

Break-out Session:

Keys to Transforming Surgery Centers into a Profitable Business



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Break-out Session Overview

Presenters:

Jim Freund – Senior Vice President, GENASCIS

- Has worked with over 800 ASCs from a technology, operational, business, and development perspective over his 20 plus years in the ASC industry

Matt Searles – Managing Partner, Merritt Healthcare

- 10 years experience as a developer, manager & consultant for ASCs, including both physician owned Centers and hospital/physician joint ventures

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Break-out Session Overview

In this Break-out Session you will learn:

- Common challenges & road blocks affecting ASCs
- Steps to understand the overall state of your business
- Direct steps & key solutions to overcoming common challenges & mistakes
- Practices & essential tools to drive financial performance

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Common Challenges & Road Blocks

- Increased Compliance & Regulatory Requirements
- Case Volume Challenges & Profitability of Cases
- Supply & Staff Management
- Reimbursement Pressures
- Lack of Revenue Cycle Optimization
- Complex Payer Contracting Processes
- Access to Essential Data
- Proper Governance

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Areas of Observation

- #1: **The Makeup of Your ASC**
- #2: **Understand your Costs**
- #3: **Business Office Effectiveness**
- #4: **Evaluate Managed Care Contracts & Payor Mix**
- #5: **Access to Data**
- #6: **Compliance with CMS, State and Accreditation Standards**
- #7: **Proper Governance**

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Observation Area #1:

THE MAKEUP OF YOUR ASC

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Analyze Case Volume, OR Utilization & Case Mix

Keys:

- Communicate with MD offices to ensure they understand which cases can be performed at the ASC. This may not always be clear to office based schedulers.
- Buy out physician members who are not performing cases, use equity to syndicate shares to surgeons who will utilize the facility.
- Continually recruit new surgeons. Even in markets with significant competition there are always opportunities to recruit new surgeons. Recruitment requires considerable lead times and effort so the process must always be a focus.
- Understand succession plans for existing surgeons. Physician owners should be encouraged to develop succession plans for their Practice

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Observation Area #2:

UNDERSTANDING YOUR COSTS

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Direct Steps & Key Solutions

Profitability of Cases

- Profitability of cases is dependent on several factors.
- Reimbursement levels for certain cases allow for significant profitability. Others may not be profitable.
- Time per case. Staff costs are higher for certain types of cases.
- Supply Costs. Must understand case costs and benchmark against other facilities to ensure lowest pricing.

Supply Costs

- Benchmark costs against other facilities.
- STANDARDIZATION of supplies can lead to considerable savings.
- Join Group Purchasing Organizations (GPOs) for supplies. Be careful to "opt out" of GPO for certain supplies which will be cheaper when purchased direct from certain vendors (e.g. phaco supplies).

Scheduling Impacts on Staffing Costs

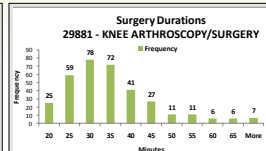
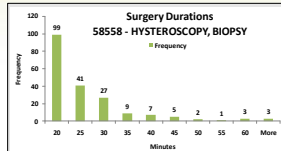
- Surgeons must be willing to block book and compress schedule – booking cases in as short a period of time as possible. Compressed OR blocks reduce costs via reduced staffing needs.
- Review block time utilization to ensure efficient use of OR time.
- Use part time staff as much as possible to supplement core of full time staff. PT staff can be used only when needed and do not require benefits.

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Surgery Duration & Labor Cost Impact

Primary Procedure Code	Case Count	Facilities	Avg. Surgery Time (mins.)	Min. Surgery Time	Max Surgery Time
28296 - CORRECTION OF BUNION	8,016	327	67	3	153
29826 - SHOULDER ARTHROSCOPY/SURGERY	15,416	319	60	20	142
29881 - KNEE ARTHROSCOPY/SURGERY	43,651	344	33	2	81
20202 - REMOVAL OF PALMAR SURTUP	10,515	263	40	2	193
42820 - REMOVE TONSILS AND ADENOIDS	16,768	249	26	0	85
47562 - LAPAROSCOPIC CHOLECYSTECTOMY	7,891	204	47	3	160
52000 - CYSTOSCOPY	9,611	133	16	0	89
58058 - HYSTEROSCOPY, BIOPSY	7,515	198	22	1	98
64721 - CARPAL TUNNEL SURGERY	21,542	350	24	1	139
60598 - CATARACT SURG W/IC, 1 STAGE	136,986	212	19	1	55

Top CPTs performed showed wide variances in surgery duration (cut time)



Surgery Duration & Labor Cost Impact

Facility A

28296 - CORRECTION OF BUNION	Case Count	Avg. Surgery Time (mins.)	Staff Cost	Avg. Staff Cost Per Case
Physician 1	1	66.0	\$157.30	\$157.30
Physician 2	2	67.5	\$242.54	\$121.27
Physician 3	3	64.7	\$198.23	\$66.08
Physician 4	22	62.2	\$265.56	\$12.07
Physician 5	5	61.6	\$54.08	\$10.82
Physician 6	9	61.0	\$143.27	\$15.81
Physician 7	5	58.2	\$55.83	\$11.17
Physician 8	3	58.3	\$86.68	\$28.89
Physician 9	7	56.1	\$53.50	\$7.64
Physician 10	11	51.5	\$102.25	\$9.29
Physician 11	7	48.3	\$74.42	\$10.63
Physician 12	3	46.0	\$36.34	\$12.11
Physician 13	4	45.3	\$55.94	\$13.99
Physician 14	16	41.6	\$196.15	\$12.26
Physician 15	27	41.6	\$299.21	\$11.08
Summary	125	56.9	\$869.79	\$108.47

Facility B

29881 - KNEE ARTHROSCOPY/SURGERY	Case Count	Avg. Surgery Time (mins.)	Staff Cost	Avg. Staff Cost Per Case
Physician 1	4	41.8	\$267.36	\$66.84
Physician 2	54	41.4	\$715.52	\$13.25
Physician 3	39	37.3	\$248.49	\$6.37
Physician 4	21	35.1	\$256.51	\$12.21
Physician 5	45	32.0	\$529.39	\$11.76
Physician 6	34	31.1	\$466.56	\$13.72
Physician 7	9	28.2	\$139.44	\$15.49
Physician 8	61	29.2	\$822.45	\$13.48
Physician 9	25	27.0	\$264.26	\$10.57
Physician 10	22	26.6	\$247.96	\$11.27
Physician 11	88	25.9	\$912.26	\$10.37
Physician 12	41	25.8	\$4736.00	\$115.51
Physician 13	34	19.1	\$248.17	\$7.30
Summary	477	31.8	\$4393.95	\$130.34

Significant variances exist within facilities for physicians performing the same procedure

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Surgery Duration & Labor Cost Impact

47562 - LAPAROSCOPIC, SURGICAL CHOLECYSTECTOMY	Case Count	Avg. Surgery Time (mins.)	Staff Cost	Avg. Staff Cost
Physician 1	1	80.0	\$81.74	\$81.74
Physician 2	38	52.9	\$242.01	\$6.37
Physician 3	39	42.2	\$708.86	\$18.18
Physician 4	33	41.3	\$772.90	\$23.42
Physician 5	25	39.9	\$188.24	\$7.53
Physician 6	41	39.0	\$792.40	\$19.33
Physician 7	12	38.8	\$192.40	\$16.03
Physician 8	8	31.9	\$72.32	\$9.04
FACILITY 1	174	45.9	\$1887.88	\$10.85
Physician 1	1	30.0	\$15.42	\$15.42
Physician 2	27	33.8	\$363.31	\$13.46
Physician 3	40	33.7	\$738.30	\$18.46
Physician 4	30	30.5	\$491.80	\$16.39
Physician 5	40	29.7	\$748.12	\$18.70
Physician 6	60	27.1	\$637.29	\$10.62
Physician 7	10	26.8	\$708.30	\$70.83
Physician 8	75	24.9	\$444.04	\$5.92
FACILITY 2	205	30.6	\$1614.80	\$7.88
Physician 1	8	49.3	\$1129.83	\$141.23
Physician 2	30	40.7	\$452.83	\$15.10
Physician 3	2	37.5	\$328.76	\$164.38
Physician 4	10	33.0	\$1330.00	\$133.00
Physician 5	30	26.9	\$688.80	\$22.96
Physician 6	64	24.7	\$884.80	\$13.83
FACILITY 3	106	38.2	\$338.88	\$3.19
Physician 1	2	42.5	\$38.77	\$19.39
Physician 2	3	31.7	\$330.57	\$110.19
Physician 3	5	31.4	\$462.50	\$92.50
Physician 4	6	30.8	\$698.94	\$116.49
Physician 5	2	22.0	\$396.20	\$198.10
FACILITY 4	18	32.7	\$296.58	\$16.48

Variances between facilities are quite large.

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Best Practice for Controlling Costs

- Track your clinical resources assigned to cases in your information system
- Educate your physicians on the time variances for same procedures
- Standardize supplies
- Do not overstock supplies
- Create annual inventory with set par levels
- Seek out peer facilities, state associations, or industry data to establish benchmarks
- Determine profitability per case is key

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Observation Area #3:

BUSINESS OFFICE EFFECTIVENESS

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Typical Issues

Reasons for the coding errors include:

- ICD-9 Code reported and billed but not documented by physician (compliance)
- Diagnosis documented by physician but not billed (compliance)
- Procedures performed but not billed (compliance / billing)
- Implants provided and documented but not billed (compliance / billing)
- Modifiers not coded per guidelines (compliance / billing)
- Improper codes added (compliance / billing)

There are a number of areas that prevent ASCs from realizing 100% of their expected revenue for the services provided including:

- Implants are not billed regularly
- Account follow-up is inconsistent and not timely
- Average time to bill is above industry standards
- Self-pay accounts appear to lack a standard process
- The charge methodology is inconsistent and can lead to compliance issues
- Poor monitoring payment per accordance to contract terms
- Insufficient staff & workflow infrastructure
- Lack of consistency in billing best practices & quality controls
- Write-offs taken with little to no regard to contractual terms

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Direct Steps & Key Solutions

Expertise & Technology

- Ensure you have highly trained staff 100% dedicated to each specialized function
- Appropriate workflow technology or processes ensuring 100% account resolution
- Make certain you have transparency into your business & compare with industry data
- Specialized & synchronized billing methodologies

Revenue

- 90% net cash collected in < 45 days
- Days to Bill best practice metric of 2 days
- Patient statements issued on a daily basis (3 statements within 90 days)
- Auditing all payments & write-offs against managed care contracts
- Daily Posting & balancing with insurance follow-up once/month

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Implant Billing Deficiencies

Many facilities do not properly bill implants.

- Implant usage sometimes doesn't get documented by physicians
- Documentation (implant invoice) is needed to get paid by payors
- **Our findings**
 - 332 facilities / 45K cases across 17 ortho codes
 - 29.6% of cases did not have implants billed
 - 7.7K cases had zero payments for billed implants

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Best Practice for Billing Implants

- Create an implant billing matrix
 - Listing of procedures that should always have an implant billed
 - Separate listing of procedures that could have an implant billed
- Check matrix at the point of coding
- Ensure proper documentation to bill and collect
- Build rules into billing and/or claims systems to flag cases for manual review

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Contractual Write-offs TOB vs. TOP

Zero Balance Cases Only, DOS July 1, 2009 - June 30, 2010, Medicare / Medicaid as Primary Payer Included

Medicare / Medicaid Included	Cases	Total Charges	Total Payments	Pd Per Case
TOTAL	1,883,662	\$ 11,930,093,529	\$ 2,879,746,953	\$ 1,529
TOP Primary	248,090	\$ 1,232,225,808	\$ 371,015,632	\$ 1,496
TOB Primary	1,635,512	\$ 10,697,863,720	\$ 2,508,730,321	\$ 1,534

Medicare / Medicaid Only	Cases	Total Charges	Total Payments	Pd Per Case
TOTAL	747,486	\$ 4,109,483,710	\$ 645,119,556	\$ 863
TOP Primary	102,638	\$ 439,846,488	\$ 81,204,788	\$ 791
TOB Primary	644,848	\$ 3,669,637,222	\$ 563,914,768	\$ 874

Taking write-offs at the TOB vs. TOP indicates facilities collect more per case

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Collections with TOS Patient Co-pays

Benchmarking Analysis | Time of Service Payment Analysis

Best Practice Adoption	Facilities	%
Taking Patient Payments at Time of Service	351	72.1%
Not Taking Patient Payments at Time of Service	136	27.9%

Charge and Collection Analysis for Best Practice	Total Patient Charges	Total Patient Payments	Collection %
Facilities Taking Pre-Payments - Patient Payments as % of Patient Obligation	\$ 547,450,349	\$ 303,893,801	55.5%
Facilities Not Taking Pre-Payments - Patient Payments as % of Patient Obligation	\$ 192,761,623	\$ 61,775,160	32.0%
Difference			23.5%

Opportunity for Improvement: Implement a Time of Service Patient Co-pay Payment Policy

Potential Opportunity	Collection Gains on Patient Payments
Facilities that adopt a TOS patient payment policy possibly could increase collection % on patient responsibility portion by up to 23.5%	\$ 45,228,265

Patient payments are 23.5% higher collection when facilities take co-payments at the TOS

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Observation Area #4:

EVALUATE MANAGED CARE CONTRACTS & PAYOR MIX

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Steps to Understand

- Properly negotiating a contract is key
- The structure or rules of payment terms are critical to a profitable contract
 - **Understand the reimbursement methodology**
 - Case Rates
 - Grouper-Based Contracts
 - Percent of Charges
 - Fixed Fee
 - Carve-outs
 - **Understand timely filing and payment terms**
 - **Understand the appeal limits**
 - **Understand recoupment time limits or take-backs**
- Size of the patient population in your service area
- Competition related to the patient population

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Direct Steps & Key Solutions

- Poor payer mix or below market commercial rates can result in lower revenue to the Facility.
- Renegotiate bad contracts, cancel if necessary.
- Use out of network plans if available as a temporary way to increase revenue while acceptable contracts are negotiated.
- Include staff labor costs when negotiating payor contracts and setting fee schedules
- Understand that an individual ASC doesn't have a great deal of leverage

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Observation Area #5:

ACCESS TO DATA

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Transparent Reporting Tools

You must have the ability to:

- Spot trends
- Forecast future performance
- Compare historically & against the industry
- Analyze key indicators & align them with organizational objectives
- Identify potential detrimental situations before they impact the bottom line



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Observation Area #6:

COMPLIANCE WITH CMS, STATE AND ACCREDITATION STANDARDS

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Key Points

- Implement educational physician guidance program
- Perform external quality audits by independent outside auditing organizations
- Execute comprehensive staff education and certification
- Employ a quarterly review of charge methodologies
- Annual pricing comparison & evaluations
- Apply consistency of processes & quality controls
- More Regulation
- Susceptible to RAC Audits

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Observation Area #7:

PROPER GOVERNANCE

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Key Points

- Operating agreement should allow for fluid management of operations and decision making. No stalemates! Board should have control of day to day decision making and major decisions should be subject to reasonable "super" majority voting.
- Operating and financial data should be readily available and transparent to members. Members/decision makers should be accountable for performance.

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CONCLUSION

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Embrace Continuous Process Improvement

- Analyze your ASC's performance
- Benchmark against other Facilities
- Be proactive in addressing deficiencies
- Structure your organization and culture to accept change and be open to improving your organization
- Information is Key
- Transparency and accountability

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Questions?

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