Same-Day Surgery®

Covering Hospitals, Surgery Centers, and Offices for More than 25 Years

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

JUNE 2005
VOL. 29, NO. 6 • (pages 61-72)

Success for surgery centers! Deletions to ASC list reduced from 100 to five

Medicare officials make 65 additions instead of 25

Instead of deleting 100 procedures from the list of procedures approved by Medicare for ambulatory surgery centers (ASCs), the Centers for Medicare & Medicaid Services (CMS) will delete only five procedures for which it received no comments, based on an interim final rule that has been published. **(See list of deletions, p. 62.)**

Michael A. Romansky, JD, Washington counsel for the American Association of Ambulatory Surgery Centers (AAASC) and Outpatient Ophthalmic Surgery Society (OOSS) says he is thrilled with the reduction in deletions.

"It is a tribute to my clients, other ASC organizations, and hundreds of individual centers throughout the country that didn't throw the towel in and decided instead to do everything that could be done to overhaul a terrible regulation," says Romansky, who is senior partner with Strategic Health Care, a health care lobbying, consulting, and association management firm in Washington, DC.

"Credit also goes to CMS for realizing that, notwithstanding their formulas designed to get them to the right answers, their analysis was faulty and that they relied on providers in the trenches for some sage advice."

EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services has dramatically changed the interim final rule on the list of covered procedures for ambulatory surgery centers (ASCs).

- There will be five procedures deleted (instead of 100) and 65 added (instead of 25).
- Additions include bronchoscopies and selected endoscopies. Laparoscopic cholecystectomies were not added.
- Legislation is being drafted to abolish the ASC list.

SDS NOW AVAILABLE ON-LINE! www.ahcpub.com/online.html for access.
For more information, call: (800) 688-2421.

Along with AAASC and OOSS, the Federated Ambulatory Surgery Association (FASA) and others provided information on the proposal, which was "misguided," says **Kathy Bryant**, FASA executive vice president.

Bryant also credits the American Medical Association, national medical specialties, and Sen. Charles E. Grassley (R-IA), the chairman of the Senate Finance Committee, for their help. **(For more information on the proposed list, see "CMS adds 25 procedures, deletes 100 from ASC list," *Same-Day Surgery*, January 2005, p. 4.)**

Grassley wrote a letter to CMS, which stated, "I am concerned that the recent proposed rule suggests deleting a number of procedures that should not be deleted as long as the procedure can be performed in an ASC setting at the same or greater level of safety as compared to an outpatient setting." His letter specifically mentioned procedures that treat congenital deformities, burn injuries, traumatic injuries, and cancer.

"Preventing ASCs from performing certain procedures in an ASC setting may affect access to care, especially in rural areas where an ASC is more convenient than an outpatient facility," the senator's letter said.

CMS also is adding 65 procedures to the existing 2,464 procedures on the ASC list. **(See list of additions, p. 63.)** This number is 40 more than CMS proposed initially. Bronchoscopies and selected endoscopies were added. "However, there are many more procedures that they did not add that should have been — numerous eye procedures for example," Bryant says.

These include trabeculoplasty (65855); retina repair, photocoagulation (67105); prophylaxis of retinal detachment, photocoagulation (67145); destruction of retinal lesions, photocoagulation (67210); destruction of retinal lesions, photodynamic therapy (67221); and destruction of extensive or progressive retinopathy, photocoagulation (67228), according to Romansky.

In many cases, CMS officials simply said their

Final List of Codes Deleted From the ASC List

CPT Code	Descriptor
21440	Treat dental ridge fracture
23600	Treat humerus fracture
23620	Treat humerus fracture
53850	Prostatic microwave thermotx
69725	Release facial nerve

Source: Centers for Medicare & Medicaid Services. 42 CFR Part 416 [CMS-1478-IFC] Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures. Web site: www.cms.hhs.gov/suppliers/asc/1478_42805.pdf.

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $495. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact Thomson American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421, ext. 5491. Fax: (800) 284-3291 Web: http://www.ahcpub.com.

This continuing education offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing. Provider Number CEP 10864 — 20 nursing contact hours. Thomson American Health Consultants (AHC) designates this continuing medical education (CME) activity for up to 20 hours in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

AHC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians. This CME activity was planned and produced in accordance with the ACCME Essentials. It is in effect for 36 months from the date of the publication.

This CME activity is intended for outpatient surgeons and other clinicians.

Statement of Financial Disclosure: Ball (editorial board member) discloses that she is a consultant and stockholder with Steris Corp. and is on the speaker's bureau for the Association of periOperative Registered Nurses. Schwaitzberg (board member) discloses that he is a stockholder in Starion Instruments. Twersky (board member) discloses that she conducts research and is on the speaker's bureau for Stuart/Zeneca Pharmaceuticals, Roche Laboratories, Anaquest, Abbot, Marrion Merrill Dow, and GlaxoSmithkline. Burke, Derby (board members), and Earnhart (board member and columnist) have no relationships to disclose. Sheryl S. Jackson, writer, has no relationships to disclose.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This publication does not receive commercial support.

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Glen Harris**, (404) 262-5475, (valerie.loner@thomson.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@thomson.com).
Senior Production Editor: **Ann Duncan**.

Copyright © 2005 by Thomson American Health Consultants. **Same-Day Surgery**® is a registered trademark of Thomson American Health Consultants. The trademark **Same-Day Surgery**® is used herein under license. All rights reserved.

THOMSON AMERICAN HEALTH CONSULTANTS™

Editorial Questions
Questions or comments?
Call **Joy Daughtery Dickinson** at (229) 551-9195.

Final Additions to the ASC List, Effective July 2005

CPT Code	Short Descriptor	Payment Group	Payment
15001	Skin graft add-on	1	$333
15836	Excise excessive skin tissue	3	$510
15839	Excise excessive skin tissue	3	$510
19296	Place po breast cath for rad	9	$1,339
19298	Place breast rad tube/caths	1	$333
21120	Reconstruction of chin	7	$995
21125	Augmentation, lower jaw bone	7	$995
28108	Removal of toe lesions	2	$446
29873	Knee arthroscopy/surgery	3	$510
30220	Insert nasal septal button	3	$510
31545	Remove vc lesion w/scope	4	$630
31546	Remove vc lesion scope/graft	4	$630
31603	Incision of windpipe	1	$333
31636	Bronchoscopy, bronch stents	2	$446
31637	Bronchoscopy, stent add-on	1	$333
31638	Bronchoscopy, revise stent	2	$446
33212	Insertion of pulse generator	3	$510
33213	Insertion of pulse generator	3	$510
33233	Removal of pacemaker system	2	$446
36475	Endovenous rf, 1st vein	3	$510
36476	Endovenous rf, vein add-on	3	$510
36478	Endovenous laser, 1st vein	3	$510
36479	Endovenous laser vein add-on	3	$510
36834	Repair AV aneurysm	3	$510
37500	Endoscopy ligate perf veins	3	$510
42665	Ligation of salivary duct	7	$995
43237	Endoscopic us exam, esoph	2	$446
43238	Uppr gi endoscopy w/us fn bx	2	$446
44397	Colonoscopy w/stent	1	$333
45327	Proctosigmoidoscopy w/stent	1	$333
45341	Sigmoidoscopy w/ultrasound	1	$333
45342	Sigmoidoscopy w/us guide bx	1	$333
45345	Sigmoidoscopy w/stent	1	$333
45387	Colonoscopy w/stent	1	$333
45391	Colonoscopy w/endoscope us	2	$446
45392	Colonoscopy w/endoscopic fnb	2	$446
46230	Removal of anal tags	1	$333
46706	Repr of anal fistula w/glue	1	$333
46947	Hemorrhoidopexy by stapling	3	$510
49419	Insert abdom cath for chemotx	1	$333
51992	Laparo sling operation	5	$717
52301	Cystoscopy and treatment	3	$510
52402	Cystourethro cut ejacul duct	3	$510
57155	Insert uteri tandems/ovoids	2	$446
57288	Repair bladder defect	5	$717
58346	Insert heyman uteri capsule	2	$446
58565	Hysteroscopy, sterilization	4	$630
58970	Retrieval of oocyte	1	$333
58974	Transfer of embryo	1	$333
58976	Transfer of embryo	1	$333
62264	Epidural lysis on single day	1	$333
64517	N block Inj, hypogastric plexus	2	$446
64561	Implant neuroelectrodes	3	$510
64581	Implant neuroelectrodes	3	$510
64681	Injection treatment of nerve	2	$446
65780	Ocular reconst, transplant	5	$717
65781	Ocular reconst, transplant	5	$717
65782	Ocular reconst, transplant	5	$717
65820	Relieve inner eye pressure	1	$333
66711	Ciliary endoscopic ablation	2	$446
67343	Release eye tissue	7	$995
67445	Expir/decompress eye socket	5	$717
67570	Decompress optic nerve	4	$630
67912	Correction eyelid w/implant	3	$510
68371	Harvest eye tissue, alograft	2	$446

Source: Centers for Medicare & Medicaid Services. 42 CFR Part 416 [CMS-1478-IFC] Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures. Web site: www.cms.hhs.gov/suppliers/asc/1478_42805.pdf.

medical advisors didn't agree with comments, Bryant points out. "This is a ridiculous process. You have the people doing the procedures commenting on them, and a few physicians employed by CMS block the additions without any discussions or visits to ASCs," she says.

Before blocking a procedure, ASC physicians should have the opportunity to meet with CMS physicians and have the center physicians share data and respond to questions, Bryant suggests. "Give and take would result in better decisions for patients," she adds.

CMS representatives defend their process for adding and deleting ASC list procedures.

"If you look at our proposed rule and the final rule, it's clear that we listened," says a CMS spokeswoman, who requested not to be identified based on her agency's policy. "There is a difference between listening and just rubber-stamping," she notes.

In addition to considering submitted comments, CMS officials met with ASC groups and individuals, the spokeswoman points out.

"It's a pretty open process and pretty effective process, from an ASC standpoint," she says.

Romansky reports frustration and says CMS did "virtually nothing to affirmatively correct their sins of omission, i.e., add a myriad of procedures to the list, which every credible source has argued for years should be available to Medicare beneficiaries in ASCs." Laparoscopic cholecystectomies are one example, he says.

RESOURCES

- For more information, contact Dana Burley in the Center for Medicare Management. Phone: (410) 786-0378.
- View the entire regulation at: www.cms.hhs.gov/suppliers/asc/1478_42805.pdf.
- Comments must be received no later than 5 p.m., July 5. In commenting, please refer to file CMS-1478 IFC. Comments may be submitted at www.cms.hhs. gov/regulations/ecomments. Attachments should be in Microsoft Word (preferred), WordPerfect, or Excel. Or mail one original and two copies to: Centers for Medicare & Medicaid Services, Attention: CMS-1478-IFC, P.O. Box 8017, Baltimore, MD 21244-8017.

Bryant says that she is "appalled" that laparoscopic cholecystectomies still are not on the list, for a couple of reasons:

"The first is that other patients have had access to lap choles in ASCs since 1988, but we are treating Medicare patients as second-class citizens and denying them access," she says.

Secondly, CMS officials' medical facts are wrong in terms of what happens when a procedure needs to convert to open, Bryant notes. "FASA data show a conversion rate of 0.62%, and for these, we show that only in one instance was the open not completed" in the ASC, she adds.

The assumption underlying this position is that the hospital is always safer, "and this is simply not a valid assumption," Bryant says.

Overall, the changes between the proposed and final rule indicate how freestanding surgery centers can make a difference with their response, experts say.

"Comments are important, but information and data were critical" in obtaining changes in the final rule, Bryant explains. More industry data gathering is essential, she says. "I would encourage ASCs to respond to surveys from their associations," Bryant adds.

The final rule was published in the May 4, 2005, *Federal Register*. It takes effect July 5, 2005. **(To access the rule or submit comments, see resource box, above.)**

Overall, "the problems with the list still exist, meaning FASA's long-term goal of eliminating the list remains a priority," Bryant says.

The groups that Romansky represents also have that goal, he notes.

"It becomes all the more clear that there is only one viable answer: the elimination of the ASC procedures list, replaced instead, as MedPAC [the Medicare Payment Advisory Commission] recommended, with a much narrower list of procedures, which considering patient health and safety, *cannot* be provided in ASCs," Romansky says. **(For more information, see "Should ASCs be cited for non-list procedures? Medicare changes coming down the pike," *Same-Day Surgery*, July 2004, p. 81.)** This will be a cornerstone of legislation, which the ASC industry is hoping to enact in Congress this year, he explains.

Craig Jeffries, executive director of the AAASC says, "AAASC members and state ASC associations have been proactive at building the case for legislation."

The legislation still is being drafted. However, at a minimum, it will be based on the following statements, according to Romansky:

- The ASC procedures list should be eliminated. The decision as to the appropriate site of surgery should be made by the surgeon in consultation with the patient.
- CMS should rebase ASC facility fees within the next two years.
- The new ASC payment system should link ASC facility fees to the payments made to hospital outpatient departments for the same surgical procedures.
- ASCs should receive the same annual updates paid to hospitals, as well as enjoy other additional payments made to hospitals, including outliers, implants, and medical devices.
- The system should be phased in over several years.

"Broad support from allied organizations and key members of Congress to enact a change is falling into place," Jeffries adds. ■

Impostors could target hospitals for terrorism

Beware of anyone posing as JCAHO surveyors

Terrorists may be behind a recent spate of incidents in which people pose as accreditation surveyors, doctors, or government officials to gain access to hospitals. Experts in hospital security and terrorism say the most likely explanation for these impostors' attempts to gain access is

they are collecting information for future attacks on health care facilities.

Impostors have been reported in New Jersey, California, Massachusetts, North Carolina, Virginia, and Ohio. Word of these impostors has spread quietly through the health care community in the past year, but the problem gained more attention recently when the Joint Commission on Accreditation of Healthcare Organizations issued warnings about people posing as surveyors to gain access to the facilities.

The Joint Commission has received three reports recently about such impostors. (See the Joint Commission's warning at www.jcaho.org/accredited+organizations/security.htm.) In all three cases, the impostors fled after being asked for proper identification.

Incidents are not part of a test

The impostors are not part of any sort of spot test of hospital security, confirms **Mark Forstneger**, Joint Commission spokesman. No other agency is authorized to use the Joint Commission's name in that way, and such use would not be tolerated, he says.

Joint Commission officials say they do not know the motivation behind the attempts, but experts in hospital security and terrorism say the circumstances point to a frightening conclusion. Health care facilities have long been known as a secondary target of terrorists, they say, because an attack at the local hospital would hamper any efforts to respond to a larger attack in the community. **(For more information, see "Sniper, terrorist threats teach lesson to SDS managers: Be prepared," *Same-Day Surgery*, January 2003, p. 1.)** And as other primary targets, such as government buildings, are hardened against attack, hospitals may become increasingly attractive as a soft target.

The FBI and other law enforcement agencies are looking into the incidents, according to a published report in *The Washington Post*.[1]

"There is no working hypothesis. It could be any number of things, from identity theft to something more nefarious," an FBI spokesman, who declined to be named, was quoted as saying.

The Department of Homeland Security also is aware of these suspicious reports, said **Brian Roehrkasse**, a department spokesman, in the published report. He added the agency doesn't have "any intelligence information that indicates al-Qaida is planning an attack or targeting hospitals."

What to expect from a Joint Commission surveyor

Question anyone claiming to be a Joint Commission surveyor at your facility, says **Joe Cappiello**, vice president for accreditation field operations with the Joint Commission on Accreditation of Healthcare Organizations.

Surveyors are well aware of the problem with Impostors and will not be offended by a request for identification or even being asked to wait while you confirm that they are who they say they are.

At a minimum, Cappiello advises taking these steps:

1. Ask them to show their Joint Commission identification badges.
2. Examine the letter authorizing their visit. If the surveyors are not expected for a scheduled survey, they will have a letter addressed to the head of the organization signed by Russell Massaro, MD, executive vice president of accreditation operations for the Joint Commission. The letter will explain who they are and why they are there.
3. If there is any doubt about the legitimacy of the credentials or other concerns, call Cappiello directly at (630) 792-5757, or call your local Joint Commission account representative. ■

The problem is larger than just the incidents reported by the Joint Commission. There have been many similar attempts to gain access and information about hospitals through impersonating other officials, and the law enforcement community is concerned enough to issue special bulletins warning of the danger.

Unlikely to be common criminals

While no one can be certain why the impostors are trying to gain access, their methods suggest they are more than just petty criminals looking to steal laptops, drugs, or financial information, says **Fred Roll**, CHPA-F, CPP, president of the International Association for Healthcare Security and Safety (IAHSS) in Glendale Heights, IL.

The average person does not even know about the Joint Commission or that surveyors could access the hospital, he says.

The impostors must be sophisticated enough

— and motivated enough — to have identified that method through research.

In addition to his work in health care security overall, Roll is an expert on the terrorist threat to health care facilities. He says the impostors are a growing threat that demands immediate attention.

"I've warned about the threat to health care facilities since 9/11, but we haven't heard too much about these impostors until the recent months," Roll adds. "We have to at least consider that these are terrorists looking for the weak points in our system, because this is an unusual, very calculated way to try to get in and get information."

If the impostors are terrorists, they are seeking information such as what resources you have, the access control points, what doors are kept open, your visiting hours, and other information that might help them get someone or something into your facility at a later date, he says.

They also may ask where you keep radiological materials or where other sensitive areas are located, Roll explains.

Impostors showing up nationwide

Stephen Gaunt, CHCHPA, a past board member of the IAHSS and director of security at a large metropolitan hospital on the East Coast, says the impostors have turned up nationwide.

Gaunt has been following the imposter reports and the related warnings from law enforcement agencies, and says they all suggest a terrorist connection.

"One of the things that Al-Qaeda is contemplating or planning is attacks on softer targets like shopping malls, schools, and health care facilities," he adds. "You put a small device in a

You must use vigilance when checking visitors' IDs

A special bulletin has been disseminated only to law enforcement agencies and select health care providers in which the authorities warn about the danger of people impersonating various officials to gain access to hospitals. The bulletin notes, "Counterterrorism analysts remain concerned that terrorist organizations may attempt to target U.S. medical infrastructure in order to cause immediate casualties and disrupt health care and emergency medical services."

The advisory was prepared by the New Jersey Office of Counter-Terrorism, Office of the Attorney General, Department of Law and Public Safety. This is an excerpt from the bulletin:

Individuals Posing as Hospital Surveyors

TO EMERGENCY SERVICES, HEALTH CARE SECTORS:

In the last two weeks, three U.S. hospitals in Los Angeles, Boston, and Detroit reported individuals posing as Joint Commission on Accreditation of Healthcare Organizations (JCAHO) surveyors arrived at their facilities and asked to tour different areas of the hospitals. According to JCAHO administrators, the individuals were not associated with the commission nor were there any planned inspections at the facilities.

Feb. 26, 2005, at approximately 3 a.m., a Caucasian man and Caucasian woman posing as JCAHO surveyors arrived at a Los Angeles hospital. The man is described as in his mid-30s, approximately 6-feet tall, and dressed professionally. The woman, also in her mid-30s, has dark reddish hair. A security guard at the hospital believed he saw the two individuals wearing badges similar to those used by genuine JCAHO surveyors. The Impostors exited after they were stopped by hospital security.

In the second incident, on March 3, 2005, at 3 a.m., a man described as 35-40, of South Asian descent, 6-feet tall, and with a short black beard and mustached, demanded to inspect a medical facility in Boston. The man left the premises after being questioned by hospital staff.

In the third incident, in the morning of March 10, 2005, a Caucasian woman described as in her mid-40s, 5 feet, 7 inches, 160 pounds, with blonde hair, entered a Detroit hospital through the maternity ward and began wandering around the facility. When hospital staff questioned her, she stated that she was a JCAHO surveyor. After further questioning, she fled the premises.

Suspicious events have occurred in the past year at New Jersey medical facilities that appear unrelated to the three incidents described in this advisory. The suspicious events have included irregular inquiries, incidents of surveillance, and suspicious employees and patients. In particular, on March 11, 2004, an adult male of Middle Eastern appearance entered the emergency department of Warren Hospital in Phillipsburg Township at approximately 4 a.m. and directed several atypical and evidently prepared questions to the duty nurse relating to the hospital's bed capacity and the means by which care is delivered to patients. ■

hospital or school, and you've got instant worldwide attention."

Dan Hodges, a retired FBI agent who is now a consultant with OpSec Consultants in Nashville, TN, also agrees that terrorism is at least one explanation for the impostors. There may be other explanations, he says.

A terrorist connection?

"It's either terrorist activity or to steal something. It's hard to say," Hodges explains. "It all goes back to access control. Many of our hospitals are wide open societies in which people can go wherever they want."

The number of incidents, and their similar circumstances, suggest a terrorist connection, adds **James M. Roberts**, CHPA, CAS, director of safety and security for Mercy Medical Center in Baltimore. Before working in health care, he spent decades working in counterterrorism efforts for the U.S. Army and is a certified antiterrorism specialist.

"Too many hospitals have been contacted" for it to be a coincidence, Roberts says.

"They're all asking pretty much the same general questions, and in some cases, they seem to be very scripted in what they ask," he adds.

Almost all of the impostors have claimed to be Joint Commission surveyors, but some have claimed to be doctors and federal law enforcement agents, he adds. The questions seem to all relate to the hospital's ability to respond to a mass emergency, Roberts says.

"In all cases in which they were challenged, they left," he notes. "They do not seem to want to have anything to do with security."

Witnesses have reported a wide range of descriptions for the visitors, including Caucasian, Middle Eastern, and Asian appearances. One incident included a blonde woman as one of the three visitors, he says.

Before 9/11, Roberts says he may have assumed the impostors had a different goal, such as a well-planned abduction of an infant.

"But after 9/11, to me it appears to be targeting data" for a future attack, he points out. That leaves one question: If that is the case, why would terrorists target a small hospital such as Newton Memorial Hospital in Sussex County, NJ, a 148-bed acute-care facility that was recently hit by the impostors?

Roberts explains that the actual hospitals visited may not be the target. Large metropolitan hospitals are the mostly likely targets for any terrorist attacks in health care, but those also are more likely to have strong security measures in place.

So instead of going to Johns Hopkins Hospital in Baltimore, the terrorists may instead go to smaller facilities such as Newton Memorial where they can gather general information about hospital processes and procedures that may be applied when attacking the larger, more preferred target, Roberts says.

"This could be an effort to just get a feel for health centers, a way to ask how secure are these places, would they make a good target for us," he says. But that doesn't mean that smaller facilities would not be a target at all, Roberts points out.

If an attack on a rural hospital put it out of commission, the impact on the surrounding community would be enormous, he says.

"And don't ever forget that the goal of a terrorist attack is not necessarily the actual damage you inflict, but the terror you create in the community," he adds. "If they want to send the message that you're not safe in rural communities, that can be one way to do it."

Reference

1. Brown D. Fake hospital inspectors probed — FBI investigates incidents at facilities in Boston, Detroit, L.A. *The Washington Post*, April 22, 2005:A10. ■

Impostors show up, but flee when challenged

Officials at two small hospitals in New Jersey confirm that impostors tried to gain access to their facility in scenarios that match the accounts heard from other hospitals across the country.

The impostors went to Newton Memorial Hospital in Sussex County, NJ, on Sunday, March 27, 2005, at about 4:45 p.m., says **Brian Grace**, director of marketing and public relations.

Three men identified themselves as doctors to an individual in the lobby of the hospital in Sussex County and began asking questions concerning the facility's bed capacity, services, hospital directory, and they requested a tour of the hospital.

"They never presented any credentials, and when we started to quiz them, they decided to

move on," Grace continues.

"There was some reason to believe them at first because we are hiring physicians, but then they started asking about the grounds and some information on security," he adds.

Once the men left, the staff reported the incident to hospital security and the local police. The lobby security camera captured good images of the impostors, which were turned over to the police and federal authorities, Grace says.

Staff at Newton Memorial were on alert for such impostors because they had heard about a similar incident at nearby Warren Hospital in Phillipsburg Township, a year earlier on March 11, 2004.

In that incident, an adult male of Middle Eastern appearance entered the emergency department at about 4 a.m., says **Kay Shea**, vice president of public relations.

"He addressed the registration clerk and asked about how many doctors the hospital had, how many employees, said he was new in the area and wanted to know the visiting hours," Shea says. "Then he noticed the security camera and turned around and walked off."

The clerk was very suspicious, partly because such a visit at 4 a.m. is so unusual, and followed the man outside.

The impostor drove off in a white van. The FBI took the security tape.

"We were fortunate to get him on tape," Shea says. "And it was a pretty good picture."

Ron Czajkowski, vice president of the New Jersey Hospital Association, said his organization used to post on its web site the names of Joint Commission on Accreditation of Healthcare Organizations surveyors working in the state. It stopped that practice two weeks ago.[1]

Reference

1. Brown D. Fake hospital inspectors probed — FBI investigates incidents at facilities in Boston, Detroit, L.A. *The Washington Post*, April 22, 2005:A10. ■

Same-Day Surgery Manager

Contracting tips — How to succeed

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

If you have ever been to a yard sale, bought something on eBay, or have children, you can negotiate your own managed care contracts. Unless you paid full price for the exercise equipment, didn't actually bid on the eBay product, or let your kids run your home, you are qualified.

Up until a number of years ago, I used to subcontract managed care contracting for my facilities. "Leave it to the experts" was my thought. However, I got angry about the price I was being charged by one of these companies, and I decided to deal with the insurance companies myself.

For the hospital folks, chances are you are not the person doing these contract negotiations. You should, however, be included in the process.

Ask the people who do this if you can participate. It is enlightening, and it gives you a better dimension on the ABCs of health care.

One thing is important to remember: The insurance companies are in the business of making a profit. Did you know you can negotiate your phone rates, bank interest on savings accounts, and interest rate on car payments as well?

Understanding the science of negotiating

Life is a compromise. After all those negotiations, the insurance companies are relatively easy to handle. Insurance negotiating is a science, not an art.

So where do you start? You'll need to know your case costs and implant costs. Then, you need to get in the right mind frame to deal with the insurance companies, so get angry!

You are getting ripped off with *every* contract you have, no matter what it is. You and your staff work your butts off for little reimbursement or gratitude.

Call every one of your insurance providers and tell them you need to begin re-negotiate your contract with them, NOW! Even if you have just contracted with them and have a year to go on the agreement, you want to start the process for the next term now.

Most contractors pay a percentage of Medicare groupers. See, right away you are starting to sweat. A grouper simply is one of nine groups of payment that all CPT codes (Current Procedural Terminology) fall into. Every surgical procedure has a unique CPT code. They are categorized based upon (supposedly) the complexity of the procedure.

It isn't important to know what falls into what grouper, because you will never be able to control that factor. These groupers are what Medicare is going to pay us — nothing more.

The vast majority of insurance companies use these same groupers to dictate what they will pay you. (The government came up with the groupers, so they must be accurate and above reproach!)

Some of the payers will pay you a percentage of those groupers. The ticket is to get the highest percentage. For years, we in the outpatient surgery industry have taken low percentages.

There are some payers that only pay a percentage of Medicare, below Medicare rates. Oh, come on! You want to start out somewhere around 300% of Medicare rates.

Be prepared. When you say that, the payers, at the very least, will roll their eyes and laugh at you behind your back. But you need to set the tone that you are not going to accept a bad contract.

For the most part, an acceptable rate is probably about 160% of Medicare allowable. You might do better and may have to settle for less, but that is a benchmark to shoot for.

However, it will take you a number of meetings to get to that rate. Other payers will contract a percentage of charges they will pay. They will throw out all sorts of numbers, and your goal is to get up to about 90% of charges.

You now need to negotiate the "carve-outs." This is another intimidating phrase designed to make you uncomfortable, like "carve out your heart if you don't accept what we offer you."

A carve-out is nothing more than adding a component to the contract that deals with your implants. Your goal is to get a percentage over what you pay for them.

You don't make any money off of them, but you do have lots of paperwork associated with dealing with them.

Your time is worth something. Five percent over what you pay is acceptable. Make sure you list EVERY implant, or it will not be counted as a carve-out.

The bottom line: You have earned the highest reimbursement possible. The insurance industry is just trying to protect its money by giving us less. You will get more respect by not accepting their initial offers and let them know that you are just doing your job.

(Editor's note: Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Do you have additional questions? Contact Earnhart at 3112 Windsor Road, Suite A-242, Austin, TX 78703. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Discharge instructions, level of pain improve

Knee arthroscopy study yield benchmarks

In the fifth annual Knee Arthroscopy with Meniscectomy study performed by the Wilmette, IL-based Accreditation Association for Ambulatory Health Care's (AAAHC) Institute for Quality Improvement (IQI), all organizations indicated they had standing procedures to prevent wrong-site surgery, and in 60% of the cases, the physician and patient initialed the surgery site.

This initialing conforms to the policy of the American Academy of Orthopedic Surgeons (AAOS) that calls for surgeons to initial the site, as well as the patient. "This response is up from 43% in 2003," says **Naomi Kuznets**, PhD, director of IQI.

Organizations that don't have a physician initialing the site are having a nurse do so, she adds.

Another indication that same-day surgery programs are focusing on patient safety issues is that 82% of the organizations indicated that they had an advanced cardiac life support (ACLS)-certified person monitoring the patient during anesthesia.

While this represents a drop from the 95% response to a similar question in the 2003 study, there was a slight difference in the way the question was asked and could be interpreted, says Kuznets.

"Participants may have an ACLS-certified staff member in the recovery area, but that person was not specifically designated as a monitor for the patient in the study," she says.

More than 98% of patients indicated that their discharge instructions were clear, up

from the 48% of patients who had indicated their discharge instructions were clear in 2002 — a marked improvement that also reduced post-procedure calls to their physicians.

The IQI collected real-time data from June through September 2004 from 43 ambulatory surgery organizations representing approximately 20,200 knee arthroscopies performed annually.

The IQI study also found that the number of knee arthroscopies performed annually at participating organizations ranged from 45 to 2,200.

Yet the data suggested there was no meaningful association between case volume and actual procedure time. The median procedure time overall was 27.5 minutes with an average time of 28.4 minutes.

The median, and average, overall pre-procedure ("waiting") time was 77.2 minutes. "Waiting time is defined as the time at which the patient arrives in the facility to the time the patient enters the operating or procedure room," Kuznets explains.

Pre-op education visits save time

The study found that organizations that had reduced their pre-procedure times attributed the performance to giving patients an in-depth education of the procedure during a preoperative visit and providing patients with pre-procedure packets that could be completed prior to the operating day.

The median setup time for the operating room was 18.61 minutes. Organizations with reduced setup times attributed their performance to having the recovery area and operating room in close proximity and scheduling like cases together.

The median discharge time overall was 82.84 minutes; the average was 87.64 minutes.

Discharge times were associated with anesthesia options, with an average discharge time of 120 minutes for patients receiving epidural/spinal anesthesia and 59 minutes for patients who received local anesthesia and intravenous sedation.

To obtain a copy of the 2004 Knee Arthroscopy with Meniscectomy study or for information on other AAAHC Institute studies, visit the AAAHC Institute web site at www.aaahc.org, then choose "Institute for Quality Improvement" in the top navigational bar. Or contact the AAAHC Institute at (847) 853-6078.

The cost of the study is $85 plus $12 for shipping and handling. ■

Breast implant surgery is safe in outpatient settings

A preliminary analysis of data collected on 246,552 breast implant procedures performed in facilities accredited by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) in Gurnee, IL, shows a high level of safety for patients undergoing the procedure in outpatient settings.

These procedures were for reconstructive or aesthetic purposes, and adverse events were reported in only one in 143 procedures performed, or less than 1% (0.7%) of the time.

The data for the study were collected through an Internet-based quality improvement and peer review program in which AAAASF facilities participate. Analysis was performed upon 913,154 surgical procedures entered by surgeons participating in the program.

Breast implantation, for reconstructive or aesthetic purposes, was performed in 27% of the studied cases, yielding 246,552 breast implant procedures analyzed.

Unanticipated complications of surgery were divided into two categories: early and late-occurring events. The early occurring events were complications that might occur with any operative procedure such as bleeding, infection, or cardiovascular irregularities associated with anesthesia.

The early events occurred within one month of the date of the operative procedure. Late events included capsular contracture, deflation of implants, loss of implants through extrusion, and miscellaneous events.

A total of 1,730 significant complications included mild postoperative nausea or lightheadedness after surgery, were reviewed. This represents an incidence of one in 143 procedures performed, or 0.7%. There were 1,059 patients who had hematomas or one in 233 procedures performed. There were no deaths associated with hematoma formation.

Other early complications included infection, wound breakdown, and pneumothorax. There were 142 patients hospitalized for management of these conditions. Two patients died, one from a pulmonary embolism five days after surgery, and the other from an asthmatic attack 12 hours after surgery.

These two events represent complications that can follow any type of surgery, says **Geoffrey**

Keyes, MD, lead researcher of the study and chairman of the AAAASF quality improvement and peer review committee. "These complications were not specific to breast surgery," he adds.

The most common late-occurring event was deflation of an implant. That occurred in 173 patients or one in 1,425 procedures. Another late-occurring event included capsular contracture, which was reported in 141 procedures or one in 1,749 of the breast implant procedures performed.

While the preliminary analysis of the data suggests a high safety level for breast augmentation surgery, a more in-depth analysis is planned, according to Keyes. "The study should be ready for publication within the next six months," he adds.

In other breast surgery news, a Food and Drug Administration advisory panel voted to allow the Santa Barbara, CA-based Mentor Corp. silicone breast implant back on the market with conditions to monitor the safety of the product. Another silicone implant, manufactured by Inamed in Santa Barbara, CA, was not recommended for return to market until more research on the product is completed.

(Editor's note: At press time, the FDA is considering the recommendation, but no time frame for a final decision has been set.) ■

HHS looks at changes to HIPAA enforcement

The Department of Health and Human Services (HHS) has published a notice of proposed rulemaking that changes rules related to investigations of breaches of the Health Insurance Portability and Accountability Act (HIPAA).

The proposed changes include expanding the enforcement rules to include all HIPAA administrative simplification provisions in addition to the privacy rule. Civil monetary penalties also could be imposed under the proposed rule change.

Clarification of the investigation process, the process for determining penalty amounts, the grounds for waiver, and the hearing and appeals process also is described in the notice.

HHS will take comments on the proposed rule through June 17, 2005. To see the proposed changes, go to www.gpoaccess.gov/fr. In the Quick Search section type: "page 20223," "45 CFR parts 160 and 164," "HIPAA," AND proposed rule. Under "fr18ap05P HIPAA Administrative Simplification; Enforcement," select the HTML file, the PDF file, or the summary. ■

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. ■

BINDERS AVAILABLE

SAME-DAY SURGERY has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **ahc.binders@thomson.com**. Please be sure to include the name of the newsletter, the subscriber number, and your full address.

If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at **www.ahcpub.com/online.html.**

If you have questions or a problem, please call a customer service representative at **(800) 688-2421**.

COMING IN FUTURE MONTHS

- Procedure moves outpatient, but is it the best alternative?
- What to do when the unthinkable happens
- What surveyors are asking about in outpatient surgery
- How to stop disruptive staff behavior before it hurts patients
- Programs realize benefits from free health screenings

Editorial Advisory Board

Consulting Editor: **Mark Mayo**
Executive Director
Illinois Freestanding Surgery Center Association
St. Charles

Kay Ball
RN, MSA, CNOR, FAAN
Perioperative Consultant/
Educator, K&D Medical
Lewis Center, OH
E-mail: KayBall@aol.com

John E. Burke, PhD
Executive Director
Accreditation Association
for Ambulatory Health Care
Skokie, IL
E-mail: johnbur@aaahc.org

Beth Derby
Executive Vice President
Health Resources International
West Hartford, CT

Stephen W. Earnhart, MS
President and CEO
Earnhart & Associates
Austin, TX
E-mail: searnhart@earnhart.com

Ann Geier, RN, MS, CNOR
Vice President of Operations
Ambulatory Surgical Centers
of America
Mount Pleasant, SC

Craig Jeffries, Esq.
Executive Director
American Association of
Ambulatory Surgery Centers
Johnson City, TN

Roger Pence
President
FWI Healthcare
Edgarton, OH
E-mail: roger@fwihealthcare.com

Steve Schwaitzberg, MD
Department of Surgery
Tufts-New England
Medical Center
Boston

Rebecca S. Twersky, MD
Medical Director
Ambulatory Surgery Unit
Long Island College Hospital
Brooklyn, NY
E-mail: twersky@pipeline.com

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care and management. (See *Success for surgery centers! Deletions on ASC list reduced from 100 to five; Discharge instructions, level of pain improve*; and *Breast implant surgery is safe in outpatient settings,* in this issue.)
- Describe how those issues affect clinical service delivery or management of a facility. (See *Impostors could target hospitals for terrorism.)*
- 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. B **22. A** **23. C** **24. A**

CE/CME *questions*

The continuing education/ continuing medical education semester ends with this issue of *Same-Day Surgery*. An evaluation form has been included in this issue, along with a reply envelope. **(See instructions, p. 71.)** If you have any questions about this testing method, please contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

21. What is the status of laparoscopic cholecystectomy in terms of the list of approved procedures for ambulatory surgery centers by the Centers for Medicare & Medicaid Services (CMS)?
    A. It is included.
    B. It is excluded.
    C. CMS has announced its intention to re-examine the procedure for inclusion in the next update.

22. In three recent cases of impostors pretending to be surveyors from the Joint Commission on the Accreditation of Healthcare Organizations, what made the impostors flee?
    A. Being asked for proper identification.
    B. Calling security.
    C. Being asked to talk to the manager.
    D. Being questioned about the timing of their visit.

23. In the fifth annual Knee Arthroscopy with Meniscectomy study performed by the Institute for Quality Improvement, what percentage of the organizations indicated that they had an advanced cardiac life support-certified person monitoring the patient during anesthesia?
    A. 35%
    B. 57%
    C. 82%
    D 96%

24. What was the incidence of significant complications in the breast implant study conducted by the American Association for Accreditation of Ambulatory Surgery Facilities?
    A. Less than 1%
    B. Between 2% and 4%
    C. 5%
    D. More than 6%