BECKER'S ASC REVIEW

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STARK II FINAL REGULATIONS ISSUED ON JANUARY 3, 2001

HCFA offered welcome relief to ASCs with its final Stark regulations. These regulations state that ambulatory surgical services provided under a composite rate by an ambulatory surgery center will not be defined as "designated health services." The final regulation also provides a specific exception for implants furnished during an ASC procedure.

AMBULATORY SURGERY CENTERS PRELIMINARY VALUATION QUESTIONS

A summary valuation can help a center evaluate its options. To generate a summary valuation for the surgery center, one needs to derive information as follows:

1. Please indicate the number of owners of the Center categorized by the principal specialty of each physician.

2. Is the Center Medicare certified, accredited, and state licensed?

3. Does the Center have a Certificate of Need? Are CON's available for in the state? Are there restrictions on the CON, including restrictions on transfer?

4. When did the center receive Medicare certification?

5. How many operating rooms and procedure rooms does the surgery center utilize?

6. Is there room for expansion? What amount of square feet does the surgery center use?

7. Does the surgery center own or lease its premises?

8. What is the per square foot and total lease rate and triple net costs regarding the surgery center space?

9. What are the top 10 procedures performed at the surgery center by volume of procedures and the average collection per procedure, for the last 3 years? Annual estimate requested.

	Procedure	Volume	Collections
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____
D.	_____	_____	_____
E.	_____	_____	_____
F.	_____	_____	_____
G.	_____	_____	_____
H.	_____	_____	_____
I.	_____	_____	_____
J.	_____	_____	_____

10. For the top 10 most commonly performed procedures. List the three physicians that perform the substantial majority of such cases. Identify changes in the list for the last three years. Does any one physician account for more than 10% of the volume of cases or revenues?

A.	_____	F.	_____
B.	_____	G.	_____
C.	_____	H.	_____
D.	_____	I.	_____
E.	_____	J.	_____

11. How many physicians are credentialed at the Center?

12. How many physicians perform more than ten (10) cases per year at the Center?

13. What is the average and the minimum investment per physician? Is the Center separately syndicated?

14. Which 10 physicians generate the most revenues for the Center? Has any of the top ten performing surgeons crease use significantly over the past two year? Is there an explanation of loss of revenue from these surgeons?

A.	_____	F.	_____
B.	_____	G.	_____
C.	_____	H.	_____
D.	_____	I.	_____
E.	_____	J.	_____

15. What is the percentage of business by payor for the top five payors? Is there concern regarding the ability to contract with specific payors.

A. _____
B. _____
C. _____
D. _____
E. _____

16. Are there significant payors in the area that the Center has not been able to contract with? Please list.

17. Are there significant payors that provide significant discounting? Please list.

18. Who are the main competitors of the Center? Are there key investors that compete?

19. What are the three greatest risks to the ASC?

20. Please provide the most recent financial statements (3 years) for the Center.

ASC COMPLIANCE POLICIES AND PLANS: PRACTICAL APPROACHES TO COMPLIANCE PLANNING

Centers should adopt a compliance policy and further clarify and ensure systematically that legal compliance is a top center priority. This article provides an overview of the initial steps to be taken to implement a compliance plan.

Initial Steps

A summary of steps to be taken to implement a compliance policy and to commence an ASC compliance effort are as follows.

1. Obtain draft policy;
2. Review the entire Policy in detail;
3. Discuss Policy and safe harbors with Center Board;
4. Edit and revise Policy; Adopt Policy at Board level;
5. Appoint Chief Compliance Officer;
6. Host initial all staff meeting to acknowledge compliance plan, obtain acknowledgment of understanding and intent to adhere to a compliance plan;

7. Review and discuss specific issues regarding:
   (a) ownership by surgeons that do not meet the safe harbors;
   (b) differing ownership amounts among physicians investing at the same time (was ownership offered or differentiated with the intent of rewarding or inducing referrals);
   (c) contractual and relationship review between the surgery center and the hospital and/or any referring members; and
   (d) cross referral relationships between hospital, surgeons and surgery center;
8. Discuss Operating Agreement or limited partnership amendments to incorporate ASC safe harbor concepts.
9. Initiate hotline and suggestion box for complaints.
10. Initiate periodic billing and coding review.

Annual and Periodic Efforts

There are a handful of specific focal points that can be used as guideposts for a compliance program. The intent of these guideposts is to provide a method to assure significantly enhanced compliance efforts on a reasonably practical basis. The guideposts include:

1. All Staff and Physician Compliance Meetings. Two or more times per year, the entity should host a one to two hour conference or discussion whereby health care regulatory concerns and issues are explained to all staff and all physicians. These should include a discussion of the impact of the Stark Act, Medicare/Medicaid Fraud and Abuse Statute, reimbursement, fee splitting and other issues of concern to the organization, its employees and physicians. These meetings may be handled in person and may be supplemented by periodic teleconferences.

2. Billing and Coding Review and Audit. At least once per year, an outside firm should be utilized to do a sample review of the entity's billing and coding efforts to assure compliance with billing and coding rules and statutes. Internally, this effort should be supplemented a number of times per year. Billing and coding remains a key focus of investigative efforts. Thus, a disproportionate amount of attention should be spent on reviewing billing and coding efforts.

3. Employee Complaints. An organization should establish methods whereby employees can report misconduct or health care regulatory concerns. Here, any reporting employee should be assured that his or her reporting will have no negative impact upon the employee's career with the company. In fact, such actions should be encouraged and applauded.

4. Seminars. Key leaders in the organization, both on an overall basis and as to the departments, should be encouraged to attend one to two compliance related seminars per year. This is intended to inform and educate such persons as to compliance issues.

5. Compliance Plan. Periodically, at least once per year, the company's compliance plan should be reviewed as a whole by counsel and key executives to assure that the plan is appropriate for the organization and to update the plan to take into account changes in the regulatory environment.

6. Compliance Manual and Periodic Updates. Periodically, specific literature in the form of articles or summaries should be provided to employees throughout the organization to help continue to raise the level of consciousness as to compliance issues.

7. Department Heads. Department heads should be encouraged to gain additional knowledge as to compliance matters on an ongoing basis. The chief compliance officer should make it a key point of his or her efforts to assure that such persons continue to gain additional knowledge on compliance related issues.

MUST PATIENT DEBTS BE SENT TO COLLECTIONS?

As long as a provider makes a bona fide collection effort and does not advertise or market the intent to not send collections to an agency, strong arguments should exist under the antikickback statute to defend a determination to not send uncollected amounts to collection agencies. To further assist in defending allegations, the ASC and physician should not internally or externally market the practice and should carefully document their collection effort.

To minimize the risk of the practice being deemed an improper kickback, neither the physician nor the practice should advertise or publically disclose in any manner to patients their practice for writing off bad debts.

Under the "Medicare Provider Reimbursement Manual", Section 3.10 defines what a reasonable collection effort must consist of: reasonable collection must involve the issuance of a bill on or shortly after discharge of the beneficiary. It must also include other actions such as subsequent billing, collection letters and telephone calls or other personal contacts with the party which to constitute a genuine, rather than token, collection effort. While this definition is not really targeted to the issue of improper kickbacks, it is helpful in understanding what constitutes a bona fide collection effort.

The manual does not indicate that a provider's collection effort has to include use of a collection agency in addition to or in lieu of subsequent billings and follow-up letters.

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