ASC GUIDE TO PROSPERITY

A COLLECTION OF INSIGHTS FROM THE LEADING INDUSTRY EXPERTS

VOLUME III

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TABLE OF CONTENTS

How Marginal Gains are Crucial for Surgery Center Growth
p. 3

ASC DEVELOPMENT
Congratulations! Your ASC Development Project Prognosis is Strong. Now What?
p. 4 - 5

ASC MANAGEMENT
2017 OAS CAHPS: Should Your ASC Implement CMS' Survey Early?
p. 6 - 7

ASC IT & SECURITY
Why Good Enough Is Not Good For ASC Cybersecurity
p. 8 - 9

ASC PROGRAM DEVELOPMENT
Starting an Outpatient Total Joint Program at Your ASC: 5 Key Questions
p. 10 - 11

PAYER CONTRACTING
Playing the ASC Reimbursement Shell Game
p. 12

REVENUE CYCLE MANAGEMENT
An Insurance Claim is Like Baking a Cake: Here's the Perfect Recipe
p. 13

ASC GOVERNANCE
Why ASC Equity Should Be In the Hands of Physician Owners
p. 14

ASC LEADERSHIP
A Clinical Approach to Healthcare Business Management & Problem Solving
p. 15

How Marginal Gains are Crucial for Surgery Center Growth

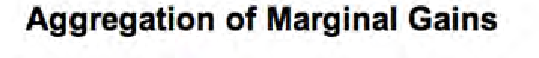
By Robert Carrera, President/CEO

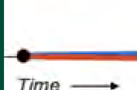
Over the course of many years, PINNACLE III has been tasked with the evaluation and turnaround of numerous failing or drastically underperforming surgery centers. In each situation, it was relatively easy to identify the pain points and devise solutions to create marked improvement in the ASC's performance.

There are many centers, however, that already operate at an elevated level. Their investors often ask us if it is possible for these facilities to improve.

To answer this question, I am reminded of a story from the 2012 Tour de France and London Olympics. In 2010, Sir Dave Brailsford was tasked with improving the performance of the professional cycling team, Team Sky. Eventually, he was asked to do the same for the British National Cycling Team. At that time, Britain hadn't had a Tour de France champion nor had they performed well in Olympic Cycling. Brailsford realized major gains in the realm of world class athletics were difficult to achieve. Therefore, he focused on the concept of marginal gains aggregation. He explained this concept as a one percent margin for improvement in everything. He believed if you improved every area related to cycling by just one percent, those small gains would add up to remarkable improvement overall.

Initially, Brailsford and his team focused on the obvious – tire weight, seat ergonomics, and athlete nutrition. Then they turned their focus on the far less obvious. This included pillow choice and its impact on sleep quality, personal grooming habits and their impact on propensity to develop saddle sores, and hand hygiene to avoid illness. Essentially, they searched for a one percent improvement in every area where they could create impact. The results, despite some recent controversies, speak for themselves. Britain's Team Sky was victorious in the Tour de France in 2012, 2013, 2015, and 2016. The British National Cycling Team also won 70% of the gold medals at the 2012 games. I realize Team Sky is not the first or only organization to espouse the benefits of such an approach. However, as a cyclist and a geek for human





performance improvement, I gravitated to this example to illustrate my point. Other examples that have paid dividends to the concept of marginal gain include David Cameron's Behavioral Insight Team which improved the wording of tax demands to increase responsiveness. Or Google testing 41 shades of blue for its advertising hyperlinks, which they claimed netted an extra $200 million in annual revenue. The examples are endless.

So, how does a successful ASC ensure continuous growth? We believe the best get better by consistently reassessing where there are opportunities to aggregate marginal gains.

Every member of an ASC's team can look for ways to identify marginal gains in their day-to-day activities. Materials management can move more items to consignment. Nursing staff can suggest the removal of unneeded items from custom packs. The revenue cycle management (RCM) team can suggest changes to a dictation template to reduce the need for payers to request additional medical records. These are just a few examples of marginal gains that can be achieved through diligent management.

It's also important to keep in mind the reverse can be true as well. A one percent decline in aggregated overtime can have significant impact on a facility's operation. The diagram above, adapted from James Clear, as referenced in "The Slight Edge" by Jeff Olson, effectively illustrates this point.

In closing, it's easy to get caught up chasing the "large whales" – implementing bundled payments, a total joint program, or a re-syndication – to enhance facility prosperity. But don't forget to attend to the "small fish" by creating a culture around aggregating marginal gains. The valleys in an ASC's growth can be filled by marginal gains. Doing so ensures the declines aren't as sharp which leads to a steadier upward slope. Overall, marginal gains are crucial to an ASC's continuous growth.

Congratulations! Your ASC Development Project Prognosis is Strong. Now What?

Lisa Austin
VP of Facility Development

When the results of your feasibility analysis indicate your ASC development project is likely to be a successful endeavor, it's important to ensure your next steps are strategic and well-planned. Developing a new center involves many tasks. If you put the cart before horse, you will end up going nowhere. Conversely, if you forget to harness the horse to the cart, you won't arrive at your destination with all the essential components. You must know the timeline, ensure you take each step in the proper order, and proficiently complete the identified tasks in a timely manner.

Here are some of the key tasks to consider on your development journey.

1. Choose an experienced health care attorney. Hire a health care attorney you trust and/or have worked with in the past to pull together the necessary legal documents. Having a solid framework in place to guide the ownership structure will be integral throughout the life of the business. Treat your operating agreement as the entity's pre-nuptial. Address items that could be potential roadblocks – how you will add new partners or assist those that need to leave the partnership, for example. It is much easier to handle these potential issues at the outset, rather than at a time when clearer heads may not prevail.

2. Devise a plan for the physical space. Do you want to build from the ground up? Do you already have land? Or, do you want to rent and remodel? These are questions to immediately consider. The cost for tenant improvements versus a new construction project can vary immensely. Location is a key consideration. Patients prefer ease of access which includes convenience from main roads, ample parking, and navigation into and out of the facility. Consider proximity to the surgeons' practices and hospitals. Establish a pros and cons list to aid in the decision-making process. The final decision will have an impact on the pro forma and loan requirements. Make these decisions early on.

3. Chose the right architect and construction company. Firms with strong knowledge of the regulations as they relate to ASCs are a must. Best practice is for your development company, architect, and construction company to work closely with each other throughout the entire design/build process. This helps ensures a licensable and certifiable building.

Oversight in the following areas is imperative:

A. Budget. Consider adding a commissioning agent or construction manager to keep bids within range and avoid cost overruns Research the associated costs in your local community to secure competitive pricing.

B. Value Engineering. A good general contractor or construction manager will actively look for ways to save money where it counts.

C. Involve surgeons in the design to ensure efficiency in the delivery of care. Surgeons are your best resource for understanding center needs related to delivery of care. They are also likely paying for the project; it's vital to keep them involved in the decision-making process. Collaboration from all parties on where to spend, and save, project money creates greater satisfaction with the final result. Maintain a record of decisions made to serve as a future reference when someone inquires why something was done a certain way.

D. Involve key regulators in the building process. Having permitting individuals from the city, county, state, and surveying bodies on site throughout the construction process allows you to proactively identify issues of concern. Waiting for the occupancy permit can lead to inconsistencies that must be remedied at a potentially significant cost.

4. Establish relationships with financial lending organizations. The terms offered on a project can vary greatly as can the required guarantees. Knowing how to effectively oversee this process allows the owners an opportunity to make the best overall decision. Complete a bidding process and interview the key banking individuals you will be working with. Secure services from financial lenders who work well with your steering committee and board members. Ask about hidden fees and closing costs. Find out how business fees will be applied as you ramp up the account. Often, the bank will be willing to negotiate early in the process to obtain the loan business.

5. Appropriately time the purchase of equipment. Starting discussions with vendors early on allows for potential price reductions on key equipment when new models are coming into the market. The prior year's model is usually less expensive or there may be loaner equipment available for purchase. Sometimes putting a down payment on equipment allows you to lock in the current year's pricing. This happens even if you don't complete the purchase until the next calendar year. Organization keeps construction on schedule, prevents delays, and ensures equipment delivery and installation occur at appropriate intervals.

6. Establish a staffing plan early. An established staffing plan allows for a smoother transition from development to operational management. Bring key staff members on board early to ensure proper operational structure prior to the opening of the facility. All staff need to demonstrate skilled organizational processes when surveyed by the state, CMS, and an accrediting body. A tiered approach to hiring allows for competency and cost effectiveness in those early months of operation.

You will not find a healthcare project more unique than developing a surgery center. It is a demanding, rigorous process. Working with experienced professionals who understand the nuances of each of the above-listed items can alleviate the feared trial and error process if you are undergoing this task for the first time. ***Prepare, ask questions, lean on the expertise of others, and collaborate. These are the keys to success in launching your new surgery center business.***

2017 OAS CAHPS: Should Your ASC Implement CMS' Survey Early?

By Michaela Halcomb, Director of Operations

The Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Provider and Systems (OAS CAHPS) collects information about patients' experiences of care in ambulatory surgery centers (ASCs) and hospital outpatient departments (HOPDs). The survey gathers patient perceptions related to communication and care provided by surgery staff, expectations prior to surgery, and planning related to discharge and recovery. Enforced implementation of the survey has been delayed until 2018, with the specific date being released in November, 2017. Surgery centers across the country are deciding if they should implement the survey as planned, or wait until the Centers for Medicare and Medicaid Services (CMS) begins enforcing survey implementation.

To assist in decision making, it's helpful to review information regarding the OAS CAHPS Survey.

Why is CMS developing this survey?

1. The number of ASCs has increased considerably in recent years as has the surgical case volume at both ASCs and HOPDs.

2. Medicare expenditures from outpatient surgical sites for ASCs and HOPDs also continues to rise.

3. Implementation of OAS CAHPS will provide CMS with statistically valid data on the patient experience to inform quality improvement and comparative consumer information about outpatient surgery facilities.

The results of the OAS CAHPS will be used to:

1. Provide CMS with information for monitoring and public reporting purposes,

2. Provide a source of information enabling prospective patients to make informed decisions in outpatient surgery facility selection, and

3. Aid facilities with their internal quality improvement efforts and external benchmarking comparatively with other facilities.

What modes are available to administer the OAS CAHPS?

1. Mail only

2. Telephone only

3. Mixed mode (mail survey with telephone follow-up of non-respondents)

4. An electronic mode of surveying is currently under review.

How often is the OAS CAHPS administered?

1. Surveys are administered on an ongoing basis.

2. An annual minimum of 300 surveys must be completed for each facility.

3. Participating facilities will provide a monthly sample of patients who received at least one surgery or procedure during the sample month to their survey vendor.

4. Vendors will initiate surveys within three weeks after the sample month closes.

5. Once a survey has been initiated it must be completed within six weeks.

The OAS CAHPS may be administered in conjunction with other surveys but sampling methods need to be followed to ensure patients are not overburdened by multiple surveys.

1. For each sample month, the survey vendor must select the OAS CAHPS sample prior to selecting the samples for any other ASC survey.

2. The ASCs cannot select the sample for any other facility survey they may choose to implement.

3. The vendor must select the sample because the sample selection for OAS CAHPS cannot be disclosed to the facility.

OAS CAHPS Survey Implementation

1. National voluntary implementation began in January 2016 with required participation scheduled to begin January 2018. CMS has proposed delaying implementation of the mandated 2018 date. The decision will be released in Medicare's final 2018 ASC payment rule this November.

2. It is unlikely the delay will be permanent because CAHPS surveys are already mandated in hospitals, home health, hospice, and dialysis centers.

3. ASCs that have voluntarily participated in OAS CAHPS have received valuable information about the quality of outpatient care provided at their facility.

There are pros and cons to implementing the survey now versus waiting until CMS mandates the survey next year. It is often better to prepare early. What should administrators consider in determining what is best for their center?

Reasons to delay the OAS CAHPS Survey until 2018:

1. Financial and administrative burden of submitting the data.

2. Decision on the electronic survey mode option.

Reasons to implement the OAS CAHPS Survey now:

1. You will know where your surgery center stands before mandatory reporting begins.

2. You will have an opportunity to address identified issues for improved survey results.

3. You can learn and understand your patients' perceptions and make changes to increase overall satisfaction.

4. Post-discharge surveying allows for a better assessment of the entire surgery process.

Peak One Surgery Center located in Frisco, Colorado has chosen to move forward with implementation of the OAS CAHPS survey now. It was an easy decision for us because it will allow us to get ahead of the competition. We can build out processes with our vendor and adjust our internal reporting systems. There will also be time for staff, physicians, and administration to learn the program. ***When my fellow administrators ask, I advise them to begin work with a vendor on voluntary implementation of the OAS CAHPS survey to avoid being at a disadvantage when the survey becomes mandatory.***

Why Good Enough is Not Good for ASC Cybersecurity

By Diane Lampron, Director of Operations

There's good news and bad news when it comes to cybersecurity and ASCs. The good news is healthcare organizations saw fewer records compromised by cyberattacks in 2016. In 2016, "only" 12 million records were compromised, down from nearly 100 million compromised records in 2015. The bad news is two-fold. First, cybercriminals compromised millions of records. And second, they focused on smaller targets, which likely includes ambulatory surgery centers.

Cybersecurity must be a high priority for ASCs. In fact, ASCs should treat cybersecurity with the same care and attention as they extend to their patients. Cybercriminals are looking to exploit even the smallest mistake or shortcoming.

Consider this scenario. An ASC performs a top-level information technology (IT) assessment. It finds frequent communications and discussions are occurring with the surgery center's IT vendor. A monthly activity log indicates the servers are routinely checked for viruses, unusual activities in event logs, and overall IT performance. Basic server maintenance is ongoing. When the IT vendor installed a new server, they implemented appropriate security measures (e.g., anti-virus and anti-spyware protection, firewall, backup system).

Sounds pretty good, right? The basics seem to be in place. Unfortunately, pretty good does not mean great, nor does it indicate perfection. And when there are imperfections, there are open doors for possible cybercriminal intrusion.

Potential risks and concerns. Here are some potentially overlooked risks and concerns.

1. Anti-virus software installed on some computers and servers. If even a single computer connected to the network or server is missed, this creates a vulnerability.

2. Like most software, antivirus and antispyware programs must undergo regular updates. When a security software update is missed, the wall of protection is weakened.

3. Servers must also undergo updates. Updates often address security gaps identified by the server's operating system developer (e.g., Microsoft). Once again, if an update is missed, security could be compromised.

4. The use of a backup system is critical. It can allow you to restore data in the event of data loss due to viruses, accidents, or disasters. However, that's only the case if the backup system is configured properly to backup data correctly. Simply "having" a backup system does not mean proper backups occur.

5. An ASC should use a firewall to protect against possible outside threats and intrusions. Think of a firewall as filling the role of disease prevention while antivirus software is more for infection control. A firewall will maximize its effectiveness when configured properly. But as with disease prevention, problems may develop if the ASC neglects anything.

Although installing a firewall is an important security step, additional steps must follow. Firewalls can filter out identified, malicious, virus-infected websites, but only with the proper configuration.

6. Conversations with an IT vendor are nice, but what happens if you need hands-on expertise on short notice? This is where the use of a remote monitoring and management system comes into play.

When installed, the system permits the IT vendor to keep an eye on what is happening with an ASC's network. When an issue is identified, the vendor may be able to address it before cybercriminals exploit the problem. If your IT looks fine on the surface, such a system may seem unnecessary . . . until it becomes very necessary. By then, it may be too late to use the system effectively. Be proactive. When it comes to cybersecurity, you cannot afford to be reactive. Put processes in place to help maintain the highest level of cybersecurity and keep cybercriminals at bay.

The Checklist To Keep Your ASC's IT Network Secure and Data Protected

Once cybercriminals breach your network, immense damage can occur. At a minimum, you may need to go partially or entirely offline. In a worse scenario, they may steal sensitive financial and/or clinical data.

Recovering from a breach can be a slow process, and an expensive one at that. Expenses can add up quickly when you take into consideration the cost of:

- investigation,
- remediation,
- patient notification (and coverage for potential identify theft and credit monitoring),
- legal fees,
- regulatory fines, and
- business interruption and associated loss.

To help keep your surgery center's network secure and cybercriminals at bay, consider performing regular information technology (IT) audits. These audits, which examine your IT systems and software, can help identify security weaknesses.

Here is a checklist of some critical IT security-related questions to answer. Speak with your internal IT director and/or outsourced IT vendor to ensure each audit area is addressed.

Network Security Protection

- Do we use anti-spyware software?
- Do we use anti-malware/malware detection software?
- Does our security software filter malicious code from websites?
- Does our security software process emails through anti-spam and anti-virus filtering?
- Do all servers and workstations have the proper security software installed?
- Is security software current/updated?
- Do we have processes to keep security software current/updated?

Firewall

- Do we have a firewall installed?
- Is our firewall configured securely? (Note: If the firewall is using factory default settings, it is likely not secure.)
- Is the firewall functioning as designed?

Network Access

- Is all remote access to the network authenticated and encrypted?
- Do we use physical security controls to prevent unauthorized access to computer networks and data?
- Do we have access controls in place with role-based assignments?

Internet Access

- Do we have internet access restrictions in place?
- Do such restrictions block potentially harmful websites?

Wi-Fi Access

- Is Wi-Fi configured to prevent unauthorized server access?
- Is Wi-Fi configured to provide public internet access without server access (i.e., a second setup)?

Software Updates and Patches

- Do we have a process for receiving notices of available security patches and upgrades?
- Do we have a process for installing and testing critical security patches?
- Do we have a process for identifying software that stops receiving support?
- Do we have a process for effectively replacing software, if necessary?

Security Assessment/Testing

- Do we have a process for performing regular testing of our cybersecurity measures?
- Do we have a process for performing an annual, full system security assessment?
- Do we have a process for effectively responding to security incidents (e.g., hacking, viruses, and denial-of-service attacks)?

Be Diligent

Cybercriminals are lurking, waiting for an individual or organization to make a mistake. While you can't keep cybercriminals from targeting your ASC, you can make your center a less appealing mark. Ensure network security is a priority. This will put you in a better position to avoid breaches, catch potential weaknesses early, and make cybercriminals look elsewhere for their next victim.

Starting an Outpatient Total Joint Replacement Program at Your ASC: 5 Key Questions

By Jack Mast
Physician Liaison

Advances to minimally invasive surgical techniques, blood loss management, and anesthetics have led to a rise in total joint arthroplasties (TJA) being performed at ambulatory surgery centers (ASCs). Orthopaedic specialists and patients nationwide are increasingly well-served with the same-day model, in which patients receive their total joint replacement and return home for recovery within 24 hours, typically on the same day as surgery. For ASCs working to initiate a credible total joint program, there are key clinical, business, and marketing elements of a well-developed program to consider.

Five questions ASC board members and investors will want to ask before approving a TJA program follow.

1. How does the ASC determine TJA patient selection criteria?

Well-formed patient selection criteria are important components of a successful TJA program. Key stakeholders will likely query, is there a national standard for outpatient TJA patient selection criteria? Unfortunately, the current answer is no. Outpatient total joints do not have as much history as that of outpatient surgery in general. And few professional societies have yet to publish specific criteria for outpatient total joint replacements. However, publications from institutions doing TJA successfully on an outpatient basis are available. To form a TJA patient selection criteria that is safe for your patients, lean on your clinical leaders. This includes your clinical nurse manager and head anesthesiologist. Begin with your center's current patient selection criteria for all patients. Then, consider American College of Surgeons National Surgical Quality Improvement Program (NSQIP) standards and American Society of Anesthesiologists (ASA) standards. Do this before reviewing accepted standards from peer-reviewed publications and other ASCs with successful TJA programs.

2. What is the ASC's clinical plan for performing total joints?

A thorough clinical plan includes patient selection criteria, pre-operative screening protocols, anesthesia plans (pre-operative, intra-operative, and post-operative), clinical guidelines, discharge guidelines/criteria, and follow-up guidelines. Once again, rely on your clinical leaders to formulate the guidelines. If you are having trouble determining some of the clinical plan components, contact a qualified total joint program consultant and/or your ASC association. You can also perform an internet search to look at what other ASCs are doing. Finally, the clinical plan should also incorporate physical therapy, which many ASCs are arranging for patients

to complete at the ASC both pre-operatively and post-operatively on the day of surgery.

3. Is the ASC's nursing staff prepared for the first TJA case?

The beauty of working with skilled nurses in an ASC is their wide-ranging experience. Their experience often includes total and partial joint surgeries at hospitals and other surgery centers. Still, you will want to work with your Clinical Nurse Manager to prepare your ASC's nursing staff for the TJA program. Identify individuals on your team with the most experience in orthopaedic surgery and in performing total joint surgeries. If you are lucky, you may even have nurses on staff who have worked on TJA cases with the physicians who will be performing them at your center. Rely on these individuals to serve as your skilled TJA nurses and teachers for the other nurses.

In advance of your first patients, prepare your operating room nurses. Arrange for a TJA walk-through with your device representatives. Prepare your pre-op/PACU recovery nurses by arranging for a lesson with a physical therapist who can teach them safe post-surgery movement and ambulation techniques that will prepare TJA patients for discharge. If overnight patient stays are part of your clinical plan, ensure nursing staff members understand patient care expectations during this extended recovery time.

4. What will be the fiscal impact on the ASC?

If you are projecting a certain number of total joint cases in your first year, identify the market and physicians who you expect will deliver these cases. For example, is there a patient population you are not treating because an outpatient total joint program isn't currently in place? Or, will your physicians be moving a sector of their current patient population to your ASC? Is there another way to capture market share? Combine projected case counts with information on reimbursements and costs to identify the potential fiscal impact on your ASC.

5. What is the marketing strategy and plan for your TJA program?

To answer this question, one must first gain direction from the ASC's governing body. Determine their interest in working collaboratively with key stakeholders such as the hospital partner to market a comprehensive total joint program. In some cases, collaborative marketing may be a strong desire of your board. Regardless, it will behoove you to create a marketing plan that divides marketing efforts into consecutive stages.

For example, the initial stage might aim to maintain the current customer base. This can include efforts like marketing to referral sources and direct-to-consumers through patient education, media/public relations, and website enhancements. The next stage could then focus on expanding the customer base by exploring new market areas and referral sources. At each stage, marketing efforts and metrics should be evaluated to determine if program goals are being met. This analysis will help determine future growth opportunities and identify further initiatives for enhancing the TJA program.

One of the key components of a successful outpatient total joint replacement program is early preparation.

Completing a clear and concise clinical, business, and marketing plan will not only demonstrate to surgery center board members the ASC is ready for total joint approval, it will also deliver a safe environment for total joint replacements performed in your facility.

Playing the ASC Reimbursement Shell Game

By Dan Connolly
Vice President of Payer Relations & Contracting

When a payer sends you a new ASC fee schedule or other changes to your surgery center's reimbursement terms, and touts an overall increase, beware! The proposed changes could unfavorably impact your bottom line. For that reason, consider reimbursement revisions with a healthy dose of skepticism.

Surgery center reimbursement changes offered by payers remind me of a sleight of hand shell game. A shell game is a gambling pastime played at carnivals or street fairs. A pea (or similar object) is hidden under one of three nutshells. The shells are quickly shifted around and the spectator is asked to track the location of the pea. Typically, the spectator loses because it's nearly impossible to follow the pea's path. The trick itself became so well known, the term "shell game" is now used figuratively to describe measures taken to deceive.

Controlling health care costs has become the great shell game for payers. They establish new rates of payment through sleight of pen, moving reimbursement from one area to another. They may transfer it altogether, shifting the payment responsibility to the patient via higher deductibles, co-payments, and coinsurance.

While we may not be able to end the shell game, we can establish a comprehensive method to deal with proposed reimbursement changes that minimizes our losses.

Reductions in reimbursement can come in various forms:

- changes in the reimbursement by payment category,
- reassignment of procedures to a different, lower paying category,
- assigning previously unassigned (aka unlisted) procedures reimbursed at a percent of billed charge to a payment category, or
- changes to the payer's multiple procedure payment logic

When you receive a payer's proposed fee schedule or reimbursement changes, the only way to identify what the true effect will be is to pay attention. Keep your eye on the pea! Compare the payer's proposed reimbursement to your facility's current reimbursement on all procedures performed for the payer's members during the last twelve months. Measure the full impact of changes by adjusting your analysis to account for procedure utilization over the same period. An analysis combining both measures will help you "follow the money" to assess the severity and frequency of the changes. Gauging the overall financial impact of the proposed changes will help you determine if you want to accept them.

Changes in fee schedules can only be used to perpetrate deception when you don't complete a comprehensive analysis. Combat sleight of pen by implementing a thorough process to accurately assess the potential impact of proposed changes. You, and the ASC industry at large, will be glad you did!

An Insurance Claim is Like Baking a Cake – Here's the Perfect Recipe

By Carol Ciluffo
Vice President of Revenue Cycle Managment

Spending time in the kitchen is my happy place. And I've been involved in revenue cycle management for many years. But I bet you're wondering what baking and insurance claims have in common. Please allow me to explain.

Certain ingredients are required to bake a cake. When you follow a recipe, paying attention to every detail along the way, you're likely to get it right. Voila! You end up with the perfect dessert. Submitting a clean claim is no different. Taking the right steps (ingredients) and following the right process (recipe) will result in a clean claim (cake). A clean claim increases the chance of being paid correctly in a timely manner (icing).

Here's a clean claim recipe:

Ingredient #1: ***Demographic information***
- Schedule patient.
- Register patient and insurance demographic information into patient accounting system.
- Verify patient's benefits and eligibility with the payor.
- Submit prior authorization request, if required.
- Prepare estimate of payor and patient responsibility for services being rendered.
- Discuss estimate with patient.
- Collect copay and/or outstanding deductible from patient prior to service.

Ingredient #2: ***Charge capture and coding***
- Assign ICD-10/CPT codes from operative note.
- Enter charges into patient accounting system.
- Review and address EDI claims edits and rejections.

Ingredient #3: ***Claims submission***
- Follow payor guidelines for paper or electronic claims submission.
- Verify receipt of the claim by the payor.
- Manage denials received.

Ingredient #4: ***Claims adjudication and collections***
- Post payor reimbursement timely.
- Transfer responsibility to secondary payor or patient.
- Forward underpaid or incorrectly paid claim to accounts receivable for appeal and resolution.
- Transmit statement to patient.
- Utilize outside collection agency when necessary (not the icing on the cake).

According to Revenue Cycle Intelligence, research from the Government Accountability Office found up to one-quarter of claims are denied. Denials can cripple the financial health of your facility. When providers do not follow payor reimbursement guidelines, payors hold claims for review. If the outlined process isn't strictly adhered to, payors respond with payment denials. That's like putting a cake in the oven and not being able to finish it for two or three months.

A strong denial management strategy is essential. It allows you to identify denial trends. When trends are identified, it is important to provide additional education to scheduling and registration personnel to address missed steps and minimize repeat mistakes. The result is an enhanced ability to fully capture the revenue that is due to you. Each step is integral to the success of the claim. Taking shortcuts is ill-advised.

Accuracy is key. The process doesn't work if you skip a step or proceed with inaccurate information. It's akin to forgetting to add baking powder to your cake. You end up with a "hockey puck" that didn't rise because of the missing ingredient. ***Ensuring you have a tight claims process will deliver the delicious outcome you desire – hard earned revenue in the bank. Now that is the real icing on the cake!***

Why ASC Equity Should Be in the Hands of Physician Owners

By Rick DeHart
Principal Partner

Investopedia defines equity as, "the value of an asset less the value of all liabilities on that asset." Or, in plain accounting terms, equity equals assets minus liabilities.

If the assets of ambulatory surgery centers are its physician owners, and the physician owners believe in themselves and the case volume they project, why would they consider giving up significant equity in their ASC?

In certain cases, physician owners are not the only assets in an ASC. Joint venture opportunities are one example. Hospital systems can not only make good ASC partners, but also have the potential to be valuable ASC assets. They can extend leverage in the market and their payor contracting clout can have significant value. Surgeons sow the seeds of ASC success. They are the primary volume drivers to the surgery center. Therefore, it is our belief that as much equity as possible should be in the physicians' hands.

Large ASC management companies often request larger portions of equity. Their rationale is typically based on two premises. First, that they will work harder for the success of the entity if they hold a significant ownership share. And second, that the services they bring to the center justify this type of equity position. We've found this is not necessarily the case. Consider the following:

- Management contracts based on a fee-for service provide the same, or even greater, incentive for the management company to perform. If a management company isn't delivering results, their own profit margin suffers. Eventually, ASC ownership will seek management expertise elsewhere.
- No management company would advise their on-site management team to work harder, or put in less effort, based on the level of ownership held.
- The leverage a management company brings in terms of vendor contracts or payer arrangements are not enhanced by equity levels.

There is something else to think about when considering giving up sizable equity. If the relationship with the management company does not work out, it is very difficult and costly to buy-out or disengage that partner.

In some cases, giving up additional equity makes sense. This is true when investing partners need a large amount of capital to build a facility and they simply do not have the financial wherewithal to pull that capital together. In this case, it behooves physician owners to give up only what's needed to finance the project – nothing more.

It may also make sense for the facility to surrender equity when the contracting clout of the large equity partner results in a significant return on that equity in the form of enhanced managed care contracts. For example, if a center is going to give up 25% of their equity, the contracting clout should return 35% in improved reimbursement.

The success of an ASC comes from physician partners utilizing the facility. The more equity the surgeons/physicians have, the more invested they are in ensuring the ASC's success. This is the best way to maximize ASC prosperity.

A Clinical Approach to Healthcare Business Management & Problem Solving

By Robert Carrera
President/CEO

I am a physical therapist (PT) by education and training. I graduated from Wayne State University in Detroit, Michigan with a Bachelor of Science in PT.

For over ten years, I practiced in a variety of settings, including my time spent as a clinical faculty member at the University. After that, I moved full time into the world of management. As my career moved away from clinical practice, I retained my clinical approach when dealing with issues related to business practices.

The American Physical Therapy Association defines a physical therapist's duties as the following:

"PTs examine each individual and develop a plan, using treatment techniques to promote the ability to move, reduce pain, restore function, and prevent disability."

Essentially, PTs evaluate the situation and assess findings to develop a treatment plan. Our goal is to return patients to their previous or higher level of function. In some cases, we develop a plan to prevent or forestall further disability. Sound familiar?

As is the case with many healthcare disciplines, we learned to evaluate someone and then document our findings in a format called the SOAP note. Here is what the SOAP note entails:

- **Subjective** – Detailed notes regarding what the patient relays about their status in terms of function, disability, symptoms, and history.
- **Objective** – This is derived from the clinician's objective observations. It can include visual observations such as posture and swelling, actual measurements such as range of motion or strength, and hands-on techniques such as palpation.
- **Assessment** – The clinician's analysis of the various subjective and objective findings yields an assessment. It explains the reasoning behind the decisions made and clarifies the analytical thinking behind the problem-solving process.
- **Plan** – Conveys how the clinician develops treatment to reach goals or objectives.

As a business leader, I use the SOAP approach to solve management problems. Here is how:

- **Subjective** – In business, it is important to seek information directly from the source when issues arise. I prefer to meet stakeholders in person to obtain the history of the situation and gain an understanding of how it developed. What areas have been impacted? What actions have been taken to resolve the issue? What, if any, impact have those efforts had? Lastly, I like to ask the stakeholders for their suggestions on resolving the situation.

- **Objective** – When appropriate, I begin the objective portion of my evaluation visually, just like when I treated patients. This can entail simply walking through the facility or office. Many times, it involves taking subjective "histories" from stakeholders. The measurement and hands-on review, in many cases, involves evaluating existing data and reports. It includes asking for additional information. This provides me with a complete view of the situation.

- **Assessment** – Again, the assessment is where the expertise and experience of the "clinician" shines through. Taking all information gleaned from the subjective and objective portions of my evaluation, I can generate a list of problems. Next, I can prioritize the items on my list.

- **Plan** - Lastly, just as in a clinical setting, I develop a "treatment" plan for the problems in my facility. The plan addresses not only the symptoms but also their underlying causes.

Many clinicians have transcended their clinical roles into business management and leadership. The skills we learned as clinicians allow us to be effective problem solvers in the operational management side of the business as well.

WANT TO KNOW MORE? CONTACT...

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