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INSIDE

INDEX

BECKER'S
ASC REVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

October 2010 • Vol. 2010 No. 8

Future of ASCs in Five Years: 10 Predictions on the Most Common Ownership Model

By Rob Kurtz

As of 2006, the most common ownership structure of an ASC was 100 percent physician-owned (61 percent of ASCs), followed by hospital/physician-owned (16 percent of ASCs) and corporation/physician-owned (11 percent of ASCs), according to data provided by VMG Health in the *2009 Intellimarker*.

continued on page 9

ASC Physicians Identify 14 Stories Which Will Impact the Immediate Future of the Industry

By Leigh Page

1. Entering uncertain times. "Healthcare in general faces a great deal of uncertainty," says Michael Redler, MD, an orthopedic surgeon at the Surgery Center of Fairfield County in Bridgeport, Conn. "We are entering uncharted waters." Predictions that the recession is ending have not come to pass. Healthcare reform should create many changes, but with no regulations yet, it's difficult to say what they would be. And the 21.3 percent physician fee cut is ready to take effect again toward the end of the year.

continued on page 14

10 Top Concerns for ASC Administrators

By Rachel Fields

With lower reimbursements, stricter regulations and physicians choosing hospital employment, it isn't an easy time for ASCs. Here, four ASC administrators identify their top 10 concerns for the next 12 months and discuss how they plan to overcome those obstacles.

1. Declining reimbursement rates. Ask any ASC administrator about their top challenges for the next year, and they're bound to mention reimbursement cuts. ASCs across the country are struggling financially as insurers offer low fees for procedures — sometimes even lower than the rates offered by Medicare. Because ASCs often lack the negotiating clout of larger facilities, administrators say the only thing to do is wait — and hope lobbying efforts pay off.

In the meantime, T. Taylor Burnett, administrator for The Plastic Surgery Center in Flowood, Miss., says the only response to being offered insurer rates lower than Medicare is to just say no.

continued on page 15

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FEATURES

Publisher's Letter

2010: A Better Year Than Expected; 8 Key Issues

2010 has been a year of more stability for surgery centers than anticipated. Here are eight issues facing ASCs.

1. National companies again start to acquire surgery centers. We have seen a return of acquisition activity by national companies. This is after a very soft 2009 in terms of acquisitions.

2. Hospitals acquire surgery centers to convert them to HOPDs. This increase has been largely driven by the huge difference in reimbursement between hospitals and surgery centers for the same services. Surgery centers get paid at about 56 percent of the amount paid to hospitals for the same service. This means that for every dollar a hospital earns from an ASC procedure, a surgery center earns $0.56. This gives the hospital a lot of incentive to try and buy a surgery center, convert it to an HOPD and pay the physicians for management or other services.

3. ASC profits remain reasonably stable. Given all the different issues circulating around healthcare and all the different economic pressures facing the country, it is remarkable how intelligently the ASC community has handled the changes and withstood the onslaught of different issues. ASC profits remain stable in many areas.

4. Great growth in employment by hospitals is not directly attacking key ASC specialties. The key specialties that drive ASCs — orthopedics and spine, gastroenterology and ophthalmology — are not at the heart of acquisition activity by hospitals. While these are not unaffected, the amount of activity pales in comparison to that focused on cardiology and certain other specialties.

5. Reimbursement remains a challenge; out-of-network is getting worse. Surgery centers that relied on out-of-network reimbursement are finding the life span of such reimbursement is quickly coming to a close. Further, ASCs have been very disappointed in how their rates were set as compared to Medicare payments for hospitals for the same procedures.

6. Administrators are getting smarter. Administrators are trained executives who must have great business savvy and also clinical smarts. Overall, it is an increasing gifted group of administrators who run the nation's surgery centers.

7. Physicians lured by co-managements and other agreements. Notwithstanding the fact that orthopedic and spine physicians, gastroenterologists and ophthalmologists are not at the heart of employment raids by hospitals, they are being aggressively lured by co-management and other types of arrangements.

8. ACOs and healthcare reform provide uncertainty. There remains tremendous uncertainty over the future and the implications of healthcare reform and accountable care organizations on ASCs.

***

We hope you find this issue of the ASC Review informative and interesting. Should you have questions, please feel free to contact myself at (312) 750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

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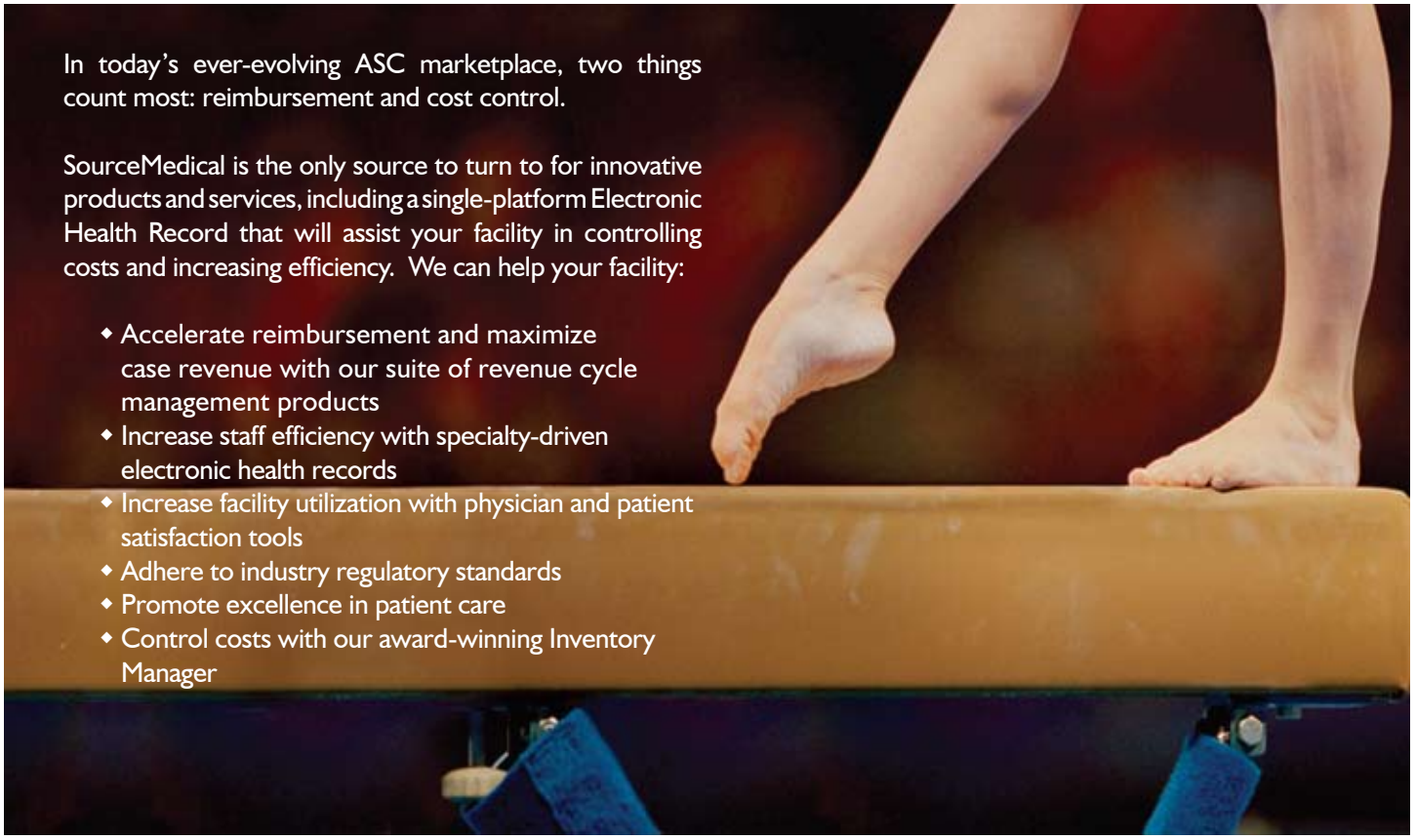

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Future of ASCs in Five Years: 10 Predictions on the Most Common Ownership Model
(continued from page 1)

With the healthcare reform law, payor issues, the decline in available physicians for recruitment and other challenges impacting the financial stability of ASCs, what will be the most common ASC ownership structure in five years — physician-owned, ASC, joint-venture ASC or HOPD? Here are 10 predictions.

Keith Metz, MD, Anesthesiologist and Medical Director of Great Lakes Surgical Center in Southfield, Mich., and Member of the Board of Directors for the ASC Association: We all recognize that the ASC industry is maturing. The main impact of the maturation of the industry is that the pool of available physicians that have practices and case volumes to support an ASC is dwindling.

Even with the right group of surgeons, the ability to develop an ASC without corporate or hospital support will be limited by the limited access to capital to private physicians.

I believe that most growth will occur in the physician/hospital joint-venture ASC for two reasons. First is that hospital/physician is the model that is favored politically under the imminent healthcare reform. Second is that by partnering with a hospital, an ASC may be able to access the employed or integrated physicians and associated procedures that would otherwise be restricted from using an ASC.

Dr. Robert Peets, DO, Ophthalmologist and Board Member, Samaritan North Surgery Center (Dayton, Ohio) — Our surgery center is part-owned by physicians — only 20 percent — and then 80 percent is owned by a hospital. One of the things that the physician-investors have spoken about is increasing their share. It would give the physicians more say in what's done with the hospital and especially with contracting. Having the hospital as a partner is certainly a good thing for our facility because it has tied our facility reimbursement rates to the hospital, which has been wonderful.

Our surgery center is administered by HealthInventures. Before that we had Johnson & Johnson and before that it management by the hospital and the physicians themselves and we didn't make any money. It wasn't until Johnson & Johnson and now HealthInventures took over that the facility became profitable and remains profitable. I would absolutely say that having these managing organizations is going to be vital to freestanding ASCs. I think that all three ASCs in Dayton are at least partially owned by hospitals. I think the physician-investors and the hospitals have sent the benefit of having an investment in these outpatient surgery centers. As far as having a standalone, physician-owned surgery center, I think that will go the way of the past unless they can successfully continue these multi-specialty facilities. For single-specialty ASCs, I just don't see how they can survive.

David Shapiro MD, CASC, CHC, CHCQM, CHPRM, LHRM, Partner in Ambulatory Surgery Company: I think we're looking at some kind of joint-venture model, such as a hospital/ASC joint venture. That is with the assump-

tion that services will continue to migrate towards sites of service with adequate reimbursement.

If we don't bend the cost curve on the way ASCs get reimbursed, many are going to cease to be able to provide services. So they're going to have to migrate over to affiliation with a hospital that can provide them with some sort of leverage in terms of being able to attach to the HOPD or at least HOPD-type rates.

Also, there are several things going on concurrently to foster the trend of physicians becoming aligned with hospital systems. For instance, hospitals are buying physician practices and incentivizing physician participation. We don't know where the concept of accountable healthcare organizations is going to go; however, the model may migrate health systems toward an integrated, capitated system gaining a big part of the market share. If that locks out freestanding ASCs that don't have a hospital or some kind of larger affiliation, I think that will cause their decline or possibly their demise.

Tom Mallon, Co-Founder and CEO of Regent Surgical Health: Quite a lot depends on whether President Obama is reelected in 2012. If he is and we have the bill that passed for healthcare reform, I believe that we will see independent ASCs selling out 100 percent to hospitals as doctors become employees. There is too much in this bill that pushes in that direction to resist it.

On the other hand, if President Obama is not reelected and we can amend this bill, then the joint-venture model which we use in half of our centers will work great. Doctors, hospitals and management companies to serve as the "United Nations" will be a sustainable model.

Larry Taylor, President and CEO of Practice Partners in Healthcare: Most crystal balls are rather cloudy with the current situation surrounding our national debt, Medicare funding and Social Security solvency. One point of clarity driving cost reduction in the correction of these issues will be the need for greater access to cost effective healthcare and specifically ambulatory surgery to address our aging population and projected increases in orthopedic care.

At Practice Partners we expect to continue to see increased activity of hospitals employing specialists. We expect to see increases the realm of HOPD and hospital joint-venture models. The ASC industry will continue to see both physician joint ventures and hospital/physician joint ventures in the future. Management companies will continue to be a critical component to these ventures both with and without equity positions.

Some of the most critical work will be focused on start-up entities replacing older, poorly planned centers that have experienced surgeon attrition. The process of turning around underperforming centers that are in need of restructuring and resyndication will be greatly required as well. Also, centers that exist in geographic areas of ASC high concentration will require the merging of entities and consolidation of partnerships to one center by closing the non strategic site and merging assets and surgeons into a new model.

Jeff Sapp, Partner, Innovative Surgical Solutions, and PhD Candidate at Capella University in Minneapolis With a Dissertation on "Factors Influencing the Decision Makers of Hospitals to Adopt Strategic Alliances with Physicians": An alternative view to the suggestions of industry leaders regarding the ASC position in the next five years is the ability to focus on establishing a single price that all payors can access. This global pricing strategy, referred to as the Prometheus Model, includes the global fee for the ASC, physician, anesthesia, pathology, PT and diagnostic testing required for providing episodic care to a patient. The model promotes and engages affiliated primary care and special-

ists to focus on three issues: price, quality, and limiting hospitalization. As a result, the model produces two positive behaviors. First, collaboration of physicians, ASCs and other providers is supported along the continuum of care. Second, this collaboration engages active efforts to reduce avoidable complications of care and the increased cost associated with complications.

Michael Porter, a leading authority on company strategy and the competitiveness of nations, asserts that the more experience physicians and teams have in treating patients in a focused factory, the more likely better outcomes and lower cost will be achieved. Not a new concept, the focus factory was first introduced in the manufacturing industry by Wickham Skinner, championed by Regina Herzlinger in healthcare and proven successful by the ASC industry since the early 1980's.

Bundling episodes of services is not a new concept. CMS established three demonstration programs in 1991, 1996 and 2001; however, despite promising outcomes for both cost and quality from these studies, intense hospital opposition to these changes prevented the incorporation of episodic bundling. CMS has once again resurrected this concept and began a new three-year study in 2008.

Medicare's need to reduce hospital costs was the initial driver that promoted the development of ASCs. Everyday, ASCs provide the government, insurers and patients a safe, affordable alternative to hospital-based surgery. Unfortunately, the current political climate attempts to undermine our accomplishments when results of a research study published in April only concluded that physician ownership of ASCs are tied to higher surgical volumes without regard to better outcomes associated with the increased volume. Even more alarming is the infection control study of a one-time cross-sectional study of a survey instrument administered in a pilot program by CMS and televised in the national media. From these studies, and the complete rewrite for the Conditions for Coverage for Medicare to increase from nine pages to 166 pages, it does not take a rocket scientist to conclude that the future will hold less innovation and more regulation.

If allowed, government will destroy the diffusion of innovation in healthcare. ASCs will be a casualty of national healthcare if we cannot reinvent ourselves or if we relent to an institutional mindset. The dialogue should change from how we fit to how we pursue our own physician-driven strategy.

It is not the strongest of the species that survive, or the most intelligent, but the one that is most responsive to change (Charles Darwin).

Jeff Peo, Vice President, Acquisitions & Development, Ambulatory Surgical Centers of America: I think that we will see a large move from the 100-percent physician-owned model towards corporate partners and hospital joint ventures.

The mounting burdens coming from compliance and regulatory issues, as well as the pressure to operate even more efficiently, due to reimbursement trends, will drive the physician-owners to bring in partners they didn't want or need previously. They will bring them in to focus on those issues, and others that will be critical to the success of the center, like payer contracting, human resources issues and vendor management.

I think there will also be a reduction in the number of corporate partners, as those organizations that have limited operational expertise will find themselves unable to operate profitably in the changing environment.

Joe Zasa, Co-Founder and Managing Partner of ASD Management: All three models will be seen going forward. Healthcare is really a "local" business and each community is distinct with its owns standards, politics and competitive issues. There will always be room for physician-owned surgery centers in the mar-

ket due to the desire of many physicians to operate in an independent setting.

However, due to payor issues, or changes in the medical community or a desire to collaborate with the local hospital, the ASC JV model will still be prevalent and is an excellent model. Our most successful surgery centers are hospital-physician joint-venture ASCs. Finally, the HOPD model is extremely attractive and is becoming a viable option. This is an excellent vehicle in CON states, for ASCs that have had limited success, or for communities where many of the surgeons are employed by the hospital. Again, this hospital (similar to the ASC JV model) employs a collaborative approach between the physician and the hospital. In sum, all three models will continue to thrive and the best model for one community could be different for another community.

Mike Russell, MD, Orthopedic Spine Surgeon and Physician-Owner, Texas Spine & Joint Hospital in Tyler: The unfortunate thing I've read was a little bit of pessimism in the ASC model, especially as an expanding market. I think there's quite a bit of concern about the healthcare bill and the future of healthcare in America. I think that one of the biggest concerns that I have is that there are so few independent physicians coming out of residencies any more. The model seems to have shifted in the last 5-10 years. Ten-plus years ago, when I got out of my residency, it was almost unheard of for a specialist to go to work for a hospital. It wouldn't even be considered by most top-tiered physicians coming out of a specialty training. And now it seems to be more the norm.

I echo some of the comments I've read — there are going to be fewer startup ASCs in the future. We've seen a maturing of the market. I think that you might see some of the established ASCs looking for some protection by making alliances or forming partnerships with their local hospitals and/or corporate ASC companies. I think that you're going to see fewer new ones come up, may see more maturing of the other ones. As a personal opinion, I hate to see that — I think the independent-minded ASC and/or physician-hospital model has been such a driving force in innovation and decreasing complications and increasing efficiencies and actually lowering healthcare costs overall that it is really sad to see the direction that things seem to be going.

Jeffrey Shanton, Director of Business Management, Journal Square Surgical Center in Jersey City, N.J.: I think it depends on what part of the country (state) and the timing. Regulatory restrictions and insurance carrier 'push back' have a lot to do with it. In areas where this is becoming endemic, you will certainly see centers purchased by corporations, as the doctor-owners seek to protect their investment, but do not want the hassle of combat with the carriers and politicians. Those states would also seem ripe for hospital joint ventures. In states saturated with ASCs, it is and will be increasingly difficult to introduce viable 100 percent physician-owned centers, due to a diminution of the pool of available investor doctors. In- and out-of-network play a part as well. Some states are not 'user friendly' when it comes to out-of-network, which makes management company ownership or joint venture more attractive, especially if the doctors are in-network. The specter of the new federal healthcare plans muddy the waters for everyone, but (to me) would seem to favor the hospital-doctor joint-venture model. ■

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ASC Physicians Identify 14 Stories Which Will Impact the Immediate Future of the Industry (continued from page 1)

2. Volume will still be down. High unemployment and the continued trend toward higher deductibles are discouraging elective procedures, leading to a drop in volume at many ASCs. Jason Lockette, MD, an otolaryngologist at Shoals Outpatient Surgery in Florence, Ala., says while volume was growing at the beginning of the year, there has been a small drop in the past few months. "If that trend continues it could be a problem," he says. "You'd like to think we've seen the worst."

3. A time of modest profits. While volume is down, ASCs do not appear to have seen a marked drop and many continue to make a modest profit. "My surgery center is making a little money; it's above break-even," says Joe Wieck, MD, an orthopedic surgeon Premier Orthopaedic Surgery Center in Nashville, Tenn.

4. Recession will linger. Ken Pettine, MD, a spine surgeon who co-owns the Loveland (Colo.) Surgery Center, predicts unemployment will stay at 10 percent through the rest of the year and perhaps as much as 10 more years. He sees better prospects for his home state of Colorado, where unemployment is at 7.5 to eight percent.

5. Centers will avoid layoffs. Many ASCs are still making modest profits, so widespread layoffs are unlikely. Since talented staff are the backbone of ASCs, "cutting back staff is not an option," Dr. Lockette says. Recently, his ASC hired a nurse. He thinks the center could survive a slump in volume because "we run a pretty tight ship."

6. The longer term seems rosy. "In the long run ASCs will prosper because they are more efficient and cheaper," Dr. Wieck says. Dr. Pettine agrees. "I'm feeling pretty good about what we're coming into," he says. "Every time I hear Obama talk, it's about quality care at lower costs. ASCs are the right entity at the right time." The healthcare reform law did not directly refer to ASCs, but proposed regulations due in the late fall should shed some light on just how they will be affected.

7. More volume for ASCs. Even if total surgery volume stays off, these physicians believe ASCs will wrest more volume away from hospitals because ASCs are more affordable. Dr. Wieck says his group is working with several major carriers to build incentives for policyholders to cases done in a preferred setting. Dr. Pettine predicts Medicare will allow more procedures, especially in spine surgery, to be done in the ASC. Hospitals have opposed this change, but as hospitals buy up more ASCs, they will support such a change.

8. More surgeons may join ASCs. Dr. Lockette says his ASC offset part of its loss in volume by recruiting a couple more surgeons in the past year. "We've been able to lose much less volume than some of our competitors," he says. But Dr. Wieck says lower returns may affect recruitment of new partners. "To buy into a mature surgery center costs more money if you won't see a high return on investment," he says. "Physicians used to count on 30 percent yearly return, but now it's something like 15-20 percent."

9. Better discounts with vendors. Vendors are still willing to cut prices, Dr. Lockette says. "We're able to see some cost reductions with vendors in some pretty aggressive negotiating," he says. "It's a competitive market and there are a lot of comparable products out there."

10. Physicians willing to make sacrifices. Hard times mean physician-partners are willing to negotiate discounts, Dr. Lockette says. "Generally speaking, they are willing to choose a less expensive option," he says.

11. ACOs begin courting centers. As hospitals and large groups start organizing accountable care organizations for a Jan. 1, 2012, launch date, they will begin to ask ASCs and their surgeons to share in bundled payments. "ACOs begin contracting for whole pieces of care, such as a rotator cuff from beginning to end," Dr. Wieck predicts. But Dr. Hathaway sees no reason to be part of an ACO. As a cataract surgeon, he already covers the whole episode of his patients' care. Dr. Pettine also plans to stay away from ACOs. "I'm a proponent of a small, specialized model," he says. "You do one thing and you do it well."

12. November election may dampen reform. Dr. Wieck says healthcare reform won't be slowed unless the Democrats have a terrible showing in the Nov. 2 elections. Even then, President Obama will veto any effort to repeal the law. The battle plays out in Dr. Wieck's backyard. His Democratic congressman, Jim Cooper, voted for the healthcare reform bill even though constituents opposed it by a margin of 2-1.

13. Medicare fee mess in December. The current temporary Medicare fee fix ends on Nov. 30. If Democrats are weakened in the Nov. 2 elections, physicians should be prepared for a replay of the payment hold-ups when the last fee fix ran out in June, Dr. Hathaway predicts. Medicare is 90 percent of his business, so when Medicare payments were postponed in June, his income practically dried up. He relied on cash payments and used his lies of credit. "I was able to survive but all my reserves were tapped," he says.

14. Colonoscopy waiver may not matter much. On Jan. 1, 2011, Medicare will waive the copay on colonscopies, but Dr. Lockette is not sure how much that will boost volume. He says many people who get colonoscopies are too young for Medicare. ■

Contact Leigh Page at leigh@beckersasc.com.

10 Top Concerns for ASC Administrators (continued from page 1)

"We're not going to accept them. We're going to tell them to take a hike," she says. "Some of the carriers have taken the opportunity to try and ratchet down on the reimbursements for ASCs and we do not have to take it. Those that can afford to stand up to the carriers should."

She says she found it particularly offensive that codes for breast reconstruction for cancer patients were paid at less than the Medicare rate. "We wanted to bring breast reconstruction patients who were immunocompromised and bring them to a facility where they could not get another infection," she says. "We wanted a safe and secure environment for those patients, and our largest carriers are lowering the rates [and preventing that]."

Asked how her center reacts to reduced reimbursements, Lynda Simon, administrator of St. John's Clinic: Head and Neck Surgery in Springfield, Mo., says, "It's a really simple answer: If our reimbursement is below what it costs to do the case, the case is sent to the hospital. If we lose 800 dollars on a case, you can't work like that. You can't live like that."

2. Stopping the flow of physicians out of ASCs toward hospitals. As reimbursement fees for surgery centers drop, many physicians are considering hospital employment, a trend that David Kelly, administrator of Samaritan North Surgery Center in Dayton, Ohio, cites as a major concern. "There's dour pressure on [physician] reimbursements and they're guaranteed a salary from the hospital, but it presents a challenge," he says. "How do you draw them back? You have to demonstrate that you have managed your costs and have a healthy bottom line and have a healthy, worthwhile investment."

The key to tackling this challenge is honesty, Mr. Kelly says. If your surgery center is successful and profitable, physicians will be more likely to work with you. "It's about reaching out and demonstrating how you do it better," he says. He says it helps to get interested physicians into the center so they can see your facility and witness staff satisfaction and quick turnover firsthand.

Judy Graham, administrator of Cypress Surgery Center in Wichita, Kan. says you can encourage physicians to stay at your center by taking extra effort to meet their needs. "There are so many places physicians can go nowadays," she says. "You have to make sure you have the best equipment and your staff has to know the procedures the physicians do." She says small touches can really make a difference: Her center made scrubs embroidered with the physicians' names, and Ms. Graham lays the scrubs out before the physicians arrive.

3. Competition with other ASCs and specialty hospitals. According to Ms. Graham, her city has about eight surgery centers and five specialty hospitals. "It's really an oversaturated market," she says. In order to remain competitive in a town that offers patients multiple options for surgery, you have to make your ASC stand out in the sea of competitors. Ms. Graham says her center has tackled this problem by marketing the center as a woman's center and offering gynecological surgery and in vitro fertilization. Because Cypress Surgery Center is located next to a breast imaging center, the two facilities can market themselves as a convenient "one-stop" location for female care.

If your surgery center is struggling to compete, Ms. Graham recommends specializing in a few surgeries that other centers do not provide. Hers is the only ASC in the Wichita area that offers pediatric dental, meaning they have a constant stream of patients who would otherwise have to travel outside the city.

She also recommends constantly evaluating any new services your ASC could offer. In the past year, Cypress Surgery Center has added sinus fusion and pediatric dental and is currently considering the addition of lap banding.

4. Bringing in new customers. Ms. Burnett says honesty is the best way to attract new customers. Make your ASC a welcoming facility that provides efficient, quality care, and patients will come to you. "Have your open house, make sure the public knows where you are and who you are, knows your success rates and superior customer service and low infection rates and fantastic outcomes," she says. "The more the public knows that, the more they're going to choose where they want to go and bring up your name when employers are negotiating employee benefit packages."

Mr. Kelly adds that increasing patient flow is not easy when your area is suffering as a result of the economy. "People aren't banging down the doors to move to Dayton, Ohio," he says. "So it becomes, how do you win that market share? How do you differentiate yourself?" He says the answer is three critical qualities: high patient satisfaction, high employee satisfaction and high doctor satisfaction.

5. Managing supplies effectively. Ms. Simon says her facility has responded to reimbursement cuts by managing supplies very carefully. "We have a very small owned inventory, so everything is in very, very short stock," she says. "We also do an annual bonus that is based on profit, so all our employees are empowered to keep cost down because they share in that bonus equally based on profit at the end of the year."

She says this means employees think twice before using supplies that may not be necessary. Before they open a suture, they make sure if it's needed. They let physicians know if they think a supply is being wasted.

Ms. Simon also holds contests to improve her staff's knowledge of the price of various supply items. The staff can participate by guessing how much a supply costs, and the person who gets closest wins a prize. "This means they know what everything costs. They know the best quality item at the best price," she says. "They're not going to skimp on quality, but they're not going to let the rep du jour just feed them products we don't need."

Ms. Graham adds that her center also keeps a small stock of inventory in the center and asks physicians to standardize their supplies. "We try to keep our inventory to just what we need," she says.

6. Meeting quality regulations. With increased focus on tracking quality and improving patient care, ASCs need to increase their quality oversight and get staff members and physicians on board with tracking their progress. For many ASCs, that means hiring a full-time quality director. At The Plastic Surgery Center, employing a quality safety director of nursing has "paid off tremendously in the quality we keep," says Ms. Burnett. They are also using a healthcare exchange interface to benchmark their facility against other ASCs across the country.

Ms. Graham adds that a center can demonstrate its quality by adequately preparing for and achieving accreditation. Cypress Surgery Center recently received AAAHC accreditation, a feat Ms. Graham attributes to "making sure you're doing all the studies and the quality control issues on a day-to-day basis, so that when the time comes around in three years for accreditation, your paperwork is up to date."

Mr. Kelly says providing high quality of care isn't just about patient safety and satisfaction: ASCs may soon have a vested financial interest in reducing infection rates and other hazards. "There's talk to having a policy so that if a patient incurs some kind of infection after discharge, your payment will be reduced," he says. "It ties into pay for performance."

Mr. Kelly says a center has to start with collected data so administrators can benchmark themselves against other ASCs across the country. "Eventually you may have to be in the top 10 percent in a pool of national surgery centers, and you'll get paid less if you fall below that," he says.

7. Meeting IT requirements with fewer personnel. Ms. Burnett says many ASCs face the obstacle of not having full-time IT personnel and still having to interface with health information exchanges, the state and other providers. If surgery centers don't educate themselves, she says, they may be taking advantage of by IT companies and carriers who charge them too much for services they may not need. "One of the things that ASC administrators really need to do is brush up on what's required and really do their due diligence in finding an IT support service that can help them if they don't have someone in-house," she says.

After Ms. Burnett was overcharged by an IT support service, The Plastic Surgery Center decided to grow its own IT support service. Ms. Burnett says that after finding smart, trustworthy people to support their information technology, the center has been able to move forward with HIE projects.

8. Motivating staff members. Most ASC administrators agree that motivating staff members in the midst of reimbursement cuts, stricter regulations and stiff competition can be a challenge. The key, Ms. Simon says, is to schedule regular activities to promote staff bonding. "We have a retreat every year, and we all do our CPR recertification on the same day," she says. "We also have office meetings where everybody has input and there's no punishment. It's all team-building, so if you come with a problem, you also come with two or three solutions."

Ms. Burnett adds that being honest with your colleagues about your financial situation will ease the process when you have to make difficult decisions about staffing.

9. Deciding whether to partner with a hospital. The relationship between an ASC and its nearby hospitals depends greatly on location, financial stability and other factors. Some ASCs choose to partner with hospitals to gain more negotiating and marketing power; others choose to remain independent.

Ms. Simon says her center's relationship with a local hospital has benefitted her ASC greatly. "Our

relationship with the hospital means they have the same supplies. If they're low on something, we can share; if we're low, they can share," she says. "It also gives us some clout with purchasing power because all the purchasing goes through the system. That gives you a little bit of extra push because the hospital is working on your behalf to get the costs as low as they can."

She said her partnership with the hospital also gives St. John's a place to admit a patient if home care is not an option.

10. Decreasing wait time while maintaining quality. In an increasingly tougher economic climate, many surgery centers will be forced to examine their procedures, supplies and staffing to determine whether they can save money by streamlining their processes. "A simple example for me would be: We do a lot of cataract surgeries and, as preparation, you have to put eye drops in to dilate the eye and wait about twenty minutes for them to kick in," said Mr. Kelly. "So instead of bringing the patient back, dilating the eye, and waiting, you could dilate the eye and then bring another patient back and get them started. You eliminate that wasted time where they're just sitting there, shorten the wait time for the second patient and become more efficient."

Ms. Graham says her center makes sure to take care of any tasks that will increase a patient's wait time and therefore decrease their satisfaction. "We get all the information on health history over the telephone, so when the patient comes to the facility, we don't waste their time," she says. "We also turn the rooms over very quickly. We can do turnover for a case in 5-7 minutes, and we use new anesthesia drugs so that patients are not nauseated or real sleepy." ■

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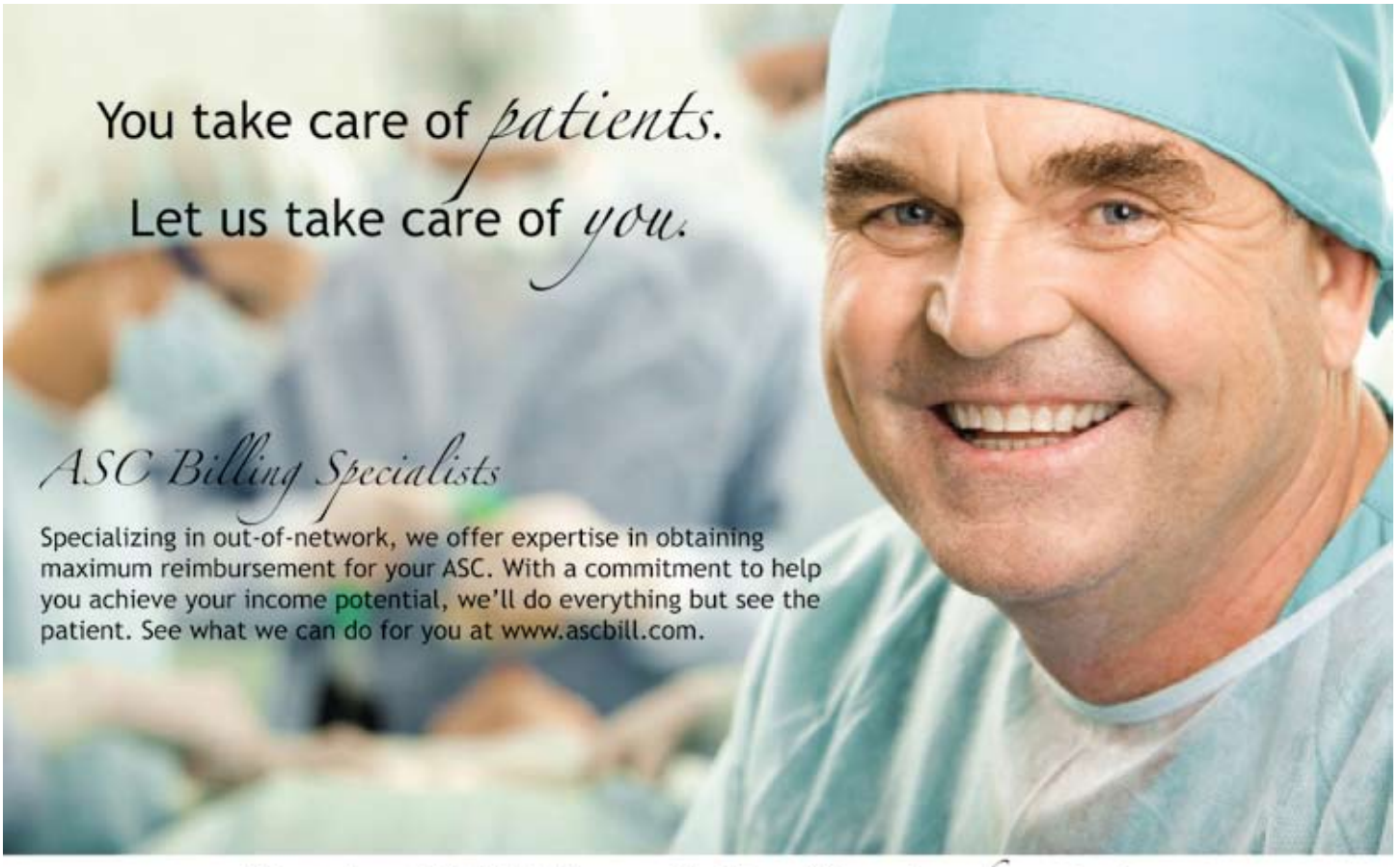

Healthcare Fraud Investigations Increase; Greater Caution Urged in ASC Share Sales to Physicians; 22 Dos and Don'ts on Selling ASC Shares

By Rachel Fields

The oversight and scrutiny of physician hospital and physician provider transactions and relationships has increased tremendously over the last few years. Scott Becker, JD, CPA, partner at McGuireWoods, discusses two legal trends affecting the relationship between surgery centers and physicians — and how ASCs can reduce the risk that transactions between the center and its physician investors will be investigated.

1. Healthcare fraud and false claims investigations have increased tremendously. ASCs have historically avoided much scrutiny regarding false claims, healthcare fraud and kickbacks — but surgery centers should not depend on this trend to continue. "We have great concern that [the lack of scrutiny] is starting to change as surgery centers become a bigger piece of the pie and the government spends more time looking at physician relationships," Mr. Becker says. More than ever, he perceives that ASCs must be very diligent in their compliance approach.

In the April article "10 Key Legal Issues Facing Ambulatory Surgery Centers," Mr. Becker and his colleagues discussed the increase in government funds allocated to healthcare fraud enforcement. "We continue to see the evolution of different types of possible anti-kickback situations," the authors said. "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."

The last few years have seen an increase in kickback allegations and settlements. For example, in July 2010, the OIG reached a $7.3 million civil settlement agreement with Chicago-based, physician-owned United Shockwave Services, United Prostate Centers and United Urology Centers over charges that United and its physician-owners received payments in exchange for patient referrals.

Between 2008-2010, there were more than 20 different HHS' Office of Inspector General physician self-referral and kickback settlements, many of which involved improper attempts at aligning with physicians. As scrutiny of hospital-physician relationships increases, surgery centers are sure to experience increased oversight as well, Mr. Becker predicts.

2. ASCs must be even more responsible about physician investment. If physicians are planning to invest in your ASC, you must be careful to avoid a situation that amounts to physicians being allowed to buy shares at below fair

market value. HealthCare Appraisers' Healthcare Transactions 2009 Year in Review reported the most common methods for determining fair market value of share price are: soliciting an independent fair market value opinion (41 percent), using a predetermined formula (28 percent) and using a board-determined amount (24 percent). In an August interview with Becker's ASC Review, VMG Health senior partner Greg Koonsman said a minority interest investor might invest at around 4-4.5 times EBITDA — compared to at 6.5 times EBITDA for a majority interest investor.

Chris Suscha, vice president of de novo business development for Meridian Surgical Partners, said an ASC should take a good look at the factors affecting the value of your ASC. You want to be able to account for the value of your shares, so take a look at your facility's historical cash flow, growth potential, recruitment opportunity, partnership stability and payor mix.

"As far as physicians investing in ASCs, they should be buying at fair market value, they shouldn't get any special deals and they shouldn't get the chance to buy more or less based on how many cases they're going to bring," Mr. Becker says. Most surgery center administrators comply with rules about self-referrals and physician investment, but because ASCs have historically suffered less scrutiny over kickbacks and healthcare fraud than hospitals, some providers are more careless than they should be.

Treat physician investment seriously and approach every investment as if it could be investigated for kickbacks and abuse. If your center wants to sell shares to physicians, make sure the shares have been evaluated by a third party to determine fair market value. "You can use an internal committee to analyze share price too, but you have to be even more careful and conservative," Mr. Becker says.

In "10 Key Legal Issues Facing Ambulatory Surgery Centers," Mr. Becker and his colleagues discussed the danger of selling 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," the authors said. "In general, it is very hard to facilitate this." They said, while a physician can attempt to buy additional shares from other partners, those partners cannot sell their shares to the highly productive physician just to keep his or her cases in the center. If the partners decide to sell the shares, they must have a reason other than to retain volume — and ensure the shares are sold at fair market value.

3. 22 Dos and Don'ts on Selling Shares to Physician Investors. In a 2009 paper on selling units in an ASC to physician investors, Mr. Becker listed 14 "don'ts" for ASCs to avoid, based on federal cases related to the syndication of interests in hospitals, labs and joint ventures:

1. Do not offer less or more shares or a higher or lower price based on the number, volume or value of referrals a physician can generate.
2. Do not reallocate shares based on the volume or value of referrals.
3. Do not focus on individual distributions being tied to the number of patient referrals. Never make any indications that could lead a potential investor to believe that referrals or performance will determine an individual's "piece of the pie." Focus on overall distributions and profits.
4. Physicians should not be allowed to invest based upon the fact that they can generate referrals for another physician who may use the center.
5. Avoid providing physicians with estimates as to the amount of revenue that will be generated from their referrals or from another physician's referrals.
6. Except as to compliance with the one-third tests, do not develop investor eligibility determinations based on the number of potential referrals. In evaluating physicians, examine compliance with all of the safe harbor criteria.
7. Do not create "target lists" of physicians based on their ability to make high amounts of referrals.
8. When creating target lists, avoid making notations indicating the potential number of referrals, the growth potential of the physician's practice, that a certain physician is a good target (based on referrals), etc.
9. Avoid using age as an influencing factor when targeting physicians.
10. Subject to non-discrimination rules, consider excluding Medicare and Medicaid referrals from any internal revenue and investment analysis.
11. Do not offer remuneration or special treatment under various disguises, such as directorship contracts or discounted lease arrangements, in order to induce investors.
12. Do not pressure a physician investor to shift their current referral patterns.
13. Do not make any indications to investors that low-referring physicians will be pressured to withdraw.
14. Units should be sold at fair market value.

Mr. Becker also included eight ways ASCs should approach physician investment:

1. Offer equal amounts of units per investor.
2. Offer units at the same price per unit.
3. Offer units at the then fair market value per unit.
4. Provide investor with the current financial statements and not their potential revenues.
5. Offer units to only physicians that will comply with the safe harbors — meet all tests and not just the one-third tests.
6. Clarify that the hospital or management company partner does not generate referrals for the ASC.
7. Review investors against compliance with the requirements of the safe harbors.
8. An ASC may ask physicians why they choose not to use the ASC. ■

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Should Your ASC Outsource Coding And Billing?

By Caryl A. Serbin, RN, BSN, LHRM, President and Founder, Serbin Surgery Center Billing

In today's economy, why should you consider spending additional money to give your most precious asset to an outsider? Before you determine that outsourcing your ASC's coding and billing is not for you, take a moment to read more about it. You can then make an informed decision on whether outsourcing might be the right choice for your center.

If you are planning to build an ASC, evaluate outsourcing your billing while you are still in the design phase. You may be able to save on square footage and the amount of business office employees needed. Even if you are already building your surgery center, look at how you might be able to reassign some of the business office area into revenue-generating clinical space.

In existing surgery centers, the idea of outsourcing is often met with resistance by physician-owners and administrators who feel that outsourcing billing is not a positive choice. Thoughts on this include:

- "My billing staff is doing a good job!"
- "Costs too much!"
- "I need to be in control!"
- "Change is BAD!"

If you have a great coding and billing staff, count your lucky stars and ignore this article.

However, if you feel your coding and billing are less than stellar, you may want to consider the following when evaluating how to improve your center's financial performance. There are several reasons why your ASC may not be collecting all that that it can.

- Lack of experienced coding may lead to leaving fees on the table. This is not about unbundling or fraud; this is about being able to interpret the operative note and charge for all allowable procedures while remaining compliant.
- What about implants? Are they being billed properly and collected fully? With today's cost of implants and the frequent use of multiple implants during a procedure, it is imperative that your billing staff understand the types of implants and when and where they are used. Operative notes are not always specific and there may be additional implants used that are not listed — this may require a surgeon's addendum to the operative note.
- Does your staff understand that you are able to charge additional fees for handling and shipping in addition to the cost of the implant?
- If your center has ophthalmology, is the full invoice amount for the shipping and handling of corneas from the eye bank being included?

Now let's dispel the "costs too much" myth. If a billing company charges you five percent of collections and you can eliminate the following expenses, which do you think is more cost-saving?

- Depending on the size of your center and the amount of business office employees, determine what salaries could be eliminated if your billing was done off-site.
- Take into account other expenses that would decrease such as employee benefits, computers, furniture, supplies, clearinghouse fees, postage for statements and business office space (maybe you can convert some of the regained space into clinical space).
- What if you could increase your gross revenue by 5 percent? How much more money would that mean in your profit bucket?
- What if you could decrease your days in A/R by 5 days? What does that mean to your bottom line?
- How about the immeasurable savings?
  - No patient phone calls about statements.
  - Chasing your denials to the highest level of adjudication (does your current collector do that?).
  - Doing lengthy deposits and taking them to the bank.

Next, let's discuss the control issue. If you are the one having to answer to the board, it is only natural that you want to control your own destiny. However, a good billing company allows you to be involved and in control — you just don't have to do the day-to-day work. If a billing company is accessing your ASC's software via an encrypted network, then you have real-time access to all of their work 24/7. All reports are current. If you have questions — they are only an e-mail or phone call away. It's just like looking over their shoulder electronically. Also, there should be regular communication, like weekly reports and phone calls and daily communication with your staff from a dedicated team-leader and liaison for your center.

Change does not have to be BAD. If even one of the following reasons apply or appeal to you, it may help you in rethinking your ideas on outsourcing.

- A lot of surgery centers cannot afford or do not have access to certified and experienced coding and billing staff. A billing company's staff is their major investment, they work to attract the best and the brightest and pay them top salaries in order to ensure optimization, accuracy and compliance. These are the people that will be working for your center.
- If your surgery center has ever had a key member of its coding or billing staff leave (even temporarily for illness or vacation), you understand the disruption that occurs. Coding/billing does not get done regularly, if at all. Revenue dips, and owners become upset. Billing companies have employees and supervisors who are able to fill in for sick or vacationing staff and your center will not even notice a slight hiccup.
- In today's climate of increased and ever-changing HIPAA and compliance regulations, peace of mind comes from knowing that your billing company is up-to-date and processing your coding and billing

with a focus on optimizing your revenue while keeping your center compliant.

We've all heard horror tales about billing companies gone wrong, especially those involved in practice management in the 80s and 90s. However, contrary to what you may have heard about billing companies, they are not all alike. That's why it's so important that you know what to look for when researching companies for outsourcing.

Know what you need to look for:

- Reputation
- Longevity
- References from industry leaders or associations
- Client references
- Employees bonded
- E&O insurance
- Experience in billing for your ASC's specialties
- Staff qualifications
- Compliance and HIPAA plans
- Red Flag policy
- Coding and billing policies/procedures
- Disaster plan
- Protection of your data
- HIPAA-compliant secure connectivity
- Auditing program
- Specializes in ASCs
- Understands APCs
- Understands managed care contracts

Reputable billing companies welcome the chance to show you how they are run, what they offer and why they are the best company to choose. Ask them to provide you with a list of services. Besides addressing these expected tasks:

- coding by a certified coder;
- claims submitted within 24-48 hours after receipt of necessary billing information;
- oversight of claims processing through the clearinghouse and verification of receipt by payor;
- collection activity begins within 15 days of submission and continues regularly thereafter;
- payment posting done within 24 hours of receipt of payment; and
- denials for no payment or underpayment started immediately…

… do they also:

- assist center with fee schedule development or changes;
- educate center regarding upcoming changes, i.e., CMS reimbursement;
- advise center when managed care contracts may need to be renegotiated;
- provide special reports when needed;
- do state reporting where required;
- provide duplicate off-site storage of data in case of disaster; and
- have experienced IT staff?

Be sure to do your homework thoroughly before making a final decision. Consider visiting the billing company offices — you can learn a lot about a company by meeting the staff.

Just don't overlook all of the advantages of off-site billing. In today's digital world, your off-site coders and billers are only a keyboard-click away. ■

Learn more about Serbin Surgery Center Billing at www.ascbilling.com.

Tom Jacobs of MedHQ on Impact of ACOs, Value of Outsourcing

By Tom Jacobs, CEO and Co-Founder, MedHQ

Now more than ever, healthcare providers must consider strategies that will enable them to maximize their ability to provide excellent patient care, while at the same time reducing cost. The *Becker's ASC Review* article by Leigh Page, "11 Things to Know About Accountable Care Organizations" (www.beckersasc.com/healthcare-reform/11-things-to-know-about-accountable-care-organizations.html) describes Accountable Care Organizations (ACOs) as a key part of the "Reform" legislation that has the potential to be a game changer in the healthcare industry.

My take away from much of the healthcare reform discussion is that if the healthcare providers learn from regulated utilities, I think they will recognize the value of outsourcing more and more non-core services so that they can focus more and more on their core service: patient care. What does the regulated utility industry have in common with the healthcare industry? I'll explain.

Prior to the 1990s, a typical electrical utility was a vertically integrated business: it owned the power plants that produced the electricity, owned the transmission lines that sent the electricity to local communities, and owned the retail distribution system that delivered the electricity to the homes and businesses, i.e., the customers. During the 1990s, the industry went through a period of deregulation. This deregulation stopped short, however, of a full-fledged free market. The resulting structure was a "retail" utility whose prices are government controlled, that is supplied by a non-price-controlled "wholesale" generation industry. In other words, power plants (analogous to "providers" in the healthcare space) are not price-regulated; but have to compete in the wholesale market for the opportunity to deliver power to the regulated utility (analogous to the "insurance company" in the healthcare space) whose prices are government controlled. The result was massive cost cutting in the power generation industry that has resulted in stable, low cost electricity during the decade that followed.

The healthcare industry has gotten to a place that is similar in structure to the electrical utility business, albeit, it has arrived there from the opposite direction: prior to healthcare reform, prices were not government controlled (at least not to the extent that they soon will be); after healthcare reform, insurance prices will soon be largely government controlled. But, providers will still compete (at the "wholesale" level) for access to revenue through the accountable care organization structure.

Notice that, like regulated utilities, ACOs will be virtual monopolies in their respective "regions" (as stated in the first bullet of the Becker's ASC Review article, there will be "one ACO per region"); this is analogous to the regional utility. The only way governments will allow these monopolies is if they can also control price. As a result, like a utility, the ACO will be analogous to the "retail" point of access to the system through which price-controlled revenues flow to the providers. At the wholesale level, then, providers will offer services and compete for the revenues as demand is driven by the needs of the customers/patients.

So, what can healthcare providers learn from this? One of the successful strategies of wholesale electrical generation businesses (analogous, in this discussion, to the "providers" in the healthcare industry) was to put a laser-like focus on their core service areas. For a typical electrical power plant their core business is "operating" the plant, including the maintenance planning and management, that enables it to achieve maximum operations

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Caryl A. Serbin
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"up time," known as "capacity factor" in that industry. Everything else that was not core to the business was a candidate for outsourcing or partnering with best-of-class providers. Power generation companies outsourced many such non-core services:

- design engineering services
- employee leasing for worksite/ contract staffing
- IT services
- human resources management
- "best of class" providers handled specialty maintenance services

In healthcare, many providers already outsource or partner with best-of-class providers, such as:

- management services (including capital financing)
- pharmacy services
- lab services
- payroll and human resources administration
- accounting services
- billing and collecting services

What providers will never outsource, of course, is their core service: patient care.

Whether healthcare reform remains as currently enacted is an open debate. Bottom line, however, is that there is now tremendous pressure to reduce overall cost of healthcare services. The ACO structure would theoretically increase average reimbursement to areas that "deserve" more reimbursement (e.g., primary care), while squeezing and/or eliminating areas that don't "deserve" as much (e.g., wasteful or unnecessary diagnostic testing services); all the while overall reimbursement will decline. What providers should consider now, more than ever, is to learn from the power generation industry and outsource as many services as possible to eliminate distractions to its core function of providing excellent patient care at as low a cost as possible. ■

Learn more about MedHQ at www.medhq.net.

Understanding Outsourced Anesthesia: Q&A With Dr. Marc Koch of Somnia Anesthesia Services

By Rob Kurtz

Marc Koch, MD, MBA, is an anesthesiologist and president and CEO of Somnia Anesthesia Services.

Q: What are the major challenges ASCs face with regard to addressing their anesthesia needs?

Dr. Marc Koch: One of major challenges is realizing that options exist. Although local clinical talent can be found in communities throughout the country, an often overlooked alternative is enlisting the assistance of a long-tenured anesthesia management company to help oversee the creation and management of a department of excellence. The best anesthesia management companies view local clinical talent as a key ingredient in that effort; they also appreciate the importance of other, non-clinical facets of providing anesthesiology services such as the determination of the right mix of MDs and CRNAs, the implementation of best practices and quality management programs and contracting with payors to ensure that billing and collections are optimized. Certain of these companies can also address the full array of human resource management. Beyond coalescing local clinicians to create a stellar clinical team, they can ensure that vacation contingencies are addressed, benefits and payroll are effectively managed and any conflicts are identified early, before they can negatively impact patient safety or bottom lines.

Q: What factors are driving these issues?

MK: Just as clinical problems and solutions have grown more complex, so too have administrative and operational concerns. They both are important and impact each other. For instance, ineffective payor contracting and revenue management leaves insufficient resources to launch a quality management program or, more fundamentally, to hire good clinicians. It also may result in a request for subsidization from the surgery center — a need that would be eliminated if processes and programs were efficient and effective from the start. Similarly, ineffective, inefficient or untalented clinical staff can generate dissatisfaction among patients and surgeons, a result even the best management cannot masquerade. Complicating effective and cost-effective management is the imbalance between anesthesia provider supply and demand. The number of clinicians who want to retire or scale back exceeds that of those who are entering the field, a reality complicated by the burgeoning growth in office-based surgery which has created even more demand. This has escalated compensation to levels that may be sobering to surgery centers whose volume and payor mix falls a little short of where it needs to be.

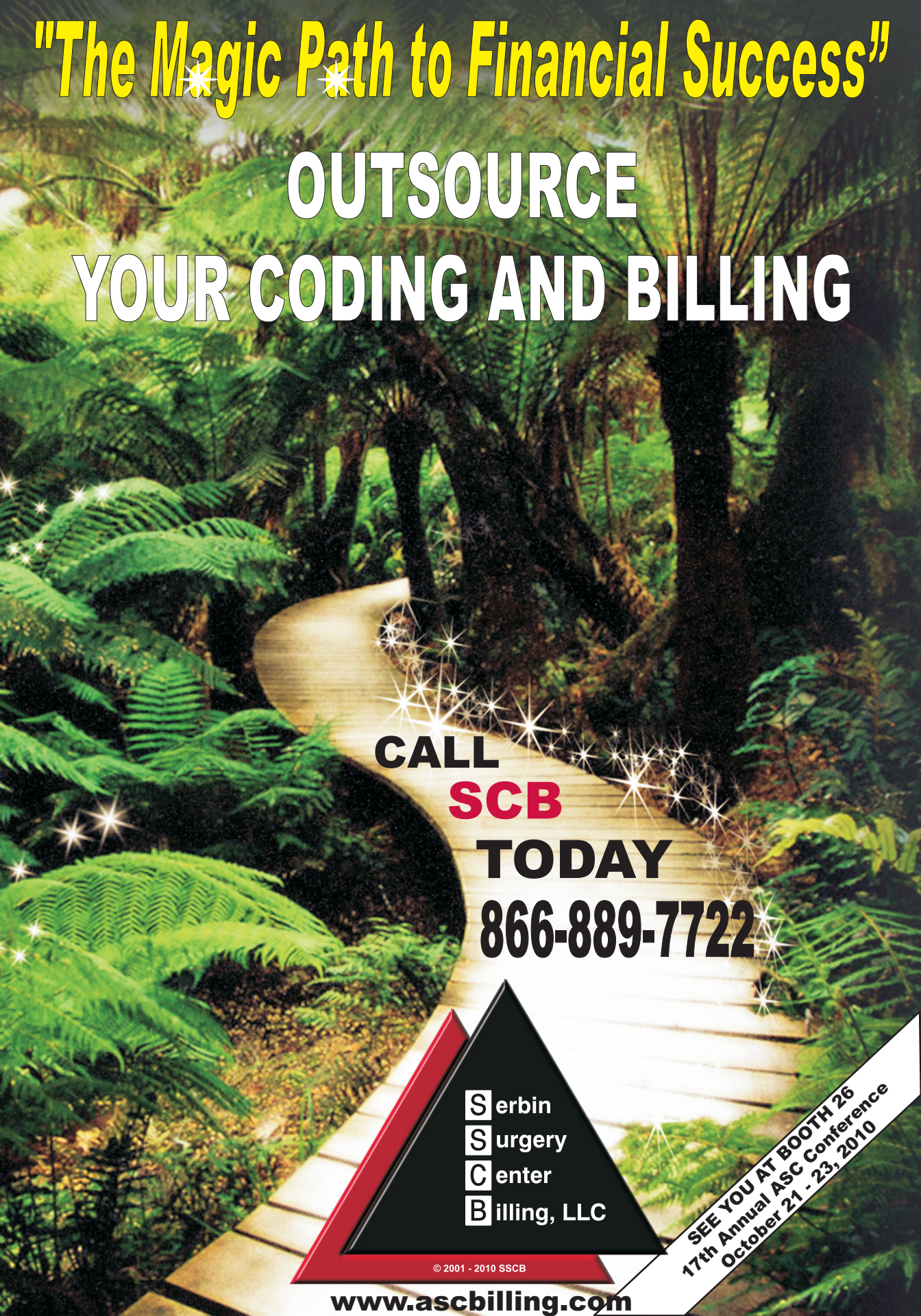
Q: Why hire an anesthesia management company instead of an anesthesiologist?

MK: Working with an anesthesia management company lets the ASC focus on its core competency: providing a safe and secure environment for outpatient surgical patients in the most fiscally prudent manner. They offer sole-source accountability and responsibility for the many facets of a successful anesthesia department and can offer the support and managerial foundation that allows local clinical talent to focus on patients and their needs. At their core, most anesthesia management companies are stewards of value — that is, they know how to achieve the best outcomes given available resources. And in today's environment, where resources are short and providers costs high, that job is not easy.

When issues or potential problems arise, an anesthesia management company can swiftly and efficiently develop and implement solutions while addressing existing relationships with surgeons and nurses and overcoming personality issues. In a case where an existing anesthesia group might follow a blended model, employing MDs and CRNAs, the management company can often mitigate seniority or governance issues and facilitate a better outcome.

Finally, it is a misconception that anesthesia management companies "parachute in" clinical staff from all over. The best companies recruit local talent and work closely and collaboratively with them to create centers of excellence at the facilities they serve. By doing so, they create mutually beneficial relationships among patients, clinical and administrative surgery center staff and anesthesia providers. That's an ideal situation for everyone. ■

Learn more about Somnia Anesthesia Services at www.somniaanesthesiaservices.com.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221 People to Know in the ASC Industry

Sami S. Abbasi. Mr. Abbasi is the chairman and CEO of National Surgical Care. Prior to joining National Surgical Care, he served as president and CEO of Radiologix, a leading national provider of diagnostic imaging services. Mr. Abbasi is the director and chairman of the audit committee for Behringer Harvard Multifamily REIT I and serves on the board of directors for American CareSource Holdings.

David J. Abraham, MD. Dr. Abraham is a physician at the Reading Neck and Spine Center in Wyomissing, Pa. He is a board-certified in orthopedic surgery and a member of the American Academy of Orthopedic Surgeons, North American Spine Society and the Pennsylvania Orthopedic Society.

Margaret Acker, RN, MSN, CASC. Ms. Acker is the CEO of the Blake Woods Medical Park Surgical Center in Jackson, Mich., a multi-specialty, physician-owned surgery center. Previously, she served as nursing supervisor/house manager at Foote Hospital and clinical nurse manager for Foote Health System (now Allegiance Health) in Jackson.

Clifford G. Adlerz. Mr. Adlerz is president and COO of Symbion. Before co-founding Symbion, he served as COO of UniPhy, as division vice president of HCA (formerly Columbia/HCA Healthcare Corporation) and as a regional vice president for HealthTrust.

Ross Alexander. Mr. Alexander is administrator at The Surgery Center of Fort Collins (Colo.), a multi-specialty ASC owned and managed by a group of surgeons, Poudre Valley Health System and Surgical Care Affiliates. Mr. Alexander began at SCFC in 2003 as its business manager but was promoted to administrator a year later when his predecessor took a position with an ASC management company.

Amy Allard. Ms. Allard is administrator of Ramapo Valley Surgery Center in Ramsey, N.J. The center opened in the fall of 2005, and surgeons at RVSC perform around 4,500 cases annually. The multi-specialty ASC focuses on orthopedics, general surgery, ENT, podiatry, pain management, ophthalmology, gynecology and dentistry. Ms. Allard has been with RVSC since early in its construction phase.

Brent Ashby. Mr. Ashby is the administrator of Audubon Surgery Center and Audubon ASC at St. Francis and Women's Surgical Center, all located in Colorado Springs, Colo. Mr. Ashby has been with Audubon Surgery Center since it opened in June 2000, and he opened the two other ASCs in Sept. 2008. Previously, he was the administrator of the Provo (Utah) Surgical Center for seven years, and he practiced law at a large firm in Phoenix.

Lisa A. Austin, RN, CASC. Ms. Austin serves as vice president of ASC operations for Pinnacle III. She currently is a board member of the Colorado Ambulatory Surgery Center Association and serves on the surgery center advisory board of Med Assets.

David Ayers. Mr. Ayers is the president of the surgical facilities division of Nueterra Healthcare. He has 20 years of experience developing, building and managing ambulatory facilities including surgery, imaging, physical therapy and urgent care centers. Mr. Ayres previously was vice president of a *Fortune* 500 company that specialized in ambulatory care product lines.

David "Buddy" F. Bacon Jr., CPA. Mr. Bacon is the CEO of Meridian Surgical Partners, which develops, finances and operates ASCs. He previously served as CEO and CFO for Medifax EDI, a healthcare information technology company based in Nashville, Tenn.

Gregary W. Beasley. Mr. Beasley is the president of the ambulatory surgery division of HCA and previously served as COO and senior development office, Western region, for the division. Prior to coming to HCA, he served as controller and COO at HealthSouth Medical Center (formerly Dallas Specialty Hospital).

Timothy Beluscak II. Mr. Beluscak is the administrator of Jacksonville Beach (Fla.) Surgery Center, a four-OR, multi-specialty surgery center that is part of the Symbion Healthcare family of surgery centers. He originally worked for Jacksonville Beach from Jan. 2001-Oct. 2005, and returned in Aug. 2009 as administrator. He previously served as director of outpatient surgery and endoscopy at Shands Jacksonville (Fla.) Medical Center.

Sandy Berreth, RN, MS, CASC. Ms. Berreth is the administrator of Brainerd Lakes Surgery Center in Baxter, Minn., a multi-specialty ASC that performs general surgery, gynecology, orthopedics, ophthalmology, facial plastics, ENT, urology, podiatry and pain management. She has been with the center since it opened in 2005.

Chris Bishop. Mr. Bishop is senior vice president of acquisitions and business development for Blue Chip Surgical Center Partners. He previously served as vice president of business development for Ambulatory Surgical Centers of America. He has 15 years of experience in leadership roles in the medical device and surgery center industries and was responsible for developing Smith & Nephew Endoscopy's surgery center sales team and strategy.

Shannon Blakeley. Mr. Blakeley is vice president of operations for National Surgical Care and works on business development, physician recruitment, financial management, operations and human resources issues. Before joining National Surgical Care, he was a vice president at HealthSouth Corp. and created a continuum of care model for HealthSouth's outpatient services.

Jeff Blankinship. Mr. Blankinship is the CEO and president of Surgical Notes, which provides transcription services to more than 450 surgery centers and 6,500 physicians in 42 states. Under his leadership, Surgical Notes has partnered with several large ASC development and management companies and leading surgeons throughout the United States.

Steven Blom, RN, MAHSM, CASC. Mr. Blom is the administrator at the Specialty Surgery Center, a multi-specialty surgery center that specializes in ENT, ophthalmology, podiatry and pain management based in San Antonio, Texas. Prior to coming to the Specialty Surgery Center in Oct. 2000, Mr. Blom started his career as an ICU nurse and progressively moved up the management ladder. He spent most of his career in critical care and cardiac catheterization labs.

Henry H. Bloom. Mr. Bloom is the founder of The Bloom Organization, a healthcare-consulting firm devoted to providing project-related services to healthcare providers. He has structured and negotiated numerous healthcare transactions including physician practice acquisitions and divestitures, joint venture arrangements between physicians and surgery center companies and syndicated physician-owned surgery centers.

T. Taylor Burnett. Ms. Burnett is CEO of The Plastic Surgical Center of Mississippi, a physician-owned surgery center in Flowoods, Miss. Ms. Burnett has been with The Plastic Surgical Center since it opened in August 2003. She started her career as a marketing major and worked as a production assistant for film and ran the office of her family's business. She later pursued a career in nursing and worked PRN in at her local hospital.

Tom Bombardier, MD. Dr. Bombardier is a board-certified ophthalmologist, Ambulatory Surgical Centers of America's COO and one of its three founding principals of the company. Before founding ASCOA, he established the largest ophthalmic practice in western Massachusetts, two ASCs and a regional referral center. Over the past 15 years, he has been a real estate developer on Cape Cod, Mass.

Regina Boore, RN, BSN, MS. Ms. Boore is the principal and CEO of Progressive Surgical Solutions. She has more than 25 years of clinical,

administrative, teaching and consulting experience in ambulatory surgery. Prior to coming to Progressive Surgical Solutions, Ms. Boore worked as a perioperative nurse, OR supervisor and ASC director.

Bonnie Brady, RN. Ms. Brady is the administrator of Specialty Surgical Center, a multi-specialty, two-OR ASC in Sparta, N.J. Ms. Brady has served as administrator of SSC since May 2008. She previously served as a regional director of nursing for three ASCs.

Brett Brodnax. Mr. Brodnax is executive vice president and chief development officer at United Surgical Partners International and is one of the ASC industry's leading development executives. Due to his leadership, efforts and integrity, he has made USPI one of the fastest-growing ambulatory surgical chains, with a portfolio of nearly 100 surgical centers and several surgical hospitals located across the country.

Kathy J. Bryant, JD. Ms. Bryant is the president of the ASC Association and leads the activities of the nation's largest ASC membership association. She also serves as president of the Ambulatory Surgery Foundation. She recently announced with will leave the association this fall.

Jason B. Cagle. Mr. Cagle is general counsel for United Surgical Partners International. Before joining USPI, he was in the corporate and securities section at Vinson & Elkins in Dallas.

Robert J. Carrera. Mr. Carrera is the president of Pinnacle III. With more than 20 years of healthcare experience, he has spent the last 15 years developing and managing ASCs, physical/occupational rehabilitation centers, diagnostic imaging facilities and occupational medicine clinics nationally. Mr. Carrera has been active legislatively at the state level regarding issues affecting ASCs in Colorado, Minnesota and Utah.

John Caruso, MD. Dr. Caruso has more than 16 years of neurological surgery experience. Since completing residencies at the Eastern Virginia Graduate School of Medicine and the University of New Mexico, he has been in private practice with Neurosurgical Specialists in Hagerstown, Md.

Frank J. Chapman, MBA. Mr. Chapman is the COO of Asheville (N.C.) Gastroenterology Associates and is past president of the Medical Group Management Association Gastroenterology Administrators Assembly and currently sits on the MGMA Patient Safety and Quality Committee. He is the first non-physician to hold a seat on the practice management committee of the American Society for Gastrointestinal Endoscopy and is also a member of the board of directors of the AAAHC.

Thomas Chirillo. Mr. Chirillo is senior vice president of corporate development at NovaMed. Mr. Chirillo has spent over 17 years in the healthcare industry, many of which were spent in eye care, with Becton Dickinson, CILCO, Ioptex Research and Guidant Corp.

Rajiv Chopra. Mr. Chopra is the director of strategic planning for The C/N Group. He has prior work experience in the banking and management consulting industries. Before joining The C/N Group, Mr. Chorpa was a principal consultant in the strategic change practice of PricewaterhouseCoopers Consulting.

Raman Chopra. Mr. Chopra is principal for The C/N Group. He oversees the firm's diagnostic imaging and hospitality operations and all marketing and technology related activities. Prior to joining The C/N Group in spring 1997, Rum spent seven years in strategic consulting, with his last position as director of consulting services for Equifax.

Ravi Chopra. Mr. Chopra is the president and CEO of The C/N Group, which is involved in the development of surgery and imaging centers throughout the country. Under his leadership, The C/N Group has completed healthcare-related projects totaling more than $80 million in capital expenditures.

Richard N. Christie, MD. Dr. Christie is a vice president of acquisitions and development for ASCOA and is a board-certified OB/GYN with a private practice in Newport Beach, Calif. As an investor and physician at The Newport Beach Surgery Center, he has extensive personal knowledge of the ASC industry. Dr. Christie was also involved in real estate development in Newport Beach and Palm Springs, Calif. He is a graduate of Baylor College of Medicine in Houston and completed his residency in San Diego.

Monica Cintado-Scokin. Ms. Cintado-Scokin is the senior vice president of development for United Surgical Partners International, and she has been with USPI since 1998. Prior to joining USPI, Ms. Cintado-Scokin provided development and operations support in the international group at HCA.

Joseph Clark. Mr. Clark is the executive vice president and chief development officer of Surgical Care Affiliates and previously held the position of COO. He previously served as president of HealthSouth's surgery center division and was president and CEO of HealthMark Partners. He is on the board of directors of ASC Association.

James H. Cobb. Mr. Cobb is the founder, president and CEO of Orion Medical Services. With 37 years in management, he has focused the last 25 years in the medical field. Mr. Cobb previously served as CEO for the Pacific Cataract Laser Institute and Pacific Eye Center. He has been a member of the Medical Group Management Association for 20 years as well as a member of the American Society of Ophthalmic Administrators.

Mary Ann Cooney, RN. Ms. Cooney is the administrator of Riverside Outpatient Surgery Center in Columbus, Ohio, a multi-specialty facility with six ORs and one minor procedure room. Currently, ROSC is a joint venture between OhioHealth and a physician group and is managed by Health Inventures. Ms. Cooney began her career in nursing and gained valuable experience in the hospital setting prior to joining the surgery center in 1981 as the administrator.

Daniel Connolly. Mr. Connolly is the vice president of payer relations for Pinnacle III. He performs all aspects of managed care contracting including contract negotiations, renegotiations, analysis, market analysis, implementation and compliance monitoring for ASCs in multiple markets. Mr. Connolly has worked in the healthcare industry for 20 years.

Rebecca Craig, RN, CASC. Ms. Craig is CEO of Harmony Surgery Center, a multi-specialty ASC in Fort Collins, Colo. Ms. Craig has been with the center since it opened nearly 10 years ago. She began her career as a registered nurse, working at a rural hospital in the OR, PACU, gastroenterology and pain management areas. She held several management roles in perioperative services before moving into outpatient and ambulatory surgery.

Bill Cramer. Mr. Cramer co-founded Access MediQuip and serves as vice chairman of the board. He has more than 20 years of experience in the healthcare industry, including experience developing hospital-based acute and chronic pain programs, and representing a variety of manufacturers in implantable device sales prior to founding Access MediQuip.

Deborah Lee Crook. Ms. Crook is the administrator of Valley Ambulatory Surgery Center in St. Charles, Ill., a seven-OR, multi-specialty surgery center. Ms. Crook has been with Valley ASC since 1993 as a pre-op nurse. She served as director of nursing at Valley's post-surgical recovery care center before becoming administrator of both facilities in 2006. Ms. Crook began her career as a staff nurse with experience in cardiac and ICU nursing.

Gregory R. Cunniff. Mr. Cunniff is the CFO of National Surgical Care and directs the financial activities of the company, including treasury, budgeting, accounting, information technology, long-range forecasting, risk management and investor relations. He was previously vice president and treasurer of United Medical Corp. and Western CFO for ASCs for HCA Healthcare Corp.

R. Blake Curd, MD. Dr. Curd is the interim executive director of Surgical Management Professionals, and is an upper-extremity and general orthopedics physician with the Orthopedic Institute in Sioux Falls, S.D. He completed his fellowship training at the Indiana Hand Center, the largest freestanding center dedicated to hand and upper-extremity care, research and education in the world. He is currently a member of the South Dakota House of Representatives.

David Daniel. Mr. Daniel is the CEO of Lakeland (Fla.) Surgical and Diagnostic Center, a large, independently-owned, freestanding, multi-specialty ASC. Mr. Daniel is a retired Navy Captain, having served for 26 years in the Navy Medical Service Corps where he managed naval hospitals and clinics in a worldwide medical system. He has also served as administrator and COO of a large medical clinic and a physician group practice before coming to the LSDC.

Eric Day, MBA, ATC, LAT. Mr. Day is the administrator at The Center for Special Surgery at the Texas Center for Athletes medical complex in San Antonio. Mr. Day started his career as an athletic trainer, working with athletes and doing sports medicine outreach activities in the Austin market for HealthSouth Corp. He made the transition into administration at outpatient rehabilitation and diagnostic imaging centers and then moved to the ASC industry.

Joey Daugherty, RN. Mr. Daugherty is the administrator of Total Pain Care, a single-specialty ASC that focuses on pain management procedures in Meridian, Miss. Mr. Daugherty has been at Total Pain Care since it opened in 2006 but has worked in healthcare since 1992, starting as a registered nurse in the emergency room at Rush Foundation Hospital in Meridian, Miss., and transferring to the Pain Treatment Center at Rush before becoming a department manager and then moving to Total Pain Care.

Gregory P. DeConciliis PA-C, CASC. Mr. DeConciliis is the administrator of Boston Out-Patient Surgical Suites and has served as administrator of Boston Out-Patient since its inception. Mr. DeConciliis is a licensed physician assistant and worked at New England Baptist Hospital prior to assuming the role of administrator at the center. He continues to remain on staff at the hospital and assists with surgical procedures at the center.

Richard DeHart. Mr. DeHart is the co-founder and CEO of Pinnacle III and has more than 18 years of experience in the outpatient healthcare industry. He provides Pinnacle III's clients with expertise in strategic planning, development and management of ASCs, diagnostic imaging and physical rehabilitation services.

Vicki Dekker. Ms Dekker is the director of business development at Blue Chip Surgical Center Partners. Prior to joining Blue Chip, she was responsible for the business office supporting the ENT, Neurosurgery and Neurology Departments at the University of Minnesota. Ms. Dekker also managed an ENT Group in Atlanta, where she developed and managed a single-specialty ENT surgery center.

Ann S. Deters, MBA, CPA. Ms. Deters is CEO and co-founder of Vantage Outsourcing (formerly Vantage Technology), which provides cataract outsourcing to hospitals and ASCs throughout the Midwest, South and Southeast. She also started 7D, a consulting and management service company for ASCs.

Ken Drazan, MD. Dr. Drazan is a physician and managing director of healthcare services investments for Bertram Capital Management based in San Mateo, Calif., which includes GENASCIS among its portfolio companies. He has been a leader and is also an investor in different businesses that serve the ASC market. Previously, Dr. Drazan was the CEO and founder of Arginox Pharmaceuticals and was a leading academic liver transplant surgeon and basic scientist at Stanford University and UCLA.

Tom Ealey, CPA. Mr. Ealey is an associate professor of business administration at Alma (Mich.) College. He has been in healthcare for more than 30 years, working as an accountant with physician offices and long-term care organizations and then as a healthcare consultant with interests that include improving administration and regulatory compliance. He went on to serve as a practice administrator, working for two orthopedic groups and a family medicine group. He recently received MGMA's Edward B. Stevens Article of the Year Award his article, "Heads Up! How You Can Model Financial Uncertainty in Anticipation of Healthcare Reform."

Vicki Edelman, RN. Ms. Edelman is the administrator of Blue Bell (Pa.) Surgery Center, a four-room, multi-specialty ASC that opened in Sept. 2008. Ms. Edelman has been with Blue Bell since May 2008, during the center's construction phase. She has been a nurse for 32 years and began her career in medical surgical nursing and high-risk obstetrics.

Rose Eickelberger. Ms. Eickelberger is the director of surgical services at Summit Surgical Center and Beacon West Surgical Center, both part of Beacon Orthopaedics in Sharonville, Ohio. Ms. Eickelberger began at Beacon in May 2006. Previously, she was the director of nursing at the Cincinnati Eye Institute for eight years, after having served as its assistant director for six years.

Stephanie Ellis, RN, CPC. Ms. Ellis is the president of Ellis Medical Consulting and has worked with most surgical specialties, assisting ASCs, physician practices, hospitals and outpatient clinics around the country in her consulting work. Prior to starting the company, she worked as the operations manager of a national case management services placement firm and served as a case manager and utilization review nurse.

Christian Ellison. Mr. Ellison is the vice president of business development for Health Inventures. He has formed numerous physician/hospital joint-venture partnerships and been instrumental in building Health Inventures' business domestically and internationally during his more than 10 years with the company. Mr. Ellison was previously a senior consultant to the healthcare industry with Arthur Andersen.

Judith English. Ms. English is the vice president of business operations and a partner with Serbin Surgery Center Billing and Surgery Consultants of America. She has more than 35 years of experience in the healthcare industry and has assisted in the development and management of multiple ASCs.

James "Jay" Etheridge Jr. Mr. Etheridge is the CEO of Implantable Provider Group. With a career in the medical industry, first pharmaceutical and then medical devices, he has a proven track record as a results-oriented senior level operating executive with a keen understanding of the implantable medical device industry.

Carolyn Evec, RN, CNOR. Ms. Evec is the administrator at The Surgery Center at Beaufort (S.C.) for eight years. Prior to coming to the center, Ms. Evec opened a surgery center in Missouri and served as the nurse manager at that location. She has 30 years of nursing experience and primarily worked in the OR.

Paul G. Faraclas. Mr. Faraclas is president and CEO of CTQ solutions. Prior to CTQ, he served as vice president of ISH in Fairfield, N.J., for four years, where he helped grow the practice into the nation's largest acute care consulting firm. Prior to his work with ISH, Mr. Faraclas served as national director of sales for professional services for USInternetworking and also spent fourteen years in managed care with Anthem Health Plans, Blue Cross Blue Shield of Connecticut and The Travelers in numerous capacities.

Alisa Fischer, CASC. Ms. Fischer is the administrator of St. Augustine (Fla.) Surgery Center. Prior to St. Augustine, she served as an administrator at HCA and BayCare Health System. She also ran the operating room schedule at a 16-suite OR in Lexington Ky.

John Fitz, MD. Dr. Fitz is the founder of The Surgery Center of Farmington (Mo.), a 10-year-old, multi-specialty surgery center, where he works as a physician. Under his guidance, the center has operated under a very successful rural-area surgery center model.

Robin J. Fowler, MD. Dr. Fowler is chairman and medical director of Interventional Management Services and the medical director of the Interventional Spine and Pain Management Center in Atlanta and is also an active staff member at the Newton and Rockdale Medical Centers. He is board-certified by the American Society of Anesthesiologists and has performed more than 5,000 epidurals and revolutionary pain procedures that have improved the quality of life for thousands of patients.

Richard E. Francis Jr. Mr. Francis serves as president and CEO of Symbion and has helped transform the company into one of the country's leading ASC management and development firms. Prior to co-founding Symbion, he served as president and CEO of UniPhy and was the senior vice president of development for HealthTrust.

Brandon Frazier. Mr. Frazier is a vice president of acquisitions and development for ASCOA, where he is focused on the recruitment of key surgeon partners in existing ASCOA centers. Before joining ASCOA, Mr. Frazier served Smith & Nephew Endoscopy in a leadership position that was exclusively focused on the ASC market. Prior to that, he spent 11 years at the nation's largest GPO working on behalf of hospitals and surgery centers across the U.S.

Jon H. Friesen. Mr. Friesen is the president of Foundation Surgery *Affiliates*. He previously served as the chief financial and strategic planning officer of FSA's parent company, Foundation HealthCare *Affiliates*. Mr. Friesen has spent the last 20 years in the healthcare industry where he has served in such progressive management positions as CFO, COO and CEO of various managed healthcare organizations.

Ed Gallo. Mr. Gallo is CEO of GENASCIS. He has over 25 years of financial, technical and general management experience in healthcare. He is responsible for GENASCIS' rollout of its single-source revenue cycle solution for ASCs, as well as all other strategic initiatives of the company.

Tom N. Galouzis, MD, FACS. Dr. Galouzis is president and CEO of the Nikitis Resource Group. He is also a practicing general surgeon in northwest Indiana and previously served as associate staff in the department of surgery as a clinical instructor of surgery at the University of Chicago Pritzker School of Medicine.

Nap Gary. Mr. Gary is chief operating officer for Regent Surgical Health. He has worked in the healthcare industry for 23 years and previously served as senior vice president and assistant corporate counsel for HealthSouth Mr. Gary currently serves on the board of directors for the ASC Association.

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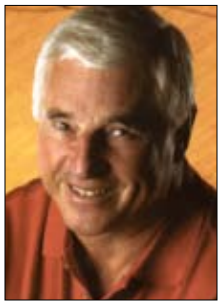
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Ann Geier, RN, MS, CNOR, CASC. Ms. Geier is a senior vice president of operations for ASCOA. She has 20 years of experience in all aspects of ASC operations, including perioperative services, and has served as a clinical coordinator, administrator and chief operating officer of a multi-specialty ASC.

David S. George, MD. Dr. George is a board-certified ophthalmologist at the Eye MDs (of George, Strickler and Lazer) and specializes in topical cataract surgery, glaucoma and diabetic eye care. He has served as a member of the board of directors for the ASC Association and the Outpatient Ophthalmic Surgery Society.

Gregory George, MD, PhD. Dr. George is founding principal of SurgCenter Development and a practicing ophthalmologist. He graduated from M.I.T., received his medical degree and a PhD in ocular physiology from Duke University in Durham, N.C. Under Dr. George's leadership, SurgCenter Development has developed over 60 physician-owned ASCs.

Eric Gleichman. Mr. Gleichman is an executive vice president and the chief development officer of Foundation Surgery *Affiliates*. Prior to this role, Mr. Gleichman had served as FSA's vice president of legal services since joining the company in 2003. Mr. Gleichman has 17 years of progressively responsible healthcare experience on both the payor and the provider sides, most notably in strategic development, contract negotiations, and mergers and acquisitions.

John J. Goehle. Mr. Goehle is the COO and partner in Ambulatory Healthcare Strategies, which specializes in providing high-level strategic, administrative and financial oversight services to ASCs. A 20-year veteran of the industry and former FASA board member, he is a nationally recognized industry leader, a frequent speaker at conferences and the author of three books on the ASC industry.

Brett Gosney. Mr. Gosney is a founder and CEO of the Animas Surgical Hospital in Durango, Colo., the first physician-owned hospital in Colorado. He is the current president of the Physician Hospitals of America. Mr. Gosney has a diverse background in healthcare spanning more than 25 years.

Michael Gossman, BSBA, CASC. Mr. Gossman is the administrator at the Cedar Lake Surgery Center in Biloxi, Miss., a multi-specialty center. Before coming to Cedar Lake in 2005, Mr. Gossman served as administrator at Methodist Ambulatory Surgery Center in New Orleans, where he oversaw the start-up of the center.

Judy Graham. Ms. Graham is administrator of Cypress Surgery Center, a free-standing, multi-specialty ASC that opened in Dec. 2000. Ms. Graham has been with Cypress for more than nine years, since construction began. She has a strong clinical background in the operating room and ambulatory surgery and previously served as an OR manager and a clinical director in ASCs before becoming an administrator.

Michael Guarino. Mr. Guarino has been in the surgery center business for more than a decade and currently works at the Orthopedic Surgery Center of Clearwater (Fla.). An accountant by trade (and former IRS employee), he has been successful in working the day-to-day operations of ASCs, along with long-term planning.

Amanda Gunthel. Ms. Gunthel is the administrator of Wilton (Conn.) Surgery Center, a two-OR, two-procedure room ASC that specializes in ophthalmology and pain management. Ms. Gunthel has been with Wilton since its inception, and before taking on the role of administrator, she worked for four years as director of practice management and development for the healthcare management firm that first opened the center.

John Hajjar, MD, FACS, MBA. Dr. Hajjar is the chief medical officer and chairman of Surgem and is a urologist. He developed one of the first ASCs in New Jersey at Fair Lawn and has been managing facilities profitably since 1992. Dr. Hajjar also operates one of the largest private practices of urology in the United States.

David Hall. Mr. Hall is chairman at Titan Health, an ASC management company; director of Cogent Healthcare, a hospitalist staffing company; and a board member for the National Pain Foundation. He has more than 25 years of experience in the healthcare industry.

Mark Hall. Mr. Hall is managing partner of Wasatch Healthcare Management, a Salt Lake City-based healthcare management and development company. Mr. Hall has 23 years of experience creating physician empowerment opportunities and ancillary income strategies.

Thomas S. Hall. Mr. Hall is president, CEO and chairman of NovaMed. Previously, he served as president and COO of Matria Healthcare and president and CEO of TSH & Associates, an independent consulting and management services company.

David Hamilton. Mr. Hamilton is the president and CEO of Mnet Financial, based in Aliso Viejo, Calif., and has become a trusted name within healthcare collections for ASCs, imaging centers and outpatient hospitals. Since 1999, he has assisted more than 300 facilities with collections. Prior to coming to Mnet, Mr. Hamilton worked in receivables management for CitiBank.

Kenneth N. Hancock. Mr. Hancock is the president and chief development officer of Meridian Surgical Partners. He has more than 20 years of experience in the healthcare industry developing ASCs and surgical hospitals, and recruiting and building relationships with physicians. He is the former executive vice president, chief development officer and co-founder of Surgical Alliance Corp.

Richard Hanley. Mr. Hanley is the president, CEO and founder of Health Inventures. He has held leadership positions in healthcare for the past 20 years and, throughout his career, has been instrumental in creating more than 100 successful outpatient ventures. He is a leading national advocate for ASCs and is a board member for the Ambulatory Surgery Center Foundation.

Anne Hargrave-Thomas. Ms. Hargrave-Thomas is CEO of Lakes Surgery Center in West Bloomfield, Mich. The ASC has continued to grow despite a local struggling economy and was recently named to *Becker's Hospital Review / Becker's ASC Review* list of the "100 Best Places to Work in Healthcare." She is a member of the Michigan Ambulatory Surgical Association and has more than 30 years of experience in healthcare and nursing.

Andrew Hayek. Mr. Hayek is the president and CEO of Surgical Care Affiliates, which operates more than 130 ASCs and surgical hospitals nationwide. Prior to joining SCA in May 2008, he served as president of VillageHealth, an insurance and care management company owned by DaVita, one of the nation's leading independent provider of kidney dialysis services. He also currently serves as chair of the Ambulatory Surgery Center Advocacy Committee.

Bill Hazen. Mr. Hazen is the administrator of the Surgery Center at Pelham, a four-OR, two-procedure-room, multispecialty center that is a joint venture between a hospital and local physicians in Greer, S.C. Prior to coming to the Surgery Center at Pelham, Mr. Hazen was director of special projects at Spartanburg (S.C.) Regional Medical Center. He also opened and developed the Hyperbaric Medicine and Wound Center at the hospital and spent some time as a neuro-trauma ICU nurse.

Allen D. Hecht, MBA. Mr. Hecht is president of Health Resources International, which is engaged in developing ambulatory care programs in new and emerging markets. Previously, he served as executive vice president and COO of the ASC Network, a national surgical center company formed as a result of a merger between SunSurgery and Premier Ambulatory Systems of Pasadena, Calif.

Tom Hearn, MBA. Mr. Hearn is senior vice president of ambulatory care at Novant Health. Before joining Novant in 2008, he served and CEO and before that as chief development officer at MedCath. He has also worked for VHA and Carolinas HealthCare System during his career.

Edward P. Hetrick. Mr. Hetrick is president and CEO of Facility Development & Management and has more than 20 years of experience in the healthcare industry. Before founding FDM, he was vice president in Healthcare Facilities Management, a firm that specializes in reimbursement consulting for physicians and outpatient hospital accounts, a position which he still holds today.

Jeremy Hogue, JD, MBA. Mr. Hogue is the president, CEO and co-founder of Sovereign Healthcare, a privately-held company based in Orange County, Calif., that partners with physicians for the ownership and management of ASCs. He previously served as vice president of Audax Group and was an associate with Lehman Brothers where he was a member of the firm's investment banking group in their New York office

Christopher Holden. Mr. Holden is the president, CEO and director of AmSurg. He has more than 21 years of experience in the healthcare industry, most of which he has spent in multi-facility and multi-market healthcare management. Before joining AmSurg, Mr. Holden served as senior vice president and a division president of Triad Hospitals.

Tracey Hood, RN. Ms. Hood is the administrator of Ohio Valley ASC and Mid Ohio Valley Medical Center in Belpre, Ohio. She previously worked as an ASC charge nurse, OR circulating registered nurse, PACU nurse, certified emergency RN, cardiac catheterization lab nurse and a critical care nurse.

Georganna Howell, RNFA, CNOR, CEN, LNC. Ms. Howell is administrator of Greenspring Surgery Center in Baltimore, part of OrthoMaryland, which opened in 2006. Ms. Howell joined Greenspring in June 2009.

Joseph W. (Woody) Hubbard. Mr. Hubbard is vice president of ambulatory care for Novant Health, a North Carolina Health System that includes 12 hospitals and 12 ASCs. Previously, Mr. Hubbard was chief development officer for Bariatric Partners, a single-specialty surgical services provider. Mr. Hubbard has more than 25 years in healthcare operational management and business development.

Thomas Jacobs. Mr. Jacobs is CEO and co-founder of MedHQ, a business office solutions provider for outpatient healthcare businesses. As CEO he has led MedHQ from start-up to a profitable company that operates in 10 states.

Richard K. Jacques. Mr. Jacques is president and CEO of Covenant Surgical Partners and has more than 15 years in the ASC industry, including holding senior management positions with both public and private healthcare companies. He previously served as president and director of Surgical Health Group, a developer and manager of single- and limited-specialty surgery centers.

Marc Jang. Mr. Jang is president, CEO and founder of Titan Health and has held executive positions in healthcare for almost 20 years. Since 1991, his focus has been specifically in ASCs. His experience encompasses finance, mergers and acquisitions, and development and operations. Mr. Jang served as vice president of finance for Sutter Surgery Centers and regional vice president for ASC Network.

Leslie R. Jebson, CMPE. Mr. Jebson is the executive director of the Orthopaedics and Sports Medicine Institute at the University of Florida. After assuming the role four years ago at the new 130,000 square-foot facility, Mr. Jebson has been a driving force in the institute's momentous volume and market growth. The Institute has doubled its number of surgical cases and outpatient visits during his tenure — with over 100,000 patient visits and more than 6,000 surgical procedures performed.

Marion K. Jenkins, PhD. Dr. Jenkins is the founder and CEO of QSE Technologies. He has held many strategic C-level positions in technology, communications and operations, including COO of NAREX, which provides artificial intelligence-based software for financial service companies; executive vice president and chief technology officer at FirstWorld Communications, a DSL, Internet services, hosting and data center provider; and vice president of sales operations at Qwest Communications.

Beth Ann Johnson, RN. Ms. Johnson is vice president of clinical systems for Blue Chip Surgical Center Partners. She joined Blue Chip from LCA Vision where she was vice president of operations responsible for the growth of the ophthalmic surgery center business. Previously, she was with Aetna as a director of provider relations, recruitment and contracting. Ms. Johnson has extensive experience in the development and ongoing management of hospital-owned, minimally invasive surgery centers.

Douglas V. Johnson, MBA. MR. Johnson is COO of RMC Medstone Capital and serves on the board of directors of Physician Hospitals of America as its immediate past president. He is a seasoned professional and administrator with more than 35 years in the healthcare industry. He has worked in many capacities in the industry and at all levels in both freestanding as well as system institutions. He has held leadership positions in both rural and urban healthcare organizations.

Sandra J. Jones, BA, MSM, MBA. Ms. Jones is a principal of Ambulatory Strategies and has served on the board of the ASC Association. She has 30 years of experience in healthcare and has overseen or contributed to the successful establishment and development of more than 75 ASCs nationwide.

Kelly Kapp, RN. Ms. Kapp is the administrator of Specialty Surgery Center in Westlake Village, Calif. Ms. Kapp began her nursing career as an OR nurse at L.A. County Hospital. She then was an assistant at Southern California Orthopedic Institute and served as orthopedic coordinator at St. John's Regional Medical Center in Oxnard, Calif., for 13 years before accepting a director of nursing position at SSC.

Mike Karnes. Mr. Karnes is the CFO and co-founder of Regent Surgical Health. He recently served as chief administrative officer of GTCR-Golder Rauner, one of the nation's largest and oldest venture capital firms. He also has been CFO for Prime Group Realty Trust and Balcor, a subsidiary of American Express.

I. Naya Kehayes, MPH. Ms. Kehayes is the founder, managing member and CEO of Eveia Health Consulting & Management. She is a nationally recognized expert in reimbursement, managed care and insurance contract negotiations for ASCs and surgical practices. Ms. Kehayes is a former president of the Washington Ambulatory Surgery Center Association.

David Kelly, MBA, CASC. Mr. Kelly is the administrator of Samaritan North Surgery Center, a multi-specialty center with four ORs and two procedure rooms in Dayton, Ohio. Mr. Kelly joined the facility in late 2006 and has a background in finance, IT and operations.

William Kennedy. Mr. Kennedy is senior vice president of business development for NovaMed. He joined NovaMed in 1996 as vice president of acquisitions. From 1992 to 1995, Mr. Kennedy was Regional Manager of CIT Group/Business Credit where he successfully rebuilt the Chicago office by restructuring a troubled portfolio, upgrading the staff and refocusing the marketing effort. Previously, Mr. Kennedy was a principal and founder of his own firm specializing in consulting and investing in middle-market companies.

R. Matthew Kilton, MBA, MHA. Mr. Kilton is a member and COO of Eveia Health Consulting & Management. His expertise is in ASC and surgical practice managed care contract negotiations and reimbursement analysis. Prior to joining Eveia, he was the CEO of Valley Orthopedic Associates and Valley Orthopedic Surgery Center, a division of Proliance Surgeons in Renton, Wash.

Beverly Kirchner, RN, BSN, CNOR, CASC. Ms. Kirchner is the owner and CEO of Genesee Associates. She served on the Association of periOperative Registered Nurses board of directors, has authored many AORN manuals and leads research in collaboration with the organization on violence in the nursing workplace.

Susan Kizirian, BSN, RN, MBA. Ms. Kizirian is the COO of ASCOA and has more than 20 years of experience in all aspects of ASC operations. She most recently worked with the University of Virginia Health System ASC program. Ms. Kizirian has served as an executive director and a consultant for ASC management and development.

Marc E. Koch, MD, MBA. Dr. Koch is the president and CEO of Somnia Anesthesia Services, where he focuses on furthering the company's mission of offering high-quality and cost-efficient anesthesia solutions to hospitals, ASCs and office-based facilities nationwide. He co-founded the medical practice Resource Anesthesiology Associates in 1996.

Greg Koonsman, CPA. Mr. Koonsman is a senior partner and founder of VMG Health. He specializes in providing valuation, transaction advisory, feasibility and operational consulting services to the firm's healthcare clients. Mr. Koonsman has acted as an advisor to more than 150 hospitals, 300 surgery centers, 20 HMOs, 1,500 physician organization transactions and a variety of other healthcare entities in the United States.

Catherine W. Kowalski, RN. Ms. Kowalski is the executive vice president and COO for Meridian Surgical Partners. She has more than 20 years of experience in the healthcare industry and is the former executive vice president of operations and co-founder of Surgical Alliance Corp., a specialty surgical hospital company. Ms. Kowalski is also a registered nurse.

Donald Kramer, MD. With a medical practice spanning more than 25 years, Dr. Kramer has developed several successful ASCs in the Houston market. He founded Northstar Healthcare, which develops and, in conjunction with physician partners, owns and operates significant ASCs in concentrated markets. He served as CEO of the company until Sept. 2008.

Brent Lambert, MD. Dr. Lambert is the chairman of the board and a founder of ASCOA. He is a board-certified ophthalmologist and responsible for business development at ASCOA. Prior to the founding of ASCOA, Dr. Lambert was the developer and owner of three ASCs, including the first eye ASC in New England. He is on the board of the ASC Associtaion.

Luke Lambert. Mr. Lambert is the CEO of ASCOA and has a background in finance, strategy and operations. Before joining ASCOA as its CFO in 1997, he worked in equity research for Smith Barney and has management consulting experience with Booz, Allen & Hamilton and Ernst & Young.

Mary Beth Lang. Ms. Lang is senior vice president of business intelligence for Amerinet and president of Diagnostix, an Amerinet subsidiary. In her position, she oversees a team that analyzes data to help Amerinet members recognize and sustain significant savings. Prior to joining Amerinet, Ms. Lang directed pharmacy distribution and process improvement efforts at the University of Pittsburgh Medical Center.

John W. Lawrence Jr. Mr. Lawrence is the senior vice president and general counsel for

NovaMed and has served as NovaMed's Corporate Counsel since 1996. He is responsible for all legal matters relating to NovaMed and its operations, including structuring and negotiating all development transactions. Mr. Lawrence's background is in general corporate practice with a focus in mergers and acquisitions.

Scott Leggett. Mr. Leggett is CEO of Surgery One, which manages four multi-specialty ASCs in the San Diego area. He has more than 17 years of experience in orthopedics and holds a master's degree in exercise and sports science from the University of Florida in Gainesville. He has also been featured on a series of educational videos on healthcare employment and interviewing on the career resource and job seeker website, www.jobing.com.

Jeff Leland. Mr. Leland is a managing partner with Blue Chip Surgical Center Partners, which focuses on developing spine, ENT, sleep, radiosurgery and multi-specialty ASCs. He previously served as executive director for Lutheran General Medical Group, a 260-physician, multi-specialty medical group located in Chicago. Mr. Leland was also once a senior-level executive with Advocate Health Care in Chicago and was responsible for both business development and Advocate's 225,000-member health plan.

Mike Lipomi, MSHA. Mr. Lipomi is the president of RMC Medstone Capital and has more than 30 years of experience in hospital and ambulatory facility management. At RMC Medstone, he and a team of experts cover all aspects of healthcare facility development, conversion and management with RM Crowe's real estate professionals. Prior to joining RMC, Mr. Lipomi was CEO of Stanislaus Surgical Hospital in Modesto, Calif., which he grew from a small surgery center into one of the nations leading specialty hospitals.

Rodney H. Lunn. Mr. Lunn is the principal of the Surgical Health Group. Over the past 17 years, he has developed more than 150 ASCs throughout the United States. He is often considered the original pioneer in taking the concept of ASCs and transforming it into a practical, successful business model in dozens of states.

James J. Lynch, MD, FACS. Dr. Lynch is the president, founder and CEO of SpineNevada based in Reno, Nev., and he also serves as the director, spine service, for Regent Surgical Health. Dr. Lynch is a board-certified neurological surgeon who specializes in complex spine surgery, cervical disorders, degenerative spine, spinal deformities, trauma, tumor infection and minimally invasive spine surgery.

Sara McCallum. Ms. McCallum is administrative director of Sheboygan (Wis.) Surgery Center, a multi-specialty surgery, endoscopy and pain management center. Ms. McCallum has many years of experience in ASCs and has opened six surgery centers throughout her career. She worked at most of the centers in a variety of roles including executive director, director, risk manager and staff nurse.

Rob McCarville, MPA. Mr. McCarville is a principle with Medical Consulting Group. He has an extensive portfolio in the field of healthcare facility management, administration and strategy. Before joining the MCG consulting team, Mr. McCarville was responsible for overseeing 16 separate physician practices, building a strong reputation by developing innovative strategies to increase profitability.

Dawn Q. McLane, RN, MSA, CASC, CNOR. Ms. McLane serves as chief development officer for Nikitis Resource Group. She was formerly a vice president for National Surgical Care in Chicago. Ms. McLane has worked in the hospital setting as director of surgical services and as a staff nurse in surgery, ER and OB.

Neal Maerki, RN, CASC. Mr. Maerki is the administrator of Bend (Ore.) Surgery Center. He started his career with BSC in 1997 as a nurse, then nurse manager and finally as administrator. He previously worked as a telemetry floor manager and an ICU staff nurse before moving into ambulatory surgery.

Tom Mallon. Mr. Mallon is a co-founder and CEO of Regent Surgical Health, which specializes in working with physician and hospital partners in the development, management and turnaround of surgery centers and specialty hospitals. Before founding Regent, he served as a founding member and remains a general partner with Gryffindor Capital Partners, a Chicago-based venture-capital fund.

Laxmaiah Manchikanti, MD. Dr. Manchikanti is the medical director of the Pain Management Center of Paducah (Ky.) and Ambulatory Surgery Center in Paducah. He is the CEO and chairman of the board of the American Society of Inteventional Pain Physicians. Through his work with various organizations, Dr. Manchikanti has been instrumental in the preservation of interventional pain management through specialty designation, mandatory Carrier Advisory Committee representation, reimbursement and the passage of NASPER.

Ajay Mangal, MD, MBA. Dr. Mangal is the founder, CEO and a board member of Prexus Health Partners and is also a board-certified ENT physician. As a hands-on executive at Prexus, Dr. Mangal has been instrumental in developing ASCs and assisting existing centers and hospitals to prosper. He is on staff at Butler County Medical Center, Fort Hamilton, Mercy Fairfield and Cincinnati Children's Hospitals.

Becky Mann. Ms. Mann is the director of Houston Orthopedic Surgery Center in Warner Robins, Ga. Ms. Mann came to Houston Orthopedic in May 2007 and was involved in the development of the center. Ms. Mann has been working in the medical industry for 37 years and in surgery or in post-surgical care for her entire career.

Tyler Marsh. Mr. Marsh is executive vice president of business development at Wakefield & Associates. He was formerly the co-owner of Affiliated Credit Services and has specialized in healthcare debt collections for the past nine years. He leads the business development unit at ACS and has been responsible for expansion into several states including California, Florida, Illinois, New Mexico, Nevada and Oregon providing collection services for ASCs, hospital systems and physician groups.

Sarah Martin, RN, CASC. Ms. Martin is a regional vice president of operations for Meridian Surgical Partners. She has close to 30 years of healthcare experience, focusing in the ambulatory surgery area for the past decade. Prior to joining Meridian, Ms. Martin was the regional director of ASCs for Universal Health Services where she managed both ASCs and specialty hospitals. She presently serves on the board of the ASC Association.

Todd J. Mello, ASA, AVA, MBA. Mr. Mello is a principal and co-founder of HealthCare Appraisers and manages the firm's Colorado office. He has 18 years of healthcare finance and valuation experience. Mr. Mello is an accredited senior appraiser, accredited valuation analyst and holds an MBA in finance and accounting. He is a frequent speaker and author on healthcare valuation topics.

Melody Mena, RN, CNOR. Ms. Mena is director of surgical services for Southern Regional Health System in south metro Atlanta, and Spivey Station Surgery Center in Jonesboro, Ga. She began her career as an x-ray technician and then as an OR nurse. In 2006, Ms. Mena became director of surgical services for the former Surgery Center at Mt. Zion (now Spivey Station). She has also served director of surgical services for the entire Southern Regional Health System in 2008.

Tyler Merrill. Mr. Merrill is a vice president of acquisitions and development for ASCOA. Prior to joining ASCOA he worked as a sales

representative for Pfizer Pharmaceuticals. In addition to traditional sales training, Mr. Merrill has experience developing business strategy for online start-ups as well as storefront ventures.

Keith Metz, MD, JD, MSA. Dr. Metz is a practicing clinical anesthesiologist and medical director at Great Lakes Surgical Center in Southfield, Mich. He has served on the board of directors for the ASC Association.

Thomas A. Michaud, CPA. Mr. Michaud is the CEO of Foundation Hospital *Affiliates*. Prior to founding FHA's parent company, Foundation HealthCare *Affiliates*, in Jan. 1996, he held the positions of COO and CFO of a regional surgery center management company. During his career, has also developed bariatric centers. Mr. Michaud is a CPA, which he earned while serving as a staff accountant with Ernst & Young.

Evelyn S. Miller, CPA. Ms. Miller is the vice president of development for United Surgical Partners International. Before joining USPI, she was executive vice president of Medway Health Systems, overseeing the financial operations of its medical clinics.

T.K. Miller, MD. Dr. Miller is the medical director at Roanoke (Va.) Ambulatory Surgery Center and physician with the Roanoke Orthopedic Center, which merged with the Carilion Clinic in Nov. 2009. He has specialty experience in sports medicine, arthroscopy and knee and shoulder reconstruction.

Krystal Mims. Ms. Mims is president of Texas Health Partners. She previously served as CFO for Physician's Medical Center, a specialty hospital in Plano, Texas; Southlake (Texas) Specialty Hospital; and Presbyterian Hospital of Rockwall (Texas). Her background in healthcare began in physician practice management. She was CFO for Texas Back Institute for three years, CFO of Practice Performance and administrator of Steadman Hawkins' Denver clinic.

Kristian M. Mineau II. Mr. Mineau is the president and CEO of Constitution Surgery Centers, based in Newington, Conn., which operates 12 ASCs in Connecticut, Rhode Island and Massachusetts. He co-founded CSC in 1997 and has led the company's growth for over 10 years. Mr. Mineau was also the founding president of the Connecticut Association of Ambulatory Surgery Centers.

Melodee Moncrief, RN, BSN, CASC. Ms. Moncrief is the administrator for the Big Creek Surgery Center in Middleburg Heights, Ohio. She has been with the center since Oct. 2005 and helped with the development, initial staff hiring and start-up of the center. She has more than 15 years of experience in the ASC industry after previously serving as a nurse's aid and an ICU nurse at a hospital. Ms. Moncrief served as an administrator of another center for 3.5 years before coming to Big Creek.

Amy Mowles. Ms. Mowles is president and CEO of Mowles Medical Management. She has successfully guided numerous new ventures and established ASCs and physician practices through the complicated maze of regulations, licensing, certification and accreditation processes.

Cindy Moyer. Ms. Moyer is the administrator of the Surgery Center of Pottsville (Pa.), a multi-specialty, two-OR center. Ms. Moyer has been with the center since it opened in 2006. She previously ran an ENT and allergy practice for 21 years and prior to that worked with an internal medicine group.

Tom Mulhern, MBA. Mr. Mulhern is the executive director of Limestone Medical Center, a large medical office building complex and ASC in Wilmington, Del. He has been a leader in the development of ambulatory surgical services and as an advocate for the industry.

James E. Mutrie. Mr. Mutrie serves as assistant general counsel and compliance officer for USPI, an owner and operator of more than 165 surgery centers and surgical hospitals in the United States and the United Kingdom. In his position, Mr. Mutrie is responsible for legal, governance and corporate compliance matters at USPI's facilities. Prior to joining USPI, he was in the corporate and securities section at Vinson & Elkins in Dallas.

Charlie Neal. Charlie Neal is the COO of HealthMark Partners. He was CEO of Alliance Surgery before its merger with HealthMark and was formerly with Symbion where he was president of the multi-specialty group that managed 47 ASCs in 17 states. He also served as the CEO of various hospitals in Georgia and Florida for HCA.

David W. Odell, CPA. Mr. Odell is the founder and president of MedBridge Surgery Center Billing, which has been providing comprehensive billing services exclusively to ASCs for more than 10 years. As a CPA by trade, Mr. Odell has over 12 years' experience in the ASC industry, with a focus on maximizing net revenue through enhanced billing and collection processes.

Jon O'Sullivan. Mr. O'Sullivan is a senior principal and founding member of VMG Health where he provides financial valuation, joint-venture development and transaction advisory services exclusively in healthcare. He has performed extensive engagements in facilities including acute care and specialty hospitals, ASCs, imaging centers, cath labs, radiation therapy, dialysis centers and physician organizations.

Fred W. Ortmann III. Mr. Ortmann is founder and CEO of Ortmann Healthcare Consultants and has more than 17 years of experience developing ASCs. He has served as an administrator with Presbyterian Hospital in Albuquerque, N.M., and as vice president for center development at AmSurg Corp. He left AmSurg in 2001 and founded Ortmann Healthcare Consultants.

Theresa Palicki, MHA, MBA, CASC. Ms. Palicki is the administrator of Eastside Surgery Center, a multi-specialty surgery center in Columbus, Ohio. The center is a joint venture between physicians and OhioHealth and is managed by Health Inventures. Ms. Palicki joined Eastside in Nov. 2005, but she has held positions in healthcare administration since starting her career. She served as administrative director for Consolidated Health Services and was practice administrator for University Orthopaedic Physicians prior to coming to Eastside.

Scott Palmer. Mr. Palmer is the president and COO of the ambulatory service center division of SourceMedical. He has more than 25 years of experience working with several companies offering services and business solutions for outpatient healthcare facilities.

Michael Pankey, RN, MBA. Mr. Pankey is the administrator of the Ambulatory Surgery Center of Spartanburg (S.C.). Before coming to the ASC of Spartanburg, he served as administrator and clinical resources manager at different locations. Mr. Pankey also served as the president of the South Carolina Ambulatory Surgery Center Association.

Richard D. Pence. Mr. Pence is president and COO of National Surgical Care and leads the development and management of the company's surgical centers. Before co-founding NSC, he served as executive vice president and COO of MAGELLA Healthcare, COO for National Surgery Centers and as controller and vice president for Medical Care International.

Jeffrey E. Péo. Mr. Péo is a vice president of acquisitions and development for ASCOA. Before joining ASCOA, he ran a knowledge management and information technology consulting division for a *Fortune* 100 company.

Thomas J. Pliura, MD, JD. Dr. Pliura is a physician, attorney and the founder and manager of several ASCs. Additionally, he is the founder of zChart EMR, an electronic medical records company.

John Poisson. Mr. Poisson is the executive vice president and strategic partnerships officer of Physicians Endoscopy, the leading company in the development and management of freestanding endoscopic ASCs. Prior to joining PE, he had more than 14 years of experience in the healthcare field, specifically focused on medical service outsourcing.

Lori Ramirez. Ms. Ramirez is the founder of Elite Surgical Affiliates and previously served as a senior vice president with USPI where she was directly responsible for developing the second-largest network of surgical facilities for USPI in Houston. In this role, Ms. Ramirez oversaw 20-plus surgical facilities. Ms. Ramirez also has extensive experience in joint venturing with health systems such as Memorial Hermann in Houston and CHRISTUS Health System in South Texas.

J. Michael Ribaudo, MD. Dr. Ribaudo is the founder of Surgical Synergies and has more than 27 years of experience as a surgeon, healthcare executive and real estate developer. He has served as executive vice president of Surgical Health Corp. and HealthSouth Surgery Centers. He currently serves on the board of directors for Flow International and chairs its compensation committee. He is also co-founder of Surgical Anesthesia Services.

Anne Roberts, RN. Ms. Roberts is the administrator at the Surgery Center at Reno (Nev.). She came to the Surgery Center at Reno in Feb. 2006 when it opened and became administrator in Oct. 2006. She began her career as a nurse in the emergency department, spending 16 years as a staff nurse and 10 years as the manager of a busy ED seeing 55,000 patients annually.

Lisa Rock. Ms. Rock is the president of National Medical Billing Services, which specializes in freestanding outpatient surgery center coding and billing. She has been in the healthcare field for 23 years.

Jay Rom, MBA, CPA. Mr. Rom is the president of Blue Chip Surgical Partners. Before joining Blue Chip, he served as CEO of a cardiology group in Cincinnati with 15 physicians and was vice president for physician services of the Franciscan Health System, where he was responsible for a 60-physician multi-specialty group.

Mary Ryan, RN. Ms. Ryan is the administrator of Tri State Surgery Center, a multi-specialty facility in Dubuque, Iowa. Currently managed by Health Inventures, the center was launched in 1998 by Medical Associates Clinics and Health Plans and Mercy Hospital. Ms. Ryan began her career in nursing in 1986 and joined TSSC in 1998 as director of nursing. She then became the administrator in 2001. Mary has also served as regional director during her tenure with Health Inventures.

Kenneth L. Rosenquest. Mr. Rosenquest is the vice president of operations at Constitution Surgery Centers, based in Newington, Conn., and oversees the company's hospital joint ventures. He served as administrator of one of the top performing orthopedic surgery centers in the country and has experience in all aspects of ASC management from operations to billing to equipment acquisition.

Michael E. Russell, II, MD. Mr. Russell is president elect of the Physician Hospital Association and is a board-certified orthopedic surgeon at Texas Spine & Joint Hospital in Tyler, Texas. He practices at Tyler-based Azalea Orthopedics and received his MD from the University of Texas Southwestern Medical School, where he also completed his residency. He then completed a fellowship in spine surgery at The Carolinas Medical Center in Charlotte, N.C.

Dan Saale. Mr. Saale is the executive vice president and CFO of Nueterra Holdings. He oversees all the financial activities of the company and directs the financial services within each of Nueterra's physician partnership ventures.

Karen Sablyak. Ms. Sablyak is the CFO and executive vice president of management services at Physicians Endoscopy. She has more than 10 years of experience in healthcare finance and business operations. Prior to joining PE, Ms. Sablyak worked as a vice president of practice management for Allegheny University Hospitals in Pittsburgh.

Donna St. Louis. Ms. St. Louis currently serves as a vice president for ambulatory services at BayCare Health System. Before joining BayCare, she was a group president for Symbion and responsible for more than 45 ASCs.

Nader J. Samii. Mr Samii is CEO of National Medical Billing Services, a leading revenue cycle outsourcing company focused strictly on ASCs. He was the co-founder and president of revenue cycle company, Ajuba International and has also worked as a corporate finance attorney and an investment banker at both Merrill Lynch and UBS.

Molly Sandvig, JD. Ms. Sandvig is the executive director for the Physician Hospitals of America. In this role she leads the organization's day-to-day business and operational functions and directs PHA's membership recruitment, public relations and political advocacy efforts.

Marcy Sasso. Ms. Sasso has been the director of operations at the Ambulatory Surgical Center of Union County in Union, N.J., since May 2004. Previously she served in many roles at other surgery centers and at Saint Barnabas Hospital. She was also the financial and legal administrator for a multi-physician practice and office manager for an outpatient physical therapy center. In 2000, Ms. Sasso and a fellow administrator started, and now co-chair, a surgery center coalition. The SCC now has over 75 other New Jersey centers as its members. She is also a very active volunteer and recently organized the shipment of medical supplies to Haiti following the earthquake.

Tona Savoie, RN. Ms. Savoie is administrative director of Bayou Region Surgical Center in Thibodaux, La. The ASC operates as a 50-50 partnership between physician investors and a subsidiary of the local community hospital, Thibodaux Regional Medical Center. It is managed by ASD Management. Ms. Savoie has been with Bayou Region since its start-up. Prior to becoming an administrator, Ms. Savoie worked as a circulator for three and a half years at a large hospital and one year as a circulator at an ASC, which was converted to a hospital.

John Schario, MBA. Mr. Schario is CEO of Nueterra Healthcare and brings together the extensive resources that let Nueterra develop, operate and nurture ambulatory care facilities including ASCs and surgical hospitals, and other ambulatory care facilities created through partnerships. Mr. Schario's managerial background includes the development and operation of surgery centers, imaging facilities and occupational medicine clinics.

Bob Scheller Jr., CPA, CASC. Mr. Scheller is the COO of the Nikitis Resource Group. In the past 15 years, he has been involved in the development and management of more than 50 surgery centers. He is currently responsible for nationwide development, management and consulting services for NRG.

Donald Schellpfeffer, MD. Dr. Schellpfeffer is CEO of Medical Facilities Corp., and has over 18 years of experience in ambulatory surgical environments and 22 years in general, cardiovascular and trauma practices. He is currently medical director of Sioux Falls Surgical Center, which he co-founded, and president of Anesthesia Associates, the largest anesthesia services provider in South Dakota.

Caryl Serbin, RN, BSN, LHRM. Ms. Serbin is the president and founder of Surgery Consultants of America and Serbin Surgery Center Billing. She has more than 25 years of experience in the healthcare industry, with the last 18 years spent in ambulatory surgery administration and consulting.

David Shapiro, MD, CPHRM, LHRM, CHC. Dr. Shapiro is a partner in Ambulatory Surgery Company, an ASC consulting firm, and is a Florida-based anesthesiologist. Previously, Dr. Shapiro was senior vice president of medical affairs for Surgis, an ASC management company, serving as the corporate medical director for more than 20 facilities.

Jeffrey Shanton. Mr. Shanton is the director of business management at Journal Square Surgical Center in Jersey City, N.J. He is an ASC industry activist and has met with New Jersey lawmakers on ASC-related legislation. Previously, Mr. Shanton served as director of billing for American Surgical Centers.

Jeff Simmons. Mr. Simmons is chief development officer of Regent Surgical Health and has more than 20 years in the healthcare industry. He served as vice president of marketing for American Medical International and founded the Immune Suppressed Institute to serve HIV patients. Mr. Simmons also founded and served as executive vice president of IntensiCare, a venture-financed hospitalist company.

Lynda Dowman Simon. Ms. Simon is the administrator at St. John's Clinic: Head & Neck Surgery in Springfield, Mo. Ms. Simon has been at her center since 1994. Prior to coming to St. John's, she worked for 13 years at a local hospital in the open heart center and urology.

Bill Simon. Mr. Simon is founder and president Innovative Healthcare, which he founded in 1995. Mr. Simon also developed the Pain & Rehabilitation Medical Group, a 7,000-square-foot outpatient facility located in the South Bay of Los Angeles. He holds a bachelor's degree in finance, as well as a juris doctorate, and is currently a member of the State Bar of California.

John Smalley. Mr. Smalley is a principal with Healthcare Venture Professionals. He has more than 30 years of experience with both public and private healthcare organizations. Prior to co-founding HVP with partner Chuck Owen, Mr. Smalley served as senior vice president for Quorum Health Resources and its predecessor companies.

Sheldon S. Sones, RPh, FASCP. Mr. Sones is president of Sheldon S. Sones and Associates, a pharmacy and accreditation consulting firm based in Newington, Conn. Established in 1985, the group, serving more than 100 sites in five states, specializes in safe medication management and pharmacy consulting to freestanding and hospital-based ambulatory surgical, endoscopy and renal dialysis centers, with expertise in accreditation success.

William Southwick. Mr. Southwick is president and CEO of HealthMark Partners. He is chiefly responsible for ASC turnaround strategies and creative joint-venture structures that have enabled HMP to partner with both physicians and hospitals in developing new or taking over underperforming facilities.

Kenny Spitler. Mr. Spitler serves as senior vice president of development for HealthMark Partners and has more than 20 years in healthcare business development. He is responsible for all aspects of development including acquisitions, de novo projects and physician syndications. He also serves as head of marketing and partners in the role of vendor relations and physician recruiting.

Donald E. Steen. Mr. Steen founded USPI in Feb. 1998 and served as its CEO until April 2004. He continues to serve as chairman of the board of directors and the executive committee.

Jim Stilley. Mr. Stilley is the CEO of Northwest Michigan Surgery Center, a multi-specialty surgery center in Traverse City, Mich. He has been with NMSC for 4.5 years. Prior to coming to the surgery center, he was an executive director with National Surgical Care and served as a lieutenant commander in the U.S. Navy.

Debra Saxton Stinchcomb, RN, BSN, CASC. Ms. Stinchcomb a consultant at Progressive Surgical Solutions and has more than 30 years of experience in the healthcare industry, including positions in administration, operations, sales and clinical areas. She previously served as director of operations preparation and transition management for Health Inventures. She has also held positions as an ASC administrator, assistant regional vice president and regional vice president.

Stephanie Stinson, RN, BSN, CASC. Ms. Stinson is the administrative director of Strictly Pediatrics Surgery Center in Austin, Texas. Ms. Stinson has been administrative director for six years and has been at Strictly Pediatrics since its inception in 2006. She has been a nurse for 17 years and has served as a staff nurse in neurosurgical ICU, surgery and the recovery room.

Alsie Sydness-Fitzgerald, RN, CASC. Ms. Sydness-Fitzgerald is the chair of the ASC Association and participated in the development of the Certified Administrator Surgery Center credential. She has been involved in the ASC industry since 1976 and has built up outstanding experience in the clinical, business and management aspects of the ASC industry as the director of clinical operations for HCA's ambulatory surgery division.

Barry Tanner. Mr. Tanner is the president and CEO of Physicians Endoscopy. Before joining PE, he was the co-founder, CFO and COO of Navix Radiology Systems of Miami. Mr. Tanner also served as COO of HealthInfusion, a Miami-based provider of home intravenous therapy services.

Larry Taylor. Mr. Taylor is the president, CEO and founder of Practice Partners in Healthcare. He has 25 years of experience in healthcare delivery, management and physician relations. Prior to founding Practice Partners, he served as president and COO of the largest provider of ASC services in the United States.

Larry Teuber, MD. Dr. Teuber is the founder and physician executive of Black Hills Surgery Center, one of the country's most successful small surgical hospitals, and is a board-certified neurological surgeon. He is president of Medical Facilities Corp., and the founder and managing partner of The Spine Center in Rapid Falls, S.D.

David Thoene. Mr. Thoene is managing member of Medical Surgical Partners. Prior to that, he was the vice president of business development for Titan Health. He has 24 years of experience consulting for and developing ASCs along the West Coast. His background and expertise includes the turnkey development of ASCs, hospitals and medical office buildings. He has developed surgery center investments for physicians, academic medical centers and health systems.

Joyce (Deno) Thomas. Ms. Thomas is senior vice president for Regent Surgical Health. Before joining Regent, she served as the executive director of Loveland (Colo.) Surgery Center and worked for HealthSouth as a regional director of quality improvement and as an administrator.

George Tinawi, MD. Dr. Tinawi is a co-founder of Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization. He was a practicing physician in Mountain View, Calif., from 1986-2004. As a practicing physician, Dr. Tinawi developed a clear understanding of the business issues faced by physicians in today's challenging environment.

Kimberly L. Tude Thuot, MAOM, CMPE. Ms. Tude Thuot is the administrator of Yakima (Wash.) Ambulatory Surgical Center, a three-OR, physician-owned, multi-specialty ASC. Ms. Tude Thuot has been with YASC since Aug. 2009, and her career spans many specialties in healthcare. She began as a nursing and dental assistant before moving into administration at dental practices. She also worked as a general manager for a dental brokerage firm and as manager of an orthopedic group and a sports medicine group.

Jon Vick. Mr. Vick is the president and founder of ASCs, Inc., and has participated in more than 200 transactions on behalf of physician-

owned ASCs, GI centers, heart centers, surgical hospitals and the associated real estate. He has extensive experience in surgery center development, business planning, operations, valuations, sales, purchases and mergers and acquisitions.

George A. Violin, MD. Dr. Violin is a board-certified ophthalmologist and one of the three founding principals of Ambulatory Surgical Centers of America. He owned and developed two ASCs and a large, multiple-office ophthalmic practice in eastern Massachusetts.

Brice Voithofer. Mr. Voithofer is vice president anesthesia and ASC services for AdvantEdge Healthcare Solutions, where he leads the AHS anesthesia, pain management and surgery center division and is responsible for operations, client support and growth. Prior to joining AHS, Mr. Voithofer worked in sales, client management, consulting and operational roles at several leading firms in the medical billing and payor industries.

Dianne Wallace, RN, BSM, MBA. Ms. Wallace is the executive director and CEO of the Menomonee Falls (Wis.) Ambulatory Surgery Center, located a few miles northwest of Milwaukee. She has been with MFASC for 10 years. She has administrative experience in hospitals, home health, medical groups and ambulatory surgery. She served as past president of the Wisconsin Surgery Center Association and the MGMA ASCA executive committee.

Michelle Warren, RN, BBA. Ms. Warren is the executive director of Powder River Surgery Center in Gillette, Wyo. She began her career in healthcare as a surgical tech and soon pursed her nursing license and a bachelor's in business administration. She spent many years as an operating room traveling nurse, working mostly in trauma, orthopedic, spine and open heart specialties.

Michael Weaver. Mr. Weaver is a vice present of acquisitions and development at Symbion. He is a nationally recognized speaker on surgery center and physician-owned hospital acquisitions and development, and is a contributor to several national trade publications.

Robert Welti, MD. Dr. Welti is senior vice president and corporate medical director for Regent Surgical Health. He previously served as the medical director and administrator of the Santa Barbara Surgery Center and also was affiliated with Santa Barbara Cottage Hospital for 20 years. His experience includes both hospital-based surgery centers and physician-owned surgery centers.

Robert Westergard, CPA. Mr. Westergard is the CFO of ASCOA. Before joining ASCOA, he worked as the controller for Truman Capital Advisors. Mr. Westergard has an additional eight years of finance and accounting experience in the software, chemical and healthcare industries.

Kathleen Whitlow, RN, BS, CASC. Ms. Whitlow serves as COO for Blue Chip Surgical Center Partners, a position she was promoted to in Jan. 2010. She joined the company in April 2008 as a partner and vice president of operations. She has more than 25 years of experience in the medical/healthcare industry, working in a variety of capacities and positions. She has worked as an ASC administrator and consultant for Health Inventures and as a director of surgical services for a large national hospital system.

William H. Wilcox. Mr. Wilcox serves as the president and CEO of USPI. Before joining USPI, he served as CEO of United Dental Care, president of the Surgery Group of HCA and president and CEO of the ambulatory surgery division of HCA.

Donald Wilson. Mr. Wilson founded a predecessor to Cirrus Health in 1996 and now serves as Cirrus' CEO. Over the last 10 years, Mr. Wilson's

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focus has been exclusively devoted to the development of medical operations platforms and medically oriented real estate projects. In addition to his work in medical operations, he has participated in more than 40 medical real estate development projects including ASCs, specialty surgical hospitals, acute-care hospitals, medical office buildings, primary care clinics, radiation oncology units and other complex medical facilities.

David Woodrum. Mr. Woodrum was a co-founder of Woodrum/Ambulatory Systems Development (now ASD Management). He is a long-time ASC industry veteran and previously served as executive vice president and COO of the American Hospital Association.

Thomas R. Yerden, MHA. Mr. Yerden is president and CEO of TRY Health Care Solutions. He was the founder and CEO of Aspen Healthcare before selling it to National Surgical Care. He has helped to plan, develop, open and manage more than 75 ASCs in 26 states.

Cindy Young, RN, CASC. Ms. Young is the administrator of the Surgery Center of Farmington (Mo.), where she started as a staff nurse and moving into the administrator position in 2002. Prior to coming to the center, she was a nurse at a rural hospital for five years and served for two years in the OR at the hospital.

Joe Zasa, JD. Mr. Zasa is the co-founder and managing partner of ASD Management and leads the company's Dallas office. He specializes in strategic joint ownership arrangements with physicians, hospitals and strategic partners, as well as assisting the firm's clientele in raising capital to finance their ambulatory care requirements.

Robert Zasa, MSHHA. Mr. Zasa is a co-founder and founding partner at ASD Management. He is experienced in all phases of business development in multi-service ambulatory care facilities, group practices, ASCs and hospitals, including management, development, expansion, acquisition, ownership structuring and marketing.

Becky Zigler-Otis. Ms. Zigler-Otis is the administrator of the Ambulatory Surgical Center of Stevens Point (Wis.), a position she has held since Jan. 2008. Before coming to the center, she worked at Bay Area Medical Center in Marinette, Wis., where she held many positions over a 10-year period, including administrative director of process effectiveness, compliance officer, director of performance improvement and interim director of health information management.

J.A. Ziskind, JD, MBA, PhD. Mr. Ziskind is the founder and CEO of Global Surgical Partners, which focuses on developing and managing hospital/physician and physician-owned joint-ventured ASCs. He has been actively involved in Florida's healthcare industry over the past 35 years, having served as CEO of Cedars Medical Center and as a healthcare lawyer since 1984.

Greg Zoch. Mr. Zoch is a partner with Kaye/Bassman and has been involved with the marketing of healthcare organizations and services, and with the recruitment of healthcare professionals since 1990. His primary focus is on the strategic growth and staffing initiatives of client companies that develop, manage, consult with or own and operate ASCs and specialty hospitals throughout the United States.

Bryan Zowin. Mr. Zowin is the president of Physician Advantage, a healthcare management company based in Peoria, Ill. The company provides management services to a wide range of healthcare specialties including ASCs, anesthesia, orthopedics, urology, ENT, OB/GYN, facial plastic, pain management and primary care. ■

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CMS Issues Proposed Rule on Changes to Stark In-Office Ancillary Services Exception

By McGuireWoods Healthcare Practice

Section 6003 of the Patient Protection and Affordable Care Act, Public Law 111-148 (H.R. 3590) makes a change to the "in-office ancillary services" exception to the Stark physician self-referral law that impacts physician practices providing certain radiology services in their offices. In short, the change requires physicians making a referral for magnetic resonance imaging, positron emission tomography and computed tomography, or certain other radiology services in their offices, to make a disclosure to the patient that such services can be provided elsewhere and to include a list of alternative providers.

At the time PPACA was passed, there were questions as to how the new disclosure requirement would be implemented, including whether the law was self-effectuating or whether the Centers for Medicare and Medicaid Services would need to first promulgate regulations to make it effective. On June 13, 2010, however, CMS published a proposed rule that included answers to many questions about how CMS thinks the law is to be implemented (75 Fed. Reg. 40140-2.). This article briefly summarizes the proposed rule.

Background

The Stark physician self-referral law, 42 U.S.C. 1395nn, prohibits a physician from making a referral for designated health services to an entity with which the physician has a financial relationship, unless an exception is met. For example, where a group practice owns or operates an MRI scanner for the purposes of providing images to patients of the practice, Stark prohibits a physician member from making a referral to the group practice for the performance of an MRI scan, unless an exception is met.

The exception most commonly relied upon by physicians in this scenario is the in-office ancillary services exception, which is set forth at 42 U.S.C. 1395nn(b)(2). The exception generally requires that the services be furnished by the group practice in the same building in which the physician furnishes services (or in a centralized location), and be billed by the physician or group practice.

Section 6003 of PPACA requires the Secretary of Health and Human Services to include an additional requirement in the in-office ancillary services exception that, for any referral for MRI, PET, CT, or other radiology services identified by the Secretary, the referring physician must:

- Inform the patient in writing at the time of the referral that the patient may obtain the services elsewhere; and
- Include a written list of other providers who furnish the services in the area where the patient resides.

The proposed rule implements the new disclosure requirement by adding a new section to the text of the in-office ancillary services exception regulation at 42 C.F.R. § 411.355(b)(7). The elements of the new disclosure requirement as proposed by CMS are described in further detail below.

R. Brent Rawlings, JD, an attorney with McGuireWoods, says that it is unclear why this change has been enacted from the perspective of the Stark Law other than increasing transparency. "It doesn't limit the utilization of these services or prevent physicians from referring to themselves; it just adds another step in the process that could result in the referral being directed elsewhere," says Mr. Rawlings.

January 2011 effective date

CMS proposes that the effective date of the new disclosure requirement be Jan. 1, 2011. It was previously unclear to many observers and industry experts whether Section 6003 of PPACA was self-effectuating, and many were concerned that the new disclosure requirement had become effective on March 23, 2010, when PPACA became law, without any further guidance from CMS. However, CMS expressed its determination in the proposed rule that the provisions are not self-effectuating, and would not become effective until after CMS promulgates a final regulation.

Only MRI, CT and PET services trigger the requirement for the time being

PPACA requires that the disclosure requirement apply to MRI, CT and PET, and grants the Secretary the authority to expand the disclosure requirement to "other radiology services" that are designated health services under Stark. However, CMS indicates in the proposed rule that it is not inclined to expand the disclosure requirement at this time.

"While CMS has the authority to expand this regulation to other radiology services, the agency has given no indication in the proposed rule that it will look at expanding this to other designated health services under Stark," says Mr. Rawlings. "It may be taking a wait and see approach."

General Disclosure Requirements

CMS is proposing that the disclosure: (1) must indicate to the patient that the MRI, CT or PET services being referred may be obtained by a supplier other than the referring physician or his or her group practice; (2) must include a list of such other suppliers who provide the services being referred, as well as each supplier's address, phone number, and distance from the referring physician; (3) must be given to, and signed by, the patient at the time of referral; and (4) should be written in a manner sufficient to be reasonably understood by all patients. CMS proposes that this would apply to all in-office MRI, CT and PET referrals with no exception for referrals made on an emergency or time-sensitive basis.

List of Other Suppliers

CMS is proposing that the list of alternative sources of MRI, CT or PET services being referred include no fewer than 10 other "suppliers" located within a 25-mile radius of the physician's office location at the time of the referral. The term "suppliers," which under the statutory definition includes entities such as physicians, group practices, and freestanding imaging centers, is opposed to the term "providers," which under the statutory definition includes entities such as hospitals, critical access hospitals, skilled nursing facilities, and rehabilitation hospitals.

CMS has proposed that no providers would be permitted to be included on the list. CMS indicates that where there are fewer than 10 other suppliers within the 25-mile radius, it would be sufficient to simply list all suppliers that exist within the 25-mile radius. Under circumstances where there are no other suppliers within the 25-mile radius, CMS proposes that the referring physician would not have to provide a list, but must still disclose in writing to the patient that he or she may receive the imaging services from another supplier.

Documentation Requirements

CMS proposes to require referring physicians to maintain a record of the patient's signature on the disclosure notification, and to include such disclosure notification in the patient's medical record.

Conclusion

The proposed rule answers many questions regarding how the new disclosure requirement will be implemented, but raises a number of issues for physicians to sort out in administering and complying with the new law. For example, how will physicians identify available suppliers within the 25-mile radius? How will they determine what types of imaging services those suppliers offer?

Despite the remaining questions, it is important that providers determine if the new rule applies to them and if so, take steps to implement procedures for these notifications by Jan 1. "Failure to comply would mean a technical violation of the Stark Law, which could expose providers to penalties, overpayments and liability under the False Claims Act," says Mr. Rawlings. "Providers are liable under Stark Law regardless of intent, so they must take careful steps to comply." ■

3 Common Problems in Underperforming ASCs

By Leigh Page

Bill Heath, chief development officer at Practice Partners in Healthcare, helps turn around underperforming ASCs. Mr. Heath says these facilities are not "train wrecks" in serious financial trouble but they do have a few fundamental problems that he sees time and again. Here he lists three of the most typical problems and what can be done about them.

1. Overbuilt. Facilities tend to have too many ORs and a great deal of expensive amenities such as marble or hardwood flooring and a swanky décor created by high-paid interior designers. Unless ASC income is improved, "They're going to be paying for this the rest of their lives," Mr. Heath says. It's nice to have a few extra ORs, but they need to be filled so they can pay for themselves.

The center needs to recruit more physicians and raise volume to justify the OR space and pay back the loan for the marble flooring. Typically, the center is completely owned by one group practice without the necessary volume to do this. They need to recruit doctors from competing groups, but that can be difficult for a rival to do. A management company, however, can present itself as a neutral third party and offer an equal partnership and dedicated block times to the new group.

2. Overstaffed. "If I come in and see four nurses standing around the nurses station and only two cases in the OR for the morning, I know you are overstaffed," Mr. Heath says. Similarly, the ASC also doesn't need four people up front answering phones and doing the scheduling. These employees should learn to multitask, he says.

Rather than coming in and immediately firing a lot of the staff, which is very disruptive, Mr. Heath prefers finding other work for unneeded staff or putting them on part-time status. For example, some of the full-time nurses could be put into a pool and be called up on busy days.

3. Underpaid. The ASC is often being underpaid either because payor contracts were not negotiated well or because the kinds of cases done there are poorly reimbursed. In the case of payor contracts, for example, an ASC might not take the cost of implants into account.

The center needs to renegotiate payor contracts, based on reliable data on costs per case. More fundamentally, it needs to examine its case mix. There are certain cases that pay too little for the ASC to make money. The facility may decide to eat the loss, but then these money-losing cases need to be supplemented with high-paying procedures. ■

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

5 Best Practices for Compensating ASC Administrators

By Leigh Page

Harlan Schmitt, principal in Schmitt, Griffiths, Smith & Co., an accounting and business consulting firm of in Ogden, Utah, makes five points about compensation of ASC administrators.

1. Emphasize the positive. Focus on positive behavior as opposed to correcting problems. People respond better to praise than punishment. This means relying on bonuses, even if they are comparatively low. "Bonuses are as much psychological as they are monetary," Mr. Schmitt observes. He recommends setting the bonus at 6-15 percent of salary.

2. Cover what administrator has control over. "Hold the administrator responsible for things they can control," Mr. Schmitt says. For example, the administrator can have an impact on staffing, expenses, surgeon satisfaction, and prompt and attentive care.

3. Don't include uncontrollable factors. For example, it would be hard to increase volume at a time when surgery volume is falling and hospitals are hiring many of the unaligned physicians. "Try to be attentive to things where it is possible to make a difference," Mr. Schmitt says.

4. Create a system to judge all factors. Mr. Schmitt works with six different surgery centers and each one has a different way to judge all the factors in an administrator's performance. Some give different weights to each factor; others simply use checklists. Whatever method is used, it should be clear and comprehensible.

5. Focus on areas needing improvement. Determine the ASC's strategic objectives of for the next year and customize expectations accordingly. If the ASC's top priority is improving its collection rate, make that the chief factor for the review.

Learn more about Schmitt, Griffiths, Smith & Co. at www.sgscpa.com. ■

Spine and Sports Medicine Surgeons Top List of Highest Paid Orthopedic Specialties

By Rachel Fields

Here are seven statistics on orthopedic surgeon compensation by specialty from 2009 data, according to the MGMA *Physician Compensation and Production Survey: 2010 Report.*

1. The median salary for orthopedic surgeons specializing in spine surgery was $613,709.

2. The median salary for orthopedic surgeons specializing in sports medicine was $599,759.

3. The median salary for orthopedic surgeons specializing in hip and joint surgery was $564,139.

4. The median salary for orthopedic surgeons specializing in trauma surgery was $526,501.

5. The median salary for orthopedic surgeons specializing in hand surgery was $486,717.

6. The median salary for orthopedic surgeons specializing in pediatric surgery was $485,283.

7. The median salary for orthopedic surgeons specializing in foot and ankle surgery was $453,543. ■

Contact Rachel Fields at rachel@beckersas.com.

Critical ASC Benchmarks Not Routinely Tracked

By Rob Kurtz

Susan Kizirian, chief operating officer for ASCOA, identifies three sets of data ASCs often do not routinely track and explains why it is important that they do so.

1. Clinical hours per case. This assures that ASCs are staffing for quality of care while controlling payroll costs. On average, clinical man hours per case (mhc) should run 9-9.5 mhc. In busy GI, pain management or eye centers, the clinical mhc should be low (4-5 mhc), as patients move through the center quickly and efficiently. In a heavy orthopedic/spine center, the mhc would be higher, closer to 10. Centers with low volume may run higher hours, especially if the cases are spread out over the day rather than compressed.

2. Percent of ORs utilized. If there is low OR utilization, then this is an indicator ORs need to be compressed to reduce costs. This can be accomplished by running fewer ORs or reducing number of days opened. If there is high OR utilization or OR utilization is climbing, then this indicates the need to increase capacity by extending OR hours or opening on Saturdays, for example.

3. On-time starts for both surgeons and anesthesia providers. If some providers are wasting time by starting late, this can result in myriad inefficiencies and increase costs on many levels. If you have surgeons or anesthesia providers who routinely start late, you must address this and work out the issues immediately. Don't ignore the problem and then try to fix it down the road — this is difficult since the late start will have become an established pattern of "accepted" behavior. You will need to set it as an agenda item and get your leadership behind it if it is already an ingrained behavior. ■

Learn more about ASCOA at www.ascoa.com.

10 Statistics About ASC Administrator Compensation

By Rachel Fields

Here are 10 statistics about compensation of ASC administrators, based on a 2009 analysis of 174 licensed freestanding ASCs, according to the VMG Health *Multi-Specialty ASC Intellimarker 2010*.

Aggregate statistical analysis:

1. The mean salary for ASC administrators was $106,794.

Based on number of operating rooms:

2. The mean salary for administrators in ASCs with 1-2 operating rooms was $105,793.
3. The mean salary for administrators in ASCs with 3-4 ORs was $106,573.
4. The mean salary for administrators in ASCs with more than four ORs was $109,235.

Based on case volume:

5. The mean salary for administrators in ASCs with less than 3,000 cases per year was $106,811.
6. The mean salary for administrators in ASCs with 3,000-5,999 cases per year was $102,981.
7. The mean salary for administrators in ASCs with 6,000 or more cases per year was $110,000.

Based on net revenue:

8. The mean salary for administrators in ASCs with less than $4.5 million in annual net revenue was $100,942.
9. The mean salary for administrators in ASCs with $4,500,000-$6,999,999 in annual net revenue was $103,063.
10. The mean salary for administrators in ASCs with $7 million or more in annual net revenue was $114,700.

Information comes from VMG Health's *Multi-Specialty ASC Intellimarker 2010* benchmarking study. VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of VMG Health's *Multi-Specialty ASC Intellimarker 2010*, visit www.vmghealth.com/downloads.html. ■

8 New Taxes Coming From ObamaCare

By Leigh Page

R. Blake Curd, MD, interim executive director of Surgical Management Professionals in Sioux Falls, S.D., itemizes just a few of the new taxes and fees that will go into effect in the next few years, mostly as a result of the healthcare reform law.

1. Tax on high-cost insurance plans. There will be a new tax on insurance plans with a price tag of more than $10,200 for an individual or $27,500 for a family. But some union workers and employees of businesses with a preponderance of older or sicker workers will be allowed higher premiums.

2. Tax on high-income employees. Under health reform, an added 0.9 percent Medicare health insurance tax will be imposed on the employee share of money withheld from paychecks for individuals earning more than $200,000 in 2013.

3. Fees for not buying insurance. Anyone who fails to maintain "minimum essential coverage" for healthcare will pay a fee amounting to 2.5 percent of his or her household income over the threshold required for filing income taxes, or $695 per uninsured adult plus half of that amount per uninsured child under age 18, capped at $2,085 per household.

4. Fees on HSA withdrawals. Increase tax from 10 percent to 20 percent for non-medical early withdrawals from health savings accounts.

5. Changes in flexible spending accounts. Pre-tax dollars from flexible spending accounts cannot be used to buy over-the-counter drugs and the amount of money that can go into a FSA is being reduced from $5,000 to $2,500.

6. Fees for healthcare industry. There will be new fees on insurance companies pharmaceutical companies, device makers and tanning parlors. All these fees will be passed on to the public.

7. Capital gains tax. When the Bush tax cuts expire, capital gains taxes will rise from 15 percent to 20 percent, a 33 percent increase. There will be another 3.8 percent increase for high earners.

8. Rise in marginal rate. The marginal tax rate will rise from 35 percent to 39.6 percent when the Bush tax cuts expire. ■

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

Appeals Court Rules Health Plan Administrator Abused Discretion in Determining Discounted Rate was "Unreasonable," Case May Have Implications for OON Providers

By Lindsey Dunn

The United States Fifth Court of Appeals has upheld a district court ruling that a health plan violated the Employee Retirement Income Security Act by refusing payment to a hospital for health services it felt were not "reasonable and customary," according to court documents. Further, the court upheld a ruling that the plan administrator abused discretion in denying the claim.

The case stems back to 2003 when a member of the Little Rock, Ark.-based Crain Automotive's self-funded health plan received medically necessary heart stents and inpatient treatment at Baptist Memorial Hospital DeSoto (Miss.). The cost for the member's inpatient stay totaled more than $41,000. Baptist Health Services Group was a preferred provider for the health plan, and as such, agreed to discount charges for all inpatient and outpatient services by 15 percent.

BMHD submitted a claim to the health plan for the cost of services, minus 15 percent. However, when Larry Crain, owner of Crain Automotive, received the claim, he refused to pay it, believing it to be "excessive," according to court documents. Mr. Crain attempted to negotiate a greater discount with the hospital, but BMHD refused. The claim remained unpaid but was never officially denied, and in Aug. 2005, BMHD filed suit under ERISA for the recovery of the plan's benefits as well as legal fees and costs. The district court ruled in favor of the hospital, determining, among other things, the plan administrator incorrectly interpreted the plan and abused his discretion by arbitrarily determining the charges to be unreasonable.

The appellate court upheld the lower court's ruling. Specifically, the court ruled that the administrator incorrectly interpreted the plan when he took it to mean the plan could exclude *any* charges that exceeded "customary and reasonable" rates. The court ruled, instead, the plan covered any customary and reasonable rates *or* negotiated rates. Thus, because BMHD's claim included the negotiated discount, the health plan was required to pay it. Additionally, the court ruled, even if the interpretation had been legally correct, Mr. Crain abused his discretion by arbitrarily determining the charge was unreasonable, rather than supporting the determination with evidence, as case law requires.

While the disputed charges in the case fell within the payor's negotiated rates, the ruling has implications for payors' dealings with out-of-network providers because it upholds previous case law requiring "reasonable and customary" determinations to be based on factual evidence. "The ruling implies that payors may not uniformly adopt an unreasonably low fee schedule for OON services," says Scott Becker, JD, CPA, a partner at McGuireWoods. ■

Contact Lindsey Dunn at lindsey@beckersasc.com.

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Surgical Notes

3 Factors That Can Increase the Value of ASCs to a Potential Corporate or Hospital Partner

By Rob Kurtz

Jason L. Ruchaber, CFA, ASA, principal with HealthCare Appraisers, discusses three ways an ASC can increase its value when preparing for or considering a sale to a corporate or hospital partner.

1. Financial reporting. One of the most important things a center can do leading up to a sale is to get their financial house in order. An investment by a hospital or corporate buyers will involve financial due diligence to support the purchase price, and a well-organized, accurate financial package will typically translate into a higher comfort level with the entity's financial performance (and a higher purchase price). Generally, a buyer will want to review financial statements and operational reports for 3-5 years. In many instances there are inconsistencies in the financial statements from year to year due to changes in reporting software, accounting firms, practice administrator, etc. It is also common for centers to report on a cash-basis, which excludes certain balance sheet items such as accounts receivables, inventories, accounts payable, etc. When preparing for a sale, the center should have a CPA firm prepare accrual-based financial statements for the entity for 3-5 years, and for larger centers an audit of the most recent 1-2 years may be advisable. In addition to the standard financial statements, buyers will want to review certain key metrics and value drivers including but not limited to case volume by specialty, payor mix and physician utilization for owners and non-owners for the prior three years and for the interim period up to the valuation/transaction date.

2. Budget/forecast. In addition to a review of historical financial and operational performance, it is important to prepare a detailed 3-5 year forecast for your center. Though a review of historical financial information provides valuable insight to a buyer, valuation is ultimately the process of estimating the future economic returns that will be earned from the investment. It stands to reason, therefore, that entities that have gone through a thorough evaluation of their strengths, weaknesses, opportunities and threats — and put these into an actionable forecast for the business — will typically realize a higher value in a sale, as the projection may be perceived as less speculative a warrant a lower discount rate.

3. Payor contracts. During the historical financial review and preparation of the financial forecast, special attention should be paid to payor contracts. I routinely value centers that cannot tell me the last time they had a conversation with major payors about their contractual rates. In many cases, revenue is being left on the table that may readily be obtained. Getting paid more for the same case volume is a surefire way to increase the value of your center. On a related topic, centers with significant out-of-network revenue should evaluate the potential implication of going in-network with one or more of their payors. Though out-of-network reimbursement is significantly higher in most cases, the risk associated with sustaining this level of reimbursement is similarly very high. Risk and value are inversely related, and though the out-of-network benefit is not likely to go away immediately, an understanding of the revenue at risk from these payors can help to support a higher value. In some instances it may make sense to try to secure contracts with payors, and though this may result in lower revenue, it may also result in higher volume and value due to the risk/value relationship. ■

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

Setting Share Price for Prospective Physician-Investors

By Leigh Page

Greg Koonsman is a senior partner at VMG Health, a valuation and financial advisory firm.

Q: My ASC is looking to bring in some physician-investors but we think the fair market value of what they would need to invest may scare off some good candidates. What can we legally do to lower the value and attract these physicians?

Greg Koonsman: There is nothing you can do legally to reduce the value of the ASC. But keep in mind that a minority shareholder — as this prospective shareholder would probably be — would have 30-40 percent lower payment on a pro-rata basis than a major shareholder, such as a hospital or management company.

That's because a smaller shareholder would have less influence over the operation. There is little this physician would be able to do, as an investor, to hurt or harm the ASC. Therefore the amount of money this physician would be required to invest would be lower per share than what a large investor would pay. The rate for the small investor would be something like four to 4.5 times EBITDA versus about 6.5 times for a large investor.

Other factors could drive up the price per share, such as age of the current physician-owners. Physicians approaching retirement are liable to leave the ASC soon, puttig the center's future into question. Another factor would be concentration of ownership in a few hands. If something happened to these investors, it would have grave repercussions for the fate of the ASC. Likewise, a single-specialty ASCs would have a higher risk, since it is more exposed to changes in reimbursement for the one specialty than a multi-specialty ASC that is reimbursed across a diversity of medical specialties. ■

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

Study: Dramatic Shortage of Anesthesiologists, Surplus of Nurse Anesthetists Projected by 2020

By Rob Kurtz

A study by RAND Corp. finds a current shortage of 3,800 anesthesiologists in the United States and projects a possible shortage of 12,500 anesthesiologists by 2020, according a news release from the American Society of Anesthesiologists.

Assuming demand for anesthesiologists' services grows at the rate of 1.6 percent, RAND's baseline projection, the 2020 shortage would be close to 4,500 anesthesiologists; but if the growth in demand is assumed to be 3 percent to account for the aging population, the shortage could reach 12,500 anesthesiologists.

RAND also identified a current shortage of 1,282 nurse anesthetists, but that figure will become a surplus of 8,000 by 2020 under the 1.6 percent growth rate projection and a surplus of 15,000 nurse anesthetists under the 3 percent growth rate projection.

"The projected shortage of anesthesiologists suggests that this country will soon face a gap in anesthesiology services that is just as important to Americans' health as the projected physician gap for primary care services," said Mark A. Warner, MD, president-elect of the American Society of Anesthesiologists, according to the news release. "Healthcare facilities have indicated that as a growing proportion of their patients become older and sicker, they will need more anesthesiologists providing the full scope of care that patients will need before, during and after their surgeries."

The study also determined that anesthesiologists work 50 percent more total work hours than nurse anesthetists and they provide more services to critical ill patients and those with acute and chronic pain. ■

Contact Rob Kurtz at rob@beckersasc.com.

Critical Guidance for Complying With Anesthesia Infection Control Rules

By Rob Kurtz

One of the biggest challenges facing the practice of anesthesia are recent changes in infection control rules, according to Clifford Gevirtz, MD, an anesthesiologist with Somnia Anesthesia Services who practices throughout New York and Long Island, N.Y. Some anesthesiologists may be struggling with the new rules, as is evidenced by recent news of violations throughout the country, including a report stating that 25 percent of ASCs in New Jersey are reusing single-dose vials, a violation of CMS standards.

Dr. Gevirtz highlights some of the major areas in which some anesthesiologists may be failing to comply with the rules and discusses what they and their organizations might do to help to keep them in compliance.

1. Follow the guidelines in USP <797>. U.S Pharmacopeia released voluntary guidelines in a publication titled " Guidebook to Pharmaceutical Compounding — Sterile Preparations," also known as USP <797>. "While USP says it's a voluntary guideline, in a court of law, when dealing with Medicare, other insurers and agencies, the guidelines are considered to be the standard of care," Dr. Gevirtz says. "If we dismiss those stakeholders by not following USP<797>, we're risking major problems. It's really good practice to follow them."

2. All medications should be drawn into labeled syringes. On an anesthesia work station, propofol is the only substance that looks like a white, milky substance. Since there is no other substance to confuse it with, the need to label every syringe with propofol may have some anesthesiologists questioning the necessity of that requirement, Dr. Gevirtz says. But according to USP <797>, they must be labeled. "The real reason is not so much to identify the syringe as containing propofol but rather to give practitioners the opportunity to date it and time them so everyone knows exactly when this was drawn," he says.

3. Do not leave medication unattended. In the past, anesthesiologists would set up their rooms, draw up all of the drugs for their anesthesia cart and prepare for a case before seeing the patient in the pre-op area or performing other tasks prior to the procedure. But according to <797>, the new requirement mandates that medication never, at any point, be left unattended. "It's

definitely a different way of thinking," Dr. Gevirtz says. "Usually what has happened in the past is that syringes would be drawn up for an entire day. If you had 10 cases, you might draw syringes and label them for narcotics, muscle relaxants, etc. — you'd really get everything ready to go in advance of the cases. You'd draw them up and administer them as each case came into the room. That is no longer an acceptable way to work."

The guidelines also state that the medication must be disposed of if it's not used within an hour of being drawn. "As anesthesiologists, we work with surgical staff to decrease turnover time," he says. "But now we need to slow down a bit and draw medications for each case as it occurs, and not in advance of the three or four cases that are in the queue."

4. Unit dose medications are prohibited from use for more than one patient. Anesthesiologists who take a single vial of propofol and draw it into four or five syringes are in violation of the rules because the labeling on the drug states it is for "single-use only."

"When carrying out the induction of anesthesia for a simple case, anesthesiologists may use 20ccs. If that's pulled from a 100cc vial, 80ccs are unusable because you can't go back into that vial," he says. "It's fire it once and that's it. I can see where that might be considered wasteful.

"That scenario in this already tight propofol environment exacerbates the challenge of trying to run an OR using propofol appropriately," he says. "Since the supply is already constrained, single use makes it more constrained. In order to get more propofol from distributors, we're ordering unusual sizes — 50cc, 100cc sizes — to accommodate simple cases but it seems some practitioners are still divvying up the vials, which is absolutely not allowed according to USP."

5. Syringes should only be used once. The strict letter of the law according to the FDA and USP mandates that a syringe is a single-use device, Dr. Gevirtz says. Once you inject a medication and have used the syringe, you must throw away the syringe even if you want to use it again for the same drug and patient.

"It has not been uncommon to find people who would draw a muscle relaxant, give the patient 3ccs or 4ccs and empty the syringe. Now practitioners must start with a fresh syringe even if it's used on the same patient," he says. "It's a real paradigm shift from how we've practiced in the past. We really have to be fastidious in order to avoid running afoul of Medicare guidelines."

Tips for ASCs to comply with infection control rules

1. Check anesthesia cart in the morning. An administrator of an ASC should open the drawers of the anesthesia cart before the anesthesiologists arrive to see if it already contains IV bags filled with drugs or syringes all of which were drawn up the night before. "You have people preparing for the next day," Dr. Gevirtz says. "They may have already drawn up syringes for the first case in the morning to get a jump on things, so you must do an early morning audit."

2. Observe anesthesiologists during cases. The circulating nurse should observe anesthesiologists' processes to identify and then report any possible violations. "Observe them drawing up medication and ask the following questions: Are they reusing syringes, are they throwing away the things they're supposed to dispose of," Dr. Gevirtz says. "While nobody wants to be in the role of monitor or tattletale, the reality is that sloppy practice has to be identified quickly before it imperils the ASC and the patient. It's important to conduct ad hoc mini audits every now and then."

3. Take proactive approach to correcting violations. Once any red flags are observed or reported, the ASC should document the problem and explain to the practitioner that such a practice is not acceptable, Dr. Gevirtz says. "Have an in-service with the anesthesiologists during a lunch break. If you start to see a bad pattern, keep documenting it. Unfortunately, if the issue is not resolved, you may need to part ways for everyone's good and because it's the law. If a Medicare inspector pulls open a drawer and finds labeled syringes and open IV bags, your ASC will be in big trouble." ■

Contact Rob Kurtz at rob@beckersasc.com.

5 Trends for GI ASCs From Barry Tanner of Physicians Endoscopy

By Leigh Page

Barry Tanner is president and CEO of Physicians Endoscopy, which specializes in development and management of freestanding, single-specialty ASCs. He identifies five trends for GI-driven ASCs.

1. Slight decline in volume. Volume was down at the beginning of the year, then it went back up and now it's down again slightly. About half of Physicians Endoscopy centers are down 1-2 percent in volume and the other half are flat or up. "I hate to call it a trend yet, but it could shape into one," Mr. Tanner says. "As joblessness lingers, savings are starting to run out and we're seeing a more conservative decision process on the part of patients for what they see as elective procedures."

2. More patients with high-deductibles. "In this period of uncertainty, with ObamaCare on the horizon, employers are using higher deductibles to pass on health insurance rate increases to their workers," Mr. Tanner says. He believes the trend toward higher deductibles can only harm volumes.

3. More colonoscopies next year. The elimination on Jan. 1 of the Medicare copayment for elective colonoscopies will have a very positive impact, Mr. Tanner says. ASCs need to reach out to family physicians who are responsible for many of the colonoscopy referrals. "We need to point out the risks of colon cancer," he says. "In past years we haven't looked as aggressively at colonoscopies."

4. More physician interest in ASCs. As physicians see their reimbursements squeezed, Mr. Tanner says they need to supplement their business through ownership in an ASC. "A great proportion of their reimbursements are at or near Medicare levels," he says.

5. New ASC growth in CON states. Endoscopy centers have not yet reached the saturation point, particularly in states with tough certificate of need regulations. Some of these states have severely restricted ASC development in the past, but Mr. Tanner believes CON authorities are looking more favorably on ASCs because they are less costly than HOPDs. ■

Learn more about Physicians Endoscopy at www.endocenters.com.

5 Financial Statistics About GI in ASCs

By Rob Kurtz

Here are five financial statistics about GI and endoscopy in ASCs, according to VMG Health's *2009 Intellimarker*.

1. GI/endoscopy makes up an average of 25 percent of cases in all ASCs; 29 percent in ASCs with a net revenue of less than $4.5 million; 20 percent in ASCs with net revenue from $4.5 million to less than $7 million; and 21 percent in ASCs with a net revenue of $7 million and higher.

2. The average surgery center performs 4,869 cases annually, which would average to about 1,217 GI cases annually for all ASCs; 1,412 cases in ASCs with a net revenue of less than $4.5 million; 974 cases in ASCs with net revenue from $4.5 million to less than $7 million; and 1,022 cases in ASCs with a net revenue of $7 million and higher.

3. Northeast ASCs have the highest percent of GI cases of their total case mix at 35 percent. Southeast ASCs have the lowest at 17 percent, which is equal to the percentage of total case volume for ophthalmology and pain management.

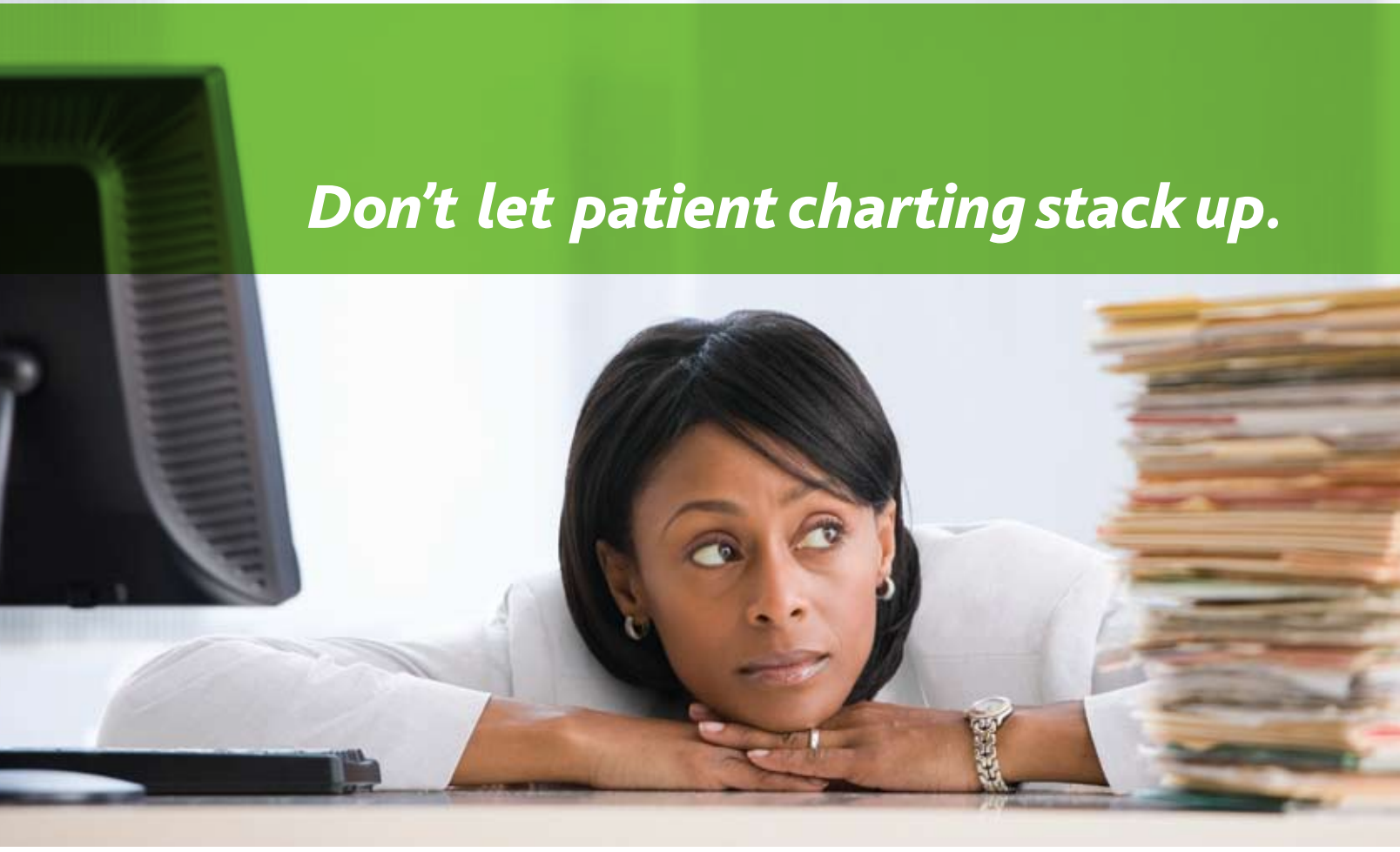
4. Here is the median gross charges per GI/endoscopy case by region of the country:

- All facilities — $3,040
- West — $2,856
- Southwest — $3,289
- Midwest — $3,593
- Southeast — $2,850
- Northeast — $2,699

5. Here is the median net revenue per GI/endoscopy case by region of the country:

- All facilities — $790
- West — $889
- Southwest — $950
- Midwest — $658
- Southeast — $653
- Northeast — $779 ■

Information comes from VMG Health's 2009 Intellimarker *benchmarking study. VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of VMG Health's* 2009 Intellimarker, *visit www.vmghealth.com.*



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6 Things Your ASC May Not Know About Billing and Coding

By Rachel Fields

As president of National Medical Billing Services in St. Louis, Mo., one of the largest ASC billing companies in the country, Lisa Rock is well-versed in the mistakes ASCs make concerning billing and coding. Here she discusses six things your ASC may not know about billing and coding that can prevent rejected claims and save you money.

Billing:

1. HIPAA-exempt carriers don't have to use standard codes. Ms. Rock says your ASC should be aware of carriers who don't have to follow standardized coding practices because of HIPAA exemption. "Worker's comp carriers, small carriers and other carriers that are HIPAA-exempt can come up with homegrown codes, and you're not going to get paid if you use standardized codes," she says. To avoid having your claims rejected, make sure you know whether your carrier is exempt. "You may have to do some digging," Ms. Rock says.

2. You will lose money if your codes aren't in the correct order. Once you've referenced the operative report and you know which codes to bill, it's essential to put your codes in the right order, Ms. Rock says. Make sure you record your codes from highest reimbursement to lowest reimbursement so that you don't lose money unnecessarily. For example, Medicare will reduce the procedure you list second by 50 percent, so if you have one procedure listed at $1,000 and another listed at $750, you want to take the cut on the $750 procedure so that you lose less money.

It may be possible to correct your reimbursement if you make this mistake, but Ms. Rock recommends doing it right the first time to save yourself a lot of hassle. "It's always possible [to fix it], but if you sequence properly the first time, you won't have that problem on the back end," she says.

3. Medicare will not reimburse for patients treated in a skilled nursing facility. Ms. Rock says many ASCs don't realize that Medicare will not reimburse for a patient who is treated in an ASC that resides in a skilled nursing facility. "It doesn't matter what you do," she says. "Medicare will absolutely not reimburse any procedure for these patients in an ASC."

ASCs that have previously treated patients from skilled nursing facilities will most likely be subject to reimbursement takebacks for procedures that occurred since Jan. 1, 2008. While there's nothing ASCs can do to combat this decision, you should still prepare yourself for takebacks by identifying your skilled nursing facility patients.

4. Understanding your managed care contract is essential. Ms. Rock says your biller should have a copy of every managed care contract and understand the details of each one. "You need to understand how long you have to submit a claim, how long you have to review an adjudicated claim, what the payment methodology is, why a carrier would reduce multiple procedures and how to appeal a claim that hasn't been paid correctly," she says. Your ASC should use your managed care contract to bill out, post payments and follow up, and you need it in every point of the revenue cycle. For example, by reading your managed care contract carefully, you will avoid taking an orthopedic case with a $2500 implant attached when you have a carrier that doesn't reimburse implants.

This problem can be solved through simple research. Make sure you have your contracts on hand and refer to them frequently. Understanding the ins and outs of your contract can help you save money and make you more aware of which procedures are most profitable to your center.

Coding:

1. ASCs can bill for different colonoscopy techniques in the same session. For example, if your ASC removes one polyp with a snare technique and a separate polyp for a hot biopsy, you can report two different codes for the session, Ms. Rock says. "We've talked to many physicians who aren't aware, so they may not even be reporting that they're doing these things," she says. However, if you remove multiple polyps with the same technique, you can still only report it once.

2. Controlling pain post-surgery is considered part of the global surgical package. Medicare will not allow you to bill for a post-operative pain block provided by the surgeon, Ms. Rock says. The NCCI Policy Manual states, "Medicare global surgery rules prevent separate payment for post-op pain management when provided by the physician performing an operative procedure." National Medical Billing Services believes that the pain block, if performed by the anesthesiologist, should be billed by the professional side only and not the ASC. ■

Learn more about National Medical Billing Services at www.nationalascbilling.com.

Fight These Third-Party Payor Contract Clauses

By Rob Kurtz

Kevin Dowdy is director of managed care for Meridian Surgical Partners.

Q: Our ASC is currently negotiating our managed care contracts. What are some clauses payors try to include in contracts that we should watch for and fight?

Kevin Dowdy: Any language where the payor has a different timeline as compared to the facility. An example is the facility must notify the payor of payment discrepancies within 90 days while the payor has the right to audit claims up to one year. All timelines must be mutual beneficial.

Make sure the dreaded, "Plan has the right to make changes to the fee schedule upon notice to provider" language is removed. With respect to the fee schedule particularly, but in general, the payor can't have the right to make unilateral changes. All changes must be negotiated prior to notification.

The ASC should fight any termination language that is tied to the renewal date of the agreement. Make sure the termination language can be at anytime upon the appropriately negotiated timeframe. If this isn't done, then the termination period could easily become a year when it should be no more than three months. ■

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

Implant Costs: Why ASC-Physician Collaboration Makes Sense

By David Forquer, Clinical Strategist, Enterprise Solutions, Amerinet

In order to survive and thrive in today's environment, it is essential for ASCs to control the cost of implants in addition to handling more complex cases. To this end, facilities, physicians and group purchasing organizations (GPOs) must work together to find a way to control implant costs. These physician engagement opportunities coupled with other physician collaboration incentives, can significantly improve quality and reduce operational costs.

A new model: ASCs and outpatient procedures

As fee schedules are slashed, physicians will have a renewed interest in outside investments, such as joint ventures with ASCs. ASC investments provide physicians efficient use of their time, financial incentives and allow them to have oversight and input into the safe care of their patients.

Some of the new technology products that are highly physician choice – spine procedures, prostate procedures, colonography – are all procedures that were traditionally done at the hospital as an outpatient and are now moving towards the ASCs. For example, wrist fractures are very common in young and old alike, and a very high percentage of those are being done as an outpatient.

The spend on orthopedic implants and cardiovascular products is increasing at a much higher rate per year as far as dollar spend and as a percentage spend vs. medical/surgical. This highlights the need to put attention into the orthopedic and the cardiovascular product areas if those procedures are being done in your centers. Also, with current economic conditions demanding even more stringent pricing controls and suppliers willing to protect their bottom lines by being more willing to discuss "deals," now is the time to engage both physicians and suppliers in those product areas. Suppliers want, and are willing to lock in business for a longer length of time at more competitive prices, or they are willing to bid for an opportunity to gain market share.

Engaging the doctors

How do you get a doctor engaged? Relevant, actionable data is the basic building block for an organization's economic direction and also provides the facts and evidence needed to communicate the realities facing every stakeholder. Efficient value analysis processes will ensure that all bases are covered with regard to high-tech and high-touch healthcare products, including reimbursement, safety, education and clinical credentialing, product standardization and appropriate utilization. Once physicians see this type of data, and especially if they have a stake in the ownership of your facility, they will engage the suppliers in getting those costs lowered. What this also allows a facility to do is benchmark those costs versus a database that shows where they need to be with that particular supplier on a particular product. Also based on credible data, facilities can work to develop custom contracts based upon a surgeon's supplier choice and the quality outcomes they want to have for their patients.

In regard to overcoming physician loyalty to a particular brand, again, it involves a thorough value analysis process that looks at the risk assessment and quality of care. Evidence-based protocols must then be established in collaboration with physicians. Capitated rates need to be coordinated with protocols.

Facilities must also take a very aggressive role in prohibiting sales representatives from going into the surgery suite. If an ASC is really going to control cost and protect patients' privacy, suppliers should not be in the operating rooms.

In terms of physician incentives, ASCs that are owned or have a joint venture with physicians have a distinct advantage in incentivizing their physicians. In addition to their ownership models, as part of the collaborative implant reduction process, ASCs may want to consider engaging a company similar to Surgical Implant Services. This GPO is farmed as an LLC and is owned by the implanting physicians. The formation of this LLC legally provides physicians with ancillary income through negotiations of best in region pricing for implants.

Transparency in choices and reporting

The value analysis process must also include a tracking and outcomes evaluation component. Outcomes tracking by the value analysis team will evaluate clinician adherence to approved standardization programs, quantify the savings gains, build credibility by attending to any unforeseen issues, and establish a new baseline for the next initiative. Proactive tracking also allows the team to ensure that protocols are working properly and make adjustments if necessary.

Collaboration and cooperation will ensure physicians function as true owners of your ASCs, not as individual practitioners. Physician collaboration, in conjunction with a culture of employee ownership of processes, including the value analysis processes grounded in good business acumen, will assure your ASC is successful. ■

Learn more about Amerinet at www.amerinet-gpo.com.

New Jersey DHSS Outlines 3 Key Steps to Comply With Use of Single-Dose Medication Vials Rules

By Jaimie Oh

The New Jersey Department of Health and Senior Services recently reported a 25 percent non-compliance rate with CMS standards that prohibit multiple uses of single-dose medication vials. Such standards were set in place in order to better control infection outbreaks.

Alison Gibson, the director of assessment and survey for the New Jersey Department of Health and Senior Services, outlines three key steps ASCs can take to avoid this problem.

1. Develop policies and procedures for staff and physicians that reflect national standards and CDC recommendations.

2. Train staff on those policies and procedures. Federal requirements and state licensing standards require each facility to have an infection control program that is under the direction of a designated and qualified professional who has training in infection control. Infection control professionals are people with specific training and certification in surveillance, prevention and control of infections. This person could be a nurse on staff who also has the necessary training and certification, but there's no requirement that the person be a nurse.

3. Make sure those policies and procedures are being carried out, which is a quality assurance issue. ASCs that wish to participate in Medicare are required to have quality assurance program in which the facility chooses what things to watch for. If a problem is identified, such as reusing single-dose vials, then that program should monitor the issue to make sure staff members are following policies and procedures properly. ■

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Guidance for Proper Peer Review: Insight From Dr. Jack Egnatinsky of AAAHC

By Rob Kurtz

Jack Egnatinsky, MD, medical director of the AAAHC and a retired anesthesiologist, provides guidance for what he has seen as a challenge for many ASCs: peer review, which is a sub-chapter in the AAAHC standards manual.

Dr. Jack Egnatinsky: Very often, all that we see within the organization's policy for completeness of peer review is review by nurses or medical records clerks to meet the requirement for chart completion and monitoring, most commonly performed every 30 days.

Simply stated, **peer review requires review by peers**. Ideally, that should be physicians of the same specialty reviewing others in that specialty, but that is not always possible. For any meaningful peer review, physicians should review other physicians' documentation and performance **utilizing criteria established by the specialist**. Results of peer review should be discussed with the reviewed physician and should be presented to the governing body periodically **to be used as one criteria when time for reappointment/recredentialing comes up**. Other providers, besides physicians, should also undergo peer review. As a general principle, physicians must review physicians, but they also can review other providers, such as RN first assistants, CRNAs, etc., and these individuals can review each other, but they cannot review physicians. Nursing peer review is becoming more common, but is not yet widespread. ■

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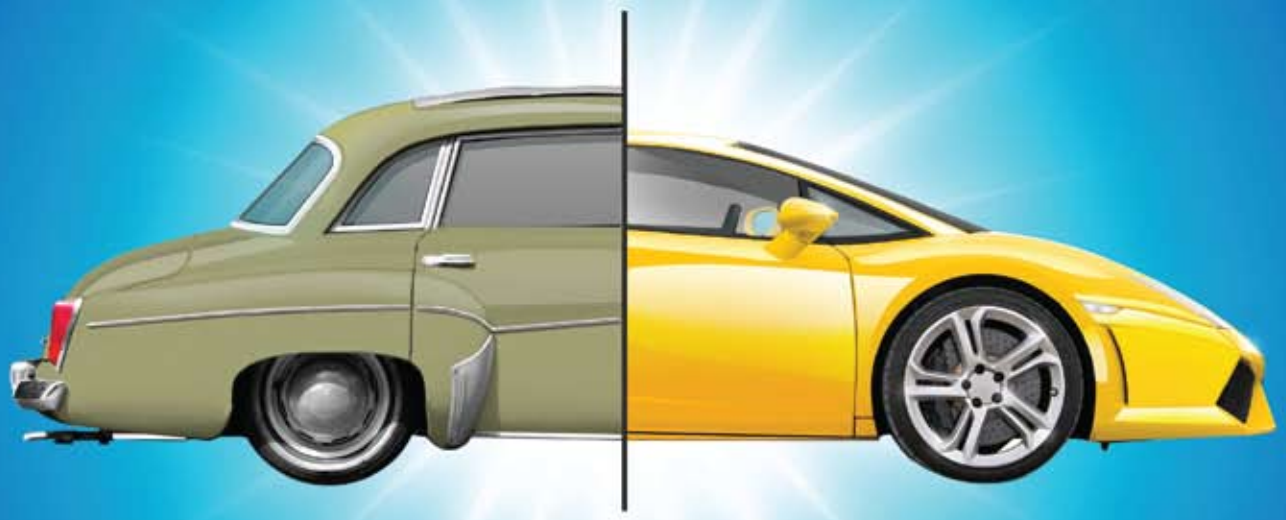

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