Same-Day Surgery®

30th Anniversary

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

AHC Media LLC

IN THIS ISSUE

- Explanation of annual updates for ASCs 103
- How will the proposed HOPD changes affect you? (ASCs included) 104
- CPT codes Proposed for Removal from Inpatient-Only List 105
- ***SDS Manager:*** Leaders share their greatest fears 106
- Are you losing thousands in denied claims? 107
- Benchmarks for SDS . . 108
- Pay attention to contracts to get best pricing 108
- Managers with focus on cost control are most effective 109

Financial Disclosure:
Author Sheryl Jackson, Senior Managing Editor Joy Dickinson, Associate Publisher Coles McKagen, Board Member and Nurse Planner Kay Ball and Board Member and Columnist Stephen W. Earnhart report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Mark Mayo reports that he is an employee of Magna Health Systems and a consultant for DayOne Health.

SEPTEMBER 2007
VOL. 31, NO. 9 • (pages 101-112)

It's a step in the right direction, but new payment system falls short, leaders say

No, the sky isn't falling; at least that's the response of most ambulatory surgery center (ASC) leaders who have examined the first major overhaul of Medicare payments to surgery centers since the mid-1980s.

While praising the Centers for Medicare & Medicaid Services for changing its approach to ASC reimbursement, industry leaders say that the new Medicare payment system has fallen short in several areas.

First, the good news about the system, which is that orthopedic procedures will see significantly higher reimbursement rates than currently. Also, for those who will experience payment rate decreases, the changes will be phased in over four years. **(See graphic, p. 102.)**

The bad news? Payment for gastrointestinal (GI) and pain cases is decreasing dramatically. "We're very pleased for softening the impact on GI and pain specialty surgery centers that the four-year transition will provide them," says **Craig Jeffries**, Esq., executive director of the American Association of Ambulatory Surgery Centers (AAASC). However, "the underlying payment rate is still simply too low a base to avoid an impact on beneficiary access to those essential diagnostic

EXECUTIVE SUMMARY

Leaders in the ambulatory surgery center (ASC) field are glad to see changes to the Medicare payment system, but they list several concerns:

- The four-year phase-in will help hard-hit specialties, including gastrointestinal and pain cases.
- The new methodology means ASCs will receive 67% of hospital outpatient department (HOPD) rates. However, based on the proposed 2008 HOPD rates, ASCs will receive only 65% of the HOPD rate, which is too low, leaders say.
- The new criteria for how procedures get added to the ASC list excludes many procedures that can be performed safely in an ASC, they say.

colonoscopy procedures."

Also, in a mix of good and bad news, CMS increased the percentage that ASCs will receive of the hospital outpatient department (HOPD) rate from the proposed 62% to 67%. However, this rule only sets the methodology, according to representatives of the Federated Ambulatory Surgery Association (FASA). The exact percentage can be determined only when final 2008 HOPD rates are set, according to FASA. Based upon the proposed 2008 HOPD rates, ASC rates would be 65% of HOPD rates, the association says. In comparison, ASCs were paid approximately 86.5% of the HOPD rate in 2003, according to FASA.

"The impact of the 65% conversion factor is still woefully below a rate necessary to sustain access for Medicare beneficiaries to the lower-cost, high-quality environment available in the ASC," Jeffries says.

Limiting rates for cases in doc offices

CMS finalized its proposal limiting ASC reimbursement for procedures added to the ASC list that are performed in physician offices more than 50% of the time to that paid to physicians for the office practice expense. (This limit does not apply to procedures already on the list as of Jan. 1, 2008.)

FASA president **Kathy Bryant** describes this part of the payment plan as "appalling." Physicians may decide an ASC is the most appropriate setting for a specific case because of the extra nursing and safeguards available there, when compared to a physician office, Bryant says. "For Medicare to say, 'It's fine; do it there, but we'll still pay you as if you were a doctor's office,' doesn't make a lot of sense to me." Bryant also points out that hospitals still will be paid the normal full rate for such procedures. "If it's safe to be done in an office, and you don't want to pay more than the office rate, why aren't you applying that to everybody?" she asks.

In other changes, the final rule adds 790 procedures to the ASC list for services provided on or after Jan. 1, 2008. The procedures include laparoscopic cholecystectomy, lithotripsy, fluoroscopy, and several spinal procedures.

Also, CMS changed its criteria for procedures on the ASC list by including all surgical procedures except those that are excluded for a specific reason. However, CMS is using a narrower approach than the one promoted by ASCs. The agency will exclude a procedure from the ASC list if the procedure:

- poses a significant safety risk to the beneficiary;

Phase-In Plan for New ASC Rate

	2008	2009	2010	2011
Percent Based on 2007 Rate	75%	50%	25%	0%
Percent Based on Current Year	25%	50%	75%	100%

Source: Centers for Medicare & Medicaid Services, Baltimore.

Same-Day Surgery® (ISSN 0190-5066) is published monthly by AHC Media LLC, 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, (customerservice@ahcmedia.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. Add $9.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. 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 $83 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 16.5 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 16.5 Contact Hours.

AHC Media LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media LLC designates this educational activity for a maximum of 20 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity is intended for outpatient surgeons, surgery center managers, and other clinicians. It is in effect for 24 months after the date of publication.

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.

Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Joy Daughtery Dickinson**, (229) 551-9195, (joy.dickinson@ahcmedia.com).
Senior Production Editor: **Nancy McCreary**.

AHC Media LLC

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

• would result in the beneficiary typically requiring active medical monitoring and care at midnight following the procedure;
• is on the inpatient only list;
• directly involves major blood vessels;
• requires major or prolonged invasion of body cavities;
• generally results in extensive blood loss;
• is emergent in nature;
• is life-threatening in nature;
• commonly requires systemic thrombolytic therapy;
• can only be reported using an unlisted surgical procedure code.

As a result of using these criteria, CMS is excluding many procedures that can safely be performed in an ASC, industry leaders maintain. In comments to CMS on the proposed rule, FASA supported reimbursing ASCs for all procedures that do not require an overnight stay or pose a significant safety risk.

"CMS' restrictions on procedures that can be done in the ASC unfortunately focus on safety rather than selection," Jeffries says. The experience of ASCs indicate that there is no safety issue as it relates to the procedures that can be done in the ASC, he says. "The issue is selection of patient cases, and here again the experience of ASCs has been outstanding," Jeffries says. "Unfortunately, CMS has not provided the physician and the beneficiary with the decision-making authority that they should have to be allowed to provide access to a broader range of procedures in the ASC."

The American Hospital Association also has expressed concerns about the final rule. Concerning the criteria for which procedures are performed in an ASC, "We're concerned they didn't adopt our recommendations for improved safety measures," says **Roslyne Schulman**, senior associate director for policy development at the American Hospital Association (AHA) in Washington, DC. "In fact, we believe they reduced the safety measures."

The AHA had recommended criteria that

SOURCE/RESOURCES

For more information on ambulatory surgery center issues, contact:
- **Dana Burley**, Centers for Medicare & Medicaid Services. Phone: (410) 786-0378.

The text of the ambulatory surgery center final revised payment system rule is available at www.cms.hhs.gov/ASCPayment.

To access a payment calculator that includes the local wage index for surgery center rates, go to www.fasa.org/rates2008.xls. The formula doesn't apply to device-intensive procedures, which are cases that have high costs for implants.

The American Association of Ambulatory Surgery Centers (AAASC) has created a 2008 Medicare ASC payment system discussion group. Go to http://cmspaymentrule.pbwiki.com/FrontPage.

How annual updates will be handled

As part of the final payment rule for ambulatory surgery centers (ASCs), payments will be adjusted each year to reflect changes in technology and resources used in performing procedures.

The Centers for Medicare & Medicaid Services (CMS) makes such adjustments as a regular part of the annual rule-making process for hospital outpatient departments (HOPDs). To make this adjustment in ASC payments, CMS will begin by recalculating the relative weights for HOPDs, according to the Federated Ambulatory Surgery Association (FASA). These relative weights will be adjusted again to ensure that changes are budget-neutral in the ASC setting, association representatives say. As a result, each year the relative values of some procedures will go up while others will go down, they say.

There will be no annual inflation update for 2009, FASA leaders say. This lack of an update does not mean that 2009 rates will equal 2008 rates, according to the association. The annual changes in procedures' relative values may cause some rates to go up and some rates to go down. Also, because of a four-year phase-in of the new payment rates, the 2009 rates will be different, FASA leaders say. In 2010 and beyond, the ASC conversion factor will increase by an amount equal to the consumer price index for urban consumers. FASA had commented that the inflation update for ASCs should be the same as the update for hospitals, which is the hospital market basket, but CMS officials left the ASC annual update as it is under the existing system.

Thus, the ASC legislation that is in Congress has grown in importance, according to FASA. The Ambulatory Surgical Center Medicare Payment Modernization Act of 2007 has 49 Congressional sponsors, according to FASA. ■

included expected blood loss and the need for an overnight stay. "Also, we are concerned that they didn't put quality reporting provisions into place," Schulman says.

Implants will be reimbursed

In other changes, the final rule provides for full payments for implants and other devices for Medicare beneficiaries. **(For information on how annual updates will be handled, see story, p. 103.)**

In setting the final payment rule, CMS officials say they assumed that about 25% of the HOPD volume of new ASC surgical procedures would move from hospitals to ASCs during the first two years of the revised ASC payment system. They assumed that 15% of the volume of new ASC surgical procedures that now are provided in physicians' offices would move to ASCs during the first four years of the revised payment system.

However, FASA predicts that some procedures performed in ASCs will be forced back into the hospitals.

It's difficult to say what will happen, Schulman says. "There's no way to crystal ball this," she says. "We'll just have to wait and see."

While some services are going up dramatically, others are decreasing significantly, Schulman says. "It's a mixed bag," she says. "It's hard to say where physicians will be referring patients." However, Schulman expects to see physicians directing the least complex and the least ill patients to the ASC. "That will leave hospital OPDs with a far more complex patient population, with multiple comorbidities and sicker with an increased cost of providing services to them," she says. ■

Bundling payments will challenge hospitals

Medicare proposes 3.3% increase for '08 OPPS

Hospital-based outpatient departments (HOPDs) providers faces changes in the proposed 2008 outpatient prospective payment system (OPPS) that include bundling intraoperative services, among other services, into the payment for the associated ambulatory payment classification (APC).

"In general, the OPPS rule, especially the part that changes to packaging provision, always presents a challenge for providers," says **Marian Lowe**, vice president of federal health policy for Strategic Health Care, a government relations firm in Washington, DC. "A hospital that is doing a lot of ancillary services with procedures is likely to be underpaid, vs. billing for every time you use them."

The seven additional services that will be bundled include intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media, observation services, and guidance services.

The Centers for Medicare & Medicaid Services (CMS) has proposed making the change to give providers incentives for efficiency, Lowe says.

In another proposed change, CMS would increase the OPPS rates by a 3.3% inflation update.

Get ready to collect quality data measures

CMS also is proposing that hospital outpatient departments submit quality data on 10 measures, including timing of antibiotic prophylaxis, and selection of prophylactic antibiotic.

The annual payment update factor in calendar year 2009 and subsequent years will be reduced by 2 percentage points for hospitals that don't report quality measures.

CMS also is seeking comment on 30 additional measures that are under consideration for reporting in future years. They include the following:

• screening for fall risk — percentage of patients ages 65 years and older who were screened for fall risk (two or more falls in the past year, or any fall

EXECUTIVE SUMMARY

Providers have until Sept. 14, 2007, to comment on the proposed outpatient prospective payment system (OPPS) for 2008, which includes a 3.3% inflation update.

- Hospitals may be underpaid if intraoperative services, along with others, are bundled into the ambulatory payment classification (APC) as proposed.
- CMS also is proposing two quality measures that affect outpatient surgery: timing of antibiotic prophylaxis, and selection of prophylactic antibiotic. In 2009, payment will be tied to submission of quality data.
- Beneficiary coinsurance would continue to be reduced to 20%. Thirteen procedures are moving off the inpatient-only list, and only three of those are moving to the ambulatory surgery center (ASC) list.

with injury in the past year) at least once within 12 months;

• needle biopsy to establish diagnosis of cancer precedes surgical excision/resection;

• colonoscopy for polyp surveillance — description of polyp characteristics.

"In the short run, what you get paid for surgical services won't be tied to clinical measures," Lowe says. "This is a dry run with measure development."

CMS is finalizing the details for the 10 measures, and the agency expects that the details will be released this fall.

HOPDs, ASCs moving toward same coinsurance

In the 2008 proposed rule, beneficiary liability under the OPPS would continue to be reduced under a formula that is designed to provide a gradual transition to 20% coinsurance.

That 20% coinsurance will make hospitals equal to freestanding surgery centers, says **Caryl A. Serbin**, RN, BSN, LHRM, president of Surgery Consultants of America and Serbin Surgery Center Billing in Fort Myers, FL. "Now there will be more competition that we didn't want," she says.

Also as part of the proposed OPPS rule, 13 procedures are being moved off the inpatient-only list, according to **Kathy Bryant**, president of the Federated Ambulatory Surgery Association (FASA). **(See list, below.)** Only three of those procedures are proposed to be added to the ambulatory surgery center (ASC) list, she says. They are:

• transmetacarpal amputation, re-amputation (CPT 25931);

• renal endoscopy through nephrostomy or pyelotomy, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic

SOURCES/RESOURCES

For more information on hospital outpatient payment issues, contact:

- **Alberta Dwivedi**, Centers for Medicare & Medicaid Services (CMS). Phone: (410) 786-0378.

For more information on reporting of quality data issues, contact:

- **Sheila Blackstock**, CMS. Phone: (410) 786-3502.

For the text of the combined outpatient prospective payment system (OPPS) and ambulatory surgery center (ASC) proposed rule, go to www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.

Comments on the proposed rule will be accepted until Sept. 14, 2007. You may submit comments electronically at www.cms.hhs.gov/eRulemaking. Click on "submit electronic comments on CMS regulations with an open comment period."

CPT Codes Proposed for Removal from Inpatient-Only List

- **21360** — Open treatment of depressed malar fracture, including zygomatic arch and malar tripod.
- **21365** — Open treatment of complicated (e.g., comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches.
- **21385** — Open treatment of orbital floor blowout fracture; transantral approach (Caldwell-Luc type operations).
- **25931** — Transmetacarpal amputation; re-amputation.
- **27006** — Tenotomy, abductors and/or extensor(s) of hip, open (separate procedure).
- **27720** — Repair of nonunion or malunion, tibia; without graft (e.g., compression technique).
- **27722** — Repair of nonunion or malunion, tibia; with sliding graft.
- **50580** — Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive or radiologic service; with removal of foreign body or calculus.
- **51535** — Cystotomy for excision, incision, or repair of ureterocele.
- **58805** — Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach.
- **60271** — Thyroidectomy, including substernal thyroid; cervical approach.
- **61770** — Stereotactic localization, including burr hole(s), with insertion of catheter(s) or probe(s) for placement of radiation source.
- **69970** — Removal of tumor, temporal bone.

Source: Centers for Medicare & Medicaid Services, Baltimore. Accessed at www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.

service, with removal of foreign body or calculus (CPT 50580)

• drainage of ovarian cyst(s), unilateral or bilateral, (separate procedure), abdominal approach (CPT 58805).

FASA plans to assess the other 10 to see if they should be added as well, Bryant says. "We want to make sure CMS is correct and they don't meet the criteria," she says. 'There's a good chance we'll find they should be reimbursed in an ASC."

A final OPPS/ASC payment rule will be published later this fall. ■

Same-Day Surgery Manager

What keeps you up at night worrying?

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

I was posed with an interesting question from the editor of *Same-Day Surgery* a few days ago: "If you lie awake at night worrying about work, what is it that you worry about?"

A good question for anyone in health care, or any business really. For me the answer is finding qualified staff members to work in the operating room environment. We still have open positions across the country, and it is difficult to find experienced individuals. It stands to reason that the pool of qualified candidates for directors, administrators, PACU, and the OR are dwindling. There are many new surgery centers and hospitals being built or expanded each year, and there are just so many people to go around filling them.

I polled my clients to ask them the same question. I was a little surprised to find that the greatest issues that kept them awake at night were related to computers/information technology. The average department/center has one server and 10 workstations (desktop computers). Keeping them all up and running and keeping staff from instant messaging is an ongoing problem for many centers.

The other issue facing the respondents was similar to mine: finding qualified staff. We recently ran an ad for a surgery center administrator in Kansas City. The ad cost $456, and we received one reply. And that was from someone who thought it sounded like a "cool" job and asked, "Do I have to have a high school diploma to apply?" Since many professionals do not (apparently) look at newspaper ads anymore, you need to get a little more contemporary in your thinking. Surprisingly, we have reached a number of people on www.Craigslist.org. This web site has local classifieds for 450 cities worldwide. It is mostly free.

The last response that I received was just "physician relations," which can mean just about anything. Getting along with surgeons is an art form. My best advice is the following:

• Recognize that like all of us, when physicians' needs have been met, they are usually docile and open to suggestions. Never confront them just after they case was canceled, the OR was not ready for them, or anesthesia is late. When they are hanging around in the lounge waiting for their late case to start is just not a good time to even look at them.

• Every case they bring to your operating room has a piece of your paycheck attached to that patient. Enough said.

• Don't download your problems to them. They have their own.

• When a particular surgeon is a problem, pick one or two people that have a good relationship with that surgeon. Have that individual/individuals approach the surgeon about problems such as signing their charts or cost per case.

• Anything you send them must be repeated three times before you get a response.

• Get to know their office managers, and relate all your issues to them. They have the greatest control over their surgeons' schedules and moods.

[If you would like to be added to Earnhart's survey group, send your e-mail to clientsurvey@earnhart.com. Various surgery-related questions are sent periodically to the group for immediate feedback. Earnhart & Associates is an ambulatory surgery consulting firm specializing in all aspects of surgery center development and management. Contact Earnhart at 1000 Westbank Drive, Suite 5B, Austin, TX 78746. E-mail: searnhart@earnhart.com. Web: www.earnhart.com.] ■

Financial errors common in outpatient surgery

Mistakes involving patient classification and preauthorization of procedures are among a lengthy list of common financial errors made in the same-day surgery arena, says **Bob Whipple**, RNC, CCM, CCS, MHA, a Boston-based senior management consultant with ACS Healthcare Solutions.

Those errors can cost facilities thousands of dollars in denied claims, as well as cause them to lose business to competitors, Whipple adds.

With regard to obtaining authorization for the surgery, "sometimes the [facility] gets it, and sometimes the physician's office gets it," Whipple says. If they pre-certed for an inpatient, and your facility performed it outpatient, the bill is denied, he says.

"People who schedule for physician offices don't know the first thing about coding," he says. "They will send a sheet that says 'possible kidney transplant,' and that's not a diagnosis."

The designation should be "inpatient" or "outpatient," but not "observation," Whipple says. His experience is that a lot of hospitals make the mistake of pre-certing a same-day surgery patient under the observation designation. "It's a big compliance issue," Whipple notes. "How do you know they will have to observe somebody after surgery? You don't have a crystal ball."

A patient cannot be put in observation status preoperatively, he emphasizes. "Postoperatively you could think about it, but I wouldn't recommend it," Whipple says. Mistakes happen with the observation designation because people don't understand what it really means, he says. "The physician thinks, 'I want to observe the patient,' [so that must be the right classification]," Whipple says.

With Medicare, there are many CPT (common procedural terminology) codes that are for inpatient-only procedures, Whipple adds. "If a procedure happens to be on the inpatient-only list and the patient receiving that procedure doesn't have inpatient status, Medicare will deny the claim and you can't appeal it, he says. "It's a technical denial," Whipple says.

There are facilities performing mastectomies, laminectomies, and thyroidectomies — all inpatient procedures under Medicare — on an outpatient basis, and when the bills for those surgeries are denied, there is no recourse, he points out.

There needs to be a clinically trained person who literally reviews every patient before he or she is placed in outpatient surgery, he emphasizes. "You can't expect office staff to do it," Whipple says. "They will put patients in a bed with wrong orders or no orders."

All areas that perform functions that are part of the revenue cycle ultimately should report to the CFO, Whipple says.

"Sometimes hospitals have the bed board report to nursing, or have some sort of pre-cert department or a transfer center that works on its own in another location," Whipple says.

SOURCE

For more information on avoiding financial errors, contract:

- **Bob Whipple**, RNC, CCM, CCS, MHA, Senior Management Consultant, ACS Healthcare Solution, Boston. E-mail: Bob.Whipple@acs-hcs.com.

Are you making any of these mistakes?

One of the costly errors that hospitals are prone to make in their same-day surgery operations has to do with cardiac interventions, such as cardiac catheterizations, Whipple says.

The Medicare reimbursement rate for cardiac caths is about $5,000, he says. However, if the physician puts in a stint as well, that procedure is angioplasty. It goes in the inpatient category, and reimbursement is about $19,000. Therefore, if the change in patient classification is not made and the surgery is billed as an outpatient procedure, the hospital loses $14,000, Whipple notes.

"When I'm doing revenue cycle assessments, these are areas where [hospitals] fall down all the time," he says. "I almost always find it with angioplasties."

Other mistakes that are frequently made in same-day surgery settings include the following, Whipple says:

- developing a process that is organized around the staff and not the patient, specifically as it relates to same-day work-up and surgery;
- not gaining cooperation from ancillary departments to facilitate and support same-day services;
- not changing surgical scheduling processes

Benchmarks for SDS

- **Wait times for outpatient registration:** less than 10 minutes.
- **Registration data accuracy:** greater than 98%
- **Abandon call rate in scheduling:** less than 2%
- **Scheduling calls per day:** greater than 95.
- **Scheduling quality:** greater than 98%.
- **Registrations/preregistrations per hour by admission representative:** greater than 6.
- **Quick check-ins per hour by admission representative:** greater than 12.
- **Precertification:** 100%.
- **Point of service collections:** greater than [your facility's current numbers].
- **Patient satisfaction score:** greater than 95% per reporting period.
- **Auditing of Medicare Secondary Payer questionnaire:** 100%.
- **Operating room cancellations:** zero.

Source: Bob Whipple, RNC, CCM, CCS, MHA, Senior Management Consultant, ACS Healthcare Solutions, Boston.

to support same-day services;

• not ensuring preregistration for all same-day patients, including preauthorization/precertification and estimation of copays for collection at time of service.

Don't forget satisfied patients

Patient satisfaction also plays a key role in the financial success of a same-day surgery program, Whipple says. He recommends a patient satisfaction survey be used in the same-day surgery area, and use the results to make improvements and to provide feedback to staff. General satisfaction surveys aren't specific enough to meet that need, Whipple says. He suggests asking questions geared toward the outpatient experience: Was it easy to get an appointment? Was the phone answered promptly? Do you feel you were given answers in a timely manner? **(See benchmarks, above.)**

Leverage as much technology as possible to keep customers satisfied, including providing on-line registration and implementing kiosks to allow service area check-in with electronic signature and payment of copays and deductibles, he advises. ■

Surgery center recovered over $5,000 in rebates

Another $14,000 saved in careful negotiations

(Editor's note: This is the second part of a series on saving money in outpatient surgery. In last month's issue, we discussed some specific ideas about how to save with equipment and supplies. This month, we discuss contracts and cost control managers.)

Paying attention to details, knowing your contracts, standardizing supplies and equipment, and being willing to purchase large volumes from one vendor can result in significant savings for outpatient surgery programs.

When you use more than one vendor to provide items for a certain specialty, you can coordinate your negotiations to come up with the best price possible, says **Darcy Thor**, MBA, senior accountant at Harmony Ambulatory Surgery Center (ASC) in Fort Collins, CO. "We use two different vendors to provide our gastroenterology supplies and equipment, but I renegotiated our contracts with them, letting them know that they were both providing pricing, to see how I could get the best pricing," she says. Rather than switch all products to one of the vendors, Thor's efforts resulted in more favorable contracts with both vendors that will save the surgery center more than $14,000 per year.

Despite her success with the two vendors, standardization of supplies is still an essential element to controlling costs, says Thor. "I noticed that we stocked eight different types of nonsterile gloves in all different sizes, and I started asking people how many different types and sizes of gloves we really used," she says.

Her investigation found that many gloves were added one at a time to the inventory without making an overall evaluation of all gloves. After arranging demonstrations and trials of different gloves, Thor was able to reduce inventory to the silver nitrate gloves manufactured by one vendor. "We only saved 2 cents per glove for a total of $50 per month, but it simplified our inventory and demonstrated the importance of evaluating all products when you want to add something," she says.

She knew that VHA, a health care provider alliance in Irving, TX, awarded the surgery center a rebate on purchases, but Thor noticed that no check had been received for two quarters. "I

found out that although VHA had sent our check to us directly in the past, a change in the rebate program meant that our check was sent to the hospital instead of us," Thor explains. It took her a few months, but she recovered three quarters' of rebates that had been sent to the hospital for a total of $5,517. Although the individual rebate checks were not huge, the rebates do add up to a significant amount of money for the surgery center, Thor says.

Maintain a close relationship with sales representatives who can alert you to potential savings, she advises. "I communicate with our pharmacy sales representative at least once a month to review our contract, changes in our purchases, and updates to prices," she says. During one conversation, the representative asked if she knew about the soon-to-be-released generic form of Zofran, she says. Although she didn't know about the timeframe for the generic, this conversation enabled Thor to switch her facility to the generic drug as soon as it was available, saving about $4,500 per quarter.

Last year Thor also was able to bring in an unexpected $3,500 from the sale of outdated equipment. "I don't recommend this as a way to make money, and I probably won't do it again," she says.

In previous years, outdated equipment and supplies that could not be turned in for credit were donated to a church mission in which a staff member was actively involved, but the nurse was no longer employed at the center. Thor worked with her group purchasing organization to identify a company that purchases used equipment. "I know that there are a lot of vendors who sell reconditioned equipment, so I assumed that there was a market for my equipment," she explains.

After several false starts with some companies, Thor finally found a company that would buy her equipment, but she warns that shipping was a "nightmare." It was difficult to find someone to pack and ship the equipment, Thor says. "I decided that the time I spent on this project wasn't justified by the money we received," she says. "Next time, I will find a charity that will accept the donation." *[Editor's note: Recovered Medical Equipment for the Developing World (REMEDY), which links donors of medical equipment and supplies with charities, has evolved its AIRe-mail service into a web-based service named Med-Eq. For more information, go to www.med-eq.org.]* ■

Cost control managers can be nonclinical

Different perspective enables potential savings

Outpatient surgery programs are so busy that staff members are required to wear many hats. When it comes to the responsibility for cost control, your efforts may not be successful if the staff member perceives this is a secondary responsibility. Even if you decide to make cost control a priority for a staff member, not all administrative or board members view the position as necessary.

"I was told that my request for an operating room business manager was approved as long as the person I hired saved at least $50,000 in the first year to cover the salary," says **Rosemary Roth**, RN, MSN, CNOR, CNAA, director of surgical services at Rochester (NY) General Hospital. "Not only did the person I hire meet this threshold, but he saved more than $150,000 the first year with his attention to contract pricing and to putting policies in place to control spending," she says.

The majority of the savings were a result of the business manager's efforts to meet with vendors and renegotiate contracts for better pricing, says Roth. "He also developed policies that described more closely controlled evaluation and purchase of new equipment," she explains.

Roth's business manager, **Dave Putnam**, has always had a top-five list of the most expensive supplies for his department. The list might include high-priced supplies such as skin graft material

EXECUTIVE SUMMARY

Surgery managers are looking for people to assume responsibility for evaluating and managing costs. A nonclinical background can be helpful.

- The person must enjoy working with details and researching product use as well as alternatives.
- The right person is a good communicator and can work with all staff members and physicians.
- An MBA ensures a broad business and financial training that can help the person identify potential cost-saving opportunities.
- The cost control manager must be visible and willing to learn about the clinical use of supplies and equipment as part of the evaluation process.

that may not be used in a lot of cases but is expensive to purchase, or it might include sutures that are relatively inexpensive but are purchased in high volumes, he explains. "I look at each item to see if we are getting the best price for the item we purchase or if we can find a suitable replacement that costs less," Putnam says. Once he believes that the cost is as low as it can be, he takes the supply off his top-five list and moves another item onto the list, he says. "I always have five supplies to evaluate," Putnam says.

Roth had primary responsibility for overseeing costs before Putnam was hired. "I was responsible for so many different things that I didn't have time to carefully evaluate prices for all of our supplies," she admits. "Finding ways to save money is a key responsibility for the business manager."

Being able to focus on pricing information, inventory, and contractual agreements makes it possible for a staff member to have a positive effect with cost savings, says **Rebecca R. Craig**, RN, CNOR, CASC, administrator of Harmony Ambulatory Surgery Center in Fort Collins, CO. Although Craig and her staff have always strived to maintain the most cost-efficient supply list, it is hard to keep supply costs a priority when you are handling patient care, staff management, and physician relationships, she points out. "My senior accountant has all materials management coordination as her responsibility, so she can make cost savings a priority," she says.

Clinical background not necessary

Because her senior accountant is not a clinician, she often sees different ways to handle equipment and supply costs, says Craig.

"She has spent a lot of time working closely with the clinical staff, observing procedures, and asking why a particular item is used," she says. Although she recognizes clinical staff members and physicians' preferences for certain brands or items, she is also able to bring in alternatives for evaluation, Craig adds. "No one had time to set up trials of different products before we hired a senior accountant, but now we get to test different supplies and equipment at no cost, to see if the lower cost items are just as good or better than what we were using," she adds.

Craig was hesitant not to use an RN in this role. "Then I realized that a business-oriented person could learn how items were used without losing sight of overall costs, professional liability, and patient safety," she says. Clinical staff members would not have the background to be able to tie all of these issues together, Craig maintains.

Not only did Roth hire a nonclinical person as business manager for the operating room, but also she hired someone with no health care experience at all. "I had six people I seriously considered, including one surgeon with an MBA who wanted to move away from the clinical side of medicine," says Roth. "I was concerned that a surgeon might have a hard time working with other surgeons in this role." Instead, Roth hired someone with an MBA and 20 years of corporate experience in project and budget management. "The MBA is important because it demonstrates that the person has the educational background to handle financial and management responsibilities," she says.

The other key facet of a successful business manager or other person to oversee cost control is the person's personality, says Roth. "He or she must be a people person who is comfortable talking to nurses, physicians, and all other surgical services personnel," she says. Not only does the person in this role have to gather information and make presentations, but they also have to be able to say "No, this won't work" in such a way that the person requesting the item understands why, she adds.

Give your cost control expert time to learn the operating room business, says Roth. "My business manager spent the first two months on the job learning health care, observing procedures, talking to staff and patients, and asking questions," she says. This on-the-job training as well as his willingness to be visible and accessible to surgical services personnel gave him credibility, she adds.

SOURCES

For more information about cost control managers in an outpatient surgery program, contact:

- **Rebecca R. Craig**, RN, CNOR, CASC, Administrator, Harmony Ambulatory Surgery Center, 2127 E. Harmony Road, Suite 200, Fort Collins, CO 80528. Telephone: (970) 297-6350.
- **Rosemary Roth**, RN, MSN, CNOR, CNAA, Director of Surgical Services, Rochester General Hospital, 1425 Portland Ave., Rochester, NY 14621. Telephone: (585) 922-4597. E-mail: rosemary.roth@viahealth.org.

Although your business manager also may supervise other staff members who perform materials management, accounting, or budget functions, be sure not to overload the person with extraneous responsibilities, says Roth. "Be sure that you let them focus on cost control and budget management as a priority," she says.

Look for a well-organized, detail-oriented person, suggests Craig. "The person you hire should be excited about digging into the nitty-gritty details of cost reports and research products to find out what's available," she says.

Craig says that the position more than pays for itself, not only in actual savings but also in the time it gives Craig. "Because I don't have to focus on supply costs, I have time to plan facility expansion, explore other revenue opportunities, and participate in state-level activities to affect legislation related to surgical services," she says. ■

Custom Ultrasonics resumes manufacturing

The Food and Drug Administration (FDA) is permitting Custom Ultrasonics to resume manufacturing the System 83 Plus Washer/Disinfector and all accessories.

The FDA previously had recommended that facilities stop using Custom Ultrasonics endoscope washer/disinfectors if alternative automated endoscope reprocessors (AERs) were immediately available and it was feasible to make the switch. The affected products included the System 83 Plus Washer/Disinfector, the System 83 Plus MiniFlex Washer/Disinfector, and all accessories.

The action followed what the FDA said were the company's deficiencies in failing to comply with FDA's Quality System regulation included failure to establish an adequate quality assurance program for manufacturing these devices, inadequate procedures to prevent and correct problems, inadequate design control, and inadequate procedures to process and analyze complaints. In addition, the FDA said the company lacked adequate procedures to report problems with these devices and failed to report problems it knew about to the agency. There were no reports of patient infections attributed directly to these devices. **(For more information, see "FDA: Stop using Custom Ultrasonics washer," *Same-Day Surgery*, May 2007, p. 63.)**

If you suspended use of your Custom Ultrasonics endoscope washer/disinfector, have the company's service department perform the start-up maintenance procedures and verify the devices' safety and effectiveness. Contact the company at (215) 364-1477, and they will provide this service at no cost. This step will ensure there isn't a high level of bacterial contamination inside the devices while they were sitting idle, as well as ensuring the devices are operating within specifications. If you continued using the Custom Ultrasonics devices, have them serviced to ensure they are operating within specifications and that they can properly clean and disinfect endoscopes.

Always use the company's prescribed cleaning and disinfection procedures when using these devices. They can be downloaded at www.customultrasonics.com. For a copy of the FDA notice, go to http://www.fda.gov/cdrh/safety/022707-ultrasonics.html. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/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 the **December** 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. ■

COMING IN FUTURE MONTHS

- What do you need to know about antibiotic prophylaxis?
- What you must know to comply with new safety goal
- Where to go to find qualified staff
- Steps that help prepare for unannounced surveys
- Biggest areas of noncompliance for same-day surgery

CNE/CME *questions*

- **Identify** clinical, managerial, regulatory, or social issues relating to ambulatory surgery care.
- **Describe** how current issues in ambulatory surgery affect clinical and management practices.
- **Incorporate** practical solutions to ambulatory surgery issues and concerns into daily practices.

9. In the final payment rule for ambulatory surgery centers (ASC), what was added to the list of procedures approved for an ASC?
A. Laparoscopic cholecystectomy
B. Lithotripsy
C. Fluoroscopy
D. Several spinal procedures
E. All of the above

10. In the proposed outpatient prospective payment system (OPPS) rule, 13 procedures are moving off the inpatient-only list. How many of those are proposed to be added to the ASC list?
A. All 13
B. Seven
C. Three
D. None

11. What helped Darcy Thor, senior accountant at Harmony Ambulatory Surgery Center, ensure that her facility switched to the generic for Zofran as soon as it was released?
A. Her group purchasing organization notified her.
B. Regular communication with her pharmaceutical sales representative to review pricing and contracts.
C. A physician alerted her.
D. Professional journal articles.

12. What educational or professional degree does Rosemary Roth, director of surgical services at Rochester General Hospital, say is necessary for any business or cost control manager?
A. RN
B. BA in business
C. MBA
D. CPA

Answers: 9. E; 10. C; 11. B; 12. C.