implementation date stand?

One question at the forefront of providers' minds is whether the July 1, 2000, implementation date will be delayed and, if not, what problems can be expected.

Several groups, including the Cincinnati-based Catholic Healthcare Partners, which owns more than two dozen hospitals in four states, are writing congressional representatives to explain problems that will result from a July 1 implementation. However, HCFA officials have said that a delay is unlikely.

In the meantime, the AHA has asked HCFA to form contingency plans to address difficulties that could arise in implementing the system. At press time, HCFA planned to release those contingency plans by May 15. HCFA also is holding teleconferences with state hospital associations and training staff at those associations, software vendors, and fiscal intermediaries. By June 1, HCFA will publicize the PRICER program, which calculates payments for APCs.

[The final outpatient PPS regulation for hospitals was published in the April 7 Federal Register *and can be accessed at the publication's Web site (www.access.gop.gov/su_docs/aces/aces140.html) or through published copies in many public libraries. For more information on the final hospital outpatient PPS rule, see* Same-Day Surgery, *May 2000, p. 49.]* ■

Days are counting down: 4 steps to take now

The July 1, 2000, implementation date of the Health Care Financing Administration's (HCFA) hospital outpatient prospective payment system (PPS) has not been delayed, so providers should waste no time doing their last-minute preparations. Consider these suggestions from same-day surgery experts:

- **Focus on scheduling.**

For freestanding facilities that are connected to a hospital, work with your scheduling department to ensure that procedures are scheduled for the correct facility, suggests **Sonia Barness**, RN, CNOR, same-day surgery nurse manager at Fairview-Southdale Hospital in Edina, MN. **(For a list of procedures that have been designated as inpatient procedures and ones that have been added to the outpatient list, see *Same-Day Surgery*, May 2000, p. 52.)**

Keep in mind that there were changes in the final rule, Barness emphasizes. "The proposed regulation said lap chole had to be inpatient, but the final rule says it can be done either place."

To ensure the correct location is scheduled for procedures, the scheduling manager at Fairview-Southdale printed the Common Procedure Terminology (CPT) codes and the facility's surgery procedure codes and is matching them, Barness says. Mismatched codes are a key reason for claim denials.

EXECUTIVE SUMMARY

With a July 1, 2000, implementation date looming for the hospital outpatient prospective payment system, same-day surgery managers need to take steps now to ensure their programs are prepared:

- For hospital-affiliated centers, work with your scheduling staff to ensure that procedures are scheduled for the correct location.
- Perform an audit to ensure the documentation is legible. Ensure that physicians document the reason for any cancelled procedures.
- Ensure your staff know how to code with Health Care Financing Administration Common Procedural Classification System and Common Procedure Terminology codes. Make sure that services performed in connection with one outpatient encounter are billed together.
- Perform a legal and financial analysis to determine your provider-based status. Don't assume that it's more beneficial to be designated as an ambulatory surgery center.

• **Ensure documentation is legible and done correctly.**

"We know, in terms of our documentation, that people are scribbling and they're not legible," Barness says. This problem could reduce reimbursement, because many medications and other items are paid by the unit, she emphasizes. "That's one of the tricky things, to make sure the orders are there and they're legible, so medical records can read what we've done [and bill accordingly]."

The documentation of cancelled procedures will change under the outpatient PPS, she says. Previously, physicians, nurses, or someone else on staff could document when a procedure was cancelled. "Now the physician needs to document the reason for the cancellation and give a description of the primary procedures that was to be performed in the medical record, if the patient is in the OR when the procedure is cancelled," Barness says.

With this documentation, facilities can receive a percentage of the procedure charge, she points out. "If anesthesia is already started, you get 100%."

"We'll probably do an audit in six weeks or so to see how we're doing and to determine if can we read everything," Barness says.

• **Make accurate coding and billing a priority.**

"One thing providers absolutely need to do is begin learning how to code, and educating their reimbursement staff how to accurately code," says **Eric Zimmerman**, JD, associate with McDermott, Will, and Emery in Washington, DC.

You will exacerbate the problems of adapting to a new payment system if you don't code correctly, he warns. "They have had incentives, and a great number of hospitals don't know how to code with HCPCS [HCFA Common Procedural Classification System] and CPT codes." However, knowing the HCPCS and CPT codes is critical to being paid correctly, Zimmerman emphasizes.

It's important to document if multiple procedures are performed, because facilities will receive reimbursement for those procedures, but it will be discounted for the second and subsequent procedures, Barness says.

In an advisory, the American Hospital Association (AHA) informed its members: "Ensure that all services provided directly or under an arrangement during an outpatient encounter are billed together — or the hospital may be subject to civil penalties. Hospitals should also improve coding of medical visits in accordance with HCFA's requirement that institutions have processes for assigning different cost and effort levels related to medical, clinical, and emergency room visit codes."

HCFA adds $50 payment for new technology IOLs

The Health Care Financing Administration (HCFA) announced, in the May 3 *Federal Register*, that two lenses meet criteria of a new technology intraocular lens. These lenses became eligible for a payment adjustment of $50 as of May 18, 2000. The payment adjustment is effective for five years. Although the notice applied specifically to ambulatory surgery centers, HCFA has stated that these lenses also will receive the additional payment in a hospital outpatient program. The following lenses are eligible:

- **Manufacturer: Allergan Medical Optical, Irvine CA.** Lens and model number: AMO Array Multifocal Model SA40N. Characteristic: Multifocal. Procedure code: Q1001 — NTIOL Category 1.
- **Manufacturer: Starr Surgical Co., Monrovia, CA.** Lens and model numbers: Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Intraocular Lens with Toric Optic Models AA4203T, AA4203TF, and AA4203TL. Characteristic: Reduction in Pre-existing Astigmatism. Procedure Code: Q1002 — NTIOL Category 2. ■

The AHA also advised its members to make needed billing and systems changes to accommodate the complicated formula for copayments. "And prepare a written notice that informs beneficiaries they'll have two copayments — one for the clinic and one for the physicians."

• **Determine your provider-based status.**

Perform financial and legal analyses to determine whether your program should be designated as provider-based, Zimmerman suggests. "In the surgery center context, I don't think they should presume that the hospital is always going to be paid more." Hospital rates are higher than the proposed ambulatory surgery center (ASC) rates in several cases, he points out.

"Depending on the case mix of the center, you might be better off as an ASC," he says.

Also, keep in mind that the Emergency Medical Treatment and Labor Act "anti-dumping" requirements apply only to facilities designated as provider-based, Zimmerman points out. "That's another reason [programs] might not want to be provider-based." ■

Avoid reimbursement delays: Accuracy is key

You monitor your supply costs; you track your operating room turnover times; and you collect data to enable comparison of your performance against other same-day surgery programs. These all are critical to fiscally responsible management, but are they enough? How closely are you watching your accounts receivables and reimbursement experience?

"There's no magic to create a good billing process, but it does require development of clear policies that are followed consistently and reviewed constantly," says **Andy J. Hetrick**, administrator of the Decatur (AL) Ambulatory Surgery Center. The center handles about 3,000 procedures per year and was averaging 90 days between the time a bill or claim was generated and receipt of payment in 1993 when Hetrick arrived. In 1998, the average accounts receivable had dropped to 28-32 days with the help of electronic claims and upfront discussions with patients and payers regarding coverage.

"There is no one thing that we did to create a dramatic drop in accounts-receivable numbers," he says. "We just looked at how we were gathering information and how we were submitting bills and identified areas that could be more efficient and more accurate."

The policies and procedures put into place at Decatur Ambulatory Surgery Center addressed key points of contact at which problems can be averted, says Hetrick. "Most problems can be avoided by taking steps upfront to identify and address potential denials."

Verifying insurance coverage specifics, such as pre-existing condition exclusions and collection of copays, and making sure the procedure is reimbursable in an ambulatory surgery setting are key activities, he explains. **(See story on solving reimbursement problems, p. 70.)**

Once the front-end verifications and financial arrangements are made and the surgery performed, the accuracy of the claim you submit is critical to avoid denials or partial reimbursements, says Hetrick.

Make sure codes match

A key reason for denials is often a conflicting Common Procedure Terminology (CPT) code or diagnosis codes between the surgeon, the anesthesiologist, or the surgical facility's claim, says **Jeff Ray Gibson**, MD, medical director of information services for perioperative and anesthesia services at Scott and White in Temple, TX. A rising number of claim denials a few years ago initiated a closer look at the specific explanation of benefits for each denied claim, he says.

EXECUTIVE SUMMARY

Good procedures can ensure accurate claims filings and speedy reimbursement for a same-day surgery program. Setting policies and following them consistently is necessary to keep accounts receivables days low and numbers of claims paid in full high. Some tips offered by experts interviewed by *Same-Day Surgery* include:

- Verify insurance coverage and specifically ask about exclusions for pre-existing conditions.
- Avoid denials based on mismatched codes between the surgeon, anesthesiologist, and facility claims by making sure your coders can communicate easily with physicians to ensure accurate coding of claims.
- Review claims denial and accounts-receivable reports regularly to identify problems at an early stage.

SOURCES

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"We discovered that the coding on the claims was not always consistent, and when codes for anesthesia and physician professional fees don't match the codes for the facility fees, part or all of the claim was denied," he explains.

The key problem at his facility: There was no employee who specialized in coding for outpatient surgical claims, says Gibson. "Because all of the coding was handled in a centralized department with no one person focusing on surgery, it was hard for the coders to spot a potential problem." Now, there is a coder who handles the anesthesiologist and surgeon part of the claims, he says.

To improve communication and make sure the coder can get the necessary information or explanations to file an accurate claim, that employee works in the department of anesthesiology. "This gives the coder immediate access to physicians who can verify exactly what was done in surgery," he says. Because the volume has grown to 771 day-surgery cases per month and the coders also handle pain management and inpatient surgery claims, now there are two coders who specialize in surgery, adds Gibson.

Freestanding day-surgery center staffs already specialize in surgery but need to establish a close relationship that makes it easy for a coder to pick up a telephone and call a surgeon's office to verify diagnosis and procedure codes, says Hetrick.

Review reports to find problems

Even when you have put the right processes in place, you must review denial reports on a monthly basis, says Gibson. Focus on the procedures that represent the highest volume or the highest number of dollars first, he says.

Hetrick also has gained a new appreciation for electronic claims filing. "We made some changes in our accounting and billing software, and for some reason, we are now unable to file electronically as we have done in the past," he explains. Having to rely upon paper-claims filing has added six to 10 days in accounts receivable, says Hetrick. Reliance on postal delivery and the additional days that third-party payers require to open the mail and scan the information into their system are the reasons for the delays, he explains.

"Denials also have increased slightly because the scanner might pick up a '3' as an '8' and create an inaccurate code that causes the denial," says Hetrick. His staff then have to call the payer to correct the error and sometimes refile the claim. The delays in payment, the increased chance for denials in error, and the additional staff time to handle the denials are great reasons for making sure your day-surgery program is capable of filing electronically, he adds.

One of the biggest mistakes managers make when reviewing accounts receivable is to focus on accounts that are 120 or 180 days old, says Hetrick. While you shouldn't ignore these accounts, the best use of time is to look carefully at your accounts that are 60 and 90 days old, he says. These accounts have a better collection success rate than older accounts, same-day surgery experts point out.

"Your 120-day-old account is already a problem that needs to be solved, but if you spend time on the 60- and 90-day-old accounts, you'll be able to keep them from becoming problems," Hetrick explains. ■

ID reimbursement problems before they appear

Same-day surgery staff can spend a lot of time talking with third-party payers about denied claims, partial reimbursements, or late payments, so it's more efficient to develop processes to identify potential problems before they appear, says **Andy J. Hetrick**, administrator of the Decatur (AL) Ambulatory Surgery Center.

Identify potential problems when the patient is scheduled for surgery, Hetrick advises. "Our billing and coding people have developed a close relationship with the office staffs of our physicians, so whenever they have a question about a scheduled procedure, they pick up the telephone

and call for more information," he says.

One of the potential problems is a procedure that Medicare and other third-party payers don't recognize as a reimbursable procedure for an ambulatory surgery center. "If it is considered minor and able to be performed in a physician's office, we won't be reimbursed," says Hetrick. Even if a lesion is small enough to remove in a physician's office, some of Hetrick's physicians don't have the capability of handling the procedure in the office. When this situation arises, he approaches it two ways. "First, we contact the payer and explain that if it can't be performed in our surgery center, the physician will have to perform it in the hospital at much higher rates. Many times, the payer agrees to allow the procedure to occur in our facility."

However, this approach won't work with Medicare, which will only pay if the lesion is on its list of Common Procedure Terminology (CPT) codes, same-day surgery experts point out.

When the payer refuses to reimburse the surgery center for a certain procedure, the billing staff talk with the patient and explain that the procedure is not on the approved list and that the nonreimbursed costs will need to be collected upfront. Medicare patients are given written notice, as required.

A typical situation is that a lesion on the approved procedures list is scheduled along with a smaller lesion that isn't on the list. "The physician doesn't want the patient to come into the office for one lesion removal and the surgery center for the other removal, so the removal of both will be scheduled at the same time," Hetrick explains.

Check for exclusions

Another key to identifying potential reimbursement problems upfront is to ask the third-party payer the right questions when verifying coverage, says Hetrick. "We don't just ask if the patient is covered. We specifically ask if the patient is covered for the procedure that is scheduled."

This step helps the surgery center staff identify a procedure that is excluded due to pre-existing conditions. "Some plans have anywhere from a 30-day to 180-day waiting period before a pre-existing condition is covered," he says. If staff discover that the patient won't be covered for another week or month, someone contacts the physician's office to see if the procedure can be delayed.

Frequently, hernia repair and knee arthroscopy fall into this category, says Hetrick. If the procedure is required because a work-related situation aggravated the pre-existing condition to the point that surgery is needed, workers' compensation comes into play and the procedure can be covered. If, however, the payer doesn't agree to cover the procedure and the patient still wants to proceed, the surgery center staff work out a payment agreement, he adds.

When talking with the third-party payer, Hetrick's staff also verify that the surgeon has received pre-certification for the procedure. "If the physician's staff haven't obtained pre-certification, we call the physician's office," says Hetrick. "If the procedure has been pre-certified, we get the pre-certification number and include it in our files in case there is any question about the claim later."

The staff at Decatur Ambulatory Surgery also collect all copays, deductibles, and uncovered charges upfront, says Hetrick. If the patient is undergoing a procedure for which the third-party payer isn't covering any of the charges, a financial plan is arranged that includes an upfront amount and a billed amount that can be paid over an agreed-upon time, he adds. About 60% of patients are paying all charges not covered by third-party payers upfront, and the remaining 40% of the patients are billed, explains Hetrick. ■

Do you have a difficult physician in your OR?

Address problem now, or risk patient safety

They tell staff they are stupid. They expect staff to answer their pages. They berate staff members when they relay information about test results that delay surgery. More complaints of dysfunctional behavior are about physicians than any other staff, according to some same-day surgery managers.

"I go across the country from New York to California, and the stories are the same in every OR," says **Suzanne Broadwater**, RN, MBA, chief operating officer of Hingham, MA-based Ambulatory Surgical Centers of America, which is a limited partner and manager of 17 ambulatory surgical centers. "It's a time-honored problem," she adds.

EXECUTIVE SUMMARY

Some same-day surgery managers report that they have more complaints of dysfunctional behavior by physicians than by other members of their staff. If the difficult behavior isn't addressed, staff might begin to withhold important information from those physicians out of fear, even if that information concerns patient safety.

- Ensure your staff know they shouldn't neglect patient care to take care of nonpriority requests, such as answering a page.
- Assure impatient surgeons that you're there to help them.
- When surgeons are angry because clinical information is delayed or is abnormal, tell them they were given the information at the earliest possible opportunity.
- Make sure staff don't have a double standard of accepting touches or off-color jokes from surgeons they like and complaining about the same actions from surgeons they dislike.

Often, physicians who are approached about their difficult behavior don't understand, says **Michael A.E. Ramsay**, MD, chief of anesthesiology and pain management at Baylor University Medical Center in Dallas.

"We're all Type A personalities — mostly high strung, with high IQs," Ramsay says. "That means we have high math and science skills, not high people skills."

But those personality traits don't mean that managers should ignore difficult behavior by physicians, he emphasizes. "Once you have a dysfunctional physician in a stressful workplace, you start to develop a loss of morale and team spirit; you get increased turnover of staff; you get poor communication; and staff will withhold information from the physician because they're frightened of another outburst from the physician," Ramsay says.

When staff withhold information, it's not the physician who suffers, but the patient, he emphasizes. "This may be information on the patient's well-being, and patient safety might start to be at risk. It's important that whatever organization is in charge, whether hospital or physicians group practice, that dysfunctional behavior in a physician is recognized early and intervention is made."

Here are some typical comments from difficult physicians, along with tips from your peers on how to address them:

• "Answer my page."

When a surgeon's beeper goes off, he or she might expect a staff member to answer the page, although that person is involved in patient care.

"You have to bring him back to reality," says **Camille L. Collette**, RN, BSN, CNOR, clinical nurse IV at Beth Israel Deaconess Medical Center in Boston. "The patient comes first. This is why you're there."

Some physicians insist you take care of matters that aren't priority, Collette says. "You just have to stand your ground as a patient advocate."

• "You don't know what you're doing."

Demeaning treatment by physicians is one of the most common problems that same-day surgery staff report. If your staff have a lot of self-confidence, they should consider this response, Ramsay suggests: "If you'd explain exactly what you want, we're here to help you." Be very respectful in your reply and not inflammatory, he advises.

In a previous position at another hospital, Collette was visiting the OR in a management role when a surgeon couldn't get a piece of equipment to work properly and threw an instrument at Collette. She left the area. "He was in no frame of mind to even discuss it." Instead, she took her complaint through administrative channels. "There are many scenarios in which they take out their anger and frustration on the first person they see," Collette says.

• "Why wasn't I given this information earlier?"

When blood work is delayed or abnormal results are relayed to physicians, staff may bear the brunt of their anger because the case might be delayed. "It's information that can only be delivered once it's known by the staff," Ramsay says. "They don't have crystal balls."

Don't respond aggressively, but speak in a calm, clear manner, he suggests. "Just point out the facts of the situation, where the information was, how they got it, and that the physician got it at earliest possibility."

• "Have you heard the one about . . . ?"

Off-color jokes aren't uncommon in ORs, but staff need to be careful that they don't have a double standard, Broadwater warns. "They seem to accept the jokes from their favorite physicians," as well as affectionate pats on the back, she says. However, "if they don't like the physicians, they don't like anything they do."

You can't have it both ways, she emphasizes. "These physicians who have been reported or

SOURCES

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counseled, they're quick to notice you're accepting that behavior from someone else." **(For information on dealing with sexual harassment, see *Same-Day Surgery*, September 1998, p. 121.)**

In any uncomfortable situation involving physicians, don't take the comments personally and react defensively, Collette advises. "Just state the situation, in your viewpoint, and usually they respond to that," she says.

Don't confront physicians one-on-one, Ramsay advises. Consider bringing a colleague of the physician's to the discussion so you have a "good cop, bad cop" scenario, he suggests. "That way the physician feels that someone is on his side, but you're all concerned about him. If you do it right, with good data presented in a clear way to the physician, most will listen and change behavior, particularly if there is a protocol out there about what will happen if behavior won't change." Some same-day surgery managers prefer to have a medical director talk to the offender privately.

Emphasize to physicians that a cooperative attitude will ultimately help them get better care from the staff, Ramsay suggests. "If you're a good leader, you can pull that off. If you can't pull it off, if someone clearly is a difficult person, you have to weigh whether it's worth having [that physician] on board." ■

Same-Day Surgery Manager

Tips on how to handle the pediatric patient

By **Stephen W. Earnhart**, MS
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Big surprises often come in small packages. That is one reason that dealing with the pediatric patient in the operating room is such a challenge. It's not just a challenge from the viewpoint of anesthesia, but from the point of dealing with the parents (sometimes more difficult than the child) and siblings of the patient, should they accompany them to surgery.

Anesthesia considerations include the increased risk in small patients and infants just from an airway standpoint for the following reasons:

- The tongue is relatively large.
- The epiglottis is short, stubby, and angled away from the trachea.
- The vocal cords have a lower attachment.
- The narrowest portion of the airway is the level of the cricoid cartilage, while in adults it is the glottic opening.

Other areas of concern with infants and small children come from the fact that they have a higher metabolic rate with increased oxygen consumption. Thus, they have less oxygen reserve and can become hypoxic much faster than the adult.

Often, and I speak from experience as a parent, NPO (nothing by mouth) status doesn't mean much to hungry children. Many times crumbs and smudges on their fingers and clothes give clues that a snack was smuggled out of the kitchen while no one was looking. As a rule, many anesthetists are suspicious of NPO compliance in outpatient surgery on a young child coming in from home.

Many centers allow parents to accompany the pediatric patient into the operating room and even stay through the induction of anesthesia, a practice I have done as far back as the late '70s. Not only is it comforting for the child, but often (if handled properly) a greater comfort for the parents. Nothing is more frightening than watching your small child, lost in a clump of sheets and

blankets, being wheeled behind those double doors on a stretcher!

A good procedure might be for the parents to walk the child back to the operating room with the nurse or use a brightly colored wagon for the staff to pull the child to the operating room. Fainting parents rarely are a problem, but staff should be prepared for a swooning mother or father. A stern look by the nurse will usually quiet a talkative family member.

While some hospitals and ambulatory surgery centers (ASCs) don't allow this practice, it's usually because the staff are uncomfortable with the concept — not the patients. It's a very worthwhile service that more facilities should adopt.

Interestingly, the state of Pennsylvania, in its recently revised ASC Licensure Rules and Regulations (October 1999), has addressed many specifically related ASC regulations concerning pediatric care. Earnhart & Associates is working with many facilities in Pennsylvania and also developing exclusive pediatric surgery centers, and we applaud these changes.

While the new regulations often can be challenging, we think that state is on the right course. Following these regulations, even if you're not located in Pennsylvania, will help you avoid risk management problems with your pediatric patients. Some of the new Pennsylvania regulations include:

• No patients younger than 6 months of age may receive treatment.

• The medical record must include documentation that the child's primary care provider was notified by the surgeon in advance of the procedure and that an opinion from the primary care provider was obtained as to the appropriateness of the procedure in the ambulatory surgery facility setting. When an opinion from the primary care provider is not obtainable, documentation explaining why an opinion could not be obtained must be in the medical record.

• Anesthesiology services must be provided by a graduate of anesthesiology residency program that is accredited by the accrediting council for graduate medical education or equivalent, or a certified registered nurse anesthetist trained in pediatric anesthesia. Both must have documentation of historical and continuous competence in pediatric care.

• The surgeon performing the procedure will be board certified or have pre-board certified status from the Board of Medical Specialties, of Osteopathic Surgery, of Pediatric Surgery, or of Oral and Maxillofacial Surgery.

• A medical professional must have completed a course in advanced pediatric life support offered by the Elk Grove Village, IL-based American Academy of Pediatrics and either the American College of Emergency Physicians or the American Heart Association, both in Dallas. That medical professional must be present in the facility when a pediatric patient is in the facility.

• The governing body is responsible to ensure the presence of a medical professional certified in pediatric life support is in the facility at all times when a pediatric patient is present.

These are interesting requirements that might be somewhat difficult to absorb, but great for our younger patients! Bottom line: When the pediatric patient goes south, they do so with alarming speed. Regulations, pre-planning, and constant diligence keep us all prepared!

(Earnhart and Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Earnhart can be reached at 5905 Tree Shadow Place, Suite 1200, Dallas, TX 75252. E-mail: surgery@onramp.net. Web site: www.earnhart.com.) ■

Nurse endoscopists increase staffing options

GI nurses perform colorectal cancer screenings

An aging population means more patients seek tests such as screening sigmoidoscopy for colorectal cancer. While this is a procedure commonly performed by a physician, some facilities are utilizing the skills of gastroenterology nurses to perform the procedure in an effort to improve efficiency and patient care.

The primary benefit of a nurse handling the screening exam is that it frees the physician to handle more acute cases, says **Irfan Hussain**, MD, chief of gastroenterology at Kaiser Permanente in Denver.

"Another benefit is that a nurse endoscopist who has screening sigmoidoscopies as a major part of the job will perform a lot more of the procedures than a physician who just occasionally has a patient that needs the screening exam," he says. "The benefit to the patient is that practice makes perfect, and the nurse who does this every

EXECUTIVE SUMMARY

As more people seek screening for colorectal cancer, physicians and same-day surgery programs that include endoscopy labs will look for ways to staff efficiently. One solution is to train qualified, experienced nurses to perform the test with specific protocols and on-site or nearby physician assistance if needed. Several issues surrounding nurse performance of flexible sigmoidoscopy must be evaluated by each facility to determine practicality of this solution.

- Nursing board regulations of nurse performance of sigmoidoscopy differ from state to state.
- Reimbursement from Medicare to a nurse performing the procedure is not possible, but other payers may negotiate reimbursement.
- Protocols and credential requirements must be clearly defined before nurses are hired and trained for the procedure.

day will have better skills than a physician who performs the test 10 to 15 times each year."

Outcomes from a nurse's performance of the screening are just as good when physicians perform the procedure,[1,2] says Hussain. "In our own lab, our review of the nurses' cases showed that no lesions were missed in 1999, and since the program began in 1996, we've found only two missed lesions," he adds. The Kaiser Permanente nurse endoscopists see more than 3,000 patients each year, he says.

Patients also benefit because nurses tend to spend more time educating the patient, making sure they are aware of the patient's pain level, and talking with the patient during the exam, says J**ane Allaire**, RN, CGRN, nurse specialist at the National Naval Medical Center Endoscopy Lab in Bethesda, MD.

The disadvantages may include reimbursement issues and state boards of nursing that do not allow a nurse to perform the procedure alone.

"Medicare reimburses for screening sigmoidoscopies performed by a medical doctor or a doctor of osteopathy only," says **Nancy S. Schlossberg**, BSN, RN, CGRN, president-elect of the Society for Gastroenterology Nurses and Associates (SGNA) in Chicago. Because the American College of Surgeons and the American College of Gastroenterologists in Chicago recommend flexible sigmoidoscopy screening for colorectal cancer beginning at age 50, there is a population covered by private payers that may provide patients for nurse endoscopists, she adds.

A facility that is considering the use of nurse endoscopists should survey the managed care companies with which it has contracts to determine if the procedure will be covered if a nurse performs it, suggests Schlossberg. The issue of whether reimbursement is reduced with a nurse endoscopist is negotiated on a payer-by-payer basis, she says. The advantage to payers is that patient access to the test is increased at a lower cost to the payer because a nurse's time is less expensive than a physician's time, she adds. Even with Medicare, Schlossberg says she has been told that sometimes a facility fee may be charged even if the nurse performs the procedure. Investigate all of these reimbursement issues because contracts differ, she suggests.

Another area that must be investigated before pursuing a screening program with a nurse endoscopist is your own state licensing board, says Allaire. A 1997 survey conducted by the staff at the Naval Medical Center found only seven state nursing boards approved screening sigmoidoscopy as a nursing practice. They were in Arizona, Maryland, Massachusetts, Nevada, Pennsylvania, Washington, and Wisconsin.

There were, however, 23 state boards that said the practice might be possible based on the state's decision-making model for scope of nursing practice, Allaire adds. Because nursing boards are constantly updating their regulations, check current practice regulations as you evaluate a screening program, she recommends.

Once you have addressed financial and regulatory issues, the key to a successful nurse endoscopist screening program is to hire the right nurses and provide a comprehensive training monitoring program and well-defined protocols, says Allaire. **(See protocol, inserted in this issue.)** Guidelines, protocol examples, and training recommendations are available from SGNA, says Allaire. **(See resource box, p. 76.)**

"The best nurse for this type of program is a gastroenterology nurse who is already familiar with the anatomy and has been assisting physicians with the procedure for years," says Allaire. Also, a gastroenterology nurse is familiar with infection control procedures and care of the equipment, she adds.

Kaiser Permanente requires that nurses have at least five years in gastroenterology, says Hussain. "A great deal of learning takes place in a GI lab that makes it possible for a gastroenterology nurse to handle flexible sigmoidoscopy." That means the training program can focus on the

nurse's goal of performing without direct physician supervision rather than the basics of scopes, he adds.

The best training programs utilize a combination of study, observation, supervised procedures, and ongoing review by physicians, says Allaire. **(See training program, at right.)** While the numbers of supervised procedures may differ from facility to facility, the SGNA recommends a minimum of 25 before the nurse performs the procedure with no direct supervision. The Naval Medical Center requires 50 procedures to be supervised, and Kaiser Permanente requires 75 to be supervised.

"It means new areas for nurses to expand their skills," Allaire says.

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SOURCES AND RESOURCE

For more information about nurse endoscopists performing screening for colorectal cancer, contact:

- **Debbie Lantz**, RN, Nursing Supervisor, Kaiser Permanente, 20th Ave. Medical Center, 2045 Franklin St., Denver, CO 80205. Telephone: (303) 861-3639. Fax: (303) 861-3679.
- **Jane Allaire**, RN, CGRN, Nurse Specialist, Division of Gastroenterology, National Naval Medical Center, 8901 Wisconsin Ave., Bethesda, MD 20889. Telephone: (301) 295-1312. Fax: (301) 295-4599. E-mail: jaallaire@cs.com.
- **Nancy S. Schlossberg**, RN, CGRN, President-elect, Society of Gastroenterology Nurses and Associates, 401 N. Michigan Ave., Suite 2200, Chicago, IL 60611-4267. Telephone: (757) 640-1452.

For guidelines and other reference material to create a program for nurses to perform flexible sigmoidoscopy for screening purposes, contact:

- **Society of Gastroenterology Nurses and Associates**, 401 N. Michigan Ave., Suite 2200, Chicago, IL 60611-4267. Telephone: (800) 245-7462 or (312) 321-5165. Fax: (312) 527-6658. E-mail: sgna@sba.com.

Solid training essential for flexible sigmoidoscopies

Any program to teach skills to nurses requires careful planning, but when you train a nurse to perform an invasive procedure that previously has been performed only by physicians, it is especially important to make sure the nurse is competent to act on his or her own after training.

If you want to use nurses to perform flexible sigmoidoscopy, start by hiring experienced gastroenterology nurses, says **Jane Allaire**, RN, CGRN, nurse specialist at the National Naval Medical Center in Bethesda, MD. "A gastroenterology nurse will not have to start by learning the basic anatomy, infection control, and care of the equipment," she says.

At the Naval Medical Center, nurse endoscopists who perform flexible sigmoidoscopy start their training by reviewing written articles. Subsequently, they practice on a colon model.

"The next step is observation of at least four procedures, then withdrawal of the scope on at least five procedures while the physician is with them," says Allaire. The nurse also has direct physician supervision on at least three biopsies and 50 complete procedures before he or she can perform the procedure without direct supervision, adds Allaire.

At Kaiser Permanente in Denver, nurses must perform 75 to 100 procedures under supervision before they are allowed to perform on their own, says **Debbie Lantz**, RN, nursing supervisor in the gastroenterology department. "We also require that a gastroenterologist be on the premises whenever nurses are performing flexible sigmoidoscopies."

Physicians review taped procedures

After training at the Naval Medical Center, nurse endoscopists are monitored by weekly physician reviews of videotaped procedures and a logbook that describes each procedure, depth of insertion, and findings of exam, says Allaire. "The logbook is important because it is used to determine competency and maintain credentials to perform the procedure." A nurse must perform at least 100 flexible sigmoidoscopy screening exams each year to maintain credentials for the procedure, she adds.

Kaiser Permanente physicians monitor findings

of screenings and observe procedures to ensure nurses are following protocol and demonstrating the proper level of competency, says Lantz.

The toughest part about training a nurse to perform a flexible sigmoidoscopy is the length of time it takes to train and the investment made in the nurse, says Lantz. "We look for nurses who will stay with us for not only the three months it takes to train but for a long time afterward." While you can't predict which employees will stay, Lantz suggests looking for someone who enjoys the autonomy of such a position so he or she will stick with it. ■

Cataract extraction study looks at costs, efficiency

Lens costs, patient attire practices compared

High volume of one type of surgery equals low supply costs and improved efficiency. This is a common belief among day-surgery program staff, but a recent study shows that programs with lower volumes can still be efficient and cost-effective.

Twenty-two same-day surgery programs that perform cataract extraction with lens insertion participated in a benchmarking study sponsored by the Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement (IQI) in Wilmette, IL. The participants were chosen randomly from facilities accredited by Accreditation Association for Ambulatory Health Care. The numbers of procedures performed by each program ranged from 160 cases per year to 3,000 per year.

EXECUTIVE SUMMARY

Twenty-two same-day surgery programs that perform cataract extraction with lens insertion participated in a study sponsored by Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement in Wilmette, IL. The report identifies best practices of top performers in cost and efficiency categories and describes specific practices that differentiate top performers from other participants.

- Lens supply cost does not correlate with volume of procedures. In fact, the best cost of $40 was reported by a program that performs less than 500 procedures per year.
- Patient attire practices greatly affect overall facility time. The facilities that don't require a patient to undress reported average facility times of almost 80 minutes less than times of facilities that required undressing.

"The most significant finding is that there is no correlation between the volume of cases and low supply costs," says **Girard F. Senn**, consultant with Clinical Benchmarking in Glen Ellyn, IL, and project manager for the IQI study. The participant with the lowest average intraocular lens cost performs less than 500 cataract extractions with lens insertions per year, he points out. At the same time, a facility that performs 1,500 procedures per year had an average lens cost of $80 more per lens than the top performer in this category. Costs for lens ranged from $40 to more than $140, with the average reported cost at $85,[1] he says.

The study also shows eye-drape costs that range from just more than $2 per case to $14 per case. Eight of the participants purchase their eye drapes as a part of a custom pack for all cases, so their charges were not included in the eye-drape costs data, says Senn.

Participants measured different periods of time for the study that included pre-procedure time, procedure time, discharge time, and overall facility time. Surprisingly, the best performer in the overall facility time category, which is defined as the time the patient arrives in the facility to the time of discharge, was not the best performer in the other three time categories.

"We were not surprised to see that we have the lowest overall facility time because we've worked hard to be as efficient as possible," says **Kathy Donigan**, RN, administrator of Fraser (MI) Eye Care Center.

The staff at Fraser were surprised to see other facilities with better time in the pre-procedure, procedure, and discharge times, she adds. "Fortunately, the report gives specific information about the practices of the best performers in each category, so we had an opportunity to review our own practices in comparison to the best practices. We implemented a number of changes as a result of this study." **(See story on making changes, p. 78.)**

The best overall average facility time — less than 100 minutes — was posted by Fraser Eye Care Center. The best average pre-procedure time, which is the time the patient arrives to the

SOURCES AND RESOURCE

For more information about the cataract extraction study, contact:

- **Girard F. Senn**, Consultant, Clinical Benchmarking, 799 E. Roosevelt Road, Suite 4-317, Glen Ellyn, IL 60137. Telephone: (800) 808-3076 or (630) 790-1264. Fax: (630) 790-2696. Web site: www.clinmarking.com.
- **Kathy Donigan**, RN, Administrator, Fraser Eye Care Center, 33080 Utica Road, Fraser, MI 48026. Telephone: (810) 296-7250. Fax: (810) 296-0276. Web site: www.lasikmi.com.
- **Naomi Kuznets**, PhD, Managing Director, Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091. Telephone: (847) 853-6079. Fax: (847) 853-9028. E-mail: naomi@aaahc.org.

To order a copy of the Cataract Extraction with Lens Insertion study, contact:

- **Accreditation Association for Ambulatory Health Care, Institute for Quality Improvement,** 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091. Telephone: (847) 853-6079. Fax: (847) 853-9028. Web site: www.aaahc.org.

time a patients enters the operating room, was 40 minutes. The best average procedure time was less than 10 minutes, and the best average discharge time (time from the end of the procedure to the patient's discharge) was less than 20 minutes.

One practice that greatly affects the overall facility time is the participant's patient dress attire practice, points out Senn.

"We found that patient attire practices differed greatly among the participants," he says. Forty-two percent of participants required no clothing removal by patients; 22% required clothing from waist up removed; and 27% required all clothing or all clothing except undergarments removed. The other 9% did not respond to the question. Patient attire practices affected average facility times, says Senn. Organizations that do not require clothing removal report average facility time of 131 minutes compared to 210 minutes for facilities that require removal of all clothing, he points out.

Follow-up studies will examine clothing practices as related to the location of the procedure, such as office-based procedure room vs. sterile operating room, says Senn.

Same-day surgery programs can request a copy of the study from IQI, says **Naomi Kuznets**, PhD, managing director of the institute. **(See source box, at left.)**

"Not only do we want to share results of completed studies in an effort to give ambulatory care centers appropriate performance measurement information, but we also want to provide a cost-effective way to participate in future studies," she explains. **(See story on other studies, p. 80.)**

Benchmarking studies give organizations a chance to gain a greater understanding of the costs and times involved with different procedures, points out Kuznets. "As all ambulatory care facilities face payment issues that result in lower reimbursement, it is critical that each manager gain a better understanding of how his or her program is performing and how performances may be improved."

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Best performers strive to improve

Even when you are a top performer in a benchmarking study, it isn't time to simply pat yourself on the back and say "good job," says **Kathy Donigan**, RN, administrator of Fraser (MI) Eye Care Center.

Donigan and her staff found themselves ranked as the participant with the best average facility time for cataract extraction and lens insertion in a recent study conducted by the Accredita-tion Association for Ambulatory Health Care's Institute for Quality Improvement in Wilmette, IL.

It takes work to retain quality standards

"We consider our practice a high-quality service, but maintaining high quality requires constant observation," says Donigan. "Our nurses are always involved in quality assessment, but benchmarking against other facilities is essential."

Although Fraser Eye Care Center did report

the best average facility time for the procedure, Donigan was surprised to see that her center was not the top performer in the individual categories that contribute to overall facility time. "We saw an opportunity to improve pre-procedure time and discharge time by evaluating some of our processes," she says.

Although the report doesn't identify individual participants, each presentation of statistical results includes a description of the category's best performer's typical practices that differentiate it from other participants. This information was helpful as Donigan and her staff reviewed their own practices and looked for ways to improve, she says.

Dressing adds time

"We noticed that many facilities did not undress the patient at all, while we have always had the patient remove their blouse or shirt to protect their clothing from accidental spills," says Donigan.

While undressing did not significantly add to pre-procedure time, it did add five to 10 minutes to discharge time, she explains. "Patients for this procedure are older and may even require assistance to dress after the procedure. We found out that our nurses were having to give discharge instructions at the same time the patient was dressing."

Now, Fraser Eye Care Center patients do not remove clothing. "We purchased extra-large gowns that easily cover the patient's clothing, and our nurses sit with the patient while they have a snack after the procedure to give discharge instructions," says Donigan. Patients have responded favorably to the change and say they appreciate the more relaxed, increased face-to-face time with no other distractions, adds Donigan.

Looking at pre-op procedures

Pre-procedure ratings also gave Donigan's staff an opportunity to improve their time even more. "Many facilities were doing preoperative assessments and history and physicals on a pre-op visit prior to the day of surgery," she says. "We were gathering some of the information ahead of time, but we did wait until the morning of surgery to gather many of the history and physical details," she explains.

The process has been changed to gather a more detailed history at the pre-op visit. "This means that we only review the history and make sure there have been no changes in health or medications since the pre-op visit," says Donigan.

Patients also now see a newly redesigned video at the pre-op visit that was produced by one of the center's physicians. "The video discusses the procedure and presents informed consent information," says Donigan. Because patients now get this information at the pre-op visit, the informed consent form is signed before the morning of surgery.

The importance of benchmarking studies is that it helps you step outside your normal environment and see how you compare to others, says Donigan. You must be willing to look for and make changes in areas that can be improved even if you are a top performer in some areas, she says.

"My tennis coach always says that if you stop and pat yourself on the back after a good shot, you will miss the next shot," Donigan says. ■

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Editorial Questions

Questions or comments? Call **Joy Daughtery Dickinson** at (912) 377-8044.

Future benchmark studies planned

Performance measurement is a critical component of any manager's job, and its importance has increased as same-day surgery programs must become more efficient and cost-effective to survive in a time of shrinking reimbursement. Add accreditation requirements that include benchmarking as a way to monitor performance, and a manager cannot ignore the importance of benchmarking. **(See story on accreditation to require benchmarking, *Same-Day Surgery*, July 1999, p. 83.)**

Participation in some benchmarking studies is too costly for many same-day surgery programs, so the Accreditation Association for Ambulatory Health Care (AAAHC) in Wilmette, IL, established an Institute for Quality Improvement (IQI) to offer quality, cost-effective benchmarking services, says **Naomi Kuznets**, PhD, managing director of the institute. "We are still in the process of setting fees, but our goal is to keep the costs as low as possible and still provide a quality service," she says.

The institute's first study on cataract extraction with lens insertion study was completed in late 1999, and there are two other studies that apply to same-day surgery programs for which the institute is seeking participants, says Kuznets. The institute is looking for 50 programs to participate in a knee arthroscopy study, she says.

"The first 50 participants will not be charged a fee, and the participation fee for participants over the original 50 will be $300," she says.

Another study for which participants are needed is for diagnostic colonoscopy, says Kuznets.

Although the institute is affiliated with AAAHC, Kuznets points out that information gathered in its studies is not shared with the accrediting organization. "We maintain the confidentiality of our participants by identifying them by number and not name, and by keeping our data separate from AAAHC information," she explains.

[To obtain more information about current and future benchmarking studies, contact the IQI office at 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091. Telephone: (847) 853-6079. Fax: (847) 853-9028. Or visit the institute's section of the AAAHC Web site at www.aaahc.org.] ■

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CE objectives

After reading this issue of *Same-Day Surgery*, the continuing education participant will be able to:

• Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. **(See "Nurse endoscopists increase staffing options" and "Cataract extraction study looks at costs, efficiency.")**

• Describe how those issues affect nursing service delivery or management of a facility. **(See "Days are counting down: 4 steps to take now.")**

• Cite practical solutions to problems or integrate information into their daily practices, according to advice from nationally recognized ambulatory surgery experts. **(See "ID reimbursement problems before they appear.")** ■