So some physicians approach a hospital for capital and to maintain a sense of community, Schaff says.

“They realize that if they take procedures away from the hospital, the hospital’s financial well-being may be negatively affected, and they may not want to jeopardize the financial health of the hospital, which may affect their community’s ability to keep a struggling hospital afloat,” he says. “So they may want to partner with the hospital instead of competing with it.”

Keep in mind that hospitals can take an active approach to try to stifle ASC ownership that is strictly physician-owned.

“Hospitals can be aggressive and try to revoke or restrict medical staff privileges at their hospital if a physician has ownership interests at a competing center,” says Melissa Szabad, Esq., healthcare attorney at McGuireWoods, LLP, in Chicago. “So if you have a hospital on board, you obviously reduce those kinds of issues.”

However, it can be a challenge to manage the roles and responsibilities of the parties involved. Before embarking on a joint venture, first consider some of the potential pros and cons.

**Analyze the pros and cons**

There are several plusses and minuses with respect to joint ventures from a physician perspective. Some of the plusses of partnering with a hospital are:

➤ Deeper pockets, so physicians have the ability to reduce risk in the venture.

> continued on p. 2
Joint ventures

Ease in obtaining a certificate of need (CON) if physician investors are looking to joint venture in a state that requires a CON. “Oftentimes, a joint venture with a hospital is necessary to get a surgery center up and running because the CON process is very political,” Szabad says. “So without hospital support, it could be difficult to obtain a CON.”

Enhanced camaraderie of the medical staff members because the surgery center would be considered a partner rather than a competitor.

Efficiencies for surgery centers with respect to payer contracting, helping them to negotiate better rates and achieve certain payer contracts that they might not have otherwise without the hospital’s support, says Szabad.

Valuable management skills and political clout from the hospital, which are important assets for a new surgery center.

Although joint venturing with a hospital has its advantages, some of the cons are:

Distrust of hospital administration because some physicians believe administrators have a different perspective and agenda.

A clash of personalities, opinions, and operating styles, which can contribute to a volatile working relationship between the hospital and the surgery center.

Differences in philosophy or management style, which can make it difficult for the two parties to relate. Physicians don’t always use all the available management tools, including technology or consulting resources. “Hospitals typically have more of a ‘business/technical’ approach. They typically consult professional businessmen and use spreadsheets to analyze the business,” Schaff says. “Many times, hospitals want to have control, and physicians sometimes resent that.”

Long-term vs. short-term perspectives. Some physicians believe a partnership with hospitals involves making decisions with transient people who come in for several years and then leave for another project.

“Physicians question whether hospital administrators are looking at the venture for the short term or the long term,” Schaff says.

An increased sense of competition. Physicians may perceive a joint venture with a hospital as a partnership with their physician competitors. “If the venture is a hospital-based surgical center, you could end up being partners with people you may not care for,” says Schaff.
Consider effects of ownership stakes

If physician owners have a minority stake in a joint venture with a hospital, physicians may receive the impression that the ASC is the hospital’s center instead of theirs. With a majority stake, hospitals likely have voting control. This arrangement can foster resentment among physicians who feel they are along for the ride while the hospital calls the shots, Szabad says.

“I think the more control physicians have, the more likely the joint venture will be successful,” she says.

Success of the business depends on whether the physicians actually use the ASC. If the physicians have a minority interest, they might not feel vested in the project and committed to making it successful, Szabad says.

“However, that’s not to say ASCs can’t be successful if physicians have a minority interest,” she adds. “You could have a group of physicians who don’t necessarily want to invest the time and resources into dealing with the day-to-day decisions involved in running the center.”

Also, they may like the leadership and efficiencies the hospital provides, Szabad says.

Focus on fostering communication

Communication is critical to managing the relationship in an ASC joint venture between physician owners and a hospital. “There should be joint committee meetings, and it is best for every owner to be comfortable with all of the managers, even the ones appointed by the hospital,” Schaff says.

If either partner is unhappy with the appointed leaders, this can create additional concerns or animosity.

“The leaders in this venture need to be level-headed and more even-keel, rather than someone on the fringes,” Schaff says.

The board should meet regularly—at least twice per year—and have an agenda so they can have periodic, open meetings for all the surgery center owners.

“Problems often grow out of minor issues, so you need to have leadership who understand how to deal with people,” Schaff says. “Minor issues disappear if you deal with them properly at the outset.”

The partners in a joint venture need to recognize that they’re partners for the long run, and they should address the other party’s needs and wants instead of bullying the other side. “The biggest problems result when people form a joint venture and they never look at it from the other partner’s perspective,” Schaff says. “It has to be a win-win on both sides for it to be successful.”

Insider sources

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To maximize the success of a newly formed surgery center, keep your caseload expectations reasonable.

Physician investors often overestimate the volume of cases other physician partners bring to the table. Investors become upset when a fellow physician brings in significantly less cases than they expected.

“You typically have several high producers and a few low producers, but in many cases, they all have the same ownership interests,” says Michael F. Schaff, Esq., chair of the corporate and healthcare departments of Wilentz, Goldman & Spitzer, in Woodbridge, NJ. “This is because you can’t build a surgery center and give physicians ownership based on the value or volume of services that they will provide at the center.”

To address this potential problem, some physician owners build a provision into their agreements that all physician investors must maintain their skill level by performing a minimum number of cases in a given time period to sustain staff privileges at the center.

Some safe-harbor tests also require physicians to provide a minimum number of procedures at the center.

“However, it’s important to note that if you utilize any contract provisions to eliminate or replace surgery center owners or reduce ownership, you have to be consistent and utilize those provisions with all owners similarly situated,” Schaff says.

Insider sources

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Tips to help ensure successful EHR implementation

Plan ahead for methodology and desired benefits

Editor’s note: This is the first article in a two-part series.

If you’re preparing to implement electronic health records (EHR), be sure to lay the proper groundwork first. Successful implementation, which includes planning, experimenting with systems, and ultimately ensuring a smooth transition from paper to electronic records, requires thorough preparation and a willingness to evolve, say Laura Jantos, FHIMSS, principal at ECG Management Consultants in Seattle, and Salvatore Volpe, MD, FAAP, FACP, CHCQM, president of Oakwood Medical Consultants in Staten Island, NY. Jantos and Volpe spoke at the May 2007 Healthcare Information and Management Systems Society virtual conference.

“You cannot overstate the value of planning,” says Volpe, who cites the old carpenter’s adage of “measure twice, cut once.” “If you scrimp on planning, it might cost you later. Also, plan for any desired benefits that you hope to realize with the EHR. Benefits will not automatically materialize upon implementation.”

For example, you won’t experience reduced transcription usage and costs if you don’t plan to have physicians stop using transcription services.

“The planning phase is the most important part of the process,” says Rebecca Maksimovich, RN, BSN, CNOR, clinical director at Lake Park Surgicare and Lakeshore Surgicare in Hobart, IN. The timing of your implementation planning is also important. Plan the details of EHR implementation as soon as possible and complete this crucial step prior to completing the system selection process.

After you sign a contract with an EHR vendor, the vendor will often ask for some payment. You will also start to incur activity-based payments and fees. If you postpone your planning and wait until after you sign a contract to determine details regarding functionality, interfaces, and system rollout, you might find that the vendor’s clock has started ticking regardless of whether you’re ready—costing you money.

Take the time to familiarize yourself with various EHR systems, and remember that just because two systems are certified by the Certification Commission for Healthcare Information Technology (CCHIT), for example, it does not mean that they offer the same functionality. “For many physicians, including myself, CCHIT is like the ‘Good Housekeeping Seal of Approval,’ ” Volpe says. “But it doesn’t mean that product is going to work in your practice.” The only way to know whether a product will fit your particular work flow is by actually using it.

To sample the different EHRs, attend as many vendor fairs as possible and be sure to bring some of your organization’s future EHR users with you. After seeing demonstrations once or twice, try out different scenarios yourself. “We encourage the physician and key personnel to do things like document a complete history and physical, a brief visit, and a prescription written electronically,” Volpe says. To get a good feel for each product, spend 20 minutes per vendor and take notes, he adds.

Don’t assume that buying an EHR and practice management system from the same vendor will necessarily give you better results than two integrated products from different vendors.

“Even though both components might be sold by the same vendor, they might not have been developed with the same code set, so the practice management might have a different look and feel than the EHR system, and there might still be duplicate data entry,” Jantos says.

There are a variety of ways to implement an EHR. If you’ve identified specific benefits that you want to obtain from the EHR, design your implementation plan and timing so that you achieve that benefit as soon as possible.

Most healthcare providers implement EHRs in a phased manner, Jantos says, but some are able to implement pieces of functionality simultaneously across the organization. For example, if your organization already has Internet-accessible lab results, you can readily have that same functionality with the EHR after converting the
data to the EHR. A second option is to employ a “deep dive” of implementation—a new technique in which providers at various sites or within various specialties learn how to use all the functionality that’s available in the EHR, such as full-blown documentation, order entry, and health maintenance reminders and alerts. Providing this level of functionality within the organization brings greater benefits more quickly.

Before implementation, use the software for at least one month, but preferably three months, Volpe says. This allows you to understand all the different functions.

Communication between your main software vendor and the electronic medical record vendor is critical. Make sure all the information transfers from the main registration into the electronic medical record system. “Make sure the two systems interface and test to make sure the system does what they say it can do,” Maksimovich says. “Sometimes, vendors oversell what they can really do, so site visits are really important. Have more than one if possible, especially for multispecialty centers.”

Eventually, EHR users will overcome their fears and become more adept at using the EHR, and you will see positive results. “Most people take pride in their work, and if they can help a patient in a more efficient manner, not only can they help more people per day, but the feedback we get from the patients is incredible,” says Volpe.

Try the following three tips for implementation:

1. Obtain multifaceted buy-in. People in the organization need to support the idea of having an EHR-based system. They need to feel good about the specific system that the organization chooses to acquire, and they need to have positive but realistic expectations about using the EHR. “EHR implementation needs to be seen as a process that occurs over time,” Jantos says.

Physician and staff buy-in is vital to a smooth system rollout, Maksimovich says. Assign one or two key people who are dedicated to walking the physicians and staff members through the implementation, she says. “We assigned someone from our quality team to this task. She was very instrumental, because it takes a detail-oriented person,” Maksimovich says. “Then I picked a recovery room person who has strong documentation skills. She does not have a lot of computer skills, but she is very organized and knew how to organize everything together.”

2. Create leadership and ensure accountability. Appoint a single project manager within your organization to be responsible for managing the implementation, Jantos and Volpe recommend. Leaders of the organization should commit to the EHR by providing any necessary resources, such as infrastructure or individuals, to help implement the system.

3. Set realistic expectations for work flow. The EHR will probably result in significant upheaval to your current processes. Be prepared to adjust work flows to accommodate the EHR and take advantage of improvement opportunities that the EHR brings. Be flexible and willing to modify processes rather than stubbornly clinging to old work methods. In fact, this is a great time to examine your processes to determine which ones are effective and which could use improvement.

“Use this opportunity to look at what you’re doing now, from the moment a patient calls for an appointment to when you actually discharge the patient, anywhere from the same day or maybe a month later,” Volpe says.

After reviewing your office’s work flows, determine how you can shift your current paper-based practice to an electronic one. However, remember that the change will take time. Don’t panic if you discover that your initial perceptions of an electronic-based practice are unrealistic.

“It’s a new paradigm for most of us,” Volpe says. “Take the time to go back and readjust things if you have to. Try and fit what’s going on during the work flow into a better practice of medicine.”

**Insider sources**

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OIG Work Plan touches upon ASC concerns

The Office of Inspector General’s (OIG) 2008 Work Plan not only maintains its focus on hospital topics, but it also addresses a couple of ASC concerns as well.

This year, pay close attention to the following potential compliance pitfalls.

Place-of-service errors being watched

One area of concern identified by the OIG is place-of-service errors.

“Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician’s office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC,” states the OIG Work Plan. “We will determine whether physicians properly coded the places of service on claims for services provided in ASCs and hospital outpatient departments.”

Although this is a continuation of a 2007 Work Plan item, physicians and billing staff members should maintain a strong focus on this potential compliance problem.

“Doctors and coders in doctors’ offices need to be careful when filling out their claim forms that they’re making the proper distinctions for site of service,” says Kathy J. Bryant, president of FASA in Alexandria, VA.

A busy practitioner who is working in multiple settings needs to make sure that he or she uses the appropriate setting when billing, says Bruce D. Armon, Esq., partner at Saul Ewing, LLP, in Philadelphia.

“Especially when ownership is involved in both the practice and an ASC, make sure your staff properly documents where procedures are done,” Armon says.

Payment system also under review

This year, the OIG will also review the new ASC payment system as a whole.

“We will examine the changes to the new ASC payment system and the rate-setting methodology used to calculate the ASC payment rates,” the OIG writes in the Work Plan.

Although this has the potential to be a more significant problem for surgery centers, any study of the new payment system will be somewhat limited, Bryant says. “I think it’s a little too soon for them to be studying [the new payment system] for it to be meaningful at all,” Bryant says. “I would be interested in any feedback they might have.”

Scrutiny will surely continue as cases migrate from the hospital setting to surgery centers.

“The OIG’s review of the payment rates could be important for Congress in terms of shaping payment issues for the entire ASC industry,” Armon says. “As more procedures are done outside of hospital venues and they continue to be reimbursed by Medicare or Medicaid, there will be continued pressure to ensure dollars are spent in an appropriate manner.”

Insider sources

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Illustration by David Harbaugh

“The doctor here just finished an appendectomy. Apparently, he was exposed to an anesthesia leak, or he found reading minutes from our last meeting incredibility boring.”
Coding corner

Stay on top of 2008 modifier updates

by Stephanie Ellis, RN, CPC, of Ellis Medical Consulting, Inc.

Modifiers are two-digit symbols that coders append to current procedural terminology (CPT) codes to signify that the physician has altered the procedure in some way. Most payers accept modifiers; however, confusion can result because payers often demand different uses for the same modifiers.

Check with payers before submitting your claims to ensure that you’re conforming with their claim requirements. Not using modifiers according to each payer’s specifications can cause unnecessary denials or cause Medicare to not pay claims properly. Some modifiers are for physician use only, and other modifiers are for use by ASCs and hospitals. The following are some guidelines for proper use of modifiers -50, -RT/-LT, -SG, -FB, and -FC.

Modifiers -50, -RT/-LT

Use modifiers -50 or -RT/-LT when a physician performs an identical procedure on both the right and left sides of the body. Different payers may have varying policies for reporting bilateral procedures.

Four methods for billing bilateral procedures include the following:

1. Bill the same code twice with modifier -50 on the second code. For example:
   - 64475
   - 64475-50

2. Bill the same code twice using the -RT and -LT modifiers. For example:
   - 64475-RT
   - 64475-LT

3. Bill the same code twice with no modifiers. For example:
   - 64475
   - 64475

4. Bill the code as one line item with modifier -50, but be sure to double the fee if you use this method. For example:
   - 64475-50

Do not mix methods or modifier types. Never use the -RT or -LT modifiers on the same code as one line item, as in the fourth example above. You can only bill one line item using modifier -50. Do not mix modifier -50 with modifiers -RT or -LT.

Many payers will reduce payment of the second procedure by one-half when you report a procedure using modifier -50. Do not use bilateral modifiers on those CPT codes with verbiage describing procedures as “bilateral” or “unilateral or bilateral.”

Beginning with claims with a date of service of January 1, 2008, CMS states that you should not bill bilateral procedures using modifiers -50 or -RT/-LT. Instead, you should use the third example above. Check with your Medicare carrier to be sure it is adopting this method.

Modifier -SG

Also for 2008, ASCs will no longer submit claims to Medicare using modifier -SG on CPT codes unless they are specifically directed to do otherwise by their Medicare carrier. Check with your local Medicare carrier to determine its requirements.

Modifier -FB

Modifier -FB is new for use by ASCs. When a physician uses a device or implant in a procedure, and the supplier replaces the device at no cost or with full credit to the ASC, CMS will reduce payment by the device offset amount that CMS estimates represents the cost of the device. You can find procedures affected by this regulation in Table 58 of CMS’ 2008 outpatient prospective payment system (OPPS) final rule (CMS-1392-FC).

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The ASC must append modifier -FB to the CPT code on the line with the covered procedure code to indicate that the implantable device was furnished at no cost.

**Modifier -FC**

For claims involving a device that was replaced with partial credit under warranty, recall, or field action, and that are listed in Table 59 of the OPPS final rule, append modifier -FC to the device replacement procedure code. If the code is not listed in Table 59, do not append modifier -FC. When you submit claims to Medicare with modifier -FC, follow this three-step process:

1. Submit the claim for the device replacement procedure after the procedure but prior to the manufacturer's/supplier's acknowledgement of the credit
2. Contact the contractor regarding a claims adjustment after the manufacturer determines the credit, or hold the claim for the device replacement procedure until the manufacturer determines the partial credit
3. Submit the claim with modifier -FC appended to the Healthcare Common Procedure Coding System code if the partial credit is 50% or more of the cost of the replacement device

It is important for coders to correctly report modifiers because using modifiers incorrectly may not only cost you money but can also present a compliance risk. ■

**Insider source**