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Five must-have provisions to include in your ASC's governing document

A governing document is a critical piece of your ASC. It not only protects the owners, but it can also substantially affect their financial future and the ongoing operations of the ASC.

But in some cases, an ASC may hire an attorney unfamiliar with the workings of an ASC or the applicable federal and state healthcare regulations to prepare this important document, says **Joshua M. Kaye,** healthcare attorney with McDermott, Will & Emery. If so, the governing document may lack crucial provisions needed to protect the ASC and the owner's interests.

If you have any doubts about what your governing document says, amend it. This is particularly important if you're interested in adding new physician investors, Kaye says, because you can present a well-drafted governing document to new investors as a finalized document. That can often lead to less costly and less time-consuming negotiations and deals.

If you just started an ASC or your ASC does not currently have a governing document, then it is absolutely vital to have one prepared, and it's best to make it right from the get-go, Kaye says.

We'll tell you why you need a governing document and give you five crucial provisions (see p. 2) to include in the document to better protect your ASC and its investors.

Why you need a governing document

A governing document is technically called a shareholders' agreement for a corporation, an operating agreement for an LLC, and a partnership agreement for a partnership. Kaye says there are three main reasons to have a governing document:

• **Preventing issues down the road.** Without a governing document, primarily state law controls your ASC and the relationships among the investors. This means that if a grievance arises among physician investors, there's often no clear guidance on how to resolve the dispute.

ASCs can often minimize the impact of the most common quarrels among its investors with a well-drafted governing document, says **John E. Garry, MD, FACS,** chair of the joint operating committee of the Central California Endoscopy Center. "You don't want there to be any issues, and if one arises, you want it resolved quickly and efficiently so that the ASC can focus on patient care and operating a good business," Garry says. "A well drafted governing document completely spells things out so any issues can be quickly eliminated."

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Robert Kurtz, Associate Editor,
rkurtz@hcpro.com
Julia Fairclough, Executive Editor
Lauren McLeod, Group Publisher
Suzanne Perney, Publisher

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• **Eliminating physicians who don't contribute to the bottom line.** Some physician owners will likely perform a greater number of procedures than others. From a purely business perspective, those physician investors who use the ASC the most often want the ASC ownership (and thus profit distribution) to reflect or at least be more in line with utilization, Kaye says. Often, these physicians argue that the lower users receive a profit windfall.

"However, what often makes good business sense doesn't fit squarely with healthcare laws," says Kaye. "Because of anti-kickback law concerns, an ASC cannot distribute profits based on each owner's utilization."

This may lead to frustration among some of the greater users because they may argue that those who use the ASC less often take money from them without making as much of a contribution to the ASC's profitability. However, with a good governing document and the right provisions, you can "better position the ASC to potentially eliminate its dead weight" by buying them out. There are substantial regulatory risks involved, says Kaye, so it's best to retain legal experienced in such matters.

• **Providing for an exit strategy.** If you decide to sell a majority interest or substantial control of your ASC to a potential suitor, particularly a large hospital system or ASC management company, a well-drafted governing document could make for a smooth transaction. That's because the purchase agreement and the governing document are the two primary negotiated documents in such a transaction.

If the new investor is already familiar with the terms of your governing document, then you may only need to heavily negotiate one primary document rather than two.

Accordingly, the governing document will also define the ongoing relationship between the new investor and the remaining physician owners following the sale. A good governing document should have provisions an ASC management company or health system will want to see and is used to seeing in its other ASC deals. These provisions might include decision-making by a governing board or medical advisory committee or restrictions on transfer, noncompete events, and redemption events.

Five provisions your governing document needs

1. Right to drag along minority investors. "Drag along" rights allow the controlling owners to force the minority owners to sell their interests.

Consider this scenario: You and another physician spend the time and money to start an ASC and then bring on three additional physicians. You and your partner, as the founding physicians, share 51% of the business, and the additional physicians own the remainder.

An ASC management company is interested in purchasing your ASC, but only if it can acquire at least a 60% interest.

You and your partner, as majority owners of the ASC want to sell, but the other three owning the minority decide not to cooperate. You are unable to force any of the minority owners to sell, and the management company is not

satisfied with owning only 51%, so the deal falls through, despite the majority owners' interests.

Without a drag-along provision, the minority owners can have a significant—perhaps too significant—say in the financial interests and future of the majority owners, Kaye says.

But with a drag-along provision, the majority owners have the right to force the minority owners to sell a percentage of their interest.

2. Right to buy out investors. Your governing document needs to outline certain events that, if they occur, will allow the ASC or other physician owners to buy out another physician owner.

"There has to be a complete listing of how you can buy out one of your partners," Garry says.

These events are called "redemption events," and in a good governing document they include

- death
- disability
- retirement
- relocation
- certain "for cause" events such as conviction of a crime and loss of medical license
- violation of a noncompete agreement

A good buyout provision can also help your ASC comply with the anti-kickback law ASC safe harbors, Kaye says.

Include a provision that gives your ASC the ability to buy out any physician who fails to satisfy the one-third tests of the ASC safe harbor.

By doing so, you will keep your ASC compliant with the one-third tests and perhaps provide encouragement for physicians to stay responsible and productive, Garry says.

The one-third tests are mandated to ensure that the physician-investor is actively involved with the ASC and uses it as an extension of his or her physician practice.

The two tests requiring this involvement state that a physician-investor must

- derive at least one-third of his or her medical practice income during the previous 12 months from the performance of procedures that require an ASC or hospital surgical setting
- have performed at least one-third of such procedures during the previous 12 months at the ASC in which the physician has invested money

3. Right to establish redemption price. If a redemption event occurs, your governing document should also outline how you'll set the amount at which your ASC will redeem an investor's interests.

Although there are many ways to establish this figure, three are commonly used in the ASC industry, Kaye says. Your governing document could set forth or require any of the following:

- A mutually agreed-upon dollar amount
- An appraisal of the ASC's worth at the time of the buy-out
- A mutually agreed-upon multiple of the ASC's earnings before interest, taxes, depreciation, and amortization (EBITDA)

***Insider* says:** The standard way of determining EBITDA when buying out a physician is to look at the 12 months prior to when the investor leaves.

However, Kaye says a more effective way of doing so is to look at the 12 months of EBITDA after the investor leaves because this will show a more accurate picture of the effect on the ASC of losing the investor and have less of an immediate impact on the ASC's cash flow.

To do this, Kaye says the ASC may want to give some cash as a down payment to temporarily satisfy the investor and a promissory note obligating the ASC for the rest of the payment.

The ASC will pay the remainder of the buy-out amount will be paid after calculating the post–buy out EBITDA in accordance with the note and payable over some period of time (e.g., 12–36 months) after the investor leaves.

Including these tests could also position the physician owners to eliminate dead weight. While punishing nonusers has regulatory implications, using the one-third tests as a basis for buying out underutilizers is one of the rare instances in which an ASC may be able to use the law to obtain a good business result.

4. Right to restrict investors' financial interests. Your governing document needs to have a provision that restricts the financial involvement of physician-investors in other ASCs. This is called a restrictive covenant or a covenant not to compete.

The provision assures that the physician-investor won't have financial ties with a competing ASC and lessen the likelihood that any surgeries that could be performed in the ASC are being performed there and not in an office setting or hospital.

Although you typically cannot prevent physician-investors from performing procedures at another ASC, Garry says, this provision will help make them prioritize performing procedures at your ASC where they have

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a vested interest.

State law determines the extent of your ability to enforce the covenant of the noncompete.

Ask your attorney to review your state's restrictive covenant laws. State laws will generally require that the geographic scope, applicable time frame, and restricted activity of the covenant be reasonable, Kaye says.

Generally, a good noncompete will apply as long as a physician is an owner and for some sort of "tail" period (e.g., one to three years) after he or she is no longer an owner.

5. Right to maintain governance and control. Include language in your governing document outlining control of the ASC.

"Your structure needs to be spelled out in black and white so that there are no issues," Garry says.

Without language in your governing document dictating control, state laws typically say that a simple majority is needed to make major decisions, Kaye says.

However, by including certain provisions, an original owner of the ASC may be able to actually maintain control even if he or she becomes a minority owner.

Kaye refers to this as the "founding principal concept." It can keep the original owners—the founders—of the ASC overseeing the ASC's management even after syndicating it to new physician-investors.

By not including this language, the owner may give up critical decision-making power to new physician-investors.

You can use this concept to exclude the founding owners from other provisions of the document, such as restrictions on transfer and redemption events.

The amount of control, though, may not always be up to you. If you bring in investors, they will want to have a say in the decision-making.

Often, minority investors will want a say in certain major decisions affecting the ASC, Kaye says, such as bringing in new investors, buying a new expensive piece of equipment, and incurring debt in excess of a certain dollar amount.

Minority owners will try to negotiate for the governing document to call for a "supermajority" vote or a vote requiring 60% or more approval to pass. (See the sidebar above for a partial list of items that typically require a supermajority vote.)

Because of the many regulatory pitfalls when dealing with physician ownership of ASCs and addressing the various issues set forth in a governing document, make sure you receive the proper legal advice regarding the applicable federal and state healthcare regulations. ■

SUPERMAJORITY DECISIONS

Here's a partial list of items that typically call for a "supermajority" vote.

1. A sale of all of the ASC's assets, a merger, or consolidation
2. Any redemption or purchase of membership interests
3. Any amendment to the governing document
4. Any incurred debt in excess of a certain threshold
5. Any matter requiring investors to contribute more money
6. Any decision that involves a corporate tax matter or the filing of corporate tax returns
7. Any matter that may cause the ASC to enter into transactions with affiliates of physician investors
8. Any issue that may require a physician investor to sign a personal guarantee for any of the ASC's debt

Source: Joshua M. Kaye, Esq. Reprinted with permission.

Insider *sources*

John E. Garry, MD, FACS: chair of the joint operating committee of the Central California Endoscopy Center, 6143 N. Fresno Street, Fresno, CA, 93710; 559/440-9100; *jegarrymd@sbcglobal.net.*

Joshua M. Kaye, Esq.: McDermott Will & Emery LLP, 201 S. Biscayne Blvd., 22nd Floor, Miami, FL 33131; 305/347-6516; *jkaye@mwe.com.*

ASK THE INSIDER

Duty to return overpayments

Q: Sometimes my center receives overpayments from payers. Do I have to return these incorrectly paid amounts?

A: Generally speaking, a provider should not keep payments for services not rendered or overpayments to which it is not entitled, says healthcare attorney Patricia O. Powers. The federal law has specific provisions governing the return of overpayment amounts incorrectly paid by a federal healthcare program.

Commercial payers often have similar requirements in their agreements that require providers to return overpayments or allow them to recoup amounts paid in error from future payment amounts.

However, surprising as it may seem, some provider agreements do not have an explicit obligation to return overpayments.

When a provider agreement does not require a refund of amounts paid in error, check your state law.

Some, but not all states require providers to return overpayments. Almost all states have conversion laws that make it illegal to keep something to which you are not lawfully entitled.

Sometimes state "escheat" laws provide mechanisms for payers to recover such amounts and allow providers to pay the money to the state if it cannot be returned to the rightful owner.

To avoid allegations of conversion or violating a state law requiring the return of overpayments, it is best to return such amounts.

The providers should also consult legal counsel to obtain advice on how to appropriately document the refund.

There have been instances in which a provider has tried several times to return unentitled money to a payer, and for unexplained reasons, the payer would not accept the repayment, Powers says. In such instances, retain legal counsel to confirm that the approach is appropriate under applicable state law and that you properly documented all steps. ■

Insider *sources*

Patricia O. Powers, Esq.: Waller Lansden Dortch & Davis, Nashville City Ctr., 511 Union St., Ste. 2100, Nashville, TN 37219; 615/850-8808; *patsy.powers@wallerlaw.com.*

HIPAA COMPLIANCE

Make sure to catch these easy-to-miss security vulnerabilities

The HIPAA security regulations require you to assess "the potential risks and vulnerabilities" to the confidentiality, integrity, and availability of your electronic protected health information (ePHI).

Most facilities can easily identify threats to ePHI such as viruses or hackers. But vulnerabilities are different than threats. A vulnerability is a defect in your security program that a threat can exploit, says information security consultant **Margret Amatayakul.**

For example, a vulnerability occurs when your ASC or HOPD doesn't always follow its policy on restricting access to information after termination. And ex-employees who continue to access the patient billing system after termination can exploit it.

Healthcare facilities commonly overlook these five security vulnerabilities during their risk analyses. Do you?

1. Improper use and maintenance of audit trails. Most facilities maintain audit trails of certain computer activities such as accesses or changes to ePHI. The problem occurs when they don't do anything with the information once they record it or they fail to keep it for a meaningful length of time.

This can become an issue, especially when trying to discipline an employee for inappropriate computer use or ePHI access, Amatayakul says. "It is virtually impossible to have a sanction policy applied consistently without audit trail records," she says. "The records provide the evidence you need."

***Solution*:** Set a policy on maintaining and using audit trails that specifies how long you will keep logs (e.g., one year) and how often you will review those logs to ensure only appropriate access to ePHI.

2. Inconsistent work force clearance procedures. You probably have methods for authorizing and supervising access to ePHI, part of which includes performing background checks on prospective employees to determine whether they have a propensity for theft or malice.

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Check *all* potential employees. Some facilities run a thorough background check on healthcare professionals but fail to check the backgrounds of nonprofessionals and temporary workers. Or they may run routine checks on key information technology (IT) staff only, leaving their ePHI vulnerable to misdeeds by other staff members.

Solution: Prepare detailed work force clearance procedures and communicate them to your human resources department. Specify within the procedures that you must thoroughly check all employees and the steps you will take to do so. Conduct random audits to make sure everyone at your organization follows the policy.

3. Insufficient work force termination procedures. Remember that employees you terminate will not suddenly forget how to access your organization's ePHI. And the termination itself provides motivation to access and use the ePHI. Avoid this by revoking access privileges after termination.

Make sure the right people know about an employee termination. For example, one lab has a high rate of employee turnover yet never informs the IT department—the department that grants and terminates access to the lab's computer system—about resignations or terminations. These continued access privileges leave ePHI vulnerable, Amatayakul says.

Solution: Inform the appropriate departments about employee terminations *before* they happen, when possible, or as soon as possible afterward. And conduct periodic reviews of all inactive accounts to determine whether the IT department terminated the account holder's privileges.

4. Backup storage too close to your organization. You may not realize it, but the location of your backup storage can put your ePHI at risk. "The minimum distance that backups should be stored is 20 miles from the facility," Amatayakul says. Depending on the disaster you're trying to protect against, you may want to store it farther away. For example, some experts suggest that healthcare facilities near or in hurricane-prone areas store backups more than 100 miles away.

Solution: Go to *www.preemptinc.com* and click on "ACP Survey: How Far is Far Enough?" to get an idea about appropriate distances in which to store your backups. Then review your backup plan to make sure it adequately addresses your disaster needs. Don't send backup tapes so far away that it will take a day or more to retrieve them. You may find it necessary to make duplicate backups, sending one to a storage facility outside of your disaster range and keeping the other close in the event you need it immediately.

5. Untested contingency plans. Most facilities work hard to create contingency plans that cover all the bases in the event of a disaster. After months of meetings and surveys, the facilities put the plans in binders and never test them. But untested plans leave these facilities' ePHI vulnerable if a disaster ever strikes.

For example, what if your key contacts during a disaster turn off their phones at night, making them unreachable? Or what happens if a fire destroys written copies of your contingency plan? Your organization may be helpless because no one knows what to do without seeing the instructions. Unless you test your plan, you don't know about either of these potential problems.

Solution: Test your contingency plans regularly, such as every six months. Make sure your employees know what to do even if they don't have a description of your contingency plan in front of them. And update your plans as needed to make sure you're prepared if a disaster ever does strike. ■

Insider *sources*

Margret Amatayakul, RHIA, CHPS, FHIMSS: president, Margret\A Consulting, LLC, 2313 W. Weathersfield Way, Schaumburg, IL 60193, *margretcpr@aol.com.*

• HIPAA security rule security management process standard, risk management implementation specification 45 CFR § 164.308(a)(1)(ii)(A).

E-TOOL

Outsourcing 101: One ASC's experience

Dear subscriber,

This month we offer you a supplementary story to go with your April issue. Last month we told you of the benefits of outsourcing your billing and how to find the right outsourcer for your needs. This month we spoke with Mike Pankey, administrator for the Ambulatory Surgery Center of Spartanburg in Spartanburg, SC, to learn about his experience with outsourcing his ASC's billing.

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AVOIDING PENALTIES

Six precautions to ensure medical necessity

Billing for services that aren't medically necessary can leave your ASC or HOPD at risk of losing Medicare certification.

In addition, providers who bill Medicare for medically unnecessary services can also be accused of submitting false claims, says healthcare attorney **Patricia O. Powers.**

If this occurs, you'll not only have to return money collected under these claims, but you may have to pay interest and, in some situations, penalties.

Submitting claims to private payers for medically unnecessary services can also lead to trouble. It will likely violate your contract with the private payer, says Powers.

And all payers will require an ASC or HOPD to return any reimbursement for services that weren't medically necessary, says ASC consultant **Michelle Williams.**

To avoid these problems, be sure you can prove medical necessity for all services you bill to Medicare or third-party payers.

"This requirement can be a little more difficult for ASCs or HOPDs to meet because they must rely on the surgeon's documentation and notes," says ASC administrator **Carol Blanar.**

To help you, follow these six precautions to ensure that you've documented the medical necessity of your reimbursable procedures.

Six precautions to follow

Although some of the following precautions are basic steps, even experienced facility staff members may sometimes overlook one or more of them.

Precaution #1: Add language to your compliance plan and general practice policies that states you'll bill Medicare and private payers for only medically necessary services.

"Doing this tells your staff and surgeons how important it is to verify medical necessity before submitting a claim to a third-party payer," says Powers.

Model policy language:

Many payers, including Medicare, will only reimburse ASCs/HOPDs for medically necessary services. [Facility] ASC/HOPD will only submit claims to such payers when the medical necessity of the procedure is adequately documented in the patient record.

Precaution #2: Ask about medical necessity when scheduling appointments. For example, when scheduling an appointment with a surgeon's office, confirm medical necessity by asking for the diagnosis that led the surgeon to schedule the surgery.

Or if you're scheduling a diagnostic procedure, you may want to ask the physician to describe the presenting symptoms that led to scheduling the procedure.

"True medical necessity can only be confirmed by a review of the patient's preoperative treatment plan, which you normally won't get until after surgery, but it doesn't hurt to get some information up-front," says Blanar.

Williams suggests getting the information in writing if possible. "Having the surgeon's office provide this paperwork in advance can give you the opportunity to discuss it with the surgeon before the procedure if necessary," she says.

But there are two other good reasons to do this. It gets the surgeon's office to double-check that it has documented medical necessity, and it gives your coders a hint when they're searching for medical necessity in the record, says Powers.

***Insider* says:** Have a check box on your scheduling form indicating the medical necessity of the procedure, says Powers. "This way your schedulers won't forget to ask," she says.

Precaution #3: Set up a procedure with each of your surgeons' offices that outlines what the staff there will do to provide you with documentation of medical necessity for each procedure they schedule.

For example, you may ask surgeons to dictate or write the final diagnosis on a separate line of the pre- or postoperative report so your coders can determine the final diagnosis.

Or your procedure may require the surgeon to give you a written summary of the patient's condition and need for surgery at the time the surgeon schedules the procedure.

Precaution #4: If your coders find that the documentation doesn't support medical necessity or if they have questions about the documentation, have them contact the surgeon's practice administrator.

"If you aren't convinced, take the extra time to contact the surgeon's office. Otherwise you're putting yourself at risk," says Powers.

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Explain what documentation you need, whether it is from a Medicare local coverage determination or a payer's policy, and why the existing documentation isn't adequate, says Williams.

Ask the surgeon to call the ASC or HOPD transcription service to dictate a revised operative or preoperative note or have the surgeon fax a revised and signed note to the coder. And set a time limit for the surgeon to provide the missing documentation—say, within 24 hours, Williams says.

***Insider* says:** If your coders continue to have the same problems, sit down with the surgeons and help them understand the Medicare coverage requirements or the payer's policy. By doing this, you may prevent future problems.

Precaution #5: Randomly audit your own records to evaluate how well you're meeting medical necessity requirements. Ask surgeons or staff to perform these audits. Remind them that Medicare's Conditions of Coverage for ASCs require an ASC to have its medical staff actively participate in a comprehensive ongoing self-assessment of quality of care.

This assessment should include a review of the medical necessity of procedures performed.

Blanar uses a utilization review program that calls for the random pulling and review of charts by surgeons of a like specialty.

"These surgeons will look for proper documentation of medical necessity for each procedure and what medical treatment was provided to that patient preoperatively to alleviate the symptoms before surgery was scheduled," she says.

She'll also pull charts for utilization review on a nonrandom basis if a problem turns up during surgery or recovery.

Precaution #6: Bring in an outside contractor to perform audits. You may want to schedule periodic medical records and billing audits with an outside contractor, advises Williams.

"This can help you pinpoint problems and modify procedures if necessary," she says.

It can also let you know whether you need to do more staff education and monitoring, Williams says. Bringing in an objective outside auditor may help your facility uncover problems that your own staff or surgeons have overlooked, Powers says. ■

Insider *sources*

Carol Blanar, RN, BS, CNOR: administrator and director of nursing, Sagamore Surgical Services, Inc., 2320 Concord Rd., Ste. B, Lafayette, IN 47909; 765/474-7854; *sagsurgctr@aol.com.*

Patricia O. Powers, Esq.: Waller Lansden Dortch & Davis, Nashville City Ctr., 511 Union St., Ste. 2100, Nashville, TN 37219; 615/850-8808; *patsy.powers@wallerlaw.com.*

Michelle Williams: manager, Business Process Engineering, NovaMed, Inc. 980 N Michigan Ave., Ste. 1620, Chicago, IL 60611; 312/780-3249; *mwilliams@novamed.com.*