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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

March/April 2011 • Vol. 2011 No. 3

6 Key Legal Issues Facing Ambulatory Surgery Centers

By Scott Becker, JD, CPA and Rachel Fields

2011 should be an interesting year for surgery center legal issues. The key issues that we see include increased enforcement under the anti-kickback and related statutes, increased impatience from physicians as to other physicians' activities at surgery centers, increased efforts by physicians to find innovative ways profit from the surgery centers, a bit of a "wait and see" time in terms of the impact of healthcare reform implementation, increased review of certain contracting issues

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7 Costs Your ASC Could Cut in 2011

By Rachel Fields

In 2010, Tampa Bay Specialty Surgery Center won National Surgical Care's "Center of the Year" Award for saving a significant amount of money on utilities, supplies, staffing and services. Laura Smith, administrator of the center, discusses how they did it.

1. Rent and taxes. According to Mrs. Smith, Tampa Bay Specialty Surgery Center realized significant savings by looking more closely at the center's lease agreement. The center shares its facility with a physician-owned group and was paying rent, electric, water, hot water and maintenance fees to the group. "I started looking into it and realized there were a lot of issues with the rent," Mrs. Smith says. "We were pay-

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12 Recent ASC Transactions

By Rob Kurtz

2010 saw a significant increase over 2009 in surgery center transactions. During 2010, the pricing of transactions tended to increase from 2009. To learn more about these trends and see examples of pricing seen in various transactions, read "ASC Transactions and Pricing During 2010: 4 Key Concepts" on www.BeckersASC.com.

Here are 12 reports on recent transactions involving ASCs.

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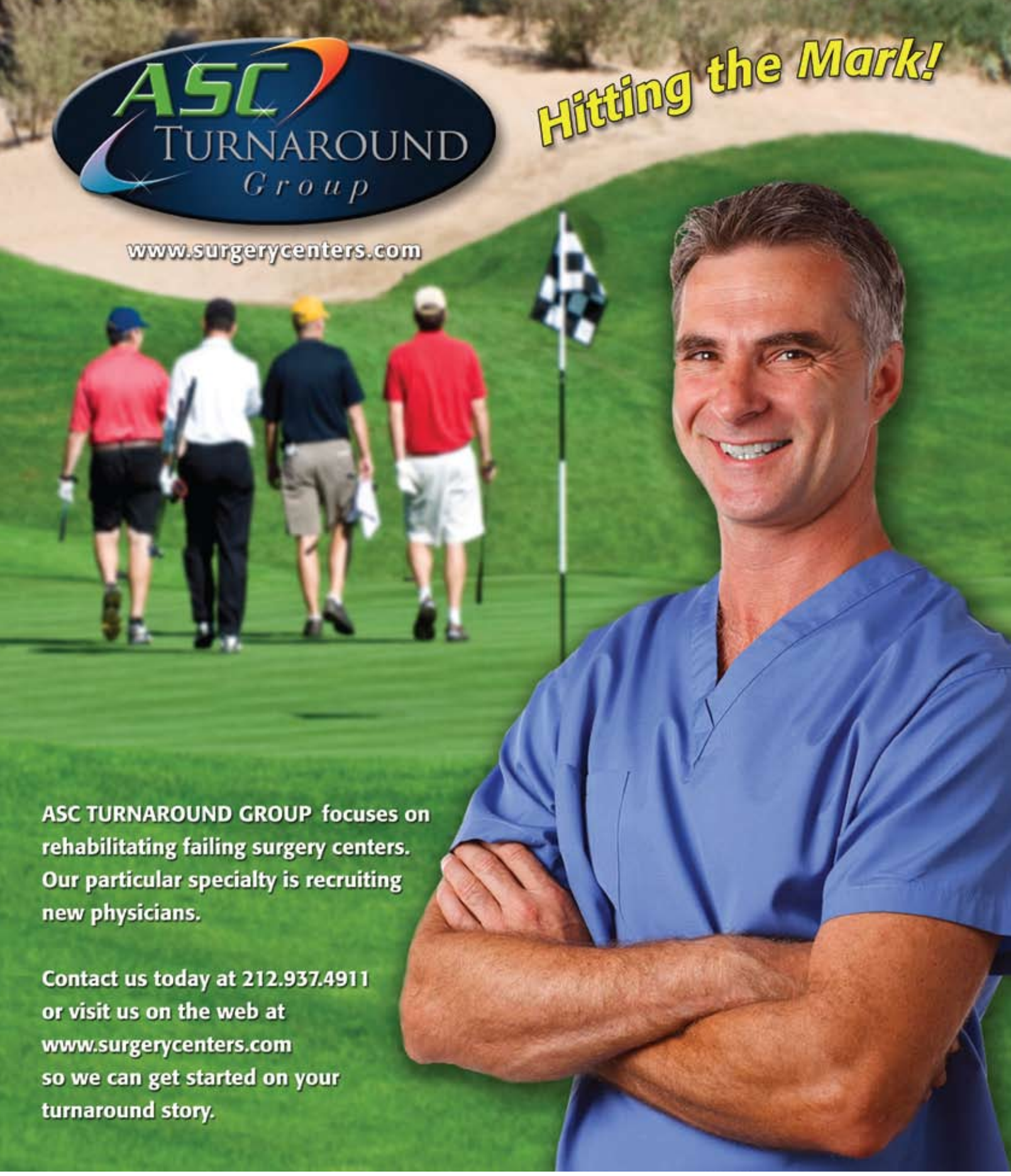

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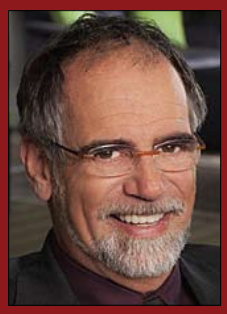

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ASCREVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

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Publisher's Letter

ASC Industry Growing, Chains More Active, Existing ASCs Working to Improve; 9th Annual Orthopedic, Spine and Pain Management-Driven ASC (June 9-11, Chicago)

Enclosed herewith is the March/April issue of *Becker's ASC Review*. The issue includes several feature articles such as:

1. 6 Key Legal Issues Facing Ambulatory Surgery Center — 2011 brings an increase of enforcement of the anti-kickback and other related statutes. This article provides an overview of six key regulatory issues for ASCs.

2. 7 Costs Your ASC Could Cut in 2011 — This article shares seven costs to ASCs that could potentially be reduced to generate significant savings for your facility.

3. 5 Areas Profitable ASCs are Still Leaving Money on the Table — Even profitable ASCs have the potential to increase their revenue. Find out how by reading this article.

We are excited to continue to see some growth in the surgery center business. While we see plenty of challenges, we also see a good deal of opportunity. Certain ASC chains are actually more active than they have been before, and there is still a certain amount of development going on. Finally, existing centers are ratcheting up their efforts to recruit physicians, improve cost containment and valuate for strategic options.

We have included in this issue the brochure for the 9th Annual Orthopedic, Spine and Pain Management-Driven ASC conference to be held June 9th to 11th, 2011. We have 134 speakers and 100 sessions as well as keynote speaker Mike Ditka, who will be speaking on leadership. We think it will be a great conference.

Should you have questions about anything listed here or desire to sign up for the *Becker's ASC Review* E-weekly, please contact me at (312) 750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

P.S. For information on advertising or exhibiting in *Becker's ASC Review* or on any of the related websites, please contact Jessica Cole or *Becker's ASC Review* at (800) 417-2035.

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6 Key Legal Issues Facing Ambulatory Surgery Centers
(continued from page 1)

between joint-venture ASCs and hospitals as to whether they can jointly contract to obtain better rates for managed care and increase in co-management arrangements. Lastly, there will continue to be struggles between surgery centers and payors over out-of-network reimbursement.

1. Anti-kickback issues. The government over the last few years has initiated huge increases in the funds allocated to healthcare fraud enforcement, which focuses on billing and collection issues, as well as physician-hospital relationships. In the past, fraud enforcement focused heavily on billing and collections issues. Now, significant fraud and abuse resources are also put towards review of Stark issues and anti-kickback relationships between hospitals and physicians. In Jan. 2011, an internal investigation by Detroit Medical Center before its sale to Vanguard Health Systems uncovered potentially improper relationships between the health system and more than 250 physicians. The relationship violations reportedly included leases with physicians not at fair market value, free advertising and tickets to events and seminars. The surgery center industry has just begun to see some level of investigation of fraud and abuse on the physician relationship side. We believe the surgery center industry is ripe for more investigative resources to be directed toward it.

We continue to see the evolution of different types of possible anti-kickback situations. These relate to situations where parties are trying to sell shares to physicians at prices that may be below fair market value, situations where facilities are leasing equipment on a per-click basis from physicians and situations where parties want to sell different quantities of shares to different physicians or pay different types of medical director fees to different physicians. From 2008-2010, there were more than 20 different HHS' Office of Inspector General physician self-referral and anti-kickback settlements, many of which targeted improper relationships between physicians and healthcare facilities..

Over the next few years, as the government allocates more money to anti-fraud initiatives, it will be important to keep an eye on what types of activities people are engaging in and what types of activities the government is particularly targeting.

(a) Safe harbors — non-compliant physicians. Over the past few years, parties have become more aggressive in trying to redeem physicians who are not safe harbor compliant as existing physicians are increasingly less patient with non-safe harbor compliant physicians. In many situations, the parties may offer the non-compliant physicians full value for the shares, even if such full value is not required under the surgery center's operating agreement. The parties may also give such non-compliant physicians a long notice period in which the non-compliant physician may come into compliance with the safe harbor. In addition, it is important that safe harbor concepts not be applied in a discriminatory manner. Rather, the safe harbor concepts should be consistently applied to all physician members if the center is going to enforce the concepts and use them to redeem parties. Further, there is at least one significant case where the use of the safe harbor concepts was challenged by a physician. While the case was dismissed on other grounds, it has provided additional comfort to parties who are looking to redeem physicians based on lack of safe harbor compliance. Again, it is critical that redemption be truly based on safe harbor compliance. There is an increase in litigation in this area.

(b) Safe harbors — indirect referrals. The government continues to express great discomfort with indirect referral sources and non–safe harbor compliant physicians. That said, the government is very cautiously but intelligently handling cross-referral relationships as evidenced by the extreme caution exercised by the OIG in issuing a positive advisory opinion to a hospital-physician joint venture where only a small number of the orthopedic physicians were not safe harbor compliant (i.e., four out of 18 physicians were not safe harbor compliant) but were potential referral sources. There, in fact, the OIG prohibited the referral of cases from the non-compliant physicians to parties that would receive such referrals and then use the surgery center for those cases. In reaching its conclusion, the OIG said:

"In the circumstances presented, notwithstanding that four Inpatient Surgeons will not regularly practice at the ASC, we conclude that the ASC is unlikely to be a vehicle for them to profit from referrals. The Requestors have certified that, as practitioners of sub-specialties of orthopedic surgery that require a hospital operating room setting, the Inpatient Surgeons rarely have occasion to refer patients for ASC-Qualified Procedures (other than pain management procedures, which are discussed below). Moreover, like the other Surgeon Investors, the Inpatient Surgeons are regularly engaged in a genuine surgical practice, deriving at least one-third of their medical practice income from procedures requiring a hospital operating room setting. The Inpatient Surgeons are qualified to perform surgeries at the ASC and may choose to do so (and earn the professional fees) in medically appropriate cases. Also, the Inpatient Surgeons comprise a small proportion of the Surgeon Investors, a majority of whom will use the ASC on a regular basis as part of their medical practice. This Arrangement is readily distinguishable from potentially riskier arrangements in which few investing physicians actually use the ASC on a regular basis or in which investing physicians are significant potential referral sources for other investors or the ASC, as when primary care physicians invest in a surgical ASC or cardiologists invest in a cardiac surgery ASC. Advisory Opinion No. 08-08 (issued July 18, 2008)."

Here, the arrangement did not meet every requirement of the safe harbor in question. However, certain other factors led the OIG to conclude that, although the arrangement posed some risk, the safeguards put in place by the parties sufficiently reduced the risk of illegal kickbacks to warrant granting the positive advisory opinion.

(c) Buy-in pricing for junior physicians and new physicians. Parties continue to look for ways to reduce buy-in amounts for junior physicians. Increasingly, there are arguments for lower valuations based on the impact of the changing economy on surgery centers and the uncertainty of profits going forward. It is also possible for junior physicians to buy fewer shares, to obtain loans from companies that are in the business of providing financing for physician buy-ins (provided such buy-ins are not guaranteed or supported by any other investor or the surgery center) and to engage in opportunities like recapitalizations to further reduce the cost and value of the center. A key issue is ensuring that the center is not selling shares to junior physicians at below fair market value to induce the referral of cases or the retention for cases. For more extensive advice on selling shares to physicians, please read "Healthcare Fraud Investigations Increase; Greater Caution Urged in ASC Share Sales to Physicians; 22 Do's and Don't's on Selling ASC Shares" on www.BeckersASC.com.

(d) Can we kill a partner physician? One question that ties closely into the safe harbor concepts is, "Can I kill a physician who does not perform cases at the center?" The answer, briefly stated, is you cannot kill such physician. However, there are possibilities to work with the safe harbors and com-

pliance guidelines to see if the party is someone that should be redeemed pursuant to not complying with the safe harbors or other operating agreement terms. For example, a physician who fails to meet the safe harbors may be subject to buyout by the ASC. There will be increased litigation in this area this year. An issue that arises in litigation relates to the purpose of the buyout and whether at fair value or not.

(e) Sale of additional shares to highly productive physicians. We often see situations where a physician who produces proportionately more than he owns wants to buy additional shares in the surgery center. In general, it is very hard to facilitate this. It is possible for that physician to try to buy additional shares from other partners. Here, the other partners cannot sell their shares to the high producing physician simply to help keep his or her cases at the center. If existing partners want to sell shares, for reasons unrelated to retaining volume, it is not illegal for them to sell shares to such high producing physicians. The sale of shares should be at fair market value.

(f) Profiting from anesthesia and pathology. Increasingly, we see situations where centers and physicians are looking for ways to profit from ancillary services such as anesthesia, pathology or other areas. Again, there are certain ways in which an ASC can lawfully profit from anesthesia in a legal manner. However, there are certain other ways, such as setting up an anesthesia management company, which are of more significant concern with respect to the legality of profiting from anesthesia. This area has recently come under attack by the American Society of Anesthesiology. A letter from the ASA to the OIG brought up the following concerns about the increasing popularity of the "company model" that allows ASCs to profit from anesthesia:

"Coupled with the increasing prevalence of the 'company model' are additional demands upon anesthesia providers to pay renumeration for services beyond what they actually receive, including non-clinical supplies, scrubs, locker room and lunch room use, and full-time administrative office staff despite providing services for only part of a work week. We feel that these requests constitute kickbacks."

The ASA put forth that the "company model" would result in overutilization of anesthesia services and is likely to result in corruption of professional judgment.

The laws with respect to profiting from pathology are somewhat murkier. There is an ability often for gastroenterology practices related to surgery centers to perform pathology services in their own office and profit from these. However, there is a whole range of analysis that has to be performed to ensure that such efforts comply with the Anti-Kickback Statute, the Stark Act, and the Anti-Markup Provisions.

(g) "Per-click" relationships. There have traditionally been several different types of "per-click" arrangements for such items as gamma knives, lithotripters, lasers, CT and MRI scanners and other types of equipment. However, the government has now outlawed most per-click relationships in the Stark context. The changes to the Stark Act do not necessarily apply to surgery centers. The analysis and concerns are applicable under the Anti-Kickback Statute to surgery centers. In ASCs, parties should be quite cautious regarding the use of per-click arrangements. CMS offered an explanation of its position in the commentary to the new rules:

"At this time we are adopting our proposal to prohibit per-click payments to physician lessors for services rendered to patients who were referred by the physician lessor. We continue to have concerns that such arrangements are susceptible to abuse, and we also rely on our authority under sections 1877(e)(1)(A)(vi) and 1877(e)(l)(B)(vi) of the Act to disallow them.

"We are also taking this opportunity to remind parties to per-use leasing arrangements that the existing exceptions include the requirements that the leasing agreement be at fair market value (§411.357(a)(4) and §411.357(b)(4)) and that it be commercially reasonable even if no referrals were made between the parties (§411.357(a)(6) and §411.357(b)(5)). For example, we do not consider an agreement to be at fair market value if the lessee is paying a physician substantially more for a lithotripter or other equipment and a technologist than it would have to pay a non physician-owned company for the same or similar equipment and service. As a further example, we would also have a serious question as to whether an agreement is commercially reasonable if the lessee is performing a sufficiently high volume of procedures, such that it would be economically feasible to purchase the equipment rather than continuing to lease it from a physician or physician entity that refers patients to the lessee for DHS. Such agreements raise the questions of whether the lessee is paying the lessor more than what it would have to pay another lessor, or is leasing equipment rather than purchasing it, because the lessee wishes to reward the lessor for referrals and/or because it is concerned that, absent such a leasing arrangement, referrals from the lessor would cease. In some cases, depending on the circumstances, such arrangements may also implicate the anti-kickback statute."

(h) Medical directorships. Medical directorships should be used only if the medical director is providing true medical direction and clinical administrative services. If a typical center has one medical director who is an anesthesiologist and/or another surgeon truly involved in that effort, that should be the core model a surgery center should consider. When looking at

other situations, for example, having a medical director for each specialty, there must be a legitimate reason for the need for multiple medical directors, the fees must be fair market value, and such arrangement must not be intended to provide a kickback in exchange for cases. Improper medical directorships and other improper employment arrangements have led to legal action against hospitals in the past several years. Ivinson Hospital in Laramie, Wyo., was alleged to provide medical director services in excess of fair market value, while Tuomey Hospital in Sumter, S.C. was alleged to pay physicians for part-time employment services that violated Stark. Increasing action against hospitals regarding improper employment arrangements suggests ASCs may also be subject to more investigations as well.

(i) IOL relationships. Increasingly, there are situations where physicians buy intraocular lenses, specifically the premium lenses, and sell them to their patients. Here, the physicians may or may not buy these lenses from the surgery center itself and some physicians may have a relationships where they directly buy the lenses and sell them to patients. Either way, these transactions raise issues as to how much money goes back and forth between the surgery center and the physicians as to the IOLs and whether the surgery center is improperly allowing the physician at the center to profit from the sale of equipment. There are also issues as to the proper pricing of such lenses sold to patients. We are also aware of certain situations where two lens manufactures may provide free sample lenses to physicians and the physicians may sell these lenses to patients. This is likely improper. In general, it is preferable that the center be the seller of the lens and not physicians.

(j) Physician-owned equipment companies. One of the interesting new scenarios is where physicians own an equipment company and sell equipment to the surgery center. In essence, the physicians become a middle man between the surgery center and the equipment provider. This allows the physicians to profit on the sale of equipment used in any cases that they perform. ASCs should be cautious regarding these relationships. This new trend follows a longstanding concern over physician ownership of diagnostic medical equipment. A 2011 Center for Studying Health System Change report showed that nearly one in seven physicians in community-based, physician-owned practices own or lease three or more types of equipment to perform laboratory, x-ray or advanced imaging services. Starting in 2011, physicians are required to make financial interest disclosures to any patients seeking imaging services and must provide alternative supplies. The report — which is not pro-physician — concluded that "given the growing evidence that physician self-referral contributes to unnecessary and costly care, policy makers might reconsider the broadness of the in-office ancillary service exemption to the Stark law."

2. Hospital outpatient department transactions and "co-management arrangements" deals. As the government has outlawed under "arrangements transactions", there has been substantial growth in situations in which a surgery center sells to a hospital and develops what is titled a "co-management" relationship. This provides the physician or physician group compensation for managing the service of the hospital but allows the hospital to really be the owner and provider of the services and to provide the services at hospital outpatient department rates. The great challenge in these relationships will be assuring that they are fair market value and paying physicians for reasonably needed services and not just a means to get money to physicians in exchange for business. The further great challenge of these relationships will be how they look 3-5 years after a transaction is completed. In essence, there is nothing as congruent in terms of interests as a true joint venture. Over time, there is a great likelihood that case volumes will be reduced and that the glue of the relationship will be not as strong as it was when first formed.

3. Out-of-network reimbursement. The ability to profit substantially from out-of-network patients continues to decrease. Payors are increasingly aggressive regarding recoupment, collection of appropriate co-payments from patients and increasing co-payment and deductible responsibilities. Thus, the ability to make outsized profits or have serious negotiation leverage through the use of OON continues to be hampered. Some state governments have also taken action to regulate OON insurance markets. For example, New Jersey released and re-released a bill in 2010 that places various additional regulators on OON surgery centers, including requirements that OON physicians and facilities inform patients whether the health services they seek are in-network or OON and others. While the bill eliminated previous language that would have required N.J. OON ASCs to charge patients out-of-pocket costs in many cases, the NJAASC still said it was "far from happy" with the end result.

On the OON side, we are seeing increasing situations where payors either issue audit letters to surgery centers, develop no pay policies OON or pay surgery centers just a fraction of what they expect to get paid. Surgery centers, on their end, are increasingly making efforts to work with state departments of insurance to explain how the cutting off of OON precludes patients from accessing true PPO benefits. There is a handful of cases that discuss whether or not payors have responsibilities to pay providers when providers are serving patients OON and in some situations reducing co-payments. This is an evolving area that continues to become more combative.

4. Antitrust issues – joint-venture managed care contracting. There are two antitrust issues that are most prevalent in the ASC industry. First, there is a question as to whether a hospital and physicians can jointly contract to try to obtain better rates from managed care payors. Here, the key issue is ensuring that two entities can be considered one entity for purposes of the antitrust laws, which makes them legally incapable of conspiring with each other. There is a significant difference in legal interpretations on this across the country. For example, if a hospital owns 80 percent or more of the surgery center and has substantial control of the surgery center, there are very strong arguments that conspiring together is not possible from an antitrust law perspective (i.e., the hospital and surgery center are one). When the ownership is between 50 percent and 80 percent, the determination differs from district court to district court, which is to say by region of the country. Further, the amount of control the hospital has over the surgery center is a critical component of the ultimate determination. Where a hospital owns less than 50 percent of the surgery center, it may still be possible for the hospital and surgery center to be considered one entity, but the hospital must have very substantial control of the surgery center.

The other common antitrust issue arises when a surgery center is excluded from certain payor contracts due to aggressive hospital competition. Here, the challenge for the surgery center is showing that the hospital provides more than simple competition but rather has conspired to harm the physician-owned surgery center or has made an effort to monopolize the market. This can be a very expensive process of gathering facts to prove such conspiracy exists.

5. HIPAA. The Health Insurance Portability and Accountability Act (HIPAA) continues to be updated in a manner that adds additional burdens. One of the biggest burdens in the most recent HIPAA amendments requires that a patient be notified of any sort of inadvertent breach of disclosure of confidential information. Previously, centers and healthcare providers could decide, on a case-by-case basis, whether or not to notify the patient of an inadvertent breach. Now, patients must be notified of any breach. Healthcare organizations have already come under fire for failing to notify patients of data breaches in a timely manner: In Nov. 2010, an Indiana attorney filed suit against Indianapolis-based health insurance company WellPoint for failing to notify 32,000 customers of a data breach until June 2010, at least eight months after the breach began. Additionally, portable devices that store electronic protected health information must be constantly tracked and controlled by employees under Section 164.310(d) of the HIPAA Security Rule, meaning the convenience of portable devices is coupled with a substantial risk. Further, under the newly revised HIPAA, the patient has the right to receive medical records with little cost even if the surgery center must incur costs to provide the medical records.

6. Healthcare reform. No one knows exactly what the ultimate impact of healthcare reform will be on ASCs. However, almost everyone expects

that it will lead to an incremental increase in the number of governmental and lower paying patients. In the short run, healthcare reform does not appear to have a very immediate negative impact on surgery centers. In fact, because the reform legislation provides certain incentives for preventive efforts, such as colonoscopies, and because there is no public option, the immediate negative impact is not clear.

Some of the concepts set forth in the healthcare reform law involve integrative efforts between hospitals and physicians to develop accountable care organizations and other efforts that allow the joint packaging of care. These efforts, together with other payment incentives for hospitals, often lead to more employment of physicians by hospitals. This reduction in the pool of physicians means a reduction in the lifeblood of surgery centers. In theory, ACOs should view surgery centers as a low-cost, high-quality alternative to other forms of care delivery, but some worry that ACOs will not fit with the traditional operation and mindset of the ASC. Saul Epstein, co-administrator of ParkCreek Surgery Center in Coconut Creek, Fla., told *Becker's ASC Review* that ASCs could turn out to be a cost center for ACOs rather than a cost-saving alternative. "When an ACO is paid a lump sum for a patient's care, surgery will be seen as a cost center," he said.

Healthcare futurist Joe Flower says ASCs, which are traditionally designed to focus on a single niche, may have trouble adapting to the "continuum of care" model. Andrew Hayek, president and CEO of Surgical Care Affiliates, wrote in *Becker's ASC Review* that ASCs involved with ACOs will need to have "robust clinical systems and sophisticated tools to improve cost and efficiency, and they will need to tie their clinical and cost analytics into the ACO's information on the overall patient population to drive ongoing improvement in outcomes and cost." This may prove a significant obstacle for ASCs that lack the assets to invest in advanced IT.

While the overall verdict on healthcare reform is not yet in, certain of the long-term trends do not favor surgical centers despite the fact that ASCs greatly reduce the cost of care. ■

This is intended as a brief summary of six key legal issues facing surgery centers today. Should you have additional questions, please contact Scott Becker at sbecker@mcguirewoods.com.

7 Costs Your ASC Could Cut in 2011 **(continued from page 1)**

ing an extra 400 square feet in rent, which [cost us] $22 per square feet." She says for three years, the center had paid taxes based on an "estimated tax bill," which the center had accepted as accurate. "Instead of somebody looking at it, it was just being paid," she says. "We were challenged at our national [management company] meeting to decrease the cost in all our centers without foregoing patient care, and I thought this would be the best place to start."

Once Mrs. Smith looked more closely at the tax bill, she realized the center was overpaying almost $5,000. With the rent and the taxes adjusted, the center saved around $13,000 — all from simple vigilance and research.

2. Water and electric bills. In addition to the overpayment for rent and taxes, the center was paying 25 percent of the facility's electric bill, regardless of the number of kilowatts per hour used. "I didn't think that was fair," Mrs. Smith says. "I thought we should pay [based on] whether we used more or less." The center had a separate meter installed and now pays only for kilowatts used, saving around 30 percent on electricity.

The water bill posed a similar problem: the center was paying 75 percent of the water bill for the building when they only occupied around 20 percent of the facility. "I had the water company and specialists come in, and they told me we should only be paying 25 percent," she says. "We now only pay 25 percent of the water bill." The center was also paying 100 percent of the hot water heater bill for the entire building. The ASC now pays for 75 percent, following Mrs. Smith's research.

3. Maintenance. According to Mrs. Smith, Tampa Bay Specialty Surgery Center was paying 25 percent of the building maintenance worker's salary prior to her research. "When I started reading into the lease, [maintenance] was supposed to be included in the lease," she says. The center approached the landlord with this concerned and ended up cutting out that cost. Mrs. Smith says when she presented these cost-saving accomplishments at National Surgical Care's yearly meeting, her main message was: look at your lease agreement. "It is so full of valuable information when you start looking into it, especially if you lease from a landlord," she says. "If [payments] have been happening over and over again, nobody ever looks at it. When you really understand the language and get to know the lease agreement, there is money that can be saved."

4. Drugs and medical supplies. Mrs. Smith says her ASC used to staff a materials manager who took little responsibility for saving money on drugs and supplies. "At the beginning of the year, I [hired someone new] and she was able to go through and really work with vendor reps for all our medical supplies and get our costs down significantly," she says. She says the materials manager went after the center's shipping charges, which originally applied to all drugs and medical supplies Tampa Bay ordered. "I asked our materials manager to contact all the vendors and re-negotiate all our charges, some of which we were paying $100 for shipping," she says.

Many ASCs run into problems when trying to re-negotiate with vendors. If the ASC has historically accepted high prices for their supplies, vendors can be hesitant to provide anything lower. Mrs. Smith says the key to re-negotiation is to get physicians involved. "If your physicians are in the room using the rep's [specific supply], and they say, 'You need to decrease the cost on this specific item or I'm no longer going to use it,' that will have an effect," she says. "Usually a vendor doesn't have the market for one special item."

5. Office supplies. Many ASCs have found success with a group purchasing organization, and Tampa Bay is no different. To save money on office supplies, Mrs. Smith says her ASC joined other surgery centers in purchasing through Office Depot. "With all of us purchasing as a group, we're offered discounts, and the more we use [Office Depot], the more we can get back from them," she says. Mrs. Smith says the center's affiliation with National Surgical Care has been essential in being able to join with 22 centers and create stronger leverage.

6. Staff salaries. Unfortunately, the need to cut costs meant Mrs. Smith was forced to lay off several staff members. "With the declining economy and decreased census, the difficult decision had to be made to lay off some key people: a clinical director, a business office team member, a PACU nurse, a pre-op telephone nurse and a GI tech," she says. The center also decreased its per diem staff. She says while layoffs weren't easy, the consolidation helped the ASC function more as a team. "We could either keep those positions and decrease everybody's hours to part time, or be able to increase some members' hours [by laying off others]," she says.

She says the "team" mindset at the ASC means that staff members never stand around when there's no work to be done. "Most of the team members get an average of 32 hours a week, and when their cases are done, they leave," she says. "Our pre-op team is absolutely wonderful. If they just have cases in the morning and there's a huge block in the afternoon with no cases until 1:00, they'll clock out, go home and come back."

7. Physician schedules. Mrs. Smith says the center saved money on staffing by asking certain physicians to condense their schedules. "One of our pain physicians had a Tuesday-Wednesday-Thursday block scheduled for him, and he'd do four cases on Tuesday, three on Wednesday and then 12 on Thursday," she says. "I asked him to condense his Wednesday into his Tuesday, and now he only uses Wednesday as an overflow day." She says the physician was very amenable to the change. ■

Learn more about National Surgical Care at www.natsurgcare.com.

12 Recent ASC Transactions (continued from page 1)

The agreement was unanimously approved by NovaMed's board of directors, including a special committee of independent directors.

The acquisition is expected to close in the second quarter of 2011.

McGuireWoods, led by Scott Becker, Geoff Cockrell and Amber Walsh, was one of the law firms which provided counsel to the buyer in connection with this transaction. For information on the McGuireWoods healthcare practice, please contact sbecker@mcguirewoods.com.

Upstate New York Hospital Acquires Syracuse Surgery Center

Upstate University Hospital in Syracuse, N.Y., has acquired the Harrison Outpatient Surgery Center in downtown Syracuse.

Upstate University acquired the six-OR, 19,000-square foot ambulatory surgery center business and its equipment for $2.3 million. It will continue to lease the space.

Following the acquisition, which was completed in Dec. 2010, the hospital renamed the ASC the Upstate Outpatient Surgery Center.

The surgery center was owned by Holdings LLC, which also owns an ASC in Camillus, N.Y.

Ohio's Fairfield Medical Center Acquires Lancaster Surgery Center

Fairfield Medical Center in Lancaster, Ohio, has acquired Riverview Surgery Center, also in Lancaster.

The 50,000 square-foot ambulatory surgery center with four operating rooms was co-owned by a group of surgeons with a 70 percent ownership stake and Mount Carmel Health, based in Columbus, Ohio, owning the remaining 30 percent.

The 222-bed, nonprofit Fairfield Medical Center spent $8.5 million on the purchase of the ambulatory surgery center, with the business costing $5.4 million and the campus costing $3.1 million.

The ASC, which was built in 1997, will retain its name.

Illinois Surgery Center in Joliet Becomes Hospital Department

Provena Saint Joseph Medical Center in Joliet, Ill., has announced the former Ambulatory Surgery Center of Joliet is now officially a department of the hospital.

Physicians at the ambulatory surgery center, which is located adjacent to the hospital, retain management responsibilities. The ASC has three operating rooms and two procedure rooms.

McGuireWoods, with a team led by Geoff Cockrell and Scott Becker, represented the ASC in this matter.

Irving Place Capital to Acquire National Surgical Hospitals

Irving Place Capital, a middle-market private equity firm, has announced it will acquire National Surgical Hospitals, an owner and operator of 14 surgical hospitals and seven ambulatory surgery centers located in 10 states.

IPC, which was advised on the deal by Cain Brothers, will replace NSH's current owners, Ferrer Freeman & Co., Charlesbank Capital Partners and JPMorgan Asset Management.

David Crane, a senior advisor to IPC, chairman of New Hope Bariatrics and former CEO for Medcath, will become chairman of NSH's Board of Directors.

John G. Rex-Waller, president and CEO of NSH, said of the acquisition in an IPC news release, "IPC's capital strength will allow us to reinvigorate our acquisition program and enhance our ability to add services and invest in the latest proven technology to empower physicians to deliver better outcomes for patients," according to an IPC news release.

McGuireWoods was one of the law firms that worked with IPC on this transaction. Krist Werling, Scott Becker and Rob Marks led the McGuireWoods team.

The terms of the transaction were not disclosed.

Owner and Operator of Two Texas Surgery Centers Acquired

First Surgical Texas, an owner and operator of two ambulatory surgery centers and a general acute care hospital in the greater Houston metro area, has been acquired by Arkson Nutraceuticals.

First Surgical Texas owns First Street Surgical Center, First Surgical Woodlands and First Street Hospital. The company reported revenues of more than $44 million for the fiscal year ending Dec. 31, 2009.

It was founded in 2002, and has more than 30 affiliated physicians and an additional 60 non-affiliated physicians that use First Surgical's locations for surgical procedures. Procedures performed include bariatrics, reconstructive and cosmetic plastics, orthopedics, pain management, neurosurgery and podiatry.

Under the terms of the acquisition, the company will change its name to First Surgical Partners, of which First Surgical Texas will continue to operate as a wholly-owned subsidiary. The company will now be publicly traded and listed on the OTC Bulletin Board.

Tony Rotondo serves as CEO and Dr. Jacob Varon serves as chairman of the board of Arkson.

Indiana Surgery Center Acquired by Good Samaritan Hospital, Ends Seven-Year Competition

The Vincennes (Ind.) Surgery Center has been acquired by Good Samaritan Hospital, also based in Vincennes.

The acquisition, which becomes effective Jan. 1, 2011, ends a seven-year competition between the Vincennes Surgery Center and Good Samaritan Hospital's Same Day Surgery Center.

"We have been competitors with Vincennes Surgery Center for seven years and it's time to move forward, together with a single focus, improving health as a regional center of excellence to all of the counties we are privileged to serve," said Rob McLin, president and CEO of Good Samaritan Hospital in the news release. "All parties involved in this agreement felt this would be

an ideal way to support development of an accountable care organization, which is a collaboration between physicians, hospitals and all providers that will be clinically and financially accountable for healthcare delivery in our community."

The Vincennes Surgery Center opened in late 2003 as a freestanding outpatient ambulatory surgery center and is on course to perform almost 2,000 procedures this year. Good Samaritan Hospital's Same Day Surgery Center opened in spring of 2004, and will perform approximately 2,325 surgeries this year.

The current owner of Vincennes Surgery Center will remain owner of the ASC's real estate.

Surgeon Group Acquires Minority Share in North Carolina Hospital Surgery Center

A group of surgeons is acquiring a minority ownership stake in an ambulatory surgery center in Cary, N.C., owned by Raleigh, N.C.-based Rex Hospital.

The physician group, the Surgical Center of the Carolinas, is working to raise $7.3 million to acquire a 45 percent share in the ASC.

The group had considered applying for a certificate of need to build its own surgery center, but with the high cost associated with the CON process and no guarantee of approval, the surgeons instead approached Rex Hospital about investing in the 4-OR ASC.

Northstar Healthcare Announces Syndication of MicroSurgery Institute of Houston

Northstar Healthcare, an owner and manager of ambulatory surgery centers, has announced the syndication of its newly formed operating partnership MicroSurgery Institute (MSI) of Houston.

The syndication involves an initial seven physician partners. Northstar will participate in the MSI partnership by leasing the surgery center assets and staff of The Palladium for Surgery – Houston to MSI for an ownership interest of 25 percent, a joint venture with an intended contractual life of one year.

Under the arrangement, Northstar will manage MSI and work to identify additional physician partners to participate in the MSI partnership.

Hawaii's Hilo Community Surgery Center Enters Into Joint Venture With Hospital

Hilo (Hawaii) Medical Center has announced it has entered into a joint venture with Hilo Community Surgery Center.

The hospital is now a minority partner with the ambulatory surgery center. Daily management and operation will continue under the ASC's administration.

The surgery center opened in June 2000 and offers specialties in gynecology, ENT, general surgery, ophthalmology, orthopedics, plastic surgery, podiatry, urology, pain management and IV therapy.

"The joint venture allows our surgeons to leverage the surgery center's services for certain outpatient procedures," said Howard N. Ainsley, East Hawaii Regional CEO of Hawaii Health Systems Corp., which governs the hospital, according to a news release from Hilo Medical Center. "This agreement also follows the accountable care organization's recommendation that encourages revenue generating partnerships between hospitals and ambulatory surgery centers."

Arkansas Health System Applies to Change Hospital to Surgery Center

St. Joseph's Mercy Health System, based in Hot Springs, Ark., has announced it is applying to the Arkansas Department of Health to change the licensure for St. Joseph's Mercy Health Center at HealthPark from an acute-care hospital to an ASC.

The decision to apply for the licensure change is a result of a merger earlier this year between St. Joseph's Mercy and HealthFirst Physicians Group. In the merger, Mercy acquired HealthPark Hospital, which had an average daily census of only five patients. St. Joseph's Mercy can absorb these patients, making it unnecessary to keep the HealthPark facility as an acute-care hospital.

"HealthPark is licensed as an acute-care facility and is open 24/7," said St. Joseph's Mercy President Tim Johnsen, according to a news release from the system. "Based on those requirements, we have to have staff in the emergency department the entire time. As we've studied it and operated it for the past four months, it's obvious that we can provide a much better patient experience by moving HealthPark to an outpatient surgery center."

The licensure change will take effect after Department of Health approval, which is expected to take 60 days.

Ohio Joint-Venture ASC to Become Hospital-Based Surgery Center

Zanesville (Ohio) Surgery Center, currently a joint venture operation with Genesis HealthCare System and community physicians, will be restructured as a hospital-based service.

The change will facilitate integration with Genesis' surgical services and improve the center's financial performance following damaging reimbursement changest.

The facility's name will change to Genesis Surgery Center, and the goals of the center will align with Genesis HealthCare's strategic plan to improve the system's overall delivery of care. ■

7 Steps for ASCs to Take Before Partnering With a Hospital or Management Company

By Leigh Page

When physician-owners of an ambulatory surgery center partner with a management company or hospital, they forge a long-term bond that would be difficult to undo if circumstances deteriorate, says Kevin McDonough, senior manager in the Dallas office of VMG Health. Mr. McDonough advises ASCs to take seven precautionary steps before signing on the dotted line.

1. Find an active manager. A passive partner might provide the needed cash but won't benefit your center over the long term. "ASCs should not focus exclusively on maximizing the upfront payment," Mr. McDonough says. "While the buy-in price needs to be competitive, the center should seek a partner who will take an active role in shepherding improved performance moving forward."

2. What can they do for you? "Prospective partners should be able to present a short and long-term strategic plan to the existing physician owners," Mr. McDonough says. "This strategic plan should highlight what their organization can bring to the table." They should detail how they plan to attract new physician volume, enhance managed care contracts, improve supply contracts, train staff in best practices and identify long-term strategic opportunities.

3. Would they respect your center's culture? The new partner will want to implement certain changes with the goal of increasing efficiency and improving performance, but it should not destroy the culture of the place. "There is a difference between making strategic improvements and making changes that undermine morale and alienate any potential existing partners," Mr. McDonough says. "Make sure you can tell the difference before commitment."

4. Look for a pro-physician attitude. Find a partner who would keep physicians involved in day-to-day management. "Someone who doesn't listen to physicians is going to drive away existing physicians and deter new investment," Mr. McDonough says.

5. How would governance work? In many cases, the new relationship requires rewriting the operating agreement, so read it carefully. In cases where physicians are giving up equity ownership, what authority would they still have?

6. Meet with the candidate. Meet with your prospective partner not just once but several times. "Treat this as you would any long-term partnership," Mr. McDonough says. He advises doing this over a length of time before signing any deal.

7. Perform a background check. Contact centers that are already affiliated with your prospective partner. "They should be able to give you a great idea as to what can be expected over the short and long-term with your prospective partner," Mr. McDonough says. "Just as you would before entering into any business relationship, you'll want to get references." ■

Learn more about VMG Health at www.vmghealth.com.

3 Frequently Asked ASC Valuation Questions

By Jason L. Ruchaber, CFA, ASA, Principal, HealthCare Appraisers

As a business appraiser and frequent speaker on valuation topics, I have the opportunity to discuss valuation issues with individuals from a wide variety of backgrounds and experience levels. Here are three of the most common questions I am asked by ambulatory surgery center owners, administrators and potential investors.

1. What are the current valuation multiples for surgery centers?

This is a question that is nearly impossible to answer. Though it is possible to draw reference to general rules of thumb or broad averages, there are a host of factors that will ultimately determine the appropriate multiple. Factors such as geographical location, local economic conditions, case mix, number of ORs, growth expectations, CON requirements, etc., can all have a significant influence on the appropriate multiple. What we have seen is that multiples for surgery centers vary significantly, ranging anywhere from 1-10x EBITDA less debt. For the majority of deals, the average multiple for a controlling interest in a multi-specialty surgery center is 5-7x EBITDA less debt and the average multiple for a minority interest is 3-4x EBITDA less prorata debt. These ranges are appropriate for approximately 50 percent of surgery centers, and more definitive guidance requires analysis by a qualified appraiser.

2. Is my center worth more if I sell to a hospital?

In some instances, hospitals buy a freestanding surgery center with the intent to convert the ASC to a hospital outpatient department and benefit from the higher reimbursement rates received by these entities. Unfortunately for owners of freestanding centers, the HOPD reimbursement benefit cannot be factored into the value that is paid for the center. This is due to the standard of value required in nearly all hospital acquisitions — fair market value (FMV). FMV requires that the price reflect the value negotiated at arms-length between two hypothetical parties and (under the Stark Law) without consideration of the value or volume of referrals. FMV requires the business to be valued "as is", giving consideration only to changes that could be reasonably attained by the existing owners or the pool of likely buyers. The consideration of a factor specific to a single buyer would be reflective of strategic value and a violation of the FMV standard of value.

3. What kinds of things can I do to increase the value of my ASC?

There are many ways to enhance the value of a surgery center. The obvious, and admittedly more difficult, methods to increase value include increasing surgical volumes, reducing operating costs, actively managing payor contracts, etc. However, there are also many qualitative factors that influence the value of a center. As an appraiser, one of my primary functions is to assess the risk of an investment in a center. All things equal, lower risk translates into higher value for a given level of profit. When I conduct my site visit and management interviews I look for established policies to actively monitor financial and clinical performance, experienced clinical and business office staff and physicians who are engaged and knowledgeable about the business of the surgery center. I also want an honest assessment about the opportunities and threats facing the business. Owners who do not plan for potential problems are not going to be able to respond when challenges arise. It is also important to have quality financial records for 3-5 years of history. If your center does not have good financial record keeping, hire a CPA to prepare reviewed financials in advance of considering a sale or appraisal. Demonstrating lower risk will frequently translate into a higher value for your center. ■

Learn more about HealthCare Appraisers at www.healthcareappraisers.com.

9 Biggest Issues for Orthopedic Surgeons in 2011

By Laura Miller

Industry experts identify nine of the top concerns for orthopedic surgeons in 2011.

1. Healthcare reform law. Over the next year, there will be an increased focus on quality measures and an influx in patients who will be able to receive medical care as a result of healthcare reform, says John Callaghan, MD, a surgeon at the University of Iowa and current president of the American Academy of Orthopaedic Surgeons. "The idea and concept that quality and value of procedures and interventions is going to be important going forward," says Dr. Callaghan. Orthopedic surgeons need to be aware of the data regarding their outcomes and have a clear idea of the measures they take to ensure quality to attract the best reimbursement rates.

An additional concern for surgeons is the lack of meaningful medical liability in healthcare reform, which will have a large impact on students finishing medical school over the next few years. "When you look at medical students coming out of school, they have to protect themselves," says Dr. Hecht. "We may not have enough surgeons to treat all the new patients." Tort reform will continue to be a contentious issue over the next year as lawmakers push forward with healthcare reform.

2. Reimbursement rates. Declining reimbursement is also a significant concern for orthopedic surgeons and an influx of Medicare and Medicaid patients due to healthcare reform could put an even greater strain on their ability to treat patients. "Everyone is concerned about the declining reimbursements for Medicare," says Andrew Hecht, MD, director of spine surgery in the department of orthopedics at Mount Sinai School of Medicine. "Taking care of Medicare patients is a labor of love for most doctors. It's really underpaid for every specialty, especially for the complexity of needs and the type of patients who are on Medicare."

Reimbursement for Medicare patients hasn't increased in years and more surgeons may need to choose to opt out of Medicare to keep their practice running in the future. "We're going to see more people insured and we need to figure out how to improve access to specialty care," says Dr. Hecht. "The solutions to these problems are going to depend on what the reimbursement rates will be and whether they can cover the cost of care."

3. Evidence-based medicine. With the reform law focusing on reducing the cost of healthcare and improving quality, more focus will be placed on evidence-based medicine. Medical organizations, such as the AAOS, put forth practice guidelines after extensive review of the literature to help their members practice using the best available evidence. For example, in September, the AAOS released a guideline on vertebroplasty, citing studies that found the benefits for the patients were no different than placebo procedures. The organization also has a guideline recommending against the use of arthroscopy to treat patients with degenerative arthritis in the knee.

Dr. Callaghan believes CMS, in the future, will stop reimbursing for the procedures when professional guidelines recommend against their use. "We think it is important that CMS pays for the things that help people, but if a procedure doesn't help our patients, we don't want CMS to have to pay for it," says Dr. Callaghan. "If we're not willing to invest in these guidelines, there's no way we're going to be able to lower the cost of medicine in this country." David Ott, MD, a surgeon with Arizona Orthopaedic Associates in Phoenix, also feels the payors will be demanding a higher level of proven effectiveness before reimbursing for procedures. "The payors, in an effort to control expenses, will demand this level of evidence to make sure the treatments they are paying for are worth it," he says.

The emphasis on evidence-based medicine means that the FDA 510(k) process will likely be reformed and it will take longer to bring orthopedic devices to the market. "New technology is going to have to be introduced more slowly and there is going to be a need for more evidence before putting these technologies into the field," says Dr. Callaghan. "There is also going to be a paradigm shift in orthopedic surgeons who consider themselves 'high tech.'" The surgeons who are interested in using the newest technology will have to curtail their use until the technology has been proven.

4. Accountability among orthopedic surgeons. There will be a greater emphasis on accountability of orthopedic surgeons in the coming years, whether the surgeons are working in a hospital or ASC setting. If there are complications with a surgery, such as a failed implant or infections, the surgeons have still been paid. However, Dr. Ott sees payors being weary of working with physicians who have high complication rates. "The most successful surgeons will have data to present to payors showing their results," says Dr. Ott. "I also think the level of service will increase because HCAP scores are going to determine reimbursement levels."

The two phrases that surgeons will be hearing about in the future are "appropriate use criteria" and "process improvement measures," says Dr. Callaghan. Appropriate use criteria involves the incorporation of the relevant research available to

determine the appropriate use of a procedure. Process improvement measures are the measures set forth by the National Quality Forum to lower costs while maintaining quality, i.e., providing value to the consumer. Surgeons will need to follow these measures and avoid unnecessary expenditures.

5. Surgeon/device company relationships. The healthcare reform bill will require full disclosure of the relationship between surgeons and orthopedic device companies in 2013. Device companies will have to publish the names of all physicians who have received a minimum amount of compensation for their consulting work and development of implants, says Dr. Callaghan. "The AAOS has been trying to educate our membership about this and recommending complete disclosure in their relationships with industry," he says. These disclosures could discourage some physicians from working with device companies in the future, says Dr. Ott, because they don't want patients or payors to feel manipulated by the industry connection.

However, Dr. Callaghan says orthopedic surgeons will continue to have a hand in developing devices in the future. "We need orthopedic surgeons to develop devices because they are the ones who know the clinical issues related to the procedures and implants they use. This is important for patient safety and optimization of patient outcomes," he says. "All this work has to be done ethically and professionally. Surgeons should disclose and explain these relationships to patients and follow Stark laws as well as other laws that become enacted."

Transparency in academic and scientific journals regarding surgeon relationships with device makers will also be a big topic in 2011. Over the past year, some physicians have been scrutinized for not revealing industry relationships in the journal articles they published, says Dr. Callaghan. The journals currently do not have a uniform set of rules for disclosure, which exacerbates the problem. "The Academy is working on getting all journal editors together to see if they can come up with a common disclosure," says Dr. Callaghan.

6. National Joint Registry. Next year will mark a big step in joint replacement surgery as the pilot programs for the National Joint Registry will begin in the United States. The registry will compile data from around the country concerning the different surgeries being performed, what implants are used and patient outcomes. The registry can also be helpful in gauging possible deficiencies with prosthetics. This year's recall of the DePuy metal-on-metal ASR hip replacement came only after reviewing data from the Australian and English joint replacement registry, says Dr. Callaghan.

"The National Joint Registry was developed by the Academy, but is independent of the AAOS and consists of a board of many stakeholders, including surgeons, payors, industry and hospitals," says Dr. Callaghan. "None of the other countries have multi-stakeholder boards." He says this aspect of the American registry will help make it a stronger resource for our country as well as other countries.

There has also been some interest in assembling a spine registry, says Dr. Callaghan, but gathering a registry for spine procedures is more difficult because of the greater amount of equipment used during spine surgery. "In spine, you may have 30 different screws and four sets of instrumentation," he says. "In a hip replacement, you only have a cup, a femoral component and a ball."

7. Spine surgery advances. There will be a significant focus on growing biologic treatment in spine surgery and improving the correct dose and formulations for the expanded use of BMP," says Dr. Hecht. Developments in BMP usage will allow for biologic surgery in more parts of the spine than are currently available. "Some of the biologic ages are going to facilitate the improved use of minimally invasive surgery," says Dr. Hecht. He sees a growing interest in cervical disc replacement heading into the next year, while he believes the interest in lumbar disc replacement surgery will wane. More focus will be on decreasing morbidity rates and conservatively treating patients who are able to benefit from pain management.

Much of the new technology developed in spine surgery is designed for less invasive procedures, though these technologies and procedures haven't necessarily been proven effective in the long term. Spine surgery technology is often very expensive, which means there will be more focus on the cost and benefit of spine surgery technologies in the future.

8. Subspecialty-focused orthopedic programs in hospitals. As hospitals scramble for physician contracts and begin hiring more surgical specialists, there will be more fragmentation among physicians, says Dr. Ott. For example, a surgeon with an emphasis on knee surgery will redirect their patient with shoulder problems to another surgeon who has an emphasis in that area. "The surgeons will be pushing patients away when they are out of their comfort zone," says Dr. Ott. "This is already happening at some larger practices and surgery centers."

Thomas Vangsness, MD, chief of sports medicine at the Keck School of Medicine at USC and the LAC/USC Medical Center, says the ability to focus on only the subspecialty at hospitals is one of the attractive aspects of hospital employment for some surgeons. He predicts hospitals will begin contracting more for surgeons in specific services. "I think that the average department will put a lot of different guys in to do different specialties," Dr. Vangsness says. "There will be a lot more subspecialties, especially if you contract with physicians."

Hospitals which want to remain competitive in multi-hospital communities will also begin pursuing opportunities for additional review approval, such as the Blue Cross Blue Shield Blue Certification or The Joint Commission's center of excellence certification, says Dr. Vangsness. Receiving recognition and certification will be used as an advertising tool to distinguish one facility from another and will most likely require physician involvement in the process.

9. Increased need for internet presence. Over the past several months there has been a greater desire by orthopedic surgeons to utilize Internet marketing as an advertisement and communication tool with potential patients. When patients receive referrals for orthopedic specialists, they are now using Internet search engines to find the surgeon before attending the appointment, says Ted Epstein, director of sales with Medical Web Experts. According to a study conducted by Pew Research Center's Internet & American Life Project, 61 percent of adults look for health information online and 60 percent of online users have consulted blog comments, hospital reviews and doctor reviews, listened to podcasts about healthcare and signed up to receive updates about medical issues. More surgeons have begun designing personal websites to supplement their practice or created hospital profiles to provide additional information about the procedures they perform.

An additional 40 percent of patients use social networking websites, according to the Pew research. Surgeons are using social media to connect with their patients, such as creating blogs or Facebook pages with videos and columns potential patients might find helpful. In response to an increasing use of social media among healthcare providers, hospitals and practices are developing guidelines for how their surgeons are able to use that space without running into legal or public relations issues. As children who grew up with the Internet mature, the number of potential patients using online media for healthcare information will continue to increase and it will become more important for surgeons to have a positive presence online, says Mr. Epstein.

Physicians are also now beginning to give patients the option to contact them through e-mail instead of by phone, says Dr. Vangsness. "There's more of a trend for Internet-based communication with orthopedic surgeons," says Dr. Vangsness. "It is really important that if a patient has a question or problem, they can send an e-mail. I think it gives them a sense of security and calm." ■

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Spine Surgery in 2011 and Beyond: 7 Points About the Future of Spine Surgery

By Laura Miller

Many of the new techniques and equipment developed over the past few years for spine surgery have leaned toward the minimally invasive approach, which is gaining in popularity across the country. However, most physicians are still performing the open surgeries they have perfected over the years, and healthcare reform could stall technological advances in the coming years due to uncertain reimbursements and increased fees on device makers. Here, industry leaders weigh in on the future of spine surgery.

1. Healthcare reform's impact on spine surgery. In the current atmosphere of anxiety regarding the "unknowns" of healthcare reform, many spine surgeons are opting to proceed with their practice cautiously. An increase in patient volume due to growth in the aging population coupled with diminishing reimbursement rates means spine surgeons will be looking for less costly surgery systems that are easy to use, says Chris Zorn, vice president of Spine Surgical Innovation. Physicians who are working in hospital settings must justify their spending, which could lead to a decrease in purchasing new and complex technologies that facilities are currently willing to purchase. While technology may continue to advance, physicians may not have the resources to learn new procedures or gain access to the equipment.

"Generally speaking, spine, like many other surgical areas, has certain things that become trendy, but my observations are that physicians worldwide are sticking to the basics," says Mr. Zorn. "We live in a world of trying to keep it simple, keep the learning steps simple, minimize the impact of surgery on the budget as well as the impact of the procedure on the staff, surgeon and patient's time."

2. Minimally invasive spine surgery vs. open surgery. Loosely defined, minimally invasive surgery means physicians are performing a procedure with a smaller incision than is used in an open procedure, and physicians dilate the muscles surrounding the spine for the least amount of muscle and nerve damage. "Spine surgery has never been one that has been amenable to smaller instrumentation and smaller incisions, but now all that's changing," says Michael Weiss, DO, a spine surgeon and chief of spine surgery at Laser Spine Institute Scottsdale (Ariz.). "The bigger benefit starts to come because you do less soft tissue destruction to get to the bone."

Some physicians consider specific fusion procedures as minimally invasive while others bill minimally invasive techniques as the alternative to fusions. The length and depth of an incision that constitutes a "minimally invasive" incision remains undefined, says Mr. Zorn, and will most likely be a topic of continued debate. A better definition would be "less invasive" surgery, says Mr. Zorn.

The popularity of minimally invasive procedures has been increasing over the past few years. In some communities, educated patients are beginning to request physicians perform "minimally invasive" surgery, says Dr. Weiss, and physicians without the ability to perform such procedures might lose out.

However, Mr. Zorn says physicians should consider their practice region before deciding to train on minimally invasive techniques. "If every surgeon in the region is already minimally invasive oriented, the other surgeons have to keep up," says Mr. Zorn. "If no other surgeons in the region are doing minimally invasive stuff, there is less competitive pressure on surgeons to change."

3. Endoscopic technology. Advances in spine surgical technology have made it possible to gain access to the patient's pathology through endoscopic instruments, says Dr. Weiss. The small scopes allow physicians to see the patient's pathology on a screen as they work within the enclosed area. The scopes navigate the physician away from nerves and arteries during the surgery. Physicians use cannula tubes running parallel to the endoscope so physicians can reach the surgical site without making a large incision. Imaging technology will continue to advance, as the newest endoscopic technology is able to project images on HD visualization screens, further magnifying the patient's pathology.

While Mr. Zorn also projects continued technological advancement in minimally invasive spine surgery instrumentation, he says the technology will grow faster than is consumable by spine surgeons. "The technological advances are faster than any gifted surgeon can keep up with," says Mr. Zorn. "Surgeons have to be on the look out for systems that are effective, easy and less costly because they need to justify everything they buy these days."

4. Spine surgery education labs. In communities where physicians are beginning to perform minimally invasive spine surgery, the other physicians will begin to explore minimally invasive spine surgery training programs. The problem is that training in these procedures requires a large amount of time, and there is a significant learning curve, says Dr. Weiss. Physicians must learn about the procedure and practice performing it several times before they are able to treat patients effectively. "Minimally invasive surgery is not something that the typical orthopedic or neurosurgeon can get good at after a weekend course," says Dr. Weiss. "It really takes a significant number of surgeries before the surgeon is really comfortable performing them."

Spine surgery education labs and programs are beginning to spring up around the country to train surgeons in minimally invasive procedures. The Advanced Spine Institute & Minimally Invasive Spine Center at Alvarado Hospital in San Diego is one such program that includes education labs for physicians to practice the procedures on cadaver spines in operating rooms that mimic traditional hospital and ASC operating rooms. Other physicians around the country trained in minimally invasive spine surgery offer training programs to mentor surgeons as they learn the technique.

Mr. Zorn says physicians affiliated with academic research centers are the surgeons most likely learn minimally invasive techniques in the future because these physicians have more of an emphasis on procedural development. In the coming healthcare climate wrought with uncertain reimbursement rates and the potential for an increase in patient volume, physicians busy serving in the operating room all day and managing a robust practice will need to search for minimally invasive systems with simple ease of use, short learning curve and high value. The physicians will invest in low-cost systems with that demonstrate beneficial patient outcomes.

5. Development of minimally invasive disc replacement procedures. The future of spine surgery will include minimally invasive disc replacement, says Dr. Weiss. Physicians currently go through the pelvis and have to sidestep organs in order to implant the new disc, which is a big procedure. However, the development of new technology could mean that physicians conduct minimally invasive disc replacements through anterior or posterior procedures. New systems would have to have the capability to get the instruments through small tubes to conduct the operation.

Randall Dryer, MD, a spine surgeon with Central Texas Spine Institute, performing surgeries at Northwest Hills Surgical Hospital, a Surgical Care Affiliates facility, has been conducting research on two level artificial disc replacements in the neck. Cervical disc arthroplasty will have implications on the future of spine surgery. "The purpose of these operations is to relieve pain and restore function while minimizing the likelihood of degeneration at adjacent levels," says Dr. Dryer. "Many patients undergoing these procedures are quite young, so the opportunity to limit future pathology is significant."

Right now, Dr. Weiss says researchers and device companies are focused on improving modern instrumentation to help physicians perfect the minimally invasive techniques and ensure these techniques are reproducible before moving on to performing more types of surgery through smaller incisions.

6. Active patient recovery. As minimally invasive surgery and pain medicine make advancements, patients are able to play an active role in their recovery process. Dr. Weiss says that some patients receiving minimally invasive surgery are able to walk and receive physical therapy the same day of their outpatient surgery. These patients are likely to return to work three to four weeks, or around six weeks for labor intensive jobs, which is faster than in the past. Incisions of an inch or less and local anesthesia contribute to the shortened recovery time for patients.

7. Disc regenerating material. The use of stem cells to treat injuries and medical disorders has gained ground in orthopedics over the past few years and spine surgery is slowly following this trend. Some physicians have begun harvesting stem cells from the patient to use as regeneration material during spine surgery. California's Geron Corp. recently became the first company to test embryonic spine cell procedures on a human patient, attempting to reverse paralysis due to spinal cord injury. However, the use of stem cells in spine surgery is still in its infancy and many physicians are wary of employing the technique without extensive clinical research and knowing the long-term affects.

In the mean time, Dr. Weiss says research will continue on regeneration material such as bone morphogenic proteins for use in regenerating disc material. Several leading device makers have received clearance for bone grafting substitutes developed to enhance spine surgery. In the future, he says companies will develop an artificial-type disc that is not metal or plastic to use during disc replacements. ■

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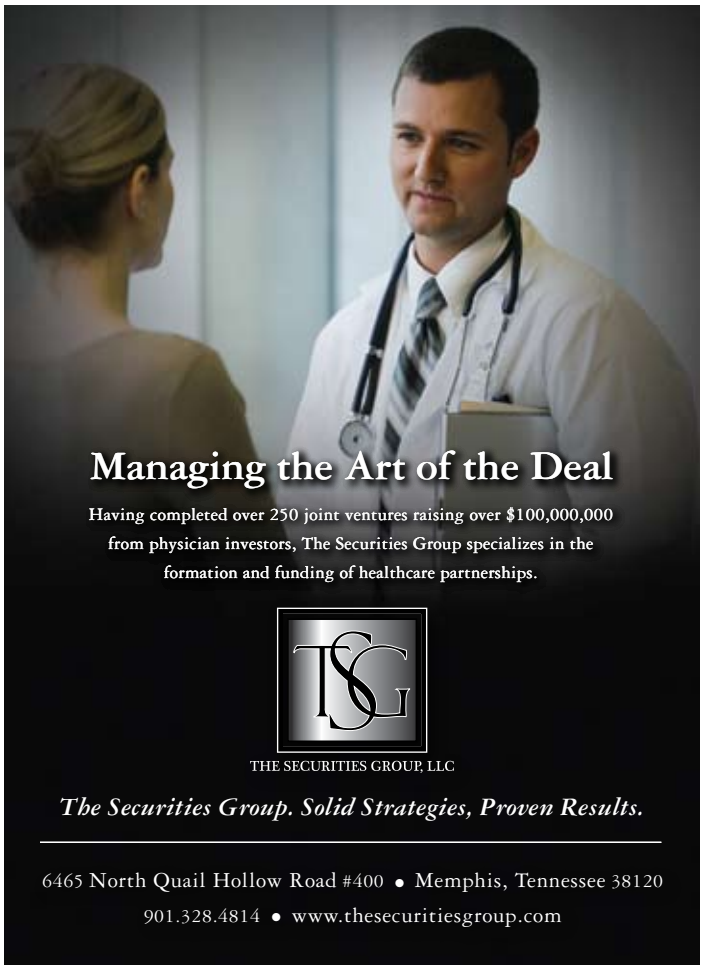

5 Areas Profitable ASCs are Still Leaving Money on the Table

By Rob Kurtz

There is a mentality at some ambulatory surgery centers that if the facility is making money, it must performing well. However, an ASC which becomes complacent with its financial performance could mean lost opportunities to perform even better. Here are five areas Joe Zasa, co-founder and managing partner of ASD Management, says ASCs should examine closely to capture potential lost revenue.

1. GPO relationship. If your ASC works with a group purchasing organization, you might assume you're purchasing supplies at the cheapest rates possible. But Mr. Zasa says it's worth putting in some time to confirm if that's actually true. "Are you having your GPO regularly audit your ASC to ensure you're getting the proper, best pricing?" he says. "And are you doing spot audits of your top supplies" to further check for savings opportunities? Both are worthwhile undertakings to confirm you're keeping supply costs as low as possible.

2. Implant costs. With vendors such as implant companies which are not typically GPO participants, Mr. Zasa says it is critical to benchmark the costs of implantable devices with other ASCs to make sure you're getting the best prices. He says it's also important to watch for price increases on implants. "Some of those companies will do several percent increases twice per year," he says. "This goes on all of the time and it ends up being a 10-12 percent increase."

ASCs not monitoring their costs might allow this to happen without their ever realizing it. "They say, 'We like the rep, we know he's getting us good pricing,' " Mr. Zasa says. "Do you really? The rep isn't doing the pricing. His job is to be your buddy."

3. Collections. Mr. Zasa says some ASCs have the misconception that they're collecting the maximum amount on their cases just because they are remaining profitable. "But do you really know if your collectors are doing a great job of collecting?" Mr. Zasa says. "Are you checking to make sure your [staff members] are working the denials? When the insurance company denies a claim, are they working the denials properly and sending along supporting documentation or are they just shredding the denial? It's a sloth-factor."

4. Internal controls. ASCs should never become complacent with their operations and they need to ensure there is an effective checks and balances system in place, Mr. Zasa says. "Is your ASC regularly having third-party audits to ensure there are proper internal controls at your facility, including proper cash management?" he says. "If somebody is changing payroll, do you know it's being done properly and making sure what's in the employee files is what they're actually being paid? Are deposits being made properly?" Regular third-party audits can identify lost money, poor processes and also help to spot potential illegal activities, such as theft by a staff member, sooner.

5. Chargemaster. "As a general rule, we're price takers, not price makers, which is why reviewing your chargemaster every single year is extraordinarily important," Mr. Zasa says. "Typically most ASCs bill a multiple of the Medicare fee schedule. When the Medicare fee schedule changed a few years ago, if you [kept] the same price list, you were actually leaving money on the table for those claims where you were receiving a percentage of billed charges." Adjusting your chargemaster every year is an area where many ASCs can easily pick up revenue, he says. ■

Learn more about ASD Management at www.asdmanagement.com. Contact Joe Zasa (joezasa@asdmanagement.com) at (214) 369-2996.

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5 More Physician Statistics ASCs Should Track and Benchmark

By Rob Kurtz

In a previously published story, Brian Brown, regional vice president of operations of Meridian Surgical Partners, identified five ambulatory surgery center physician statistics to track and benchmark (Read "5 Physician Statistics ASCs Should Track and Benchmark" on www.BeckersASC.com). Here Mr. Brown identifies five more physician statistics ASCs should monitor.

1. Physician satisfaction. This is a statistic Mr. Brown says is critical for ASCs to monitor closely. "It's very important to try to keep a finger on the pulse our physicians," he says, and that's for both physician-investors and physician-users. "Along with patients, they're your major customers."

Physician satisfaction is a challenge to track, which is why ASCs should, at least annually, send out a formal survey to all physicians. Mr. Brown says Meridian asks physicians at its surgery centers to rate the following 10 areas of their ASC's performance:

1. Efficiency of business office.
2. Ease of scheduling.
3. Availability of operating room time.
4. Procedure start time as scheduled (did the physician's procedure start when it was supposed to).
5. OR turnover time
6. Availability of equipment to do your cases.
7. Quality of equipment.
8. Adequacy of nurse staffing.
9. Nursing staff knowledge and expertise.
10. Staff morale.

The Meridian survey offers five categories of ratings: excellent, above average, average, below average and poor. "Anything that gets less than an above average rating, you want to follow up first with the administrator and then team management and identify what's going on in those areas and how you should respond," Mr. Brown says.

He says it's also worthwhile to have physicians rate, in those five categories, the quality of patient care delivered by the staff by department: pre-op,

OR, PACU, anesthesia and administration. On the bottom of the survey, provide a comments section where physicians have the option to share additional thoughts.

If an ASC undergoes significant changes, Mr. Brown says it might be worthwhile to conduct the survey more frequently.

2. Top five CPT codes by physician. In all patient accounting/billing systems, Mr. Brown says you should be able to track CPT codes by physician. What this information will allow you to do is analyze the subspecialty mix of your physicians. "For example, does your ASC have an orthopedic physician who focuses on shoulders or a physician who is doing heavy cases like ACL repairs," Mr. Brown says. "[That data] will let you be able to prepare for that physician's patients in a unique fashion, whether it be scheduling time, looking to see if that physician needs more block time, the cost of doing those cases and it will let you be able to examine your physician base at the ASC and identify what could be a nice compliment through recruiting a new physician."

For example, if you have several orthopedic surgeons but none focusing on hand surgery, that's a very efficient orthopedic subspecialty you can work to add to your ASC, he says.

3. Physician payor mix. Mr. Brown says this is a very important statistic from a top line perspective as it will allow you to determine your net revenue per case (i.e., the specific reimbursement). "For example, if you're managing an ASC in South Florida, the payor mix is probably heavy Medicare and Medicare HMOs, which are mostly paying Medicare rates," he says. "You've got to manage block times, staffing and your costs well because you know you're in a very low reimbursing area of the country."

While you do not want to make any changes which will compromise patient care, understanding your payor mix will allow you to identify areas you should focus upon to increase efficiency and bring your ASC to a place where it can operate effectively while still delivering profits.

4) Collections by physician. This statistic can reveal a number of areas for your ASC to focus on for improvement, Mr. Brown says. Looking at it from an operational perspective, are you struggling to collect for one physician versus another? Can you identify a particularly difficult payor who is paying you at a slow rate or at a rate that you need to get paid? If so, do you need to go back to the negotiating table to renegotiate some of these contracts with these payors based on the mix that physicians are bringing to your ASC (looking at payor mix by CPT codes)? Do you have carve-outs on all of our payors, which might be critical if, for example, your surgery center focuses heavily on podiatry?

This statistic, like many you should track, can help your ASC improve its ability to cater to your physicians' needs. "We want the ASC to serve primarily as an extension of the physician's practice," Mr. Brown says. "If we're not able to accommodate a physician's cases and he or she has to jump all over town to do cases because the ASC can only allow them do some of the cases, the physician's practice efficiency is affected negatively.

"Can we funnel this down to where we can take this information — the collections, payor mix, CPT code — and create a more efficient operation for physicians, their practices and also physicians' patients," he says. "As we all know, outpatient cases are best served in an efficient surgery center."

5. Hours per case by physician. This is a statistic which should be noted for every case in the OR record. Your ASC should then go the extra step and have a staff member enter it into your patient accounting system. "Now you can compare it to physicians doing similar or the same cases," Mr. Brown says. "This will help you identify how you can be more efficient and productive for the care you provide."

You can benchmark this statistic against industry averages and identify if there is a physician you can work with to achieve a better time per case. Or perhaps your ASC can conduct a quality study using the data you gather.

Just be careful not to jump to conclusions if one of your physicians is taking longer on similar cases than other physicians. "There may be nothing wrong with what the physician is doing," Mr. Brown says. "Make sure you accommodate all physicians appropriately. There are some times where a physician may take longer and you might just need to manage the cases differently and make sure your staffing is scheduled appropriately. For faster physicians, do the same thing — move those cases through the system to accommodate the pace that physician is operating at." ■

Learn more about Meridian Surgical Partners at www.meridiansurgicalpartners.com.

8 Areas to Reinvest in an ASC

By Leigh Page

Physician-owners need to continually reinvest in their surgery centers to make sure the facilities are safe, well- run and attract patients, says Mike Lipomi, president and CEO of Surgical Management Professionals in Sioux Falls, S.D., which runs 11 ASCs and one physician-owned hospital. Here he pinpoints eight areas to reinvest in.

1. Buy new technology. Management has to take a fiscally responsible yet forward-thinking approach to new technology. "In some cases the technology is not going to bring in more money, but it could still improve quality of care," Mr. Lipomi says. "The beauty for physicians owning a center is they can say, 'We need this technology.' "

2. Maintain the physical plant. In addition to maintaining clinical equipment, make sure your center looks inviting. The floors, walls and ceilings should be in good shape. Cracked tiles present a risk of infections. The look of the place has an effect on patients. "Patients may not understand the quality of care, but they do understand cleanliness, and they associate cleanliness with quality of care," Mr. Lipomi says.

3. Invest in staff education. A properly educated staff will be efficient and safe. "Everyone should be educated and it should be done regularly," Mr. Lipomi says. Even housekeeping staff should be educated so that they are aware of such matters as keeping areas sterile. It does not have to cost a lot. "In most cases, there will be plenty of opportunities to find the education you need locally," he adds.

4. Provide adequate salaries. Even very satisfied staff members can jump to other facilities that pay more. Salary benchmarks can be obtained from the Ambulatory Surgery Association and Physician Hospitals of America.

5. Maintain adequate staffing levels. Low staffing levels lead to dissatisfied patients, overworked employees and errors. But there is no exact benchmark for the correct staffing level because it depends on such factors as patient acuity.

6. Invest in outreach. Outreach increases public awareness of the center. Surgeon-owners may want to volunteer to talk about their work and their facilities at service clubs like the Kiwanis, senior homes and schools. Orthopedic surgeons may help out sports teams and talk about sports injuries. Clinical staff may offer health screenings checking blood pressure, glucose levels and cholesterol.

7. Keep patients informed. The center should provide instructions to patients both pre- and post-operatively. This will help assure the operation runs smoothly and recovery progresses as planned.

8. Keep striving. Lastly, "remember what made you great," Mr. Lipomi said. "When you forget that, you start to go downhill." He takes a lesson from the restaurant industry. "When the restaurant was little," he says, "Mama made the pasta sauce. Then it got bigger, but Mama no longer made the pasta sauce and the food wasn't so good anymore. It can happen to surgery centers, too." ■

Learn more about Surgical Management Professionals at www.surgicalmanprof.com.

4 Ways Surgeons Can Increase ASC Distributions

By Rachel Fields

Thomas Wherry, principal for Total Anesthesia Solutions and medical director for Health Inventures, discusses four ways ambulatory surgery center surgeons can increase their distributions by cutting significant costs.

1. Be more flexible with block time and scheduling. According to Dr. Wherry, many surgery centers do a poor job of tightening the schedule to decrease staffing costs. The schedule will show large gaps between cases, or the center will open for just one case. "The cost associated with keeping staff there obviously reduces distributions," Dr. Wherry says.

If ASC data shows OR utilization around 40-50 percent, the center is almost certainly losing money and something needs to be changed, he says. "There's an inherent conflict between the surgery center agenda and [the physician's] own personal office agenda, and that requires the administrator and management company to have a strong relationship with the surgeon scheduler," Dr. Wherry says. Surgeons can help increase distributions by facilitating that relationship and cooperating with the surgery center's requests to compress schedules. "It does require the surgeons to be more creative with their schedule, as opposed to "this is my block time and don't touch it,"" Dr. Wherry says.

2. Attend meetings for payor contract negotiations. Many centers don't review their contracts regularly enough, meaning they may be losing money from poorly negotiated contracts. Reviewing ASC contracts means considering carve-outs for certain high-cost procedures, negotiating improved reimbursement with the payor and considering a move to out-of-network if in-network rates are too low. "I think the surgeon can be helpful by attending meetings with insurance companies," Dr. Wherry says. "[The center] is certainly more powerful if a surgeon is present versus just an administrator." He says surgeons can also boost ASC leverage by writing letters to the insurance company's medical director on the key issues for a particular contract.

3. Pressure other surgeons to standardize supplies. An ASC will lose money if it stocks five or six different brands of one supply, Dr. Wherry says. In standardizing supplies, he says ASC leaders should start with high-end supplies, such as screws or implants, and work down to disposable supplies. Benchmarking data on different specialties can also help determine which specialties, cases and surgeons use the most expensive supplies. Surgeons can help reduce supply costs by showing transparent reports on their preference card costs to other surgeons. "I think with education and some outside pressure from other surgeons, you will see surgeons that will change their practice," Dr. Wherry says. "If you can get half of [the surgeons] to change [supplies], I would consider that a success."

4. Consider case contribution margin, not volume. When asked how to improve ASC profits, many ASC administrators refer to an old stand-by: increasing case volume. But Dr. Wherry says surgeons should be careful about bringing more cases to the center if those cases are not profitable. "When surgeons look at their own practices, they should work with the administrator and management company on identifying cases that provide a good contribution margin," he says. For example, some orthopedic cases have very high supply costs and can be performed at a loss if a center receives inadequate reimbursement. "It might be more prudent to take that case somewhere else," Dr. Wherry says. Surgeons should look at case costs and reimbursement rates to determine profitability and make sure case volume increases are worthwhile. ■

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4 Kinds of Physicians Who Have Not Yet Invested in an ASC

By Leigh Page

Bill Heath, chief development officer at Practice Partners in Healthcare, in Birmingham, Ala., identifies four kinds of physicians who have not yet invested in an ASC and what it might take to persuade them to invest in your ASC.

1. Hasn't found the right time to invest. A young physician may still have medical school loans to pay off or has just bought a new home and has no money to invest. An older physician may be going through a divorce or just bought a new boat. Once they get some money freed up, they could be ready and willing to invest in a center. "In these cases, it's simply a matter of waiting for these physicians to be ready," Mr. Heath says.

2. Concerned about the risks of a start-up. These physicians may have previously rejected a start-up project because they were not convinced it would succeed. They might be more likely to buy into a center that is already in operation and is showing a return on investment. In fact, they might even be interested in a center that is just breaking even and simply needs the volume of one more physician to bring it into the black.

3. Solo or small group. These physicians have too little volume to start their own center and have been uncomfortable partnering with a competing group or with the hospital. The solution might be asking them to reconsider a partnership with the competing group and bringing in a third-party administrator to act as intermediary.

4. Already invested in an ASC and got burned. "These physicians were involved in a center that got in over its head," Mr. Heath says. It planned for twice the volume that it had and put in marble floors. It was so costly there was no way they could pay off the loan, and it went under." These physicians need a lot of assurances that things will turn out better this time around. "Give them the data they need, send them a financial plan," he says. ■

Learn more about Practice Partners in Healthcare at www.practicepartners.org.

12 Decisions That Can Cripple a Surgery Center

By Rob Kurtz

Brent Lambert, MD, founding principal, and Luke Lambert, CEO, of ASCOA, make regular visits to ambulatory surgery centers throughout the United States which are struggling financially and in need of a turnaround. They say some of these facilities can be saved because, fortunately, the poor choices made by the owners are correctable over time. Unfortunately, that's not true for all of these ASCs.

"We actually look at a lot of centers we don't think we can fix because of decisions made," says Luke Lambert.

Here are 12 decisions (or "fatal flaws" as Dr. Brent Lambert terms them) which they have seen cripple an ASC.

1. Overbuilding. One of the most common mistakes they see is when physicians have grandiose plans and therefore overbuild their facility. "We've seen a center with four ORs and yet they're only doing 150 cases a month," says Luke Lambert. "That fixed cost of the large center is a long-term burden for a relatively low volume facility."

Dr. Brent Lambert says this hurts physicians two ways: "It hurts the doctors who spend all this money on the build-out but then it's a two-way sword because they're spending all this money for rent."

2. Expensive lease. The signing of a lease that's too expensive is a related mistake to overbuilding, says Luke Lambert. "Physicians sometimes feel like they need to be in a fashionable location for their facility," he says. "Of course, none of the payors pay you extra for being in a fashionable location."

3. Signing contracts without negotiating. Another mistake made by startup ASCs seen quite frequently occurs when a physician group is anxious to start using their new center to perform procedures that they will sign any contract offer from the payors without negotiating the rates. "That locks them into payment rates that can be very disadvantageous over the long term," says Luke Lambert. "They may be busy right away but maybe they don't make money because they signed on to rates that were too low. Once you're doing the cases, it's very hard to negotiate them upwards.

"Your point of greatest negotiation advantage is when the cases are being done at a high-cost place, like the hospital, and you're offering to move them to the low-cost place, like your new ASC," he says. "If you demonstrate a willingness to leave them in the hospital unless you're given a good contract, that's your best position of negotiation."

4. Terminating contracts but keeping the cases in an ASC. The most leverage ASC physicians have over payors is their ability to dictate where they perform their procedures. Sometimes physicians who are frustrated with the rates they are receiving will terminate a payor's contract with the threat of taking the cases out of their ASC in order to gain this leverage.

But instead of taking the cases to a high-cost place, they will take them to another ASC.

"This doesn't cost the payor any more money so [the physicians] don't achieve any leverage," says Luke Lambert. "If you want leverage, you have to take your cases to a high-cost place like the hospital."

5. Holding on to hospital block time. Oftentimes, new ASCs are started by physicians well-established in their careers, says Luke Lambert. They may have spent many years influence peddling and cajoling to optimize their schedules and earn what they see as their perfect block time at a hospital. When these physicians open their ASC, it is conceivable that half of the time they were spending at the hospital performing procedures should now go to the ASC. For some specialties, it might be all of their time. But this doesn't always happen.

"Because so much of their professional life was spent obtaining that block time, they don't want to give it up," he says. "To try to maintain it, they don't take everything they could to their own ASC. They sort of starve their center and keep sprinkling cases into their [hospital] block so they don't give up what they see as almost a prime piece of real estate."

6. "Hijacking" the ASC by senior partners. Dr. Brent Lambert says he regularly sees situations where senior surgeons nearing retirement will "hijack" their ASC. "They don't want the monthly distributions to stop," he says. "If there's no language for redemption at time of retirement, they actually prevent any [language] from getting into the bylaws and the operating agreement of the center, so these guys will have income for life."

He notes one ASC which was distributing checks to physicians for 10 years after they retired, and says he has seen situations where anywhere from a quarter to a half of the physicians receiving checks are non-performers.

"It's discouraging for the people in [the ASC], it destroys the morale," Dr. Brent Lambert says. "We don't allow that. The moment they retire, they are redeemed at fair market value."

7. Formation of an executive board. In some ASCs, a few dominant physicians will convince the other physicians that the facility needs an executive board or committee to make the significant decisions for the facility. Whatever name they assign to it doesn't matter to Dr. Brent Lambert as it means only one thing to him: a red flag.

"If we're acquiring an ASC with an executive board where three guys are speaking for 20, we don't allow it," he says. "We say everybody has one vote so it can't be dominated by these three people. If they're fighting to maintain this executive committee, my antenna goes up and I ask why it is so important for them. Then you start seeing medical director fees or even board fees in some of these places."

8. Plastic surgeons as partners. Another common mistake seen is when an ASC brings one or two plastic surgeons into the partnership. "The plastic surgeons can be very persuasive, they can use a lot of the center, but if they're cosmetic plastic surgeons, we've rarely seen them as profitable," says Luke Lambert.

The challenge with plastic surgeons who focus primarily on cosmetic procedures and see these cases in the ASC is that the surgery center will often unintentionally subsidize the professional payments of the plastic surgeons.

"Let's say the plastic surgeon wants the ASC OR for an hour and will pay $400," Dr. Brent Lambert says. "That's a money loser for an ASC." The plastic surgeon may find a hospital willing to offer that rate, so the ASC tries to compete with that pricing to keep the physician happy and performing procedures at the surgery center.

"These plastic surgeons have a global fee of let's say $25,000 for a facelift," Dr. Brent Lambert says. "Out of that they have to pay the facility fee, anesthesiologist fee and themselves. If they can cut the facility fee by two-thirds, then they get to keep it. If you allow a plastic surgeon partner to have a room for $400 when they really should be paying $1,000 or $1,200, then the ASC is basically handing the plastic surgeon money.

"If a plastic surgeon has ORs at the local hospital for $400-$500/hour, and he's going to be in the ASC, he wants the ASC to match those rates and then the center loses money," he says.

The ASC would be better off letting the physician take these procedures to the hospital, but then the surgery center still has the problem of a non-performing physician-owner.

9. Physician involvement with human resources. When a physician becomes involved in the hiring and firing of staff, it can cause many challenges for an ASC. For example, if a surgeon critical to the surgery center's volume and income hires a family or significant other to a staffing position, if there is ever a problem with this staff member, it becomes a problem for the entire facility.

"They're the favorite of this doctor … and they know they don't have to produce anymore because they have a virtual lifetime employment contract," says Dr. Brent Lambert. "Those kinds of staffing/HR problems can really corrupt a center and cause wholesale defections of the other staff that see this and they know what's going on. It's

very demoralizing; the other partners don't like it. It can destroy the chemistry of the center."

It is scenarios like this which make it critical for ASCs to keep their physicians out of the human resources component of the operations and task hiring and firing to an independent person.

10. ASCs built in or near physicians' offices. In today's market, it's becoming harder for a single practice to support an ASC effectively, says Luke Lambert. Many practices will develop their ASC in a real estate space that is either in or next to their office. That affiliation or perceived connection between the practice and the ASC can create challenges for recruiting additional surgeons.

"Maybe they're an orthopedic practice and they want to recruit the other orthopedists in town," says Luke Lambert. "The other orthopedists aren't going to want to send their patients to another practice for their surgery. This can create a problem for growing the center and keeping it viable long term."

11. Lack of rules for conduct. Every surgery center should, as part of its bylaws, include rules for proper conduct which applies to all physicians and staff members who work at the ASC.

"You have to protect your employees from some of the surgeon-partners (and also staff members) who may have obstreperous personalities that offend and create hostile work environments," says Dr. Brent Lambert. Without rules of conduct and clearly spelled-out ramifications for violating the rules, an ASC could quickly lose its staff because of the actions of a single person.

"Some partnerships are very cognizant of this so they put it into their documents," he says. "If [a physician] ever does such and such, we'll give him a warning. If he ever does it again, he's redeemed."

Luke Lambert says this challenge is most often seen in smaller centers where 1-2 partners are very dominant. "The reason they tend to be small centers is other people don't put up with it as partners or they may have started small but have been unable to grow because these types of issues keep people away," he says.

One of the advantages of a corporate partner is the ASC has a disinterested third-party who can adjudicate such situations, Dr. Brent Lambert says. "You can't write a document that covers everything," he says.

12. Physician-owners stuck in a single-specialty dream. Many physicians who open an ASC envision it at the start as a single-specialty entity which will help to define who they are as surgeons, and they cannot fathom cohabiting the facility with any other specialty, says Dr. Brent Lambert. This, he says, is a huge flaw in the thinking of ASC owners.

"They envision this single-specialty orthopedic (for example) ASC that they walk to from their office," he says. "They have a rehab facility on the same floor for their total joint patients. They come up with an idealized dream of what would be a perfect ASC.

"Well, if you look around the country, there are all of these single-specialty ASCs not thriving," he says. "They haven't been making any money for years and [the physician-owners] have had to feed the ASC cash in order to maintain this single-specialty status, which means nothing. It actually is a huge detriment to them. If they could bring in other specialties and cover their costs, they would be distributing money but instead they're fixed on this dream concept. It's the height of ego fulfillment." ■

Learn more about ASCOA at www.ascoa.com.

Money-Makers: 15 Statistics on Physician Compensation

By Rachel Fields

Here are 15 statistics on physician compensation for the top three specialties that drive case volume in ASCs. Data is drawn from MGMA's *Physician Compensation and Production Survey: 2010 Report Based on 2009 Data.*

Gastroenterologists

1. The average gastroenterologist salary was $496,139.
2. Gastroenterologists in single-specialty groups made more than those in multi-specialty groups, at $507,106 versus $437,711.
3. Gastroenterologists practicing in the Midwest United States made more than in any other area, with an average salary of $507,717.
4. Male gastroenterologists made more than female gastroenterologists, at $480,020 compared to $357,145.
5. Gastroenterologists with 8-17 years in the specialty made more than any other tenure, at $500,250.

Ophthalmologists

1. The average ophthalmologist salary was $376,943.
2. Ophthalmologists in single-specialty groups made more than those in multi-specialty groups, at $417,744 versus $321,951.
3. Ophthalmologists practicing in the southern United States made more than in any other area, with an average salary of $378,305.
4. Male ophthalmologists made more than female ophthalmologists, at $350,832 compared to $312,837.
5. Ophthalmologists with 18 or more years in the specialty made more than any other tenure, at $347,537.

Orthopedic surgeons

1. The average orthopedic surgeon salary was $524,259.
2. Orthopedic surgeons in single-specialty groups made less than those in multi-specialty groups, at $470,323 versus $475,403.
3. Orthopedic surgeons practicing in the Midwest United States made more than in any other area, with an average salary of $536,317.
4. Male orthopedic surgeons made more than female orthopedic surgeons, at $486,847 compared to $299,673.
5. Orthopedic surgeons with 8-17 years in the specialty made more than any other tenure, at $510,419. ■

Learn more about MGMA at www.mgma.com.

ASCs Play an Important Role in ACOs

By Andrew Hayek, President & CEO, Surgical Care Affiliates

The Accountable Care Organization provision within the healthcare reform law has generated a significant amount of discussion and speculation. We have heard a broad variety of interpretations of what ACOs are and what they mean for community physicians and surgery centers.

Our organization, Surgical Care Affiliates, partners with Monarch HealthCare, a leading independent practice association based in Orange County, California. Monarch was recently named as one of five pilot ACOs in the country, designated by the Brookings Institution and Dartmouth College.

Monarch has been collaborating with independent community physicians in Orange County for 17 years to improve health outcomes, to enhance the patient experience, and to reduce healthcare costs, as part of their managed Medicare and commercial HMO products. Monarch's position as a nationally recognized leader in care coordination and physician collaboration contributed to the decision to include them as one of five pilot ACOs in the country.

Monarch's ACO is in partnership with Anthem Blue Cross of California, and the goal is to manage beneficiaries in a PPO, using the structure of an ACO. In this partnership, Monarch will manage tens of thousands of Anthem PPO beneficiaries in an ACO model.

Because of our partnership with Monarch, we have an interesting vantage point from which to observe the role that ASCs play in ACOs.

Purpose and intent of ACOs

Before getting into specifics, it is important to step back and examine the overall purpose and intent of ACOs. The fundamental premise of an ACO is that physicians can improve quality and reduce healthcare cost by collaborating together in new ways and by being held accountable to the health outcomes and total healthcare cost of a patient population. In this way, an ACO is very similar to health maintenance organizations (HMOs), which have been prevalent for more than 30 years.

HMOs operate with "closed" networks, meaning that patients are required to see an approved physician, which allows a health plan to work with the physicians in the network to influence how care is delivered. The goal of an ACO is to extend some of the most important benefits of an HMO into "open" network structures, like fee-for-service Medicare and PPO products.

The hope is that ACOs can accomplish this by allowing for greater physician-to-physician and physician-to-facility collaboration and by creating shared bonus structures that allow physicians and other ACO participants to share in cost savings, as long as quality and clinical outcome goals are met.

There are three primary payment incentive structures in discussion – a shared savings program (in which a payer, like Medicare, continues to pay fee-for-service rates and adds a potential retrospective bonus payment based on savings demonstrated in the ACO's population), partial capitation (a combination of a flat "per member per month," or PMPM, fee as well as fee-for-service payments), and full capitation (a flat PMPM fee only, as many IPAs currently utilize).

Hospitalizations, chronically ill are main targets

The main target for care improvement and cost reduction is hospitalizations. Payments for hospital inpatient care by Medicare in 2009 totaled $136 billion, 28 percent of Medicare's total expenditures. (Total Medicare payments to ASCs in 2009 were $3 billion, less than one percent of total Medicare expenditures.)

From a beneficiary perspective, ten percent of Medicare's beneficiaries account for 63 percent of Medicare's expenditures. These beneficiaries consume an average of $44,000 per year in cost to the Medicare program, whereas the other 90 percent of beneficiaries consume only $3,000 per year.

The defining characteristic of these high-cost beneficiaries is the prevalence of chronic illness (diabetes, CHF, COPD, hypertension, etc.). An estimated 75 percent of total healthcare expenditures are driven by chronic disease treatment.

Therefore, to bend the curve of rising healthcare costs, ACOs will need to reduce expenditures for patients with chronic illness and reduce hospitalizations, which account for the majority of cost. By comparison, reducing the cost of every case performed in an ASC to zero would reduce Medicare's cost by only 0.6 percent.

Structure of ACOs still unclear

As with many elements of the healthcare reform bill, a significant amount of uncertainty remains as to how the vision of the bill will be translated into day-to-day reality. With respect to ACOs, there is even more uncertainty, because it is not

yet clear how some basic functions of ACOs can or will work.

One of the major open questions is how to manage patients who are in "open" networks, like Medicare fee-for-service and PPO products. HMOs have been effective because of their ability to control where patients receive care by utilizing a closed network of providers. Whether ACOs can effectively manage the cost of care using an "open" network, in which patients can see any willing provider, remains to be seen, and may not be possible in many areas.

There are a wide variety of other very fundamental challenges – like how to assign patients to a primary physician (which could include cardiologists, ob/gyns, and other specialists, in addition to primary care physicians), how to track patients care and costs in an open network, and how to create sufficient incentives and accountability for changing care delivery.

These are significant challenges that will take years to resolve and operationalize. As a result, we estimate that it will take several years for ACOs to become a material part of healthcare delivery, and we predict that many ACOs will fail to realize the goal of reducing cost.

IPAs are in a relatively stronger position to launch ACOs, as they have been working with physicians to improve care and reduce cost for many years, and they have the experience and infrastructure to take risk on total medical costs for large populations.

SCA's role in Monarch's ACO

In addition to 17 years of improving care and reducing cost through physician collaboration, Monarch also knows the ASC model very well. One year ago, Monarch co-invested with SCA in two surgery centers in Orange County, and we are exploring adding a third center together. Monarch executives, including Monarch's CEO (Dr. Bart Asner), attend the surgery center's board meetings and are integrated into our management process.

Monarch's interest in ASCs is based on three goals: improving the quality of care and clinical outcomes, enhancing the patient experience, and lowering unnecessary medical costs. Well-run ASCs are able to deliver on each of these three goals, which are essential to the success of the ACO model.

We are also working with Monarch to further enhance the value of ASCs by collaborating together in new, more coordinated, ways to enhance clinical outcomes, improve the patient experience, and reduce unnecessary cost.

We use the National Quality Forum endorsed quality metrics in all SCA centers, and we use these statistics with Monarch to track quality outcomes. Given Monarch's data regarding overall patient health outcomes, we are exploring how to expand and refine our quality measures to tie to total health outcomes of Monarch's patient population – in other words, which specific aspects of care in our ASCs tie most consistently with better overall health outcomes for patients?

On the cost side, we have very precise data within SCA that tracks the labor and supply cost of each procedure. We use this data to work with physicians to think through how to improve efficiency and reduce unnecessary cost. This data is very helpful to Monarch, and we are working on how to expand our cost analysis to tie to total healthcare costs for the patient population. The question being: What can we do in an ASC that helps reduce total healthcare costs for a given patient population?

Summarizing the challenges

Based on our experience, we would summarize our thoughts regarding ASCs and ACOs as:

1. ACOs are in a very early stage of development, and it will take several years to create viable ACOs outside of the current pilot environment.

2. Many ACOs will struggle, given the complexity of creating and managing physician networks and the complexity of assuming risk, particularly in an open network structure.

3. The main focus of ACOs will be reducing hospitalization costs and managing costs for patients with chronic illness, which account for the majority of Medicare spending.

4. While surgical costs will not be a main focus, ASCs will play a role in helping to improve quality and reduce costs for outpatient surgery.

5. For ASCs to contribute to an ACO, they will need to have robust clinical systems and sophisticated tools to improve cost and efficiency, and they will need to tie their clinical and cost analytics into the ACOs information on the overall patient population to drive ongoing improvement in outcomes and cost.

SCA's experience participating in an ACO in Southern California underscores why we are so passionate about ASCs – we are an important part of improving the healthcare system by improving clinical quality and reducing cost. The ACO structure can further align incentives in the healthcare system to achieve the benefits that ASCs provide. ■

Learn more about Surgical Care Affiliates at www.scasurgery.com.

Outpatient Spine: 6 Big Questions

By Jeff Leland, CEO, Blue Chip Surgical Center Partners

There is no doubt that the market for outpatient spine surgery continues to evolve and mature. However, surgeons who wish to develop a spine-focused ambulatory surgery centers or add spine to an existing surgery center must be prepared to address important questions, including those with regulatory, legal, financial and strategic impacts. In a time of constant market flux, new opportunities may present themselves, but there are real risks for those spine ASCs that are not closely attuned to the shifts.

1. Will hospitals regard ASCs as competitors or potential partners? Hospitals and health systems willing to think creatively and identify the right surgeon partners stand to enjoy many benefits of ASC ownership, like improved surgeon loyalty, lower price points and more convenience for patients. Even modest stakes can produce these gains. At several centers, we have found mutually valuable structures and working agreements based on shared risk and reward, clearly defined management responsibilities and open communication. A key starting point: Both sides must invest in building trust, rather than viewing the other side as the enemy. Outpatient spine is an arena where, we believe, surgeons and hospitals can collaborate productively.

2. How will self-referral and other relevant regulations evolve? Keeping track of regulatory concerns is nearly a full-time job, especially when it comes to outpatient spine. Unfortunately, there are no easy or sweeping rules that apply across the board. The devil truly is in the details. But, again, innovative structuring of legal entities and creative contracting may allow surgeon-investors to offer an integrated experience for patients, while still generating excellent financial outcomes and complying with state and federal regulations.

3. Will the growth of consumer-driven healthcare change the playing field? Fundamentally, we believe that consumer-driven healthcare will be a net positive for all types of ASCs, including spine-focused facilities. In a consumer-driven world, the benefits of ASCs (including superior comfort and convenience, more efficient treatments and lower out-of-pocket costs) only become clearer and more attractive to patients. Further, hospitals and health systems will want to join ASC partnerships to offer patients lower price points.

4. Will access to capital improve for groups of surgeon-investors? Our sense is that capital will flow more freely in 2011 than it has during the last few years. However, one lingering effect of the recent financial crunch is that business plans must be truly comprehensive and compelling. Financers are very careful in their evaluations and want to see, among other things, accurate revenue projections and proven management expertise before they will lease to or invest in new or expanding centers.

5. Can payors be induced to embrace cost-efficient outpatient surgical care through improved contracting models? Here, again, the opportunities are revealed only through careful examination of in the details and creative structuring of win-win contracts. Relationships also matter; often it is only senior-level executives at various payor organizations who are willing to listen to non-standard agreements or to renegotiate existing agreements.

6. How can targeted spine-focused centers compete in areas saturated with ASCs, many of which are underperforming? Size matters when it comes to spine-focused ASCs. But that doesn't mean bigger is always better. In our experience, the strongest business cases often involve small centers with 1-2 operating rooms. Overbuilding remains a real risk in the outpatient spine market. It's more important to master case volume and case payor mix. Volume is all about surgeon-partners delivering the cases they projected to bring, while the right case payor mix will vary by market and payor environment, though it may include pain management and orthopedic procedures. ■

Learn more about Blue Chip Surgical Center Partners at www.bluechipsurgical.com.

ASC Ambulatory Surgery Center Association

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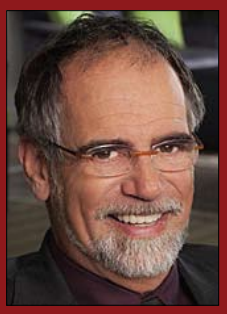
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- 134 Speakers
- 25 CEOs as Speakers
- 30 Physician Leaders as Speakers
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PROGRAM SCHEDULE

Pre Conference – Thursday, June 9, 2011

11:30am – 1:00pm	Registration
12:00pm – 4:30pm	Exhibitor Set-Up
1:00pm – 5:40pm	Pre-Conference Workshop • Concurrent Sessions A, B, C, D, E, F
5:40pm - 7:00pm	Reception, Cash Raffles and Exhibits

Main Conference – Friday, June 10, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:20pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:20pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday, June 11, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:10am – 1:00pm	Conference

Thursday, June 9, 2011

Track A – Turning Around ASCs, Ideas to Improve Performance, and Benchmarking

1:00 – 1:40 pm
Key Concepts to Fixing Physician Hospital Joint Ventures Gone South - Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, ASCOA

1:45 – 2:15 pm
How to Determine When to go In Network vs. Out of Network, Thomas J. Bombardier, MD, FACS, Principal & Founder, ASCOA

2:20 – 2:50 pm
How to Add Spine and Orthopedics to an Existing ASC - Best Practices - Mike McKevitt, Senior Vice President, Business Development and Bo Hjorth, Vice President Business Development, Regent Surgical Health

2:55 – 3:25 pm
10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them - Brian Brown, Regional Vice President, Operations, Meridian Surgical Partners

3:30 – 4:00 pm
Grow Your ASC's Profits 10% or Greater in 1 Year - Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners, Introduced by Melissa Szabad, Partner, McGuireWoods LLP

4:05 – 4:35 pm
ASC Turnarounds - 5 Key Steps for Success - Kenny Spitler, SVP Development and Robin Fowler, MD, Founder, Interventional Management Services, Introduced by Bart Walker, Partner, McGuireWoods LLP

4:40 – 5:40 pm - Keynote
Leadership and Management in 2011 - Mike Ditka, Legendary NFL Player and Football Coach

Track B – Spine and Orthopedics

1:00 – 1:40 pm
Business Planning for Orthopedic and Spine Driven Centers - Jeff Leland, CEO, Blue Chip Surgical Center Partners

1:45 – 2:15 pm
Developing a Spine Driven ASC: The Essentials for Success- Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

2:20 – 2:50 pm
Navigating an Orthopedic Practice and its ASCs Through a Changing Healthcare Environment - David Fitzgerald, CEO, Proliance Surgeons, Inc.

2:55 – 3:25 pm
Minimally Invasive Spine Surgery in ASCs - Greg Poulter, MD, Peak One Surgery Center, and Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

3:30 – 4:00 pm
Keys to Successfully Establishing and Growing a Premier Spine Center - Why Partner With a Management Company, Why Partner With a Hospital, Challenges and Opportunities - William Tobler, MD, The Christ Hospital Spine Surgery Center, and Michael Stroup, Vice President Development, United Surgical Partners International, Inc.

4:05 – 4:35 pm
Key Thoughts on Hand and Knee Surgery in ASCs - What Makes Sense Financially - David J. Raab, MD, President, Board of Managers, and Jeffrey L. Visotsky, MD, Member, Board of Managers, Illinois Sports Medicine & Orthopedic Surgery Center

Track C – Pain Management, Joint Ventures, Legal Issues

1:00 – 1:40 pm
Managing Pain Practice-Protocols, Branding and Other Tips to Improve Profitability - Vishal Lal, CEO, Advanced Pain Management

1:45 – 2:15 pm
Pain Management, The Best Practices in Office and ASCs - Nameer R. Haider, MD, Spinal & Skeletal Pain Medicine

2:20 – 2:50 pm
Best Practices for Pain Management in ASCs - Business and Clinical Issues - Marsha Thiel, RN, MA, CEO, Medical Advanced Pain Specialists

2:55 – 3:25 pm
Interventional Pain Management - New Concepts to Reduce ER Visits, Hospitalizations and Re-Admissions - Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

3:30 – 4:00 pm
Successful Three Party Joint Ventures - Christian D. Ellison, Vice President, Health Inventures

4:05 – 4:35 pm
6 Top Legal Issues for ASCs - Scott Becker, JD, CPA, Partner, and Melissa Szabad, Partner, McGuireWoods LLP

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Track D – Valuation and Transaction Issues

1:00 – 1:40 pm
ASC Transactions, Current Market Analysis and Valuations - Greg Koonsman, Senior Partner, VMG Health

1:45 – 2:15 pm
A Step by Step Plan for Selling Your ASC - How to Maximize the Price, Terms and Results and How to Handle the Process - Luke Lambert, CFA, MBA, CASC, CEO, ASCOA, Introduced by Scott Downing, Partner, McGuireWoods LLP

2:20 – 2:50 pm
Co-Management Relationships With HOPDs - Scott Safriet, MBA, AVA, Principal, Healthcare Appraisers, and Kristian Werling, JD, Partner, McGuireWoods LLP

2:55 – 4:00 pm
Selling Your ASC - A Process and Plan - What Can you Expect? - Evelyn Miller, CPA, Vice President, Mergers & Acquisitions, United Surgical Partners International, Michael Weaver, Vice President Acquisitions & Development, Symbion, Inc., Thomas J. Chirillo, Senior Vice President, Corporate Development, NovaMed, Inc., Jon O'Sullivan, Senior Partner, VMG Health, John Fennebresque, Jr. Managing Director, Fennebresque & Co., and Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

4:05 – 4:35 pm
ASC and Healthcare Transactions - The Year in Review - Todd J.Mello, ASA, AVA, MBA, Principal & Founder, Healthcare Appraisers

Track E – Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Keys to Transforming Surgery Centers Into a Profitable Business - Jim Freund, Senior Vice President, GENASCIS and Matt Searles, Managing Partner, Merritt Healthcare

1:45 – 2:15 pm
Operational Best Practices - Sarah Martin, MBA, RN, CASC, Regional Vice President, Operations, Meridian Surgical Partners

2:20 – 2:50 pm
Coding Tools to Capture, Code and Improve Billings in the High Volume Orthopedic Center - W. Harwood Runner, CEO, Kerlan-Jobe

2:55 – 3:25 pm
Supply Chain Management - How to Work with Suppliers - Scott McDade, Vice President, Surgery Center Sales McKesson Medical, Jim Ricchini, Marketing Manager, Ambulatory Surgery & Oncology Markets, B. Braun

3:30 – 4:00 pm
How to Combine in Network and Out of Network Reimbursement, Caryl Serbin, RN, BSN, LHRM, Executive Vice President and Chief Strategy Officer, Source Medical Solutions, Inc. and Nancy Easley-Mack LPN, Business Office Manager, Short Hills Surgery Center

4:05 – 4:35 pm
Value Priced Implants for Orthopedic and Spine Surgery - Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute, and Blair A. Rhode, MD, Orland Park Orthopedics

Track F – Quality, Infection Control, Accreditation, Management

1:00 – 1:40 pm
Dealing with Difficult Physicians - Michael R. Redler, MD, The OSM Center, Introduced by Holly Ramey, Vice President of Operations, Surgical Care Affiliates

1:45 – 2:15 pm
How to Effectively Measure and Track Patient Quality - David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

2:20 – 2:50 pm
Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs - Raymond E. Grundman, MSN, MPA, Senior Director, External Relations, Accreditation Surveyor, AAAHC

2:55 – 3:25 pm
Infection Control in ASCs - Best Practices and Current Ideas - Cassandra Speier, Senior Vice President of Operations, NovaMed, Inc.

3:30 – 4:00 pm
TBD

4:05 – 4:35 pm
TBD

5:40 - 7:00 pm
Cocktail Reception, Cash Raffles and Exhibits

Friday, June 10, 2011

7:00 – 8:00 am
REGISTRATION and CONTINENTAL BREAKFAST

GENERAL SESSION

8:00 am
Introductions – Scott Becker, JD, CPA, Partner – McGuireWoods LLP

8:15 – 8:55 am - Keynote
The Changing Face of Healthcare Delivery - What to Expect Over the Next Ten Years - Joe Flower, CEO, The Change Project

9:00 – 9:35 am
The State of The ASC Industry - Andrew Hayek, CEO, Surgical Care Affiliates

9:40 – 10:15 am
The Best Ideas for Orthopedic, Spine and Pain Management-Driven ASCs - Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners, Larry Taylor, President & CEO, Practice Partners in Healthcare, Jeff Leland, CEO, Blue Chip Surgical Center Partners, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

10:15 – 11:00 am
Networking Break & Exhibits

Track A

11:00 – 11:40 am
Key Priorities for the ASC Association - William Prentice, JD, Executive Director, ASC Association

11:45 – 12:30 pm
Healthcare Reform and Its Impact on ASCs and Healthcare Delivery - Paul Savoca, M.D., Fairfax Colon & Rectal Surgery, Brent W. Lambert, MD, FACS, Principal & Founder, ASCOA, William Prentice, JD, Executive Director, ASC Association, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track B

11:00 – 11:40 am
Spine Surgery - The Next Five Years - James Lynch, MD, Surgery Center of Reno, Introduced by Chris Zorn, Vice President, Sales, Spine Surgical Innovation

11:45 – 12:30 pm
Key Concepts to Improve the Profitability of Spine Programs - John Caruso, MD, FACS, Neurosurgeon, Parkway Surgery Center and Jeff Leland, CEO, Blue Chip Surgical Partners

Track C

11:00 – 11:40 am
Orthopedics - The Next Five Years - John Cherf, MD, MPH, MBA, President, OrthoIndex

11:45 – 12:30 pm
ACO's - An Overview of What to Expect and How to Prepare - Andrew Hayek, CEO, Surgical Care Affiliates

Track D

11:00 – 11:40 am
Keys to a Successful Turnaround of a Physician/ Hospital Joint Venture ASC - Tom Fry, MD, Board Member Lutheran Campus ASC, Karen Scremin, VP of Finance, Exempla Lutheran Medical Center, Diane Lampron, RN, BSN, CNOR, Administrator, Lutheran Campus ASC, and Director of Operations, PINNACLE III

11:45 – 12:30 pm
Hospital Within A Hospital Joint Venture - Case Study - Dennis Martin, Senior Vice President of Health Systems, Health Inventures, LLC

Track E

11:00 – 12:30 pm
A 90 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, CFO, Cathy Rudisill, RN, MHA, CNOR, CASC, BSN, Senior Vice President of Operations, and Ann Geier, Senior Vice President of Operations, RN, MS, CNOR, CASC, ASCOA

12:30 – 1:30 PM
Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F

Track A – Orthopedics and Spine

1:30 – 2:00 pm
Assessing the Profitability of Orthopedics and Spine Cases - Vivek Taparia, Director of Business Development, and Matt Lau, Director of Financial Analysis, Regent Surgical Health

2:05 – 2:35 pm
The Future of Minimally Invasive Spine Surgery - Why a Spine-Focused ASC is Important - Richard Hynes, MD, Orthopedic Surgeon, Melbourne, FL

2:40 – 3:10 pm
An Analysis of Clinical Outcomes for Spine - Procedures Performed in ASCs - Ken Pettine, MD, Loveland Surgery Center

3:10 – 3:40 pm
Networking Break & Exhibits

3:40 – 4:10 pm
How To Achieve Great Results for Spine Surgery/ Neurosurgery in an ASC - Joan F. O'Shea, MD, Neurosurgeon & Orthopedic Spine Surgeon, The Spine Institute of New Jersey

4:15 – 4:45 pm
Minimally Invasive Outpatient Lumbar Fusions and Multi-Level Outpatient Cervical Disk Replacements - Robert Nucci, MD, Citrus Park Surgery Center, Tampa, FL

4:50 – 5:20 pm
Is There a Place for Orthopedics in ACOs? - Michael Redler, MD, The OSM Clinic

Track B – Orthopedic and Spine ASC and Clinical Issues

1:30 – 2:00 pm
Current Issues in Orthopedics and ASCs - Michael Redler, MD, The OSM Clinic, and John Cherf, MD, MPH, MBA, President, OrthoIndex

2:05 – 2:35 pm
Establishing and Operating Successfully in a Small Market - Joseph Zasa, JD, Partner, ASD Management, and TK Miller, MD, Associate Professor, Dept. of Surgery, VTC School of Medicine, Medical Director, Roanoke Ambulatory Surgery Center, Carilion Clinic Orthopaedics/Sports Medicine

2:40 – 3:10 pm
Handling Complex Spine Cases in an ASC, Clinical and Financial Issues - Marcus Williamson, President, Neospine Division, Symbion, Inc.

3:10 – 3:40 pm
Networking Break & Exhibits

3:40 – 4:10 pm
Key Developments in Cartilage Restructuring - Brian Cole, MD, MBA, Professor, Department of Orthopedics, Department of Anatomy and Cell Biology Section Head, Cartilage Restoration Center at Rush Division of Sports Medicine, Rush University Medical Center

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4:15 – 4:45 pm
Biologic Joint Replacement: The Future of Joint Replacement Surgery Using Stem Cells Paste Grafting, Meniscus Allografts, Shell Grafting and Allo and Xenograft Ligaments - Kevin R. Stone, MD, The Stone Clinic

4:50 – 5:20 pm
Hand Surgery in ASCs - Key Concepts for Clinical and Financial Success - R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

Track C – Joint Ventures, Co-Management, Orthopedic and Pain Management

1:30 – 2:00 pm
Role of Workers' Compensation in a Spine Focused ASC - John DiPaola, MD, Orthopedist, Oregon, and Scott Gibbs, MD, Neurosurgeon, Cape Girardeau, MO

2:05 – 2:35 pm
Key Tips for Success - Orthopedics in ASCs - What Works and What Doesn't - Greg Deconciliis, Administrator, Boston Out-Patient Surgical Suites

2:40 – 3:10 pm
Pain Management in Offices and ASCs: Best Practices and Business Guidance and New Ideas - David Kadish, President, Medi-Corp, Inc., and Leslie Johnson, Director of Coding and Education for Medi-Corp and Founder of Askleslie.Net

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Co-Management Arrangements - Stuart Katz, Executive Director, FACHE, CASC, Tucson Orthopedic Surgery Center

4:15 – 4:45 pm
A Roundtable on Joint Ventures - Allen Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President Development & Acquisitions, ASCOA

4:50 – 5:20 pm
Business and Financial Relationships with Hospitals - Co-Management, Joint Ventures and Employment - Ed Hetrick, President & CEO, Facility Development Management

Track D – Physician Owned Hospitals, Orthopedic Practices

1:30 – 2:00 pm
The Best Ideas Now; 3 Ways to Improve Physician Owned Hospital Profits - Tom Mallon, CEO, Regent Surgical Health, Paul Kerens, Senior Executive Officer, Kansas City Orthopaedic Institute, Michael J. Lipomi, Surgical Management Professionals

2:05 – 2:35 pm
Reducing Implant Costs - Terry L. Woodbeck, CEO Tulsa Spine and Specialty Hospital

2:40 – 3:10 pm
Physician Owned Hospitals - A Prognosis and Plan for the Next Four Years - Brett Gosney, CEO, Animas Surgical Hospital

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Key Legal Issues Facing Physician-Owned Hospitals - Scott Becker, JD, CPA, Partner, and Amber Walsh, Partner, McGuireWoods LLP

4:15 – 4:45 pm
Key Ideas for Improving Orthopedic Practice Profits - David Wold, Chief Operating Officer, Illinois Joint & Bone Institute

4:50 – 5:20 pm
Orthopedic Practices - How to Explore Strategic Options - Stay the Course or Sell - Marshall Steele, MD, CEO, Marshall Steele

Track E – Managed Care, Reimbursement and Syndication Issues

1:30 – 2:00 pm
Orthopedic and Spine Contracting - A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors - I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting & Management

2:05 – 2:35 pm
Best Practices in Physician Syndication - Michelle Trammell, President, and Chase Neal, Vice President, The Securities Group, Larry Taylor, President & CEO, Practice Partners in Healthcare

2:40 – 3:10 pm
Key Concepts for Conducting Internal Investigations - Scott Becker, JD, CPA, Partner, David J. Pivnick, Associate, and Lainey Gilmer, Associate, McGuireWoods LLP

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Improving Managed Care, Contracting Results - A Case Study Step by Step Approach - I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting and Management

4:15 – 4:45 pm
Billing Process Improvement 101 - Bill Gilbert, Vice President Marketing, AdvantEdge Healthcare Solutions

4:50 – 5:20 pm
10 Ways to Improve an ASCs Coding - Document Deficiencies, Financial Impacts and How to Work with Physicians, - Kelly Webb, Director, ASC Billing

Track F – Reducing Costs, Market Consolidation, Hiring, and Golf

1:30 – 2:00 pm
Avoiding Critical ASC Mistakes: Hiring Great Staff, Reducing Hours Per Case, Physician Utilization - Joyce Deno Thomas, RN, BSN, Senior Vice President, Operations, and Robert Welti, MD, Senior Vice President, Operations, Regent Surgical Health

2:05 – 2:35 pm
Can an ASC Improve Profits Through Market Consolidation - William J. L. Kennedy, MBA, SVP Business Development, NovaMed, Inc., and Michael Weaver, Vice President, Symbion, Inc.

2:40 – 3:10 pm
Three Ideas to Streamline Costs and Improve Profits - Jeff Blankinship, President, Surgical Notes, Tom Jacobs, President & CEO, MedHQ, Bill Cramer, CEO, Access MediQuip

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Top Traits of ASC Leaders and How to Recognize Them - Greg Zoch, Partner, Kaye-Bassman

4:15 – 4:45 pm
How to Immediately Improve Your Golf Swing, Aaron Bergman, PGA Golf Pro

4:50 – 5:20 pm
Hiring Winners Not Whiners - Tracy Hoeft-Hoffman, Administrator, Hastings Surgical Center

5:20 – 7:00 PM
Cocktail Reception, Cash Raffles and Exhibits

Saturday, June 11, 2011

7:00 – 8:10 am – Continental Breakfast
General Session

8:10 – 8:55 am
Leveraging Ideas from Other Industries to Improve ASC Profits - W. Michael Karnes, Chief Financial Officer, Regent Surgical Health, and Michael Rucker, EVP and COO, Surgical Care Affiliates

Track A

9:00 – 9:45 am
Buying and Selling ASCs - HOPDs and National Companies, Co Management and ACOs - Current Market Trends - Scott Becker, JD, CPA, Partner, Scott Downing, JD, Partner, and Amber Walsh, Partner, McGuireWoods LLP

9:50 – 10:50 am
How and Why Might Orthopedists and Neurosurgeons Team and Partner to Create Musculoskeletal Centers of Excellence - John Caruso, MD, Neurosurgeon, Parkway Surgery Center

10:55 – 11:55 am
Lessons Learned - What Did I Do Right and What Might I Do Differently When Creating a Spine ASC? - John Caruso, MD, Neurosurgeon, Parkway Surgery Center, Scott Gibbs, MD, Neurosurgeon, Cape Girardeau, MO, Richard Hynes, MD, Orthopedic Spine Surgeon, Melbourne, FL, Moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners

Track B

9:00 – 9:45 am
New Advances in SacraIliac Joint Problems - Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute

9:50 – 10:50 am
Pain Management in ASCs - Current Ideas to Increase Profits - Amy Mowles, President & CEO, Mowles Medical Practice Management

10:55 – 11:55 am
Threats to Physicians and Strategies to Protect Your Practice and Investment - Robert M. Schwartz, Executive Director, Proliance Surgeons, Inc.

Track C

9:00 – 9:45 am
Clinical Excellence Every day: Director of Nursing 101; Lesson Learned from Overseeing 100 Plus Centers - Linda Lansing, Senior Vice President of Clinical Services, Surgical Care Affiliates

9:50 – 10:50 am
Accrediation, A 60 Minute Workshop – HFAP

10:55 – 11:55 am
Given the Economic Downturn, Why Now is Actually a Great Time to Develop a Facility - John Marasco, AIA, NCARB, Principal & Owner, Marasco & Associates

Track D

9:00 – 9:45 am
The Best Ideas to Immediately Improve ASC Profits - Sandra Jones, MBA, MS, CASC, FHFMA, Chief Executive Officer, Executive Vice President, ASD Management, Monica Ziegler, Administrator, Physicians Surgical Center, Susan Glendon-Bealieu, RN, LHRM, Administrator, Surgical Center for Excellence, Kara Vittetoe, Administrator, Thomas Johnson Surgery Center, ASCOA

9:50 – 10:50 am
Physicians, Hospitals, and Management Companies - What it Takes to Make a Winning Partnership and ASC - Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

10:55 – 11:55 am
Short and Long Term Strategic Planning and Setting Annual Goals and Objectives - John Goehle, CASC MBA CPA, Ambulatory Healthcare Strategies, LLC

Track E

9:00 – 9:45 am
Information Technology for Surgery Centers – Achieving Positive Outcomes and Avoiding Complications - Marion Jenkins, PhD, Founder & CEO, QSE Technologies, Inc., Todd Logan, Vice President Sales - Western Region, and Ron Pelletier, Vice President, SourceMedical

9:50 – 10:50 am
ASC Litigation, Non Competition, Employee Litigation and Other Kinds of Litigation, Key Thoughts - Jeffrey C. Clark, Partner, and David J. Pivnick, Associate, McGuireWoods LLP

10:55 – 11:55 am
Coding Inaccuracies That May Put an ASC or Practice at Risk With the OIG and RACs - Pain Management Medical Necessity/Over-Reporting, Orthopedic Incorrect Reporting on Knees and Shoulders, Spine Overstating Work/Unbundling - Cristina Bentin, CCS-P CPC-H CMA, President Coding Compliance Management

GENERAL SESSION

12:00 – 1:00 pm
ASC Safe Harbor Redemptions, Physician Compensation Compliance, Internal Investigations, and Increased Government Investigations - Scott Becker, JD, CPA, Partner, Gretchen Townshend, Associate, and Sarah Chacko, Associate, McGuireWoods LLP

1:00 pm - Meeting Adjourns

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Are You an Excellent Employer?: Professional Employer Organizations for Your Healthcare Human Resource Functions

By Tom Jacobs, President and CEO, MedHQ

Are you prepared to handle all of the challenges associated with being an employer?

Each business' answer to this important question is different. Some businesses benefit from a stable, dependable workforce that is inherent to their situation: perhaps there is core group that was with the business "from the beginning"; perhaps the business has always had consistent and excellent leadership; perhaps the business has market conditions that attract great employees. There are many scenarios that may enable a great staff and a great culture to grow organically within a business, and continue indefinitely as a great work environment. We'll call these businesses the "lucky ones".

Not all businesses are so "lucky." For many businesses, developing or maintaining an excellent staff is a constant challenge and for others, employment challenges seem to come and go in peaks and valleys with different causes and story lines for each episode. The result is a host of business challenges created by employees that expose the business to large risks, and act as a drag on revenue and profit growth.

Here are four risk factors employers should look out for:

1. Inexperienced supervisors that unknowingly expose the business to lawsuit or safety risks.

2. Unmanaged employee benefits programs that either don't deliver what was expected or cost more than they should.

3. Lack of access to efficient ongoing training programs that could otherwise mitigate some of the risk exposures

4. Wage and benefit programs that are inconsistent with the local market, and thereby expose the business to unnecessarily high turnover or high cost.

For these businesses, access to a great HR team can make a big difference. The solution is referred to as a "professional employer organization" (PEO) arrangement (PEO). Human resource management and administration is such a wide ranging field and so large that it is impossible for a single person to have all the knowledge and skills necessary to meet the day-to-day needs of your organization. Your organization needs a support "team," but your budget may only be able to handle a single person. Hiring a PEO company can improve the overall efficiency and profitability of your organization. Just as you have a strategy for controlling supply costs and capital structuring, there is a very real need to implement a "people strategy" — developing, communicating and enforcing the standards and culture you want to instill in your company.

PEOs can help your company:

- reduced employee turnover rates;
- handle high risk employment situations worth millions of dollars in risk exposure, with minimal realized claims expenditure;
- reduce employee benefit program expense through effective negotiation and "economies of scale" associated with the PEO model;
- set up management/supervisor training programs at a fraction of the cost of what a professional could obtain on their own;
- consolidate your company's HR services vendor lists from to a single point of contact; and
- roll out a fully automated, online HR system from timekeeping through direct deposit of each employee paystub, electronic online enrollment of benefits, and online employee self service.

Whether you decide to utilize internal resources or to outsource to a PEO, expertise is required when handling not only your most valuable asset — but also your greatest potential liability — your employees. ■

Learn more about MedHQ at www.medhq.net.

4 Ways for ASCs to Provide Competitive Benefits

By Rachel Fields

Pam Carter, business controller, and Sandy Berreth, administrator of Brainerd Lakes Surgery Center in Baxter, Minn., discuss strategies they use to keep benefits competitive.

1. Shop around for insurance. Ms. Carter recommends ambulatory surgery centers shop around for health insurance. "On a yearly basis or every couple of years, check the big insurance companies and see what kind of premiums they'll give," she says. Don't assume that your traditional insurance provider is giving you the best rates.

2. Provide benefits that hospitals do not. If your ASC is competing with a local hospital, you may find it difficult to offer competitive benefit packages. "I can't match a hospital on health insurance and short-term and long-term insurance," says Ms. Berreth. "A hospital that

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employs hundreds or even thousands of people has a much better ability to contract with insurance companies." However, as hospitals look to cut down on non-essential benefits because of financial pressures, your ASC may be able to offer benefits they don't provide. Ms. Berreth says hospitals rarely provide supplemental insurance coverage from companies like Aflac, which allows the employee purchase extra protection in case they're ill or have an accident. "Often, hospitals won't even let that kind of insurance in the door because they don't want to mess with it," she says. "It would be a logistical nightmare."

She says your ASC might also consider more creative benefits, such as pet insurance, to give you the edge over a larger facility.

3. Promote your intrinsic "benefits." The bottom line: You may not be able to compete with a hospital or larger ASC regarding traditional benefits. Instead, Ms. Berreth says you should promote the ASC's other strong points — for example, no weekend shifts, no call and no night shifts. You should also consider offering an annual bonus, a measure many hospitals don't or can't take because of economic pressures. "Just based on the profitability of the surgery center, those are the kind of benefits we're able to give," Ms. Berreth says.

4. Talk as a team about vacation requests. Most employees are attracted to jobs that provide great vacation benefits, but small ASCs can find it difficult to grant vacation requests when the staff is limited. Ms. Berreth and Ms. Carter say their ASC experiences the most vacation requests around the holidays, which is inconveniently also a busy time for elective surgeries. Unlike a hospital, where vacation requests might be handled by an HR department, your ASC has the advantage of being able to sit down as a team and talk about requests together. Instead of rejecting a request out of hand, you can explain to the staff that everybody wants time off and only a certain amount can be granted.

This holiday season, Ms. Carter says, "We actually sat down together as a group and talked about the time we wanted off during December. We took a team approach and talked about how we could make that happen for each one of us." By approaching vacation this way, the ASC was able to give each employee enough vacation time without angering staff or disrupting the center's operations. ■

Contact Rachel Fields at rachel@beckersasc.com.

5 Ways to Incent Good Behavior With Staff Bonuses

By Rachel Fields

Surgery center administrators agree: Staff members respond to financial incentives. Here are five ways to improve staff performance and your ASC's operations by distributing bonuses.

1. Don't distinguish bonuses based on job title. Rosemary Lambie, administrator of the SurgiCenter of Baltimore, a five-OR ASC in Owings Mills, Md., says all 20 employees at her ASC equally share the payments in her bonus program, no matter what work they do. For example, the four people in the business office share the bonus for collections with everyone else. Everyone has an influence over this category because it is based on net revenue, Ms. Lambie says. Also, "we're a team," she says.

2. Tie bonuses to specific thresholds. According to Sarah Martin, regional vice president of operations for Meridian Surgical Partners, good incentive programs are tied to financial and quality aspects of the ASC's business. "For example, all staff can assist the facility to meet supply and salary goals for the month, based on flexing their hours worked and not opening unnecessary supplies, as well as helping to identify other sources for supplies," she says. She says the key is to base the bonus on "meeting or exceeding expectations," rather than letting the bonus become an expectation among employees regardless of effort.

3. Give schedulers bonuses for improving physician office communication. If your center is looking to improve relationships between physicians and your ASC, you might consider giving bonuses to schedulers for keeping in closer contact with physician offices. "We work really hard with the schedulers and incentivize them if they demonstrate staying on top of [schedules] by providing Starbucks gift cards and organizing big luncheons for them with the physicians," says Sue Leveque, RN, administrator at Central California Endoscopy Center in Fresno, Calif. "It's important to keep good relationships with the schedulers."

4. Give out bonuses based on patient collections. Larry Taylor, president and CEO of Practice Partners in Healthcare, says ASCs should keep a log showing how many patients paid their bill. Once the log has been kept for a few weeks, start offering a bonus for those who collect 90 percent of more of patients' payments. "The goal here is to reinforce the importance of collecting from patients," he says.

5. Hold a "good idea" competition and distribute a bonus to the winner. Joe Zasa, co-founder and managing partner of ASD Management, says ASCs thrive when staff members are encouraged to contribute good ideas on saving money, improving patient care and increasing physician satisfaction. He recommends asking for ideas from staff and creating a monetary award for the best ideas. "The purpose of the bonus plan is to simulate ownership in your ASC and incentivize the staff to think and act like owners," he says. ■

Contact Rachel Fields at rachel@beckersasc.com.

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10 Recent Findings on Anesthesia Quality Issues

By Rachel Fields

1. Regular training sessions could prevent anesthesia awareness. According to a report published in the current issue of *Deutsches Ärzteblatt International*, two of every 1,000 patients wake up during their operation, and unintended awareness is classified as an occasional complication of anesthesia. The authors recommended making providers aware of various awareness risk factors by conducting regular training sessions with medical personnel. Additionally, they said anesthesia providers should measure anesthetic gas concentrations regularly and monitor brain electrical activity by EEG.

2. Multimodel analgesia is important for spine surgery preop. In a review of methods published in the Dec. 15 issue of *Spine*, researchers Asokumar Buvanendran, MD, and Vijay Thillainathan, MD, of Rush University Medical Center in Chicago, reviewed the current literature on anesthesia and analgesia for minimally invasive spine surgery and considered applying other principles used for other types of minimally invasive surgery. The study pointed out the importance of using multimodal analgesic therapy during preoperative visits and stressed that multimodal analgesia should also be continued postoperatively.

3. Anesthesia circuit device could prevent post-operative cognitive decline. Michael Schmidt, MD, professor of anesthesiology at Dalhousie University in Germany, has developed a device that could prevent post-operative cognitive decline. The device is designed for the removal of carbon dioxide in the anesthesia circuit, which could make anesthesia safer and prevent patient memory loss and other forms of cognitive dysfunction. Dr. Schmidt hopes to bring the device from "bench to bedside" by 2014, pending clinical trials and a regulatory process.

4. SSI, HCAI studies should be repeated in more facilities. Healthcare-associated infections and surgical site infections deserve more attention from the anesthesia community, and hand-washing studies should be repeated at other institutions, according to the authors of an editorial published in *Anesthesia & Analgesia*. According to the editorial, anesthesiologists should take the following measures to decrease the incidence of HCAIs and SSIs:

1. Determine the effectiveness of local anesthesia work area decontamination protocols.
2. Continue to administer the proper antibiotic in a timely manner.
3. Continue to wash hands in all cases.

5. Anesthesiologist and surgeon perception of turnover times could be flawed. Managers should not rely on surgeons or anesthesiologists for expert judgment on turnover times, according to a study published in *Anesthesia & Analgesia*. The study concluded that perception of turnover times were influenced by opinion of team activity during shift change, and time of day influenced perception of turnovers. According to the researchers, managers should not interpret comments about turnover times as literally referring to the time, but instead as factors perceived as contributing to the time.

6. Anesthesiologist ordering could reduce unnecessary tests. According to the results of a study published in *Anesthesia & Analgesia*, more than half of the patients examined had at least one unnecessary test based on testing guidelines. Among the 175 anesthesiologists who responded to the survey, 46 percent ordered one or more of the tests considered unnecessary. Likelihood of anesthesiologists ordering unnecessary tests was considerably lower than the likelihood of gynecologists, otolaryngologists, orthopedists and general surgeons ordering unnecessary tests.

7. Methadone reduces post-op pain in complex spine surgery patients. Perioperative treatment with a single bolus of methadone improves postoperative pain control for patients undergoing complex spine surgery, according to a study published in *Anesthesia & Analgesia*. Results of the study showed methadone reduced postoperative opioid requirement by approximately 50 percent at 48 hours after surgery, and pain scores were lower by approximately 50 percent in the methadone group 48 hours after surgery.

8. Body temperature can be monitored non-invasively with new technique. Anesthesiologists Marc Abreu, MD, David Silverman, MD, and colleagues at Yale University in New Haven, Conn., have identified an area of the brain that transmits brain temperature to an area of the skin and has the potential to prevent death from heat stroke and hypothermia and to detect infectious diseases, according to a *Yale News* report on the study. The researchers found that a small area of skin near the eyes and noses is the point of entry to the "brain temperature tunnel," a connection to a thermal storage center in the brain.

9. Anesthesia information management systems improve case documentation. Accreditation organizations should support uploading of case log files based on anesthesia information management systems, as AIMS databases have been widely adopted by academic anesthesia departments, according to a study published in *Anesthesia & Analgesia*. The researchers found that manually-entered cases were rife with errors — with more than 50 percent of residents either underreporting or overreporting total case counts by at least 5 percent — compared to the AIMS database.

10. Preoperative cerebral oxygen saturation prevents health risks. Researchers observed Sc02 levels in 1,178 patients by using noninvasive near-infrared spectroscopy, a quick and simple method of monitoring the adequacy of a patient's brain oxygen supply, in a study published in the Jan. 2011 issue of *Anesthesiology*. The study's data indicated that preoperative Sc02 levels reflect cardiopulmonary function, meaning patients with low preoperative Sc02 may not be appropriate for surgery. A preoperative ScO2 level of less than 50 percent was an independent indicator of mortality in the patients observed. ■

3 Ideas for Boosting GI Case Volume Through Marketing

By Rachel Fields

Here are three ideas to increase case volume in your GI-driven ASC through marketing to members of the physician and local community.

1. Talk to primary care physicians in the community. Most ASCs rely on their physicians to bring cases to the center, but primary care physicians in your community may also be a valuable source of referrals. GI centers should talk to primary care physicians about the importance of colon cancer screenings and your center's availability. If primary care physicians are aware that your center performs screenings, they may recommend colon cancer screenings to their patients and then send them your way.

"We do a lot of work in just educating the [physician] community, talking to primary care physicians, ob/gyns and other specialists about colon cancer," says Nancy Nikolovski of Physicians Endoscopy Center in Houston, Texas. "They're still the gatekeepers, and they really do direct patients' care, so they are instrumental in making sure patients get screened."

2. Add a procedure that other ASCs don't offer. Philip Grossman, MD, FACP, FACG, AGAF, FASGE, CEO and medical director of Kendall Endoscopy and Surgery Center in Miami, says his ASC has experienced the best results from direct-to-consumer marketing when the facility adds a procedure or service that is not available elsewhere. "For example, a new medical device comes out and it's in clinical trials, and it saves somebody from a big operation to fix a problem, and the physician who's running it is in your facility," he says. "You might put out an ad that says, 'Do you suffer from heartburn? Are you tired of taking pills every day? Come to the XYZ ASC and get your heartburn solved without medication or surgery."

He says the new procedure has to target a large enough segment of the population that the cost of the marketing is offset by your increased revenue. He says for the most part, marketing on the quality of your service is not as effective because most patients are brought to the ASC without their input.

3. Send out reminder cards. Direct-to-consumer marketing doesn't always have a significant impact on ASC case volume, but GI-driven ASC administrators say they've seen a substantial rise in volume by sending out colonoscopy reminder cards.

"We have a budget for direct-to-consumer marketing for colon cancer screening, and we send out end-of-year 'use it or lose it' postcards," Ms. Nikolovski says. "We remind [people in the community] that colon cancer is preventable if caught early." ■

Contact Rachel Fields at rachel@beckersasc.com.

ASC Best Practice: Communicate and Confirm Patient Financial Responsibility Prior to Day of Surgery

By Rob Kurtz

Ambulatory surgery center industry experts regularly preach about the difficulties ASCs face when attempting to collect co-pays and deductibles following a procedure and patient discharge. If the payment isn't collected up front, there's a good chance the surgery center will never collect it or will only collect a small fraction of what is owed. ASCs should not assume they will collect from patients on the day of surgery unless the patient is told how much they will owe and can come prepared to cover that cost, says Rob Morris, vice president of marketing and new business development for GE Capital's CareCredit, a third-party payment plan provider.

With increasing deductibles and co-pays, ASCs are asking for more money directly from patients, making it even more critical for surgery centers to inform patients of their responsibility as early as possible to allow the patient to secure the funds needed to cover the facility fee.

An effective way of doing so, and one Mr. Morris has seen some of his clients use, is to parlay the routine phone call made to patients a few days in advance to discuss the particulars of their procedure and responsibilities leading up to it into a discussion concerning the patient's finances. The topics discussed during these calls typically include insurance verification, patient history, confirming time and location of the procedure, what the patient can eat or drink prior to surgery and what the patient should bring to the ASC. After those responsibilities are discussed, the patient is then transferred to a member of the business office to discuss what they will owe for the facility fee.

"That phone call is a good qualifying opportunity," says Mr. Morris. "Patients are often surprised that they'll be charged separately by the ASC. They might assume the cost is included in the surgeon's fee."

This approach is used by Upper Cumberland Physicians Surgery Center in Cookeville, Tenn., according to Pat Brown, business office manager for the ASC.

"We tell them that it is an estimated cost and we're very adamant about saying this is for the facility, this is for us only," Ms. Brown says. "We remind them that they are still going to have a bill from the doctor's office and anesthesia office. Sometimes they are aware of it, sometimes they're surprised by it."

Confirm patient's understanding

Mr. Morris says there are a few important steps to take to ensure patients truly understand their financial responsibilities to the ASC.

ASC should have a financial policy and follow it," he says. "They should say to the patient, 'You're going to owe us $1,100. We accept cash, check or credit cards.' Give them an opportunity to commit to one. If they say they're going to come in with a check, [the business office staff member] should repeat that.

"It's the same thing done at a restaurant when a waiter repeats an order," he says. "Reinforce with that patient through a verbal commitment that they'll be there that day with the $1,100."

If there's time, send a letter

If Upper Cumberland Physicians is able to determine the approximate facility fee patients will owe well in advance of the procedure, the ASC will usually send a letter indicating the amount and telling patients if they can't pay the amount in full on the day of surgery to contact the facility.

"If the letter goes out and we don't hear from them, we generally assume they're going to pay in full because it states it right in [the letter]," Ms. Brown says.

Offer payment alternatives

Ms. Brown says patients will often express concern about their ability to use traditional means of payment (cash, check or credit card) to cover the facility fee, which is why Upper Cumberland Physicians has two payment plans it can set up with patients in advance of the procedure.

Upper Cumberland Physicians' preferred alternative is a third-party payment plan (which, in this ASC's case, is CareCredit). The third-party payment plan is essentially a healthcare-dedicated credit card which allows a patient to pay off what they owe over a 6-60-month period. CareCredit plans start for patients at Upper Cumberland Physicians who will owe $300 or more.

"It gets the patients off of our books and we don't have to worry about them and I don't have back-door collections to worry about," says Ms. Brown. "If I get them on CareCredit, they're CareCredit's problem."

Upper Cumberland Physicians has a second alternative for patients: an in-office payment plan.

"The in-office comes into play if they really insist they don't want CareCredit or if they try to apply for it and they're denied," Ms. Brown says. "Then if it's under $300, we'll try to break it down for them for up to four months, with the first payment due on the day on service."

She says the in-office plan is a last resort. "The ones who set up the payment plan with us, if they owe $100 and then only send us $50, now I have back-door collections going on and I have to work a little harder at it," she says.

Regardless of what payment options an ASC offers patients, all facilities need to take a proactive approach to collecting payment before a procedure is performed. ■

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10 Assertions Payors Make in ASC Contract Negotiations and How to Respond

By Leigh Page

T.K. Miller, MD, medical director of Roanoke (Va.) Ambulatory Surgery Center, cites 10 assertions payors make in contract negotiations and how he would respond.

1. "This is all you're going to get." Negotiations are particularly tough with Anthem, which controls 60 percent of the local market. "They tend to start off negotiations by telling you, 'This is all you're going to get,'" Dr. Miller says. He says it's important to get past that demand and explain to them why you need to be paid more.

2. "We want to negotiate one-on-one." The local hospital owns 50 percent of the ASC. It might well be preferable to negotiate through the hospital, because it has more clout, but the hospital is a silent partner that does not get involved in contract negotiations and the payors like it like that. "We negotiate on our own," Dr. Miller says. Since the hospital also owns an HOPD, "there was a concern that if the hospital weighed in, there would be a conflict of interest," he adds.

3. "We don't believe your cost data." When the ASC last negotiated with Anthem in 2007, "we did not have as firm an idea of our costs, and they didn't believe our data," Dr. Miller says. "We could give them a range but not an exact number." But in negotiations for a new contract three years later, Anthem wasn't able to refute the center's cost data. Every expense could be pinpointed. Anchors, shavers, sutures and other supplies are now bar-coded and scanned at the point of use. The center rounds out its data with national benchmarks supplied by a management company. This time the center could quote costs down to the decimal point. "We could give them a valid argument for our prices," he says. "We could get to the real cost."

4. "We want to stay with groupers." When CMS switched payments from groupers to ambulatory payment classifications, it reduced payments for eye, GI and ENT procedures and substantially raised them for orthopedics. Staying with groupers might be advantageous for a GI-only facility, but two-thirds of Roanoke's cases are in orthopedics. The ASC had to insist on more favorable rates than groupers.

5. "We'll give you a flat increase." Anthem offered Roanoke a 3 percent across-the-board increase. That might be acceptable if Roanoke were equally involved in all specialties, but it did not reflect increases in its major specialty. "We said, wait a minute, we just had a 50 percent increase in orthopedics alone," Dr. Miller says. Furthermore, the price of

orthopedic implants, a big part of the total cost, rises about 9 percent a year. The ASC needed to go beyond a flat increase and specifically address orthopedics.

6. "We don't allow carve-outs for implants." Anthem doesn't normally allow carve-outs for implants. Under a carve-out, the ASC would get a percentage increase for each procedure to reflect the implant. Since his ASC could not use carve-outs, Dr. Miller decided to negotiate fees based on the center's average cost. For this to work, the ASC needs to know the exact amount for each CPT code, which it can do now, because of bar-coding and other improvements.

7. "Costs are lower in our region." Anthem's usual argument is that rates can be lower in southwestern Virginia because the cost of doing business there is lower there. This may be true for staff salaries, but not for supplies like implants, which represent a big part of the total cost of orthopedic surgery.

8. "Volume for this case is too low to matter." The volume of each procedure makes a difference in negotiations. For instance, Anthem considers a cadaver graft used in ACL reconstructions to be an implant, meaning the center loses about $1,000 on each operation. Dr. Miller hinted that surgeons might have to move these operations to the high-priced hospital, but payors just shrug at that. "They in effect said, 'Go ahead, your case volume here is not a big financial issue for us,'" he says.

9. "But we do want you to stay open." Even if it isn't exactly said, both sides know it's in the insurer's best interest that the ASC makes enough money to stay open, and that can be a powerful negotiating tool. "We're still cheaper than the hospital, but if we can't get the rates we need, we'd have to go out of business," Dr. Miller says. "Imagine, 4,000 procedures a year suddenly shift to hospital-based charges. That is a significant increase in cost for the payor."

10. "We want spine out of the hospital." Roanoke recently started giving spine surgeon's block time, and Anthem is pleased because it means moving spine out of the hospital. "They'd love to have spine out of the hospital," Dr. Miller says. "We said to them, 'If you give us a good across-the-board rate, we will make a conscious effort to move spine cases out of the hospital and into this facility.'" ■

Learn more about Roanoke Ambulatory Surgery Center at www.roanokeasc.com.

California ASCs Face 20% Reduction in Workers' Compensation Reimbursement

By Rob Kurtz

Ambulatory surgery centers in California are facing a 20 percent reduction in reimbursement under proposed regulations from the California Division of Workers' Compensation (DWC), according to a news release from the California Ambulatory Surgery Association.

The DWC is proposing to keep HOPDs at the current fee schedule and reduce ASC reimbursement to 100 percent of the CMS HOPD fee schedule.

According to the news release, "The CASA Board takes exception to the DWC removing ASCs from parity with the HOPD. The services provided to the injured worker are the same regardless of the site of service and the reimbursement should reflect this. Disrupting the equilibrium between HOPDs and ASCs will cause surgery centers to opt out of treating workers' compensation clients due to cost concerns and creates potential gamesmanship incentives to move patients to a more 'lucrative' setting."

CASA is calling for surgery centers to voice their displeasure about the proposal and submit comments to the DWC. ■

Visit CASA online at www.casurgery.org to learn more.

10 Key ASC Managed Care Contract Provisions and Terms to Know

By Rob Kurtz

Ken Bulow, COO of GENASCIS, identifies 10 key provisions and terms to look for in your surgery center's managed care contracts and offers recommendations for what you should expect under these terms.

1. All product clauses. These allow the payor to extend the contract to other payors."If your payor has affiliates, ensure your contract includes an addendum that list all affiliates upfront at the time of signing," Mr. Bulow says.

2. Filing limit. Request a minimum of 120 days. "It's also important to get an exception to the timely filing deadline for patients who provide inaccurate coverage information," he says.

3. Appeal limits. The recommended minimum is 120 days in which to file an appeal. "Payors like to set short timeframes," he says. "Don't allow it."

4. Timely payment. Though many states have their own laws pertaining to timely payment, your contract should define a payment as 15 days upon receipt of a clean claim that has no defect, impropriety or special circumstance and meets Medicare's guidelines for claim submission.

5. Recoupment time limits or takebacks. Avoid signing a contract that allows for unlimited overpayment recovery. Make sure there is a specific time frame in the contract — the shorter, the better. "It's only fair," says Mr. Bulow. "The payor puts a time limit on how long you have to file an appeal, so you should put a limit on the recoupment window."

6. HMO Withholds. Request no HMO Withholds. HMO Withholds are a cost containment feature incorporated into physician or facility contracts whereby the HMO withholds a portion of the agreed upon consideration and agrees to pay the amounts withheld back to the physician at the end of the year if the utilization of referral patterns have been favorable.

7. Contract term. Make sure you understand the contract terms. Do the rates increase year over year? Are you comfortable signing a three-year term, or are you better off with a one-year term?

8. Charge increases cannot exceed XX percent. You want no limit on charge increases. "As a facility, you have your own methods and reasons for establishing your chargemaster," Mr. Bulow says. "You cannot have a third party dictate what your charges can be and for that reason, we always recommend against charge limits in contracts."

9. Eligible charge. All charges for eligible procedures should be included. "Do not accept a contract with language about 'eligible charges' because you could end up providing approved services to a covered patient and the payor could tell you that certain of the procedures are not 'eligible' for reimbursement," he says.

10. Medical necessity. Make sure the contract clearly defines when authorization is needed for procedures. ■

Learn more about GENASCIS at www.genascis.com.

17 Steps to Take When a Payor Changes Payment System From Medicare-Grouper to APC-Based

By I. Naya Kehayes, MPH, Managing Principal & CEO, EVEIA HEALTH

What should you do when a payor notifies you that it is changing its payment system from a Medicare-grouper methodology to an APC-based methodology? Here are 17 steps your ambulatory surgery center should take.

1. Do not sign an amendment or agree to the proposed change in methodology until you have analyzed and understand the revenue implications. It may warrant negotiation if the value of the new methodology results in a loss.

2. Verify the year of the APCs and the publication date to ensure accuracy in reimbursement modeling.

3. Verify if the payor is using area adjustments or national weights.

4. Request from the payor a copy of its CPT ASC-allowed code list so that there is a clear understanding of the CPT codes that map to the APC payment methodology that will be used for the new contract.

5. Ask the payor how it will compensate for CPT codes that are not on the mapping and are considered non-APC-grouped codes for ASCs.

6. Make sure payment for non-grouped codes is addressed in the language of the payment provisions, under the new methodology, so that you do not lose access to business.

7. If you are paid for implants separately as a carve-out on a Medicare-grouper based methodology, clarify the payment provisions on implants when you move to the new methodology.

8. If the payor intends to include payment for implants in the APC rate as a global allowed amount, then ensure you have completed a reimbursement analysis to determine if the APC rate is high enough to cover your cost of surgery plus the implant. In addition, ensure there is no value loss when compared to the total reimbursement allowed under the Medicare-grouper based methodology with the additional payment on the implant.

9. Verify the payment methodology for multiple procedures and request that it is consistent with CMS. CMS allows for multiple procedures for specified codes at 100 percent of the full value, which is common amongst device-intensive procedure classed codes under the APC methodology. Ensure you are capturing this same level of reimbursement in accordance with the CMS logic for multiple procedure payments.

10. Compare and contrast volume by CPT code of current rates to proposed new rates on the new methodology.

11. Evaluate and understand the impact by specialty so you can understand the opportunities and threats of moving to the new payment system.

12. If you have a significant loss realized in a specific specialty which is a direct result of the change in methodology, seek carve-outs with the payor or modifications to the conversion factor for a specified group of codes, if there is a sizable volume that is resulting in an overall loss.

13. If the payor is not using 2011 fully implemented APCs, make sure you understand when the payor will update the year.

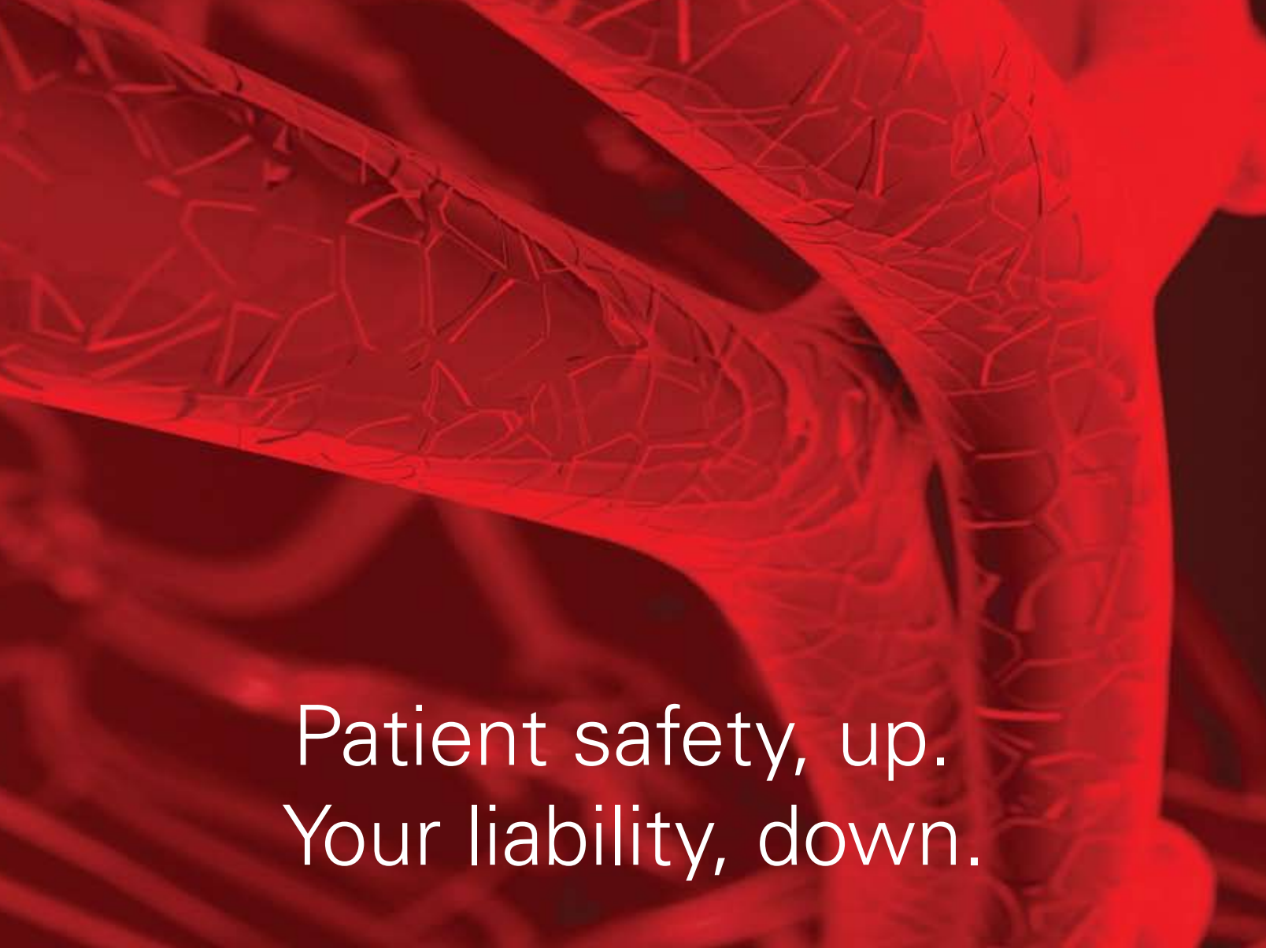
14. Changes in the year may warrant adjustments to conversion factors and or percentages of the base payment.

15. If the contract change in methodology proves to result in a loss, the contract is in need of negotiation with the new methodology change.

16. If the requested change in the payment system comes at the time of an annual renewal, and you are in negotiations, factor in the percentage increase targets you need on the new methodology.

17. If you perform surgery that is not on the approved list under the APC methodology that previously had coverage on the old contract under a non-grouped provision or carve-out provision, seek a carve-out and/or non-grouped provision that will enable your ASC to continue performing these cases. ■

Learn more about EVEIA HEALTH at www.eveia.com.



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8 Ways to Limit Vendor Reps' Influence Over ASC Surgeons

By Leigh Page

When Larry Teuber, MD, talks about vendor representatives entering ambulatory surgery centers, his voice rises like a father talking about the undesirable boyfriend of his teenage daughter. He says that's a fitting analogy, because in his view, vendor reps only mean trouble for ASCs in the form of higher prices for devices, particularly orthopedic implants.

While you can't bar your surgeon from seeing the rep, you can restrict his visits and hope the surgeon learns to choose better, says Dr. Teuber, a neurosurgeon, president of Medical Facilities Corp. and physician executive of Black Hills Surgery Center, an 11-OR facility in Rapid City, N.D., with 14 orthopedic and 5-6 spine surgeons. He provides eight ways to limit vendor reps' influence in surgery centers.

1. Sign-in required. Reps who visit the surgery center should sign in, providing the time, date and a legitimate purpose for the visit. They should then be given a prominent nametag indicating their vendor status so that everyone knows their purpose wherever they go.

2. No parking near the ASC. Do not allow reps to park in the patient, physician or staff lots. "I've had vendors' cars towed out of the doctors' parking lot," Dr. Teuber says. "Their car is put in a flatbed truck and towed past the OR for all to see."

3. No access to the supply room. Representatives have been known to go into the supply room on their visits and put more implants on the shelf as "consignment" items, which are owned by the vendor until they are opened and used. In a facility that intentionally keeps inventory low, reps know that extra implants on the shelf is an incentive to use them.

4. No entry to physician areas. Reps should not be allowed into the physicians' lounge or locker rooms. They must use the staff lockers to change into scrubs. "The more time you put a rep in front of a surgeon, the more opportunities he has," Dr. Teuber says. Representatives that have more time with surgeons can "upsell" their wares.

5. Surgeons must sign a disclosure form. Surgeons who do not disclose a relationship with the rep it could lead to the suspension of their privileges.

6. Talk to the surgeon. Showing the relative costs of implants can sometimes sway them. The rep's implant might cost $12,000, compared with the $3,500 implant the ASC can get in a single-vendor contract. It also helps to show the rep's income. A rep can get 12-15 percent commission on implants, which can translate into more income per hour than the surgeon makes on a Medicare total joint.

7. Be patient. Being realistic may not have any effect at first, because the surgeon and the rep can have a very deep bond. When confronted, "the doctor says he won't abandon the rep because he's a good friend," Dr. Teuber says. "He doesn't understand it's a conditional relationship. If the surgeon doesn't give him any business, he will not be his friend."

8. Understand the profit motive. "I've never heard of a not-for-profit implant company," Dr. Teuber says. "The goal is to sell metal. The sales guys are driven by the regional sales managers. They want better and better sales performance. The rep learns how to suck up to the surgeon: 'That was a *real* fast case you did!' or 'I've never seen a patient lose so little blood!' " He adds: "It's our job as physicians to strike a balance between clinical indications and the product." ■

Learn more about Medical Facilities Corp. at www.medicalfacilitiescorp.ca.
Learn more about Black Hills Surgery Center at www.bhsc.com.

4 Biggest Opportunities in Spine Surgery — From Spine Surgeon Dr. Jay Khanna of Johns Hopkins

By Rob Kurtz

A. Jay Khanna, MD, MBA is an associate professor of Orthopaedic Surgery and Biomedical Engineering at The Johns Hopkins University and serves as the co-director of the Division of Spine Surgery at Johns Hopkins Orthopaedic Surgery at Good Samaritan Hospital. In addition, he serves as the clinical director of the Johns Hopkins Center for Bioengineering, Innovation and Design (CBID). Dr. Khanna discusses what he views as the four greatest opportunities for spine surgery in the immediate future.

1. Minimally invasive spine surgery

Much of the spine surgery that we currently perform — and that has been developed by generations of surgeons before us — is relatively invasive. The spine is a deep structure and somewhat difficult to access. We often end up creating a great deal of collateral tissue damage to get down to the area of interest. For surgery on the lumbar spine, for example, we may have to make an 8- to 12-inch incision to get down to a much smaller region in the spine. That additional exposure creates a substantial amount of risk, potential morbidity and cost.

The field of minimally invasive spine surgery is still in its early stages, and I believe it will continue grow in popularity, both from a surgeon and a patient standpoint. I compare this to the evolution of a number of other procedures that were performed in open fashion 10-15 years ago and are now frequently performed in a minimally invasive fashion; laparoscopic cholecystectomy, arthroscopic rotator cuff repair and arthroscopic ACL reconstruction are several examples.

Minimally invasive procedures have the potential to reduce hospital stays, improve patient recovery and decrease risk to the patient. However, the procedures tend to be more expensive (due to the instruments and implants we use to perform them), rely on techniques that can take some time and experience for surgeons to learn and require fluoroscopic guidance; in addition, the overall long-term efficacy is not yet fully understood. There is also difficulty achieving fusion because we do not expose the posterior aspect of the spine, as with minimally invasive pedicle screw placement, for example. Another downside for surgeons is that working through a small portal may limit our ability to address certain complications if they occur and may lead to inadequate decompression of neural structures.

Minimally invasive spine surgery is still relatively early in its development. As surgeons address and resolve some of the challenges we are currently facing, I anticipate that minimally invasive procedures will evolve to the point where a larger proportion of spine surgeries will be performed using these techniques.

2. Cost containment in spine surgery

I believe that increasing healthcare costs are the biggest threat to the future of spine surgery — we all know that continuous increases are ultimately unsustainable. One of the largest sectors of the total healthcare spending is medical devices. Spine surgery has seen a disproportionate growth in the cost of implants and biologics over the last 10 years, and this clearly cannot continue. I believe that new models must be created to help contain the cost of providing spine surgical services, including those related to devices such as pedicle screws, interbody devices, and plates and biologics, such as BMP (bone morphogenetic protein).

It is imperative that we address costs with regard to hospital stays, and I believe that this is where minimally invasive procedures and the shift to outpatient care come into play. One area that people tend to scrutinize is surgeons' professional fees — my impression is that these fees are as low as they can get. It's imperative to continue to incentivize the most talented people to practice orthopedic, spine and neurosurgery. A surgeon's professional fees comprise a very small part of the total expenditure on spine surgery services, and there is very little room for these fees to be reduced; of course, I am probably biased in this regard.

In addition to advances in device technology, I believe that new business and distribution models could save the system money in the long run. Many orthopedic and spine device companies are very management- and distribution-channel heavy. A careful evaluation of organizational structure and a move toward leaner and stronger companies would go a long way toward helping the bottom line.

3. Increased use of biologics in spine surgery

Biologics are a hot topic in spine fusion surgery. There are three main factors to consider with biologics: efficacy, in terms of ability to reliably achieve fusion; safety, morbidity and the impact on the patient; and cost. Many products on the market perform well in two of these areas, but we have not yet found the product that achieves all three.

Iliac crest bone graft is thought to be the "gold standard" in spine fusion surgery, but many surgeons don't like to use it frequently because of patient morbidity and pain, and the additional time and effort required to harvest bone from the iliac crest. BMPs have been widely popularized and used over past several years, but there are some lingering concerns about safety, especially in the cervical spine. They are also very expensive.

I do think biologics can help achieve fusion. Many companies, scientists, and surgeons are working on this problem, and I'm confident we will see better options in the next 5-10 years.

4. Image guidance safety and radiation dose reduction

Many spine surgical procedures, especially minimally invasive spine procedures, require the use of image guidance or fluoroscopy. One minute of fluoroscopy in a 70kg patient has the equivalent radiation dose of 150 chest x-rays. Typically,

we use about 10-30 seconds of fluoroscopy for a spine case, but some surgeons may occasionally use up to 3-4 minutes, especially for minimally invasive procedures. Surgeons, especially those who use fluoroscopy for their cases, experience a large amount of radiation exposure. This includes surgeons who perform disproportionate amounts of minimally invasive spine surgery, orthopedic surgeons who treat hip fractures and surgeons who handle other trauma cases.

Research in this area has increased in the past several years, and we are now beginning to understand the impact of such radiation exposure on cancer rates as well as other adverse outcomes, such as cataracts, in orthopedic surgeons, interventional radiologists and interventional cardiologists.

We need to maximize safety for the patient and OR personnel during minimally invasive spine procedures and even routine spine surgery, so many surgeons use fluoroscopy. We also have to make sure the patient is protected from high radiation doses. So what is the best way to resolve those two issues? This is where the field of image guidance in spine surgery is taking us. I expect to see new, advanced image guidance technologies being developed that allow for excellent visualization in the operating room while drastically decreasing radiation dose.

The major concern that many surgeons have is that these technologies are cumbersome and can severely affect workflow in the operating room. I believe that the main challenge is to find image guidance technologies that decrease radiation dose to the patient, surgeon, and operating room staff; optimize or improve safety and accuracy; *and* have no negative impact on workflow in the operating room. ■

Learn more about Dr. A. Jay Khanna at www.hopkinsortho.org/a_jay_khanna_md.html.

Physician/Hospital Contracting — A Compliance Approach: 11 Key Concepts

By Scott Becker, JD, CPA, and Lainey Gilmer, JD, MBA, McGuireWoodss

The federal government has greatly increased its regulatory efforts related to investigating, prosecuting and combating healthcare fraud.[1] This focus, combined with the movement of physician providers into employment, medical director or other compensation relationships with local hospitals, has led to an increased focus and scrutiny on hospital-physician financial relationships and contracting issues. Further, a number of recent cases based on alleged improper physician compensation arrangements demonstrate that significant settlements or damages may occur if an improper arrangement is alleged or prosecuted. The magnitude of potential damages has placed physician arrangements on the agenda of U.S. Attorneys and private citizens with the potential to recover a portion of the damages or settlement.[2] In response, hospitals and providers have become proactive in analyzing existing physician compensation relationships, developing the procedures and templates for establishing new relationships and initiating internal investigations of current arrangements. Such internal investigations allow the entity to address and correct any potential liability areas and consider self disclosure if necessary.[3]

The concepts and recommendations contained in this article are aimed at assisting hospitals and providers in analyzing and evaluating their current physician compensation arrangements, as well as presenting a number of best practices used to standardize physician contracting within an organization and to increase compliance with both the Anti-Kickback Statute and the Stark Law.

1. Financial relationship sign-off. A specific person, preferably from the hospital compliance department or a specially-formed compliance group (a "Compliance Committee"), should sign off on each direct and indirect financial arrangement between a hospital and a physician, including all employment agreements, management agreements and medical directorships. Ideally, an individual not involved in negotiating the arrangement between the hospital and the physician would be responsible for the sign-off. Similarly, the Compliance Committee should be comprised of individuals who are independent from the contracting parties and others invested in the potential relationship.

Further, when an arrangement is above a certain dollar threshold, or in the case of highly compensated management agreements or other types of agreements in which a physician provides purely management or administrative services, the hospital should consider greater levels of approval and sign-off on the relationship. Here, the approval of both a chief compliance officer and another individual or committee (i.e., a special compliance subcommittee), along with the general counsel's office, may be required. The committee would review and evaluate the fair market value nature and the commercial reasonableness of the compensation, document such determinations and present its findings to the chief compliance officer and the general counsel's office.

Finally, when a hospital enters into highly compensated, unusual or politically-charged arrangements, it is increasingly important that it develop, maintain and approve a clear record of the facts and need supporting such an arrangement. The facts, discussions, valuations and negotiations that gave rise to the agreement should all be documented and retained.

2. Internal valuation memo. For each hospital-physician financial relationship, including all employment relationships and medical directorships, there should be a specific valuation memorandum on file which articulates the manner in which the compensation was determined, the surveys utilized for comparison and benchmarking and whether an outside valuation opinion was sought. The Compliance Committee should review and sign off on this fair market valuation review. In terms of timing, this fair market review should be completed prior to final negotiations of the applicable contract and prior to execution by the parties. Valuation guidance or review should be conducted on each compensation relationship between the hospital and a physician (or an organization comprised of physicians). For compensation arrangements above a certain amount, an external valuation opinion should also be sought.

CMS has historically commented that the fair market value of physician arrangements is a significant element of any relationship:

> We emphasize, however, that we will continue to scrutinize the fair market value of arrangements as fair market value is an essential element of many exceptions.
>
> Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating fair market value. Ultimately, the appropriate method for determining fair market value for purposes of the physician self-referral law will depend on the nature of the transaction, its location, and other factors. As we explained in Phase II, although a good faith reliance on an independent valuation (such as an appraisal) may be relevant to a party's intent, it does not establish the ultimate issue of the accuracy of the valuation figure itself.[4]

Based on the foregoing, full reliance on an appraisal may not suffice in defending a compensation arrangement. Rather, the hospital and the Compliance Committee should ensure that a full record, including all relevant analysis, is maintained.

3. Compensation cap. The hospital should consider for each hospital-physician financial arrangement, especially if a productivity-driven compensation structure, or containing the potential for a significant bonus, including a reasonable compensation cap. This cap is particularly important in the cases of exempt hospitals and should be consistent with the fair market value of the services performed under the arrangement. A cap on the total compensation will be important for establishing a rebuttable presumption of reasonableness for any non-fixed payments and the compensation as a whole.[5]

4. Employed and/or highly compensated physician in private practice. A hospital system should take extra caution in situations where a substantially full-time physician employee, or highly compensated employee, has the right to earn outside income and in situations where a paid physician employee or indirect contractor is permitted to remain a private practice physician. The Compliance Committee, or individual responsible for signing off on the arrangement, should ensure that the services provided to the hospital are identifiable, measurable and recorded. Time and activity logs will assist the hospital in defending that the compensation paid to a physician who also engages in outside activities is consistent with the services he or she is actually providing and the time spent providing such services.

5. Stark Act and safe harbor regulatory compliance sign-off. As part of the compliance review, legal counsel, internal or external, should review the agreements to assure they meet a core exception under the Stark Act and a safe harbor to the Fraud and Abuse Statute. These may be exceptions and safe harbors that are related to "bona fide employees" or to personal services or independent contract arrangements. The fundamental concepts guiding many of the key thoughts in this article are based on these applicable exceptions and safe harbors. In general, a physician contract must (i) be set forth in writing, (ii) be for commercially reasonably purposes, and (iii) provide for compensation that is set in advance, consistent with fair market

value and not determined in a manner that takes into account the volume or value of referrals or other business generated between the parties. Additional requirements will vary slightly depending on the safe harbor or Stark exception being utilized, but the core requirements set forth above will generally always apply.

6) Job descriptions and roles and responsibilities; need assignment. All physician-employment contracts, management contracts and similar arrangements should contain a clear job description, which includes a list of the services to be provided and an approximation of the time commitment. The hospital's internal files should contain a copy of the particular job description along with an analysis and record as to why the position is reasonably needed by the system. Such file should be periodically reviewed to confirm that the position remains necessary. Similarly, in the case of newly created roles, there should be great clarity as to why such role is needed and what services it will provide. This assessment should also be placed in the contract file.

7. Contracting checklist/contract file. A hospital should develop, implement and maintain a simple contract checklist that can be utilized in virtually all physician compensation relationships. This checklist will provide a standard step-by-step process for creating, analyzing an implementing a financial relationship. If general, a hospital should maintain consistency throughout its physician-contracting. Each arrangement should be subject to the same type of review, analysis and documentation. If investigated, a hospital should benefit by demonstrating that it systematically analyzed each relationship in a meaningful manner. Any variations from this checklist or procedure should be documented and explained.

Similarly, a physician contract file should be maintained for each compensation arrangement. As mentioned throughout this article, the file would contain support for the services to be provided under the arrangement, the compensation to be paid, along with an explanation, analysis or valuation as to its fair market value, and any amendments or changes to the arrangement with a brief explanation as to why such modification was necessary.

8. Review of existing compensation relationships. When conducting an internal investigation or updating the hospital physician contracting procedures, the hospital should review each existing physician-employment agreement and each management, development and marketing agreement. This review should focus on (i) the fair market analysis of the compensation paid pursuant to the arrangement; (ii) the true need for the services provided pursuant to the arrangement; (iii) ensuring the job descriptions set forth in the agreement, if any, are property documented; (iv) ensuring the allocation of medical versus administrative services is consistent with the services that are actually being provided by the physician; and (v) whether the full-time or part-time designation or expected time commitment is consistent with the services being provided under the arrangement and taking into account the physician's outside activities. In cases where the physician is also providing clinical services through his or her private practice and separately billing and collecting for those services, the physician employee should not be designated a full-time employee. Finally, during the course of the review, an internal analysis and record should be created with respect to each compensation relationship which documents the findings and support for each relationship and which is retained in the contract file.

The review of existing arrangements may lead the hospital to restructure, renegotiate or improve the documentation of certain arrangements. In cases in which an arrangement must be restructured, the contract file should include an internal memo or analysis which supports and justifies each resulting change. If investigated, the hospital must be in a position to justify changes and modifications made to its physician compensation arrangements and to demonstrate that such changes were not carried out on a random, unsupported or arbitrary basis to unjustifiably reward a physician.

9. Ongoing periodic reviews. The hospital should task the Compliance Committee (or some other specially formed group or department) with developing a schedule pursuant to which each compensation relationship is periodically reviewed on an on-going basis. In the physician-employment context, the review should focus on the services being provided and the submitted time and activity sheets. The review should also ensure that proper documentation and justification supports any changes to the relationship or compensation. With respect to other compensation relationships, the review should ensure that the parties are complying with the terms of the agreement and that the proper documentation supports the compensation and services being contracted for.

10. Medical director agreements and other clinical/administrative agreements. Often, hospital systems utilize an hourly compensation arrangement for medical director or clinical administrative systems. However, when a contract for administrative or medical director services sets forth an aggregate compensation, the Compliance Committee should ensure that such amount is consistent with the time and services being provided. For example, if a physician is annually compensated thirty thousand dollars ($30,000) for his medical director services, and there are strong arguments that the hourly rate for such services is equal to approximately two hundred dollars ($200 per hour), the physician should be spending between one hundred (100) and two hundred (200) hours a year providing medical director services to the hospital. The hospital may employ a similar calculation to determine the appropriate compensation under an arrangement and to periodically confirm that a physician is providing both the time and the services required to support his or her compensation.

11. Standards for department chairs; special chairs, medical director. For similar positions that exist in numerous departments (e.g., department chair and department vice chair), a relatively standard set of responsibilities and hours expectation should be internally established by the hospital. An hourly rate and an annual compensation should be determined for such position, regardless of the department. Then, any variations in annual or hourly rates, as determined in contract negotiations or otherwise, should be signed off by the Compliance Committee or some other specially designated committee.

There may be reasonable and persuasive justification for compensating one department chair at a much higher rate (e.g., time commitment, number of employees being managed, etc.), but when great disparity exists between similar positions throughout the hospital, and justification for such variance is not recorded or contained in internal files, the hospital may face a greater challenge in defending the compensation of certain positions. ■

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[1] The Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111- 148, 124 Stat. 119 (2010), together with the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), Pub.L. No. 111-152, 124 Stat. 1029 (2010), provide over $300 million for the purpose of fraud and abuse enforcement.

[2] *See.* McAllen Hospitals, located in Houston, Texas, which settled claims of "sham" transactions with physicians for $27.5 million, with the qui tam plaintiff (i.e., the "whistle blower") receiving $5.5 million of such settlement.

[3] While self-disclosure does not guarantee lesser damages, recent changes due to the Patient Protection and Affordable Care Act ("PPACA"), may increase the benefits of this option when a Stark Law violation is identified. Under the Centers for Medicare and Medicaid Services ("CMS") "Self-Referral Disclosure Protocol" (SRDP), CMS has authority to reduce the damages associated with a Stark Law violation based on a number of factors including: (i) the nature and extent of the improper illegal practice; (ii) the timeliness of the self-disclosure; (iii) the cooperation in providing additional information; (iv) the litigation of risk associated with the matter; and (v) the disclosing party's financial position. This potential reduction, however, does not apply to violations of the Anti-Kickback Statute.

[4] 72 Fed. Reg. 51012 (Sept. 5, 2007).

[5] *See.* 26 C.F.R. 53.4958-6(d)(2): If the authorized body approves an employment contract with a disqualified person that includes a non-fixed payment (such as a discretionary bonus) subject to a specified cap, the authorized body may establish a rebuttable presumption with respect to the non-fixed payment at the time the employment contract is entered into if: (i) prior to approving the contract, the authorized body obtains appropriate comparability data indicating that a fixed payment of up to a certain amount to the particular disqualified person would represent reasonable compensation; (ii) the maximum amount payable under the contract (taking into account both fixed and non-fixed payments) does not exceed the amount referred to in paragraph (d)(2)(i) of this section; and (iii) the other requirements for the rebuttable presumption of reasonableness under paragraph (a) of this section are satisfied.

Interpreting the New Medicare Same-Day H&P Guidance for ASCs

By Rob Kurtz

Dawn Q. McLane, RN, MSA, CASC, CNOR, regional vice president of operations, and Cindy A. King RN, CPHQ, director of clinical, quality and compliance, for Health Inventures share their interpretation of the recently issued guidance clarification from CMS for ambulatory surgery centers concerning ASCs performing a patient's history and physical (H&P) on the same day of surgery.

Dawn Q McLane: Many surveyors felt the interpretive guidelines indicated that the H&P was to be performed prior to the date of surgery and was to be updated on the day of survey. Further that the surgeon's H&P is distinct from the anesthesia provider's anesthesia assessment. One reason for this is that it assists the center in determining if the patient meets the admission criteria and is an appropriate patient for the ASC environment. Now Medicare says that the H&P can be performed on the day of the procedure. It helps some specialties like GI and pain, but may be problematic for the more complex cases or patients who have a more complex medical history and comorbidities and could lead to more same-day cancellations.

Cindy A. King: In addition to the above, there still seems to be some remaining questions regarding which elements of the H&P assessment that can be combined with some, but not all of the elements of the same day presurgical assessment. This pertains to an H&P that is conducted prior to the date of surgery; a pre-surgical assessment must be completed by a physician or other qualified practitioner in accordance with state law on the date of surgery that includes at a minimum, documentation of an exam for changes in the patient's condition since completion of the most recent H&P including allergies to drugs and biologicals. The physician or qualified licensed practitioner uses his/her clinical judgment based upon their assessment of the patient's condition, comorbidities, etc., as it correlates to the patient's scheduled procedure in order to decide the extent of this update assessment and corresponding documentation.

It is important to note that the assessment of the patient's procedure/anesthetic risk must be conducted separately from the H&P and separate from the other elements of the pre-surgical assessment that update the H&P.

As a final note, the documented H&P must be placed in the patient's medical record prior to the surgery/procedure. ■

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