

## EVALUATING AND ADDING SPECIALTIES TO TAP INTO NEW SOURCES OF REIMBURSEMENT

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Adding specialties to tap into new sources of reimbursement is critical for the life of a surgery center. There are key reasons to open the center for a new surgical specialty-loss of an existing specialty, new partnership opportunity through admission of a group practice, or revenue erosion to the point fresh sources must be located for continuing existence.

There are areas to consider prior to determining which specialty to add, if given the luxury of choice.

- A. Which surgical line is a fit with the center's current specialties?
- B. Which surgical line is a fit with scheduling rules and available time?
- C. Which surgical line is a fit with the center's current anesthesia and staffing competencies?
- D. Which surgical line is a fit with the center's financial resources for purchasing equipment and supplies?
- E. Which surgical line is a fit with the payor mix and reimbursement in the market?

This article addresses the first three questions with the remaining two questions presented at the Today's Surgicenter meeting in September.

- A. Suitable with current specialties. There are a couple of obvious matches all administrators can name: pain with orthopaedics, podiatry with orthopaedics and urology with gynecology. The patient base and/or instrumentation are similar such that entry into the market is facilitated through similarities of service delivery or marketing targets. Pain management patients can be found through the orthopaedist's practice given musculoskeletal disorders. Podiatry and orthopedics use to a large extent the same capital equipment, so outlays for implants, hardware and instrumentation are minimized. Urology and gynecology initially both used the same scope, but on an outpatient basis these specialties have taken different courses regarding equipment. However, given the intimate nature of urological and gynecological procedures, these patients require a level of privacy and empathy no other surgical specialty demands.
- B. Scheduling rules and available time. Each center establishes its own method of communicating the additions, cancellations or time modifications of procedures externally to the office and internally to the center's departments. The tolerance level for cancellations or time modifications could negatively impact staffing

levels if a group of specialists has a patient population which fluctuates. One example is the gastroenterology service line. A busy group of 6 gastroenterologists can schedule 300-400 cases a month. The level of cancellations in endoscopy is unusually high compared to other surgical specialties. The most frequently cited reasons are the following: the colonoscopy patient changed his mind because he didn't want to undergo the bowel prep; gastric symptoms instigating the gastroscopy improved; the Medicare patient's gap insurance was dropped due to personal finances as the patient is on a fixed income and the co-payment is due; no one is available to accompany the patient; or the patient just does not keep the scheduled appointment without giving notification nor a reason. Another example is the pain management patient. This is another patient population with a higher "no-show" rate or cancellation rate.

If your center is considering adding either of these specialties, the center and practice administrator must discuss with their respective schedulers how to establish a firm communication protocol. This allows the practice office to insert new patients when there is sufficient notification of the cancellation. This protocol also should include the notification by the center to the office when there are "no-shows", for tracking and possibly rescheduling.

The ability to handle "add-ons" and last-minute scheduling is important to gynecologists. Having unblocked time and a process to pre-operatively prepare these patients in a short timeframe will increase the center's case volumes through its flexibility.

- C. Anesthesia and staffing competencies. The center's contract with its anesthesia group should have language not only guaranteeing coverage and quality outcomes by anesthesia, but the ability to diversify its techniques to optimally fulfill the anesthesia requirements of the surgeons. This may mean adding an anesthesiologist who can insert peripheral nerve blocks for extended pain relief or the addition of CRNAs who can rapidly administer and recover pediatric patients in the presence of their parents. These are both examples of specific skills and clinical experience in anesthesia professionals that may not be present in the center's current anesthesia group.

The center's clinical staff may be challenged by procedures the operating room technicians have not performed or by instrumentation the central sterile technicians have not processed in the past. The PACU nurses need to know how to respond to the pediatric patients' recovery phases and to pediatric emergencies which are vastly dissimilar from adult emergencies. There is an educational level and a tolerance level for understanding and providing nursing care to the various age groups, be it the young or the elderly. The staff must not only be competent, but also attracted to providing care to their patients, as not all nurses enjoy all levels of age groups. Major changes to the patient populations must involve the Clinical Director and the staff impacted in order to ascertain any obstacles to the successful assimilation of a new specialty.

The decision-making from a financial perspective will be discussed in detail at the Las Vegas meeting. Topics covered will be a review of basics on case costing, performance of several cost-to-benefit analyses and payor contract analysis for a new service line.

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