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IN THIS ISSUE

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Surgery center inspections compared to taco trucks and come up short

Washington Post *article points to lack of federal funds for state reviews*

Taco trucks are inspected twice a year in California, while ambulatory surgery centers (ASCs) are inspected an average of once every 12 years in that state. That eye-catching news introduced a *Washington Post* story published in July that went on to say that under federal rules, surgical centers across the country are required to be inspected once every six years, but many are not.[1]

"This has been an ongoing problem within the state [of California] and will continue to be a problem as long as the DHS [Department of Health Services] remains understaffed and underfunded," says **Arthur E. Casey**, CASC, president of the Sacramento-based California Ambulatory Surgery Association (CASA). California does not have a specific regulation related to frequency of surveys as some other states do, Casey explains. "Arizona, for example, requires surveys to be conducted annually for a facility to maintain its licensure," he says.

DHS in California can't provide that level of review annually without doubling the size of the department, Casey adds. "Even if the legislature were to enact a requirement for surveys, unless specific funding is also authorized, the department would be unable to comply," he says.

States rely on the Centers for Medicare & Medicaid Services (CMS)

EXECUTIVE SUMMARY

A recent *Washington Post* article examined the fact that surgery centers and other health care providers are inspected less often than, for example, taco trucks in California.

- States say federal funds are lacking and have restrictions. States have developed a four-tired priority system, with surgery centers in the bottom group of facilities that are first to be cut from the inspection list.
- Surgery center representatives say the lack of surveys doesn't mean facilities aren't safe.

for most of the money they use to inspect surgery centers and other health care facilities. Regulators from several states say federal funding is lacking and has restrictions, so they must prioritize their inspections, according to the story.

Under congressional rules, nursing homes must be inspected annually, and that requirement takes about 70% of their oversight funds, the story said. "The result is that thousands of facilities, including outpatient surgery and kidney dialysis centers, go years without review," the *Post* said.[1] The article did not refer to any patient health and safety problems associated with the care provided in ASCs.

Thomas E. Hamilton, director of the Survey & Certification Group, wrote in the article that Medicare officials have put inspections into four levels of priority, with nursing homes in the top priority tier and surgery centers in the bottom one.[1] When states run out of funds, they cut back on the bottom tier first, he noted.

The federal budget requires prioritizing where the greatest need for quality oversight is, says **Craig Jeffries**, Esq., executive director of the American Association of Ambulatory Surgery Centers (AAASC) in Johnson City, TN. "While ASCs are not an area of high priority because of their good experience, AAASC does not want the absence of periodic inspections to raise concerns about patients receiving optimal care," he says.

"In our experience, accreditation provides an important alternative where the public can be assured that health care facilities, including ambulatory surgery centers, meet rigorous and contemporary standards for patient health and safety," Jeffries adds.

Are surgery centers safe?

Casey says he is not greatly concerned by the lack of state surveys in California for several reasons. One is that, in general, there typically are fewer problems identified in ASCs than in skilled nursing facilities (SNFs) or general acute care hospitals, he notes. Additionally, the vast majority of ASCs in California are accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) or the Joint Commission on Accreditation of Healthcare Organizations. Several surgery centers have deemed status and are surveyed randomly at least every two to three years, Casey says.

"Also of note is that the accreditation process is voluntary, so the ASCs are subjecting themselves to this review on their own accord," he points out.

The California DHS has pushed to survey the vast majority of ASCs throughout the state in the past couple of years, Casey says.

"In fact, every facility that I have worked with has been surveyed in the last three years," he continues. DHS also investigates all complaints made against any facility, Casey explains, "so although there may not be a consistent frequent schedule for surveys, those facilities that have

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had complaints filed are surveyed."

The national Office of Inspector General (OIG) performed a study a few years ago on quality oversight in surgery centers, and the OIG did identify for CMS that some states had quite a period of time lapsing between inspections, says **Kathy Bryant**, executive vice president of the Federated Ambulatory Surgery Association in Alexandria, VA. **(See "OIG report blasts surgery center oversight." *Same-Day Surgery*, April 2002, p. 45.)**

"Their recommendation is exactly what CMS did: CMS should consider the nature and risks of ASCs in determining when they should be surveyed," says Bryant, who points to Hamilton's explanation of a four-tired system that cuts out inspection from the bottom tier.

"I think that, like myself, CMS is saying it's not greatly concerned about ASCs, that they seem to be operating very safety," she notes.

Both patient care and surgery centers are incredibly safe today, Bryant says. "We certainly have no problem with ASCs being inspected more frequently — as long as government officials allocate funds to do that regular surveillance," she says. "I don't think that because surgery centers aren't inspected more frequently, that patients are at risk when they go to surgery centers."

The California association fully supports consistent unannounced surveys of all health care facilities, Casey says.

"Unfortunately, being compliant with regulations does not necessarily correlate to high-quality patient care," he explains.

"It only means that the facility is good at completing paperwork; but for now, this may be the best method possible," Casey adds.

Reference

1. Gaul GM. Lack of funds reduces frequency of health inspections. *Washington Pos*t, July 25, 2005:A08. Web site: www.washingtonpost.com/wp-dyn/content/article/2005/07/24/AR2005072400945.html?sub=new. ■

Medicare to increase hospital rates by 3.2%

23 procedures move to APC list

Hospital-based outpatient surgery departments will receive a 3.2% inflation update in Medicare payment rates in 2006 under a proposed Outpatient Prospective Payment System (OPPS) rule from the Centers for Medicare & Medicaid Services (CMS).

However, when hospitals factor in cuts in payments for drugs and other items required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the actual increase is 1.9%, "less than inflation," says **Roslyne Schulman**, senior associate director for policy at the American Hospital Association in Washington, DC.

Underfunding for Medicare patients

"Our general concern is that the entire OPPS system continued to be underfunded," she says. "It only pays 87 cents for every dollar of care provided to Medicare beneficiaries."

For calendar year 2006, CMS proposes to remove 25 procedures from the inpatient list and assign 23 of the —, including nasal/sinus endoscopy (HCPCS 31293 and 31294) — to ambulatory payment classifications (APCs). **(See list, p. 100.)**

The agency is not adding two anesthesia procedures for which a separate payment is not made under OPPS. Those procedures are anesthesia for procedure in lumbar region; chemonucleolysis (CPT 00634) and anesthesia for obturator neurectomy; intrapelvic (CPT 01190).

CMS annually reviews items within an APC group to determine if the median of the highest cost item in a group is more than two times

SOURCE/RESOURCE

For information on the proposed rule, contact:

- **Rebecca Kane**, Centers for Medicare & Medicaid Services, Baltimore. Phone: (410) 786-0378.

To view the proposed regulation, go to www.cms.hhs.gov/providers/hopps/2006p/1501p.asp and click on "CMS-1501-P." In commenting, please refer to file code CMS-1501-P. You may submit comments to www.cms.hhs.gov/regulations/ecomments. Attachments should be in Microsoft Word (preferred), WordPerfect, or Excel. You may submit written comments (one original and two copies) by mail to Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1501-P, P.O. Box 8016, Baltimore, MD 21244-8018.

Proposed Procedure Codes to Remove from Inpatient List and Proposed APC Assignment, Effective Jan. 1, 2006

HCPCS	Long Descriptor	New APC Assignment
20662	Application of Halo, including Removal; Pelvic	0049
20663	Application of Halo, Including Removal; Femoral	0049
20822	Replantation, Digit, Excluding Thumb (Includes Distal Tip to Sublimis Tendon Insertion), Complete Amputation	0054
20972	Free Osteocutaneous Flap with Microvascular Anastomosis; Metatarsal	0056
20973	Free Osteocutaenous Flap with Microvascular Anastomosis; Great Toe with Web Space	0056
21150	Reconstruction Midface, Lefort II; Anterior Intrusion (e.g., Treacher-Collins Syndrome)	0256
21175	Reconstruction, Bifrontal, Superior-Lateral Orbital Rims and Lower Forehead, Advancement or Alteration (e.g., Plagicephaly, Trigonocephaly, Brachycephaly), With or Without Grafts (Includes Obtaining Autografts)	0256
21195	Reconstruction of Mandibular Rami and/or Body, Sagittal Split; Without Internal Rigid Fixation	0256
21408	Open Treatment of Fracture of Orbit, Except Blowout; with Bone Grafting (Includes Obtaining Graft)	0256
21495	Open Treatment of Hyoid Fracture	0253
27475	Arrest, Epiphyseal, Any Method (e.g., Epiphysiodesis); Distal Femur	0050
31293	Nasal/Sinus Endoscopy, Surgical; With Medial Orbital Wall and Inferior Orbital Wall Decompression	0075
31294	Nasal/Sinus Endoscopy, Surgical; With Optic Nerve Decompression	0075
36510	Catheterization of Umbilical Vein for Diagnosis or Therapy, Newborn	N/A
37183	Remove Hepatic Shunt (Tips)	0229
37195	Thrombolysis, Cerebral, by Intravenous Infusion	0676
54560	Exploration for Undescended Testis with Abdominal Exploration	0183
55600	Vesiculotomy	0183
59100	Hysterotomy, Abdominal (e.g., for Hydatidiform Mole, Abortion)	0195
61334	Exploration of Orbit (Transcranial Approach); With Removal of Foreign Body	0256
62160	Neuroendoscopy	0122
64763	Transection or Avulsion of Obturator Nerve, Extrapelvic, With or Without Adductor Tenotomy	0220
64766	Transection or Avulsion of Obturator Nerve, Intrapelvic, With or Without Adductor Tenotomy	0221

Source: 70 *Federal Register*, 42,746 (July 25, 2005).

greater than the median of the lowest cost item in that group.

This often is referred to as the "two-times rule." CMS is reassigning 58 HCPCS codes, including proctosigmoidoscopy (from 0146 and 0147 to 0428), sigmoidoscopy (from 0147 to 0146), and laser treatment of retina (from 0237 to 0672). **(For information on accessing the proposed rule, see resource box, p. 99.)**

CMS also has proposed changing the criteria for establishing new pass-through device categories to include items that are surgically inserted or implanted either through a natural orifice or a surgically created orifice, as well as those that are inserted through a surgically created incision.

The proposed rule was published in the July 25, 2005, *Federal Register*.

Comments will be accepted until Sept. 16, 2005, and a final rule is scheduled to be published by Nov. 1, 2005. ■

Plan carefully before adding new procedures

(Editor's note: In this second part of a two-part series on financial nightmares, we tell you about providers who have added new procedures and made them profitable. Last month, we told you about some providers who have had their payment methodologies changed without their knowledge.)

Financial Nightmares

Can you imagine spending almost three years renegotiating a payer contract? That's exactly what the administrator did at Amherst-based Ambulatory Surgery Center of Western New York, with the help of a consultant. The center opened as a single specialty center (ophthalmology), but wanted to become multiple specialty. However,

EXECUTIVE SUMMARY

When adding a specialty, a surgeon, or a particular procedure, avoid losing money by thorough planning.

- Visit a facility that performs those types of cases and ask about stumbling blocks they encountered.
- To ensure the physicians' case estimates are accurate, call the facilities where they worked formerly or their residence programs if they are newly trained. Ask how long they take to perform a typical case.
- Renegotiate contracts with payers. Show them potential cost savings by sharing national hospital Medicare data.

the center's payer contracts didn't allow for secondary procedures or implants, which was particularly troublesome because the center wanted to add orthopedic procedures.

The result? "My new contract accommodates for secondary and third procedures," says **Joan Dispenza**, RN, MSN, CASC, the administrator. "They accommodated for an alternate payment methodology and accommodated separately for the cost of the implants." Some payers were not willing to allow carve-outs, Dispenza says. In those cases, she asked the payers to pay particular attention to groups 3, 5, and 7, which include the orthopedic procedures. The payers worked out amenable rates with the center.

When adding new procedures, such planning is critical, according to **Joni M. Steinman**, managing principal in AUSMS Healthcare Consultants in San Diego.

Don't assume that adding new procedures is always a wonderful opportunity, she warns. "More is not always better if what you're bringing in, in terms of new procedures, changes the way in which you can allocate costs within your organization or assume new costs within your organization, or if you aren't clear as to the payer mix you're going to be incorporating and the associated reimbursement for all procedures."

Sometimes, new procedures can wreak havoc on your cost and reimbursement structure, warns Steinman. "Be strategic in how you add new procedures by ramping up your diversification effort over time," she suggests. "In this way, you will be able to monitor the impact of each new addition and mitigate against effects that may damage ongoing operations."

For example, an ear, nose, and throat (ENT) center may want to add orthopedics, says **I. Naya Kehayes**, MPH, CEO and principal for Millennium Health Consulting in Issaquah, WA. She spoke on adding new procedures at the most recent annual meeting of the Federated Ambula-tory Surgery Association (FASA).

Managers may assume that their contracts will generate the same profitability for orthopedics as they did for ENT cases, but that belief may not be accurate, notes Kehayes.

Orthopedic cases have the most disproportionate assignment with respect to the low-paying reimbursement groups, she says. "If you're not used to that, you'll lose your shirt," she warns.

Knee and arthroscopy cases are predominantly in groups 3 and 4. "The cost of those codes can be two to three times other CPT codes in much higher groups," Kehayes says.

If your contract keeps those procedures in groups 3 and 4 and doesn't carve them out, you may need a 300% payment increase to profitably add those cases, she advises.

When adding a specialty, surgeons, or a particular case, it is imperative that adequate research and planning are done before making these changes, says **Dawn Q. McLane-Kinzie**, RN, MSA, CASC, CNOR, vice president of National Surgical Care Aspen in Niwot, CO. "I would say 75% planning, 25% implementation is the first rule," she says.

Analyze the staffing and the cost of the supplies and equipment, McLane-Kinzie suggests. If you're adding a new specialty, visit a surgery center that already performs that specialty, she adds. Ask what stumbling blocks they faced and how they handled those, McLane-Kinzie advises.

"When I ask other centers how this works for [them], I'm as much interested in what didn't work as what did," she says. "That's where you learn and make your changes." **(For information on performing a financial analysis, see story, p. 102.)**

When physicians are adding a new service, call the facilities where they worked formerly, or their residence program if they are newly trained, to ensure that the case estimate from the physicians is accurate, suggests **Vanessa Vu**, MD, PhD, chief operating officer and medical director at ORegon Surgicenter in Roseburg, OR. Two physicians at her center recently wanted to perform gastrointestinal endoscopy.

"If you know they want to do 100 cases a month, but it takes them an hour to do a case, that's not feasible over the time period that they think they'll do it," she says.

Payers typically are open to facilities offering new services if it will save them money, Kehayes

SOURCES

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- **Joni M. Steinman**, Managing Principal, AUSMS Healthcare Consultants, P.O. Box 16948, San Diego, CA 92176. Phone/fax: (619) 283-0245. E-mail: ausms@cox.net.

explains. You have to disclose some information about which physicians are interested and which reimbursement codes correspond to the cases they will be doing, so they payers can perform their own research, she says.

If you've recruited the physicians and they're working already at your facility, look at the CPT codes that are high cost and delay starting those cases until your contracts are negotiated, Kehayes suggests.

When Ambulatory Surgery Center of Western New York wanted to become a multispecialty facility and asked for carve-outs, the payer officials couldn't or wouldn't adapt their systems, Dispenza says. To have the payers work with them, administrators had to show national Medicare data and demonstrate the cost savings of moving the procedures to their facility.

"What I was asking for was clearly a cost savings for them," she says. The most important tip? Do your homework ahead of time, Dispenza says. "Be persistent with payers," she adds. "If I wasn't persistent for 2½ to three years, I would have thrown up my hands." ■

Perform financial analysis before adding cases

When adding new procedures at your facility, performing a financial analysis is a critical step.

"Take everything into account," says **Dawn Q. McLane-Kinzie**, RN, MSA, CASC, CNOR, vice president of National Surgical Care Aspen in Niwot, CO. Perform a complete financial analysis of the anticipated additions or changes, including capital investment and payback, additional resources that will be required including human resources and supplies, scheduling, and reimbursement by payers for the anticipated procedures, she says.

Financial Nightmares

Equipment or supply vendors may have information, including coding and pricing, but it must be verified, outpatient surgery managers say.

Talk to your physicians who are adding cases to find out if they foresee any downtime, she suggests. Examine the needs for instrumentation and supplies. Determine if you can use supplies that are reusable, resposable, or disposable to reduce costs, McLane-Kinzie continues. "If it takes a few months of planning, it's worth it," she adds.

When Amherst-based Ambulatory Surgery Center of Western New York facility was going multispecialty, **Joan Dispenza**, RN, MSN, CASC, the administrator, asked her surgeons for the preference cards so she could purchase the supplies and also to determine the cost per procedures.

"I realized that if I didn't go back to payer and see changes in my reimbursement, I literally wouldn't be able to do those cases, " she says. "I'd be losing on every case that came in."

How many cases needed to recoup costs?

When adding new procedures that require a significant investment of capital, such as orthopedics, determine how many cases you're going to have to perform to recoup your costs. Talk with you vendors about equipment, and examine your options, McLane-Kinzie suggests. Determine if you should buy or lease on a cost-per-case basis, she advises.

When two new physicians wanted to perform gastrointestinal endoscopy at ORegon Surgicenter in Roseburg, OR, the center financed the equipment on a cost-per-case basis, with a minimum number of cases per year, says **Vanessa Vu**, MD, PhD, chief operating officer and medical director.

Another option is to lease equipment on a trial basis to determine if the service will be successful before making a capital outlay, McLane-Kinzie says. One of her centers was adding cataracts, but the eye surgeons were not owners. Also, there was another eye surgeon opening a facility in that town at the same time.

"We were a little worried they wouldn't stay," she says. In response, the center leased the equipment on a cost-per-case basis. "We reduced our risk," McLane-Kinzie notes. "If the surgeons had left, we would have been stuck with all that equipment." ■

Same-Day Surgery Manager

Cell phones, rude staff, other problems addressed

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

Question: What is a good policy on cell phones in the operating room environment? We have phones going off all over the place in here. I find it very distracting!

Answer: I agree with you. The best policy is that cell phones stay off during working hours but can be used during breaks and meals. Cell phones have caused a whole new set of company policies. Our own office staff are not allowed to use them during business hours, and they must be turned off. Make sure staff members are allowed to receive emergency calls via your facility, however, as that is a big issue with parents.

Question: We have a computer in the lounge for the surgeons to use during breaks. It's some marketing thing we started last year, but they only use it to play Solitaire. What a waste of money.

Answer: First, have you ever played solitaire? Very addictive. Second, they are harmlessly playing a game, they are not hassling you, and they are not asking for anything. What's the problem?

Question: We have had numerous complaints about our receptionists from patients, who claim they are rude, insensitive, and uncaring. Several of our doctors have complaints about them as well. They have worked together for more than 10 years, and with the exception of their customer services skills, we have been very pleased. Any ideas?

Answer: First, check with your HR department for guidance to make sure you are compliant with your internal polices. After that, understand what makes departments like your successful: patients! Managers must be committed to the quality of the patient experience. Next, let them know your competition is hiring.

Question: Our department has 78 FTEs and every winter (our busiest season due to the snowbirds coming down from the North), we have a problem with being short-staffed because of all the staff vacations. The person in the position before me several years ago would not let staff take vacations during the summer at all, but she eventually got fired because of staff revolt. I don't want to get into that situation myself, but I now see why she had to do it. Your thoughts?

Answer: Consider offering an incentive to staff who delay their vacations until the slow months. You might consider offering them a 2-for-1 deal. Give them two weeks of vacation time for each week they take during off-peak periods. Next, consider allowing staff to receive vacation pay with current pay if they work through their vacation time during peak season. Another idea for a morale booster is to offer Fridays or Mondays off so staff can take a long weekend during the busy season. The needs of the department come before the needs of staff, but there is a human factor. Vacations may be more important to staff with young children, so maybe you can get them to barter time with staff who have more flexible schedules.

(Editor's note: Contact Earnhart at 3112 Windsor Road, Suite A-242, Austin, TX 78703. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.) ■

Ensure clean claims for maximum payment

Wrong code. Out-of-date referral. Inaccurate patient information. All three of these items are simple pieces of information that can cause big problems for your same-day surgery program because they all lead to denials of your claims.

While correction of these simple mistakes and resubmitting the claim might result in a payment, the extra staff time and delay of payment affect the financial success of your program by increasing employee costs and reducing cash flow, says **Amy Mowles**, president and chief executive officer of Mowles Medical Practice Management, a consulting firm in Edgewater, MD, and a speaker at the most recent annual meeting of the Federated Ambulatory Surgery Association. "Every same-day surgery program must implement a system that ensures the filing of clean claims the first time," she says.

One of the first steps to avoiding denials is to know upfront what your payers will cover, says Mowles. "The best way to stay up to date on this information is to designate an employee, usually

EXECUTIVE SUMMARY

One way to ensure a positive cash flow for your same-day surgery program is to know that your claims are accurate, complete, and timely. Evaluate your claims filing process carefully.

- Designate a staff member to stay up to date on payer information and contract requirements.
- Monitor denials to identify trends.
- Cross-train employees so they can see how their job responsibility affects the final claim.

the billing manager, as your expert," she suggests. This employee will be responsible for reading payer newsletters and update notices and educating other staff members about changes, she says.

One of Mowles' clients uses the staff lounge bulletin board as an education center. "She reviews the payer newsletters, highlights the information that is important to her billing and collections staff members, and posts the newsletters on a bulletin board in the breakroom," she says. The bulletin board is divided into sections based on payers with the updated information posted by date so the latest news is easy to spot. "At staff meetings, billing and collections employees are quizzed on the information," she adds.

Because proper coding is essential to filing a clean claim, be sure your staff members understand the importance of modifiers, Mowles notes. "Be sure that the modifier is accurate and presents a clear picture of the services the patient received," she says. **(See list, at right.)**

Another key is to monitor denials and payments, says Mowles. Don't just post a payment when it arrives, she advises. "Have someone responsible for reviewing the payment to make sure that the amount paid is correct according to the contracted amount and that the payment reflects all multiple or bundled services correctly," Mowles adds. "If there is a difference between what you expected to receive and what you received, follow up with the carrier immediately."

Monitor your denials with a log that lists denials by payer and procedure, and review it regularly, suggests **Christine Yoder**, RN, director of nursing at Wyomissing (PA) Surgical Services. The log gives you a chance to identify trends in denials.

"We noticed that we were getting prior approval for specific pain management procedures, then the surgeons would perform a different procedure on the day of surgery," she adds. "These claims were denied because the procedures weren't approved."

After investigating the reason for the change in procedure, Yoder's staff discovered patients were seeing physician assistants (PA) in the surgeons' offices prior to surgery rather than the surgeon. "The PA would order a specific procedure, but the surgeon would not be involved in the decision," she says. Now, when the surgeon's office calls the surgery program to schedule a procedure, the scheduling staff remind the caller that the surgeon needs to sign off on the procedure.

"If the patient is in our center when the physician decides to perform a different procedure, we delay the procedure to try to obtain approval. If the approval cannot be obtained quickly, we reschedule for another day," she says. Physicians are more aware of the need for preapproval now, and Yoder reports that she is seeing fewer changes in procedure on the day of surgery.

Know your modifiers to ensure clean claims

One of the most common mistakes same-day surgery programs make when filing claims is to use incorrect modifiers, says **Amy Mowles**, chief executive officer of Mowles Medical Practice Management, a consulting firm in Edgewater, MD.

"A modifier gives the physician the means to indicate that the procedure has been altered by a specific circumstance but that the procedure's initial definition or code has not changed," she explains.

Key modifiers that are specific to same-day surgery include:

- **Freestanding facility.**
  -SG. This modifier must be on the Centers for Medicare & Medicaid Services 1500 claim to identify a freestanding facility.
- **Discontinued services.**
  -73. Discontinued outpatient procedure prior to the administration of anesthesia.
  -74. Discontinued outpatient procedure after the administration of anesthesia.
- **Additional procedures.**
  -58. Staged or related procedure or service by the same physician during postoperative period.
  -76. Repeat procedure by the same physician.
  -77. Repeat procedure by another physician.
  -78. Return to the operating room for a related procedure during the postoperative period.
  -79. Unrelated procedure or service by the same physician during the postoperative period.

"It is also important to realize that modifiers for unilateral vs. bilateral procedures are usually payer-specific, so it is critical that billing and coding employees understand the individual payer contracts," Mowles notes. ■

SOURCES

For more about avoiding claim denials, contact:

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Tracy Odom, RN, administrator of Pain Consultants of South Mississippi in Hattiesburg, obtains preapprovals in writing. While preapproval does not guarantee payment if the payer representative makes a mistake, the documentation is essential to your appeal, she adds.

"If the payer can't or won't fax a preapproval, my staff members write the name of the person who gave the approval, the time and day of the conversation, and the name of the procedure that was approved," she says. This documentation is essential if the claim is denied, Odom adds.

"I will even check denial reports on certain procedures," she notes. "I look at the procedure by payer to see if there are any trends that require my follow up with my staff or the payer."

While coding and understanding the payers' requirements is important to filing timely, accurate claims, gathering correct information early in the scheduling and pre-admission process also is key, Odom says. "I only have six people who handle admissions, billing, and coding, but I find it helpful to cross-train them so that they see how their primary job responsibilities affect the other areas," she says. While Odom doesn't expect her front-desk employee to take over the billing employee's job, the cross-training did reap advantages, she adds.

"When she sat with the billing employee to learn some of the basic duties, she made the comment that she now understands why certain pieces of information are important to collect," Odom says. "Cross-training gives everyone a chance to see how a simple mistake at any point can grow into a major problem." She also recommends same-day surgery staff establish a relationship with key contact people for each payer. "It's much easier to resolve problems when you know whom you are calling," Odom explains. She also suggests being prepared and staying calm.

"I've learned that no matter how mad you might be that a claim was denied, you need to be nice and understand that the payer has a job to do, and that job involves denying claims," she says. "If you have your documentation and your facts ready when you contact the payer, and you present the information calmly, you are more likely to resolve the problem." ■

Surgery centers report financial benchmarks

The average net income per case reported by participants in a Midwest benchmarking study — *2005 Midwest Ambulatory Surgical Center Benchmark and Salary Survey* — ranged from $94.31 to $307.20 per case, with the average total operating expense ranging from $528.84 to $1,241.23. **(See financial data, p. 106.)** The gross charges per case ranged from $1,642.74 to $2,479.64, according to the study.

The fourth annual survey was conducted by Somerset CPAs — Health Care Group in Indianapolis. The statistics are based on data provided by participating centers in six Midwest states: Indiana, Illinois, Kentucky, Michigan, Ohio, and Wisconsin.

Of the 79 responses, 54% (42) were owned by multiple physicians or physician groups; 27% (21) were joint ventures; 3% (3) were owned by a single physician or group; 1% (1) was owned by a corporate chain; and 15% (12) designated their ownership as "other." Most (65%) were multispecialty. Of

Unplanned Transfers to Hospitals

Number of Transfers	Responses	Percentage of Total Respondents
0	12	15%
1-5	37	47%
6-10	9	12%
11-15	12	15%
16-20	1	1%
>20	4	5%
No Response	4	5%
Total	79	100%

Source: 2005 Midwest Ambulatory Surgical Center Benchmark and Salary Survey, Somerset CPAs, Indianapolis.

the 28 facilities that reported being single specialty, 12 were ophthalmology, nine were gastroenterology, two were orthopedics, and two were otorhinolaryngology. Gynecology, urology, and plastics had one response each.

The average number of full-time equivalent OR registered nurses per facility ranged from 2.67 to 7.22. **(See chart, below.)** Most facilities (47%) reported one to five unplanned transfer to hospitals per year. **(See chart, p. 105.)**

Caution should be used in interpreting the data because the survey is not based on a formal random sample, says **Catherine M. Weaver**, CASC, CHFA, health care consultant and manager at Somerset CPAs — Health Care Group. Also, when the response rate in a category is low, the results could change significantly with the addition of a few more data samples, she says.

"Our challenge in reporting the statistics is that we understand simply looking at data with one

Financial Data — Average Per Case Based on Case Volume

Average Number of Cases Per Year	Cases 0-999	Cases 1,000-1,999	Cases 2,000-2,999	Cases 3,000-3,999	Cases 4,000-4,999	Cases 5,000-5,999	Cases 6,000-7,000	Cases >7,000
Number of Respondents	2	12	11	5	11	4	5	7
Total Operating Expenses	*	$1,241.23	$788.95	$528.84	$738.98	$625.10	$620.45	$673.02
Net Income	*	$94.31	$225.94	$307.20	$300.88	$190.04	$247.98	$304.03
Gross Charges for Fiscal Year	*	$2,479.64	$2,182.52	$1,642.74	$2,216.92	$2.396.25	$1,829.48	$2,306.45

* Indicates fewer than three responses. This category has been omitted to ensure confidentiality.

Source: 2005 Midwest Ambulatory Surgical Center Benchmark and Salary Survey, Somerset CPAs, Indianapolis.

Average Number of FTE Employees — Per Facility Based on Number of Cases Per Year
Nursing and Other Health Care Professionals

Number of Cases per Year	Cases 0-999	Cases 1,000-1,999	Cases 2,000-2,999	Cases 3,000-3,999	Cases 4,000-4,999	Cases 5,000+
Number of Respondents	3	16	12	6	12	20
Nurse Supervisor	1.5	1.33	1.4	1.87	1.75	1.93
Pre-op Registered Nurse	2.67	2.34	2.87	1.32	4.68	4.52
Post-op Registered Nurse	2.67	3.87	2.85	3.28	5.51	5.12
OR Registered Nurse	2.67	3.62	3.35	2.98	5.01	7.22
Certified Registered Nurse Anesthetist (CRNA)	*	4.4	2.5	*	3	1
Licensed Practical Nurse (LPN)	*	0.75	2	1.5	1.25	1.81
Surgical Technologist	2.25	2.93	1.91	2.6	5.84	3.17
Medical Assistant	*	1.24	7	1.33	2.33	1.67
Physician Assistant	*	*	*	*	*	1.83
Nurse Practitioner	*	*	*	*	*	1
Instrument Room Technician	*	2	1.17	1	1.75	2.38
Other	*	*	*	*	*	*
Average Total for Health Care Professionals	10.5	14.32	11.73	13.26	23.33	22.69

* Indicates fewer than three responses. These numbers have been omitted to ensure confidentiality.

Source: 2005 Midwest Ambulatory Surgical Center Benchmark and Salary Survey, Somerset CPAs, Indianapolis.

SOURCE/RESOURCE

The *2005 Midwest Ambulatory Surgical Center Benchmark and Salary Survey* is available for $100. Contact:

- **Catherine M. Weaver**, CASC, CHFA, Health Care Consultant and Manager, Somerset CPAs — Health Care Group, 3925 River Crossing Parkway, Suite 300, Indianapolis, IN 46240. Phone: (317) 472-2230. Fax: (317) 208-1230. E-mail: cweaver@somersetcpas.com. Web: www.somersetcpas.com.

additional breakout, such a facility specialty, can change the data results," Weaver says.

They have chosen to focus their data breakouts on case volume and facility size to provide consistency from year to year. For example, the financial data for endoscopy-only facilities would show lower collections per case, because of lower reimbursement, which is the opposite of orthopedic centers. Also, if you compared volume per room, based on the number of procedure/ORs, you likely would find higher per-room volume for endoscopy vs. orthopedic, she says. ■

Baxter recalls infusion pumps

Baxter Healthcare Corp. in Deerfield, IL, is recalling all models of its Colleague Volumetric Infusion Pumps because they can shut down while delivering medication and fluids to patients.

Baxter has received six reports of serious injury and three reports of death associated with this shutdown problem. The affected models are 2M8151, 2M8151R, 2M8161, 2M8161R, 2M8153, 2M8153R, 2M8163, and 2M8163R. This is a Class-I recall, which is the most serious type of recall that involve situations in which there is a reasonable probability that the use of the affected product will cause serious injury or death.

Baxter also advised customers March 15, 2005, to stop using any pumps that exhibit a failure code beginning with 402, 403, 533, 535, or 599 related to the electronic problems. It also advised customers to stop using any pumps that show failure codes 810:04 and 810:11 related to air-in-line sensor problems until they are inspected by authorized service personnel. In addition to the shutdown problem, the device may exhibit two additional failure modes: Users inadvertently might press on/off key instead of start key when attempting to start an infusion. Also, disconnecting or connecting the pump from the hospital monitoring system while the pump is powered "on" can result in a failure code, which requires the infusion to restart.

At this time, users should not return the pumps to Baxter. The company's letters to customers are available on its web site (www.Baxter.com). Under "recent links," click on "NEWS: Baxter Receives Notice from FDA Classifying Colleague Infusion Pump March 2005 Corrective Action as a Class I Recall." Click hyperlinks for letters at the bottom of that notice. ■

JCAHO expectations for 2006 patient safety goals

Organizations accredited by the Joint Commission on the Accreditation of Healthcare Organizations can see detailed implementation expectations for the 2006 National Patient Safety Goals on its web site. Two new goals that must be implemented by January 2006 include a standard approach for handoff communications and labeling of all medication containers.

To meet the new goal regarding handoff communications, implementation expectations include limiting interruptions during communications, presentation of up-to-date information, verification of information, and giving an opportunity for the receiver to review information and ask questions. The goal related to labeling of medication requires medications to be labeled on and off the sterile field and that labels include name and strength of medication or solution as well as the date and initials of the person preparing the label.

To see the entire list, go to www.jcaho.org. Under "Top Spots," choose "National Patient Safety Goals and FAQs," and scroll down to "2006 Implementation Expectations." ■

COMING IN FUTURE MONTHS

- ■ New option for breast surgery
- ■ Learn how to address handoff communication
- ■ Handle after-hours care without risk
- ■ Free outpatient surgery information on the web
- ■ Acquiring tissue for grafts at a reasonable price

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 answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing this semester's activity with the December issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. ■

CE/CME objectives

After reading this issue you will be able to:

- Identify clinical, managerial, regulatory, or social issues relating to ambulatory surgery care. (See *Medicare to increase hospital rates by 3.2%* in this issue.)
- Describe how current issues in ambulatory surgery affect clinical and management practices. (See *Plan carefully before adding new procedures* and *Perform financial analysis before adding cases.)*
- Incorporate practical solutions to ambulatory surgery issues and concerns into daily practices. (See *Ensure clean claims for maximum payment.)*

CE/CME *questions*

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.

9. Although hospital-based outpatient surgery departments will receive a 3.2% inflation update in Medicare payment rates in 2006 under a proposed rule, what is the actual increase when hospitals factor in cuts in payments for drugs and other items, according to Roslyne Schulman, senior associate director for policy at the AHA?
   A. 1%
   B. 1.9%
   C. 2.1%
   D. 3%

10. What can be the potential problem with adding orthopedic procedures to your case mix, according to I. Naya Kehayes, MPH, CEO and principal at Millennium Health Consulting?
   A. Orthopedic cases have the most disproportionate assignment with respect to the low-paying reimbursement groups.
   B. Orthopedic cases require four times the capital investment of any other type of surgery.
   C. Orthopedic surgeons prefer to perform procedures in hospitals.
   D. You can easily obtain carve-outs for orthopedic cases, but the reimbursement may not be enough.

11. When Ambulatory Surgery Center of Western New York facility went multispecialty, why did the administrator ask her surgeons for the preference cards?
   A. To purchase supplies
   B. To determine the cost per procedures
   C. A and B
   D. none of the above

12. What is one way to identify trends in claims denials for your same-day surgery program, according to Christine Yoder, RN, director of nursing at Wyomissing Surgical Services?
   A Review reports issued by payers.
   B. Study individual Explanation of Benefits statements.
   C. Monitor a log of all denials by payer and procedure.
   D. Ask collections staff to produce a report each year.

CE/CME answers

9. B **10. A** **11. C** **12.C**