November/December 2007
Vol. 2007 No. 6

BECKER'S ASC Review

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Healthcare Information Technology: 8 Key Benefits

By Stephanie Wasek and Scott Becker, JD, CPA

ASCs, with a little diligence, can implement and reap the benefits of electronic medical records, digital dictation, coding and billing software, inventory management, and cost- and quality-data gathering, say experts. What's more, moving ahead with healthcare IT is a big part of the answer to fixing – or at least improving – the nation's healthcare problem, says David Dranove, MBA, the Waltner McNerney Distinguished Professor of Health Industry Management and professor of management and strategy at Kellogg School of Management.

"If we don't adopt healthcare information technology – and I realize this is a cost burden to all of you – we're just going to go around in circles trying to develop unified, linked standards [for quality and costs]," Mr. Dranove said in his speech, "Code Red: Reviving the American Healthcare System," at the Improving Profits and Business and Legal Issues for ASCs conference Oct. 19 in Chicago. "[The ASC industry] needs to do this so we don't have to hear the message again, that it's time to adapt this technology."

In short: HIT can improve business operations and the tracking of quality indicators and can help ASCs manage their businesses much better. Moreover, more expertise and better tools than ever are

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ASC Case Studies: Different Approaches Can Help Facilities Find Turnaround Success

By Dana Kulvin, JD, MPH

Recent statistics from California, which legally requires ASCs to report their finances, reveal that each year one-quarter of all ASCs in the state lose money, one-quarter break even and one-half achieve an average profit of 20 percent.

"Whereas California is generally a bellwether for healthcare trends, it is safe to assume that these figures are generally representative of ASCs throughout the nation, and while these numbers are better than the one-third rule that has applied for years – one-third of ASCs lose money, one-third break even and one-third make money – they still reveal that a good half of all ASCs are not performing well and are not making money," says Brent Lambert, MD, FACS, the president and founder of Ambulatory Surgical Centers of America. "This is not positive for the ASC industry,"

Despite the revealing statistics, Dr. Lambert says there is hope for struggling ASCs. "No matter how desperate the situation, most ASCs can be saved if the right people execute appropriate changes, whether that is a motivated physician-owner or management company," he says. However, an ASC cannot be "saved" without someone first identifying the reasons for its failure through evaluation, observation and benchmarking and then applying effective solutions.

Good third-party management companies that have specific expertise in the ASC industry are often successful in turning around and can be the answer for financially struggling facilities. This is because they are able to evaluate an ASC's operations and effectively identify problem areas and resolve them. The six case studies presented here depict lessons learned in identifying concerns and providing turnaround solutions.

Case study No. 1: Florida ASC stops losses and sheds $2.5 million of debt

A small southwest Florida multi-specialty ASC had recurring losses and could not dig its way out of its debt of $2.5 million. When ASCOA was engaged to evaluate the ASC, it found a multitude of problems including an administrative staff with limited billing experience, poor scheduling, inadequate surgery fees, old equipment, bad debt and a negative reputation in the healthcare community. For example, the ASC was open for five days sitting vacant for much of the time and the ASC signed every single payor contract presented to it regardless of the terms, recounts Dr. Lambert.

To remedy the situation, ASCOA took many steps including compressing the surgery schedule to two days and having staff leave when they were not needed, expanding the types of cases to include spine, orthopedic and ENT, canceling inadequate payor contracts and renegotiating others, revising the fee schedule, streamlining supplies and training staff in billing and collecting, especially in regards to the accounts receivables.

"The accounts receivables in this instance were only nine days out – they were too good!" says Mr. Lambert. "We discovered that, in order to balance

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Letter from the Editor

This issue of the *Becker's ASC Review* focuses on a few core issues. First, we cover a number of case studies relating to turning around ASCs. We hope that this provides useful guidance and thoughts for those trying to improve the profits of their facilities. Second, we include a feature article on healthcare information technology for surgical centers. For a variety of reasons, the improvements in IT available for surgery centers are starting to make a huge difference on both the clinical and business sides of surgery. We hope that you also find this article helpful. Finally, we have included a number of other articles relating to items such as conditions for coverage for surgery centers, pain management in ASCs, legal and regulatory considerations for ASCs, and certain other issues.

To subscribe to the *Becker's ASC Review*, please complete the form on p. 23.

1. The next issue of the *Becker's ASC Review* will focus on bariactric surgery in ASCs and how to perform the same profitably, as well as our annual story on 40 companies to watch in the surgery center sector. It will also include our first edition of the Orthopedic and Spine Medical Device Market Newsletter.

2. There seems to be a record number of consolidation and deal issues emerging. There also seems to be very good interest from both strategic and financial buyers for these transactions. Interestingly enough, there seems to be a shortage of hyper-profitable independent facilities available. This may be because the one-off facilities focused on orthopedics or in part with a good reimbursement mix are very optimistic regarding reimbursement changes and are cautiously reviewing sale possibilities rather than aggressively attacking the same.

3. The federal and state governments are again increasing the amount of investigative resources focused on healthcare activities. The following is a list of nine key fraud and abuse considerations that surgery centers should be aware of as they operate their ASCs.

- Surgery centers should not sell shares at below fair market value to referring physicians.
- Surgery centers should not sell more or less shares to physicians based on the volume or value of their referrals.
- Surgery centers should not bring in as owners those that are principally brought in as indirect referral sources or for the purpose of generating referrals for other investors in the center.
- Surgery centers should show care in redeeming people for not meeting the safe harbors or other items that could be tied to use of the surgery center. One wants to avoid being viewed as overzealous in this regard. Safe harbor compliance, yes; overzealous as to cases, no.
- Surgery centers should be very cautious about paying special directorships, particularly where the directorships are held by the busiest and highest-volume surgeons.
- Surgery centers should be very careful of leasing out their ORs.
- Surgery centers should generally avoid the use of "per-click" leasing relationships where the lessor is a referring physician or owned by referring physicians.
- Surgery centers should be very cautious of deals structured as per-click, particularly "retail" per-click, "under-arrangements" ventures.
- Surgery centers should generally avoid entering into percentage-based or volume-driven management or directorship contracts with physicians or physicians groups that refer to the center.

This is a short list of relationships that surgery centers should be wary of.

4. Our Orthopedics-, Pain Management-, and Spine-Driven ASC Conference will be held June 19 to 21. We had a record 600 attendees this year at our fall conference held in conjunction with FASA. We also expect record attendance at this event. Last year, 480 persons attended the Orthopedics-Driven Conference. The conference this year will again held at the Michigan Avenue Westin Hotel in Chicago. Should you desire more information on the conference, please visit www.BeckersASC.com or e-mail me at sbecker@mcguirewoods.com.

5. We are seeking suggestions for topics or speakers, and proposals from potential speakers for both the Orthopedics-Driven conference (June 19 to 21) and the ASC Communications-FASA Conference (Oct. 23 to 25). Please send proposals to sbecker@mcguirewoods.com.

6. Should you have subjects that you would like to see covered in *Becker's ASC Review*, please e-mail me at sbecker@mcguirewoods.com.

7. We have added a great number of terrific advertisers to the *Becker's ASC Review*. Certain of the new companies include Amkai (www.amkai.com), B. Braun (www.bbraunsutures.com), HST (www.hstpathways.com), Surgical Notes (www.surgicalnotes.com), Nueterra Healthcare (www.nueterra.com), KBKG (www.costsegregation.com), JCB Laboratories (www.jcblabs.com), Kaye Bassman (www.kbic.com), Foundation Surgery Affiliates (www.foundationsurgery.com), HBE (www.hbecorp.com), Sanders Trust (www.sanderstrust.com), Source Medical (www.sourcemed.net), Orion Medical Services (www.orionmedicalservices.com) and Galil Medical (www.galilmedical.com).

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Letter from the Editor

Top Priorities for the Industry in 2008

By the time this issue of *Becker's ASC Review* hits your mailbox, the new Medicare ASC-HOPD payment system will have been finalized (well, at least theoretically). In addition to the whole set of issues that brings up (see "Spotlight On: Coding, Billing and the New Medicare Payment System" on p. 22), there are also new proposed Medicare conditions of coverage for ASCs (see "CMS Issues New Conditions for Coverage for Ambulatory Surgical Centers" on p. 14). Physician-owned hospitals were required to begin disclosure of physician ownership on Oct. 1, and the industry narrowly avoided a fight with Congress over ownership (reported on p. 2 in the Sept./Oct. issue of *ASC Review*).

Suffice it to say 2007 has been on the busy side for the ASC and surgical hospital industries. What will 2008 do for an encore? I talked to Kathy Bryant, JD, and Craig Jeffries, Esq., about the ASC industry – including the merger of their respective groups, FASA and AAASC, into the Ambulatory Surgery Centers Association – and to Molly Sandvig, JD, the president of Physician Hospitals of America, about what lies ahead for physician-owned and surgical hospitals.

"The more effective presence in Washington will increase in importance after the presidential election, when Congress and the White House look at objectives."

The nation's two largest ASC associations announced in October that they are merging, the culmination of five months of discussions between AAASC, FASA and the Foundation for Ambulatory Surgery in America (known as the Foundation). Beginning Jan. 1, the unified organization will be known as the ASC Association – on the same day Medicare begins to implement the biggest change in its ASC payment system in the last 20 years.

"Both [AAASC and FASA] have very strong programs," says Mr. Jeffries. "Over the next year, we'll see where the strengths are best blended to bring additional value to the combined memberships."

The educational and research arms will also be combined under the Ambulatory Surgery Foundation. What was originally AAASC's own meeting will be cancelled, and the Foundation will conduct a meeting in San Antonio, May 14 through 17; it will serve as the annual meeting for the ASC Association.

Ms. Bryant delineated the ASC Association's three top priorities for 2008:

- to provide ASCs with the advocacy they deserve at the federal and state levels in both the legislative and regulatory arenas, [including] continuing advocacy support for reasonable reimbursement rates and appropriate quality measures and opposition to restrictions on ASCs' ability to provide high-quality, cost-efficient care;
- ensuring that changes to the Medicare conditions for coverage do not impede or add unnecessary burdens to ASCs; and
- assisting ASCs in meeting the day-to-day challenges of operating, [such as] helping to manage changes in reporting requirements, dealing with insurance restrictions and providing information about ASCs, including all the services they offer and the many ways they benefit their communities.

"The state associations will benefit, and the more effective presence in Washington will increase in importance after the presidential election, when Congress and the White House look at healthcare priorities," says Mr. Jeffries. "Yes, the payment area is much more stable and we have a clearer path than we have in years past, but I would not characterize our efforts as being totally satisfied – the GI situation is still critical."

AAASC and FASA clinical benchmarking efforts will be combined to better define quality and quantify outcomes. These activities and, most importantly, dissemination of that information will be necessary to demonstrate that 65 percent of HOPD rates doesn't mean 65 percent of HOPD care.

"A major impediment to ASCs is that, so often, policy makers and the public lack a good understanding of exactly what ASCs are and do," says Ms. Bryant. "To the extent that the ASCA can inform the public about what really happens in ASCs, like the top-notch surgical care they provide and the off-the-charts patient satisfaction levels they consistently report, along with the cost savings they offer, we will.

"ASCs are also reporting growing problems with insurers who refuse to contract with ASCs. We'll definitely be looking into these problems."

ASC participation will be a determining factor in how successful the ASC Association is in carrying out its missions.

"If we're at about 40 percent of the industry, we'd like to double that, get up to 70 to 80 percent, more in line with the AHA's participation," says Mr. Jeffries. "Many physicians are currently active through specialty society involvement, and they are supporting the direction we're going as an industry. Many of our member centers are physician-owned, and as it's clear physician-ownership is on the federal radar screen, the ASC leadership can help [physician-owners] with the issue that concerns them most."

"At its heart, our industry is simply not just about financial incentives. Physicans start hospitals because they see a need in the community for a more patient-centered, physician-friendly facility."

Ms. Sandvig is certain that, in the next couple months, the physician hospital industry will be challenged again legislatively in a Medicare package bill that will include language similar to the summer's CHAMP Act in that it will contain anti-physician-ownership language.

"Primarily, we have political challenges to deal with, that's our main issue — and it has been for quite some time," says Ms. Sandvig. "[The legislation] is basically the symptom of a larger problem: hospital-physician relations. And right now, the way some systems are being run, hospital administration is really in opposition to physicians and their needs. So physicians are doing their own things and competing.

"What's been interesting to me is the studies have all indicated that hospitals actually thrive when there are phys-owned hospitals in the same area. Communities become healthcare centers of excellence. Instead of viewing the competition as an incentive, hospitals view it as an aggravator."

As a result of the political nature of the problem, physicians have to become more involved, she says: fundraising to provide money to the PHA's PAC and to elected officials; visiting Capitol Hill personally and relaying their stories to elected officials; and undertaking grassroots education efforts such as writing letters, sending e-mails and making phone calls, are all things physicians can do "to ensure officials know who we are and what we're doing."

As with ASCs, another top issue is quality and getting the word out about the quality of work performed at physician-owned hospitals.

"Across the country, there's a drive toward quality, which differs depending on whom you're talking to," says Ms. Sandvig. "What we're interested in is supporting national efforts – groups such as the AMA and think tanks such as the Brookings Institute – in defining quality and how to measure it. Our definition includes patient safety and satisfaction and physician satisfaction; we want to put together our numbers [with other national efforts' numbers] so we can display and relate those numbers to Congress and our local communities."

PHA's third priority for 2008 is community stewardship – "stressing within our industry the need to be community participants," she says. "A lot of our hospitals do charitable work; although our industry is for-profit, they have the interests of the community in mind. We need to make sure those efforts are not only recognized, but that they become the standard of excellence for the physician-hospital industry."

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available to help ASCs do so (see "12 Key IT Products for ASCs" on p. 7). The driving factors in the hesitation, say experts, are cost and lack of interoperability – but they needn't hold you back.

"The hardest part in an ASC is that the return on investment for $50,000 to $60,000 – which is generally what these systems cost – is difficult to justify in many cases," says Matt Petty, the senior vice president of IT at Meridian Surgical Partners. "But it's a matter of value for the money."
Here are eight key ways that HIT can benefit your facility. This article also takes a quick look at the interoperability issue.

1. Improve A/R management and billing and collections. Billing and collections software can accelerate your revenues by automating manual processes, so it's essential that you have a sound collections process in place to begin with, says Robert Westergard, CPA, the CFO of Ambulatory Surgery Centers of America (ASCOA).

"You can do a very good job with paper, but it requires that you be extremely well organized and well disciplined and that your process is basically water tight," he says. "It's a tremendous benefit to have software check your payments vs. the contract rates, record and show the collection history [on an account], and help you drive your collection activities."

The result is that you can get paid faster; Meridian works to implement appropriate IT solutions in all its facilities because, ultimately, the ROI is there.

"Even though an information management system costs money, having the ability to perform tasks electronically gets you your money faster," says Mr. Petty. "There's value in eliminating delays. You can reduce days in A/R significantly."

Essentially, there's a clock ticking from the time the case happens to when a payor reimburses you – and each day that you have to wait knocks some value off each dollar reimbursed. Mistakes can delay claims or cause the payment window to expire entirely.

"The older receivables get, the less chance you have of collecting them," says Mr. Westergard. "Once they get to 90 days old, your chances of collecting the money start to drop significantly, especially if it's money that's due from patients. If you haven't billed properly, your chances of getting reimbursed are slim. Electronic billing software can help eliminate billing mistakes and expedite claim payment by 2-3 weeks."

Avoiding long-outstanding claims can significantly improve cash on hand and EBITDA, he says. That's why Mr. Petty recommends software to "scrub" claims – flag them for mistakes and inconsistencies, in order to make corrections and submit clean claims to the payor the first time.

"If you can ensure that payors reimburse you, and do it quickly, the bottom line will benefit," says Mr. Petty. In fact, such a system can pay for itself many times over at implementation and over its lifetime.

"Improving your AR process often provides a large dollar benefit in a short timeframe," says Mr. Westergard. "Say your average days in A/R is 60 and you're collecting $500,000 per month; the software can help you streamline your process and realistically cut that figure to 35 days. That will bring in $300,000 to $500,000 right away.
"The cost of implementation is low and, used properly, the results are dramatic."

2. Benchmarking and case costing. IT can enable data gathering and benchmarking analysis that is almost impossible to do manually.

"For example, it's easier to do case-costing," says Mr. Petty. "We're finishing up a cash-lag analysis which helps us determine when we are getting reimbursed per case by payor or financial class, and we can tell who's paying us slowly, figure out why, and fix it so the reimbursement comes in faster in full.

"Once you input data, it's just a value for analysis, and it can be done on one screen instead of 15 spreadsheets. But if you don't have the data – if you don't go electronic – you simply can't get there."

Another key to ensuring that HIT solutions with case-costing components work is having a good underlying process in place, reminds Mr. Westergard. Further, because of the initial input legwork necessitated by such systems, their up front costs will be much higher. But, done right, you can see a huge return on investment.

"We cost every case, every month," says Mr. Westergard. "We want to break each case down by, supplies and overhead – which includes wages. Then we compare it to what we've collected. For example, one orthopedic surgeon may perform knee arthroscopies for between $1,200 and $1,500, while another does them for $500. If reimbursement is $1,200, you need to show the expensive surgeon how his colleagues do it for less. Again, a paper process can work, but the software helps automate what can be a very manual process.

"Good information can help you turn money-losing cases into money-makers. Every money-losing case you can do profitably in the future has twice the profit impact."

3. Outsourcing transcription and coding. In addition, technology can free you up to explore new options for ancillary business services. Robert Welti, MD, the medical director of Santa Barbara Surgery Center in Santa Barbara, Calif., has used a combination of a Web-based dictation portal and an outsourced coding service to speed the process and save money for his facility.
"Our physicians dictate to the Web-based program, and our coding company is able pull the information from off-site," he says. "The next day, they send us the codes electronically — it's 25 percent of what it would cost [to have an in-house staff]." Surgical Notes is a leader in medical transcription technology.

4. Minimize space and time through electronic records as opposed to paper records. The physical footprint of any facility is a big issue, says Mr. Petty: "At some point, he says, you will simply run out of space for storage for all the paper files. It's a lot cheaper to buy another hard drive than it is to add a room that cannot be utilized to generate revenue."

Once implemented, IT solutions are faster to use as well and, while it may be difficult to quantify the cost savings derived from time savings, they do exist.

"I'm a big fan of scanning every single item – every contract, every communication, every legal document – so I can have a searchable database on my laptop at all times," says Dr. Welti. "I've made all our forms on Excel Spreadsheets and combined them according to specialty into PDFs to create ortho charts and eye charts and general charts, for example. All we have to do tomorrow, then, is look at the schedule, hit a button, and we'll have the necessary charts, preassembled."

The next step in his facility, says Dr. Welti, is implementing EMR, which would present even more efficiency.

"Not only do people not know what the cost is of paper charts in terms of supplies, they're also not accounting for the costs of time and effort," says Kent Barber of zChart.

He uses the example of simply admitting copying a patient's insurance card before a procedure: "You need to take the insurance card, and make copies – front and back – on new pieces of paper. Even though the patient has had to have this done how many times with the initial visit and the specialist visit, the information is not available," he says. "The most expensive thing was the time taken to do it; you have to look at the cost of paying personnel to do busy work. And what about what they could be doing if they weren't making photocopies? Staff might find they have more time to spend with patients, or you might find you have too many people employed."

5. Demonstrating quality through accurate reporting. Quality reporting is key to ASCs' continuing to gain acceptance with the public and on Capitol Hill, notes Kathy Bryant, JD, the executive director of FASA in "Top Priorities for the Industry in 2008" on p. 3, and the demand for public reporting of outcomes is on the rise. HIT and its data-mining abilities can help with both. Further, ASCs are known for leading the way in the surgical marketplace, and staying a step ahead in the IT arena is a necessary component of that in the digital age.
"I understand that market pressures can make it

difficult for ASCs to step back and take a long view of the strategic technology components that will make them competitive and profitable," says Azadeh Farahmand, founder and CEO of GHN Online. "In the long-run, however, ASCs cannot afford not to do the due diligence required to develop and implement a technology vision that integrates transparency, interoperability and access. I believe these IT capabilities will define ASC market leaders."

6. Inventory management. A good inventory technology system should allow an ASC to track inventory levels and better understand both inventory turnover and inventory value. This, in turn, can allow centers to hold less excess inventory and tie up less capital in inventory.

Dr. Welti worked with a local company develop an inventory management and case costing system for Santa Barbara Surgery Center that costs about $300 a month. The system was implemented over the summer, but he's already seeing the benefits.

"We now know the exact costs of each case and across surgeons, so I can prove to surgeons what they could do to lower their costs," says Dr. Welti. "Being able to get the eye surgeons to come together on the lenses and the packs we use for eye surgery is going to be huge for us; just by getting two eye surgeons to do what another one of our surgeons is doing [in terms of supply costs] will save us $50,000 a year, easily."

Acceptance of the system in the facility was driven by the fact it only takes a minute to use during any given procedure and doesn't encumber short cases, he says.

7. Scheduling. By using Web-based scheduling software, ASCs can dramatically improve the use of their time and reduce both paperwork and staffing needed to track scheduling. Companies such as ScheduleSurgery.com report hugely improved reduction in case cancellations due to scheduling mistakes, improved confirmation notification to surgeons and patients for appointments, and reduced staff time devoted to scheduling.

8. Dashboard reporting. Great managers want to know each day, not each month, the state of key variable such as collections, receivables, cash balances, cases scheduled, case mix and other key factors. Dashboard reporting through systems such as Source Medical, HST, Amkai and others are now available (and also can be customized) to enable managers to track their businesses and to plan and implement strategies much more efficiently and timely.

Market forces demanding more from manufacturers

Interoperability, or lack thereof, is another major issue. There are two ways around it: Buy individual modules according to your needs from one company, or seek out open-platform software that fits each task you want to be able to perform. There are advantages to both. The former simplifies HIT implementation, say experts, letting you deal with just one company instead of one or more during the initial process and later, when bugs crop up (as they inevitably will). The latter is more work, but also lets facilities better customize solutions.

The market is trending toward a wider variety of choices for ASCs, says Chris Beavor, senior vice president, sales and marketing, for Healthcare Systems and Technologies (HST): "Up till now, there was not a lot of choice. If you take the pulse of the market, it's starting to happen, and choice and competition breed better service, better pricing and better products."

Which is why interoperability is coming into vogue.

"ZChart and other companies are recognizing that the data belongs to the surgery center, patient information belongs to the patient and the ASC, and we need to be pretty careful about whether we're seen as monopolizing those things, I think," says Mr. Barber. "So we're going for interoperability and trying to make things as user-friendly as possible and not throw up a bunch of road blocks," so facilities will be more likely to pursue IT solutions.

More to the bottom line, says Mr. Petty, the ability to pick and choose can save you a lot of money.

"For some tools, there's just not a measurable ROI," he says. "Hospitals benefit from robust materials management, but a small ASC doesn't have so much going on that it can't manually manage something approaching perpetual inventory. ASCs by nature

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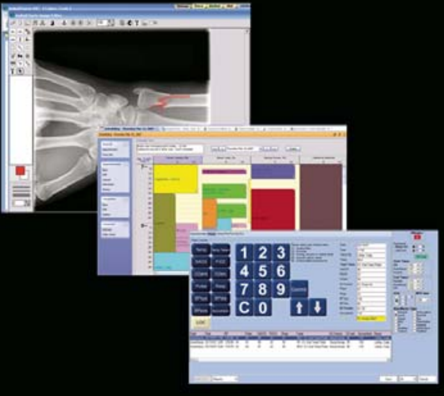

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need to look for solutions that fit into smaller, more limited-scope settings."

Coding and billing software, EMR, smaller scale materials management, scheduling software that interacts with the physician offices' software and dictation are among those that fit the bill, say the experts we talked to. ■

Contact Stephanie Wasek at stephanie@beckersasc.com.

3 Tips for HIT Success

By Scott Riemenschneider

Ensuring your success as a customer in new technology ventures mainly rests on three key issues.

1. Selecting an appropriate solution. It's important to have a good understanding of your current processes in order to identify the type of change and the value that a new technology can bring. In essence, you need to know what you are trying to accomplish through the use of technology. Perform an introspective assessment of your current environment to determine current areas of need. Externally, you need to look at the products available on the market; once you identify potential solutions and get in touch with the vendors, it's good practice to test drive the products. Involve representatives from all areas of your facility to evaluate the products and to start building buy-in from your staff.

2. Selecting the right vendor. A good vendor will quickly be able to deliver you a list of references that operate in environments similar to yours. When you follow up with the references, ask not just about the product you're interested in, but the implementation process as well as the training and level of support provided by the vendor to get a feel for its services. Equally important, a vendor should answer any and all questions about implementation honestly – some parts of the process will be rough, and any vendor who doesn't brief you on those isn't telling you the whole story.

3. Creating a high level of commitment in your staff. Even with the best software solution, it takes a strong commitment from the customer as well as the vendor to realize an efficient and successful implementation. Your vendor can help – when you hit bumps or see potential ones coming, share them. The vendor wants its product to succeed, and it should help you through challenges, engendering in your staff a sense of comfort and positive feelings as a result.

Mr. Riemenschneider (sriemen@schedulesurgery.com) is the president of Focal Point Health's ScheduleSurgery.com.

12 IT Products for ASCs

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ASC Case Studies: Different Approaches Can Help Facilities Find Turnaround Success (continued from page 1)

the A/R, administrative staff was writing off any bill that was not paid within nine days. Thousands and thousands of dollars were being left on the table."

As a result of its work, the center was able to accomplish the following:

• Staffing costs went from 39 percent to 20 percent of revenue.
• Supply costs went from 27 percent to 14 percent of revenue.
• Rent went from 8.5 percent to 3 percent of revenue (the rent did not actually decrease but ended up representing a smaller portion of the increased revenue).
• A/R went from nine to 39 days outstanding – but almost no unpaid bills were being written off.
• A/P went from $640,000 to being current (less than one month outstanding).
• Average revenue per case increased over 300 percent: from $807 to $2,600.

After one year, the severely in-debt ASC had cut its losses and was profiting each month, says Dr. Lambert.

Case study No. 2: Hiring a leader to turn an ASC around

A multi-specialty joint venture ASC was losing money and came to Surgical Management Professionals for help. On its face, it appeared that the ASC simply had some billing problems that adversely affected revenue. However, on closer inspection, SMP determined that the ASC was failing because it lacked any real leadership. In response to the immediate fiscal issues, SMP reviewed and resolved the ASC's billing and revenue issues. For the long-term, it sought out and hired a qualified and effective on site leader for the ASC.

The ASC was operating with an unproductive and inefficient front-office resulting in a loss of cases. "For example, the front office did not operate in a customer friendly manner and so physicians and patients had a difficult time scheduling appointments," recalls Doug Johnson, the executive director of SMP.

In addition, there were billing problems. "We found big piles of charts that were either not billed or re-billed in accordance with the payor's requirements. Many of the charts were also coded incorrectly so that maximum revenue would not be billed. Cleary this resulted in a huge loss of revenue for work that had been performed and because this earned revenue was not entered in accounts receivables, there was no way for a bookkeeper to know it was missing," he explains.

To resolve these issues, the center instituted a customer friendly policy throughout the ASC, reworked the charts, submitted or resubmitted the bills to payors and restructured the entire coding and billing system so that all charts would be coded correctly and submitted properly.

However, the biggest underlying problem was the lack of leadership. It was this leadership void that ultimately led to the billing and revenue problems because the staff had no concrete guidance. It also led to the hiring of an ineffective director of nursing and business officer manager. Not surprisingly, the ASC had huge staff turnover.

"The ASC had no leader and was not functioning as a team," says Mr. Johnson. "The anesthesiologists thought they were in charge, the physicians thought they were in charge and, the investor group and board did not know who was in charge. Ultimately, the Board's role is to set policy and ensure leadership, neither of which was done here."

Also, not surprising is that SMP found that a lot of people – patients and healthcare professionals alike – were angry with the ASC. After firing the director of nursing and front office manager, SMP sat down with the staff and asked for patience while it restructured the facility and hired effective leaders. "Fortunately, the board and staff trusted us and we hired a site manager with excellent leadership skills, hired an effective director of nursing, and stabilized staff turnover," says Mr. Johnson. "With these staffing changes alone, that first year we skimmed the losses and broke even and since then we have been profiting more each year."

Case study No. 3: Leadership invigorates physician base to bring financial health to ailing ASC

A 12-year old multi-specialty ASC losing close to $50,000 a month and burdened with excessively high debt approached HealthMark Partners to assist in a turnaround. HealthMark determined that the ASC was not generating sufficient revenue because many of the physician owners were not committed to using the facility and non-owners believed the center would soon fail. HealthMark concluded that the non-use mainly resulted from three problems: The ASC was old and outdated; it was not considered a healthy, vibrant ASC within the community; and there was a perception that some difficult physicians were operating at it. Further, HealthMark uncovered that many of the cases being performed at the ASC were not generating sufficient revenue.

HealthMark resolved to invigorate the ASC's ownership base with committed, highly-regarded physicians through marketing its turnaround and modernizing the facility.

"This step was taken so that any successful turnaround initiatives would accrue to the benefit of the members who understood the financial risks and were willing to commit to turning the ASC around," explains William G. Southwick, president and CEO of HealthMark Partners.

In order to attract new, committed and qualified physicians, HealthMark reestablished its core types of cases and chose those with high turnover and low acuity that would work successfully within the small ASC (two ORs and two procedure rooms). It then, with the help of a few of the remaining physician owners, identified physicians within the community who fit the new focus of the ASC and whose needs would be met by the ASC.

"With this targeted approach to find high-quality, committed physicians, we were able to double the number of active physician owners at the ASC. The ASC is performing very well now and has become a go-to facility in the community," explains Mr. Southwick.

Further, the ASC has been able to obtain robust contracts with area payors, some of whom were in a position to direct business to the ASC. Lastly, with the expansion of active physician investors and a restructuring of the surgical case focus, the ASC is presently undergoing a renovation to make it technologically modern, more efficient and aesthetically appealing.

"By boosting its physician base, the ASC has gone from being in debt and in doubt, to being a reliable profit center with community recognized quality," says Mr. Southwick, "and this could not have been achieved without rigorous study, difficult choices and the commitment and entrepreneurial spirit of the ASC's physician leaders."

Case study No. 4: Renegotiating key fiscal contracts to pull an ASC out of the red

In 2002, a failing multi-specialty ASC approached Prexus Health Partners for help. The 13,000 square foot center opened in 1999 and had 19 physician investors. Despite a volume of more than 6,000 cases in the previous year, the ASC lost approximately $300,000 that year. The center and Prexus discovered many fiscal and operational problems within the ASC.

This center had four main problems: inadequate managed care contracts; rent far above the community standard; debt financed by excessively high interest rates; and disproportionately high used equipment costs.

Upon taking the ASC on as a client, Prexus and the center took the following steps. First, it evaluated the ASC's managed care contracts and renegotiated those that were unprofitable so that they would provide adequate compensation. "In some cases Prexus was unable to obtain sufficient

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compensation and in those cases advised the ASC to drop contracts," explains Mr. Jansen.

Second, Prexus renegotiated the ASC's facility rental contract to a monthly payment the ASC could afford and one that was more reflective of the market rate for the community. The ASC had been paying a rent that was 65 percent higher than the standard in the community. "This renegotiation was not an easy one and basically occurred 'under the threat of bankruptcy,' a concept the landlord could understand," says Mr. Jansen.

Third, to cure the enormous debt expense, Prexus refinanced the ASC's debt to a more manageable rate that better reflected the current lending market. "We were able to work with a bank experienced working with our company in order to achieve a more reasonable interest rate for the ASC's loan," says Mr. Jansen. In three years, the center successfully decreased the ASC's debt expense by more than 25 percent. Lastly, Prexus and the center addressed the issue of the equipment costs but could not undo the past mistakes. Here, Prexus advised the ASC on how to make knowledgeable equipment purchases in the future, he adds.

Prexus' turnaround scheme at the ASC has been a great success. After instituting these changes and making the ASC more efficient, in three years the ASC went from a loss of 8 percent of its net revenue to a gain of 23 percent. "We continue to work with this ASC and the physician owners continue to garner a profitable return on their investment," says Jansen.

Case study No. 5: Management turned around ASC with new operating system and policies

A marginally profitable large midwest multispecialty ASC took proactive measures and contacted WoodrumASD to help it increase its profitability and avoid future financial problems. WoodrumASD examined the ASC's revenues and expenses and found opportunities for improvement in both areas. "Fortunately, this ASC approached us early so money had not been lost yet and its problems were solved in a manner that did not disrupt its business; we found essentially that no one was watching the till," says Joe Zasa, ASC consultant and CEO of Woodrum Ambulatory Systems Development.

On the revenue side, the ASC had not been operating to its fullest financial capacity in three main ways. First, it had not raised its fees in 10 years. Second, its contract with its one major payor did not provide for carve-out reimbursements for expensive implants and other high-cost items. Lastly, none of the ASC's payor contracts were loaded into the database system so those payments were not part of the system's accounts receivables. WoodrumASD evaluated the ASC's fees and adjusted them to market rate.

"So much in regards to technology and processes had changed in ten years, that the ASC's rate structure did not provide adequate compensation for the services it was providing," explains Mr. Zasa.

In addition, WoodrumASD and the center renegotiated those payor contracts that did not provide for carve-outs and loaded all of the ASC's payor contracts into the data system so that the ASC could properly monitor its payments and accounts receivables. As Mr. Zasa details, "accounts receivable days is the financial measuring stick for a business office and provides the necessary data needed to determine if the business office is operating efficiently."

Further, the center took important proactive measures.

"To avoid similar revenue issues in the future, we established policies requiring the ASC to review its fees and payor contracts at least annually and established a management program to monitor billing, coding and collecting," says Mr. Zasa.

On the expense side, the ASC had not evaluated its vendors' costs, including its group purchasing organization, in years, and as a result was overpaying for a lot of supplies and equipment. It also had

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not converted its employee benefit plans to other, less expensive but equally suitable plans, resulting in overpaying on this line item. WoodrumASD evaluated the ASC's supply costs and identified GPOs and vendors that offered less expensive options.

"This worked out well because the physicians did not have to change what they were using but simply got to pay less for those items," says Mr. Zasa.

In addition, WoodrumASD presented the ASC with alternative employee health plans that provided the same or better coverage but at lower rates. Lastly, WoodrumASD again established policies that required the ASC to examine its equipment, supply and health insurance costs on an annual basis. As a result, by lowering its fixed costs and realizing all of its revenue, WoodrumASD helped the ASC to increase its profits exponentially.

"Professional management and the necessary policy changes provided this ASC with the tools to thrive and flourish," says Mr. Zasa.

Case study No. 6: Conversion of an ASC's ownership structure was a winning strategy

Regent Surgical Health helped a hospital owned multi-specialty ASC design a plan to restructure itself to become profitable; the facility had been close to failure and had no history of distributing profits since its inception in 1987. "Being hospital-owned, physicians did not have any great incentive to improve the quality of services there," recalls Regent Surgical Health founder and CEO Tom Mallon. However, the hospital wanted to retain control of the ASC and was thus resistant to selling off any ownership shares.

To provide the hospital with the control they desired and the profitability, Regent separated the ASC's real estate from its operations and created two distinct entities. The hospital then retained 100 percent ownership of the real estate and the operations side became a joint venture between the hospital (39 percent), the physicians (51 percent) and Regent (10 percent).

"The hospital liked this idea because it still retained a fair amount of control. It also was in an advantageous fiscal position whereby it would now enjoy two revenue streams," says Paul Skowron, an administrator with Regent. "First, as the owner of the real estate and landlord of the facility it would receive rental income. Second, it would receive profit distributions from the joint venture operations entity," explains Paul Skowron.

The venture has been a success. Mr. Skowron reports that only six months after converting its ownership base, the ASC made its first profit distribution ever. He states that the attention to the ASC has increased greatly and the gross margins have sharply improved.

"Further, the ASC was able to improve its payor mix in part by drawing in more commercial payors and worker's compensation business," he adds. With Regent's continued involvement and guidance, the ASC will next launch a new spine program and plans to renovate and expand are currently being reviewed. ■

Sources

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Seven Common ASC Mistakes that May Lead to Failure

Brent Lambert, MD, FACS, suggests the following seven reasons that ASCs fail and offers advice for improvement.

1. Poor case volume. Inadequate case volume is often the primary reason for an ASC's failure and thus it is imperative that an ASC increase it. "The best way to increase case volume is to recruit qualified, active and efficient physicians who understand the benefits of an ASC and plan to use it," says Dr. Lambert. In return, the ASC must commit to supply those physicians with the space and equipment they will need to efficiently and effectively perform their surgeries. He adds that the ASC's existing physician-owners may be the best resource to locate and recruit the right type of physicians. In addition, get commitments from those existing physicians that they will use the center. "Many physicians are afraid that if they don't perform a substantial number of their surgeries at the hospital, the hospital will cut off their privileges. We have rarely, if ever, seen this to actually occur," he says.

2. High staffing costs. High staffing costs, those that exceed 20 percent of an ASC's total revenue, generally are a big drain on profits. The single most effective method to decrease staffing costs is to compress the ASC surgery schedule so that any vacancies in the schedule are eliminated. "The cost of keeping an ASC open without any surgeries scheduled is astronomical," says Dr. Lambert. "By compressing all the scheduled surgeries into, say, a four hour block of time or three days instead of five, permits the ASC to close down early and send staff home. Basically, turn off the lights when the cases are done." Of course, this method assumes that the ASC employs part-time or per diem staff that can be sent home without pay.

3. High supply costs. High supply costs eat away at profits, and should not exceed 20 percent of total revenue, advises Dr. Lambert. Most struggling ASCs have supply costs over 20 percent because they have not taken advantage of group purchasing organizations, which leverage their large membership in order to purchase supplies and equipment in bulk and at a discount. In addition, ASCs should case cost all of their procedures in order to identify which physicians are cost outliers. "Physicians will likely decrease their case costs if they realize that another physician in the ASC is spending less on the same type of case. In one ASC, we discovered a $900 discrepancy between two physicians performing the same arthroscopy with meniscectomy. By uncovering this, we were able to encourage the outlier physician to cut his costs," says Dr. Lambert.

4. Ineffective operations. Turnaround time between surgeries needs to be kept to a minimum in order to maintain the ASC's schedule, staffing and effective operations. "Unfortunately many ASCs take too long. To maintain efficiencies, turnaround times should average seven minutes or less, and certainly not be more than ten minutes," says Dr. Lambert.

5. Poor payor contracts. Payor contracts that do not pay an ASC enough for its procedures must be renegotiated or cancelled. "All payor contracts must be reviewed annually to ensure adequate reimbursement and ASCs should not be afraid to cancel a contract and possibly go out-of network rather than losing money on a case," says Dr. Lambert. "We have found that payors start to pay up once they realize an ASC will not tolerate inadequate reimbursement."

6. Poor A/R management. Poor management of accounts receivable usually results in decreased profits. The benchmark for A/R days outstanding is no more than 40; accounts should generally be paid within 35 days or fewer. In addition, 65 percent of A/R should be current at all times, with nothing due after 90 days. To help reach these benchmarks, an ASC should always bill on the same day of service and do its billing and collection on-site, says Dr. Lambert. "Billing on the day of service is a necessary efficiency and on-site billing and collections allows an ASC to maintain proper

control and ensure that the A/R is not falling behind," says Dr. Lambert. Be sure the ASC administrator is well-trained in coding, posting, collecting and submitting. "Only a knowledgeable administrator will be able to expertly manage and enforce the A/R processes and know immediately if there are problems."

7. Staggering debt service. High debt service is a cost most ASCs can avoid by shopping around for lower interest loans or amortizing the debt over several years, recommends Dr. Lambert.

– Dana Kulvin, JD, MPH

Use ASC Benchmarks to Pinpoint Weak Areas

The table below presents benchmarks that can be used to evaluate an ASC and determine those areas of the center that may require improvement. The benchmarks were developed by Ambulatory Surgical Centers of America and can be applied universally throughout the nation and for all types of ASCs. The seven benchmarks are separated into the areas of costs and operations.

Areas	Element	Benchmark
Costs	Lease	No more than 10% of revenue.
	Staffing	20% or less of revenue.
	Supplies	20% or less of revenue.
Operations	Case revenue	$1000/case on average.
	Accounts receivable	Less than 40 days, with sixty-five percent (65%) current at all times and nothing due over ninety (90) days.
	Accounts payable	Less than 30 days.
	Turnaround time	Average of seven minutes or less, no more than 10.

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14. Huntingdon Valley Surgery Center, Huntingdon Valley, PA
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17. Medcenter Ambulatory Surgery, Houston, TX
18. Nacogdoches Surgery Center, Nacogdoches, TX
19. New Braunfels Surgical Center, New Braunfels, TX
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CMS Issues New Conditions for Coverage for Ambulatory Surgical Centers

By Scott Becker, JD, CPA, Amber Walsh, JD, and Ryan Higgins, JD

The Centers for Medicare and Medicaid Services released a proposed rule on Aug. 31 that would revise the conditions for coverage for ASCs. [*See* 72 Fed. Reg. 50,470 (proposed Aug. 31, 2007) (to be codified at 42 C.F.R. pt. 416).] The proposed rule includes the most significant revisions to the conditions for coverage in more than two decades. According to CMS, these changes "reflect contemporary standards of practice in the ASC community, as well as recommendations from the HHS Inspector General."

Specifically, the proposed rule would revise three existing conditions for coverage: Governing Body and Management; Evaluation of Quality, which would be renamed Quality Assessment and Performance Improvement; and Laboratory and Radiology Services. The proposed rule would also add three new conditions for coverage: (1) patient rights; (2) infection control; and (3) patient admission, assessment and discharge.

Part one of this article discusses the substance and effect of two key changes to the conditions for coverage. Part two highlights the remaining changes.

Key Changes

All in all, the additional conditions for coverage would increase information collection requirements and other administrative obligations for ASCs. That stated, the most significant *business* impact of the proposed rule could arise from two key provisions. These are the addition of a newly codified definition for "overnight stay" in the context of ASCs and a statement and a new rule applicable to patient transfers.

• **New definition for overnight stay.** The existing conditions for coverage define an ASC as "any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with CMS to participate in Medicare as an ASC, and meets the conditions set forth in subparts B and C of this part." (42 C.F.R. § 416.2.) The proposed conditions for coverage would add a new and clearer overnight stay element to the definition of ASC.

Regarding the definition of ASC and the new overnight stay element, CMS stated the following:

Ambulatory surgical center or *ASC* would mean any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring an overnight stay following the surgical services, has an agreement with CMS to participate in Medicare as an ASC, and meets the conditions set forth in subparts B and C of this part. The overnight stay definition would read as follows:

Overnight stay, for purposes of the ASC CfCs, would mean the patient's recovery requires active monitoring by qualified medical personnel, regardless of whether it is provided in the ASC, beyond 11:59 p.m. of the day on which the surgical procedure was performed.
To provide further clarification on the overnight stay definition, we are proposing to use the 11:59 p.m. threshold as the standard for determining a patient's status when receiving services in an ASC facility. In the Medicare cost reporting manual (Provider Reimbursement Manual, Part 1, Section 2205 (Medicare Patient Days, page 22–16)), we

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> have defined a hospital inpatient day as beginning at midnight and ending 24 hours later. Consistent with this longstanding policy, we would codify in regulations that any patient whose recovery requires active monitoring by qualified personnel beyond 11:59 p.m. of the day on which the surgical procedure was performed, is a patient who may require hospitalization or more intensive care. Accordingly, ASCs that are Medicare-certified may not keep patients beyond 11:59 p.m. of the day on which the surgical procedure was performed.

The potential codification of this new definition raises two important issues. First, the proposed rule could impact the ability of surgical centers to see non-Medicare patients that stay past 11:59 p.m. The existing conditions for coverage do not include an overnight stay element in the definition of ASC; rather, the conditions merely limit *reimbursement* to surgical procedures "generally requiring a post-operative recovery room or short-term (not overnight) convalescent room" without further defining the term "overnight." [42 C.F.R. § 416.65(a)(3).] CMS contends that the proposed definition is consistent with a "longstanding policy," described in the Medicare cost of reporting manual, of defining "a hospital inpatient day as beginning at midnight and ending 24 hours later."

• Patient transfers. A second issue relates to the requirement for transfer agreements between surgical centers and local hospitals. Here, CMS appears to recognize that there are often political and competitive issues between local surgical centers and hospitals that often make it difficult for an ASC to obtain a transfer agreement with a local hospital. Notwithstanding this issue, the comments state that the ASC must transfer the patient to the most appropriate local hospital regardless of business at those hospitals. Specifically, CMS states:

> …Regardless of any business issues that may arise between ASCs and their local hospital, the ASC would be required to transfer patients to the nearest, most appropriate local hospital, since this would affect patient health. Any transfers that do not meet the requirements of proposed § 416.41(b)(1) and (2) would be determined to be out of compliance with Medicare regulations.

Currently, the conditions for coverage require only "an effective procedure for the immediate transfer to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC." (42 C.F.R. § 416.41.) The proposed rule could pose challenges for ASCs by potentially placing ASCs in a difficult bargaining position with hospitals.

Remaining Changes

The remaining changes to the conditions for coverage provide for additional controls, some of which are bureaucratic in nature. Commentary issued with the conditions of coverage provides insight into the agency's rationale behind the proposed changes.

• Statement and rule on patient rights. The proposed rule adds a new condition not previously included in prior rules requiring ASCs to notify patients of their rights and providing for exercise of such rights. Specifically, the proposed rule addresses the following:

- notice (orally, in writing and on the wall) of patient rights, including the name and address of the application state agency to which patients can direct complaints (and communications must be given clearly in the patient's own language either through an English-speaking representative of the family or a translator);
- disclosure of physician financial interests in the ASC orally and in writing prior to the first visit to the ASC;
- policies relating to advance directives and the provision of information relating to advance directive options under state law to patients;
- grievance process pursuant to which patients can address patient rights issues at the facility level including a time frame for response and follow-up that patients can expect;
- protection of patient dignity and property (including a specific example described in the commentary, which includes providing space for patients to

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disrobe privately and to await surgery separate from clothed family members and others); and
- confidentiality of clinical records, including compliance with existing HIPAA rules and the requirement that clinical records cannot be disclosed or used without patient written consent ASCs to give patients information about federal and state laws pertaining to these issues.

Many of these new patient rights requirements have been implemented and routinely followed by ASCs to date. However, the new requirements will surely necessitate additional time and resources during admission and consultation stages. In particular, the advance directives policies and explanation will require the ASC to be well-versed in advance directives rules in its state and to be able either to answer questions relating to advance directives or be willing to reschedule procedures until any raised questions can be answered fully.

It is also unclear whether the new confidential records requirement will defer to certain exceptions set forth under HIPAA for the sharing of records with certain provider affiliates, during the course of an audit or extraordinary transaction, etc.

An excerpt from CMS commentary relating to the patient rights requirements is as follows:

The proposed standard at § 416.50(a), Notice of rights, would require the ASC to provide the patient or representative with verbal and written notice of the patient's rights in a language and manner the patient understands prior to furnishing care to the patient. The ASC would also be responsible for posting written notice of the patient rights in a place or places within the ASC where they are likely to be noticed by patients waiting for treatment. In addition, the notice of patient's rights must include the name, address and telephone number for a representative in the State agency to whom patients can report complaints about ASCs, and the CMS web site for the Medicare Beneficiary Ombudsman (http://www.cms.hhs.gov/center/ombudsman.asp). (Section 923 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173)(MMA), mandated the creation of the Medicare Beneficiary Ombudsman at section 1808(c) of the Act, to ensure that Medicare beneficiaries receive the information and help they need to understand their Medicare options and to apply their rights and protections. A Medicare Beneficiary Ombudsman Open Door Forum (ODF) has been established to provide an opportunity for beneficiaries, their caregivers and advocates to publicly interact with the Medicare Beneficiary Ombudsman to discuss issues and concerns regarding ways to improve the systems and processes within the Medicare program.

The ASC would also be responsible for meaningfully disclosing, if applicable, physician financial interests or ownership in the ASC facility in accordance with 42 CFR Part 420 (Program Integrity). The ASC must disclose the information in writing and furnish it to the patient prior to the first visit.

The disclosure of financial information should be such that patients and their representatives are able to clearly understand if the physician(s) who will be performing a procedure has a financial relationship with the ASC. It is incumbent on the ASC to be able to provide information that is not only technically correct, but which is also easily understood by persons not familiar with financial statements, legal documents or technical language. The ASC should be aware of the age and the cognitive abilities of its patients and recognize that older patients may be confused when presented with a document that they cannot readily understand at first glance.

In § 416.50(a)(2), Advance directives, the ASC would also be responsible for providing the patient or representative with verbal and written information concerning its policies on advance directives, including a description of applicable State law and, if requested, official State advance directive forms. In addition, the ASC would be required to inform the patient or representative of the patient's right to make informed decisions regarding their care, and to document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.

We believe that ASCs should be given flexibility to meet this requirement within the context of their unique patient populations. Differences exist among ASCs and, therefore, ASCs should be allowed to determine the process they would use to comply with this proposed requirement. As a result, we are not establishing specific guidelines for implementation. We also believe that the ASC should be aware that questions may arise when informing patients of their rights; and therefore, they should provide ample time for answering questions.

We are also proposing a requirement entitled "Submission and investigation of grievances" at § 416.50(a)(3). This requirement would respond directly to the OIG report referenced earlier regarding management of patient grievances and any alleged violations against patients.

Grievance procedures are already in effect for numerous health care providers including ASCs. Similar to other internal procedures (for example, admission and discharge procedures, infection control procedures and others that are common to health care entities) the development and implementation of grievance procedures vary. Therefore, we have determined that it would be better to allow ASC to establish the specifics of a grievance system that may match its current one or needs rather than requiring that every ASC conform to a single grievance system. We are proposing that the ASC would establish clearly explained procedures for documenting the existence, submission, investigation, and disposition of grievances presented to the ASC (either written or verbal) made by the patient or the patient's representative. ASCs would document all alleged violations related to and including, but not limited to,

mistreatment, neglect, verbal, mental, sexual or physical abuse. If other allegations of mistreatment arise, such as theft of personal property, the ASC would document this allegation, as well. The ASC would immediately report these allegations to a person in authority in the ASC, the State, and local bodies having jurisdiction, and the State survey agency if warranted, to the extent that such reports are consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) and privacy provisions.

We are proposing that the grievance process specify time frames for review and response to the grievance. We are also proposing the ASC would be required to investigate, document, and respond to all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.

We are proposing that certain information be captured when documenting and responding to grievances. Proposed documentation should include such information as how the grievance was addressed, the steps taken during the investigation; written notice to the patient or representative of the ASC's decision (containing the name of an ASC contact person); the results of the grievance process; and the date the grievance process was completed consistent with HIPAA and privacy requirements. ASCs could use different approaches to effectively meet this CfC. We would set forth the general elements that should be common to grievance processes across all ASCs, but we are not explicitly delineating strategies and policies that ASCs are required to use to comply with the requirement. Also, we would leave the degree of documentation to the discretion of the ASC.

We would propose at § 416.50(c), Privacy and safety, that patients have the right to personal privacy and safety, to receive care in a safe setting, and to be free from all forms of abuse or harassment. For example, ASCs would be required to provide a private space in which patients could disrobe and wait until the surgical procedure begins because we believe it is inappropriate for patients to be required to sit in a public waiting area while in a hospital gown with other fully clothed or similarly gowned patients or be in a common patient area without the benefit of partitions. This right would also allow patients, for example, to identify and report dangerous or unsafe conditions, harassment or abusive behaviors within the ASC that the patient believes could negatively impact the services received at the ASC. We believe this requirement would act as an additional safeguard to patient health and safety.

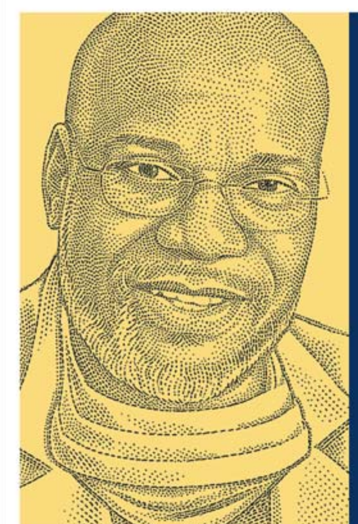
The proposed "confidentiality of clinical records standard" at § 416.50(d) is designed to safeguard patients against unauthorized use of their clinical record. We would assure that the patient's right to confidentiality consistent with HIPAA standards and that access to or release of patient information and clinical records is permitted only with written consent of the patient or representative or as authorized by law. We are proposing to add this requirement because patients have the right to communicate with health care providers in confidence and to have the confidentiality of their health care information protected. In addition, all ASCs would be required to comply with the HIPAA health information privacy rule at 45 CFR parts 160 and 164.

• Governing body and management. With respect to governing body and management, CMS stated:

> …We are proposing new language in the condition statement which would require the governing body to assume direct oversight and accountability for the QAPI program. The governing body would be responsible for ensuring that QAPI efforts, at a minimum, focus on identifying areas needing improvement and that QAPI is implemented in accordance with § 416.43 of this part. Specific governing body QAPI responsibilities are detailed in the proposed QAPI requirement at § 416.43. By focusing on QAPI, ASC management would be expected to be better able to improve care being furnished to patients. We are also proposing that the governing body be responsible for creating and maintaining a disaster preparedness plan. In addition, we are proposing to retain the current requirement which provides that the ASC can contract for services with an outside resource. However, we propose to incorporate this language into a separate standard, located at § 416.41(a). The ASC's governing body would still be responsible for the services that are furnished.
>
> …The ASC's governing body, as part of the ASC leadership component, would be responsible for maintaining a written disaster preparedness plan that would provide for the emergency care of patients in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that threaten the health and/or safety of its patients and staff members.

• Quality assessment of performance improvement. CMS also included a revised condition for quality assessment programs. Regarding this condition, CMS stated:

> …To raise the performance expectations for ASCs seeking entrance into the Medicare program, as well as the expectations of those ASCs already participating in Medicare, we are proposing that each ASC also develop, implement, and maintain an effective QAPI program. Our aim is to support the development of patient-centered, outcome-oriented efforts that focus on patient health and safety. An ASC QAPI program would be designed to stimulate the ASC to constantly monitor and



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In proposed § 416.43(a), Program scope, we are proposing that the ASC's QAPI program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and with the identification of medical errors.…

Monitoring care in an ASC can be challenging since the typical patient may be seen for only one visit. Therefore, it is critically important that an ASC's QAPI program identify high-risk areas and areas of problematic care and conduct follow-up analysis in a timely manner to identify specific areas in need of improvement.…

At proposed § 416.43(c)(1), Program activities, we propose to require that the ASC set priorities for its performance improvement activities that: (1) Focus on high risk, high volume and problem-prone areas; (2) consider the incidence, prevalence and severity of identified problems; and (3) give priority to improvement activities that affect health outcomes, patient safety and quality of care. We expect an ASC would take immediate action to resolve any identified problems that directly or potentially threaten the care and safety of patients.…

- **Laboratory and radiological services.** The conditions also include a new condition for laboratory radiological services. Regarding this condition, CMS stated:

In § 416.49, we would divide the current condition into two separate standards: Laboratory and radiologic services; in addition, we are proposing the expansion of the radiologic services requirement. The laboratory standard requirements would not change.

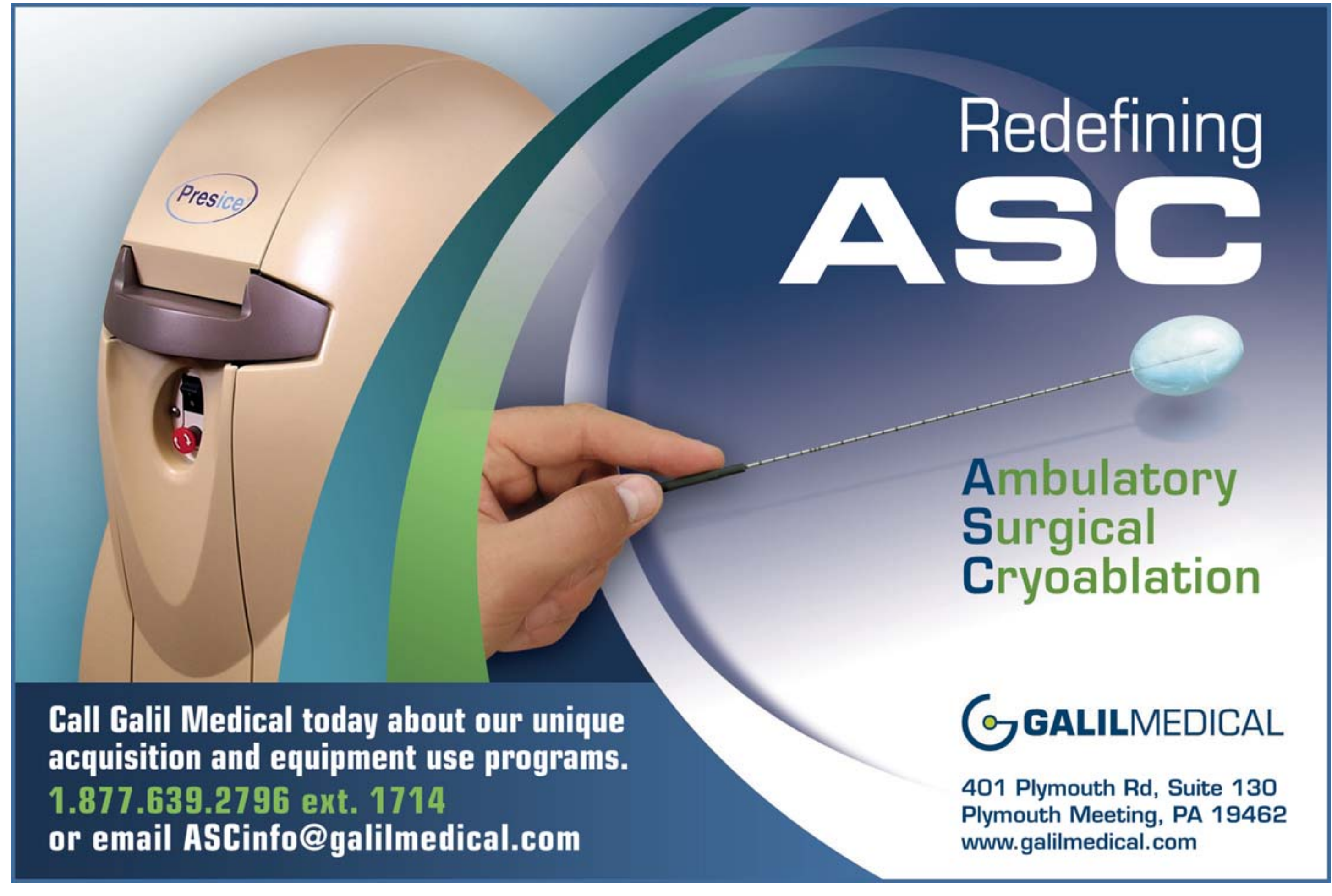
The proposed changes to the radiologic services standard would parallel the current laboratory standard by including requirements that the ASC would be required to meet, if applicable, when providing services directly or under arrangement.

The requirement at § 416.49(b)(1) is part of the current laboratory and radiologic services condition and the language would remain unchanged. The proposed language at § 416.49(b)(2) would require the ASC to meet the requirements of the CfCs for portable x-ray suppliers found at § 486.100 through § 486.110 of this chapter if it is furnishing these services directly. We have also proposed that radiologic services furnished under arrangement would be performed by an entity that was certified by Medicare as a supplier of portable x-ray services by meeting the Medicare CfCs for portable x-ray services. This change would better ensure that high quality radiologic services are available to ASC patients.

- **Infection control.** With regard to a new condition for coverage for infection control, CMS stated:

We propose to establish a separate condition for infection control since control of infection is critically important to overall patient and staff health and safety.

We believe that surgery in an ASC must not entail a greater risk of infection to the patient than surgery in an inpatient setting. Medicare approved surgical procedures are performed in a variety of settings and we believe that an effective infection control program should be present in all ASCs. One primary cause of infections is poor surgical technique and follow-up care. The Centers for Disease Control and Prevention (CDC) 1999 Guideline for Prevention of Surgical



Site Infection [Infection Control and Hospital Epidemiology, Vol. 20 No. 4], also states that serious surgical infections can be explained by the emergence of antimicrobial-resistant pathogens and the increased numbers of surgical patients who are elderly. Furthermore, the CDC also reports that two million people are affected by infections that annually occur in hospitals and not including those healthcare associated infections that occur in long-term care facilities, ambulatory-care facilities and outpatient settings (CDC. Public health focus: surveillance, prevention and control of nosocomial infections (MMWR 1992; 41: 783–7)). A recent report on maximizing hand hygiene compliance and improved outcomes published in Infection Control Today reported that healthcare associated infections subject patients to increased risk of morbidity and mortality, increased durations of care and increased healthcare treatment costs (E. Fendler and P. Groziak; Maximizing Hand-Hygiene Compliance to Improve Outcomes: A New Tool for Infection Control, Infection Control Today, November 2001). Furthermore, the report by Fendler and Groziak, according to CDC estimates, states that implementing effective infection control programs prevents one-third of these infections.

As noted by the former CMS Administrator, Dr. Mark McClellan, during his testimony before the Senate Finance Committee on May 18, 2006, "Medicare payments to ASCs are expected to better reflect the resources required to perform specific surgical procedures and to be similar to payments under other payment systems. In its 2005 Report to Congress, CMS found that many orthopedic surgical specialty hospitals were more similar to ASCs than to acute care hospitals." To address this problem, CMS is developing revisions to the payment rates and also the list of procedures eligible for payment. …

We are proposing this new condition as a method to capture specific patient care requirements in the pre-admission, pre-surgical, post-surgical and discharge phases of the ASC surgery process. The core objectives of this condition would be to ensure: (1) The patient can tolerate a surgical experience; (2) the patient's anesthesia risk and recovery are properly evaluated; (3) the patient's post-operative recovery is adequately evaluated; (4) the patient receives effective discharge planning; and (5) the patient is successfully discharged from the ASC.

Under the first proposed standard, "Admission and pre-surgical assessment," we would propose that each patient must have a comprehensive medical history and physical assessment completed not more than 30 days before the date of scheduled surgery by a physician (as defined in section 1861(r) of the Act), or other qualified practitioner in accordance with State law and ASC policy. We are proposing the 30-day time limit to remain consistent with our hospital conditions of participation that also requires a medical history and physical assessment be completed no more than 30 days before an elective procedure or admission. In addition, to ensure the ASC healthcare team would have all patient information available if needed, the ASC would be required to place the medical history and physical assessment in the patient's medical record before the surgical procedure is started. …

The proposed standard § 416.52(b), "Post-surgical assessment" would require the ASC to ensure that a thorough assessment of the patient's post-surgical condition is completed, documented in the medical record and that any post-surgical needs are addressed and included in the discharge notes. We propose to retain the current standard at § 416.42(a) that requires a physician to evaluate each patient for anesthesia recovery before discharge. The post-surgical assessment must be performed by a physician or other qualified practitioner in accordance with State law. The post-surgical assessment would assess all body systems and identify any unforeseen or unanticipated post-surgical medical issues. The goal would be to decrease the amount of post-surgical complications experienced after discharge in the home recovery setting.

Conclusion

These proposed rules would, taken as a whole, have a significant impact on ASCs from an operational and business perspective. CMS accepted public comments through Oct. 30 and expects to publish a final rule near year's end. ■

Vending Machines – Not all Bad!!

By Chloe Freed Becker

A vending machine would be great for our school. Sometimes you do not remember your nutrition needs. Also, there can be fit and healthy foods in a vending machine. I would like a vending machine because there are healthy choices and it can help those who forget their lunch.

Did you know some things in the vending machine could be healthy for you? First of all, you can get healthy apples and fruits in the vending machine. So, you can be healthier and ready for your day. Also, you can get healthy drinks like Gatorade, Propel, and water. So, you won't get dehydrated and you won't get sick.

Did you know sometimes you can forget your food for school? You can forget your snack so you can go to the vending machine and then, your not whining to your teacher that you are hungry. In addition, you can forget your lunch so you can get a sandwich, chips, and fruit. Then, you're not hungry and not worried.

A vending machine would be excellent for a school. There are fresh foods in a vending machine. You can forget your snack or lunch. I would like a vending machine because sometimes I need food to eat! ■

Pain Management ASCs – Here to Stay in 2008 and Beyond

By Amy G. Mowles and William E. Lindeman, AIA, NCARB

While you might be hearing a lot of doom and gloom about pain management's future in ASCs after CMS's transition to HOPD-based facility fees, an assessment beyond a rudimentary sampling of the most common procedure codes reveals a significantly different picture. In fact, as the traditional "grouper-based" facility fees for individual procedures are being eradicated, there are new sources of payment previously unavailable in freestanding (non-HOPD) facilities.

Depending on the specific procedure volume and payor mix, pain management ASCs may see few adverse effects – and could, in fact, come through the transition just fine. To assess the impact of the new payment system, one needs to understand and evaluate the overall complexity for 2008 and beyond, from reductions in payment for some procedures, to increases for others, to payments entirely new to ASCs.

Identifying payment indicators

The road map to this understanding starts with grasping the payment indicators stipulated by CMS to guide the four-year transition (to be complete by beginning of 2011) to an HOPD-based system for all ASC services. Payment indicators specify the method and timing for application of revised payments; and there are 16 ways that is proposed to happen. Luckily, single-specialty pain management ASCs need only work with a few of them. They include the following;

- The **old groupers**, or procedures already classified as receiving facility fees in 2007, will make the multi-year prorated transition from the 2007 basis to 65 percent of the HOPD rate.
- **New procedure codes** not previously considered appropriate to office-based facilities (they were exclusive to hospital-based facilities) will be paid immediately (starting Jan. 1, 2008) at 65 percent of the HOPD rate.
- **Device-intensive procedures** (such as neurostimulators and drug-infusion pumps) will be paid according to the multi-year prorated transition to the HOPD basis plus an additional scheduled amount addressing the costs of the devices themselves.
- **Codes that were considered "office-based"** and did not previously qualify for a facility fee, but instead paid a higher professional fee if performed in the office setting. The difference between the enhanced fee and that paid to the surgeon if using someone else's facility is/was commonly referred to as the site-of-service differential and represented the minimum fee an ASC should be paid for use of the facility by the surgeon to avoid the appearance of subsidizing use of the ASC. These procedures are each being assigned a transitional value (different from the site-of-service differential) that is applied immediately (starting Jan. 1, 2008) as the facility fee.
- **Two new categories** for handling diagnostic radiology codes are applicable where a technical component is now payable in addition to related procedures (but many others remain "bundled" with the associated code); these fees are to be applied starting Jan. 2008.

Understanding the reimbursement

If you look only at the prorated transition of the familiar groupers from the 2007 basis to the proposed 65 percent of HOPD rates, the outlook is indeed not good, with most facility fees reduced between 24 percent and 35 percent. But as seen above, that is only part of the picture. While the basic values for those codes are going down, ASCs can now be paid additional fees for some of the more expensive drugs and biologics used during qualifying procedures and, with a few procedures, additional fees for the technical component of ancillary diagnostic radiology services. Add to that the significant number of codes qualifying for new or higher payments and the situation brightens considerably.

For example, a large joint injection [20610] under the 2007 system only offered an ASC the office-based site-of-service differential amount as anticipated

compensation: a whopping $21.22, which is particularly offensive considering nothing additional can be charged for the drug administered. Under the HOPD system, the ASC will be paid a basic facility fee approximately 75 percent higher than the 2007 site of service differential plus separate payment for drugs.

No two codes previously practice-based are treated the same, however. The increase over 2007 site-of-service differential values for non-radiological pain management procedures ranges between 23 percent and 128 percent, but all those payments for the most common pain management codes are increasing, and additional payments will be made for drugs and biologic agents.

Then there are payments that "jump" codes to identify a facility fee, resulting in another gain for the ASC, such as cervical discography's [62291] new connection to radiological interpretation [72285]. Under the 2007 system, discography was treated as a practice-based code, meaning an ASC's anticipated compensation was tied to the site-of-service differential in professional fees. Under the HOPD system, the payment indicators direct the ASC to bill the technical component of the discography under a separate radiology code that not only creates a defined facility fee, but increases payment by about 42 percent.

One of the important distinctions with the newly defined facility fees, higher and in lieu of site of the older service differential values for office-based procedures, is they will be paid directly to ASCs. While it was understood the practice-based differentials (as an absolute minimum) should be paid to ASCs, it was a political and/or cash flow problem for the ASC to collect payment from the operating surgeon because the amounts were paid directly to the physician as global professional fees. For ASCs used by non-owner surgeons, the new system eliminates the potentially unpopular process of extracting payment from part of a surgeon's professional fees and clearly defines the facility fee due directly from the CMS carrier.

Uncovering other new advantages

Office-based codes are not the only silver-lining with the new system. For example, vertebroplasty procedures will not only generate a facility fee for the procedure code (22520, 22521, or 22522) but also for the necessary diagnostic imaging technique (fluoroscopy under 72291, or CT under 72292). While the completed transition to a HOPD basis is projected to reduce the primary code's value by about 25 percent, the newly applicable diagnostic imaging technical component should help offset the loss.

Some other procedures, such as neurolytics, will fair better under the HOPD-based system because it accounts for the costs of expensive needles, probes and grounding pads – something the old system clearly did not. Stimulators and pumps (which have long involved extended negotiating and compromise to get paid for) are now included in the Ambulatory Payment Classification, offset by a "device percentage."

The overall effect of these changes (transition to an HOPD rate basis) is highly dependent on the specific procedures performed. To give you a better idea, annualized procedure data for four unrelated pain management groups across the country were run through feasibility projections for 2007 through 2011. The resulting projections (no escalation of fees for inflation adjustments where assumed or applied, except as noted) yielded some interesting insights:

- CMS payments for ASC pain management procedures in 2008 will be up from 2007, with a weighted average increase slightly over 2.5 percent. They will then decrease annually as the transition to a purely HOPD basis progresses. Consequentially, investors who have delayed developing new ASCs while waiting to see CMS's final methodology have missed the strongest year for Medicare reimbursement in the recent past and foreseeable future.

- The net effect at the conclusion of the transition to the HOPD basis will be a weighted average reduction in payment a little under 6 percent – a far cry from the 35 percent or greater losses touted by inadequately informed resources.

- If HOPD rates are projected to increase a modest 3.5 percent to 4 percent annually for each year of the transition (except 2009 where blocked by CMS), the net effect will be an increase in weighted average payment of approximately 5.3 percent over 2007's.

Though such a small sample of pain management groups is hardly extensive or statistically precise, it should serve as a wake up call for those fearing the worst case scenarios postulated elsewhere. The greatest point to be made, however, is how insignificant those modest reductions can be in a well conceived and efficiently run pain management ASC.

Productive through 2011 and beyond

In the end, any pain management ASC with adequate patient volume to keep staff productive and equipment busy will be profitable (given a normal procedure mix). As long as that is the case, compensating for a 5.3 percent loss, even if from all payors, should be covered by roughly an annual procedure volume increase of less than 2.5 percent (comfortably within most groups' capabilities and expectations). Considering the likelihood that CMS is not the only payor, and is probably the lowest payor, the volume increase to cover the projected reduction should be even less.

A busy pain management ASC has long been an excellent investment for owner-surgeons, and the transition to the proposed HOPD basis will do little or nothing to change that. To get the most from their investment, pain management groups should size their facilities to be efficient from the onset but capable of supporting longer-term projected-volume increases – beyond a break-even level, each percent of volume growth can increase profit many fold. Single-specialty pain management ASCs tend to have an advantage pursuing efficiency increases compared to multi-specialty ASCs, simply because they avoid the down-time of adapting procedure room equipment and arrangement between cases, and have staff attuned to the relative high volume possible for the specialty.

A final push toward ASCs, and away from practice-based pain management procedures, may come from the regulatory side — and in fact already is in some states, such as Pennsylvania, where the health department has recently written opinion that the acuity of pain management patients and the procedures performed are only acceptable in licensed and certified ASCs. The transition to the more inclusive HOPD procedure list will only increase the acuity of patients treated and the risks associated with the more provocative procedures allowed. Then there are expectations of significant cuts in office-based procedure fees – but that is anyone's guess at this point, and another discussion entirely.

*Ms. Mowles (**amymowles@aol.com**) is the president and CEO of Mowles Medical Practice Management (**www.mowles.com**). Mr. Lindeman (**weldesigns@gmail.com**) is the president of WEL Designs (**www.weldesigns.com**).*

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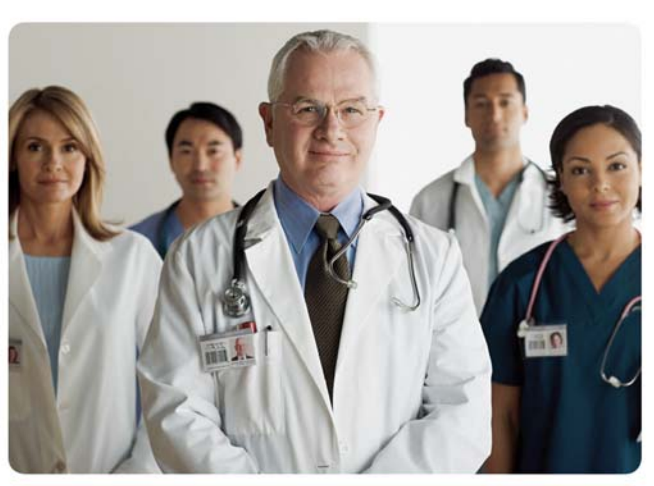

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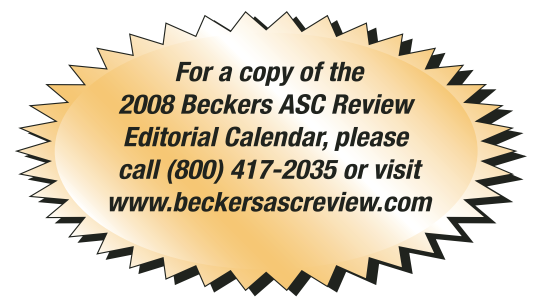

Your Questions Answered

By Scott Becker, JD, CPA

Q: Can a surgery center have two different classes of stock for physicians?

A: Generally, there are two core differences in types of classes of stock. These differences can relate to (1) voting rights or (2) financial rights. This article strictly discusses different classes of stock amongst physician-owners. It does not discuss different classes of stock between non-physicians and physicians.

Over the past few years, we have examined different types of concepts related to different classes of stock for physicians. First, can you sell shares to physicians at a lower price because the physician owned shares will not have any voting rights. Second, can you sell shares at a different price due to the concept that one class of shares has a preferred financial return to the other class of shares.

We generally do not encourage either one of these strategies as a means to help price shares for physicians at a more affordable rate. For example, we have seen situations where a company will price a new class of shares lower because the initial holders of shares will have the ability to receive all distributions up to a certain point. As an example, assume that the surgery center currently makes $800,000 a year in net income. With this type of preferred stock concept, the initial shareholders, those that hold shares before selling to the new shareholders, might receive all of the distribution up to $800,000, before the new shareholders have the right to share in distributions. Then, the new shareholders would share in distributions based on some percentage between the new shareholders and the old shareholders such as based on their percentage of ownership.

We generally do not view this as a recommended course of action. First, the hurdle to reach to receive distributions can be viewed as encouraging the new physicians to bring a great deal of cases to the surgery center such that they will meet the initial hurdle and be able to share in distributions. This is different than being able to share in distributions from the first dollar or profit in the surgery center. Second, this runs contrary to a good deal of the guidance set forth by the Office of Inspector General related to sharing in returns pro rata based on ownership. Hence, even though there may be justifiable reasons for such a type of preference or preferred stock, we generally recommend against such a strategy.

We also generally recommend against differentiating the prices amongst classes of shares amongst the physician owners based on voting rights. It is generally acceptable where a party is buying in without control rights and without liquidity, to use a valuation firm and have such an independent third party account for these factors. However, we would be very cautious about using a strategy whereby physician shares are discounted compared to other physician shares because some of the shares are purposely developed without voting rights. While there may be justifiable reasons for this, we have concern that an investigator would view this as simply a means to try and reduce the share price for physicians to entice more physicians to invest and to help capture their business at the surgery center.

Q: If a hospital owns 51 percent of the shares of a venture, can the ASC bill for services at higher rates?

A: Generally, a hospital's owning 51 percent of a joint-venture ambulatory surgical center would not itself enable the surgery center to bill for higher rates to Medicare or Medicaid patients.

The ownership of 51 percent may place the joint-venture in a situation where the hospital can treat the joint venture surgery center as an affiliate on certain of its managed care contracts. At 51 percent, many managed care contracts provide that a hospital can add on to its managed care contracts any venture in which it has controlling interests. Accordingly, depending on managed care contracts, this type of venture might be able to bill payors under the managed care contracts of the hospital.

Another consideration as to this question evolves under the antitrust laws. Generally, the antitrust laws prohibit a conspiracy amongst two different parties to decide on the prices to be charged to a third party. Where there is only one party, there is no possibility of "conspiracy" under the antitrust laws. Generally, the antitrust laws treat two parties as "one party" if the first party owns more than a certain percentage of the second party (such as an ASC). Typically, if a first party owns more than 80 to 100 percent of the second party (the ASC), this becomes close to a non-issue. In essence, they are almost always treated as one party. In contrast, where the first party owns less than 80 percent of the second party, the extent of freedom under the antitrust laws to jointly contract depends upon the control the first party has over the second party. If the first party has essentially all decision making over the second party (the joint-venture), there may also be significant freedom to jointly managed care contract. ■

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Sample Code of Conduct for ASCs

A code of conduct is simply one piece of an overall compliance plan. It puts forth a number of core concepts that should be incorporated into the compliance plan. Often, a surgery center will have a difficult time administering and starting to put together a comprehensive compliance plan. This is not an excuse for not having a compliance plan. However, even in these surgery centers, it can be very easy for a surgery center to develop a code of compliance that serves as standard rules by which the surgery center operates. This can become the mantra and the cornerstone of a culture of compliance that every surgery center should have. These items set forth below are the introduction to the pieces of a compliance plan that a surgery center should have. We hope that you find this helpful.

The Center strives to provide quality health care services to the community. The Center's values and goals include the achievement of excellence in the treatment of the patients and the compliance with all laws applicable to the Center's operations. The operation of the Center in compliance with all laws shall take precedence at all times over any interest in generating profits. All references herein to "owners" of the Center shall include both direct and indirect owners. The Center, in its business and clinical operations, will strive to abide by the following principles:

1. The Center, each owner, and each employee shall use best efforts to protect the confidential information of patients and families of patients.

2. The Center, each owner, and each employee will abide by all policies applicable to such person's positions with the Center, as well as all state and federal laws and conditions of participation in health care reimbursement programs.

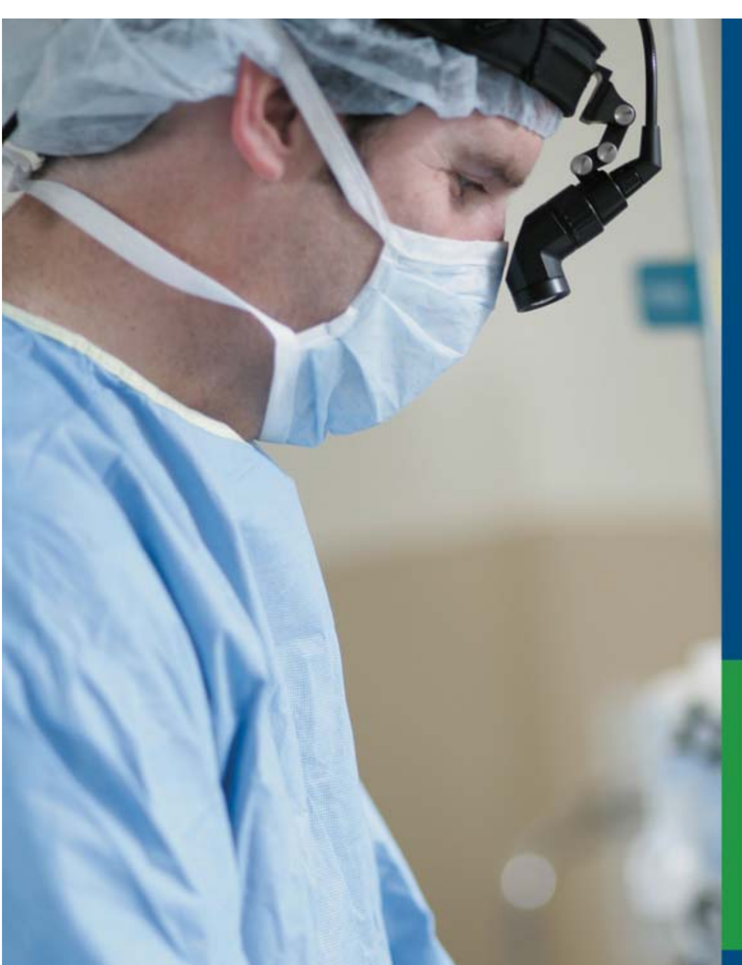
3. The Center, the owners, and the employees will not encourage or participate, directly or indirectly, in activities such as theft, bribery, kick backs, misappropriation, false statements, submission of false claims, discrimination, boycotts, price fixing, or violations of environmental or work place safety laws.

4. The Center, the owners, and the employees will not make any payment, or offer to make any payment, whether in cash or in kind, to any physician, patient, hospital, facility, or other party in order to induce the referral of patients or other items or services to the Center.

5. The Center shall not enter into relationships with any person or entity that may refer business to the Center unless such arrangements involve compensation for fair market value and the arrangements are fully compliant with all laws. No such arrangement shall take into account the volume or value of referrals by such person.

6. The Center will only bill for services in a manner that is legally appropriate. Owners and employees who are involved with billing functions will not submit any claims for amounts other than in accordance with the Center's policies. In the event that any owner or employee discovers any intentional or unintentional improper billing practices (including the submission of any false claim), such person shall immediately report it to the appropriate Center personnel.

7. Owners and employees who refer patients for services to the Center will only refer patients for services or procedures that are medically necessary or cosmetic in nature. Services that are neither medically necessary nor cosmetic in nature shall not be performed at the Center.



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8. The Center, each owner, and each employee shall treat all patients (including Medicare, Medicaid, and indigent patients) in a non-discriminatory manner in accordance with Center policies regarding acceptance of patients.

9. The Center shall not offer shares in exchange for referrals. Shares in the Center may only be sold at fair market value, and the sale of more or less shares depending on the referrals generated by such person is strictly prohibited.

10. All distributions of Center earnings shall be based on the number of shares held by the owners and shall in no way be based on the volume or value of referrals to the Center.

11. Each owner shall notify patients of his or her financial interest in the Center if he or she refers such patients to the Center.

12. Each owner and employee shall treat all patients, Center personnel, and other members of the community with dignity, respect and compassion.

13. The Center, each owner, and each employee will maintain a safe working environment, will fulfill all duties in a safe manner, and will notify the proper Center personnel immediately of any hazard, injury, equipment problem, or other potential safety issue.

14. If an owner or employee becomes aware that any Center staff or owner or other person providing services to the Center has engaged in any of the behavior prohibited above, such person must notify the appropriate Center personnel.

15. The Center and each owner will strive to maintain compliance with the ambulatory surgery center Safe Harbor to the Federal Anti-Kickback Statute, and, except to the extent of efforts to comply with the one third tests of the ambulatory surgery center Safe Harbor, the Center, the owners, and the employees will not pressure any person or entity to refer patients or cases to the Center. In furtherance of such, the following principles shall be followed:

A. Any services provided to the Center by owners or other persons or entities will be provided pursuant to a written contractual arrangement directly with the Center or an affiliate. Any such contract, whether it is directly between the Center and physician owner or other person or entity, a subcontract with an affiliate, or otherwise, will be negotiated and entered into by all parties at arm's-length.

B. Any services by owners to the Center shall be legitimately needed services and shall be clearly enumerated in the contract. All such services shall also be necessary to the maintaining or improving the quality and/or efficiency of the Center's operations.

C. No physician owner or other person or entity will receive any compensation or remuneration, either directly or indirectly, from the Center, or any affiliate of the Center, that is related to the volume or value, or potential volume or value, of such physician's or other person's or entity's referrals of patients to the Center (i.e. based on such physician or other person or entity's referrals).

D. Neither the Center nor any affiliate of the Center will provide any incentive to owners to refer patients to the Center and the Center will not withhold any compensation from any owners who do not refer patients to the Center.

E. No owner, except as specifically required under the ASC Safe Harbors, shall be required to perform services to the Center and all contracts pursuant to which owners provide services to the Center should clearly state the same.

F. No physician owner shall condition referrals to another physician or otherwise require another physician to perform cases referred by such first physician at the Center.

G. No physician shall be admitted as an owner or allowed to become or remain an owner based on his or her ability to generate referrals for other physicians. ■

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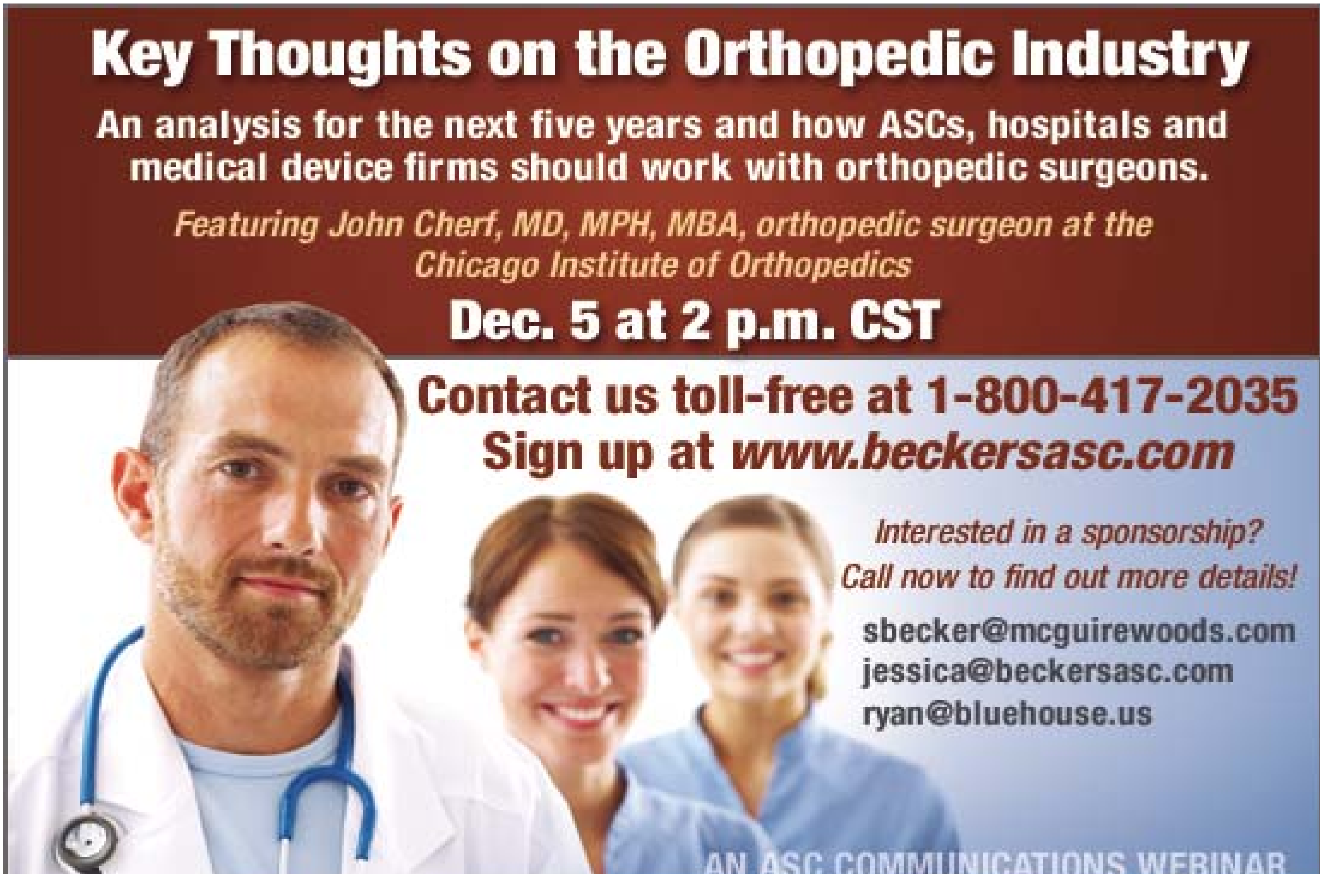


Physician-Hospital Joint-Ventures: An Outline of Arrangements

This short article briefly outlines several methods by which hospitals attempt to align interests with physicians. Some of these options may be useful for different types of projects. Further, depending on whether pursuing an imaging venture, an ASC venture, a nuclear camera venture, a cardiac cath venture or other type of venture, some of the models may be more or less useful. Briefly stated, the core models are as follows:

Minimal integration models. We generally view the following as minimal integration models. Typically, this means that the arrangements are short term and generally do not require the development of partnership agreements or require extensive capital contributions.

- **Medical directorships.** This involves an agreement with a physician or physician group who will provide various services to the venture, such as administrative services, training of employees and staff, etc., in exchange for a set fee.
- **Management contracts.** These are situations where either the hospital would manage a physician practice or a physician would manage a department of the hospital or some other effort on behalf of the hospital.
- **Gain-sharing efforts.** Gain-sharing usually involves the hospital and physicians working together to achieve cost savings in purchasing for certain surgical procedures or other procedures and then sharing those savings between each other. While a minimal integration model, these efforts take a great deal of time and effort to put together.
- **Under-arrangement joint-ventures.** In the traditional under-arrangement joint-ventures, a hospital simply buys an existing service from a physician group or similar entity and then bills for the services. This is differentiated from the more extensive under-arrangement ventures being put together today and noted below.
- **Part-time employment arrangements.** Here, the hospital or a related party employs physicians on a part-time basis to provide services to the hospital.
- **Independent contractor.** Here, like an employment agreement, the hospital typically contracts directly with a physician and has him or her provide services on the hospital's behalf. In other independent contract arrangements, such as hospital-based independent contractor arrangements, the physician provides services and bills third parties. Often, there is very little economic difference.

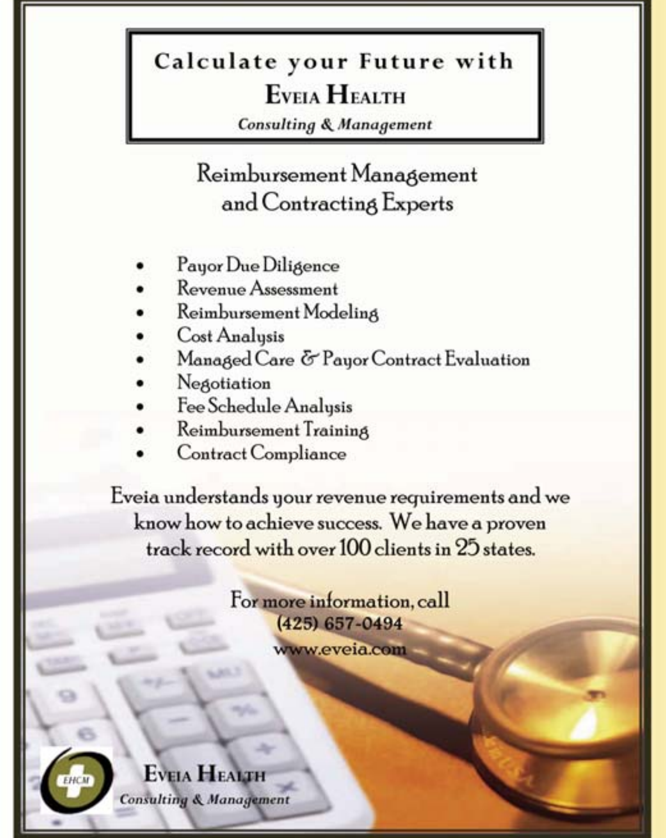
Medium integration models. We generally view the following as medium integration models. They require more effort to put together than a minimum integration model and often require capital contributions and the development of various partnership type agreements.

- **True joint-venture.** Here, the physicians and hospital joint-venture to be the actual provider of services, and they develop the joint-venture provider together. The provider of services bills third party payors and Medicare. This is a typical or traditional model for a surgery center.
- **Equipment, real estate or infrastructure joint-venture.** Under these types of joint-ventures, the physicians and hospital jointly invest in an equipment joint-venture or real estate joint-venture. Then, this venture leases equipment or real estate to either a physician group or a hospital group or both.
- **Under-arrangements joint-venture.** Under this scenario, the physicians and hospital will often put together a much fuller under-arrangements venture than under the minimal integration under-arrangements. Then, this joint venture will include everything except the provider number and license. Rather than providing services to third parties and commercial payors, it will provide its services to the hospital and the hospital will bill its services as hospital outpatient department services to third parties. These types of under-arrangements and joint-ventures involve several regulatory risks. Nevertheless, they have become increasingly common and popular.

Full integration models. There are also several complete integration models, of which the following are a few:

- **Income and employment through hospital directly.** The typical full integration generally includes full and complete employment of the physicians. Here, the hospital directly employs physicians. This has the benefit of satisfying the Fraud and Abuse Statute employment safe harbor and the Stark Act employment exception.
- **Hospital employs the physicians through a subsidiary.** Here, the hospital creates a subsidiary company and employs the physicians through the subsidiary. Again, this provides the hospital with increased control of its ability to provide services over time and to control the physicians' services.
- **Professional corporation or foundation model.** Under this type of scenario, the hospital provides services through a captive or related professional corporation that employs the physicians. Here, we note certain recent IRS private letter rulings regarding UBIT in practice corporations owned by hospitals.

This article is not a legal analysis of the models discussed herein. Rather, this is intended as an overview of certain of the options. As one moves forward with any of these options, one should consider the provision of more comprehensive legal guidance, as well as the review of different valuation issues that are involved in each model. ■



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About the speakers: John Cherf, MD, MBA, MPH, is an orthopedic surgeon at the Chicago Institute of Orthopedics, a clinical advisor for Sg2 and a thought-leader in orthopedics. Dr. Cherf founded the Midwest Orthopedic Institute, an orthopedic physicians group with full integration of diagnostic imaging, rehabilitation, ambulatory surgery and occupational medicine under one roof. He presently practices in Chicago and is once of the founding members of the Chicago Institute of Orthopedics. With more than 15 years’ experience and fellowship training in sports medicine, he has served as team physician for several collegiate and professional sports teams in addition to U.S. Soccer. Dr. Cherf has published in numerous peer review journals, speaks internationally, and serves on several advisory boards for healthcare-related businesses.

Scott Becker, JD, CPA, is a partner in and co-chair of the health depatment at the national law firm of McGuireWoods in Chicago. For more information, visit his McGuireWoods profile (www.mcguirewoods.com/lawyers/index/Scott_Becker.asp) or www.BeckersASC.com.

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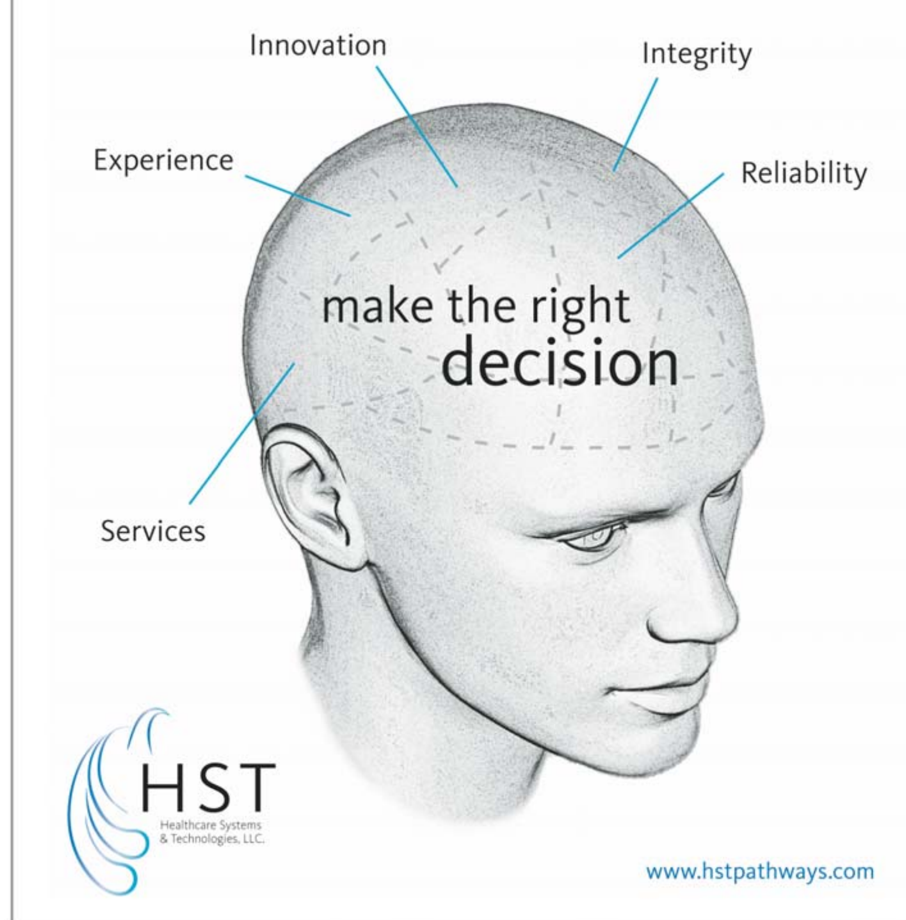

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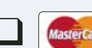
❑  ❑

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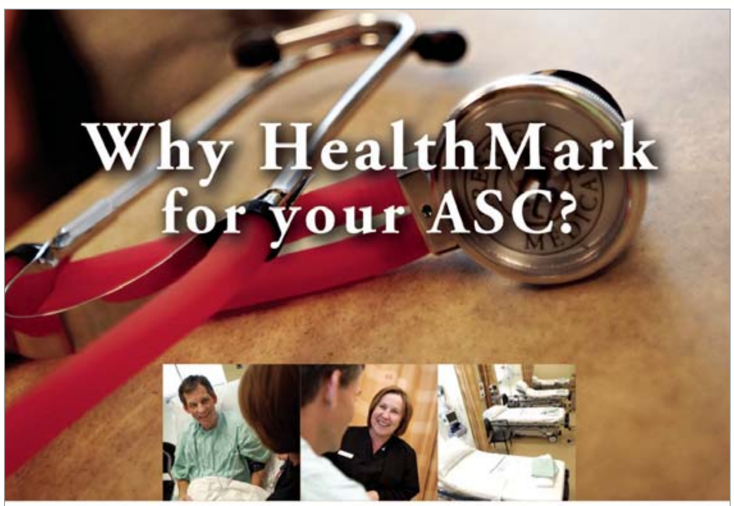

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Six Core Investing Concepts

By Scott Becker, JD, CPA

There are at least two people that are undisputed leaders in their own fields. These include Peter Drucker in management and Warren Buffet in investing. Previously, we have provided an analysis of the ASC industry based on a framework developed by Peter Drucker. Currently, with the stock market and the lending market in a period of significant uncertainty, we summarized a few of the investment concepts set forth by Warren Buffet. Aside from the fact that Warren Buffet has made a good deal of money through investing, the investment concepts themselves are relatively simple and are driven by common sense. Here are six of the basic concepts.

• **Cash and liquidity in part is fine.** An investment broker will often tell you that you need to be fully invested in the stock market, and that this is particularly true if you are younger and have a longer period of time until retirement. In contrast, Warren Buffet articulates that a good degree of liquidity is critical. In short, there is nothing wrong with having a certain percentage of your assets in cash and not invested in the stock market.

• **Wait for the right pitch.** When investing, whether looking at surgery centers or investment opportunities, the idea is not to swing at every pitch. Rather, wait till you have an opportunity that you believe with a good deal of certainty is a good bet. I recall my first surgery center investment; there, I was so excited to have the opportunity to be asked to invest that I promptly did so. This was despite the fact the center did not have enough cases and, on top of this problem, was located in a very poor reimbursement market. Thus, I showed tremendous brilliance by investing in a center with both too few cases and poor reimbursement. I promptly lost all the money I'd invested. Since that point, I have better recognized the wisdom of this concept. Unfortunately, one of the challenges that we all face is that we are not constantly looking for investment opportunities, and thus do not have the chance to look at so many pitches that one can comfortably sit on the sidelines and wait for the "fat" pitch. However, this is clearly the right notion. Further, as one gains experience investing in stocks or in surgery centers, or in other healthcare businesses, one can gain a better and better understanding of what actually is the "fat" pitch.

• **Don't over-diversify.** One of the mantras that is spoken is that of diversification. One of my closet colleagues, an investment manager at the famous Oak Mark Funds, Bob Burnstine, long ago said to me that you are far better off having three to four core investments (in this case a few mutual funds) than 15 different mutual funds or for that matter 50 to 60 different stocks. In essence, you are far better off having 10 to 15 high quality investments than 30 to 40 which are harder to manage, harder to watch and harder to pay close attention to. Further, it is almost impossible to closely follow more than a certain number of investments.

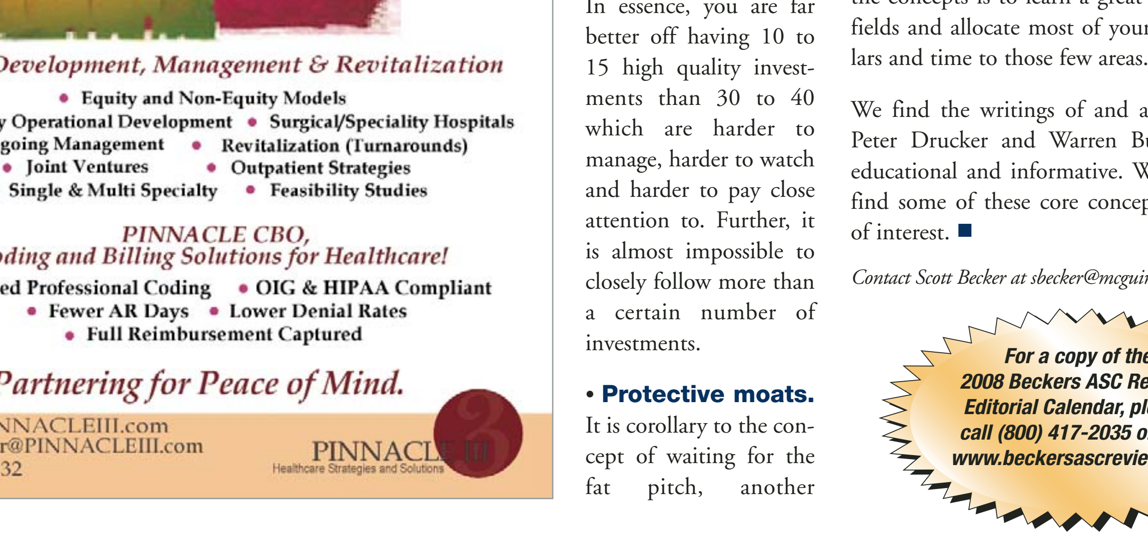
• **Protective moats.** It is corollary to the concept of waiting for the fat pitch, another Warren Buffet investment rule is to attempt to invest in something that has a significant moat around it. This means that it has some sort of protective barrier to entry that makes it hard to run or compete with. In business, this may be a brand such as Coca-Cola, or a huge reinsurance entity that has so much capital that it is hard to compete with. In surgery centers, this may be a center built around the 800-pound-gorilla hospital in the town, the core orthopedic group in the town, or built with certificate of need protection. In any event, the concept is to look to investments where there is some protection that is likely to give a certain amount of protection to the investment over time. Try to understand what the built-in edge of a company is and evaluate whether that edge is significant enough to invest for the longer term.

• **Invest in projects and companies for the longer run.** While one needs to periodically evaluate whether a company is significantly overvalued or not, the core concept is to look for 10 to 15 great investments and to invest in them for the long run. In essence, do not look to be an in-and-out trader.

• **Stick to your area of competence.** It is very difficult to be a master of too many disciplines. For example, one might be an expert company in selling or developing medical equipment, such as Alpine Surgical Equipment or BBraun. In contrast, those same companies might not do a terrific job of managing surgery centers or in building or constructing surgery centers or hospitals. The same concept holds true for investment. One may become a fairly good investor in a certain type of company, banks or financial institutions, or an area such as real estate or healthcare. However, it is almost impossible to be a terrific investor in all areas. In essence, one of the concepts is to learn a great deal about a few fields and allocate most of your investment dollars and time to those few areas.

We find the writings of and about people like Peter Drucker and Warren Buffet to be very educational and informative. We hope that you find some of these core concepts set forth here of interest. ■

Contact Scott Becker at sbecker@mcguirewoods.com.



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Spotlight On: Coding, Billing and the New Medicare Payment System

An interview with Caryl Serbin, RN, BSN, LHRM

Stephanie Wasek: From your perspective, what's the immediate impact of the new Medicare payment system on ASCs?

Caryl Serbin: For the most part, I think everybody is just really trying to get their arms around what the changes are, do some modeling and look at the potential financial impact. It's tough not knowing the final percentage of HOPD rates until at least November, because typically, the budgeting process starts in August. So everyone is going to be behind the eight-ball in that regard.

SW: What can ASCs do to avoid as much as possible falling behind?

CS: Go ahead and start the budgeting. You might not be able to figure out Medicare's reimbursement yet, but you can work through expenses and forecasting volumes. That's time-consuming as it requires your physicians to let you know what amount of volume increase or decrease they are forecasting. Allocate time for budgeting, accept from the start that it will be more lengthy and difficult, and designate somebody who's really Excel-proficient. I think the take-away is this: Just because you don't have that final piece of information, don't hold up the budgeting process.

In order to determine which procedures you can afford to do and which ones you can't, you need to compare the proposed reimbursement to what it costs you to do the case. Case-costing should be ongoing anyway, but now that there's even more emphasis because of the radical reimbursement changes, make sure you are up-to-date.

Another area to focus on is how Medicare changes are going to affect your fee schedules. Compare your reimbursement from both Medicare and managed care and develop a reasonable fee schedule (need that Excel expert again). Currently most ASC fee schedules are based on a percentage of Medicare groupers and, since groupers are going away, you will have to rethink and revamp. Most ASCs will end up basing their fee schedules not only on a percentage of mark-up of Medicare rates, but will do cost-basis as well.

During the development of your fee schedule, be aware that some of the new Medicare reimbursement rates can be $20 or less (office-based procedures). As an example, a fee based on 300 or 400 percent of Medicare APCs results in an unacceptable reimbursement rate for those procedures, so look at setting a minimum default fee. It's very important to be able to tell insurers what the minimum is that you can accept for a particular case, and that figure is going to vary per center based on overhead.

If your plan is to dump in the APCs, do a multiple and build off of that, you're going to be in trouble. You have to do a lot of data mining to determine how these numbers translate. You may also consider doing a percentage of the unadjusted HOPD rates. The message is it's going to take a lot of research. Try different methods until you find the right one, or usually a combination of several. As you experiment, you may find the results of one configuration are too low, but another can be substantially too high. For example, orthopedics as it ramps up may no longer lend itself to 500 percent of Medicare, so you're really going to have to look at individual procedure codes. Whatever you decide, allot enough time to do this and do it right.

SW: Does the new payment system affect billing of private insurers? If so, how?

CS: Yes and no. Currently there aren't many changes in the billing process for private insurers, except for the new UB-4 form. However, the thought is that managed care may do something similar in the near future, such as a single fee schedule based on a percentage of hospital rates.

The new system will affect how you renegotiate your managed care contracts. Review your contracts for renewal dates and determine those whose reimbursement is based on Medicare groupers. Develop a proposal based on the new Medicare rates. Once you have your new fee schedule and case costing in place, these will be excellent tools for negotiation.

SW: How can ASCs help their coders and billers prepare?

CS: In terms of coding, the CPT codes are the same, so that's not a change. That's not to say you shouldn't educate coders and billers on what the changes are and how they're going to affect processes. There are new approved procedures now; that's the big thing the coders and billers are going to have to know – what they are, how to code them properly, and information about packaged items.

We're changing from a one-digit grouper to a four-digit APC, which should be a function of the software. If your center is using traditional ASC software, these changes should have been prepared for. It may be more difficult for those who have other types of software. We're getting a lot of calls saying, "We have outdated or non-ASC software, would it be smarter to outsource?" or "We don't want to pay for software and/or we just lost our coder." We're also seeing clients from bigger centers who just don't want to deal with this. Although they're sophisticated and understand the new payment system, it's sort of the straw that broke the camel's back. I also think it's fueled by managed care: They're more demanding than ever. It has become such a challenge, has become a science to get paid at all.

When they did the NPI form change, it was a simple thing, but that really affected everyone's collection — not for a long period of time, but centers that bill on their own weren't ready for the blip. They didn't see it coming, and they lost revenue during that time. Well, this Medicare change is a much bigger blip than the form changes.

SW: How can a coding and billing company help?

CS: A billing company is immersed in this all day long; it's a focused effort, so the end result is better. The next couple of years are going to be a challenge. If an ASC has few resources, it's likely going to have a rough time. For years physicians said, "What does a management/billing company do for me?" I don't believe that will be the situation anymore. Practices and ASCs often begrudgingly outsourced billing in the past, now there's excitement – "Here, you take it!" We will probably reach a point where we'll have to say we can take some clients, but not others.

Another area where outsourcing may make a difference is the struggle ASCs are having with repeated appeals. Going forward, it will be the ability to chase the money and do two and three and four appeals that make the difference between success and failure for some ASCs. It's especially important with managed care, because if they think they can get away without paying you, they'll do it.

SW: Any other advice on surviving the changes?

CS: Yes! ASCs need to start hoarding some cash. Because of the last-minute modifications in the reimbursement plan and just due to the complete revamping of the system, I don't see any way this can be accomplished on time without severe glitches. Even the best-prepared ASCs can still expect delays and errors in payments.

Typically, a profitable surgery center does a quarterly distribution. Consider modifying or eliminating that during the last quarter in 2007. I advised our governing boards to either hoard cash or open a line of credit right away as this often takes time to accomplish. Educate your physicians; explain why they need to hold that money and I'm not so sure you wouldn't want to secure a credit line anyway as a backup. It's the same thought process as preparing for Y2K. That didn't happen. But this is going to happen.

Remember, all things considered, this is a positive change for most surgery centers. However, preparation is key in this situation — it certainly won't eliminate all the problems associated with this major change, but if your ASC does all of these things, you'll have a better chance to come out smiling on the other side. ■

Ms. Serbin is the founder and president of Fort Myers, Florida-based Surgery Consultants of America and Serbin Surgery Center Billing.

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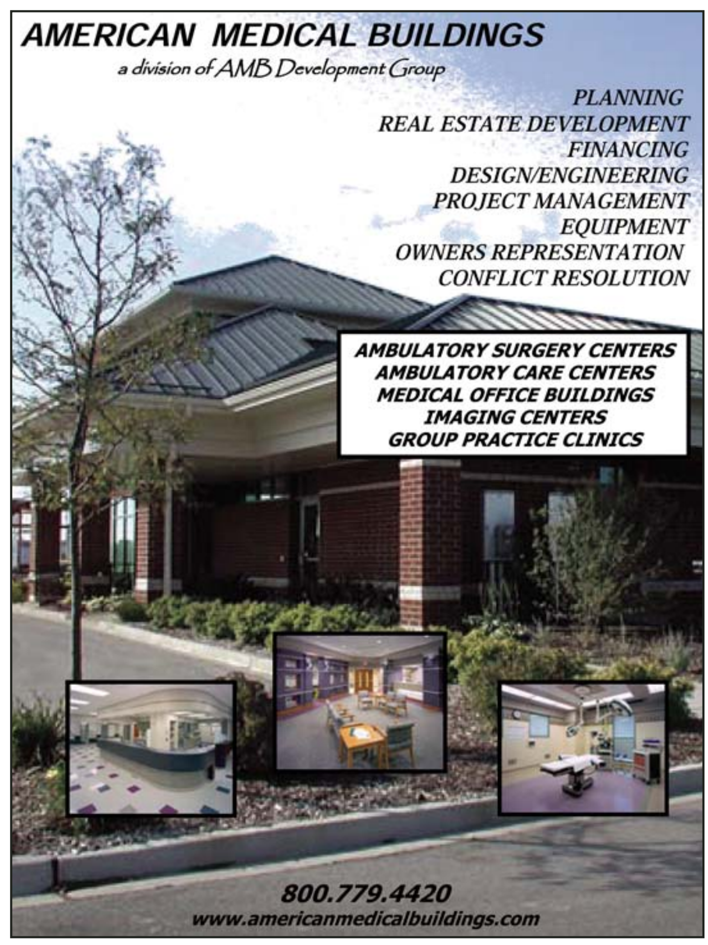

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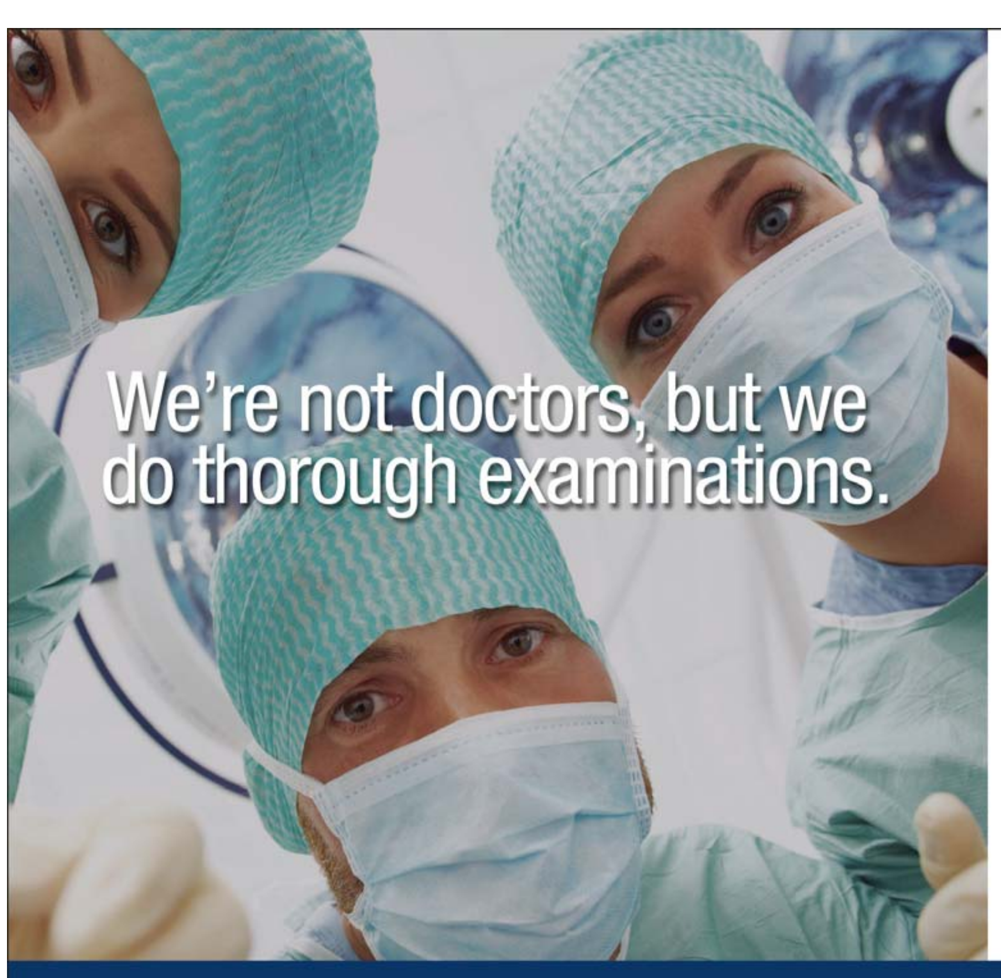

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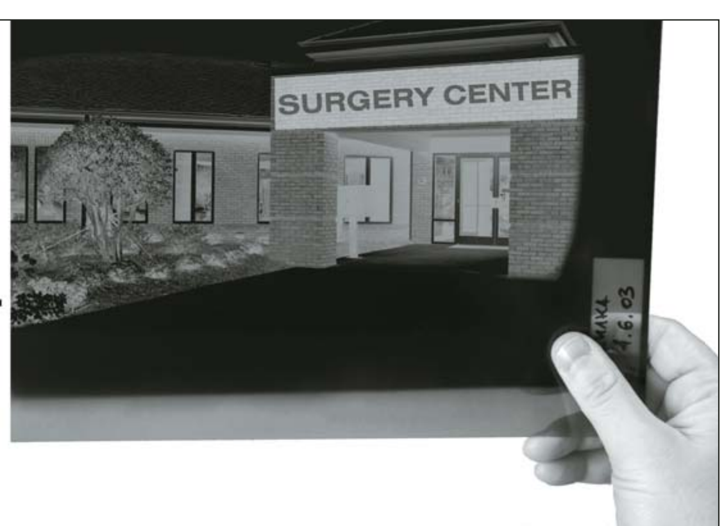

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