Surgery: Office-Based

What's the Risk?

Outpatient surgeries account for half of all surgeries in the United States. Patients find that it offers a comfortable, convenient, and cost-effective alternative to hospital-based surgery, while physicians enjoy more autonomy in scheduling and increased revenue and patient satisfaction. A review of Coverys' inpatient and outpatient claims from 2011 through 2015 reflects both the volume and severity of outpatient surgery claims to be lower than that of inpatient surgery. The highest percentage of outpatient surgery claims were related to elective dental or cosmetic procedures, such as dental restoration, laser, dermatology, orthopedic procedures, and general surgery (e.g., colonoscopies).[1] A recent review of 2014-2018 Coverys data reveals this data remains the same.

In many ways, outpatient surgery is considered safer than inpatient surgery. However, what can go wrong in the inpatient setting can also occur in the outpatient setting. Outpatient surgery risks include:

- Inappropriate patient selection and assessment.
- Skilled surgical and/or anesthesia personnel scarcity.
- Patient monitoring equipment scarcity or failure.
- Inconsistent state regulatory and accreditation requirements with regards to office-based surgery centers.

Any one or a combination of these risks may result in suboptimal patient outcomes, injury, or death. This was undoubtedly the catalyst for the development of regulations, National Patient Safety Goals, and accreditation procedures for office-based surgery.[2,3]

A review of Coverys closed outpatient surgical claims from 2014 through 2018 identified the top risk issues for outpatient surgery are technical skill, behavior-related, and clinical judgment.

Technical skill issues include:

- Unexpected technical problem (usually involves a known complication and when there is an adverse outcome there is little or no information as to why there was an adverse outcome).
- Poor clinical decision making.
- Inadequate skills.
- Retained foreign object.

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Behavior-related issues include:

- Patient unhappy with result.
- Non-compliant patient.

Clinical judgment issues include:

- Inadequate/inappropriate testing.
- Selection of appropriate therapy.
- Failure to obtain specialty consult or referral.
- Family/personal history.

When Is This Risk an Issue?

With increasing numbers of office-based surgical procedures performed each year, it is key for all office-based surgery centers and ambulatory surgery centers to recognize and consider the safety vulnerabilities and issues outlined below.

Classification of Office-based Surgery

Many states classify office-based surgeries according to the procedure types performed and anesthesia types required. The following levels I-III refer to surgical complexity, as used by some state medical boards, while classes A-C refer to the anesthesia level provided, as described by the American College of Surgeons (ACS) in its "Guidelines for Optimal Ambulatory Surgical Care and Office-Based Surgery." The generally recognized levels are as follows.[4]

Level I office-based surgeries are considered minor procedures performed under local, topical, or block anesthesia that do not involve an altered level of consciousness.

Class A are minor procedures performed under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation.[5]

Level II office-based surgeries are minor or major procedures performed in conjunction with oral, parenteral, or IV sedation or under analgesic or dissociative drugs. In addition to all of the Level I requirements, full emergency equipment and medications must be on hand, and formal peer review and performance improvement must be in place and be accredited by an approved accrediting organization.

Class B are minor or major surgical procedures performed in conjunction with oral, parenteral, or IV sedation or under analgesic or dissociative drugs.[6]

Level III office-based surgeries are major in nature; are performed under deep sedation/analgesia, general anaesthesia, or major conduction blocks; and require support of

vital bodily functions. In addition to all Level I and II requirements, at least one BLS/ACLS-certified healthcare professional/practitioner must be immediately available to monitor the patient recovery.[7]

Class C are major procedures that require general regional block anaesthesia and support of vital bodily function.[8]

Accreditation

A growing number of states require accreditors of office-based surgical facilities to evaluate practices versus state inspections, according to a report by the American Society of Anesthesiologists' Committee on Ambulatory Surgical Care and the Society for Ambulatory Anesthesia's Office Based Anesthesia Committee. Facilities providing Level II and III office-based surgeries that require the anesthesia types described above should be accredited.

It is important to remember that a practitioner must conduct a thorough evaluation to determine the best setting for a patient to undergo any procedure regardless of the facility's accreditation level. This is because a practitioner may prescribe different sedation levels for exactly the same procedure based upon patient evaluation. For example, a practitioner may prescribe pre-procedure oral sedation for one patient while electing deeper sedation for another patient for the same procedure. While Level II accreditation is recommended for facilities administering oral sedation, we are aware that many practitioners safely administer this sedation type in unaccredited facilities.

In any situation, it is important for the practitioner to anticipate the necessity of moving to a higher sedation level and be prepared to do so. In summary, thorough patient evaluation and the facility's accreditation level are strong considerations in determining the optimal facility for performing any procedure. These, in conjunction with guidance from a practitioner's professional society and the American College of Surgeons, may result in the best outcome for the patient.

Agencies that accredit office-based practices are The Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Accreditation Association for Ambulatory Health Care (AAAHC), and the American Osteopathic Association (AOA).

Scope of Services

The ACS recommends adhering to the list of procedures that each office is accredited for, staffed, and equipped to perform. Having written anesthesia administration protocols and

infection prevention and control guidelines in place is also critical in producing optimal results and reducing adverse outcomes.

Credentialing and Qualifications

It is unethical and potentially illegal for a practitioner to perform or to advertise that they perform office-based surgical procedures outside of their specialty and their education, proficiency, and credentialing levels. Practitioners are expected to be credentialed with the same privileges to perform the same or very similar procedures in either the hospital- or office-based setting or to be able to document successful completion of training. This also holds true for anesthesia practitioners.

An office-based setting may not have the same level of oversight found in the hospital setting, so it is especially important to be mindful of a phenomenon known as “practice drift.” This refers to healthcare practitioners practicing outside the scope of their training, certification, and their state scope of practice acts. While the “drift” may seem minor in nature, it has the potential to place patients at risk, perhaps beyond the practitioner’s ability to recognize and/or adequately respond to the patient’s deteriorating condition.

Patient Assessment and Selection of Procedure

The ACS recommends that the operating practitioner conduct a thorough preoperative patient assessment that includes an anesthesia assessment, X-ray and laboratory testing, and medical clearance from other specialists when indicated. These help determine whether the patient’s surgery should be performed in a hospital setting rather than an office-based setting. The level of office-based surgery may dictate if the surgery can be performed within the facility.

Other considerations include the patient’s previous surgical experiences, response to anesthesia, the anticipated degree of blood loss, and/or other factors that may favor a hospital setting.

The patient’s anticipated condition post-surgery, their ability to follow post-procedure instructions, the setting in which they will recuperate, the need for home care and/or special equipment, and the strength and availability their support system are important factors to consider when determining the appropriate setting for the planned procedure.

Anesthesia

Assessment

The American Society of Anesthesiology (ASA) recommends that the anesthesia practitioner who will attend the patient during the office-based surgery perform a thorough anesthesia assessment. It is important that the operating practitioner’s findings, test results, and all medical

clearances are available to the anesthesia practitioner at the time of the anesthesia assessment. Conducting this assessment well in advance of the surgery allows time for modification of the anesthesia or surgical plan if and when needed.

Anesthesia Practitioner
The anesthesia practitioner may be a physician, anesthesiologist, certified registered nurse anesthetist (CRNA), or dentist. Any anesthesia practitioner needs to act within the bounds of their scope of practice and comply with national and state regulations and their professional society guidelines. They are expected to be familiar with the office-based facility setting, staff skill levels, intraoperative monitoring and rescue equipment, and facility policies and procedures. It is also critical that the anesthesia practitioner be involved in the practice's quality improvement, peer review, and risk management programs.

Levels of Sedation
Sedation levels are classified as minimal, moderate, deep, and general. The ASA has established required credentialing guidelines for practitioners to administer each sedation type. To ensure compliance with these and any state guidelines, it is important to define the credentialing requirements of each office-based facility.

Minimal sedation (anxiolysis) is a state in which the patient will respond normally to verbal commands; cognitive function and coordination may be impaired, but does not typically affect ventilation or cardiovascular functions.[9]

Moderate sedation (conscious sedation) is a state in which the patient will respond to touching or verbal requests; ventilation is typically not affected, and cardiovascular function is usually maintained.[10]

Deep sedation (analgesia) is a state in which the patient cannot be easily aroused, will respond to painful or repeated touching, and may require ventilator support; cardiovascular function is usually maintained.[11]

General anesthesia is a state in which the patient cannot be aroused through painful stimulus, may require ventilator support, and may have impaired cardiovascular function.[12] Procedures that require general anesthesia also require more surgical time, intensive monitoring, and sophisticated equipment. In addition, general anesthesia administration may place the patient in a risk category that is too high for easy management in an office-based setting.

Monitored anesthesia care is basically an anesthesia service specific to a particular diagnostic or therapeutic procedure.[13] The indications for monitored anesthesia care include the procedure

type, the patient's clinical condition, and/or the possibility of conversion to general or regional anesthesia.[14] Indeed, since monitored anesthesia care may involve varying levels of sedation, analgesia, and anxiolysis, the practitioner must be both qualified and prepared to convert to general anesthesia when necessary.[15]

Informed Consent

The practitioner who performs the planned surgery and anesthesia administration is also responsible for obtaining individual informed consent, as they are in the best position to explain the intended procedures and services and respond to patient questions. For more information on informed consent, see the chapter titled ***Informed Consent: Process***. Although not required, consider developing a patient rights brochure and providing it to patients during the informed consent discussion.

Preoperative and Intraoperative Care

Preoperative patient care includes written instructions for the following key areas:

- Diet – if and when to limit or stop food and beverages.
- Medications – if and when to take regular and preoperative medications.
- Skin preparation – if and when to perform skin preparation.
- Procedure – name and site for the planned procedure.
- Transportation – need/requirement for an individual to transport the patient after surgery.

The immediate preoperative period focuses on the following:

- Patient identification – using two patient identifiers.
- Medications – confirming the patient's medications that have been taken and will be administered.
- Diet – confirming patient compliance with dietary restrictions.
- Skin preparation – confirming compliance with any specific skin preparation instruction.
- Site marking – ensuring the practitioner performing the procedure marks the site.
- Surgical site cleansing.
- Timeout or pause – conducting a timeout with active participation of the entire surgical team prior to surgery to confirm the patient's identity, the procedure to be performed, and the surgical site.[16]

The ASA recommends that the surgical team members carefully consider and agree upon the individuals and specific responsibilities for intraoperative care. It is also important to determine the surgical team's method to communicate patient status, equipment function, pathological samples taken, and medication administration prior to initiating surgery. In addition, a policy should address documentation requirements for all of the above.

The ASA also recommends continual intraoperative evaluation and documentation of the patient's oxygenation, ventilation, circulation, and temperature during administration of all anesthetics. The ASA defines continual as "repeated regularly and frequently in steady rapid succession."[17] Some states further require capnography/End Tidal CO_2 monitoring in patients receiving moderate sedation, deep sedation, and general anesthesia. Capnography has been found to decrease the number of adverse events, including apnea and hypoxia. The New York State Department of Health notes this to be an evidence-based practice recommended by professional organizations and societies as a standard of care for these patients.

Discharge Planning and Post-Procedure Care

Discharge planning for post-surgical patients is most effective when it begins at their initial assessment and selection process. Evaluation of the patient assessment elements outlined above provides an opportunity to confirm the information and any changes thereto.

Post-Procedure Documentation

Comprehensive medical record documentation of clinically pertinent information regarding the procedure performed is encouraged. Complete documentation helps ensure continuity of care among practitioners.

Post-Procedure Instructions

The ASA recommends monitoring respiratory function, cardiovascular function, neuromuscular function, mental status, temperature, pain, nausea and vomiting, fluid assessment, urine output and voiding, drainage, bleeding, or any early infection signs in the post-anesthesia assessment. It is critical to comprehensively document the post-procedure assessment described above. A lack of or incomplete documentation of a patient's condition both post-procedure and at the time of discharge suggests that the patient's status was not assessed. If the patient later develops a complication that leads to a medical professional liability claim, the post-procedural assessment and care would be difficult to prove and defend.

Post-Procedure Instructions

Engaging the patient in shared decision-making and managing the patient's post-procedure expectations is key. Providing written post-procedure instructions involves the patient in their care and provides evidence that they have been provided with and understand the information they need for ongoing care and recovery. An educated patient is more likely to follow appropriate treatment and post-procedure instructions, which can reduce the risk of an adverse outcome.

Post-Procedure Follow-up Calls

Follow-up calls offer an opportunity to assess patients for complications and signs or symptoms

of infection, determine their compliance with the treatment plan, address complaints, and follow-up on instructions and education provided to patients. Follow-up calls made within 24 hours post-procedure are most beneficial to assist with timely identification of potential complications, lack of understanding, or noncompliance with the treatment plan, and afford the opportunity to intervene when indicated.

The Medical Professional Liability Association, formerly known as Physician Insurers Association of America (PIAA) Data Sharing Project identified 4.8 percent of closed claims for surgical medical specialties between 2006 and 2015 showed postoperative infection as the most prevalent outcome.[18]

Emergencies and Transfers

Medical emergencies can and do occur during outpatient surgery. Planning and preparing for medical emergencies can help minimize their risks. The ASA recommends office-based surgery facilities have written protocols that address anticipated medical emergencies, external disasters (including those that are common to the geographical region), and surgical fires.[19] They also recommend checking equipment and medications used for patient rescue on a regular basis, with documentation to support these checks.[20] For more information, see the chapter ***Emergencies: Medical***.

The ACS recommends the practitioner and healthcare personnel be certified in appropriate rescue techniques, either basic cardiac life support (BCLS) or advanced cardiac life support (ACLS), depending upon the procedure complexity and anesthesia level used at the facility. Pediatric advanced life support (PALS or PLS) is required if pediatric patients are cared for in the facility.

Having an emergency transfer plan in place is strongly recommended. In addition, having a written transfer agreement with a hospital facilitates a timely transfer should a patient require a higher level of care. Reviewing the emergency transfer plan with all personnel at least annually and conducting transfer simulation drills twice a year has demonstrated enhanced effectiveness with managing patient transfers in emergent situations.

The ASA recommends having a method in place for reporting surgery-related and/or anesthesia-related events that result in an emergency situation and/or transfer. Such reports are to be submitted to the appropriate agencies according to ACS guidelines.

Cosmetic Procedures

Some seemingly uncomplicated cosmetic procedures may lead to greater safety risks than originally anticipated. Among these are procedures such as liposuction and facial injections,

commonly known as “fillers” and “paralytics.” The patient may want, or a practitioner may decide, that a more extensive procedure is needed to produce the desired effect. It is wise to clearly establish and agree upon the extent of the planned procedure. This is best addressed during the informed consent discussion with another review before the performing the procedure. For more information, see the chapter titled ***Cosmetic Procedures***.

How Can I Reduce Risk?

Practicing safe medicine and ensuring patient safety are the key concerns. The following guidelines are offered to all practitioners who perform office-based surgery, regardless of the state in which they practice. In addition, practitioners should be familiar and comply with any state law requirements.

Develop Policies and Procedures	
Implement policies and procedures	• Develop and implement policies and procedures addressing issues that include, but are not limited to, the following: ○ Organizational structure. ○ Scope of services. ○ Office-based surgery facility classification. ○ Licensure, credentialing, and certification requirements for all professionals. ○ Job descriptions for and duties of all personnel. ○ Education and competency assessment. ○ Patient rights. ○ Preoperative assessment and patient selection criteria. ○ Preoperative, intraoperative, and postoperative care. ○ Patient discharge planning. ○ Follow-up on specimens sent to pathology. ○ Emergency care and transfer.

Develop Policies and Procedures

- Documentation requirements.
- Medical record maintenance and security.
- Equipment requirements.
- Equipment maintenance requirements.
- Infection prevention and control.
- Quality improvement and risk management activities.
- Facility and safety, including controlled drug supply, storage, and administration.

Ensure Proper Training, Licensing, Certification, and Privileges

Staff appropriately	• Require that all staff members involved in direct patient care are professionally qualified; possess the proper training, licensure, and credentials to perform the procedure; and are certified in patient rescue and resuscitation appropriate to the surgery level performed at the facility. Ensure that all staff members perform duties within their defined scope of practice and are supervised by the proper personnel.
Ensure privileges or ability to transfer care	• Ensure that practitioners have current hospital privileges at a licensed facility to perform the same or similar procedures performed at the office-based setting.
Work within credentials	• Advertise and perform only the office-based surgical procedures for which you have current professional credentials, including license and, whenever possible, board certification.

Plan for Emergencies

Develop an emergency plan	• Develop a written plan that directs staff members in perioperative emergency management. Require the immediate availability of age-appropriate emergency equipment, supplies, and medications. Ensure that the plan describes indications and procedures for transfer to a hospital. For more information, see the chapter titled ***Emergencies: Medical***.
Have a transfer agreement in place	• Ensure that the practice has a transfer agreement with a hospital that will accept patients in the event of an emergency or untoward event.
Report anesthesia- or surgery-related events	• Report anesthesia- or surgery-related events according to the guidelines from the American College of Surgeons.

Organize and Maintain the Physical Environment

Ensure patients understand the office-based concept	• Ensure that patients understand they are in an office-based surgical setting rather than an ambulatory surgical center or similar facility. Consider multiple means to accomplish this, such as posting signs in the office and including a statement on consent forms and postoperative instruction sheets.
Ensure regulatory compliance	• Ensure that the facility meets all local and state environmental codes and accreditation requirements. If the facility is accredited, maintain copies of accreditation documents in a central repository and post a copy of the accreditation certificate.
Ensure a safe surgical environment	• Comply with all accrediting body environmental recommendations regarding the immediate surgical environment, equipment, and supplies that are appropriate for the procedure types performed and the patient population served. • Check supplies and medications for expiration dates on a regular, periodic basis.

Organize and Maintain the Physical Environment

	• Maintain a supply of IV fluids and monitoring and resuscitative equipment (including, when necessary, pediatric equipment) to meet the realistically anticipated needs of the patient population served. Include, at a minimum, an automated blood pressure cuff, cardiac monitors, and pulse oximetry and resuscitation equipment (e.g., oxygen, bag/mask ventilator, oral and nasopharyngeal airways, appropriate drugs, and suction).
	• Ensure that the office has enough weight-appropriate beds, stretchers, operating tables, and wheelchairs to meet the surgical patients' needs. Utilize an area other than the general patient waiting room for patient recovery.
Ensure emergency electrical backup	• Ensure that an adequate emergency power generator is readily available in the event of a power failure.
Test and maintain equipment	• Develop and implement protocols to test and maintain equipment according to the manufacturer's recommendations, either by a qualified person within the practice or through a contract with the manufacturer. Educate staff members to immediately remove faulty equipment, tag it as "do not use," and report problems to the appropriate person and regulatory agency if indicated.
Ensure infection prevention and control	• Develop and maintain an infection prevention and control plan that meets Occupational Safety and Health Administration (OSHA) requirements. Provide timely and regular reports of all infections to the appropriate personnel.

Determine Service Levels

Determine service levels	• Determine the levels of care the office will provide according to the classifications of surgery. Refer

Determine Service Levels	
	patients requiring a higher care level to a facility with the capability and capacity to manage such patients. Determine whether the patient can be properly recovered within a reasonable time frame and consider establishing the maximum time a patient can remain under anesthesia.

Develop and Implement a Preoperative Protocol	
Select appropriate patients	• Develop and adhere to patient selection criteria and ensure that each patient falls within the applicable ASA classes that are available at the facility.
Conduct preoperative and pre-anesthesia assessments	• Conduct a thorough preoperative assessment to determine whether the patient is a candidate for the office surgery. Ensure that the anesthesia practitioner conducts a separate patient assessment and that all available test results and medical clearances are available to this provider. Require the anesthesia provider to reassess patients immediately before surgery to confirm the appropriateness of the procedure and planned anesthesia.
Respect the anesthesia practitioner's right to refuse to administer anesthesia based upon their assessment	• Do NOT perform an office-based procedure if the patient is granted surgical clearance but denied anesthesia clearance.
Obtain informed consent	• Obtain the patient's informed consent for the planned procedure and anesthesia administration. All informed consent discussions should include the risks, benefits, alternatives, and prognosis if the procedures are not performed. Document these discussions in the medical record. For further information, see the chapter titled ***Informed Consent: Process***.

Develop and Implement a Preoperative Protocol	
	• Provide the patient with a patient rights brochure, if one has been developed for the office.
Staff appropriately	• Ensure that all staff members who assist in surgery are appropriately trained, credentialed, and knowledgeable about the planned procedure and the ASA class of anesthesia administration. It is also imperative that each individual within the operative suite understand their responsibilities during surgery and any emergency protocol that may be invoked.

Develop and Implement an Anesthesia Protocol	
Ensure qualified practitioners	• Ensure that the anesthesia practitioner is qualified by education, licensed by the state medical licensing board, and credentialed by a licensed healthcare facility to administer the anesthesia levels required for the procedures offered at the office.
Determine criteria for selecting anesthesia	• Develop protocols that address the anesthesia levels, the corresponding anesthetic agents for each level, the credentials required to administer each level, and any supervisory requirements.

Develop and Implement a Recovery Protocol	
Define recovery period	• Develop written protocols that define the minimal recovery period for all procedures, assessment elements, assessment time intervals, and documentation requirements.
Staff appropriately	• Ensure that staff members are certified in the appropriate rescue protocols.
Involve anesthesia practitioner	• Ensure that the anesthesia practitioner remains on-site until the patient fully recovers from anesthesia.

Develop and Implement a Discharge Protocol	
Develop discharge criteria	• Adopt specifically approved criteria for patient discharge for each sedation level that meets the ASA guidelines. Document the patient's readiness for discharge in the medical record. Specific criteria should include: o Stable vital signs. o Stable respiratory and cardiac status. o Appropriate mental status. o Ability to ambulate without dizziness, unless contraindicated by postoperative instructions.
Involve operative provider prior to discharge	• Ensure that the operating practitioner evaluates and documents the procedural site's condition and the patient's post-procedural status and vital signs prior to discharge. Recognize that procedures may not always go by the book. Patients may respond and recover differently, which may lead the need for closer oversight, continued monitoring, or refusal to discharge home post-procedure.
Provide written discharge instructions	• Review written discharge instructions with the patient and also with their family member(s) if the patient gives consent. Ensure that the instructions address the procedure performed, wound care, medications and actions to be taken, what to expect during the immediate recovery period, and who to call if pain or bleeding increases or signs and symptoms of post-procedure infection or other untoward symptoms develop. • Write post-procedure instructions at a fifth-grade level in terminology that considers healthcare literacy and patients with limited English proficiency. Make instructions available in the languages of the major populations of the practice. For more information,

Develop and Implement a Discharge Protocol	
	see the chapter ***Cultural and Linguistic Competence***. • Document the instructions provided in the medical record.
Plan follow-up	• Ensure that the patient is given a follow-up appointment before they leave the office.
Discharge patient with a responsible adult	• If the patient is unable to ambulate, ensure that a staff member accompanies or transports the patient to the facility exit and assists them into the vehicle. Reinforce the importance of avoiding driving after sedation. Document that the patient has been discharged with a responsible adult or the patient's refusal to comply with this instruction.
Call patient	• Call patients within 24 hours of discharge to determine their postoperative status and to evaluate their understanding of and compliance with the discharge instructions. Respond to their questions and advise them of the continuing availability of the office staff during normal business hours and after hours. Document all follow-up calls, including the patient's response in the medical record.
Document	
Maintain medical record	• Ensure that every patient who is assessed and/or treated has a medical record.
Document each procedure	• Document each procedure performed in the medical record. Include the patient's diagnosis and indication for the surgery, the patient's signed informed consent, anesthesia type, anesthesia provider, names of all in attendance, surgical start and end times, fluids and medications administered, continual oxygen monitoring, vital signs, procedure description,

Document	
	recovery course, the patient's condition at discharge, and procedure-specific discharge instructions.

Address Safety Issues	
Ensure availability of equipment for reasonably foreseeable emergencies	• Comply with all applicable federal, state, and local laws, codes, and regulations relating to fire prevention, occupational health and safety, and medical and hazardous waste disposal.

Develop and Implement an Infection Prevention and Control Program	
Comply with standards	• Comply with current OSHA standards and regulations, state-specific standards and regulations, and national clinical guidelines concerning infection prevention and control. For more information, see the chapter titled ***Infection Prevention***.
Train staff members	• Train staff members in cleaning, disinfecting, and sterilizing rooms and equipment.
Use universal precautions	• Teach staff members to use universal precautions with all patients and in all surgical cases. Make protective clothing and equipment available for use as needed.
Maintain a log	• Log all cleaning, disinfecting, and sterilizing of equipment.

Develop and Implement Continuous Quality Improvement (CQI) Program	
Develop a CQI program	• Develop and implement a CQI program that includes a review of all procedures, complications, transfers, reversal agent use, deaths, negative trends, and patient complaints. Provide regular, periodic feedback to all staff members.

Bill Appropriately	
Ensure charges are allowable	• Be certain that the amount billed for an office-based surgical procedure is the allowable charge for the procedure code that has been assigned to the surgery.

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