Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **Central Connecticut Endoscopy Center, LLC**

Docket Number: **03-30187-CON**

Project Title: **Establishment of a Single-Specialty, Outpatient Endoscopy Center**

Statutory Reference: **Sections 19a-638 and 19a-639, Connecticut General Statutes**

Filing Date: **April 7, 2004**

Decision Date: **June 25, 2004**

Default Date: **July 6, 2004**

Staff: **Laurie K. Greci**

Project Description: Central Connecticut Endoscopy Center, LLC ("Applicant") proposes to establish a single-specialty, outpatient endoscopy center to be located at 440 New Britain Avenue, Plainville, Connecticut, at a total capital expenditure of $1,650,355.

Nature of Proceeding: On April 7, 2004, the Office of Health Care Access ("OHCA") received the Applicant's Certificate of Need ("CON") application seeking authorization to establish a single-specialty, outpatient endoscopy center to be located at 440 New Britain Avenue, Plainville, Connecticut, at a total capital expenditure of $1,650,355.

The Applicant is a health care facility or institution as defined by Section 19a-630, of the Connecticut General Statutes ("C.G.S.").

A notice to the public concerning the Applicant's proposal was published in *The Herald* (New Britain) on April 15, 2004, pursuant to Section 19a-643-45 of OHCA's

Regulations. OHCA received no comments from the public concerning the Applicant's proposal.

OHCA's authority to review and approve, modify or deny this application is established by Sections 19a-638 and 19a-639, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

FINDINGS OF FACT

Clear Public Need
Contribution of the Proposal to the Quality and Accessibility of Health Care Delivery in the Region
Impact on the Applicant's Current Utilization Statistics

1. Central Connecticut Endoscopy Center, LLC ("Applicant" or "CCEC") is a newly formed limited liability company; it was formed for the single purpose of establishing the proposed endoscopy center. *(January 20, 2004, CON Application, page 6)*

2. CCEC includes seven physician-members and two hospital members. Based on the capital contributions made, each physician-member has an 8.82% ownership interest in the corporation and each hospital member has a 19.12% ownership interest. *(April 2, 2004, Completeness Response, page 89)*

3. The hospital members ("Hospitals") of CCEC include New Britain General Hospital ("NBGH") and Bristol Hospital ("BH"). Each Hospital has an investment interest in CCEC, but does not play a direct role in the management, operation, or provision of services. *(September 29, 2003, Letter of Intent, page 10)*

4. The physician-members of CCEC are board-certified in gastroenterology and currently practice in the Central Connecticut area. Mark R. Versland, M.D. will be the Medical Director and he is currently Chief of the Division of Gastroenterology at NBGH. Thomas J. Devers, M.D., Barry J. Kemler, M.D., and Edward P. Toffolon, M.D. are Attending Physicians at NBGH. Ronald S. Green, M.D., Kenneth Krasner, M.D., F.A.C.G. are Attending Physicians at BH. Daniel N. Smiley is a member of a private practice in Bristol. *(September 29, 2003, Letter of Intent, page 10 and January 20, 2004, CON Application, Attachment N)*

5. The Applicant proposes to establish an endoscopy center ("Center") with four procedure rooms at 440 New Britain Avenue, Plainville, Connecticut. The Center will occupy approximately 9,925 square feet in a new structure that will be built as an addition to an existing building. *(January 20, 2004, CON Application, page 18)*

6. The Center will enable the physician-members of the CCEC to perform a broad range of gastroenterology services, including endoscopies, colonoscopies, and other diagnostic gastrointestinal procedures. *(January 20, 2004, CON Application, page 6)*

7. Only CCEC physician-members will have privileges at the Center; currently the physicians perform their procedures at NBGH, BH, and Bradley Memorial Hospital ("BMH") in Southington. *(January 20, 2004, CON Application, page 9)*

8. Under OHCA Docket Number 95-560, the parent corporations of NBGH and BMH merged under a new single parent entity, the Central Connecticut Health Alliance. On April 7, 2004, OHCA received a complete Letter of Intent for the consolidation of the two hospitals under a single acute care hospital license. *(April 7, 2004, Docket 04-30280-LOI, pages 8 and 9)*

9. CCEC's primary service area is comprised of Berlin, Bristol, Burlington, New Britain, Newington, Plainville, Plymouth, and Southington. The secondary service area is comprised of Avon, Unionville section of Farmington, Cheshire, Middletown, and Meriden. The proposed service areas are based on the towns of origin of the current patients seen at the offices of the physicians participating in this proposal. *(April 7, 2004, Completeness Response, page 2)*

10. No single-specialty, outpatient endoscopy centers are currently located in the proposed primary service area. Outpatient endoscopy services are provided in the area by hospital-based facilities located at NBGH, BH, and BMH. *(January 20, 2004, CON Application, page 7)*

11. The Applicant based the need for the proposed Center on the anticipated increases in demand for endoscopies and colonoscopies, scheduling backlogs due to insufficient supply of procedure rooms, and the continued prevalence of colorectal cancer within the population. *(January 20, 2004, CON Application. pages 9 -10)*

12. The Applicant projected that the demand for colonoscopies would continue to increase due to the aging of the service area's population, the societal guidelines that recommend persons age 50 and older receive a screening for colorectal cancer, and the promotion by various agencies and societies for persons to receive colorectal cancer screening. *(January 20, 2004, CON Application. pages 9 -10)*

13. Colorectal cancer is the second leading cause of cancer-related death in the United States and one of the most commonly diagnosed cancers. More than 90% of colorectal cancers are diagnosed in people aged 50 years or older. Approximately 70% of colorectal cancers occur in people with no known risk factors. The most effective way to reduce the risk of colorectal cancer is by having screening tests beginning at age 50. *(January 20, 2004, CON Application. pages 9, 10, and 107)*

14. Reducing the number of deaths from colorectal cancer depends on detecting and removing precancerous colorectal polyps, as well as on detecting and treating the cancer in its early stages. *(January 20, 2004, CON Application, page 74)*

15. Colonoscopies offer the advantages of complete visualization of the entire colon and therapeutic potential. During a colonoscopy, tissue may be collected for closer examination and polyps may be removed. *(January 20, 2004, CON Application, pages 75 and 108)*

16. The focus of the current colorectal cancer screening guidelines are persons aged 50 years and over. Population data from Census 2000 and the State of Connecticut Office of Policy and Management indicate that the 45-64 age cohort for the service area population will increase by 14.5% from 2000 to 2005. *(January 20, 2004, CON Application, page 10)*

17. The estimated population in the primary service area for 2005 is presented in the following table. The 2005 population is based on the Census 2000 count and adjusted for anticipated increases in population.

Table 1: Projected Population in the Primary Service Area in 2005

	Age Group					Total	
Town	**0-14**	**15-44**	**45-64**	**65-84**	**85 +**	**All Groups**	**45 yrs and up**
Berlin	3,459	6,555	5,508	2,526	389	18,437	8,423
Bristol	11,426	24,980	15,795	7,477	1,470	61,148	24,742
Burlington	1,877	3,321	2,726	630	69	8,623	3,425
New Britain	14,208	32,538	15,643	8,287	1,876	72,552	25,806
Newington	5,092	10,224	8,092	4,642	913	28,963	13,947
Plainville	3,088	6,843	4,997	2,266	375	17,579	7,638
Plymouth	2,413	4,790	3,159	1,250	202	11,814	4,611
Southington	7,423	14,931	11,381	5,432	831	39,998	17,644
Total	**48,985**	**104,193**	**67,301**	**32,509**	**6,125**	**259,114**	**105,936**

(January 20, 2004, CON Application, page 60)

18. Waiting time data for non-emergent endoscopic procedures compiled by the physician practices at the Hospitals over the last year show that no cases could be accommodated with less than 30 days of wait time. Sixty-three percent of the patients had to wait over 60 days and 28% experienced delays of greater than 90 days. *(January 20, 2004, CON Application, page 7)*

19. NBGH is currently performing approximately 9,000 procedures per year in its four endoscopic procedure rooms. In order to meet the existing demand, NBGH has implemented extended hours, reduced turnaround time, and tighter scheduling. NBGH has found it complicated to schedule staff for the extended hours and often must fill the shifts with overtime. Extending the hours of operation has also been difficult due to physician schedule conflicts and patient preference. *(April 2, 2004, Completeness Response, page 3)*

20. NBGH considered expanding its hospital-based endoscopy suite. This option is not feasible at this time due to a lack of available space. *(September 29, 2003, Letter of Intent, page 11)*

21. In 2001, under OHCA Docket Number 00-565, BH received CON approval to modernize, expand, and relocate its surgical services. The existing three endoscopic procedure rooms were relocated and modernized. *(March 8, 2001, Final Decision, Docket Number 00-565, pages 1 and 3)*

22. According to the Ambulatory Care Centers of America ("ACCA") guidelines, an ambulatory surgery center management and development company, the maximum capacity of an ambulatory operating room is approximately 1,500 cases per year, assuming a one-shift operation. *(May 2, 2003, Final Decision, Docket Number 03-30018-CON, page 4)*

23. The Applicant estimated that 60% of each physician-member's practice caseload will be performed at CCEC and 40% will be performed at one of three hospitals, NBGH, BH, or BMH. The physicians will use the hospital-based procedure rooms based on the required procedure type, patient condition, and patient preference. *(April 2, 2004, Completeness Response, page 6)*

24. The Applicant based its impact on the procedure volumes at NBGH assuming a 9%, 6%, and 4% growth rate in Fiscal Years ("FYs") 2005, 2006, and 2007, respectively; the growth rate for BH was assumed to be 7% for each year. *(April 7, 2004, Completeness Response, page 4)*

25. The total projected numbers of procedures to be performed at NBGH and BH, without implementation of the proposal and assuming the demand could be met, are given in the following table:

Table 2: Projected Procedure Volume – Meeting Demand

	FY Actual Volumes			FY Projected Volumes			
Facility	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
NBGH	6,291	7,083	7,539	9,016[1]	9,827	10,417	10,834
BH	3,359	3,666	3,979	4,392	4,699	5,028	5,380
Total	**9,650**	**10,749**	**11,518**	**13,408**	**14,527**	**15,445**	**16,214**

(April 7, 2004, Completeness Response, page 12)

[1] Based on the actual volume of procedures performed during the first four months of the fiscal year.

26. The total projected numbers of procedures to be performed at NBGH and BH, without implementation of the proposal and allowing for the current resources, are given in the following table:

Table 3: Projected Procedure Volume – With Current Resources

	FY Actual Volumes			FY Projected Volumes			
Facility	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
NBGH	6,291	7,083	7,539	9,016[1]	9,000	9,000	9,000
BH	3,359	3,666	3,979	4,392	4,699	5,028	5,380
Total	**9,650**	**10,749**	**11,518**	**13,408**	**13,699**	**14,028**	**14,380**

(April 7, 2004, Completeness Response, page 12)

27. The impact of the proposal on the procedure volumes at NBGH and BH after implementation of the proposal is given in the following table:

Table 4: Projected Procedure Volume – Impact of Proposal on NBGH and BH

	FY Actual Volumes			FY Projected Volumes			
Facility	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
NBGH	6,291	7,083	7,539	9,016[2]	7,049	6,601	6,904
CCEC[2]	0	0	0	0	2,779	3,816	3,930
BH	3,359	3,666	3,979	4,392	2,985	2,673	2,954
CCEC[3]	0	0	0	0	1,715	2,355	2,426
Total	**9,650**	**10,749**	**11,518**	**13,408**	**14,528**	**15,445**	**16,214**

(April 7, 2004, Completeness Response, page 12)

28. The Applicant has projected that in the Center's first year of operation its caseload will be 5,991 procedures. This volume will result in an average daily caseload of 23.7 procedures per day based on 260 weekdays minus 7 holidays. Each of the four proposed procedure rooms will average 5.9 procedures per day. With a procedure capacity of ten per day, the Center's procedure rooms will have an initial utilization rate of approximately 60%. Based on these calculations, the Applicant proposes to initially utilize three rooms and add the fourth as volume grows. *(April 7, 2004, Completeness Response, pages 2 and 3)*

29. In the second and third years of operation, the number of procedures projected to be performed is 6,167 and 6,356, respectively. The 3% increase per year is a conservative estimate of growth. Each physician-member has an established and

[1] Based on the actual volume of procedures performed during the first four months of the fiscal year.
[2] Number of procedures that will be performed at CCEC instead of NBGH; based on FY2002 actual percentage of procedures performed by the physicians at NBGH.
[3] Number of procedures that will be performed at CCEC instead of BH; based on FY2002 actual percentage of procedures performed by the physicians at BH.

active practice and would need to add additional practitioners to their practice to meet current demand. *(April 7, 2004, Completeness Response, page 4)*

30. The projected numbers of procedures, by procedure type, to be performed in the first three years at the Center are given in the following table. Procedure volume was estimated to increase at an approximate rate of 3% per year based on a historical average of endoscopy center growth.

Table 5: CCEC's Projected Number of Procedures for FY 2005, 2006, and 2007

Procedure Description	2005	2006	2007
Colonoscopy	3,142	3,234	3,333
Upper gastrointestinal endoscopy	1,662	1,711	1,763
Sigmoidoscopy	1,150	1,184	1,220
Ligation of internal hemorrhoids	9	10	10
Dilation of esophagus	7	7	8
Gastrostomy tube	7	7	8
Small intestinal endoscopy	4	4	4
Hemorrhoidectomy	4	4	4
Anoscopy	4	4	4
Esophagoscopy	2	2	2
Total	**5,991**	**6,167**	**6,356**

(January 20, 2004, CON Application, page 33)

31. The Applicant's projected payer mix is as follows:

Table 7: Applicant's Projected Payer Mix

Payer	Projected
Commercial	60.8%
Medicare	34.8%
Medicaid	4.4%
Other	0%
Total	100%

(January 20, 2004, CON Application, page 22)

32. CCEC proposes to be accredited by the Accreditation Association for Ambulatory Health Care. *(January 20, 2004, CON Application, page 23)*

33. The Medical Director of the Center shall function as the Director of the Conscious Sedation Services. Conscious sedation will be administered at the proposed facility by a physician or by a nurse under the physician's direct supervision. A physician shall be available at the Center at all times to provide care for patients. *(January 20, 2004, CON Application, page 316)*

34. The Center will have equipment available to monitor blood pressure, pulse, cardiac activity, and oxygen saturation. Equipment for emergency resuscitation, including a crash cart with defibrillator, intubation equipment, manual ventilation, and reversal drugs will also be available. *(January 20, 2004, CON Application, page 24)*
35. The Applicant has developed plans for emergency resuscitation of patients. In addition, the Applicant will enter into a formal written transfer agreement with NBGH to accommodate the emergency transfer of patients. *(April 2, 2004, Completeness Response, page 161)*

36. The hours of operation for the proposed Center will be Monday through Friday from 7:00 a.m. to 5:00 p.m. *(January 20, 2004, CON Application, Page 7)*

37. Section 19a-613 of the Connecticut General Statutes authorizes OHCA to collect patient-level outpatient data from health care facilities or institutions, as defined in Section 19a-630.

Financial Feasibility of the Proposal and its Impact on the Applicant's Rates and Financial Condition
Rates Sufficient to Cover Proposed Capital and Operating Costs
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services

38. The total capital expenditure with this proposal is $1,650,355 includes the following components:

Table 8: Capital Expenditure Components

Item	Cost
Construction/Renovation	$1,061,078
Medical Equipment (Purchase)	413,412
Non-Medical Equipment (Purchase)	89,400
Sales Tax, Delivery, and Installation	86,465
Total Capital Expenditure	**$1,650,355**
Capitalized Financing Cost	22,106
Total Capital Expenditure, including Capitalized Financing Cost	**$1,672,461**

(January 20, 2004, CON Application, page 17)

39. An Olympus Endoscopy Scope System will be acquired through an operating lease. The fair market value of the system is $538,194. The cost-per-procedure rate is $39.69 based on 6,000 procedures per year. The approximately monthly cost of endoscopy system is $4,900. *(January 20, 2004, CON Application, page 17 and 150)*

40. The source of funding for the proposal is $415,000 of the Applicant's equity, and a conventional loan of $1,061,078. The Applicant's have also established a $750,000 commercial line of credit. *(January 20, 2004, CON Application, page 20)*

41. Construction will consist of tenant improvements on the new structure of approximately 9,925 square feet. The construction will provide four procedure rooms, twelve recovery beds, and six step-down recovery recliners. *(January 20, 2004, CON Application, page 18)*

42. The renovations costs consist of the following:

Table 9: Renovation Cost Breakdown

Item	Cost
Building Work	$ 941,416
Site Work	29,800
Architectural and Engineering	57,000
Contingency	22,204
Building Permit	10,658
Total	**$1,061,078**

(January 20, 2004, CON Application, page 18)

43. The Applicant is projecting the following revenues and expenses for the first three years of the project:

Table 10: Projected Revenues and Expenses

Description	FY 2005	FY 2006	FY 2007
Revenue from Operations	$3,098,405	$3,911,116	$4,148,634
Expenses			
Salaries and Fringe Benefit	789,378	838,037	888,785
Professional Services	186,006	197,472	209,430
Supplies and Drugs	477,905	506,968	537,927
Facility Lease	119,100	122,673	126,353
Depreciation	190,068	190,068	190,068
Interest Expense	121,470	130,188	116,100
Other	485,979	519,517	540,315
Gain from Operations	**$ 728,499**	**$1,409,193**	**$1,539,656**

(January 20, 2004, CON Application, page 215)

44. The equipment lease expense is included in the category of "Other." The equipment lease expense will be $237,783, $244,927, and $252,270 for FYs 2005, 2006, and 2007, respectively. Utilities, bad debt allowance, outside services, maintenance, telephone, insurance, and miscellaneous are also included as other expenses. *(April 2, 2004, Completeness Response, page 144)*

45. In Fiscal Year ("FY") 2006, NBGH and BH will each see a reduction of approximately 2,400 procedures due to the proposal. Any net revenue loss will be partially offset by the Hospital's profits from its membership in the CCEC and the alleviation of costs due to the extended hours and use of overtime. *(April 2, 2004, Completeness Response, page 5)*

46. After the Center begins operations, NBGH expects to expand the number of endoscopic ultrasound procedures performed at the Hospital. As these cases are more time-consuming than conventional endoscopic procedures, they will utilize a higher proportion of the procedure rooms' resources. *(April 2, 2004, Completeness Response, page 5)*

47. The Center will be managed by Calisher & Associates, Inc. ("Calisher"). Calisher has a two-year management agreement with CCEC to provide the general business services financial services, and marketing services. CCEC will compensate Calisher at the rate of $12,000 per month, or five percent (5%) of the net revenues collected (whichever is greater). *(April 2, 2004, Completeness Response, Attachment C)*

Consideration of Other 19a-637, C.G.S. Principles and Guidelines

The following findings are made pursuant to other principles and guidelines set forth in Section 19a-637, C.G.S.:

48. There is no State Health Plan in existence at this time. *(January 20, 2004, CON Application, page 6)*

49. The Applicant has adduced evidence that this proposal is consistent with the Applicant's long-range plan. *(January 20, 2004, CON Application, page 6)*

50. As a new entity, the Applicant will make every effort to operate the Center in a productive and cost effective manner. *(January 20, 2004, CON Application, page 14)*

51. The Applicant's proposal will not result in a change to the Applicant's teaching or research responsibilities. *(January 20, 2004, CON Application, page 15)*

52. There are no distinguishing characteristics of the Applicant's patient/physician mix as compared to that of other endoscopy programs. *(January 20, 2004, CON Application, page15)*

53. The Applicant has sufficient technical, financial, and managerial competence to provide efficient and adequate services to the public. *(January 20, 2004, CON Application, Attachment N)*

Rationale

Central Connecticut Endoscopy Center, LLC ("Applicant" or "CCEC") proposes to establish a single-specialty, outpatient endoscopy center ("Center") at 440 New Britain Avenue, Plainville, Connecticut, at a total capital expenditure of $1,650,355. The Applicant is a newly formed limited liability company. Its members consist of seven physician-members and two hospital members. The Center will have four procedure rooms for the performance of a broad range of gastroenterology services, including endoscopies, colonoscopies, and other gastrointestinal procedures. Endoscopic services at the Center will be performed exclusively by physician-members; no other procedures will be performed.

The need for the proposed endoscopy center is based on increasing demand for screening procedures and the shortage of facilities in the area to meet that demand. There has been a rapid increase in patient demand for endoscopy procedures over the past several years. Within the Center's proposed service areas, there are over one hundred thousand residents aged 45 and older. The focus of the current colorectal cancer screening guidelines is persons aged 50 years and older. As the population ages, the demand for screening procedures continues to increase. The Hospitals are experiencing a scheduling backlog of thirty days or more for non-emergent procedures. However OHCA could not independently verify the backlog data.

Two of the service area providers, New Britain General Hospital and Bristol Hospital ("Hospitals"), are members of CCEC. The actual procedure volumes for 2003 and the and the Applicant's projections for 2004, 2005, and 2006, are used to calculate the procedure volume per endoscopy rooms at each Hospital and are presented in Table A. Using the capacity guideline of 1,500 procedures per year per room for a single-shift operation, New Britain General Hospital is already above, its capacity in 2003. Bristol Hospital will exceed its capacity in 2006, the second year of the CCEC's proposed operation.

Table A: Average Procedure Per Room at the Hospitals

	Actual	Projected		
Fiscal Year	**2003**	**2004**	**2005**	**2006**
New Britain General Hospital				
Number of Procedures	7,539	9,016	9,000	9,000
Number of Endoscopy Rooms	4	4	4	4
Procedure Volume/Room	**1,885**	**2,254**	**2,250**	**2,250**
Bristol Hospital				
Number of Procedures	3,979	4,392	4,699	5,028
Number of Endoscopy Rooms	3	3	3	3
Procedure Volume/Room	1,326	1,464	1,566	**1,676**

Commencement of operations at CCEC will initially decrease the procedure volume at the Hospitals. However, with the increasing demand for endoscopic procedures, as well

as the performance of other outpatient procedures, such as endoscopic ultrasound procedures, the Hospitals will be able to return to a reasonable utilization level. The Hospitals will also realize revenues through their membership in the CCEC and the decreased dependence on extended hours and staff overtime.

The Applicant's proposal will improve the quality and accessibility of health care delivery in the region. Additional availability of endoscopic procedure rooms will allow those persons in the 50 years and older age group to receive timely screening colonoscopies as well as other routine examinations, such an upper gastrointestinal endoscopies and sigmoidoscopies. Section 19a-613, C.G.S. authorizes OHCA to collect patient-level outpatient data from health care facilities or institutions. The submission of quarterly utilization reports to OHCA by the Applicant will provide OHCA with the data necessary to monitor the accessibility of care provided at the proposed facility.

The proposal is financially feasible. The project has a total capital expenditure of $1,650,355, funding will be provided by a combination of the Applicant's equity and conventional loan. The Applicant projects a gain from operations for each of the first three years of operation; these projections appear reasonable and achievable.

Based upon the foregoing Findings of Fact and Rationale, the Certificate of Need request of Central Connecticut Endoscopy Center, LLC for the establishment of a single-specialty, outpatient endoscopy center to be located at 440 New Britain Avenue, Plainville, Connecticut, at a capital expenditure of $1,650,355 is hereby GRANTED.

ORDER

Central Connecticut Endoscopy Center, LLC is hereby authorized to establish a single-specialty, outpatient endoscopy center to be located at 440 New Britain Avenue, Plainville, Connecticut, at a total capital expenditure of $1,650,355. The authorization is subject to the following conditions:

1. All gastroenterologists who perform procedures at the endoscopy suite shall be members or employees of Central Connecticut Endoscopy Center, LLC.

2. The ownership interest of New Britain General Hospital and Bristol Hospital in Central Connecticut Endoscopy Center, LLC may not fall below 19.12%.

3. If Central Connecticut Endoscopy Center, LLC proposes in the future to change the scope of services, permit non-members or employees to use the facility, or change the ownership interests of the Hospital-members prior OHCA approval will be required.

4. Central Connecticut Endoscopy Center, LLC will provide OHCA with utilization reports on a quarterly basis. The data elements and the format and submission requirements are described in Attachment 1. In addition to basic data analyses, OHCA will use the submitted data to assure that residents of the greater Plainville area have appropriate access to the site.

5. The Applicant will initially operate three endoscopic procedure rooms. Once the procedure volume increases to a level where the need to open the fourth, and final, procedure room becomes necessary, the Applicant will notify OHCA is its intention to operate the fourth procedure room.

6. This authorization shall expire on June 29, 2006, unless the Applicant presents evidence to OHCA that the endoscopy center is in operation.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Office of Health Care Access

June 25, 2004

Signed by Cristine A. Vogel
Commissioner

CAV/lkg

Attachment 1

Central Connecticut Endoscopy Center, LLC shall submit patient-specific data as listed and defined below for those patients that receive service, care, diagnosis or treatment at the Central Connecticut Endoscopy Center. This information may be extracted from either the medical abstract or billing records or both and submitted to the Office of Health Care Access ("OHCA") in accordance with this Attachment.

I. The data are to be submitted in ASCII or Excel format on a computer disk.

II. Column headers to be used are listed below in field name after the name of each data element.

III. Data formats to be followed are listed for each data element.

IV. The disk or file should be clearly marked with the applicant's/facility's name, file name, docket number and its contents.

V. Accompanying the data submission, the applicant/facility must submit a full written description of the data submitted and its record layout.

VI. Initial data shall be submitted at the end of the first quarter in which the facility begins to provide the service for which it is licensed. Subsequent data for a calendar quarter shall be filed before the end of the calendar quarter following the calendar quarter in which the encounter was recorded. This data set shall contain the data records for each individual encounter from that facility during the preceding calendar quarter. For example, the data set to be filed before June 30, 2004, shall contain the data records for each individual encounter at that facility from January 1, 2004 until March 31, 2004.

VII. All data collected by OHCA will be subject to the laws and regulations of the State of Connecticut and the Office of Health Care Access regarding its collection, use, and confidentiality.

Outpatient Facility Encounter Data Layout
(For Institutions)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
1	Record Type Indicator: **01**	recid	Num(2)
2	Facility ID Code - The last four digits of the Medicare Provider Number for the unit from which the patient was discharged for the encounter being recorded.	facid	Char(4)
3	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. **Format: string (20, zero filled to left if fewer that 20 characters)**	mrn	Char(20)
4	Patient Control Number – unique number assigned by the facility to each patient's individual encounter that distinguishes the medical and billing records of the encounter. **Format: string (20, zero filled to left if fewer that 20 characters)**	patcont	Char(20)
5	Social Security Number – patient's SSN **Format: string (9, hyphens are implied). Blank if unknown**	ssn	Char(9)
6	Date of birth – the month, day, and year of birth of the patient whose encounter is being recorded. **Format: date (8, yyyy-mm-dd)**	dob	Date
7	Sex – patient's sex, to be numerically coded as follows: 1. Male = 1 2. Female = 2 3. Not determined = 3	sex	Char(1)
8	Race – patient-identified designation of a category from the following list, and coded as follows: A. White = 1 B. Black/African American = 2 C. American Indian/Alaska Native = 3 D. Native Hawaiian/Other Pacific Island = 4 (e.g., Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander.) E. Asian (e.g., Asian Indian, Chinese, Filipino, = 5 *Japanese, Korean, Vietnamese, other Asian)* *F. Two or more races = 6* *G. Some other race = 7* *H. Unknown = 8*	race	Char(1)
9	*Ethnicity – patient-identified ethnic origin from categories listed and coded as follows:* *A. Hispanic/Latino = 1* *(i.e., Mexican, Puerto Rican, Cuban or other Hispanic or Latino)* *B. Non-Hispanic/Latino = 2*	pat_eth	Char(1)
10	Patient's State – patient indicated state of primary residence.	patstate	Char(2)
11	Town – patient indicated town of primary residence.	twn_cty	Char(3)
12	Zip Code - zip code of the patient's primary residence	patzip	Char(5)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
13	*Relationship to Insured1 – means the patient's relationship to the identified insured or sponsor. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines:* (A) Patient is insured/Self = 01 (B) Spouse = 02 (C) Natural child/Insured financial responsibility = 03 (D) Natural child/Insured does not have financial responsibility = 04 (E) Step child = 05 (F) Foster child = 06 (G) Ward of the court = 07 (H) Employee = 08 (I) Unknown = 09 (J) Handicapped dependent = 10 (K) Organ donor = 11 (L) Cadaver donor = 12 (M) Grandchild = 13 (N) Niece/Nephew = 14 (O) Injured plaintiff = 15 (P) Sponsored dependent = 16 (Q) Minor dependent of a minor dependent = 17 (R) Parent = 18 (S) Grandparent = 19 (T) Life partner = 20	r_insure1	Char(3)
14	Employment status (e_stat) – means the patient's employment status. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines: (A) Employed full time = 1 (B) Employed part time = 2 (C) Not employed = 3 (D) Self employed = 4 (E) Retired = 5 (F) On active military duty = 6 (G) Unknown = 9	e_stat	Char(1)
15	Insured1's employer – means the name of the insured's employer. Blank if unknown or not applicable.	employ1	Char(50)
16	Insured1's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i1_state	Char (2)
17	Insured2's employer – means the name of the insured's employer. Blank if unknown or not applicable	employ2	Char (50)
18	Insured2's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i2_state	Char (2)
19	Insured3's employer – means the name of the insured's employer. Blank if unknown or not applicable.	employ3	Char (50)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
20	Insured3's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i3_state	Char (2)
21	Payment sources (Primary (ppayer), Secondary (spayer) and Tertiary (tpayer)) - the major payment sources that were expected at the time the dataset was completed, from the categories listed below: Self pay = A Worker's Compensation = B Medicare = C Medicaid = D Commercial Insurance Company = E Medicare Managed Care = F Medicaid Managed Care = G Commercial Insurance Managed Care = H CHAMPUS or TRICARE = I Other Government Payment = J Title V = Q No Charge or Free Care = R Other = M	ppayer	Char(1)
22	As defined in (19). Blank if not applicable.	spayer	Char(1)
23	As defined in (19). Blank if not applicable.	tpayer	Char(1)
24	Payer Identification (payer1, payer2, payer3) – the insured's payer (or National Plan ID) that identifies the payer organization from which the facility expects, at the time of the encounter, some payment for the bill. Up to three payer organizations shall be reported in the order of their expected contributions to the payment of the facility's bill. **Format: string (9, zero filled to left if fewer than 9 characters)**	payer1	Char(5)
25	As defined in (22). Blank if not applicable.	payer2	Char(5)
26	As defined in (22). Blank if not applicable.	payer3	Char(5)
27	Encounter type – indicates the priority of the encounter. Emergent = 1 Urgent = 2 Elective = 3	etype	Char(1)
28	Operating Physician – CT Provider ID identifying the provider who performed the service/treatment/procedure	ophysid	Char(7)
29	Attending Physician – CT Provider ID of the physician primarily responsible for the patient for this encounter.	pphysdocid	Char(7)
30	Charges – Total charges for this encounter **(Round the actual value contained on the discharge's bill to the nearest whole dollar amount, zero filled and right justified)**	chrg_tot	Num(8)
31	*Disposition – the circumstances of the patient's discharge. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines:*	pstat	Char(2)

DATA RECORD TYPE 1			
#	**Description**	**Field Name**	**Data Type**
	Discharged to home or self care, (routine discharge) 01 Discharged or transferred to another short term general hospital for inpatient care 02 Discharged or transferred to a skilled nursing facility (SNF) 03 Discharged or transferred to an intermediate care facility (ICF) 04 Transferred to another type of institution for inpatient care 05 Discharged or transferred to a home under care of an organized home health service organization 06 Left or discontinued care against medical advice 07 *Discharged or transferred to home under the care of a home IV Provider 08* Admitted as an inpatient to this hospital 09 Expired 20 Expired at home 40 Expired in a medical facility (e.g. hospital, SNF, ICF or free standing hospice) 41 Expired – place unknown 42 Hospice – home 50 Hospice – medical facility 51 Discharged or transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital 62 Discharged or transferred to Medicare certified long term care hospital (LTCH) 63 Discharged or transferred to a nursing facility certified under Medicaid but not certified under Medicare 64 Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 65		
32	Principal Diagnosis – the ICD-9-CM code for the condition which is established after the study to be chiefly responsible for the encounter being recorded. **Format: String (5, do not include decimal place -- decimal place is implied)**	dx1	Char(5)
33	Secondary Diagnoses (dx2 through dx10) – the ICD-9-CM codes for the conditions, exclusive to the principal diagnosis, which exist at the time the patient was treated or which developed subsequently to the treatment and which affect the patient's treatment for the encounter being recorded. Diagnoses which are associated with an earlier encounter and which have no bearing on the current encounter shall not be recorded as secondary diagnoses. **Format: String (5, do not include decimal place -- decimal place is implied)**	dx2	Char(5)
34	As defined in (31).	dx3	Char(5)
35	As defined in (31).	dx4	Char(5)
36	As defined in (31).	dx5	Char(5)
37	As defined in (31).	dx6	Char(5)
38	As defined in (31).	dx7	Char(5)

DATA RECORD TYPE 1			
#	Description	Field Name	Data Type
39	As defined in (31).	dx8	Char(5)
40	As defined in (31).	dx9	Char(5)
41	As defined in (31).	dx10	Char(5)
42	E-code (ecode1 to ecode3) – The ICD-9-CM codes for external cause of injury, poisoning or adverse effect. **Format: string (5, do not include decimal place -- decimal place is implied)**	ecode1	Char(5)
43	As defined in (40).	ecode2	Char(5)
44	As defined in (40).	ecode3	Char(5)
45	Principal Procedure – the ICD-9-CM code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient. Blank if not applicable or not coded. **Format: String (4, do not include decimal place -- decimal place is implied)**	px1	Char(4)
46	Secondary Procedure (px2 through px10) – the ICD-9-CM codes for other procedures. Blank if not applicable or not coded. **Format: String (4, do not include decimal place -- decimal place is implied)**	px2	Char(4
47	As defined in (44).	px3	Char(4)
48	As defined in (44).	px4	Char(4)
49	As defined in (44).	px5	Char(4)
50	As defined in (44).	px6	Char(4)
51	As defined in (44).	px7	Char(4)
52	As defined in (44).	px8	Char(4)
53	As defined in (44).	px9	Char(4)
54	As defined in (44).	px10	Char(4)

	DATA RECORD TYPE 2		
#	Description	Field Name	Description
1	Record Type Indicator: **02**	recid	Num(2)
2	Facility ID Code - The last four digits of the Medicare Provider Number for the unit from which the patient was discharged for the encounter being recorded.	facid	Char(4)
3	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. **Format: string (20, zero filled to left if fewer that 20 characters)**	mrn	Char(20)
4	Patient Control Number – unique number assigned by the facility to each patient's individual encounter that distinguishes the medical and billing records of the encounter. **Format: string (20, zero filled to left if fewer that 20 characters)**	patcont	Char(20)

	DATA RECORD TYPE 2		
#	**Description**	**Field Name**	**Description**
5	Social Security Number – patient's SSN **Format: string (9, hyphens are implied)**	ssn	Char(9)
6	Revenue Code - A UB-92 code that identifies a specific accommodation, ancillary service or billing calculation	rev	Char(4)
7	HCPCS Code – A uniform code used to report procedures, services and supplies for reimbursement. Blank if not applicable.	hcpc	Char(5)
8	First Modifier Code – means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod1	Char(2)
9	Second Modifier Code means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod2	Char(2)
10	Third Modifier Code – means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod3	Char(2)
11	Fourth Modifier Code means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. Blank if not applicable.	mod4	Char(2)
12	Units Of Service –number of days for multiple days or units of supply	units	Num (4)
13	Charges – charge for the listed service **(Round the actual value contained on the discharge's bill to the nearest whole dollar amount, zero filled and right justified)**	chrg	Num (6)
14	Service Date – The month, day, and year for each procedure, service or supply. **Format: date (8, yyyy-mm-dd)**	servdate	Date

*** Multiple rows of Data Record Type 2 will be needed to report all HCPCS/CPT and revenue codes recorded for an encounter; however there should be only unique occurrences of combinations of revenue and HCPCS codes and of revenue codes (if no HCPCS code is assigned) for an encounter.**