Case Costing and Advanced Benchmarking for Ambulatory Surgery Centers

90-minute audio conference

August 6, 2008

2:00 p.m.–3:15 p.m. (Eastern)
1:00 p.m.–2:15 p.m. (Central)
12:00 p.m.–1:15 p.m. (Mountain)
11:00 a.m.–12:15 p.m. (Pacific)
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ASC Communications
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Phone: (800) 417-2035
E-mail: sbecker@mcguirewoods.com
Web site: www.beckersasc.com
Welcome!

We are pleased that you have chosen to set aside a part of your day and join us for our **Case Costing and Advanced Benchmarking for Ambulatory Surgery Centers** audio conference with Ann Geier and Susan Kizirian. We are sure you will find the conference educational and worth your time, and we encourage you to take advantage of the opportunity to ask our experts your questions during the audio conference.

If you would like to submit a question before the audio conference, please send it to rob@beckersasc.com. Although we cannot guarantee your question will be answered during the program due to time constraints, we will include it if time permits.

If you have comments, suggestions or ideas about how we might improve our audio conferences, or if you have any questions about the audio conference itself, please do not hesitate to contact me.

Thanks again for taking part in this program.

Sincerely,
Robert Kurtz
Director of Communications
Phone: (410) 874-7681
rob@beckersasc.com
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<td>Speaker contact information</td>
<td>108</td>
</tr>
</tbody>
</table>
Speaker bios

Ann Geier, RN, MS, CNOR, CASC, is the vice president of operations for Ambulatory Surgical Centers of America (ASCOA). She has worked in ASCs since the mid-80’s. In her various roles, she has worked with controlling costs while maintaining the quality of care provided to patients. Ms. Geier is currently involved on a national level with the Ambulatory Surgery Foundation (ASF), AORN and the ASC Quality Collaboration Expert Group in setting standards for quality of care strategies. She teaches in the AORN Ambulatory Surgery Manager’s Certificate Program twice a year and teaches the annual financial management for Ambulatory Surgery Managers course. Ms. Geier is also on the AORN PNDS Data User Base task force, is a surveyor for AAAHC and speaks at national and regional meetings several times a year.

Susan Kizirian, RN, MBA, is the chief operating officer for ASCOA. Ms. Kizirian has more than 17 years experience in all aspects of ASC operations, serving as executive director and as a consultant for ASC management and development. Most recently, Ms. Kizirian worked with the University of Virginia Health System ASC program. Additionally, she has 15 years of practice management experience and eight years of expertise with clinical site research. She currently serves as lifetime past president emeritus on the board of directors of the Florida Society of Ambulatory Surgery Centers, and is past treasurer of the American Association of Ambulatory Surgery Centers and past president of the Ambulatory Surgery Management Society of the Medical Group Management Association.
Presentation

by Ann Geier and Susan Kizirian
All Roads Lead to Case Costing

- Human Resources
- Cost Drivers
- Surgeon Recruitment
- Case Costing
- Schedule Efficiency
- Charge Master
- Eliminate Losses
- Implants & Prosthetics
- Payer Contracting
- Carve Outs
Why Do Case Costing?

- Hone strategic plans
- Highlight possible opportunities & problem areas
- Address cost and revenue sources to maximize your bottom line
- Benchmark your costs against other ASCs
Historical: Cost Setting Initiatives

- Medicare – ASC vs. OPPS
  - Charges
  - Cost Surveys
  - APCs

- Milliman – 1991 selected cases
Medicare

- Fee Schedule – Origination
  - 1980 - Based on Cost extrapolations from hospital data
  - CMS (then HCFA) required to perform cost survey every 5 years (Current Rates rebased in 1990 based on 1986 cost survey plus periodic adjustment for inflation)
    - 35% of fee is Labor – with adjustor
    - 65% of fee is Overhead
    - Last cost survey 1994 – Data not useable
    - Attempted cost survey in 1998—tabled
How CMS Determined ASC Costs

- The Report of the Conference Committee accompanying section 934 of the Omnibus Budget Reconciliation Act of 1980 (Public Law 96–499), which enacted the ASC benefit in December 1980

  "This overhead factor is expected to be calculated on a prospective basis utilizing sample survey and similar techniques to establish reasonable estimated overhead allowances for each of the listed procedures which take account of volume (within reasonable limits).” (See H.R. Rep. No 1479, 96th Cong., 2nd Sess. 134 (1980).)
Medicare

- 1998 – APCs proposed (based on OPPS methodology) – majority of fees extrapolated from charge data and hospital cost data - tabled
- 2008 APC System enacted
  - Payments 65% of Hospital OPPS (HOPD Rates)
    - Relative value
    - Conversion Factor
    - HOPD Cost Survey Data
2008 Rate Setting Methodology

HOPD System

CPT \Rightarrow APC \Rightarrow Relative Weight

Relative Weight \times Conversion Factor = Payment

ASC System -- 2008

CPT \Rightarrow APC \Rightarrow Relative Weight

Relative Weight \times (Conversion Factor \times 65\%) = \$Rate
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Rate 1</th>
<th>Rate 2</th>
<th>Result 1</th>
<th>Result 2</th>
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<td>23.8649</td>
<td>8.5030</td>
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<td>8.5030</td>
<td>63.694</td>
<td>41.401</td>
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</table>

**HOPD System**

\[23.8649 \times 63.694 = 1520.05\]

\[8.5030 \times 63.694 = 541.58\]

**ASC System**

\[23.8649 \times 41.401 = 988.03\]

\[8.5030 \times 41.401 = 352.03\]
Milliman 1991 ASC Cost Survey (no longer available)

- On Selected High Volume Procedures – IOL, Arthroscopy, GI
  - Detailed costs
    - Disposable Medical Supply & Implant costs – Calculated an industry average
    - Cost of anesthetic gas, O2 per minute
    - Staff costs per minute
  - Unable to replicate most “industry average” costs
Charges
Charge Master

- Setting Charges
  - Best – Cost with mark up
  - **Most Common** – Multiple of Medicare ASC or HOPD rates with some carve outs

- Billing Charges
  - **Most Common** - Global
  - Modified Line Item
  - Line Item
Reimbursement
Reimbursement

- Reimbursement Schedules
  - Medicare
  - Medicare Like
  - Fee for Service
  - Out of Network
Reimbursement - 2

1. Federal Payers
   - Medicare
   - Tricare

2. State Payers
   - Worker’s Compensation
   - Medicaid
     - Paid according to the Surgery Case Rates
     - Obtain from State Medicaid Manual
     - All inclusive rates but some allow specific human tissue, implants and/or prosthetics
Reimbursement - 3

3. Commercial - Have own rate setting methodologies
   - Most follow closely to Medicare’s lead
   - In some cases, Commercial plans pay less than Medicare
Reimbursement - 4

“What do we get paid?”

- Depends on:
  - Payer mix
  - Payer Contracting Expertise

Example: CPT : 43239 EGD w/bx

- Medicare $427 (60%)
- Aetna $400 (20%)
- Blue Cross $550 (10%)
- “Deluxe” Plan $650 (10%)
Methodologies
Case Costing Methodologies

- Basic – Expenses/Cases
- Intermediate - \(\frac{OH}{OR \text{ Minutes}}\) + Supplies
- Complex – Cost Accounting
  - Multiple Components
  - Labor intense data collection system
  - Software Applications
- Adjunct - Costs vs. Benefits
Case Costing Methodologies - 2

- 3rd Dimension – Leadership & Implementation
Basic - Averages

Expenses \div \text{Cases} = \text{Cost/Case}

(\text{Reimbursement} - \text{Expenses}) \div \text{Cases} = \text{Profit/Case}
Basic - 2

**Advantages**
- Simple Accounting
- Not labor intense

**Disadvantages**
- Don’t know:
  - Which procedures are winners
  - what to focus on
Intermediate

Step 1: By Accounting Period (Month)
Overhead (minus Supplies) ÷ OR Minutes = O/H Per OR Min

Step 2: By 1° CPT/Surgeon:
(OR Mins x O/H per OR Min) + Supplies = Case Cost
Intermediate - 2

Step 3: By 1º CPT/Surgeon/Payer:

Reimbursement - Cost By Surgeon Per CPT = Profit Per Case
Intermediate - 3

**Advantages**
- Lumps expenses into small number of categories
- Gives you Surgeon, CPT and Payer Specific Data
- Allocates all costs to OR utilization (which is THE revenue generation activity)

**Disadvantages**
- Requires higher order of knowledge & skills
- Lumps expenses into categories
Intermediate - 4

Requirements –

- Accounting Software
  - COA’s
    - Labor – Administrative & Clinical
    - Services
    - Rent
    - Medical Supplies
      - Disposable Medical
      - Pharmaceuticals
      - Implants & Prosthetics
Intermediate - 5

- ASC Software
  - Inventory
  - OR Log
  - Scheduling
  - AR
  - Reports
  - Preference Cards
Intermediate - 6

- Preference Cards
  - By Surgeon by CPT
    - Items Used in Preop, Anesthesia, OR, PACU
      - OR: Prep, Drapes, Gloves, Irrigation, Sponges, Suture, Meds, Needles & Syringes, Dressings, & Misc
  - Standardize
  - Keep Up to Date
Intermediate - 7

- Human Resources
  - Accounting & Bookkeeping proficiency; CPA oversight
  - ASC Software knowledge & skills
  - Materials Management & Purchasing capability
  - Excel expertise
  - Communications adept
  - Change agent know-how
Complex

- True Cost Accounting
  - Multiple Components
  - Labor intense data collection system
  - Multiple Software Applications
<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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<tr>
<td>Detail knowledge</td>
<td>Complex</td>
</tr>
<tr>
<td>Slight tweaks can have major impact</td>
<td>Labor Intensive</td>
</tr>
<tr>
<td></td>
<td>Costs outweigh benefits</td>
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</table>
Cost vs. Benefit

- Cost of Procedure or Service vs. Reimbursement

- Need to have at a minimum the Intermediate Case Costing Methodology in place to be useful
# Cost vs. Benefit - 2

## Cost Benefit Analysis

### Holmium Laser

**Procedures Impacted:**
- 53210 - Cystourethroscope with removal of calculus
- 52317 - Lithotripsy, crushing or fragmentation of calculus by any means; simple (less than 2.5 cm)
- 52318 - Lithotripsy (as above); complex (over 2.5 cm)
- 52352 - Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus
- 52353 - Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy

<table>
<thead>
<tr>
<th>Equipment (5 Yr)</th>
<th>$55,000</th>
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<tr>
<td>Accessories</td>
<td>$4,500</td>
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<tr>
<td>Maintenance (5 Yr)</td>
<td>$19,250</td>
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<td>$78,750</td>
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### Equipment Cost/Case

#### Volume Based

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<th>Cycles Per Year</th>
<th>Per Case Supplies</th>
<th>$170</th>
<th>$170</th>
<th>$170</th>
<th>$170</th>
<th>$170</th>
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<tbody>
<tr>
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<td>$474</td>
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<td>Stent</td>
<td>$72</td>
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<td>$72</td>
<td>$72</td>
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<tr>
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<td>Laser Fiber</td>
<td>$60</td>
<td>$60</td>
<td>$60</td>
<td>$60</td>
<td>$60</td>
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<tr>
<td></td>
<td>Equipment</td>
<td>$630</td>
<td>$315</td>
<td>$210</td>
<td>$156</td>
<td>$79</td>
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</table>

### Weighted Averages

| Total Cost Per Case | $1,406 | $1,091 | $966 | $934 | $855 |
## Cost vs. Benefit - 3

### Cost Benefit Analysis:

**Holmium Laser**

<table>
<thead>
<tr>
<th>Annual Volume</th>
<th>Procedures Impacted</th>
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<tr>
<td>18</td>
<td>52317 - Litholaapaxy; crushing or fragmentatin of calculus by any means; simple (less than 2.5 cm)</td>
</tr>
<tr>
<td>0</td>
<td>52318 - Litholaapaxy (as above); complex (over 2.5 cm)</td>
</tr>
<tr>
<td>164</td>
<td>52352 - Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus</td>
</tr>
<tr>
<td>27</td>
<td>52353 - Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy</td>
</tr>
<tr>
<td></td>
<td>Secondary procedure - 52310 - Cystoscopy with removal of stent</td>
</tr>
<tr>
<td></td>
<td>Secondary procedure - 52332- 59 Cystoscopy, with insertion of indwelling ureteral stent</td>
</tr>
</tbody>
</table>

### Per Case Analysis (assuming 200 cases per year)

<table>
<thead>
<tr>
<th>PAYER</th>
<th>PRIMARY PROC FACILITY REIMB</th>
<th>2NDRY PROC FACILITY REIMB</th>
<th>TOTAL REIMB</th>
<th>FACILITY COST</th>
<th>FACILITY INCOME (LOSS)</th>
<th>PROJECTED INCOME (LOSS)</th>
<th>% CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCR</td>
<td>$605</td>
<td>$214</td>
<td>$819</td>
<td>$855</td>
<td>($35.65)</td>
<td>($601.90)</td>
<td>7%</td>
</tr>
<tr>
<td>CHP</td>
<td>$988</td>
<td>$342</td>
<td>$1,310</td>
<td>$855</td>
<td>$455.00</td>
<td>$34,580.00</td>
<td>38%</td>
</tr>
<tr>
<td>BCBS</td>
<td>$817</td>
<td>$229</td>
<td>$1,046</td>
<td>$855</td>
<td>$191.00</td>
<td>$6,494.00</td>
<td>17%</td>
</tr>
<tr>
<td>HPSE</td>
<td>$909</td>
<td>$321</td>
<td>$1,229</td>
<td>$855</td>
<td>$374.00</td>
<td>$19,448.00</td>
<td>28%</td>
</tr>
<tr>
<td>OTHER</td>
<td>$788</td>
<td>$241</td>
<td>$1,009.00</td>
<td>$855</td>
<td>$154.00</td>
<td>$3,896.00</td>
<td>12%</td>
</tr>
</tbody>
</table>

| Total  | $63,716.10                  |                           |             |               |                        |                        | 100%    |
COST DRIVERS

- Cost Drivers
  - Rent
  - Service Contracts
  - Labor
  - Supply Costs
  - OR Utilization
  - Physician Variables
    - OR Time & Utilization
    - Supplies
    - Surgeon Preferences
    - Anesthesia Preferences
Rent

- Cost per Sq Foot
- CAM (Common-Area Maintenance) Charges
- Varies by Site
  - New Projects
  - Existing Projects
Service Contracts - Equipment

- Required for Equipment & Building:
  - Electrical Safety
  - Anesthesia Machines & Monitors
  - HVAC
  - Emergency Generator
  - Vacuum Pump
  - C-Arm (tube)
  - Gas Manifold
Service Contracts – Equipment 2

- **Required:**
  - high volume endoscopy services should carry contracts on the scopes

- **Not Recommended:**
  - microscopes,
  - monitors (anesthesia gas monitors should be part of the anesthesia machine contract,
  - cautery
  - video equipment
Service Contracts – Equipment 3

- **Required:**
  - Other Hi Tech Equipment

- **PM Service Contract Options:**
  - $ - PM check only, technician labor and travel time. For some hi-tech equipment this will include software releases/upgrades
  - $$ - The above plus parts are included
  - $$$ - The above plus labor and travel time for non-PM service (not recommended)

*hi-tech equipment where software releases/upgrades are part of the service contract
Service Contracts - 4

- Linen & Laundry
- Cleaning
- Fire Systems
- Other
Labor

- Allocate globally
  - Types:
    - Direct:
      - Specific activities tracked to specific patient
    - Indirect:
      - Activities necessary to provide services that are not directly tracked to specific patient
Supplies

- Disposable Medical
  - Case Specific
    - Preop, OR, PACU
      - Routine supplies
      - Pharmaceuticals
      - Gases
    - Surgeon Preference
      - Procedure specific supplies
      - Pharmaceuticals
      - Implants & Prosthetics
Supplies - 2

- Anesthesia
  - Routine Supplies
  - Pharmaceuticals
  - Gases

- Supplies – Other
  - Necessary to provide services either non-medical or not directly tracked to a specific patient

- Implants & Prosthetics
  - Demand vs. Preference
  - Device Benefits Managers
OR Utilization

- **Cost per minute to operate OR**
  - OR Time: Patient Out Time – Patient In Time
  - Total Expenses for accounting period minus supply costs divided by Total OR time in minutes for same time period

- **Schedule Utilization**
  - Compress Unused Time
Intermediate – More
Preference Card

<table>
<thead>
<tr>
<th>SUPPLIES IN COMMON</th>
<th>SUPPLIES THAT DIFFER</th>
</tr>
</thead>
<tbody>
<tr>
<td>ITEM</td>
<td>PRICE</td>
</tr>
<tr>
<td>-----</td>
<td>-------</td>
</tr>
<tr>
<td>PRE-OP</td>
<td></td>
</tr>
<tr>
<td>ANESTHESIA</td>
<td></td>
</tr>
<tr>
<td>OR/PROCEDURE ROOM</td>
<td></td>
</tr>
<tr>
<td>prep</td>
<td></td>
</tr>
<tr>
<td>grapes</td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
</tr>
<tr>
<td>Cautery</td>
<td></td>
</tr>
<tr>
<td>Irrigation</td>
<td></td>
</tr>
<tr>
<td>Sponges</td>
<td></td>
</tr>
<tr>
<td>Suture</td>
<td></td>
</tr>
<tr>
<td>Meds</td>
<td></td>
</tr>
<tr>
<td>Needles and syringes</td>
<td></td>
</tr>
<tr>
<td>Dressings</td>
<td></td>
</tr>
<tr>
<td>Misc</td>
<td></td>
</tr>
<tr>
<td>PACU</td>
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</table>

TOTAL

Average time in minutes

NAME OF YOUR FACILITY
NAME OF PROCEDURE/CPT CODE /DATE
# Analyzing Case Cost

**Instructions**

1. Complete the name of your facility at the top of the form
2. Enter the Name of the procedure/ CPT code and date you are completing
3. Enter all of the physicians names or their ID number in the space marked "Doctor"

4. **Enter items and prices that are common to all of the doctors in the first column (Column A) of the form**
5. **Enter all of the items that differ from the other physicians in their column of the form**

6. If you are not familiar with excel you can add lines by placing your arrow over the number on the far left side of the page and "insert row".

7. Account for all items utilized for your patient from admission to discharge for the CPT that is being reviewed.

| **DO NOT INCLUDE** | Medical gases, linen's, cleaning supplies or office supplies |

8. When listing a supply that is routinely **reprocessed**, indicate this by adding an **R after the Price**
9. When listing a supply that is a **multiuse** item - indicate this by adding an **M after the Price**

10. Please group your items under the subheadings when possible
11. Enter the average room time* for each physician doing the procedure.
12. Lastly email the completed form to schottbj@aol.com by the 15th of the month and a copy to your VP

* Room time is the time your patient enters the OR until they leave the OR
NAME OF FACILITY

COST COMPARISON

DATE: 
Procedure: 

<table>
<thead>
<tr>
<th>SUPPLIES IN COMMON</th>
<th>Doc Name</th>
<th>Doc Name</th>
<th>Doc Name</th>
<th>Doc Name</th>
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<tbody>
<tr>
<td>ITEM</td>
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</table>

<table>
<thead>
<tr>
<th>SUPPLIES THAT DIFFER</th>
<th>ITEM</th>
<th>PRICE</th>
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<tbody>
<tr>
<td>TOTAL COST</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| AVERAGE OR TIME      |        |       |        |       |        |       |        |       |        |       |

| OPPORTUNITIES:       |        |       |        |       |        |       |        |       |        |       |

ANNUAL REALIZATION IN REVENUE
Proposed change times number of cases annually equals = potential annual savings to facility
## NAME OF FACILITY

### COST COMPARISON

**DATE:** 8-2005  
**Procedure:** BMTs

### SUPPLIES IN COMMON

<table>
<thead>
<tr>
<th>ITEM</th>
<th>DR. A PRICE</th>
<th>DR. B PRICE</th>
<th>DR. C PRICE</th>
<th>DR. D PRICE</th>
<th>DR. E PRICE</th>
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<td>Circuit</td>
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<td>$10.02</td>
<td>$10.02</td>
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### SUPPLIES THAT DIFFER

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<th>ITEM</th>
<th>DR. A PRICE</th>
<th>DR. B PRICE</th>
<th>DR. C PRICE</th>
<th>DR. D PRICE</th>
<th>DR. E PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tubes</td>
<td>$9.92</td>
<td>$9.92</td>
<td>$17.28</td>
<td>$38.00</td>
<td>$19.20</td>
</tr>
<tr>
<td>Collar Button</td>
<td>$39.25</td>
<td>$39.25</td>
<td>$39.25</td>
<td>$39.25</td>
<td>$2.95</td>
</tr>
<tr>
<td>Floxin</td>
<td>$5.70</td>
<td>$2.85</td>
<td>$5.70</td>
<td>$5.70</td>
<td>$2.85</td>
</tr>
<tr>
<td>Cannister</td>
<td>$1.07</td>
<td>$1.07</td>
<td>$1.07</td>
<td>$1.07</td>
<td>$1.07</td>
</tr>
</tbody>
</table>

**TOTAL COST**

<table>
<thead>
<tr>
<th>DR. A</th>
<th>DR. B</th>
<th>DR. C</th>
<th>DR. D</th>
<th>DR. E</th>
</tr>
</thead>
<tbody>
<tr>
<td>$83.15</td>
<td>$80.30</td>
<td>$90.51</td>
<td>$71.98</td>
<td>$43.02</td>
</tr>
</tbody>
</table>

### AVERAGE OR TIME

<table>
<thead>
<tr>
<th></th>
<th>13</th>
<th>17</th>
<th>14</th>
<th>45</th>
<th>16</th>
</tr>
</thead>
</table>

### OPPORTUNITIES:

- Use only one suction per case
- Change to single use Floxin

### ANNUAL REALIZATION IN REVENUE

Proposed change times number of cases annually equals = potential annual savings to facility

- Floxin: $11,456.64 annually based on 312/year
- Suction: $1,057.68 annually based on 312/year
## Analyzing Case Costs

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure</th>
<th>Payer</th>
<th>Standard Charge</th>
<th>OR Mins</th>
<th>O/H Costs $28.66/ min</th>
<th>Supply Costs</th>
<th>O/H Costs Plus Supply Costs</th>
<th>Reimb</th>
<th>% Collected</th>
<th>Income (Loss)</th>
<th>Collection Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>28296</td>
<td>CORRECTION, HALLUX VALGUS</td>
<td>MCD</td>
<td>6,662</td>
<td>78</td>
<td>2,235</td>
<td>244</td>
<td>2,480</td>
<td>507</td>
<td>7.61%</td>
<td>-1,973</td>
<td>PAID</td>
</tr>
<tr>
<td>28296,28285,8699X2</td>
<td>CORRECTION, HALLUX VALGUS</td>
<td>BC</td>
<td>11,412</td>
<td>74</td>
<td>2,121</td>
<td>256</td>
<td>2,377</td>
<td>3,018</td>
<td>26.44%</td>
<td>641</td>
<td>PAID</td>
</tr>
<tr>
<td>28296,28285X2,28270X2,8699X2</td>
<td>CORRECTION, HALLUX VALGUS</td>
<td>BC</td>
<td>25,786</td>
<td>100</td>
<td>2,866</td>
<td>347</td>
<td>3,213</td>
<td>23,328</td>
<td>90.47%</td>
<td>20,115</td>
<td>PAID</td>
</tr>
<tr>
<td>28296,28126,28288,8699</td>
<td>CORRECTION, HALLUX VALGUS</td>
<td>BC</td>
<td>15,952</td>
<td>95</td>
<td>2,723</td>
<td>250</td>
<td>2,973</td>
<td>6,592</td>
<td>41.33%</td>
<td>3,620</td>
<td>PAID</td>
</tr>
<tr>
<td>28296,8699</td>
<td>CORRECTION, HALLUX VALGUS</td>
<td>CIGNA</td>
<td>6,662</td>
<td>77</td>
<td>2,207</td>
<td>242</td>
<td>2,449</td>
<td>0</td>
<td>0.00%</td>
<td>-2,449</td>
<td>Carrier Issue-Claim is in process</td>
</tr>
<tr>
<td>TOTALS</td>
<td></td>
<td></td>
<td>66,474</td>
<td>424</td>
<td>12,152</td>
<td>1,339</td>
<td>13,491</td>
<td>33,445</td>
<td>50.31%</td>
<td>19,954</td>
<td></td>
</tr>
</tbody>
</table>

### Notes:
- **Payer** indicates the insurance provider.
- **Standard Charge** represents the standard charge for the procedure.
- **OR Mins** denotes the operating room minutes.
- **O/H Costs** and **Supply Costs** are expenses associated with the procedure.
- **Reimb** shows the reimbursed amount.
- **% Collected** indicates the percentage of reimbursement collected.
- **Income (Loss)** reflects the net income after expenses.
- **Collection Status** denotes whether the claim is paid or in process.

### Summary:
- The total standard charge for the procedures is $66,474.
- The total operating room minutes is 424.
- The total O/H costs are $12,152.
- The total supply costs are $1,339.
- The total reimbursed amount is $13,491.
- The total income (considering the loss) is $33,445.
- The total collection status is $19,954.
High Impact Metrics
High Impact Metrics

- Actual cases as % of projected cases
- Case per day
- Collections as % of charges
- Supplies as % of collections
- Payroll as % of collections
- AR – days outstanding
- AR & AP % current
Cases % of Projected

- Before development, we estimate the expected case volume.
- If you’re not reaching anticipated case volume, you need to know why.
- If case volume falls significantly short of plan, losses can result.
- Quality care and efficiency will attract additional cases.
Cases / Projected

Excellent > 172%

Average = 115%

Poor < 58%

Apr-07  May-07  Jun-07  Jul-07  Aug-07  Sep-07  Oct-07  Nov-07  Dec-07  Jan-08  Feb-08  Mar-08
Cases per Day

- Measure of ‘throughput’.
- More cases performed per day means lower per case overhead costs.
- Wage costs for a day of surgery is relatively fixed.
Cases per Day

Average Cases per Day

- Excellent > 33
- Average = 24
- Poor < 15

Apr-07 May-07 Jun-07 Jul-07 Aug-07 Sep-07 Oct-07 Nov-07 Dec-07 Jan-08 Feb-08 Mar-08
Collections as % of Charges

- If % too low then perhaps billing or collections are troubled.
- If % is too high, you are likely either not charging enough or cleaning up an AR problem.
- Can only assess this metric well over several months.
Collections as % of Charges

- Excellent > 32%
- Average = 25%
- Poor < 19%

Month:
- Apr-07
- May-07
- Jun-07
- Jul-07
- Aug-07
- Sep-07
- Oct-07
- Nov-07
- Dec-07
- Jan-08
- Feb-08
- Mar-08
Supplies % of Collections

- Always one of top two ASC costs
- Largely physician driven - but you can guide them
- Reduce cost by sourcing through group purchasing organizations (GPO)
- Case costing critical to reduce
- Provide recommended preference cards
Supplies % of Collections

Medical Supplies % of Collections

Poor > 27%

Industry Median = 22%*

Average = 20%

Excellent < 14%

Payroll % of Collections

- Typically the largest single cost of an ASC.
- Compress your schedule to reduce.
- When the work is done, turn off the lights and send people home.
- Use PRN staff when possible.
- Pay more per hour for the right people.
Payroll as % of Collections

Industry Median = 27%*

Poor > 27%

Average = 22%

Excellent < 18%

Supplies and Payroll

- Can be controlled
- Change thought processes
- Track savings
- Calculate annualized savings
- Share information with staff
- Present to the Board
AR Days Outstanding

- \(((\text{Total Outstanding Charges}) / (\text{Total Monthly Charges})) \times 30\) days.
- The higher your AR days the more likely you’ll never collect.
- $ collected is $ you can pay owners.
- Clean-up pays for itself 10 - 20x.
- Success by a sound process.
AR Days Outstanding

Industry Median = 47 Days*

Poor > 38

Average = 34

Excellent < 29

AR Percentage Current

- Higher is better because you don’t want any of your AR getting old.
- An imperfect measure because you often get paid in less than 30 days which leads to a lower figure.
- You want your ‘over 30’ AR to be low due to fast collection.
AR % Current

Excellent > 77%

Average = 68%

Poor < 60%

Industry Median = 50%*

3rd Dimension – Leadership & Implementation
Typical Reaction to the Initial Preference Card Discussion

Will Scope for Food
Physician Variables - Surgeons

- Surgeons
  - OR Time – on time, speed and efficiency
  - Preferences
    - start time
    - staff
    - supplies
    - implants
    - instruments & equipment
    - medications
Physician Variables - Anesthesia

- Speed & Efficiency: degree integrated into patient & schedule flow
  - Preop review
    - Preop protocols
      - Preop testing
      - Preop meds
  - PACU protocols
    - PACU meds
    - Pt recovery time

- OR Medication protocols
- Discharge protocols
  - N/V management
  - Pain management
Stakeholder Planning

- What financial or emotional interest do they have in the outcome of your work? It is positive or negative?
- What motivates them most of all?
- What information do they want from you?
- How do they want to receive information from you? What is the best way of communicating your message to them?
Stakeholder Planning - 2

- What is their current opinion of your work? Is it based on good information?

- Who influences their opinions generally, and who influences their opinion of you?

- How will you win them around or manage their opposition?

- Who might be influencing their opinions?
**Power-Interest Grid with Stakeholders Marked**

**Controlling OR Costs**

<table>
<thead>
<tr>
<th>POWER</th>
<th>INTEREST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Grid Analysis: Most effective where there are a number of good alternatives and many factors to take into account

- Lay out your options as rows on a table.
- Set up columns to show your factors.
- Allocate weights to show the importance of these factors.
- Score each choice for each factor using numbers from 0 (poor) to 3 (very good). Multiply each score by the weight of the factor, to show its contribution to the overall selection.
- Add up the total scores for each option. Select the highest scoring option.
## Grid Analysis – C-Arm Purchase

<table>
<thead>
<tr>
<th>Factors:</th>
<th>Cost</th>
<th>Quality</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weights:</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
<th>Quality</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>GE-OEC</td>
<td>1x3=3</td>
<td>3x5=15</td>
<td>3x4=12</td>
</tr>
<tr>
<td>Siemens</td>
<td>2x3=6</td>
<td>2x5=10</td>
<td>2x4=8</td>
</tr>
<tr>
<td>Phillips</td>
<td>2x3=6</td>
<td>2x5=10</td>
<td>1x4=4</td>
</tr>
<tr>
<td>Ziehm</td>
<td>3x3=9</td>
<td>2x5=10</td>
<td>1x4=4</td>
</tr>
</tbody>
</table>

Score:
- GE-OEC: 30
- Siemens: 24
- Phillips: 20
- Ziehm: 23
Ladder of Inference*

- Our beliefs are *the* truth
- The truth is obvious
- Our beliefs are based on real data
- The data we select is the *real* data

I draw Conclusions
I add Meanings (cultural & personal)
Observable “data” and expectations (as a videotape recorder might capture it)
I adopt Beliefs about the world
I take Actions based on my beliefs
I make Assumptions based on the meanings I added
I select “Data” from what I observe

The Reflexive Loop: Our Beliefs affect what data we select next time
Dr. X is not going to comply with cost efficiencies.

Dr. X obviously thinks he doesn't have to follow the rules like the other surgeons.

Dr. X uses the most expensive supplies (as a videotape recorder might capture it).

I don't ever need to discuss supply costs with Dr. X.

Dr. X will never change; talking to him is useless.

Dr. X doesn’t embrace the cost effective culture of ABC Surgery Ctr.

Dr. X only chooses the most expensive supplies.

Ladder of Inference – An Example

Set belief every time this behavior is observed.
Using the Ladder of Inference

- What is the observable data?
- Does everyone agree on what the data is?
- Can you run through the reasoning?
- How did we get from the data to the abstract assumptions?
- When you said (what was inferred), did you mean (what was interpreted)?
Balancing Inquiry and Advocacy*

- Advocacy: Present and argue strongly for one’s position or belief
- Inquiry: Lay out reasoning and thinking to learn about others views and have them learn about yours
- Goal: Create dialogue for movement towards and acceptance of change; road to continuous improvement

---

*Senge, Peter. The Fifth Discipline Fieldbook, pgs. 253-263
Conversational Recipes for Improved Advocacy

<table>
<thead>
<tr>
<th>What to Do</th>
<th>What to Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>- State your assumptions and describe the data that led to them</td>
<td>- “Here is what I think, and here is how I got there?”</td>
</tr>
<tr>
<td>- Explain your assumptions</td>
<td>- “I assumed that . . .”</td>
</tr>
<tr>
<td>- Make your reasoning explicit.</td>
<td>- “I came to this conclusion because . . .”</td>
</tr>
</tbody>
</table>
Conversational Recipes for Improved Inquiry

What to Do

- Gently walk down the ladder of inference and find out what data they are operating from.

- Use unaggressive language, particularly with people you are not familiar with these skills. Ask in a way which does not provoke defensiveness.

- Check your understanding of what they have said.

What to Say

- “What leads you to conclude that? What data do you have for that? What causes you to say that?”

- “Instead of “What do you mean?” Or “What’s your proof?” Say “Can you help me understand your thinking here?”

- “Am I correct that you’re saying . . .”
Conversational Recipes for Balancing Advocacy with Inquiry

When . . .

- Strong views are expressed without any reasoning or illustrations
- The discussion goes off on an apparent tangent . . .
- You perceive a negative reaction in others . . .

. . . You might say

- “You may be right, but I’d like to understand more. What leads you to believe . . .?”
- “I’m unclear how that connects to what we’ve been saying. Can you say how you see it as relevant?”
- “When you said (give example)...I had the impression you were feeling (fill in emotion). If so, I’d like to understand what upset you.”
Benchmarking

- MGMA – ASC Performance Survey
- ASCA
  - Salary & Benefits Survey
  - Financial Benchmarks
  - Benchmarking for Dummies
- Peer Facilities Network
Benchmarking: Overview

- Process of establishing a standard of excellence and comparing activities to that standard
- Provides goals for process improvement
- Provides understanding of the changes to facilitate improvement
- An ongoing process - not a one-time event
Benchmarking: Benefits

1. Understand your strengths and weaknesses
2. Objectively evaluate your own performance
3. Compare measurements externally against peers and “better performers”
4. Analyze what others do, so you can learn from their experience (and not make the same mistakes)
5. Convince internal audiences of the need for change
Benchmarking: 10 Step Process

1. Establish practice objectives and strategy
2. Identify performance indices
3. Identify benchmark sources available
4. Data collection
5. Perform data comparison
6. Communicate findings
7. Develop action and assessment plans
8. Implement plans and monitor progress
9. Assess practice objectives; evaluate benchmark standards; recalibrate measurements
10. REPEAT!
MGMA ASC Performance Survey

- Medical Group Management Association: ASC Performance Survey [www.mgma.com](http://www.mgma.com)
  - Compares Specific Overhead Costs
    - Per OR
    - Per 1000 cases
    - Per Annual caseload
    - Per Selected Specialties (Ophthalmology & GI)
MGMA Survey

- **Report Tables**
  - Accounts Receivable
  - Payer Mix
  - Staffing and Cost
  - Operating Cost Categories
  - Clinical Outcome Measures (demographic only)

- **Standards**
  - Aggregate
  - As a Percent of Medical Revenue
  - Per Square Foot
  - Per Case
  - Per Procedure
  - Per Operating Room
## Key Performance Indicators

<table>
<thead>
<tr>
<th></th>
<th>Cases 1,999 or fewer</th>
<th>Cases 2,000 to 2,999</th>
<th>Cases 3,000 to 4,999</th>
<th>Cases 5,000 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Case Volume</td>
<td>1303</td>
<td>2547</td>
<td>4100</td>
<td>6208</td>
</tr>
<tr>
<td>Total Cases per month</td>
<td>109</td>
<td>212</td>
<td>342</td>
<td>517</td>
</tr>
<tr>
<td>Total Procedures</td>
<td>1949</td>
<td>2985</td>
<td>5088</td>
<td>8547</td>
</tr>
<tr>
<td>Total Gross Charges</td>
<td>$3,065,495</td>
<td>$4,126,365</td>
<td>$6,718,497</td>
<td>$13,742,500</td>
</tr>
<tr>
<td>Total Medical Revenue</td>
<td>$1,422,021</td>
<td>$2,228,451</td>
<td>$3,879,094</td>
<td>$6,449,700</td>
</tr>
<tr>
<td>Total Medical Revenue per Case</td>
<td>$962.92</td>
<td>$882.90</td>
<td>$1,068.52</td>
<td>$912.11</td>
</tr>
<tr>
<td>Total Employed Support Staff</td>
<td>9.30</td>
<td>13.12</td>
<td>24.06</td>
<td>33.75</td>
</tr>
<tr>
<td>Total empl support staff cost as a % of medical revenue</td>
<td>25.00%</td>
<td>23.91%</td>
<td>24.86%</td>
<td>24.63%</td>
</tr>
<tr>
<td>Medical and surgical supply as a % of medical revenue</td>
<td>20.37%</td>
<td>18.14%</td>
<td>16.40%</td>
<td>20.01%</td>
</tr>
<tr>
<td>Medical and surgical supply cost</td>
<td>$304,773</td>
<td>$460,627</td>
<td>$730,919</td>
<td>$1,313,403</td>
</tr>
<tr>
<td>Medical and surgical supply cost per case</td>
<td>$232.91</td>
<td>$180.85</td>
<td>$179.42</td>
<td>$194.29</td>
</tr>
<tr>
<td>Total Operating Cost per Case</td>
<td>$895.28</td>
<td>$670.06</td>
<td>$765.23</td>
<td>$657.85</td>
</tr>
<tr>
<td>Net Inc from Operations as a % of medical revenue</td>
<td>23.29%</td>
<td>26.80%</td>
<td>32.09%</td>
<td>33.39%</td>
</tr>
<tr>
<td>Net Income from Operations</td>
<td>$335,127</td>
<td>$469,258</td>
<td>$1,185,579</td>
<td>$1,836,585</td>
</tr>
<tr>
<td>Net Income per Case</td>
<td>$289.20</td>
<td>$210.28</td>
<td>$292.90</td>
<td>$262.03</td>
</tr>
</tbody>
</table>

Source: MGMA ASC Performance Survey: 2003 Report Based on 2002 Data
ASCA Salary & Benefits Survey

- The leading and only comprehensive ASC salary survey
  - National, Regional and Select State Data
  - Salaries for 17 ASC Positions
  - Bonus Information
  - Employee Benefits Data
ASCA Financial Benchmarks

- Key ASC Indicators
- Performance Ratios
- Accounts Receivable
- Costs Per Case
- Salaries and Benefits
- Medical Supplies and Drug
ASCA Financial Benchmarks

Cost Per Case - All ASCs

- Salaries & Benefits: 36%
- Medical Supplies & Drugs: 25%
- Building Lease & Depreciation: 8%
- Miscellaneous: 31%

ASCA Financial Benchmarks - 2

- Operational Information
  - Accounting Method
  - Anesthesia Professional Type
  - Anesthesia Service Arrangements
  - ASC Location
  - Facility Accreditation & Organization
  - Facility Size (Total Square Feet)
  - Facility Size (Square Feet per OR/Procedure Room)
  - Patient Encounter Distribution
  - Payer Mix
ASCA Financial Benchmarks - 3

- Procedure Specific Data
  - Gross Charges Per Case
  - Net Revenue Per Case
  - Costs Per Case – Medical Supplies & Drugs
  - Minutes Per Case
ASCA Financial Benchmarks - 4

- Procedure Specific Data
  - CPT 29826 – Shoulder Arthroscopy
  - CPT 29877 – Knee Arthroscopy
  - CPT 42820 – Remove Tonsils & Adenoids
  - CPT 45380 – Colonoscopy with Biopsy
  - CPT 66984 – Cataract Surgery w/IOL
  - CPT 69436 – Create Eardrum Opening
  - Others
ASCA Financial Benchmarks - 5

- Financial Statements
  - Per Case
  - Per Case by Specialty
  - Per OR/Procedure Room Hour
  - Per Patient Hour
  - Per OR/Procedure Room
  - Per OR: 1-2, 3, 4-5, > 5
  - By Ownership
  - Multi-specialty, Single Specialty
  - Per Square Foot
  - Years in Operation: 1-3, 4-6, 7-10, > 10
Benchmarking: Analysis

1. What differences exist between your facility’s data and the survey report values?

2. Do the differences indicate that a performance outcome is significantly or negligibly out of line with the survey?
   - Are the differences reasonably explained? (i.e., data collection, definitional)
   - How great have special circumstances such as the market competitiveness or regulatory changes affected the outcome?
3. By what methods can the financial or operational indicator be internally and/or externally changed or controlled?

4. How should your ASC measure performance for the financial or operational indicators that represent the organization’s most challenging shortcomings?
   - Do your systems and processes allow for the appropriate assessment of the indicator?
Managing the Bottom Line

- Cost Drivers
  - Surgeon Recruitment
  - Eliminate Loss Procedure(s)
  - Implants & Prosthetics
- Human Resources
- Schedule Efficiency
- Charge Master
- Carve Outs
- Payer Contracting

Case Costing
Speaker contact information

Ann Geier  
Ambulatory Surgical Centers of America  
Phone: (843) 216-2432  
E-mail: ageier@ascoa.com  
Web site: www.ascoa.com

Susan Kizirian  
Ambulatory Surgical Centers of America  
Phone: (850) 510-8203  
E-mail: skizirian@ascoa.com  
Web site: www.ascoa.com