

## 2007 FREESTANDING AMBULATORY SURGERY CENTER SURVEY (FASCS)

January 1, 2007 through December 31, 2007

### - IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, .09 and other regulations or statutes.

The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

### 2007 FREESTANDING AMBULATORY SURGERY CENTER SURVEY ACCESS FORM

The 2007 Freestanding Ambulatory Surgery Center Survey (FASCS) can be completed using an online interface. Microsoft Access databases will no longer be used to collect survey information. Providers of cardiac catheterizations may access the online survey by pointing their web browser to <http://www.georgiahealthdata.info/>. Notification letters were mailed to facility administrators regarding the 2007 FASCS which included a unique facility identification number (UID) and a facility password. Both the UID and password will be needed to access and complete your survey. Instructions for accessing and completing the web-based survey are provided at the Health Planning Surveys web interface (<http://www.georgiahealthdata.info/>).

**The deadline for filing the completed webform for your facility is October 3, 2008.**

**Survey Completion Status** – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division, the survey is considered a public record. Generally, the survey will be deemed complete on the day it is received by DCH. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date.

**Copy of Completed Survey** – The webform allows for printing (or saving) at completed copy of the survey. It is extremely important that you retain a copy of your completed survey. You must have your browser's pop-up blocker turned off for our website for the save and print feature to function properly.

**Revising or Amending the Survey** – Pursuant to Rule 111-2-2-.04(1)(e) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions.

**Data Validation Requirements** – Once you are ready to submit the survey, you can determine if the required survey totals are in balance and that all required items are complete by clicking the "submit survey" button. This button produces a message containing a description of any out of balance totals and any required data items that are missing. If there are no errors you will get a message thanking you for submitting the survey.

**PART A: GENERAL INFORMATION**

**Facility Name and Address** – Please provide your facility’s current name and address as requested.

**Medicaid and Medicare Numbers** – Please enter the appropriate numbers for your facility. Do not enter dashes or alpha characters for either provider number.

**Report Period** - The required report period is January 1, 2007 to December 31, 2007. If the facility was in operation a full year, 12 months of data must be reported even if the ownership or management of the facility changed. It is the responsibility of the current owner or operating entity to obtain data from the prior owner/operator if necessary. Please note if the facility was not in operation for the entire report period.

**PART B: SURVEY CONTACT INFORMATION**

Please provide contact information for the individual authorized to respond to questions regarding your facility’s survey.

**PART C: OWNERSHIP, OPERATION AND MANAGEMENT**

Please provide the following information as applicable to your facility. If certain fields do not apply the form will allow you to enter only “Not Applicable” in the Full Legal Name column.

**1.a & 1.b - Owner** - Provide the full legal name of the facility’s owner and the owner’s parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change of ownership that has occurred since December 31, 2006.

**1.c & 1.d - Operator** - If the operating entity is other than the owner, provide the full legal name of the facility’s operator and operator’s parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change in operating entity that has occurred since December 31, 2006.

**1.e & 1.f - Manager** - If a management contract is in effect, provide the full legal name of the facility manager and the manager’s parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change in management contractor that has occurred since December 31, 2006.

**PART D: AMBULATORY SURGERY ROOMS, PROCEDURES AND PATIENTS**

**Definition of procedure:** The relationship between the number of surgical patients and the number of surgical procedures to be reported depends upon whether a patient has two or more unrelated operations at the same time. The count of patients and procedures may often be the same for a single patient encounter because all surgical functions/processes are carried out as integral parts of a whole, and therefore, would constitute a single procedure. However, when an unrelated function/process is done (while the surgeon has the patient in surgery) that is not an integral part of the whole (i.e., the primary reason for the surgery), the additional surgery would be considered an additional procedure(s). When the latter occurs, report an additional procedure(s) for that patient. If a person leaves surgery and later returns, that person should be counted as a second patient for the second patient encounter.

**D.1.A – Operating Procedure Rooms** - Provide the number of “procedure rooms” in the Ambulatory Surgery Center, the number of procedures performed in those rooms, and the number of patients receiving procedures in those rooms. Pursuant to the licensure rules of the Department of Human Resources Rule 290-5-33-.01(u), 290-5-.10, and Department of Community Health Rule 111-2-2-.40(2)(n), “procedure room” means any room or area of the ambulatory surgical treatment center in which surgical procedures are performed. “Procedure rooms” should include all rooms authorized through the CON process and/or added through other CON-authorized means. Provide the number of procedures, and patients receiving such procedure(s), under the authorized license or permit to operate an ambulatory surgical center issued by the Department of Human Resources.

**D.1.B – Other Procedure and Endoscopy Rooms** – Provide the number of rooms, procedures, and patients for rooms at your facility where minor endoscopy procedures were performed.

**D.2 - Hospital Admissions** - Please complete as requested.

**D.3 - Race/Ethnicity** - Report the number of unduplicated patients by the categories as defined by the United States Census bureau. Please note that total patients reported here should balance to totals reported by gender below and also to the total number of patients reported in Part I (Patient Origin).

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Multi-Racial: A person having racial origins from two or more of the above definitions.

**D.4 – Gender** – Report as requested. Please note that total patients by gender and total patients by race should balance to the total number of patients reported in Part I (Patient Origin). Total patients by gender **must** equal the total number of patients reported in Patient Origin.

## **PART E: SURGICAL PROCEDURES IN CON-AUTHORIZED ROOMS**

Please complete this section as requested. Be sure to include the CPT codes. The sum of these procedures should not be larger than the total reported in Part D.

## **PART F: UTILIZATION AND REVENUE BY PAYER SOURCE**

**F.1 – Revenue by Payer** - Provide the total patients, number of visits, Gross Patient Revenue, and Net Patient Revenue during the Required Report Period. On the line for "managed care", report the ambulatory surgery center's total patients, total visits, gross patient revenue and net patient revenue for managed-care third party payers such as HMO's, PPOs, etc. Enter "0" if there were none. Since it is possible for the same patient to be served and counted under two or more payment sources, the total patients reported here may exceed those reported elsewhere as unduplicated patients.

**F.2 – Indigent and Charity Care** – Provide the number of patients treated and the number of procedures performed in the CON-Authorized operating procedure rooms where the patient was considered to be an indigent or charity care case.

## **PART G: FINANCIAL SUMMARY AND INDIGENT AND CHARITY CARE INFORMATION**

Information concerning access to health care services, including freestanding ambulatory surgery centers, is vital to the Health Planning Division's planning and regulatory functions. One measure of financial access is the amount of care provided to persons unable to pay.

Provide information concerning the ambulatory surgery center's policies during the report period, if any, concerning the provision of indigent/charity care. Do not provide information concerning policies commencing after the end of the report period.

**Indigent Care** - Indigent care should be defined and reported as unpaid charges for services to patients whose family income is less than or equal to 125% of the Federal Poverty Guidelines.

**Charity Care** - Indicate whether the policy included provision for care defined as charity care for the purposes of this survey, *i.e.*, whether the policy included provision for care for patients whose incomes exceeded 125% of Federal Poverty Guidelines.

**Revenue** - Report ambulatory surgery center revenue data for the calendar-year report period as instructed below. If any revenues are shared between the ambulatory surgery center and another entity such as a hospital, report only that portion allocable to the ambulatory surgery center.

**Gross Patient Revenue** - Report the ambulatory surgery center's gross patient revenue. Gross patient revenue includes charges generated by all patients at full, established rates and before provisions for contractual and other adjustments, including any revenue forgone for indigent or charity patients at full, established rates.

**Deductions From Gross Patient Revenue** - Report all deductions from gross patient revenue as specified for each item. Deductions from gross patient revenue include contractual and other adjustments deducted from gross patient revenue to determine net patient revenue. For the purposes of this survey, uncompensated indigent care and charity care (*i.e.*, the revenue forgone for indigent or charity patients at full established rates) are reported as deductions from revenue. For the purposes of this survey, bad debt is reported as a deduction from revenue rather than as an expense. (See instructions below at "bad debt.") If any recoveries of amounts reported in prior years as deductions from revenue (uncompensated indigent/charity care, bad debt, or other) were made, reduce the same deduction category in the year of the recovery by the amount of the recovery.

**Contractual Adjustments** - Contractual adjustments are the differences between charges at full, established rates and amounts received, or to be received, from third-party payers under contractual agreements. For patients covered by third-party payers, any charges not paid by the third-party payers which cannot be billed to the patient are to be reported as contractual adjustments; however, charges for which the patient can be billed (*e.g.*, periods of service not covered, services not covered, and deductibles/coinsurance) may be included in charity care if the patient qualified as a charity care case under your facility's charity care policy guidelines.

**Medicare Contractual Adjustments** - Report contractual adjustments for Medicare separately from all other contractual adjustments.

**Medicaid and Peachcare for Kids Contractual Adjustments** - Report contractual adjustments for Medicaid separately from all other contractual adjustments. Include Contractual Adjustments for Peachcare for Kids and Medicaid CMO programs with Medicaid Contractual Adjustments.

**Other Contractual Adjustments** - Report contractual adjustments for all payers other than Medicare and Medicaid, *e.g.*, contractual adjustments for Blue Cross-Blue Shield, HMOs, PPOs, CHAMPUS, etc. "Other contractual adjustments" should not include amounts properly classified as "other free care" for the purposes of this survey.

**Bad Debt** - While bad debt may be reported as an expense in the your facility's financial statements, it must be reported as a deduction from revenue in this survey. Generally, the amount recorded as "bad debt expense" in the ambulatory surgery center's accounting records should be reported as a deduction from revenue in this survey, adjusted according to the following instructions. For the purposes of this survey, report as bad debt all patient charges due from patients or other responsible parties which have not been or are not expected to be collected for patients not identified as having income levels 125% of Federal Poverty Guidelines (FPG) and which are not otherwise categorized as charity care, contractual adjustments, or other free care for the purposes of this survey. For the purposes of this survey, services for patients identified as having income levels 125% of FPG is to be included in "indigent care" even if the ambulatory surgery center wrote off the amount as bad debt. For the purposes of this survey, bad debt may include amounts which otherwise would have been reported as charity care if all requirements for reporting those amounts as charity care had not been met. Note also that item #2, "Total Expenses," should exclude bad debt since it is reported instead as a deduction from revenue. Note also that, for patients covered by third-party payers, any charges not paid by the third-party payers which cannot be billed to the patient are to be reported as contractual adjustments; however, charges for which the patient can be billed (*e.g.*, periods of service not covered, services not covered, and deductibles/ coinsurance) may be included in bad debt if otherwise appropriate.

**Gross Indigent and Charity Care Charges** – Gross indigent and charity charges are those uncompensated charges to patients that would be defined as either indigent or charity as defined above.

**Indigent and Charity Care Compensation** – Report total compensation for indigent and charity patients where requested.

**Other Revenue** - Report all non-patient revenue and gains, excluding extraordinary gains, whether operating or non-operating. For the purposes of this survey, other revenue includes gains even though gains are itemized separately in the ambulatory surgery center's financial statements. Do not include compensation for indigent or charity patients.

**Total Expenses** - Report expense data for the calendar-year report period. If any expenses are shared between the ambulatory surgery center and another entity such as a hospital (e.g., payroll expenses for shared staff), report only that portion allocable to the ambulatory surgery center. For the purposes of this survey, bad debt is reported as a deduction from revenue and should not be included in expenses even though it may be reported as an expense in the ambulatory surgery center's financial statements. Include all expenses such as payroll, employee benefits, professional fees, contract personnel, depreciation, interest, other operating expenses, and non-operating expenses. Include all ordinary losses but exclude extraordinary losses.

**Adjusted Gross Revenue** -- Adjusted Gross Revenue (AGR) is calculated by subtracting Medicaid and Medicare Contractual Adjustments *only* and bad debt from the facility's Total Gross Revenues. AGR is used as the basis for determining a hospital's level of uncompensated indigent and charity care services. Generally, these figures are presented as a percentage of the facility's AGR. Include Medicaid CMO and Peachcare for Kids Contractual Adjustments with Medicaid Contractual Adjustments.

**Calculated Totals** – The following financial items will be automatically calculated by the database from the numbers you enter on the survey form:

- Total Contractual Adjustments*
- Uncompensated (Net) Indigent Care Total*
- Uncompensated (Net) Charity Care Total*
- Total Uncompensated Indigent and Charity Care*
- Total Net Patient Revenue*
- Total Net Revenue*
- Adjusted Gross Revenue (as defined by DCH)*
- Percentage of AGR that is Uncompensated Indigent and Charity Care Charges*

**Indigent and Charity Care Commitments** – Some ambulatory surgery centers have commitments to provide a specified level of indigent and charity care as part of their Certificate of Need authorization. For those facilities that have a CON commitment to provide indigent and charity care, the commitment (usually expressed as a percentage) is multiplied by the facility's AGR to calculate the amount of uncompensated indigent and charity care provided. Please contact the Division of Health Planning if you have additional questions regarding indigent and charity care commitments.

**PART H: ACCREDITATION**

Respond as appropriate.

**PART I: PATIENT ORIGIN OF AMBULATORY SURGERY PATIENTS IN CON-AUTHORIZED ROOMS**

In the spaces provided report the total number of Georgia patients by county of residence. The Grand Total reported on this page must equal the totals reported for total patients in Part D.

**SIGNATURE PAGE**

The Signature Page is where the facility's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. An electronic manually entered version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Page also will identify any out of balance edit checks and any validation rule criteria that are not correct. All edit and balance requirements and all required fields must be completed before the survey can be submitted.