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BECKER'S ASC Review

PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

27 Tips to Get Paid Fairly By Medicare and Third-Party Payors

By Rob Kurtz

The decision by CMS to move ASCs to the new Medicare payment system created numerous opportunities and challenges for reimbursement. Add this major changes to the many issues ASCs were already facing, and getting the payments you want, and rightly deserve and earn, from both Medicare and third-party payors, is no easy task. Here are 27 tips to help you make the most of your reimbursement opportunities and overcome the challenges you face.

Medicare

The new Medicare payment system may not have been a welcome change for all specialties, but CMS is at least trying to keep providers happy with fast claims processing and reimbursement. While this aspect of the new system is going smoothly, there are still a few tips for ASCs to help ensure they are capturing all of the reimbursement owed to them by Medicare.

1. Stay informed of payment system updates.
The move to the new ASC/outpatient prospective payment system (OPPS) brought with it a new challenge — the possibility of monthly and quarterly updates to the system, says Judie English, vice president of business operations and a partner in Surgery Consultants of America and Serbin Surgery Center

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41 Things You Should Know About ASCs

By Scott Becker, JD, CPA, and Rob Kurtz

There are many misconceptions about ASCs and the best ways to run them. This is a list of 41 things that you should know about surgery centers.

1. CMS's new rates are viable. Last year, we wrote that the new Medicare rate for surgery centers would generally be negative. After further study, and a better understanding of the political and economical impact, we tend to disagree with this earlier conclusion. The new rates from CMS are generally positive for higher-acuity procedures and negative for lower-acuity procedures. There are several winners and several losers under the new rates. Overall, the less your center is heavily focused on lower-acuity procedures like gastroenterology, pain management or ophthalmology, the more the overall impact of the changes is likely to be positive or of minor ultimate impact. Further, the changes should provide greater stability for several years to surgery centers. Finally, the changes' hard-wired-in concept of surgery centers being reimbursed 65 percent of hospital outpatient departments provides a tremendous political card to be used constantly for surgery centers in Washington, D.C., and other places. In essence, each time a procedure is done in the surgery center, there is almost no question that the federal Medicare program is saving money.

"At Practice Partners facilities, we are, as anticipated, experiencing increased reimbursement in those cases with higher acuity — specifically orthopedics," says Larry Taylor, president and CEO of Practice Partners in Healthcare. "Our pro forma materials for centers reflect the anticipated phased-in reimbursement for both the increases and decreases depending upon specialty. We believe that there is continued success in the specialty of pain intervention and will continue to experience excellent margins."

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See conference brochure on page 31.

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Empowering Healthcare

Letter From the Editor: 5 Legal Developments; 15th Annual ASC Conference; Launch of *The Hospital Review*

This continues to be a fascinating time in the surgery center area. There continues to be growth, although it is slightly slower. There is also an increasing variety of legal issues and concerns that are facing ASCs. There have also been a number of interesting legal developments.

Current legal developments. Current legal developments include these issues:

1. Advisory opinion. The Office of Inspector General recently issued an advisory opinion relating to holding ownership interest in a center by non-safe-harbor-compliant physicians. There, the OIG highlighted heavily several different prophylactic steps being taken by the surgery center to avoid indirect referrals.

2. Pain management. CMS and the OIG continue to have great concern as to the extent of pain management being performed nationally.

3. Imaging. The OIG now believes that imaging costs more than the Iraq war. In all seriousness, each month a new report seems to be issued by the government that highlights the extent of their concern about the overuse of imaging. This has led to several different new initiatives aimed at reducing physician-owned imaging.

4. Syndicate-and-flip transactions. Recently, we have seen situations where parties examine the concept of selling units on one day and then having those physicians as well as others sell their units to a national company on the next day. This type of transaction structure can cause great concern from an Anti-Kickback Statute perspective. It can have the net effect of letting physicians own shares for almost no cost because they are able to sell half their units and profit on that sale and thereby almost wholly offset the cost of investing.

5. Electronic health records. The hospital sector and physician sector continue to exponentially increase the extent by which electronic health records are becoming the norm. The OIG issued an advisory opinion that sets forth the kinds of linkage modules that do not constitute competition. The OIG has also issued an exception to the Stark Act to allow for the joint sharing of the development costs and implementation cost of EHR. There, physicians must pay 15 percent of the costs. A detailed discussion of these issues will be set forth in the Nov./Dec. *Becker's ASC Review*. It can also be found on the Web site at www.BeckersASC.com.

15th Annual ASC Conference, Oct. 23 to 25. We have our 15th Annual Conference this fall, in association with the ASC Association and the Ambulatory Surgery Foundation. We have an outstanding program. To register, take any of the following actions.

1. contact the Ambulatory Surgery Foundation at (703) 836-5904;
2. register on line at www.ascassociation.org/chicagooct.cfm; or
3. send an e-mail to registration@ascassociation.org.

Here are some of the sample topics that are being discussed at that meeting. Overall, there will be more than 75 presentations. We expect an outstanding turnout.

- "Gastroenterology, ENT, Ophthalmology, Pain Management and Bariatrics in ASC — What Works and What Doesn't" — Anne Roberts, RN, Surgery Center of Reno; Steve Blom, RN, MAHSM, CASC, San Antonio Surgery Center; John Poisson, executive VP, Physicians Endoscopy; Doug Hoisington, DO
- "Successful Structuring of Physician/Hospital ASC Joint-Ventures" — Joe Zasa, CEO, Woodrum ASD; Deanne Manchester, USPI; Amber Walsh, JD; Elissa Moore, JD
- "Orthopedics in ASCs — What Can You Expect in the Next Five Years" — John Cherf, MD, department of orthopedics, The Neurological & Orthopedic Hospital of Chicago
- "How to Reduce Staffing Hours Per Case" — Lisa Cooper, administrator, El Camino Surgery Center; Mary Sturm, SVP of clinical operations,

Surgical Management Professionals; Michelle Smith, director of clinical operations, Nueterra
- "The State of the Union for ASCs" — Kathy Bryant, JD, president, ASC Association
- "Making Urology a Success in Your ASC" — Bill Mobley, MD, Urology Specialists; Herb Riemenschneider, MD, Knightsbridge Surgery Center
- "How to Turn Around Your ASC" — Luke Lambert, CEO, and Tom Bombardier, MD, chairman, Ambulatory Surgical Centers of America
- "Can Two Centers Thrive by Merging?" — Tom Yerden, CEO and founder, TRY Health Care Solutions
- "Practical Case-Costing and Benchmarking for ASCs" — Alsie Sydness-Fitzgerald, RN, chairperson, ASC Association
- "Assessing the Profitability of Different Specialties in ASCs" — Luke Lambert, CEO, ASCOA
- "From ASC to Hospital — What Are the Pros and Cons of a Conversion to a Hospital?" — Brett Gosney, CEO, Animas Surgical Hospital
- "Will the Stark Laws Close Down ASCs?" — Amber Walsh, JD, and Melissa Szabad, JD, McGuireWoods
- "10 Key Statistics You Should Review Each Week" — Boyd Faust, CPA, CFO, Titan Healthcare
- "How to Recruit and Retain Great Directors of Nursing and Great Nursing Staff" — Lisa Cooper, Mary Sturm, Michelle Smith
- "Safe Harbor, OIG Work Plan and Out-of-Network Issues" — Scott Becker, JD, CPA, and Scott Downing, JD, McGuireWoods
- "Key Steps to Establishing ASCs" — Bill Southwick, president and CEO, Healthmark Partners

The Hospital Review. We are excited about the growth in ASC Communications. We are launching *The Hospital Review — Business and Legal Issues for Hospital Leadership* this month and its related Web site. Also, the *Becker's Orthopedic and Spine Review* will be launched in January.

Should you have questions, please contact myself at 312-750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

Letter From the Editor: Surgeons' Wish List Is Simple: Convenience, Efficiency, Ease of Practice

Within hospitals, surgeons are the least satisfied of all specialty physicians, according to a new Press Ganey Associates report. The firm surveyed 27,671 physicians practicing at 302 hospitals/facilities nationwide between Jan. 1 and Dec. 31, 2007 to compile *Hospital Check-Up Report 2008: Physician Perspectives on American Hospitals*.

What is it that's prompting the low surgeon satisfaction scores? If you said problems with the OR, pat yourself on the back. According to the report, in the OR specifically, surgeons are least satisfied with the ease of scheduling inpatient surgery (a satisfaction score of 72.3). Ease of scheduling outpatient surgery isn't far behind: Physicians gave that factor a 72.4 satisfaction score.

"Scheduling cases in the OR is a chore and not surgeon friendly," says one physician quoted in the report. "Often, the surgical consult is not timely at all — they are not placed during work hours but late at night when the patient has been in the hospital all day."

They are slightly happier with how up-to-date the medical equipment is (75.5), and are much happier with anesthesiology services overall (80.4). While a score is not listed, it seems physicians are also not entirely satisfied with the efficiency of hospital ORs.

"We should have an 8:00 a.m. 'cut time,'" says a

surgeon quoted in the report. "We do not. Since complaining has fallen on deaf ears, perhaps the competition of a local surgery center will wake up the OR."

Ah, dreaded competition. But when you look at how the surgical specialties rate their satisfaction, it's not surprise physicians have taken matters into their own hands: 12 of 14 reported levels below the mean satisfaction score, and four of the five least-satisfied specialties were surgical (though, admittedly, the bottom three were inpatient-geared specialties — cardiovascular, vascular and thoracic surgery).

Oral surgery was the only surgical specialty to make the top five; ophthalmology was also above the mean satisfaction score of 72.5. In descending order of score, gynecology, gastroenterology, other surgical specialties, urology, orthopedics, neurological surgery, plastic surgery, anesthesiology and general surgery all garnered satisfaction ratings below 72.5. It is further interesting to note that physicians employed by their hospitals/facilities (20 percent of those surveyed) reported higher overall satisfaction (75.2 satisfaction score) compared with those who are not (72.4 satisfaction score). In particular, surgical specialties not employed by hospitals reported lower satisfaction with their practice at the hospitals.

Press Ganey reported the specific satisfaction of just three surgical specialties employed by hospitals: gynecology (75.0 satisfaction score), general surgery (72.9) and other surgical specialist (72.5). Far more surgical specialties made the non-employed list: ophthalmology (74.6), urology (72.7), gynecology (72.4), orthopedics (70.5), other surgical specialist (70.3), anesthesiology (69.5) and general surgery (69.4).

"The hospital administration isn't doing enough to advertise the hospital as a surgical center and has not adequately addressed the fact that surgical cases are dropping and surgeons are getting older and leaving," says another physician quoted by the report. "Money is being lost because surgical cases are not increasing and they aren't using OR time effectively."

Based on the scores and comments, it's clear physicians largely turn to ASCs and surgical hospitals for convenience, efficiency and ease of practice (not so they can perpetrate self-referrals and overutilization of services, as some would like you to believe). If you're thinking about opening your own center, check out our package on construction and real estate development beginning on p. 38. There, you'll find tips from experts, administrators and physicians for success, a discussion of current real estate issues and sample pro formas and costs for building, owning and leasing.

If you're not interested in the ASC route, know that the hospital administration isn't necessarily on a different page entirely.

"Administrators regularly cite physician-administrator relations and physician retention as two of their top concerns, and they know that alienating physicians can lead to physician attrition and lower patient volumes," says the report. Further, "Press Ganey research also shows that the most satisfied physicians refer the greatest number of patients. Hospital administrators who acknowledge the demands on their medical staff and take steps to partner with physicians can see not only increased physician retention. but increased patient volumes and healthier bottom lines.

"The health care landscape is changing, but there is still incredible potential for growth — and, more important, improved patient care — for hospitals that choose to partner with their physicians.

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ON THE WEB
Hospital Check-Up Report 2008: Physician Perspectives on American Hospitals
www.pressganey.com/galleries/default-file/Press6_Checkup-Physician_072308.pdf

Letter to the Editor: Doc-Owned Facilities Aren't the Bad Guys

A recent article in *Modern Healthcare* reported in its headline that there are "Savings still seen in House measure on doc-ownership of hospitals: CBO (Congressional Budget Office)." I find it almost laughable that there are folks in Washington who think all physician-owned facilities are the "bad guys" in this melodrama and that wiping them out would solve the healthcare crisis. It would be laughable if it were not so dangerous.

We trust physicians to make life-and-death decisions on a daily basis for their patients. Studies have shown that upward of 92 percent of the Medicaid population treated by physician owners are done in their own facilities. Oftentimes the other 8 percent are taken to the hospital because of other factors in the patient's medical history, not because physician-owned facilities are doing wallet biopsies. A surgery center cannot provide services for a patient with an American Society of Anesthesiologists score of four and higher because it is not safe to perform the surgery in the ASC setting. The patient is more likely to need inpatient hospitalization than is a patient with an ASA score of one. Medicare frowns on physicians performing an outpatient procedure knowing that the patient is highly likely to be transferred to an acute facility for inpatient services because of the underlying medical condition of the patient's.

While there may be some physician-owned facilities that meet the description of a "villain," the vast majority do not. Hospitals have missed the industrial revolution, if you will. Hospitals do not need to be all things to all people any more. Does General Motors manufacture its own tires? No; it obtains them from other suppliers. I am of the opinion that physician-ownership should be done in cooperation with a local community hospital unless the hospital is unwilling to cooperate. Many hospital administrators have failed to realize that physicians are not the enemy but, if they were to engage the physicians and align some of the incentives, conquering many of our crises could occur. We are fortunate here in Tucson that our hospital partner recognizes this valuable relationship and has endeavored to make the bonds stronger between it and its medical staff.

Quality studies have shown that specialty hospitals have better outcomes in terms of infections rates and other quality measures than do the general hospitals. Patients have shorter stays and better results, for the most part. Access to care is enhanced, not diminished. Will increasing access to care improve the overall healthcare of the country or will it decrease healthcare? The answer is obvious to all but those outside of the system who think they know better.

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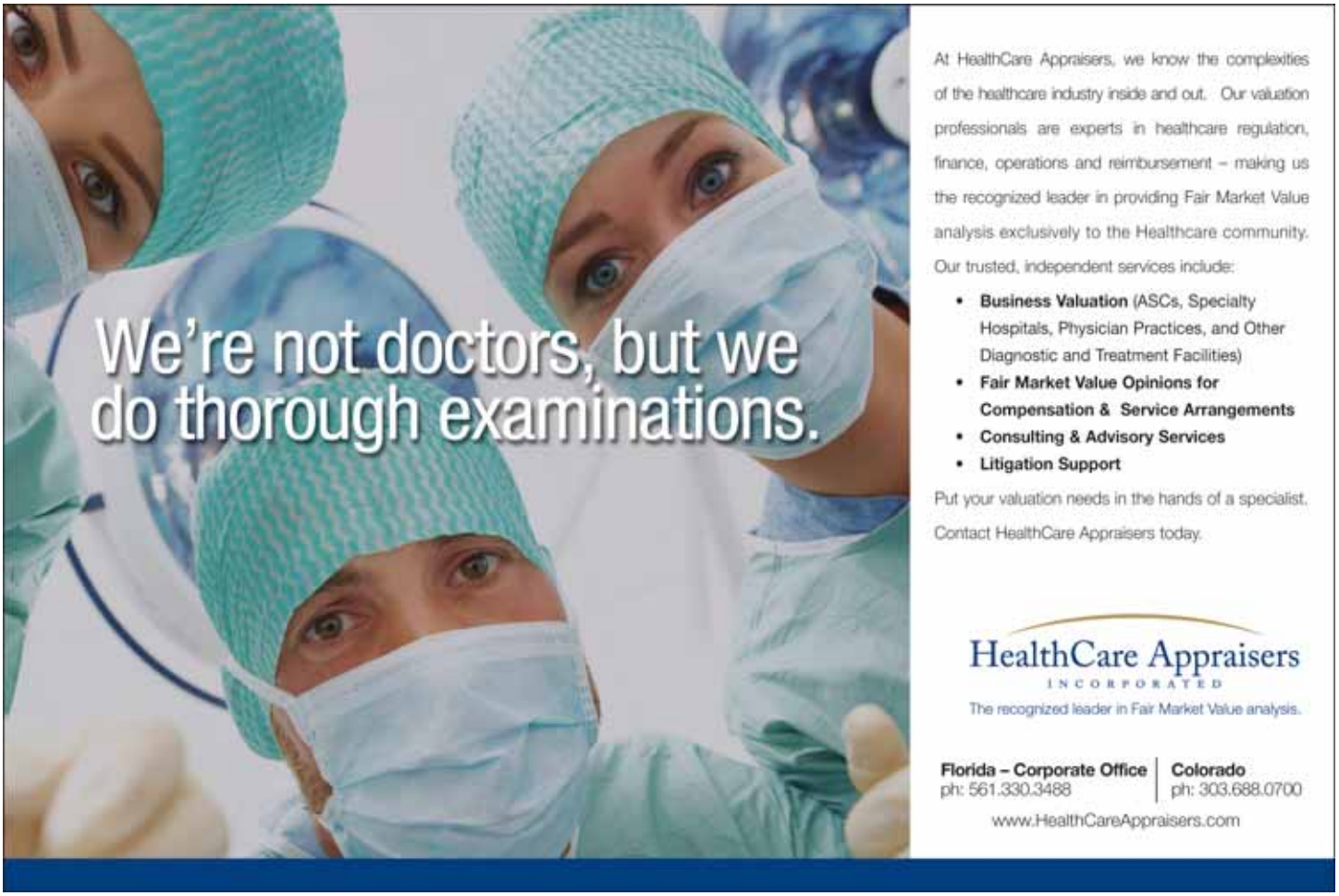

27 Tips to Get Paid Fairly By Medicare and Third-Party Payors
(continued from pg. 1)

Billing. This is something that hospital outpatient departments (HOPDs) are used to, since they fall under the OPPS system, but such frequent adjustments are new for ASCs.

"I now know why HOPDs have bigger billing staffs — it's because just trying to keep up with the things that CMS changes from minute to minute is really difficult," Ms. English says. "They change the price of the drugs and what's covered (ancillary procedures) … and it's a lot of sorting to go through."

But it is sorting that you must do to ensure your Medicare contract information is correct.

"Just between January and April, they had a chance of just a few cents on several of the drugs on the list," Ms. English says. "It wasn't a lot, but it was enough that it was different."

(View this update from CMS at www.cms.hhs.gov/transmittals/downloads/R1488CP.pdf.)

CMS sends free e-mail alerts announcing these updates, so if you are contracted with Medicare, it is likely you are already receiving them. Some of the updates that come to you may not apply to ASCs, as they address changes to the entire OPPS system. But you must make sure a member of your business office staff is reviewing all of these updates, and identifying which ones do apply to your organization and how you are affected by them.

"I think this is going back to the very, very basics — realize when it's changing, what's changing, assign someone from within your organization to keep up on it and disseminate that information," says Caryl Serbin, RN, BSN, LHRM, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing.

2. Closely monitor impact of new payment system.
While you may have projected how the new payment system would impact your ASC's bottom-line in 2008 (and beyond), you should be closely monitoring the exact effect now that you are receiving the new reimbursement rates from Medicare.

"We're watching it carefully each month to see our volume of Medicare, reimbursement from Medicare and what it's doing to our bottom-line," says Dana McGrath, RN, MSN CASC, administrator for Algonquin Road Surgery Center.

Ms. McGrath says Algonquin Road has made some significant changes over the past year as a result of the movement to the new system, eliminating ophthalmology procedures, slightly increasing podiatry and significantly increasing orthopedics. When comparing her Medicare net revenue per case from June 2007 to June 2008, she has seen a 36 percent increase thanks to these changes.

By reviewing the data and sharing it with the ASC's physician-investors, she hopes to see the net revenue increase even more.

"While I review the data monthly with our management company, Health Inventures, the physician-investors also get to see it monthly," Ms. McGrath says. "We review a list of their patients by payor and charges, collections, contribution margin and net income. So I'm showing them, month to month, what patients they are bringing in here by what payor. It's pretty transparent."

This not only helps the physician-investors to become more conscious of the cases they bring to the center, but it has also encouraged them to look more closely at the ASC's operations and determine if there are areas to tighten expenses, such as supply or clinical costs, she says.

3. Get paid … for what you should get paid for.
Under the new payment system, ASCs can get paid for many new

ancillary procedures and drugs. But ASCs won't get paid unless they know to include these reimbursable items on their Medicare claims.

"I'm still finding that a lot of people didn't know what things are covered and not covered," says Caryl Serbin, RN, BSN, LHRM, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing. "The big thing is that they don't have a mechanism" for capturing the charges.

The first step to resolving this issue is for the administrator to go to the Medicare ASC-approved list and identify what procedures and ancillary procedures the ASC performs, and what drugs it uses that are covered by Medicare. When this information is gathered, disseminate it to the entire billing office staff.

"I would imagine that there are a lot of ASC coding people who may not even be aware of some of the ancillary procedures they can now charge for," says Ms. English.

If your ASC adds a new surgeon, verify whether this addition will require your list of covered procedures/drugs to include new items, says Ms. Serbin.

Once you have this list developed, now you must address the next challenge — ensuring your billers and coders know when a physician performs any ancillary procedures or provides any covered drugs.

You want to certainly encourage your physicians to perform their dictations and encourage the nurses to provide all the information and details about the cases as well. You may also want to consider developing a charge sheet, says Ms. Serbin.

"There needs to be a charge sheet to say that you used mitomycin, or this or that," she says. "No system has been put in place to capture the charges for things they didn't get to charge before."

You will want your charge sheet to list just the covered ancillary procedures and drugs that apply to your center. Omit anything that does not apply to your center to keep the charge sheet simple and concise. After a procedure, the nurse can go through the charge sheet and check off the reimbursable items that apply to that particular case.

"You used to do this when you charged for supplies back when we originally could bill for supplies with Medicare many moons ago," says Ms. English. "We always had a list — taken from the preference cards — and put it in the chart, and you just checked off what was used. But now just have it with these ancillary procedures that are applicable to your specialty."

If there are only a few ancillary procedures/drugs that apply to your center, such a charge sheet may not be necessary. But it's still wise to explore other methods to remind physicians and nurses about these reimbursable opportunities they should note on their reports.

"Maybe hang a little sign [listing these items] where the nurses do their charts or where the doctors dictate that says, 'Remember, starting in 2008 you can get paid for this, this and this by Medicare,' rather than creating a big checklist to go through," says Ms. Serbin. "If you've got it culled out to five or six things, then they'll be able to go, 'Oh, yeah, I used that.' It helps with the education process."

Third-party payors

Getting fair, let alone good, contracts with third-party payors is still a major challenge for ASCs. Even if you think you've obtained a contract with desirable reimbursement rates, there are still many potential barriers you could face that could lower the value of the contract. To help you receive the money you deserve from commercial payors, our experts offer the following insight and tips.

4. Not all payors care about the new Medicare methodology.

Many commercial payors model their fee schedule off of Medicare's, and likely had your ASC's contract following a grouper system similar to Medicare's nine-grouper system. But not all payors use a payment system based upon CMS methodology, so your efforts to get these payors to increase your reimbursement for procedures that are now paid higher under the new Medicare system may be met with blank stares.

"Payors that are not on a payment system that's based upon the CMS methodology, they don't really care" about the new payment system, says I. Naya Kehayes, MPH, managing principal and CEO of Eveia Health Consulting & Management. "It has absolutely no impact on them if they have a proprietary payment

methodology/fee schedule that is not based upon the Medicare system, in my opinion."

While you can certainly try showing these payors Medicare's new reimbursement rates and hope they are willing to consider them as a baseline, another good approach is to …

5. Show payors they save with you.
If your ASC is not performing some procedures that you can and would like to bring into your center because of low reimbursement rates offered by payors, it is likely that these procedures are going to the hospital. If this is the case, your payors are probably reimbursing the hospital at a higher rate than you would expect and be willing to accept to perform the same procedures. If you can demonstrate the savings opportunity that exists for the payors if these procedures are performed at your ASC, you may find better success with your negotiations.

"You can say, 'There's a lot of opportunity if you negotiate with us a reasonable rate that lets us move these cases from the hospital,' but you have to be able to get your hands around the volumes that your doctors are doing at the hospital," says Ms. Kehayes.

If this data is not something you can obtain from your physicians, the payors should have the ability to gather this information.

"The payors have access to that information in their claims databases, but it's a matter of getting them to look at the data," Ms. Kehayes says. "What they typically need to look is really the group's names or their tax ID numbers. If [the physicians are] your partners, you should be able to disclose that to them, but it might be a good idea to review the approach with your partners and inform your surgeons that the payor needs this information in an effort to enhance the ASC's contract."

Once you can demonstrate the potential volume the payor could move to your ASC and the money it could save as a result, you will want to have a strong argument for the particular reimbursement rate you are seeking for your contract. Fortunately, there are some logical arguments (tips six and seven) you can make to support your claim for good rates that will still save the payors money.

6. Take advantage of transparency.
With a little research, you can determine the baseline for what hospitals in your area are receiving for the procedures you want to perform.

"Go through the payor Web sites or CMS," says Elizabeth Smallwood, CMPE, vice president, contracting and reimbursement, for Blue Chip Surgical Center Partners, and a former director of contracting for Humana of Ohio, with experience working for Aetna, and Anthem Blue Cross and Blue Shield.

By visiting the payor Web sites, you can enter location information (zip code) and estimate how much the hospital receives for these procedures. Some of the sites list an "average cost" without adding ancillary and professional costs, she says. Some sites break down the cost for facility, professional, anesthesia and ancillary costs. You will at least be able to get a ballpark figure with which you can approach a payor.

"From a negotiating perspective, I can now go back to the payor and say, 'I know what you're paying the hospital; I'm willing to take a 20 or 30 percent discount,'" says Ms. Smallwood. You will want to make sure that whatever discount you offer will still keep the procedure you want to perform in your ASC profitable, but demonstrating any savings opportunities should help your case with the payor.

7. Accept less than HOPD Medicare rates.
Medicare reimbursement to HOPDs is often the baseline to look at for presenting the argument that the ASC presents a cost savings opportunity, and it is public information available on the CMS Web site.

If your case mix proves to be advantageous under the APC payment methodology, and your contracts are based upon a Medicare grouper methodology, they are typically going to value at rates below hospital Medicare rates. In these situations, "Go and try to negotiate 90, 95 or even 100 percent of the hospital (Medicare) rates," says Ms. Kehayes. "You can demonstrate to the payor how much money you can save them by making the assumption (that they use Medicare as a baseline). I say to the payors all of the time that 'there's no way you can tell me you're paying a hospital in this urban location Medicare rates. This is what I can offer you to help save you money.' You're now showing the payor how you can save them money."

This approach can be most effective when the payor is eager to have cases move out of the hospital. However, it is critical that the ASC understand where their current contract value is in terms of APC compensation, which is highly impacted by case mix.

With the new payment system reimbursing ASC-approved procedures an average of 65 percent of HOPD's Medicare rates, a contract that brings these rates up to 90 percent or more should be a nice boost if your case mix is favorable under the new system, such as orthopedics, general surgery and ENT.

Success with this tactic is not uncommon. In one particular situation, an ASC Ms. Kehayes works with was not performing cases because the reimbursement rates were not high enough.

"I kept saying to the insurance companies, 'why wouldn't you want to do this deal? If you do this deal, you're going to move volumes from the hospital,'" says Ms. Kehayes. "How many commercial payors do you think are paying a hospital the hospital Medicare rates? A good guess would be none. They're paying some percentage above that. If a surgery center can do surgery at below hospital Medicare rates, that's your argument because now you're on the same payment system, on the same playing field."

8. Push for fully implemented Medicare rates.
While many payors that have followed the Medicare methodology in the past are fighting a switch to the APC system, if you have a payor that is willing to consider the new Medicare payment rates as a baseline from which to negotiate your contract, push for the fully implemented rates in circumstances when the fully implemented rates are more profitable for your center than the transitional rates.

"I show them the fully implemented rates published in November 2007," says Ms. Kehayes. "You can argue that the fully implemented rates are a better representation of cost since the new payment systems is based upon the hospital outpatient prospective payment system and there is cost data collected from hospitals and reported to CMS that impact APC payment weights and rates for HOPDs. Therefore, it can be argued that the fully implemented rates are a better representation of cost which is being acknowledged by CMS, and oftentimes increases the success of negotiations with payor by providing more data to support your claim for increased compensation."

9. Make the nine groupers still work for you.
Payors that have followed Medicare's payment system in the past, but don't want to switch to the new system, may give you myriad reasons/excuses — they need more time to analyze the methodology, their systems don't have the capability to handle the change, etc. But, if it's advantageous for you, at least push payors to acknowledge the new payment rates are a fair baseline from which to negotiate.

"If they pay you based upon 2007 rates, then you're accepting less from that payor than you are Medicare, so essentially a governmental program is subsidizing a private payor," says Ms. Smallwood. "I say, 'You have to convert to the 2008 rates and give me something plus Medicare. We can debate about what that plus Medicare is, but you need to at least made Medicare's 2008 rates as the baseline.'"

If you can get a payor to agree to this argument, but it is just unwilling to switch over and wants to keep you in the old nine-grouper system, you can still find financial benefits by staying in the groupers, says Ms. Smallwood. Consider the following approach that Ms. Smallwood takes with carriers:

• Identify those procedures in each of the nine groupers that your ASC intends to perform during the next year of the contract.

• Determine the estimated volume for each of these cases based on 2007 volume and any anticipated growth.

• Determine the 2008 Medicare rate for each of these procedures.

• Multiply the 2008 Medicare rate for each procedure by the number of cases you anticipate performing during the year (the estimated revenue you will earn over the next year from each case).

• Using the figures you derived in step four, you will now determine a new rate to apply to the procedures that fall in each of the groupers:

• Add together the figures you derived in step four for all of the procedures that fall under each of the groupers.

• Add together the estimated volume of cases you anticipate performing that fall under each of the groupers.

• Divide the "step five" figure by the "step six" figure and you have a new average rate to apply to each of the groupers.

For example, let's say you identify two procedures in grouper one that you intend to perform over the next year of your contract. You plan to perform 15 of procedure X and 10 of procedure Y.

Procedure X reimburses at a 2008 Medicare rate of $500, while procedure Y is $1,000. You will perform 15 cases of procedure X at $500 each, meaning you will perform $7,500 worth of procedure X. You will perform 10 cases of procedure Y at $1,000, meaning you will perform $10,000 worth of procedure Y.

So, between procedure X and Y in grouper one, you anticipate performing $17,500 worth of procedures spread out over 15 cases. Therefore, your average reimbursement would be $700 ($17,500/25), which is what would become the new grouper one rate.

Don't forget that you want to negotiate a rate above Medicare, but at least now you have a better rate from which to negotiate.

But what about the few hundred new Medicare-approved procedures that ASCs can now perform that weren't included in the original nine groupers? This is where the "default rate" grouper — which most third-party payors include — comes in to play, says Ms. Smallwood.

To determine the default rate grouper rate, identify all of the new procedures you intend to perform. Then determine the volume you estimate performing for each of these procedures.

"I would utilize the physicians private practice data for the prior year of the volume of cases he did for place of service 'outpatient hospital' (i.e. place of service code 22) and the corresponding volume projected for that payor I'm modeling for," says Ms. Smallwood.

Repeat the process described earlier for the nine groupers and you have your default rate.

With so many potential new cases, likely with a wide range of reimbursement, to add to this default rate, you might wonder if you could potentially set a default reimbursement rate that's too low.

"If you base your projections on prior year actual from your physicians' private practices, you should be okay," says Ms. Smallwood. "It's very important that you have buy-in and commitment from the physicians to bring that mix of patients the projections are based on."

While approximately 600 of the more than 800 new codes (not including ancillary pass-through codes) added to the ASC-approved list have 2008 Medicare reimbursement rates less than $400, a majority of the approximate 200 codes greater than $400 are significant cases with high reimbursement, she says. If you intend to perform many of these cases, you may find that your default rate is very high and draws questioning from the payor.

"It is important that you determine correctly the projected volume of those codes because if you are doing those codes, you'll need to point out to the carrier that this is why the default rate may have to have a very large increase," says Ms. Smallwood.

Keep in mind that the many of the large payors, such as Aetna and Anthem, have proprietary groupers, and in 2008 they slotted the new procedures into their grouper system, Ms. Smallwood says. For payors that have remained true to the groupers (such as small regional plans), they have likely placed these procedures into the default category.

By following this process to determine the new rates for the nine groupers, you will hopefully see your reimbursement rates increase and can feel comfortable remaining in the system that some of your payors prefer.

10. Make sure "grouper" means what you think it means.
It's understandable to see the term "grouper" and immediately think of it as a Medicare methodology reference. Unfortunately, looks can be deceiving. "ASCs can sign a contract that says it is based upon a grouper methodology, but it doesn't necessarily say that it's Medicare groupers and they just assume it's Medicare groupers just because it says grouper," says Ms. Kehayes.

Going by this assumption of Medicare groupers, an ASC may not request the "mapping" from the payor, which describes which payment group a CPT code will fall under, because the ASC thinks it already knows the rates since it knows the Medicare grouper system. Only after performing a few cases does the ASC learn that its contract follows a different grouper methodology.

"People get caught on that all of the time," says Ms. Kehayes. "Make sure you request the mapping to the methodology. Unless they tell you it's based upon Medicare — then the language needs to say it's following Medicare's mapping."

If it follows a different methodology, obtain the mapping and take, at least, your top 20 codes and make sure you understand their payment amounts, she says.

11. Keep CPT codes in the groups you agree to.
So you sign a contract which follows a grouper methodology. You're happy with the reimbursement rates which correlate with each group. Several months go by and everything looks fine. Then, suddenly, one of your top procedures is reimbursed significantly less than you contracted. You call the payor and ask why this happened. That's when you learn the payor moved that procedure's CPT code from its original group into a group that reimburses less.

"You have to watch for contract language allows the insurance company to change the assignment of the CPT code to the group," says Ms. Kehayes. If they include this language, "they don't have to renegotiate with you. They just have to send you a notice. They just say, 'dear provider, effective Jan. 1, find our CPT mapping.'"

Unfortunately, announcements like these are sometimes thrown away because they appear to be updates that ASCs do not think apply to them, perhaps because their contract extends through this new date. But with language in the contract allowing grouper-placement flexibility to the payor, ASCs can find themselves in a bind,

It can be interpreted that, "You've agreed to (the new contract) once you cashed a check," Ms. Kehayes says. "It's implied consent."

When this happens, it may warrant further discussion with a legal advisor.

12. Fight for GI and pain management.
We've discussed some ways to encourage payors to follow the new Medicare payment system because it benefits many specialties, but some specialties are not so lucky, particularly GI and pain management. If your ASC performs cases in these specialties, which took a reimbursement hit with the movement to the new system, you will want to preserve the rates in the old payment system and use them as your baseline.

"You need to do your analysis and show the payors how much you are going to lose (by moving to the new rates) and you need to negotiate that conversion factor up," says Ms. Kehayes.

If you're in a multispecialty ASC that performs GI and pain, along with some of the other

specialties receiving a boost under the new system, and a payor is moving to APCs, you will want to split the conversion factor.

"What that means is you're negotiating two different conversion factors for groups of codes," Ms. Kehayes says. "Because when you get into the APC world, you're actually negotiating conversion factors just like you do for RBRVS (Resource-Based Relative Value Scale, the physician payment schedule for Medicare) for physician compensation.

While you can't negotiate the relative weights, a measure that CMS uses to rank the costs of performing procedures in one APC as compared to other APCs, you can negotiate the conversion factor for APCs.

"Say to (the payors), 'I want this conversion factor for this band of codes, and for this other band of codes, I want this conversion,'" Ms. Kehayes says. "They may tell you their computer systems can't handle it, but I would push that argument hard."

13. Give yourself ample time to negotiate a contract.
To convince a payor that you deserve fair reimbursement usually requires patience and persistence. ASCs need to allow ample time to negotiate contracts or the consequences can be devastating.

"The one thing the doctors do not understand is that negotiating a big contract — let's say their top three carriers — the time frame for that has probably gone to eight months or a year for a good contract," says Ms. Serbin. "I'm talking a lot of hard work, and no one seems to grasp that. And so they give up, they sign lousy contracts and they kill their center prematurely. It's just out of the ground and they've signed rates they can't make money on.

"Just how (the payors) are going to wear you down, you have to wear them down," she says. "I think that's where everybody fails on the managed care piece. You have to have the stamina, the time and the staff to wear them down."

If you sign a bad contract, it is likely that you are going to violate our next tip.

14. Do not sign a contract that will cause you to lose money on procedures.
It's not uncommon for an ASC to sign a contract that includes reimbursement rates that will actually cause it to lose money on some of the cases it performs. The reasons given can range from desperation to work with a new payor to conceding losses on some cases for gains on other cases. But if the contract you sign includes reimbursement rates that are too low to ensure a profit on cases you want to and will perform, you are likely doing more harm than you realize.

"I listen to doctors who say that it's okay to lose money on certain cases," says Ms. Serbin. "I hear that time and time again. We don't make enough money in any ASC to be able to do cases where we purposely lose money."

Consider the possible implication if the payor with which you contract is then acquired by another payor or has relationships with other payors. That poor rate you agreed to could become the limit that payors push you to accept in the future since you've agreed to it the past.

You can also expect the original payor you signed the contract with to be very hesitant in the future to consider moving much higher than that rate.

"You're demonstrating to the payor that you can perform that surgery at that rate, so you lose your negotiating power," says Ms. Kehayes. "As soon as you start performing surgery with consistency on these cases and you try to tell the insurance company they're not paying you enough, your actions speak louder than words. You have effectively told them that you can afford to do those cases."

You're better off stating your arguments for why you can't perform those cases and then do not perform them if you cannot get fair reimbursement.

"It's really important that the ASC refrains from doing those cases if they cannot afford to do them, and communicate that to the insurance company," says Ms. Kehayes. "Keeping the cases you cannot afford to do in the ASC at the hospital sends a very loud message. This is what helps them to understand and see the opportunity of saving money by working with the ASC."

15. Give up those cases you can to get the procedures you really want.
Successful contract negotiations usually involve some compromises. The payor is not likely to give you everything that you request, so to get what you really want you must be prepared to give the payor a little of what it wants.

It is important to go to the negotiating table with a list of cases you really want to do — the cases that drive the financial stability and success of your ASC — and to be prepared to argue confidently and diligently for those you cases. You should also have a list of cases that you could perform in your ASC if the reimbursement was right, but would be willing to take less money to receive better rates on the cases that will make or break your organization.

"Sometimes a key doctor at a center will get fixated on one or two CPT codes that might represent five cases a year," says Ms. Kehayes. "It's a give and take situation. Give up on the little cases to make the money on the big cases. Give up on the cases that represent a very, very small volume that don't put the center at risk" if you stop performing them.

If you're on a grouper methodology, you need to understand the distribution of your cases among the groupers and come to the table knowing which groupers are your most important and which are not.

For example, let's say you're in a traditional nine-group methodology; fifty percent of your cases are in group three; 2 percent in group one; 30 percent in group four; 10 percent in group five and nothing in group eight.

"Trade off the groupers that don't have a lot of volume, such as groups one and eight, so you can focus on the groups that add more value," says Ms. Kehayes. "You can leverage that, but you have to understand where your distribution of cases is in their methodology. You should at least look up your top ten codes with each payment methodology."

You certainly want to have the data and arguments to speak to why you should receive excellent rates for all of the cases you could perform in your ASC, but understand in the back of your mind where you will give a little to the payor to hopefully gain a lot.

16. Use local government contracting trends to support your case.
If you are looking to strengthen an argument with a payor for why you should receive higher reimbursement using Medicare as a baseline, look no further than your local government.

In many states, Medicaid, the state workers' compensation and even the state's employee health plan are following the new Medicare payment system to determine their reimbursement rates. If you do your research and learn that this is true in your state, you can argue with your payors that these other major contracts view Medicare as an accurate and meaningful guide for what is considered a fair reimbursement baseline.

"People should determine whether your state's wokers' comp moved to it, has Medicaid moved to it — that's all public information," says Ms. Kehayes. "In Washington, workers' comp, July 1, went to a multiple of the fully implemented (Medicare payment system) — they didn't do the

transitional. The state plan is following suit and we expect Medicaid to move in the same direction in the very near future."

Finding this information should not prove difficult. Your ASC likely received notifications about any changes, although they may have been overlooked. Ms. Kehayes suggests a visit to your state department of health and department of labor of industries Web sites to learn about any contracts that have moved or plan to move to the new APC methodology.

17. Outsource your implants.
Some payors will work with you to arrange carve-outs for your implants, but you will likely contract with a few payors that will not. In those instances, you must choose to you can absorb implant costs and still make money on the cases; not perform the cases because implant costs make them unprofitable; or outsource your implants.

When you outsource implants, a separate company will purchase the implants for you to use and will obtain reimbursement from your payors after you use them, a strategy employed by Algonquin Road Surgery Center in Lake in the Hills, Ill., when it could not arrange carve-outs for some of its orthopedic and podiatry procedures.

"They take on the burden and responsibility, and they work with payor contractor and work out pricing and payment for the implant," says Ms. McGrath. "With most payors, and with shipping and taxes, we're not often making money on the implants anyway, so at least this (arrangement) allows us to perform our cases."

Algonquin Road does not pay a fee for its service, so it is not sacrificing any part of the reimbursement it receives for the procedures by outsourcing. Unfortunately, there are instances in which outsourcing companies do not have a contract with a payor and, therefore, cannot purchase the implants for you. When that happens, you must determine whether you can still afford to perform the procedure on patients with this insurance provider or should send the cases to the hospital.

18. Ensure a new payment system-based contract transitions or ends.
If one of your payors is willing to base its contract on the 2008 rates of the new payment system, make sure the contract says the rates will follow the transitions so you do not remain stuck at 2008 rates.

"If they will not commit to moving with the transition of Medicare, then you either need an escalator that equates to the same amount or you need it to be a defined term so that it forces you into renegotiation, or you could effectively be falling below," says Ms. Kehayes.

Ms. Kehayes notes she asks for a 10 percent escalator to keep the rates close to the transitions if she cannot convince the payor to follow them.

19. Expect out-of-network coverage to initially be a trial-and-error process.
Receiving out-of-network reimbursement is becoming more and more difficult, says Ms. English.

"Not that we've ever necessarily been a proponent of it, but when you're still trying to contract with somebody, or they won't contract with you or they won't give you decent rates, it's become almost impossible now to do out-of-network," she says.

Payors are trying to come up with different ways to keep you from going out-of-network, says Ms. Serbin.

"Sending payments to the patients; giving you different discounts from being in-network; and different usual and customary (fees) applied to one set rules to in-network and one set of rules to out-of-network," she says. "If you can get them to tell you what their tactics are, this is good. But generally they won't exactly tell you."

If you can't find this out from the payor, you have to find another way to learn what happens when you go out-of-network, and the only way may be to perform just a few cases and monitor the results, says Ms. Serbin. In some instances, payors simply won't reimburse you. In other instances, they may pay you or they may send the payment to the patient. Once you've learned the results, you can determine whether going out-of-network is worthwhile for your ASC or something to avoid entirely.

20. Prioritize up-front collections.
You should already have a strong policy and procedure for up-front collections in your ASC. If it is weak or non-existent, it is critical that you focus on the process, says Ms. Kehayes.

Payors are looking for higher premiums from employers, and employers are eager to keep premiums low. A mechanism for insurance companies to reduce premiums is to give more of the risk to the patient.

For example, let's say a payor contracting with an employer has had the payor pay 90 percent of the allowed amount and expected 10 percent from the patient. The payor tells the patient's employer that it wants a 20 percent increase in the employer's premium and the employer asks how to decrease this premium.

The solution is to shift the burden of the premium to the patient, so now perhaps the patient has to cover 30 percent and the payor 70 percent.

If your ASC was able to negotiate a 10 percent rate increase with the payor but you have poor up-front collections, your cash can actually go down because you are receiving so much less from the payor and not collecting from the patient.

"You've negotiated a good contract but you're not realizing the cash because your business office isn't collecting from the patient up front," says Ms. Kehayes. "That trend is going to keep going because employers can't afford 20 percent increases every year and that's how employers are able to keep their premiums from going so high — by shifting their risk to the employee. You think you've negotiated this stellar increase, but unless your business office is doing the job up front, you may not see the money."

If you don't collect money from the patient up front, you're likely going to struggle to collect it after the procedure.

"Any billing company will tell you the probability of collecting after the fact than collecting up front drops immensely," says Ms. Kehayes.

Further, you could run into even more problems with up-front collections if you allow a clause in your contract that says you will not collect up front.

"I think you'd be remiss in your duty if you let that go through with that language in there because I don't think it's any of the payors' business to determine whether you can collect from the patient up front," says Ms. English.

If your state law says you cannot collect up front, then the language would be acceptable. Otherwise, keep this clause out of your contract as this is an uphill battle you will want to avoid.

21. Educate self-insured employers.
An increasingly growing trend has insurance providers writing their plan designs in such a way that they are selling capped outpatient surgery rates to employer groups, observes Ms. Smallwood.

"In the benefit plan design, they'll limit (for example) all outpatient surgeries to $1,200," she says. "Some are also saying that they will only follow Medicare's rules for what is on the ASC-approved procedure list; if a CPT code is not on the CMS ASC list, then it cannot be done in an ASC setting — like spine. "We've seen a lot of carriers writing that into their plan design, so it makes it difficult for out-of-network providers to get reimbursed for that," Ms. Smallwood continues. "I think you're going to see health plans writing their certificates of coverage differently for their outpatient surgery benefit."

Education of employer groups about these limitations is crucial so the employers can decide whether this is the kind of restricted care they want to offer their employees. An ASC would be wise to reach out to the employers and serve as an informational resource.

"It's going to be important for ASC leadership and governance to talk to the self-insured employers in their area — the large employer groups — to make sure they understand that when they buy a consumer-driven health plan PPO that it may not be a PPO because they capped a specific site of service or restricted it based on reimbursement limitations," says Ms. Smallwood.

It is also important for the front office of an ASC, when scheduling a patient, to confirm whether the patient has a capped outpatient surgery rate.

"Ask, 'What is the allowable amount for this procedure?' If they just asked that one more question, they would determine that it's capped at $1,200 when [the patient is having] a $2,000 procedure," says Ms. Smallwood. This question could make the difference between performing a procedure for a loss and, perhaps wisely, sending the procedure to a hospital.

22. Don't blindly stay with a clearinghouse.
If you work with a clearinghouse and are not satisfied with its results, consider looking into alternative clearinghouses. The decision to make a switch was critical for Goshen (Ind.) Ambulatory Care Center.

"Probably the most important step we have taken lately was to change clearinghouses," says Deborah Starnes, administrator at Goshen. "Reimbursement has been much faster. We can go online and know the status of our claims at all times, and do not have to wonder whether or not our claims have been received by the payer. Rejected claims can be corrected online and quickly resubmitted. This change has been positive on our accounts receivable."

Goshen made the change when its software vendor reported problems with the original clearinghouse and suggested switching to one its preferred clearinghouses.

23. Watch out for evergreen clauses that lock in your rates.
If your contract includes an evergreen clause, you may think that the contract doesn't expire and will just rollover to the next year. While this is may be true, the problem is that the rollover often does not include a rate boost, thus leaving your reimbursement stagnant for another year.

"If you let it roll at the same rate, you can then lose the opportunity to negotiate again for another year depending upon what their clauses say," says Ms. Kehayes. Make sure the payment terms include an annual escalator. If they are following the "current" Medicare ASC methodology, it might be advantageous to includes language indicating the rates will be adjusted in accordance with the transitional payment percentages with the system. Of course, this is assuming that the case mix of the center result in a favorable increase by converting to the new payment methodology, she says.

"Surgery centers leave money on the table [with such an oversight]," she says. "The ASC has a responsibility and has to take accountability for calling the insurance company on a regular basis for increases. Have a reminder notice going off three to six months before their contracts are up for renegotiation and, at a minimum, they need to ask for 4 to 5 percent each year to keep up with the Consumer Price Index."

24. Review termination clause language closely.
If a proposed payor contract includes a termination clause, you will want to closely scrutinize its language before agreeing to the terms as you may be limiting when you can and cannot terminate the contract.

"You have to look at your notification and termination clauses — there's a difference between a termination clause with an anniversary date versus one that doesn't have an anniversary date," says Ms. Kehayes. "You can have a contract that says you can give 90 days notice at any time versus another clause that says you can send notice only 120 days before the anniversary date, and if you don't do it at that time, the contract automatically rolls on the same rates for another year.

"Look for anniversary date language that may limit your time period for providing notification to the payor on renegotiation and/or termination of a contract," she says. "You can get yourself locked up for another year, and sometimes it says it rolls for another two years."

25. Put physicians to work.
If the responsibility of negotiating your ASC's contracts falls solely on the administrator, this is a process to seriously reconsider.

"Shame on the center that allows the administrator make that unilateral decision, and shame on the administrator for doing it," says Ms. Serbin.

Your ASC's board of directors should review any contracts to help identify areas of concern and prevent bad contract signings.

"They know the ins-and-outs of the contracts, and they can help make educated decisions," Ms. Serbin says.

You can take their involvement one step further — bring them into the contract negotiations. However, make sure you're bringing the right voice and personality into the process.

"We've primed physicians with what to say and then had them call up to the carrier and chat about the disappointment in the negotiations and the rates, and (the payor) takes a little bit of a different tone when they're talking to a doctor," says Ms. Serbin. "But the caution there is that if you know the doctor is a screamer, a yeller, a not-nice-on-the-phone type, that wouldn't be the doctor to have call as I've also seen where physicians can hurt that process. But if they can get on the phone, not lose their temper and talk intelligently and sort of woo them over, that works a lot."

26. Take a proactive approach to claims accuracy.
Even the smallest error on your claims can lead to a denial and delayed payment. The good news is that the information you need to fill out your claims is available to you. You just need to seek it out, and do so on a regular basis as it can change regularly.

"When I was on the third-party payor side, one of the biggest frustrations for us was the education of the business office staff," says Ms. Smallwood. "They need to be proactive in going out to the National Uniform Billing Committee (NUBC) and pulling down its instructions. Before they even submit their claims, they need to be accountable and just make sure their system libraries are mapping to the correct form blocks."

In some cases, a payor's requirements will differ from the NUBC, says Ms. Smallwood. Assigning someone on your staff to visit to all of your payors' Web sites quarterly to look for any changes is a wise decision.

"Those instructions are out there on all of the payors' Web sites and they even have example forms and definitions," she says. "You can't just check them this year and leave it in place forever. Assign a specific staff person that is accountable for reviewing that information and updating that system. Office managers often think the software vendors are responsible for making changes to their electronic billing or their libraries, and they're not."

What's the harm in missing a change? Consider that, this year, Maryland's workers' compensation changed the way it's reimbursing its claims, having moved to the Medicare guidelines and a grouper system from a system based on a percentage of billed charges.

"Had we not constantly been out there looking at our payors on a quarterly basis, we never would have known that," says Ms. Smallwood. "Our claims would have went in, they would have been denied and it would have taken 90 or 120 days to get that cash, so it would have seriously interrupted cash flow."

In addition to visiting the payors' Web sites regularly, make sure someone is watching your mail and e-mail closely and reviewing anything that could serve as notification of a pending change.

27. Watch for secondary (complimentary) payor tactics.
Ms. Starnes says Goshen Ambulatory Care Center recently faced a situation where it had contracted with a payor and believed it was contracting for a primary network. Then Goshen learned that the payor was functioning as both a primary and secondary (complimentary) network.

"The payor was applying the secondary network discount and also the out-of-network discount, resulting in a 'double dip' situation," says Ms. Starnes. "There was no advantage for us to participate in this kind of arrangement and we have since terminated these contracts."

Unfortunately, the networks that are conducting this practice do not represent themselves as secondary networks during contract negotiations, Ms. Starnes says, so you will want to closely monitor new contracts to ensure you do not run into a similar situation. ■

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Office of Inspector General Issues Advisory Opinion — Physician/ Hospital Joint-Venture

By Scott Becker, JD, CPA, and Melissa Szabad, JD

The Office of the Inspector General recently issued Advisory Opinion 08-08. This Advisory Opinion deals with a physician/hospital joint-venture surgery center. Here, the Advisory Opinion was requested because certain physicians who invested in the joint-venture were themselves not "safe harbor" compliant. In essence, some of the physicians practice principally in an inpatient setting. The OIG, based on the number of prophylactic steps and the overall facts, determined that the joint venture would pose minimal risk of abuse under the Anti-Kickback Statute. Scott Becker, JD, CPA, and Melissa Szabad, JD, of McGuireWoods served as counsel to the requesting center. Tom Mills and Marion Goldberg of Winston and Strawn and Neal Goldstein of Much, Shelist were also instrumental in assisting the center to obtain the opinion.

It reasoned as follows:

1. Use of pass-through entity

"First, the Arrangement does not qualify for the protection of the hospital/physician-owned ASC safe harbor, because the Surgeon Investors do not hold their investment interests in the ASC either directly or through a group practice composed of qualifying physicians. Rather, the Surgeon Investors hold their individual ownership interests in the Surgeon Partnership. The Surgeon Partnership, in turn, holds an interest in the Company that owns and operates the ASC. We have previously expressed concern that intermediate investment entities could be used to redirect revenues to reward referrals or otherwise vitiate the safeguards provided by direct investment, including distributions of profits in proportion to capital investment. However, in this case, the use of a 'pass-through' entity does not substantially increase the risk of fraud and abuse. Each Surgeon Investor's ownership in the Surgeon Partnership is proportional to his or her capital investment.[1] The Surgeon Partnership's ownership interest in the Company is, in turn, proportional to its capital investment. Thus the individual Surgeon Investors receive a return on their ASC investments that is exactly the same as if they had invested directly."

2. Four surgeons don't pass one-third tests

"Second, four of the eighteen Surgeon Investors (the Inpatient Surgeons) fail to meet the safe harbor requirement that at least one-third of a physician investor's income from medical practice for the previous fiscal year or previous 12-month period be derived from the performance of ASC-Qualified Procedures.[2] This 'one third' test helps ensure that the safe harbor applies only to investment income to physicians who are unlikely to use the investment as a vehicle for profiting from their referrals to other physicians using the ASC. Safe harbor protection is limited to physician-investors who, because they perform a substantial number of ASC-Qualified Procedures, are likely to sue the ASC on a regular basis as part of the medical practices."

3. Rare referrals; all surgeons; small portion of total surgeons

"In the circumstances presented, notwithstanding that four Inpatient Surgeons will not regulatory practice at the ASC, we conclude that the ASC is unlikely to be a vehicle for them to profit from referrals. The Requestors have certified that, as practitioners of sub-specialties of orthopedic surgery that require a hospital operating room setting, the Inpatient Surgeons rarely have occasion to refer patients for ASC-Qualified Procedures (other than pain management procedures, which are discussed below).[3] Moreover, like the other Surgeons Investors, the Inpatient Surgeons are regularly engaged in a genuine surgical practice, deriving at least one-third of their medical practice income from procedures requiring a hospital operating room setting. The Inpatient Surgeons are qualified to perform surgeries at the ASC and may choose to do so (and earn the professional fees) in medically appropriate cases. Also, the Inpatient Surgeons comprise a small proportion of the Surgeon Investors, a majority of who will use the ASC on a regular basis as part of their medical practice. This Arrangement is readily distinguishable from potentially riskier arrangements in which few investing physicians actually use the ASC on a regular basis or in which investing physicians are significant potential referral sources for other investors or the ASC, as when primary care physicians invest in a surgical ASC or a cardiologist invests in a cardiac surgery ASC."

4. Pain management

The OIG also comments on the fact that the physicians certified that no surgeon investor would refer patients for pain management procedures (i.e. "indirect referrals") unless he or she themselves personally performed the surgery.

"As noted above, the Inpatient Surgeons do have occasion to refer patients for pain management procedures that are ASC-Qualified Procedures. This raises the possibility that an Inpatient Surgeon or other Surgeon Investor might refer patients to other practitioners for pain management procedures performed at the ASC, for the purpose of generating a facility fee for the ASC. The Requestors have certified, however, that no Surgeon Investor will refer patients for pain management procedures to be performed at the ASC, unless the procedure is to be performed personally by the referring Surgeon Investor. This serves to mitigate the potential for abusive referrals, with regard to this type of procedure."

5. Hospital prophylactic steps

The Advisory Opinion also commented positively on the steps taken to avoid the hospital driving referrals to the venture. Here, the arrangement included certain commitments limiting the ability of the hospital corporation to direct such referrals.

"Third, the Arrangement does not qualify for the safe harbor for ASCs jointly owned by physicians and hospitals, because the Hospital Corporation is in a position to make or influence referrals to the ASC and to the Surgeon Investors. However, the Arrangement includes certain commitments limiting the ability of the Hospital Corporation to direct or influence such referrals. The Hospital

Corporation refrains from any actions to require or encourage Hospital-Affiliated Physicians to refer patients to the ASC or to its Surgeon Investors; it does not tract referrals, if any, by Hospital-Affiliated Physicians to the ASC or to its Surgeon Investors; any compensation paid to Hospital-Affiliated Physicians is at fair market value and does not take into account any referrals Hospital-Affiliated Physicians may make to the ASC or to its Surgeon Investors; and the Hospital Corporation informs Hospital-Affiliated Physicians annually of these measures. In light of these safeguards, the ability of the Hospital Corporation to direct or influence referrals to the ASC is significantly constrained."

6. Limitations on indirect pain management referrals; full disclosure to patients; hospital steps

This is the type of advisory opinion that a couple of years ago should have been extremely easy to attain. However, currently, the OIG has expressed great concerns with both indirect referrals and is also concerned regarding issuing advisory opinions which may serve as examples or precedent to others. Currently, it takes a great deal longer than would have otherwise been anticipated to receive an opinion.

"There are eighteen Surgeon Investors, of whom fourteen meet the following test: Each received at least one-third of his or her medical practice income for the previous fiscal year or previous 12-month period from the performance of procedures payable by Medicare when performed in an ambulatory surgery center ("ASC-Qualified Procedures"). The four remaining Surgeon Investors (the "Inpatient Surgeons") do not meet this test. Each of the Inpatient Surgeons derives at least one-third of his or her medical practice income from procedures requiring a hospital operating room setting, but receives little or no medical practice income from the performance of ASC-Qualified Procedures. The Requestors have certified that the Inpatient Surgeons rarely have the occasion to refer patients to other physicians for ASC-Qualified Procedures, except for pain management procedures. The Requestors also have certified that none of the Surgeon Investors will refer patients for pain management procedures to be performed at the ASC, unless the pain management procedure is to be performed personally by the referring Surgeon Investor.

"The Surgeon Investors inform patients of their ownership interest in the ASC by posting notices in the two offices in which Surgeon Investors practice and through a written notice to each individual patient. The Requestors have certified that, in the future, in the absence of exigent circumstances, such written notice to individual patients will be provided prior to the date of the procedure in the ASC.

"The Hospital Corporation is in a position to make or influence referrals to the ASC. The Requestors have certified that, in order to limit such ability, the Hospital Corporation has refrained and will refrain from any actions to require or encourage physicians who are employees, independent contractors, and medical staff members ('Hospital-Affiliated Physicians') to refer patients to the ASC or to its Surgeon Investors, and has not and will not track referrals, if any, by Hospital-Affiliated Physicians to the ASC or to its Surgeon Investors. The Requestors have further certified that any compensation paid by the Hospital Corporation to Hospital-Affiliated Physicians has been and will be consistent with fair market value and has not been and will not be related, directly or indirectly, to the volume or value of any referrals Hospital-Affiliated Physicians may make to the ASC, its Surgeon Investors, or the Surgeon Group. The Hospital Corporation will inform Hospital-Affiliated Physicians annually of these measures." ■

*Contact Scott Becker (**sbecker@mcguirewoods.com**) or Melissa Szabad (**mszabad@mcguirewoods.com**).*

[1] We express no opinion with regard to any future sales of membership interests in the Surgeon Partnership that may result in individual investors having ownership interests that are not proportional to their investment.

[2] The safe harbor for hospital/physician-owned ASCs (42 C.F.R. § 1001.952(r)(4)) incorporates by reference this requirement of the safe harbor for surgeon-owned ASCs (42 C.F.R. § 1001.952(1)(ii)).

[3] If this certification proves incorrect, this advisory opinion is without force and effect.

BECKER'S
ASC Review
PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

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Tom Mallon, CEO and founder of Regent Surgical Health, is also seeing strong gains in orthopedics.

"We analyzed the Medicare reimbursements for every one of our centers," Mr. Mallon says. "All received a net gain — from $20,000 annually on the low side for a center with high GI and cataracts, to $200,000 for a heavy ortho center."

2. Under-arrangements transactions. Over the last few years, several transactions were developed that were driven by under arrangement structures. These promised that the physicians and hospital that own the infrastructure company would thrive and, at the same time, the hospital would be able to make an extra delta between the amount it was paid as a hospital outpatient department by commercial payors and Medicare, while paying surgery center infrastructure companies a lower amount. Thus, these transactions seemed to be a win-win for hospitals and surgeons investing in the infrastructure company. However, in the past 18 months, CMS has commented extremely negatively on these arrangements. Thus, they are not nearly the panacea that they used to be.

Jon O'Sullivan, a senior partner with VMG Health, offers these three observations about under arrangements:

1. "Generally under-arrangement structures do not pass the 'commercially reasonable' test. In order for a venture to have a fair market value, it must also be commercially reasonable. Commercially reasonable is generally defined as a standard of reasonableness applied to ventures conducted in good faith and that the generally accepted commercial practices were followed, which is a subjective test of what a reasonable person would do in the individual circumstance, taking all factors into account. Under this test, in order for an under-arrangement to be commercially reasonable, it should be a structure that a hospital would enter into with a third party regardless of referral relationships. In actuality, most, if not all, hospitals would never enter into an under-arrangement relationship with anyone other than a referring physician, thereby bringing into question whether the structure is a commercially accepted practice of what a reasonable person would do."

2. "Under-arrangements structures generally result in a higher cost of care to the payor (resulting from the higher hospital reimbursement) for a service that is no different that that which is provided in an outpatient setting. As such, under-arrangements are often viewed as a manipulation of the system whereby the hospital uses its higher level of reimbursement to affect a relationship that is designed to preserve or enhance referral relationships."

3. "Finally, in many cases, the amount of 'reimbursement' paid to the physicians for services provided to the hospital under the under arrangement relationship is suspect. In most cases these reimbursement structures do not carry the same risk or administrative costs as compared to normal payor billing processes, but are often more lucrative to the physicians. As such, establishing fair market value standards for these relationships can be complicated and problematic."

3. A hospital partner does not solve all problems. A hospital partner can make it easier to obtain contracts and can make it easier to recruit physicians. But the extent of the benefit that a hospital can provide to an ASC on managed care contracting is quickly declining. However, there are still several other benefits a hospital partner can provide to surgery centers.

"In some cases, a hospital can contribute to securing better payor contracting," says Rick DeHart, CEO of Pinnacle III. "This depends on the hospital's experience with ASC contracting and the amount of leverage it is willing to apply based on its other agreements. The other benefits could include supply purchase agreements and shared service agreements (i.e., bio-med service, housekeeping, maintenance, etc.). Also a hospital partner can add benefit to efforts such as physician recruitment, physician referrals and community support."

"If a hospital owns a minority share of the project, the hospital may not be all that helpful with contracting initiatives," says Jeff Leland, managing partner with Blue Chip Surgical Center Partners. "Hospitals

often have excellent banking relations in the community and will be very helpful when arranging financing. Often the hospital will have surplus equipment which may be purchased at reasonable cost. The hospital, of course often provides credibility, and when a partner the politics of launching a new ASC will be minimized.

4. Setting a bad contract for a small number of patients is not smart. In essence, we are increasingly seeing situations where surgery centers sign a bad contract for a very small percentage of their patients. This contract might not be heavily negotiated and it may be at a low price. The surgery center reasons that this has little impact to them because these patients represent a small percentage of their patients. However, increasingly, one preferred provider organization or insurance company sells their contract rates and leases out the network to another party. Thus, when somebody thought they were contracting for 1 to 2 percent of the patients, they find over the course of time that they are actually contracting for a great number of their patients. Thus, surgery centers have to be increasingly vigilant about walking away from contracts that are not at rates that are profitable.

"Why would you ever sign a contract that you're going to lose money on?" asks Brent Lambert, MD, FACS, chairman of the board and a founder of Ambulatory Surgical Centers of America. "Once you've signed a contract with a payor, it's very hard to move it. You're establishing a relationship in which they think of you as a sucker. "You may sign a contract — it may not be a terrible contract but it's not a very favorable contract — with a small payor, and you find out they have other relationships with other payors, and now you're locking yourself into very unfavorable payments with other payors where you could be getting more if you went to them individually," he says.

5. The loss of a few physicians is not fine. Surgery centers are increasingly becoming businesses that may profit when they hit a critical mass and perform more than a threshold number of cases. In the past, a few lost physicians could be easily replaced by other free physicians. However, there seem to be fewer and fewer independent and free surgeons available. Thus, each surgeon is starting to have more impact than each used to have.

"The loss of a surgeon is never acceptable due to the expense of establishing each provider, much less the loss of revenues and margin," says Mr. Taylor. "This is an issue that has always plagued ASCs — as any business with top-line decreases, the point of less independent physicians not currently involved in a center has decreased, but there continues to be availability of physicians in the market place to support both new facilities and increase productivity in existing centers. The point to be emphasized is that customer service, efficiency and profitability are retention issues that the entire facility staff needs to clearly understand and be a part of. Instances where one center's loss is another center's gain depends upon what end of the equation you are on."

Mr. DeHart agrees: "Many ASCs operate in mature markets where the majority of surgeons are committed to their operating facility. Therefore, losing a surgeon and easily replacing him is a difficult task. I believe that ASCs need to continue to work hard on customer relations to maintain their physician bases. There are too many choices in today's environment."

6. Spine procedures and orthopedic procedures can sometimes not mix well in a surgery center. It is often the case where spine procedures cannot receive reasonable contracts from managed care payors. Then, the surgery center is faced with the situation where both the spine and orthopedic procedures have to be out-of-network or both have to be in-network. This can cause great problems because the spine reimbursement may be horribly inadequate, a forced scenario if the center wants to be in-network for its orthopedic reimbursable cases.

7. Many ASCs still fail. Despite their growth throughout the country (nearly 6,000 total ASCs; nearly 5,000-plus Medicare-certified ASCs), a number of ASCs still fail. The failures occur mostly due to bad management, overstaffing, low volume, poor reimbursement or overbuilding. Knowing the risks involved in developing an ASC can help to ensure that your ASC will prosper and not fail. Working with experienced managers in developing a center can also help prevent failures.

8. Surgery centers should not be run like convenience stores. The most profitable

surgery centers are open those days and hours that they need to be open. In contrast, it makes little sense to operate a surgery center five or six days per week when case volume only supports operation on two days per week. We have seen several surgery centers fail due to this policy of trying to be open at all times.

9. Surgeons must commit. When a surgeon is party to multiple different surgery centers, or when surgeons do a great deal of their cases in their offices, it is a sure sign of problems for a surgery center. Surgery centers built around and planned for a small number of committed physicians are better than surgery centers built around many physicians with little commitment. Where a surgery center is built around a handful of physicians who are heavily committed to the surgery center, it is easier to standardize costs, set schedules and build an efficient surgery center. In contrast, where a surgery center has 40 different physicians each performing 20 to 50 cases annually, it is incredibly hard to manage costs, to manage schedules or otherwise keep a staff in sync with the surgeons.

"We want partners who will go the full measure to bring every possible case," says Mr. Leland of Blue Chip Surgical Center Partners. "Multiple ownership of ASCs conflicts the surgeon, unless there are unique geographic or political differences (i.e., a large river or a state line, such as the Ohio River, Mississippi River or Willamette River) which are adequate reasons for a surgeon to own a portion of two ASCs. Few other explanations make much sense to me."

10. Surgery centers remain a growth industry. There has been a slowdown in growth in surgery centers, most markedly in same store growth for some surgery centers chains. However, there remains growth in the surgery center industry; it is likely to be slower growth in cases and reimbursement than has been seen over the last 10 years.

11. RNs often make superior administrators. Experienced registered nurses often make great ASC administrators. The RN must study and be interested in the business side of ASCs. Generally, RNs are trained to be disciplined and dedicated workers, a work ethic that carries over to the administrator position.

"An RN or a business-trained person, like a CPA, can each make a great administrator," says Dawn Q. McLane RN, MSA, CASC, CNOR, chief development officer for Nikitis Resource Group. "However, an RN with a business background or training makes a superior administrator. An RN with experience in the surgical clinical area, particularly the OR and especially an ASC setting, possesses an unparalleled knowledge about how the center functions should function from a clinical perspective and how it should be managed from a business perspective. A qualified and proven OR RN with clinical leadership and business training and experience would always be my first choice when recruiting for an ASC administrator."

12. Leasing equipment from physician-investors is often a bad idea. While it can look attractive, leasing equipment from entities owned by ASC physicians is often a legally risky business. These arrangements can be viewed as thinly veiled disguises to incentivize physicians to use the centers; arrangements generally viewed by the government as illegal. As such, these arrangements, as a rule, should be supported by a fair market value (FMV) analysis, make business sense regardless of referrals and preferably be set as a fixed annual fee and not "per-click."

But it's important to note that the use of a fixed fee can create a new set of problems, says Todd Mello, ASA, AVA, MBA, principal of HealthCare Appraisers.

"For example, let's assume that the fixed fee assumes a particular level of volume/activity (e.g. 100 procedures per year) and the FMV per click fee is determined to be $250, for example," Mr. Mello says. "Using these numbers would result in a flat fee of $25,000 per year. However, what happens if actual volume is only 50 (i.e., as opposed to 100)? Then assuming a fixed fee of $25,000, the equivalent "per click" fee is now $500, which is greater than FMV. Accordingly, in the context of non-exclusive equipment/tech use arrangements, we favor a per click fee and have performed dozens and dozens of these types of FMV analysis for lithotripsy, green light and holmium laser arrangements throughout the country.

"If, however, the equipment is exclusive use to the ASC and is not moved in and out as needed, then a flat fee reasonably consistent with what the ASC's annual lease expense would be if it were to lease it directly from a third-party equipment vendor (i.e., as opposed to an MD-owned venture), would be appropriate," he says.

13. High-quality management is key to success. High-quality management is critical to an ASC's success. Many management companies offer superior services. However, many are of little value. All management companies are not equal. For this reason, it is important to work with an experienced management company that has a proven track record of successes. Working with a low-quality, inexperienced company will do more harm than good.

14. Paying fees plus equity to a management company is often the norm. In addition to a management fee, increasingly, the leading management companies are requiring a small portion of equity in the surgery center. Before writing off such an arrangement, evaluate how that management company compares to other management companies.

15. Buying-out non-productive partners is an option. There is no silver bullet for buying out the equity in a center held by a physician who does not produce as expected. There are heavily-weighted legal issues that relate

to such issues. Whether or not you can buy out a partner is a critical legal question that must be examined in light of the ASC safe harbor regulations and their "one-third/one-third" rules, amongst other factors. Newly touted strategies like "squeeze out" mergers often carry substantial risk.

"When buying out physicians who are not safe harbor compliant, we generally recommend that all safe harbor tests be applied to all physicians, that the physician be granted the opportunity to cure the default and that, wherever possible, the ASC will offer the person the non-adverse versus the adverse price even if, for contemplated reasons, it has the option to pay the person the adverse price," says Joe Zasa, CEO of Woodrum/ASD.

Further, "Be sure to give the non-compliant physician notice and a reasonable period to cure the situation," Mr. Zasa says. "Speak directly to the physician and obtain feedback about the center. Communication is key; try to determine if his or her low census is due to equipment issues, staffing issues or patient preference. These may impact utilization. We believe that open dialogue with the physician and a reasonable period to cure effectively addresses any miscommunication and deflects any ill will going forward."

16. Turnarounds have become more common than startups. Over the last few years, as more surgery centers have been built and fewer independent physicians are available, there has been greater growth and attention paid to turn around surgery centers than to building new surgery centers. We expect this trend to continue. Turnaround ventures typically see one party buying out a developer or surgeons in a surgery center with the intent of re-syndicating and trying to develop a new and more successful surgery center at the same place.

"Turnarounds are definitely less expensive and less time-consuming than a pure start-up," says Mr. Mello of HealthCare Appraisers. "ASCs typically have heavy investment in fixed costs (equipment and leaseholds), so obtaining sufficient volume is critical in maximizing staff efficiency and covering heavy fixed cost burdens. Once fixed costs are covered, and assuming staff is sufficient to cover the volume (i.e., staff is not purely variable and behaves in a step-wise function in that there is a certain level of minimum staffing required regardless of volume, and at various case levels, new, incremental staff may be required), incremental costs are limited predominantly to supplies (and perhaps billing if outsourced), which causes the margins on incremental cases to be significantly higher."

"New physicians added to an existing ASC is a win-win for all parties in that existing owners, while diluted, share a smaller percentage of a larger pie, and new investors are allowed the opportunity to forego a very risky start-up and expeditiously begin doing cases," he says.

17. Distributing income based on referrals is illegal. A surgery center cannot distribute ASC income, whether the ASC is owned indirectly or directly by physicians, based upon the referrals or the value or volume of referrals by physicians. The federal government (and many state governments) deems these type of distributions illegal. There is no "clean" way to avoid this rule.

"Under the old saying, 'You get what you measure,' it would seem to make sense for a rational business to incentivize business referrals through compensation related to the volume or value of those referrals," says Mr. O'Sullivan. "Real estate agents get paid commissions, insurance agents get paid commissions, lawyers and investment professionals get a percent of the business they bring in, why not surgeons?"

Simply put, he says, the federal government understands the old saying (i.e., it doesn't want to increase referrals, it wants to reduce them); because Medicare is funded by taxpayer dollars, our legislators don't want tax dollars "wasted" as a result of doctors who perform unnecessary procedures; and "you can't trust greedy doctors to make decisions based on medical necessity versus dollars."

But there is a major disconnect here.

"If CMS and other payors don't want physicians to increase referrals, then why is it that all of healthcare is reimbursed based on individual procedures?" Mr. O'Sullivan says. "If a physician wants to make more money, he should see more patients and bill for more procedures. Isn't that why healthcare costs have been going up each year — more volume? (The answer is yes.) This is a quandary, a clear contradiction and

evidence of a broken system. Maybe physicians can be compensated on keeping people healthy (before they need surgery for obesity, a hip replacement or a heart bypass). Then physicians can be partners in staying healthy and can be compensated on the ability to keep patients at statistically measurable levels of good health (i.e., not obese, heart healthy, etc.).

"A little far flung ... but maybe a better method of compensating physicians in the long run."

18. Growth strategy is key. An ASC will not succeed long-term without an ongoing comprehensive growth strategy. A growth strategy should include goals for increasing case volume and types of procedures, and potentially increasing the ASC's size and number of physician investors. A stagnant ASC will not be able to effectively compete with other centers and hospitals that are actively vying for business.

"When thinking about and designing growth strategies, ASCs should also incorporate feedback from the payor community into that process. Many times the payors have information related to case volume they would like to see move along in the continuum of care and out of the hospital environment and into the ASC environment," says Elizabeth C. Smallwood, CMPE, vice president of contracting and reimbursement for Blue Chip Surgical Center Partners and a former director of contracting for Humana of Ohio. "Payors also know who the new surgeons are in the region and could direct you to them. Touch base with the medical directors and case managers of the carriers; remember, they direct and control the surgical authorization process so they have many opportunities to suggest to their members that perhaps their cases may be appropriately performed in the ASC setting and provide the member's with their listing of preferred provider centers. In addition, payors may be able to give you feedback on your local market in general related to where you may find new cases."

Mr. Mallon says a lack of activity with your physicians can be detrimental to growth.

"Every physician partnership is a depreciating asset," he says. "If you are not buying out, retiring or moving physicians and bringing in younger docs, your center will stagnate."

19. An ASC can have too many physician investors. You *can* have too many physician partners. With too many physician investors, there is often a dilution of individual physician responsibility and ownership interests. With less skin in the game, physician investors often lose their commitment to the ASC and look for other alternatives.

20. Think twice before opening a second site. Business may be booming and you may be considering opening a second site. Before embarking on this project, stop. The surgery center business is based on economies of scale and, therefore, the more cases that can be performed at any one site with one staff results in higher profits. Opening another site creates double the overhead, which often results in diluting the profits at both sites. For this reason, opening a second site is generally bad, not good, for business.

"It's more a question of whether excess capacity exists and there's the ability to spread center overhead over more cases," says Marc Jang, CEO of Titan Health Corp. "Obviously, if excess capacity exists and you can add additional cases, the average overhead cost per case is reduced and center profitability improves at an accelerated rate."

21. Third-party reimbursement. High reimbursement of procedures by third-party payors at ASCs is becoming more difficult to obtain. Further, reimbursement differs dramatically throughout the country. There are increasingly fewer reimbursement options and a decline in very profitable workers' compensation programs, great out-of-network situations or situations where payors simply have not exerted significant market power.

"Third-party payors are relying more on transparency information and publicly available information in order to set their reimbursement rates. Therefore, reimbursement is becoming more market driven which places great variability in reimbursement rates throughout the country," says Ms. Smallwood. "Reimbursement mechanisms are becoming much more sophisticated with many variables impacting your bottom line results."

She continues: "While all of these factors — declining workers' comp reimbursement, out-of-network

reimbursement, payors exerting market power — are challenging, they are not impossible to overcome in designing an effective reimbursement strategy for ASCs to ensure their success. ASCs should incorporate strategies for dealing with each of these issues into their planning processes."

22. Ophthalmology procedures are still profitable. Do not make a blanket decision to not seek ophthalmology as a specialty. ASCs can still profit from ophthalmology procedures if the ASC has significant volumes and has effective internal cost control (i.e., it is run very efficiently).

"We believe that, depending upon the surgeons, we can make substantial profit margins," says Dr. Lambert of ASCOA. "You have to have a surgeon that has a short operating time for a phaco. What that means is certainly under 15 minutes per case. That's four an hour, and he can keep his total supplies under $220, which is easily done. Our overhead expenses, except for supplies, through our centers, average $18 per minute for every minute the patient is in the OR. Let's says it takes 15 minutes to do the (surgery). That would be $270 in overhead and then $220 in supplies. You're getting $960 reimbursement on average. Those are very good numbers.

"And there are many surgeons who can do these (procedures) in six to ten minutes, and then it can be very substantial profit margins," he continues. "But if someone is going to say they do two (procedures) an hour, then we're going to make hardly any money, regardless of how good of a surgeon he is, because he's up around $540 on his minutes. Many of the surgeons who take a long time, in our experience, are also expensive users of supplies. It's sort of a double whammy and you can get killed by it."

23. Pain management can be a problem. Pain management services are often provided in an office setting. Centers are increasingly concerned that physician investors will perform their pain management procedures in their own offices rather than in the ASC. Medicare's site-of-service differentials, which often pay more for in-office procedures, along with other incentives, may very well encourage physician investors to perform these procedures in their own offices. Because of this, ASCs should plan accordingly and diversify services to accommodate a potential loss of pain management revenue. CMS has also provided large reductions in pain management reimbursement for ASCs.

"Only Medicare and select commercial payors offer site-of-service differential," says Mr. Jang. "There are capital barriers to entry in setting up an in-office procedural suite, so if the doctors at practices of pain medicine have limited Medicare, it most likely will not prove financially feasible for these doctors to set up in-office procedural suite, thus mitigating risk."

24. Endoscopy. GI, if volumes are high enough, remains profitable for ASCs. Gastroenterologists will increasingly have to minor in anesthesiology. It is becoming more common that payors will not pay physicians separately for anesthesia procedures provided in connection with gastroenterology procedures. Thus, there is a greater onus on gastroenterologists that they must be competent at offering all types of anesthesia procedures.

25. Cosmetics/Plastics. Plastics, at least cosmetics-driven plastics, are often problematic for ASCs. In many situations where the physician bills globally, the ASC and physician can be adverse to each other and the ASC must negotiate its own rates with the surgeon.

"It is critical to use a time-based fee schedule in increments of 15 minutes with discounts built so that a case taking one hour is relatively more expensive than a three-hour case," says Mr. Zasa. "Also, if a surgeon starts late and the center incurs overtime, the overtime should be built into the fee unless the start time is not the fault of the surgeon. Finally, consistent cost tracking by physician is mandatory if a center performs plastics.

"The idea is to effectively reward faster, more efficient surgeons and penalize slower surgeons," he says. "Plastics can be a winner in an ASC setting. We know since Woodrum/ASD developed and operates an ASC devoted exclusively to plastic/aesthetic surgery comprised of six independent plastic surgeons. The center just celebrated its five-year anniversary and is doing better than ever despite the current economy. Don't shy away from plastics, but be smart about these cases and they will augment your facility."

26. Bariatrics may have reasonable long-term profit potential. Bariatric procedures are

growing rapidly and increasingly being performed in ASCs. Initially, ASCs will earn outsized profits from these procedures. However, as the number of bariatric providers increases and price competition evolves, the prices on these procedures will eventually normalize and become less profitable.

While the addition of bariatric procedures may seem like a good way to boost profits, careful planning is essential, says J. Woodward Hubbard, chief development officer of Bariatric Partners.

"Minimally invasive bariatric surgery, most notably the gastric band procedure, continues to become more attractive to multispecialty surgery centers as the focus toward managing obesity grows nationally," says Mr. Hubbard. "While many surgery center administrators see bariatric procedures as a boon to their overall revenue, adding a bariatric surgery program requires more than just purchasing new equipment and recruiting a surgeon."

Namely, that the gastric band procedure is both elective and expensive.

"Cost considerations beyond the actual surgery include a $3,200 device plus high patient acquisition costs," he says. "Bariatric patients do not typically come via the normal referral channels, resulting in the need to develop a targeted media campaign using a combination of search engine marketing, print and electronic media. Potential patients typically acquire most of their bariatric surgery education via the internet, support groups and informational seminars. The seminars are a key component of the acquisition process and surgery centers should be prepared to develop this process with the surgeon."

Another factor to consider before investing in bariatric surgery is that the care of a bariatric patient extends beyond the surgical experience.

"Another challenge for the surgery center is development of an aftercare program to support the post surgical patient," says Mr. Hubbard. "For the patient to maximize weight loss through use of the gastric band, they must receive regular adjustments and follow strict dietary and nutritional care plans. Otherwise, weight-loss outcomes with the gastric band procedure will not be satisfactory. Weight-loss surgery is a comprehensive program and not just a diagnostic or therapeutic procedure.

"Additionally, while the elective nature of the procedure has created a cash-pay opportunity, the long-term profit potential must be tempered by the fact that the global fees necessary to produce the predicted margins are already under pressure from surgeons willing to trade lower margins for market share.

"Finally, insurers and managed care plans continue to evaluate how to reimburse for gastric banding in a surgery center," Mr. Hubbard says. "Their preference would be to simply pay for a laparoscopic procedure plus a device. However, with aftercare a critical part of successful patient outcomes, they must be amenable to cover costs associated with these necessary support programs. This will present a challenge in negotiating future contract rates with insurers."

27. LASIK. LASIK is best left to practices rather than surgery centers.

"There is a strong overlap on the service side of LASIK that naturally connects the ophthalmology office to the LASIK suite," says Edward Colloton, MD, an ophthalmologist at Eye Surgical Associates in Bloomington, Ill. "Many patients think of LASIK as a quick 'laser thing' — in and out in 20 to 30 minutes and I see great — not like 'real surgery.' Patients do not expect the stepped-up level of care that would be seen in a typical multi-specialty ASC when they are undergoing LASIK. They also like to see the same faces that they saw in the office at their pre-op appointments. The service side of this procedure is so important that there is little room for compromise.

"On the economic side, these are really single-use laser devices with high costs and frequent upgrades," Dr. Colloton says. "Nearly all LASIK docs use a global fee that includes the surgery facility costs, but the net all flows through the MD practice. Costs associated with the procedure can be shifted, deferred or 'eaten' much easier in the MD office environment. The LASIK specific center with multiple surgeons is a model that has worked, especially with the high costs of laser technology and in more urban settings, but given the opportunity, most LASIK surgeons would like the laser in or adjacent to their primary office."

28. Do not overbuild. Overbuilding an ASC can result in its demise. A center with substantial fixed building and equipment costs will likely face long-term cost problems. To prevent this from happening, the ASC should be built to meet the expected volume and specialty needs. There are not many things that can predict the long term death of a center more than over expenditure on fixed building costs and fixed equipment costs. These are costs that almost never go away. Where appropriate and fiscally viable, an ASC may consider building to accommodate future growth but this should be done with caution.

"The best way to make sure you do not overbuild is to let data drive the process of determining the scale of the facility," says Kenneth Hancock, president and chief development officer of Meridian Surgical Partners. "Determine the net transfer of cases from the physicians to the new center by analyzing billing reports and conducting in-depth interviews with the physicians to validate the information and gain additional intelligence.

29. A great staff makes for a successful ASC. A great staff is crucial to an efficient and profitable ASC. You need not necessarily employ your staff fulltime. However, you are best off paying your staff extremely well and attempting to obtain the highest quality staff — even if paid high on an hourly basis. It is also critical that you treat the staff extremely well so that you are able to recruit and retain the best possible staff. Finding and retaining an experienced and competent staff can be difficult.

"Great staff is not an accident; it is done with great care and thoughtfulness on the side of the administrator or nurse manager," says Sandy Berreth, RN, BS, MM, CASC, administrator at Brainerd Lakes Surgery Center in Baxter, Minn. "A great staff is made. Ambulatory care is unlike any other setting — the nurse must be a savvy nurse while being a healthcare advocate for the patient as well as being concerned about customer satisfaction. Teach by example, with respect, kindness and a willingness to find out the facts about every situation.

"I believe staff appreciate being part of the solution, they want to be included not in just the 'medical' part, but involved with making a center a viable business entity," she continues. "Staff must be allowed to determine their future and the success of their future. Share the financials — good and bad — as well as safety and quality. And remember: It is not always about money. Respect, kindness, and extra kudos —

verbal and situational — do a lot to keep staff happy and, more importantly, engaged in your facility."

30. Partnering with single physicians is risky. An ASC developed with only one or two physician investors is a risky proposition in most cases. It can create both political and financial problems. Often, one or two physicians generally cannot generate enough business to make the operation profitable. However, there are some situations where an ASC can be profitable with only one or two physician investors. For example, an ENT physician specializing in sinus procedures may succeed himself or with a single partner if the ASC is run efficiently and the procedure volume is high.

"We have acquired centers where you had one surgeon with a considerably higher ownership position than the other partners and have found this to be a fatal flaw for the center's possible success," says Chris Bishop, vice president of business development for ASCOA. "It actually demoralizes the other surgeons' motivation to support the center because they feel their production is lining the majority shareholder's pocket. It also limits the ability of the center to recruit additional surgeons because of the prospective surgeon's reluctance to join a venture in which there is one dominant surgeon owner.

"The other risk is if you have one to two dominant investors/producers in the venture, and if one is disabled or meets an untimely death, you have — overnight — moved to an unprofitable venture under substantial strain," Mr. Bishop says. "We prefer to diversify the centers with multiple specialties to lower risk. This is analogous to my retirement portfolio being invested in multiple stocks, across multiple size and categories, as opposed to being 100 percent invested in Enron. The banking industry is being pummeled by the markets at present but because I am diversified, I have very little personal exposure here, and it is important to view your surgery center investor list in a similar fashion.

"In fact, we will not close an acquisition transaction until we have recruited a minimum number of surgeon partners across multiple specialties that greatly reduces risk," he says. "We walk away from projects that do not meet these requirements and this discipline has saved us from ever making a mistake in pursuit of an acquisition.

"Despite these rules, we have seen many surgeons unwilling to dilute their position to equal ownership, despite us showing them that a 10 percent position in a highly profitable venture is much preferable to a 75 percent ownership position of a money losing venture … hubris is a difficult flaw to overcome in some instances," Mr. Bishop says.

The addition of just one physician-owner can make a big difference, says Mr. Taylor.

"At Practice Partners facilities, we have seen centers focused on two physicians with higher than average volume do exceptional both clinically and profitability," he says. "We increase the cash reserves in these centers to add a valuable cushion in the case of physician decrease in volume for a variety of circumstances.

"Also, centers with two physicians tend to follow very similar practices, thus reducing expenses as well," Mr. Taylor says. "Centers with two physicians would also need a succession and growth plan to assure viability in the future, additional partners or growth in a single group are often seen. We have also seen lower number physicians attract other groups to reach traditional critical mass and great upside when reviewing the initial expectations. Those centers that started with only two core physicians often pave the way for more partners, often sooner than later."

31. Choosing the right anesthesia provider is vital. ASCs should treat anesthesia as more than just a requirement to run their business. Anesthesia is a critical component to patient care and profitability, which is why it is vital that ASCs perform due diligence when making their choice of an anesthesia provider. The better providers will have experience working in ASCs and will buy into the mission of the center.

"The key is understanding that anesthesia is the backbone of any successful operating room or surgery center," says Marc Koch, MD, MBA president and CEO of Somnia. "My belief is the better the anesthesia group, the better performing the OR. With that in mind, it is critical that an ASC Anesthesia group be multi-faceted by delivering on clinical quality, patient safety and financial results equally to enable the facility to meet its objectives."

ASCReview

Traffic Report: 15 Most Popular Articles on www.BeckersASC.com

1. 10 Valuation Facts and Statistics for ASCs
www.beckersasc.com/ambulatory-surgery-center/surgery-center-business-issues/10-valuation-facts-and-statistics-for-ascs.html

2. 10 Interesting Facts and Statistics for ASCs
www.beckersasc.com/ambulatory-surgery-center/surgery-center-education/10-interesting-facts-and-statistics-for-ascs.html

3. 10 Keys to Turning Around Financially Troubled ASCs
www.beckersasc.com/ambulatory-surgery-center/surgery-center-business-issues/10-keys-to-turning-around-financially-troubled-ascs.html

4. 10 Benchmarking Statistics for Ambulatory Surgical Centers
www.beckersasc.com/ambulatory-surgery-center/surgery-center-education/10-benchmarking-statistics-for-ambulatory-surgical-centers.html

5. California Licensure and Accreditation Concerns — Ambulatory Surgical Centers
www.beckersasc.com/ambulatory-surgery-center/surgery-center-legal-issues/california-licensure-and-accreditation-concerns——ambulatory-surgery-centers.html

6. N.J. Decision May Cause Big Challenges for State's Physician-Owned ASCs
www.beckersasc.com/ambulatory-surgery-center/surgery-center-legal-issues/n.j.-decision-may-cause-big-challenges-for-states-physician-owned-ascs.html

7. Establishing an Ambulatory Surgery Center: A Primer from A to Z
www.beckersasc.com/ambulatory-surgery-center/surgery-center-planning/establishing-an-ambulatory-surgery-center-a-primer-from-a-to-z.html

8. The Fraud and Abuse Statute and Investor-Owned Ambulatory Surgery Centers
www.beckersasc.com/ambulatory-surgery-center/surgery-center-legal-issues/the-fraud-and-abuse-statute-and-investor-owned-ambulatory-surgery-centers.html

9. CMS Proposes 3 Percent Increase for Outpatient Services, Adding 9 Procedures to ASC List
www.beckersasc.com/healthcare-business/healthcare-business-issues/cms-proposes-3-percent-increase-for-outpatient-services-adding-9-procedures-to-asc-list.html

10. 12 Interesting Statistics from the VMG Health Endo Centers Financial and Operational Benchmark Study
www.beckersasc.com/ambulatory-surgery-center/surgery-center-business-issues/12-interesting-statistics-from-the-vmg-health-endo-centers-financial-and-operational-benchmark-study.html

11. Top 10 Billing Errors ASCs Make
www.beckersasc.com/ambulatory-surgery-center/surgery-center-business-issues/top-10-billing-errors-ascs-make.html

12. Litigation Against ASCs on the Upswing
www.beckersasc.com/news-analysis-asc/antikickback-legal-regulatory/litigation-against-ascs-on-the-upswing.html

13. Ambulatory Surgery Centers and Physician-Owned Hospitals — What Causes the Political Chasm?
www.beckersasc.com/white-papers/white-papers/ambulatory-surgery-centers-and-physician-owned-hospitals——what-causes-the-political-chasm.html

14. Compensation Up for 8 Core Specialties That Regularly Practice in ASCs
www.beckersasc.com/healthcare-business/healthcare-business-issues/compensation-up-for-8-core-specialties-that-regularly-practice-in-ascs.html

15. Average Salaries for Top Recruited Specialties
www.beckersasc.com/healthcare-business/healthcare-business-issues/average-salaries-for-top-recruited-specialties.html

When performing due diligence on the selection of a new anesthesia provider or group, Dr. Koch recommends ASCs consider the following questions:

- Does it have relevant ambulatory anesthesia experience? Related operational benchmarking data?
- Does it currently or is it in the process of seeking ambulatory accreditation?
- Does it have a quality assurance program?
- Does it have a transparent financial model?

32. Surviving as a hospital if legislation occurs will change the game. If legislation does not allow physician-ownership, it is critical that the hospital have a great core group of physicians, have plenty of cash and have a sufficient portfolio of business to build the transitions into a more typical and fuller hospital. In these situations, you will likely see these hospitals, for all practical purposes, operated similarily to how competitive non-physician-owned not-for-profit and for-profit hospitals are operated.

"Assuming legislation — as it has been recently offered — were to pass requiring, at a minimum, dilution of physician ownership you will certainly ee some hospitals transition, says Todd Flickema, senior vice president of Surgical Management Professionals. "Some will move into the classic version, from a services-offered perspective, of the full-service hospital. I think largely that will be dictated by the market where each hospital is located. There will be a second group that will continue to operate in their niche. Here, again, markets will or should dictate this, and one of the main reasons is that this is still the place physicians want to work. They don't want to sell to the not-for-profit because they do not want it in someone else's control. They want to control the clinical experience for themselves, their patients and their staff.

"In these instances, the hospitals will need to attain a corporate partner that helps them maintain the mission for which they were first created and adds value," he says. "This will dictate that hospitals start having these conversations and looking at the potential corporate partners that are out there now rather than be reactionary."

33. General surgeons remain vulnerable to challenges from hospitals. General surgeons increasingly remain vulnerable for dispute of referrals from general hospitals. General hospitals still control through a variety of means referrals to general surgeons. Thus, general surgeons at surgery centers are often not able to generate nearly the types of business that they generated when not related to another surgery center.

"A general surgeon who practices in a market that is dominated by a fully-integrated health system certainly feels these pressures," says Mr. Flickema. "They get the message from their referring physicians that 'you're either for us or against us.' The system begins to dictate the delivery of healthcare in these markets. The free market does not get to sort out who are the best providers of care, as the health system determines that almost solely based on whether or not a particular surgeon brings his cases to the health system.

"So a surgeon who is, at best, a marginal provider of care can actually do well in these markets. As long as he is insulated by the health system, he can continue to provide marginal care and there are no checks and balances."

34. Work with experienced lenders. Working with experienced lenders will facilitate the financing of an ASC. It can be tempting to work with a friend or a local bank, but this could be a mistake. Often with ASCs, time is of the essence and problems occur which are normally much better handled by an experienced lender than with a friend. For the best result, look for a lender with specific ASC financing experience.

"Even though it is our preference to work with national lenders with standard documents, many are on the sidelines," says Mr. Mallon. "You really need to bring in local lenders with physician relationships in order to ensure closing the transaction. The guarantees will be more than the national lenders but at least the transaction will close."

35. Continually recruit new good partners. Generally an ASC should regularly recruit new surgeons. New surgeons can add capital and provide a transition from older or retiring surgeons, to keep the ASC viable. While it is important that new recruits be productive physicians and that they meet the safe harbor tests, it is equally important that they be high-quality people and team players. Often in

ASCs, one difficult physician (or staff member) can ruin a great center.

36. Neurosurgery and orthopedics remain strong specialties. Orthopedic procedures remain great procedures for ASCs, and neurosurgery spine procedures increasingly so. They remain popular and growing specialties for ASCs. Orthopedics profits from the new CMS surgery center rates. Spine procedures can be increasingly performed in ASCs. These are likely to remain good specialties for ASCs for a long time to come.

"To date, most orthopedic ASC cases have been commercial pay, hence younger patients," says Mr. Leland of Blue Chip Surgical Center Partners. "With the new CMS orthopedic fee schedule, ASCs will likely see older, less healthy orthopedic patients — we must be cautious. As for spine cases, they will continue to transition from inpatient to outpatient, but remain a challenge both clinically and commercially. Spine cases are not for every ASC — we believe a 'go slow attitude,' careful patient selection, thorough staff training and excellent contracting skills are necessary for successfully supporting physicians performing complex spine surgery in an ASC ... clearly not for every ASC."

37. Waiver of co-payments and deductibles presents more risks than ever before. Increasingly states are attacking the waiver of co-payments and deductibles and insurance companies are challenging such actions through a variety of means. These include recruitment efforts, efforts to only pay the patients and efforts to slow pay parties that are out-of-network. We see providers increasingly have to look at different options than using out-of-network strategies and reduction of co-payment strategies as a means to combat bad contract options.

"It's a chancy situation when you do out-of-network patients and offer them deals," says Caryl Serbin, RN, BSN, LHRM, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing "You must tell the insurance companies that you're going out-of-network, preferably at the time that you're doing the insurance verification. Some states and some insurance companies require that you fax their notifications to them. On the claim form it has to be clearly marked that you are following out-of-network benefits, and if that's the case, you have to offer the same discount you are offering to the insurance company that you are offering to the patient.

"As far as the attorneys are concerned, if you do one without the other so that you can get the higher out-of-network payment and charge the patient the in-network deductible, this is where you're becoming non-compliant because you should be offering both of them the same deal."

38. Information technology is critical. At one time, parties took pot shots at the use of new information technology in surgery centers. Now, as outstanding management becomes more critical to sustain surgery center success. In such surgery centers, the proper and intelligent use of information technology becomes that much more important. We expect centers to make more significant investments in information technology and as importantly, software systems that go with the technology to help them better handle case costing, benchmarking and other statistical analysis for their surgery center.

ASCs have been slow to invest in and adapt these new technologies, observes Arvind Subramanian, CEO of Wolters Kluwer Health Clinical Solutions and ProVation Medical.

"In March of this year, our company conducted a survey of 175 ASC administrators and found that while adoption of electronic health records (EHRs) is viewed as inevitable, only 18 percent of ASCs surveyed currently use an EHR," Mr. Subramanian says. "Barriers to adoption cited included upfront capital investment, the fear of lost revenue during implementation, and worries about integration with other electronic systems.

"But relying on paper in an era of electronic documentation and communication is inefficient and expensive. The key to streamlining processes, increasing patient safety and cutting administrative costs through electronic documentation lies in choosing an EHR with a proven record of integration, from a company with a robust training and implementation plan that can minimize the initial workflow disruption and offer ongoing support."

The good news is that while ASCs face many

continued on page 36

Ambulatory Surgery Centers

Improving Profitability and Business and Legal Issues

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THE 15th ANNUAL CONFERENCE FROM
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SAMPLE TOPICS INCLUDE:

- Gastroenterology, ENT, Opthalmology, Pain Management and Bariatrics in ASC — What Works and What Doesn't
- Successful Structuring of Physician-Hospital ASC Joint Ventures
- Orthopedics in ASCs — What Can You Expect the Next Five Years
- How to Reduce Staffing Hours Per Case
- The State of the Union for ASCs
- Spine and Bariatrics in ASCs
- Making Urology a Success in Your ASC
- How to Turn Around Your ASC
- Can Two Centers Thrive by Merging?
- Practical Case-Costing and Benchmarking for ASCs
- The Future of ASCs
- Assessing the Profitability of Different Specialties in ASCS
- Orthopedics, Gynecology and Opthalmology in ASCs
- Will the Stark Laws Close Down ASCs?
- 10 Key Statistics You Should Review Each Week
- How to Recruit and Retain Great Directors of Nursing and Great Nursing Staff
- Developing Strategies for Managed-Care Contracting
- Key Practical Tips to Improving an ASC's Coding Efforts
- Safe Harbor, OIG Work Plan and Out-of-Network Issues
- Key Steps to Establishing ASCs
- Core Strategies to Succeed with Orthopedics and Neurosurgery in ASCs

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For a full list of the speakers and the agenda visit ***www.BeckersASC.com.*** *Sign up for the Becker's ASC Review E-Weekly at* ***www.BeckersASC.com.***

CONFERENCE PROGRAM

THURSDAY, OCTOBER 23, 2008

12:00 – 2:00 pm – Registration

Pre-Conference Workshop – Concurrent Sessions A, B, C, D, E

2:00 – 3:00 pm

A. Successful Strategies and Methods to Rejuvenate an ASC
Luke Lambert, CEO; Tom Bombardier, MD, Chairman, Ambulatory Surgical Centers of America

B. A Case Study Approach to Building an ASC
Tom Mallon, CEO, Regent Surgical Health; Jeff Simmons, President, Western Division, Regent Surgical Health; Jim Lynch, MD, Chairman, Director, SpineNevada and Surgery Center of Reno, Director of Spine Services, Regent Surgical Health

C. Gastroenterology, Ophthalmology (and Retina) and ENT, Pain Management and Bariatrics in ASCs — What Works and What Doesn't? Tips For Improving Profits
Anne Roberts, RN, Administrator, Surgery Center of Reno; Steve Blom, Specialty Surgery Center in San Antonio, Regional Director, National Surgical Care; John Poisson, Executive VP, Physicians Endoscopy; Doug Hoisington, DO

D. How to Reduce Hours Per Case; How to Recruit and Retain Great Directors of Nursing and Staff
Lisa Cooper, Administrator, El Camino Surgery Center; Mary Sturm, SVP of Clinical Operations, Surgical Management Professionals; Michelle Smith, Director of Clinical Operations, Nueterra

2:00 – 2:30 pm

E. Valuing ASCs for Sale and for Syndication, and ASC and Hospital Compensation Issues
Todd Mello, Principal, Health Care Appraisers

2:30 – 3:00 pm

E. The ASC Risk Profit Mix — How Partnership Risk Affects Value
Greg Koonsman, Founder, VMG Health

3:00 – 4:00 pm

A. Payor Trends, Impact on Negotiation Strategies and the Impact of the CMS Conversion in Methodology on Commercial Contract Negotiations
Naya Kehayes, CEO, Eveia Health Consulting and Management

B. Successfully Structuring Physician Hospital Joint Ventures — Key Tips for Short- and Long-Term Success
Joe Zasa, CEO, Woodrum/ASD; Deann Manchester, USPI; Amber Walsh, JD and Elissa Moore, JD, McGuireWoods

C. Orthopedics in ASCs — What Can You Expect in the Next Few Years?
John Cherf, MD, Dept. of Orthopedics, Neurological & Orthopedic Hospital of Chicago

D. Difficult Spine and Orthopedic Cases in an ASC
John Caruso, MD, Parkway Spine Surgery Center; John Dipaola, MD, East Portland Surgery Center

3:00 – 3:30 pm

E. From ASC to Hospital — What are the Pros and Cons of a Conversion to a Hospital?
Brett Gosney, CEO, Animas Surgical Center, now Animas Surgical Hospital

3:30 – 4:00 pm

E. Physician Recruitment in 2008: Some Key Thoughts and Challenges on Recruiting ENT, Gynecology and Ophthalmology
Brett Gosney, CEO, Animas Surgical Center, now Animas Surgical Hospital

4:00 – 5:00 pm

A. Applying the Concepts of Six Sigma to Operating an ASC
Earl Walz, COO, The Urology Group; Greg Zoch, Partner, Kaye/Bassman International Corp.

B. 4 Different Methods to Improve Your ASC — Recruiting and Physician Buy-Ins, Collections, Patient Financing
Chris Bishop, VP of Bus. Development, ASCOA; Doug Lewis, Managing Director, Physicians Capital; Tyler Marsh, Affiliated Credit Services; Rob Morris, CareCredit

C. Do you Play Hockey? — Why Centers are Using Canadian Markets to Sell Their ASCs
Donald Kramer, MD, President, Northstar Healthcare; Larry Teuber, MD, President, Medical Facilities Corp.

D. 10 Keys to Outstanding Benchmarking and Case Costing
Susan Kizirian, COO, and Ann Geier, VP of Operations, ASCOA

THURSDAY, OCTOBER 23, 2008

4:00 – 5:00 pm

E. Key Legal Issues and Are Stark and Self-Referral Law Going to Close Down ASCs and Physician-Owned Hospitals?
Amber Walsh, JD, and Melissa Szabad, JD, McGuireWoods

5:00 – 7:00 pm – Networking Reception and Exhibit Hours

FRIDAY, OCTOBER 24, 2008

7:00 – 8:00 am – Registration and Continental Breakfast

7:00 – 10:00 am – Exhibitor Setup

Main Conference – *General Session*

8:00 am

Introductions
Scott Becker, JD, CPA, Partner, McGuireWoods

8:00 – 8:55 am

Healthcare: The Next Five Years
Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics, Princeton University

9:00 – 9:40 am

The State of the Union for ASCs
Kathy Bryant, President, ASC Association

9:45 – 10:20 am

Understanding Industry Trends and How They Impact Independent ASCs and National Chains
Sami Abassi, CEO, National Surgical Care

10:20 – 11:10 am – Exhibits Open

11:10 – 11:55 am

Building a Brand in the World of Healthcare
Rick Kolsky, Professor of Marketing, Kellogg School of Business

11:55 – 12:30 pm

Assessing the Profitability of Different Specialties in ASCs
Luke Lambert, CEO, ASCOA

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

Concurrent Sessions A, B, C, D, E

1:30 – 2:05 pm

A. Making Urology a Success in Your ASC
Bill Mobley, MD, Urological Associates; Herb Riemenschneider, MD, Knightsbridge Surgery Center

B. Controlling Implant Costs, Staffing Costs and Supply Costs — Strategies for Success
Larry Teuber, MD, President, Medical Facilities Corp.; Scott Jackson, VP, Surgery Center Division, McKesson Surgical

C. Developing an ASC Managed-Care Contracting Plan and Strategy With Your Partnership
Matt Kilton, COO, Eveia Health Consulting and Management

D. Effective Billing and Coding for ASCs in the Wake of CMS Changes
Caryl Serbin, President and Founder, Surgery Consultants of America, Serbin Surgery Center Billing

E. Key Legal Issues — The OIG Work Plan for 2008, Safe Harbor Compliance, Out of Network, and Other Legal Issues
Scott Becker, JD, CPA, Partner, and Scott Downing, JD, McGuireWoods

2:10 – 2:45 pm

A. How a Hospital Partner Can Help an ASC — Should Your Hospital Own Shares and How Much Should It Own?
Phil Taylor, MD, Knightsbridge Surgical Center; Robert Carrera, CEO, Pinnacle III; Ed Hetrick, President, Facility Development and Management

B. An Administrator's Viewpoint and Success Stories — How to Get My Doctors to Do What I Think They Should Do Without Yelling, Breaking the Law or Losing My Job
Rob Welti, MD, Corporate Medical Director and COO, Western Region, Regent Surgical Health

CONFERENCE PROGRAM

FRIDAY, OCTOBER 24, 2008

C. Can Merging Two Centers Lead to Success?
Tom Yerden, CEO and Founder, TRY Solutions

D. Ophthalmology and ENT in ASCs — How to Succeed with Eyes and ENT
Steve Blom, Specialty Surgery Center in San Antonio, NSC; Doug Hoisington, DO

E. Using Benchmarking to Measure Risks and the Real Value of Physician Shares in an ASC
Jon O'Sullivan, Principal, VMG Health

2:45 – 3:45 pm – Exhibits Open

3:45 – 4:20 pm

A. How Much is Your ASC Worth?; What Terms Can You Expect?; What Does a National Company Want After a Deal?; 10 Facts That Will Drive a Buyer Away
Bill Kennedy, SVP of Business Development, NovaMed; Kenny Hancock, President and CDO, Meridian Surgical Partners; Rick Pence, President and COO, National Surgical Care; Mike Weaver, VP of Acquisitions and Development, Symbion; George Goodwin, SVP and CDO, Symbion

B. Which Back-Office Services Can you Effectively Outsource? — What Works; What Doesn't Work — What Are the Costs and Benefits?
Steve Dobias, Principal, Somerset CPAs; Tom Jacobs, President and CEO, MedHQ

C. Core Tips and Strategies to Succeed with Orthopedics and Neurosurgery in ASCs
Mike Lipomi, President, RMC Medstone

D. Performing Complex Spine Procedures in an ASC
Greg Poulter, MD, Surgeon, Peak One Surgery Center; Lisa Austin, RN, CASC, VP of ASC Clinical Operations, Pinnacle III

E. What Do You Do When a Major Payor Cuts Your Reimbursement by 20 Percent?
Robyn Finnegan, VP of Managed Care, and Don Jansen, VP of Marketing and Development, Prexus Health Partners

4:20 – 4:55 pm

A. How Much is Your ASC Worth?; What Terms Can You Expect?; What Does a National Company Want After a Deal?; 10 Facts That Will Drive a Buyer Away (continued)
Bill Kennedy, SVP of Business Development, NovaMed; Kenny Hancock, President and CDO, Meridian Surgical Partners; Rick Pence, President and COO, National Surgical Care; Mike Weaver, VP of Acquisitions and Development, Symbion; George Goodwin, SVP and CDO, Symbion

B. Practical Case Costing and Benchmarking for ASCs — Strategies and Ideas You Can Use Monday Morning
Alsie Sydness-Fitzgerald, RN, Chairperson, ASC Association

C. Establishing an ASC — Key Concepts for Success
Bill Southwick, President and CEO, Healthmark Partners

D. GI and Endoscopy — How ASCs Still Thrive with GI
Barry Tanner, President and CEO, Physicians Endoscopy

E. Orthopedics in ASCs — What Works and What Doesn't From a Business and Clinical Perspective
John Cherf, MD, Dept. of Orthopedics, Neurological & Orthopedic Hospital of Chicago

4:55 – 5:30 pm

A. The Future of ASCs
Marc Koch, MD, President and CEO, Somnia; Tom Mallon, CEO and Founder, Regent Surgical Health; Tony Taparo, Group President, Symbion

B. Current Strategies to Handle Out-of-Network and High Deductible Patients
Cathy Weaver, Senior Manager, Somerset CPAs; John Seitz, CEO, Ambulatory Surgical Group

C. How to Hire Great Administrators and What They Should Be Compensated
Roger Manning, President, Manning Search Group

D. Effectively Managing a Board in Congruence With Physician Leadership
Nap Gary, President, Eastern Region, Regent Surgical Health

E. Converting From an ASC to a Hospital — How to Assess the Financial Case for Conversion
Mike Griffin, CFO, and Mary Ann Gellenbeck, RN, COO, Prexus Health Partners

5:30 – 7:00 pm – Networking Reception & Exhibits

SATURDAY, OCTOBER 25, 2008

7:30 – 8:15 am – Continental Breakfast

8:15 – 8:55 am

5 Core Strategies ASCs Can Use for the Next Five Years
Tom Mallon, CEO and Founder, Regent Surgical Health

9:00 – 9:40 am

A. Creative Restructuring of a Physician-Hospital Joint-Venture ASC — A Win-Win-Win Solution
Jeff Leland, Managing Partner, Blue Chip Surgical Partners; Mark Beaugard, MD, and George Trajtenberg, MD, Turks Head Surgery Center

B. 10 Ways to Maximize the ROI and Use of Your ASC's IT System
RVP of Ops, Meridian Surgical Partners; Marion Jenkins, PhD, CEO, QSE Technologies; Brien Fausone, Administrator, Michigan Endoscopy Center

Concurrent Sessions A, B, C, D

9:45 – 10:20 am

A. The 10 Key Statistics You Should Look at Each Week and Month
Boyd Faust, CPA, Chief Financial Officer, Titan Healthcare

B. Succeeding Without Orthopedics — How A Multi-Specialty ASC Can Thrive Without Orthopedics
Steve Holst, MD, and Scott Bateman, MD, Founders, Sheridan Surgical Center

C. Should Your Anesthesia Providers Be Owners of Your ASC, Be an Employee of Your ASC, Both or Neither?
Joe Zasa, CEO, Woodrum/ASD; John Poisson, Executive VP, Physicians Endoscopy

D. General Surgery in ASCs — Why More General Surgeons Are Moving to ASCs; Are General Surgeons Worth Pursuing as Partners?
Tom Galouzis, MD, President, Lake Park Surgicare

10:25 – 11:00 am

A. Primary Care Physicians as Procedurists in ASCs
Steve Lloyd, MD, Medical Endoscopy of South Carolina

B. Key Practical Tips to Improving an ASC's Coding Efforts
Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting

C. The Best Opportunities for ASCs Now
Larry Taylor, President and CEO, Practice Partners in Healthcare

D. Buyer's Perspective on Selling Your ASC — What An ASC Needs to Know Going In
Evie Miller, Director of Acquisitions, United Surgical Partners

11:05 – 11:40 am

A. How to Recruit High-Quality and Productive Surgeons to Work at Your ASC
Rob Carrera, CEO, Pinnacle III

B. Implementing and Marketing Bariatrics in ASCs
Jamie Carr, RN, President, Carr & Associates; Kimberly Taylor, President, Taylor & Associates

C. Hand Surgery in ASCs — Is it Still an Extra-Base Hit?
Jeff Peo, VP of Business Development, ASCOA

D. 10 Things We've Learned From the New CMS Reimbursement System and Coverage Rules
Robert Cates, National Director of Managed Care, NSC

11:45 – 12:20 pm

A. Financing and Recapitalizations for ASCs and Specialty Hospitals
Jeff Fox, VP, Hospitals, Surgery and Dialysis, MarCap

B. Seven Deadly Sins in Purchasing for an ASC
Larry Lane, Supply Chain Management

C. Revitalizing an ASC — A Case Study
Don Cook, President and CEO, Pacific Surgical Partners

D. 3 Ways to Add Profits to an ASC
Steve Burton, CEO, ION Healthcare; Bob Wood, VP of Strategic Planning, Acclarent

12:20 – 1:00 pm – *General Session*

Safe Harbors, Legal Question and Answer (and) Peace or War? What to Do When a Hospital Tries to Put Your ASC Out of Business
Scott Becker, JD, CPA, Partner, McGuireWoods

1:00 pm – Meeting Adjourn

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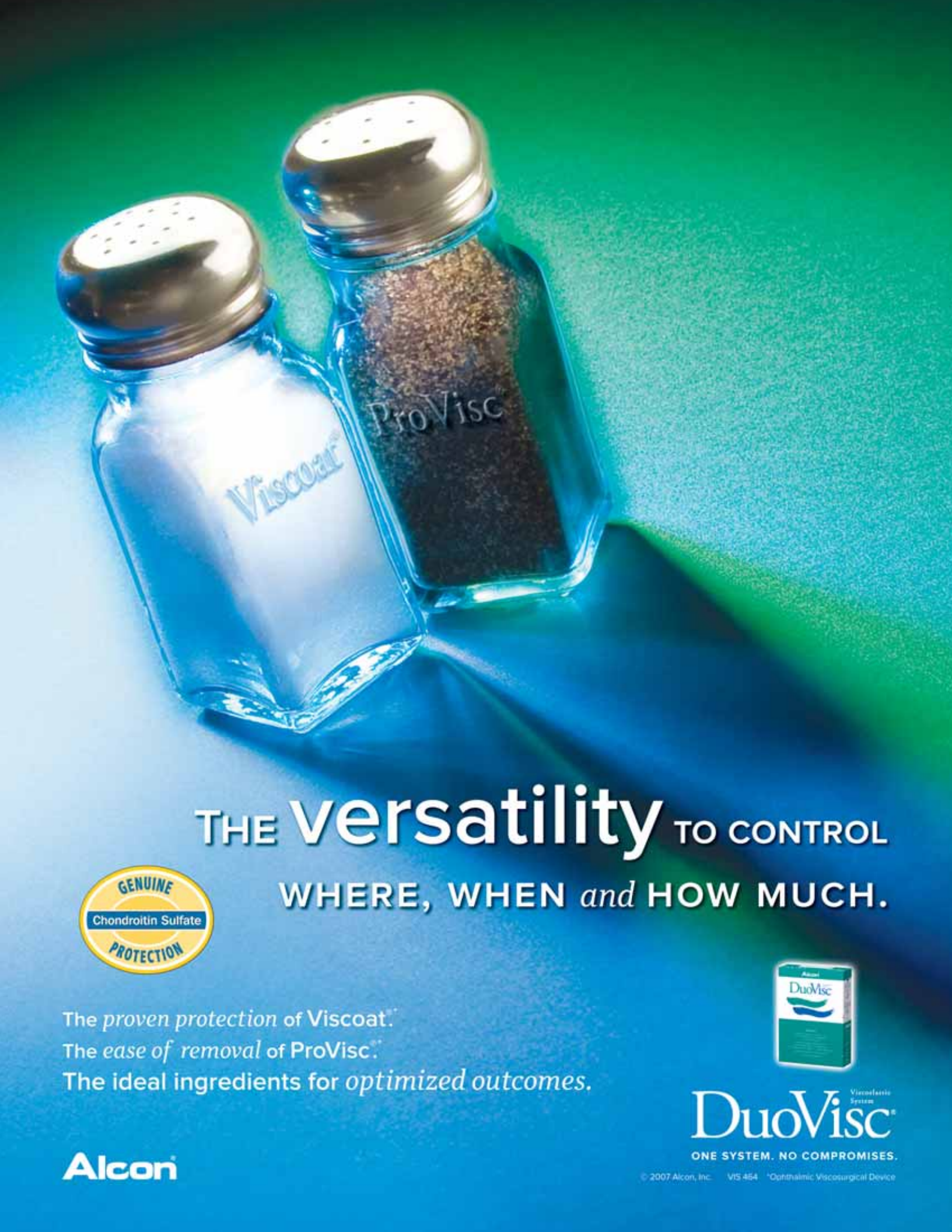

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41 Things You Should Know About ASCs (continued from pg. 30)

challenges, technology is available to assist with overcoming them.

"One pressing issue faced by centers today is the reduction in reimbursement money," says Jeff Blankenship, president of Surgical Notes. "This reduction, many times, is a direct result of inaccurate data being transmitted to the payor. These inaccuracies are, many times, a direct result of having multiple data entry points of the same ADT (admission, discharge and transfer) information. This duplication of duties greatly increases the likelihood of errors and increases employee cost.

"Proper utilization of technology lets ASCs eliminate these multiple points of data entry into the system, thereby reducing possible transposition errors and greatly increasing reimbursement amounts by delivering accurate data to the payor," he continues. "In the past, information technology solutions were expensive. That is not always the case now. Do your homework and you will find very affordable and functional technology. Companies have seen the need for these services to be affordable and there are great solutions available for reasonable amounts. You owe it to your facility to investigate these solutions. The right technology can greatly increase your facilities bottom line results and reduce errors."

39. Good A/R, billing and collections are key to a successful ASC. Well-managed accounts receivable and billing and collections departments are critical to the success of an ASC. Cash collection is critical to an ASC, and any delays or defaults in billing or payment can damage a bottom line. Consider hiring billers and coders or a billing company with specific ASC billing experience.

"We all strive to provide the very best patient care possible, but we are still a business," says Ann Geier, RN, MS, CNOR, CASC, vice president of operations for ASCOA. "The business office needs to function like a well-oiled machine, and good processes empower the employees to do this. Everyone should understand what is expected, the goals that they are trying to meet, and the benchmarks that they will be evaluated against."

"For example, if A/R days are to be at 35 days, how are they to achieve this?" asks Ms. Geier. "The processes would include timely follow up with all accounts, including Medicare. Persistent phone calls to the payors with detailed documentation of the calls. Any rise in A/R days should signal that something may be amiss. Are the collector's behind in their follow-up calls? Is too much time elapsing between calls? The cost of hiring another collector more than pays for itself in the additional collections brought in."

Hiring the right coders is also a crucial cog for successful collections efforts.

"Experienced, ethical, cautious coders are among your best assets in the ASC billing world," says Nancy Burden, RN, MS, CPAN, CAPA, the director of BayCare Ambulatory Surgery in Largo, Fla. "Look for someone who will be aggressive in analyzing physician documentation and who is not afraid to ask for clarification in writing. It is, likewise, essential that the administrator stand behind the coding if controversy occurs. We want neither upcoding nor loss of revenue from missed procedures."

"Cash collections should be a team effort between both the front end and back end business teams," Ms. Burden says. "Securing co-pays and deductibles prior to the surgery is not only good business practice, but an essential part of the center's financial health. The demeanor of the front end team should be such that they are friendly but persuasive and not afraid to offer payments alternatives to patients. Another important aspect is to ensure that the preoperative nursing advice about leaving valuables at home does not conflict with the patient's understanding to bring their required payment."

40. Charity care. Providing a fair share of charitable care is a positive and good thing.

"I like to see the boards of my ASCs approve a percentage of their net revenue to provide charity care to patients in the community," says Ms. McLane. "Many physicians feel that this is a very important part of the care they provide to the community and will often want to be very generous in this regard. We qualify all patients who report that they cannot pay their bills.

"All our centers have policies for providing charity care that often mirrors the hospital partner's policy if there is one," she continues. "In any event, the policy usually describes a sliding scale for writing off a portion up to all of the patient's financial responsibility for services provided,

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according to ratio of their net income related to the nationally published poverty level. For instance, we may begin writing off a percent of the patient's financial responsibility if the patient's net income is less than 350 percent of the published poverty level."

41. ENT continues to be strong. ENT continues to be a strong specialty for surgery centers. It continues to be reimbursed reasonably well in many markets.

"CMS changes are generally favorable for ENT," says Mr. Jang. "However, there are capital barriers to entry, so a new program generally requires more than one surgeon." ■

Contact Scott Becker at ***sbecker@mcguirewoods.com*** *or Rob Kurtz at* ***rob@beckersasc.com****.*

10 Things You Should Know About Construction

By Stephanie Wasek

Here are 10 top things in new and expansion construction our expert panel says you should do to ensure a successful project.

1. Perform proper site due diligence

"Before moving forward with final selection or acquisition of a site for the proposed facility it is important to do a thorough comparative analysis of the various sites under consideration including visibility, access, zoning, utility availability, future growth, cost, configuration and topography, setbacks, and other easements or requirements that affect usable area," says Rustin Becker, vice president advance planning with Madison, Wis.-based Erdman (A Cogdell Spencer Company). "Due diligence should include a formal survey, environmental site assessments and soil borings. Addressing problems that arise from these issues later in the development process can add significantly to projects costs or adversely affect your speed to market."

2. Seek an architect experienced in your state

The only thing that's certain when you build is that there will be myriad regulations to meet. But because they vary widely by state, it's important that your architect be well-versed in all the regulations imposed by your state's department of health, certificate of need board (if it has one), building codes and more.

"For example, in Illinois, you are only allowed to spend a certain dollar amount and build to a specified square footage, or else you risk losing your CON," says Mike T. Leopardo, vice president of healthcare construction for Illinois-based Leopardo construction. "Say you want to put an ASC into an existing building, and you have to upgrade the utilities and infrastructure to meet mechanical requirements — all those costs can really push the CON limit, so you need someone who is up to speed, especially as the regulations change."

3. Right-size the facility

"Many facilities have been designed around conceptual block scheduling or anecdotal utilization, such as 'orthopedics one operating suite, three days a week,'" says Mr. Becker. "Facilities developed in this manner tend to be oversized. Rather, they should be designed around anticipated or actual physician case

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volumes. Projected volumes should be discounted for factors such as payor contracts, acuity, and scheduling and convenience, then best-in-class ALOS factors and utilization rates should be applied to determine the number of operating suites and support beds needed. Facilities that are right-sized will have the lowest fixed costs, a big factor in positioning the entity for financial success."

4. Expect building costs to spiral

Currently and going forward, it's going to be difficult to use historical cost data to project building costs for any construction project.

"Materials and labor rates in our industry are volatile right now," says Mr. Leopardo. "Every June, with labor negotiations, those rates go up. That's nothing new. But now, because a lot of construction materials are petroleum-based, those costs are spiraling, especially when you factor in the higher cost of transport.

"Because of this, the time to build is as soon as you can get it built."

5. Design to suit the specialties

Here are some considerations for building, depending on the specialties that will utilize the facility, from John A. Marasco, principal of Denver-based Marasco and Associates.

• **Gastroenterology and pain management.** "These physicians do not want to deal with the sterility issues associated with a full-fledged, class C OR," he says. "These cases are non-sterile in nature, and treating them as sterile cases only slows down the surgeons, staffs and patients throughput process."

Accessibility to the OR should therefore not be off of the sterile corridor, but instead directly from the prep/recovery area. If you place this OR between the prep/recovery area and the sterile corridor, rather than on the other side of the sterile corridor, by placing doors into the OR from both the sterile and non-sterile sides, the design lets the OR swing back and forth, depending on the cases that are being performed and what access door remains unlocked.

"We call this a swing OR," says Mr. Marasco. "Of course this transition does not occur per case, but instead per surgical block period. For instance, an ophthalmologist may use the operating room in the morning as a sterile environment with the OR swinging in the afternoon to be used by a gastroenterologist as a non-sterile environment. This design technique takes no additional space, allowing a much more flexible ASC."

• **Orthopedics.** For more complex orthopedic cases (such as arthroscopies, spine and rotator cuffs), at least a class C, 400-square-foot (preferably 500) OR and plenty of equipment storage should be provided, he suggests.

• **ENT.** For ENT cases and their pediatric and adolescent patient base, additional privatized recovery stations should be provided.

• **Ophthalmology.** For ophthalmology cases (primarily cataracts) where several patients are blocked at once before entering the OR, additional prep stations should be provided.

"A little extra space now could save you a lot of headaches later," says Mr. Marasco. "In addition to the above-mentioned design issues, we recommend that any class B operating room (250 square feet —primarily used for minor cases such as gastroenterology and pain management) or above be at least piped with nitrous oxide anesthesia capabilities. All these issues are relatively inexpensive to address during the initial design process and can save you a lot of stress and potentially make you more money in the future when it comes to add specialties or sell to other specialties."

6. Consider the working environment

"Temperature and humidity control in the OR is one of the top complaints we hear about," says Mr. Marasco. "Although Medicare and state departments of health requirements allow for a 68-degree minimum temperature, to most surgeons this is unacceptably high. They typically like to have their operating rooms at 65 or even 62 degrees."

Depending on where you are located in the country, this temperature can be difficult to achieve with a standard rooftop HVAC mechanical unit while maintaining the required humidity level.

"Therefore, upgrading your HVAC system should be explored before completing the construction documents to allow for this control to be integrated into your ASC," says Mr. Marasco. "Do not let your architect or engineer design around the minimum requirements, which is typically their inclination, but instead use an experienced team that understands what levels your facility should meet in order to have happy users."

7. Select and integrate equipment.

"We find it is well worth the investment of engaging an equipment planner for proper and early selection of medical equipment and to effectively manage procurement," says Mr. Becker. "This will ensure that equipment has been appropriately budgeted during development of the financial pro-forma, allow for timely integration of the equipment needs into the construction drawings, and eliminate delays and associated change orders during construction of the facility."

8. Don't underestimate expansion

It's easy to approach expansion as a simple matter of adding an OR — but that's far from the case. Ancillary space, such as pre- and post-op bays, sterile processing, sterile storage, the waiting room and the parking lot will all have to be expanded as well, says Steve Dickerson, principal at Michigan-based Eckert Wordell.

Some rules of thumb for one-OR expansion:

• three more post-op cubicles at 100 square feet each;
• one more pre-op cubicle at 100 square feet;
• six to eight more waiting room chairs, depending on the lengths of procedures your facility performs; and
• four parking spaces per OR, plus one for each staff member, plus 30 percent (for a four-OR facility, this means a 51-space parking lot).

The idea he says, is to ensure there will be no bottlenecks created up or downstream from that new OR.

"Have the medical designer do a throughput study that takes into account the amount of time for each step in the process: check-in, pre-op, procedure,

post-op and discharge," says Mr. Dickerson. "It will tell us if we have any bottlenecks in the whole flow system and how many patients the center has the capability to process. The number can be used to not only to determine construction requirements, but to fine-tune equipment and supply requirements, which in turn determine how big the supply room needs to be."

9. Consider the effect on day-to-day operations

It's likely you don't want to shut down entirely and lose out on revenue for any extended period of time, so it's important to consider how you can renovate or expand, without disrupting existing services or operations.

"I highly recommend pulling the contractor in earlier to work out a plan for phasing the renovation and keeping some of the ORs and pre- and post-op bays up and running during working hours," says Mr. Dickerson. "What we like to do is perform an infection control risk assessment and work with the contractor to isolate the noise and infection potential, dust and debris from the occupied area."

Some measures he recommends include

• building temporary partitions that are insulated for sound;
• separating mechanical systems so they can't circulate dust and debris from the construction area;
• shutting down affected ducts or covering them with filters;
• putting HEPA filters into use in the construction zone;
• isolating the construction traffic from the ASC traffic, so patients don't see construction workers and vice versa; and
• setting a maximum decibel level, "so there's not interpretation as to what 'loud' is."

"Everyone has a job to do in these tight quarters during renovation, so it's very important to assign an owners' rep, one of the nurses or someone who is in the ASC day-to-day, who talks to the project manager and the contractor if there is an issue," says Mr. Dickerson. "If there's not a representative, nurses will often ask the contractor to stop what they feel is disruptive activity, but next time there's a project meeting, there will be a change order that will cost the physician owners money. Point-to-point communication prevents this common problem."

10. Know the pitfalls of existing space

Hurdles about if you are looking to renovate an existing building for use as an ASC, says Mr. Dickerson. Among the design changes you'll likely have to make:

• ensuring there are no combustible materials (i.e. upgrading to masonry and steel — the standard wood of an office building is not code for ASCs, he says);
• installing a full sprinkler system;
• adding an emergency generator to service the facility;
• installing a new air-handling unit (rooftop units are cheaper and easier to access, but the lifespan is usually about five to 10 years less than for those housed in a mechanical room within the building);
• if you are looking at space on the second floor or higher, upgrading to hospital-grade elevators; and
• raising the structure height (the office standard 10 or 11 feet is too low; Mr. Dickerson recommends 13 feet floor-to-top-of-structure in ASCs).

"That last one is actually the No. 1 problem I see with existing space; oftentimes the physicians have already purchased it, and you can't really raise the roof up," says Mr. Dickerson. "If the building is only one story, the solution is to look at putting the mechanicals on top of the roof over OR, which minimizes the amount of ductwork required."

He further advises that, with regard to existing space, you "look for buildings with separate, covered areas for entrance and discharge — or that are amenable to adding that feature. Also look for space that will allow natural light in the post-op area, whether through windows or skylights; the more ASCs we do, the more we find out how important that is." ■

Contact Stephanie Wasek at ***stephanie@beckersasc.com.***

Lessons from 3 Construction Projects

By Stephanie Wasek

Here, a physician and two administrators discuss their experiences with construction projects, representing various stages, building types and project types, and give their best advice for ensuring your project runs smoothly.

1. Getting started with a new ASC

James Gesler, MD, of Wooster Orthopedics in Wooster, Ohio, is experiencing the early stages of construction on a new ASC that will be flanked by two medical offices in a medical office building. The ASC operations will be physician-owned, and a group of physicians (some of whom own the ASC, as well as others who will be working in the ASC but who do not have office space) will own the MOB.

"We're not far enough along yet to know what we should have done differently," he says, but he does have advice for the all-important planning stages — which can take as much or more time than the construction itself (Dr. Gesler's group's project has spanned two-and-a-half years so far). Here are two bits of early-stages advice to consider.

Find ways to bring the physicians together

"The struggles we've had have been largely in organizing the doctors and getting them on the same page — it's been described as being like herding cats," says Dr. Gesler. "Physicians are fiercely independent in general."

Naturally, building a new ASC means a lot of meetings that need attending, and myriad decisions that need making. So how do you bring the physicians together for these purposes?

• Keep the end goal in mind. "As physician reimbursement continues to decline relative to the cost of living, the only way to maintain that level is to see more volume," says Dr. Gesler. "The only way to do that is to be more efficient, which the ASC, housed within the MOB, will let us achieve. I stress this to keep us on track. It also helps to remind them that the burden of financing is very much on the physicians — the more efficient we are, the better we make use of our money."

• Maximize electronic communication. Dr. Gesler and his group use e-mail to schedule meetings, send reminders and to distribute summaries of the most recent meeting along with outlines of what's anticipated at the next meeting.

"Without e-mail, I don't know how we'd do this," he says. "Not all docs use e-mail regularly, but for the most part they recognize that is a liability, because we have made it clear that communication is largely going through e-mail."

• Use proxy votes. Some physicians are natural leaders who step to the fore early in a project. For those physicians not necessarily interested in the minutiae (or physicians who may not be able to make a given meeting), you may consider letting them give their say by proxy to other physicians in the partnership whom they trust to vote in their best interests. This can speed decision-making considerably.

Get your development team involved early

Dr. Gesler's group brought in a design/build firm early in the game to advise on everything from choosing the building site to the light fixtures.

"We're busy; we don't have time for all the extra work of coordinating architect, contractor, builders and suppliers," he says. "So we did our due diligence to find a strong, experienced firm, and brought it in early, after we'd determined that we were going on our own, without a hospital partner, and that we wanted to own. The physicians are well-informed about progress and all important decisions, but we are kept at a higher level. We can keep doing what we're doing and, based on the consistency and support we have gotten, trust that things are going well, which has been invaluable."

2. Building and remodeling of a medical office building including ASC

Don Schreiner, CEO of Rockford Orthopedic Associates in Rockford, Ill., has overseen the building of an ASC and medical office building in a highly restrictive certificate of need state, as well as the MOB's subsequent remodel to add more clinic space. The 7,300 square foot ASC, with two ORs and a procedure room was finished in July 2004; the 43,000 square foot MOB was completed in July 2006; the remodel of the MOB's lower level was recently completed — three months ahead of schedule and without a single change order — in July. Here's what he's learned over the course of the MOB's development.

Do your homework to put together the right team

The most important thing you can do is to find a good team —architect, contractor and builder — says Mr. Schreiner. Rockford Orthopedics had two important requirements that helped it achieve that end with the initial MOB construction (and subsequent expansion and remodel).

• The architect had to have built an ASC in Illinois within the previous three years. "We couldn't build one inch bigger or go over budget because the CON here is very restrictive," he says. "It forced us to be very disciplined and very efficient, but it also made it critical that the team we hired have experience in this state with ASCs."

• The architect had to be based in the region. "When I was checking references, it became pretty apparent that we didn't want an architect from, say, California," says Mr. Schreiner. "It's not that there aren't architects there who are good and experienced in our state, but we didn't want to lose time if something needed immediate attention. We chose an architect that is just a two-hour drive from the center, so we could have someone here face-to-face quickly."

• The architect was to pick a local builder. "It's a good idea to have one person in charge of coordinating everything, and we chose the architect in charge (some may choose to put the general contractor in charge)," he says. "We asked the architect to work with us to pick a local builder, so we could be sure the architect and builder were on the same page, and it worked out great." Rockford Orthopedics ended up using both firms for the subsequent work on the MOB.

Listen to your builder

"One thing our builder recommended that we don't do was build a 30-foot tower at the entrance," says Mr. Schreiner. "It looks nice and makes the waiting room look bigger than it really is, but I wish we had listened."

The tower, which resulted in a large open ceiling space above the waiting room and part of the offices, cost Rockford Orthopedics an extra $80,000 to build — and continues to cost the ASC in extra heating and cooling costs.

"It also required 15 to 20 feet of material for a sort of drop ceiling to install a sprinkler system; it's hard to clean and maintain; and there's an echo," he says. "The architects are brilliant with getting everything up to code, compliant with the CON and designing elements that look great and that the physicians love. The builder has a practical, efficient side — if they tell you they have a better design or more economical way to do something, listen."

See it before you build it

The big debate among Mr. Schreiner's physicians when initially building was office space — some physicians wanted large offices, others wanted a bullpen-type area in which everyone would have a cubicle in a larger room. They eventually settled in the middle, on 10" x 10" offices, the same size as exam rooms; that way, if need be, the offices can be converted to exam rooms and vice versa.

"We did a cost analysis of 10 feet by 10 feet and 12 by 12 and took to heart the contractor's advice to go smaller," says Mr. Schreiner. "We were both thinking to the future and about how much time the physicians actually spend in their offices — the exam rooms are where physicians will really be spending most of their time."

In order to understand what that size would mean in practice, he had the builder construct a prototype exam room in his warehouse.

"The builder built the room with the exact countertop, exam table, and lighting fixtures that the physicians had chosen," says Mr. Schreiner. "The walls were painted the color we'd chosen, and everything — the computer and desk setup, cabinets, the door — was put where we'd planned. The physicians got to do a walkthrough and test how it would work in practice, long before it was actually built."

A lot of tweaks resulted: furniture, lighting, the desk setup and location, the placement of the call button, and the exam table size were among the modifications.

"It was easy to make those changes at that stage, prevented our being left with a design that didn't work for the physicians, and vastly cheaper than remodeling," says Mr. Schreiner. "Even better, when they saw the size of the exam room, it calmed everyone down about the sizes of their offices; they knew how big that was going to be, too."

Build for expansion — without overbuilding

It's a good idea to plan for future expansion of your facility. After all, such growth in your business would be healthy. However, that doesn't mean you have to shell out to build a utility area with the cost- and labor-intensive infrastructure necessary in case you want to turn it into an OR someday. After all, there is a chance "someday" might not actually pan out. Mr. Schreiner recommends a more modular approach.

"We built in such a way that, at the end of the hall, we have a big window, which is much easier to take out to extend the hallway than a wall," he says. "All the

HVAC and plumbing systems are capped off there. We purposely purchased an HVAC system powerful enough to handle another OR. So if we decide to add one, we don't need to upgrade — we just need to knock out that window, extend the utilities and build."

In the meantime, the frosted glass window lets more natural sunlight into the facility, he says, and "the docs love that."

Think outside the building

When Rockford Orthopedic Associates underwent the remodeling to add more clinic space to the MOB, it had to contain the remodel within the existing footprint in order to comply with state regulations. To free up space, Mr. Schreiner moved the administrative staff — including transcription, coding and billing, accounts receivable, and customer service — to an off-campus rented office site. In addition, office space costs less per square foot than medical space, so it makes sense financially to use medical space for its intended purpose in order to make good on the investment.

"We didn't want to stick them in a dark box, so we took all the people who don't need to be on hand with the patients and put them in a nice professional building," says Mr. Schreiner. "They're much more productive because they aren't interrupted by doctors or clinical staff; they're in a business environment, which is really more appropriate, rather than a clinic environment. They love it."

Because the MOB is fully electronic and IT connectivity is top-of-the-line, "it's as if they're right next door," he says. Further, "if we decide to add a clinic in one of the surrounding communities, this will become our corporate office," housing all the business activities of a far-reaching practice.

3. Expanding/remodeling your ASC

Margaret Acker, RN, MSN, has been through three expansion and remodeling projects during her tenure as the CEO of Blake Woods Medical Park Surgery Center. On the first, she headed up the certificate of need effort and worked with a general contractor to add a third OR to the center; on the second, a remodel of the clinic area, she acted as general contractor in addition to fulfilling her daily surgery center duties; and on the third, a remodel of the PACU area, she oversaw the project but handed the reins back to a general contractor. Here's are four lessons she's taken away from these experiences.

"Do what you do well, and pay people to do what they do well."

While Ms. Acker learned much about construction, plumbing, electrical wiring and more from acting as general contractor, the most important thing was that it's incredibly difficult to handle all aspects of such a project (especially one outside your skill set) at the same time you're trying to handle all aspects of an ASC. Which is why, for Blakewoods' next project, a contractor was hired.

"Not only did it take the pressure off, he knew what we could and couldn't do, and what was economically feasible," says Ms. Acker. "They were able to move the hopper to the janitor's closet, showed us how we could move a wall to create the space we needed — things we wouldn't have thought of on our own.

"The other component that made him really worthwhile was his ability to coordinate all the people you need to come in. Does the plumber need to come in first? Can the carpenter go any farther? This guy had it like clockwork."

Ms. Acker says that coordination was probably the biggest challenge when she acted as general contractor.

"The contractors have that expertise, and a dependable one will have your best budgetary interests in mind," she says. "My project certainly took far longer, and I think it actually probably cost more, because I was reluctant to pay for those skills. My No. 1 lesson learned is to do what you do well, and pay people to do what they do well. It may sound simple, but it's true."

Keep patients in the loop

When you are expanding or remodeling, it's best to tell patients straight away that you are undergoing construction, the appearance of which patients may find discomforting in a medical environment. Assure them that, while the center may not look like itself, noise is being kept to a minimum and all infection protocols are being adhered to.

"Patient satisfaction scores went down for the month that we were undergoing construction," says Ms. Acker. "We put a sign up and made a point to apologize, but we didn't do that until about a week in — patient satisfaction dipped for that week. We learned

how important it is to inform patients up front."

In order to accommodate patient flow, Blakewoods also planned its PACU remodeling project for its least-busy month; the Michigan center performs mainly cataract procedures, and so choose a winter month when many of its potential patients would be vacationing in warmer climes.

Prep staff for the challenges

Unless your construction project is wholly separate from existing space, it's going to interfere in lots of little ways with how your nurses and other staff go about their days. Inform staff of the changes you expect, and take steps to ensure they know how things will change before you start.

"We made a checklist of everything that would need to be done each day: wipe off all cupboards, wash all the gurneys every day, put away certain items each night," says Ms. Acker. "We had very neat builders, but you still have dust to deal with. We also increased the hours of our cleaning crew for the duration of construction; they probably had the most frustration, because they were trying to work after-hours, when the construction crew was working."

There's not just extra work; workflow will likely be disturbed as well.

"We stored a lot of supplies on carts that could be pushed into unaffected areas at the end of each day," says Ms. Acker. "It's stressful, because you can't just automatically reach for what you need. It was kind of like redoing your kitchen at home: Your silverware might be in the living room, while the can of beans you need is on the porch."

It's also important to keep staff apprised when unexpected changes occur — generally on a daily basis.

"We would come in to find plastic up on a new area that was not usable; you never could get used to it all," says Ms. Acker. "We have two doors from our PACU into our sterile hallway to the ORs, and we posted signs to direct traffic because it changed day to day. Some changes made it harder to turn a cart or a gurney, but nothing was unworkable."

Watch the budget

When you look at your project, it's wise to build end dates for each stage into the contractor's contract, with penalties if the deadlines are missed — "it keeps them moving and helps keep you on budget," says Ms. Acker.

She also advises tracking construction expenses separately, so you're "not ordering supplies, for example, out of the same basket. This way, you know exactly what expansion really costs you, where your expenses are running high and low, and you can watch your money tighter," says Ms. Acker. "If you have a constant in-flow of cash, you might not see your construction budget as shrinking. My accountant helped me set everything up. The added benefit is that, down the line, we'll have a clear record of what we spent of fixed assets, building — everything related to the project." ■

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Cost to Build: Sample 2-OR ASC

By Stephanie Wasek

Usually running about $1 million per OR, a small, single-specialty center with two surgical suites ranges from $2 million to $3 million, with larger-multispecialty ASCs costing $4 million to $8 million, according to calculations provided by Meridian Surgical Partners, which partners with physicians seeking to develop new ASCs in addition to acquiring interests in existing physician-owned facilities.

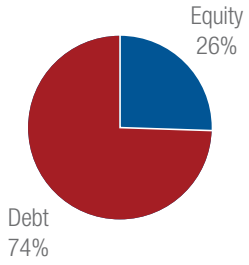
See the chart on page 47 for an analysis from a sample project: Design and construction makes up the single greatest cost, followed closely by capital expenditures to outfit the facility after it's built.

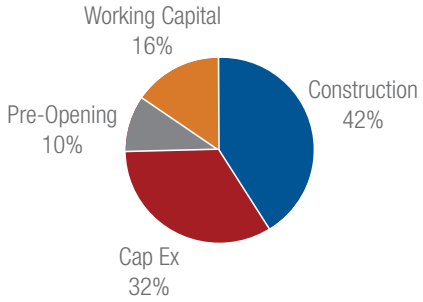
"One aspect of the project summary not included here is the land-use portion, which captures the cost of the real estate, the shell building and typically a tenant improvement allowance for interior construction," says Kenny Hancock, president and chief development officer of Meridian. "Those TI (tenant improvements) can

Facility Size	
Square Feet	8,300
Operating Rooms	2
Procedure Rooms	1

Sources of Capital		
Physician Partners	70%	770,000
Corporate Partner	30%	330,000
Total Equity Financing		**1,100,000**
Debt Financing		3,158,400
Total Sources		**4,258,400**

Uses of Capital	
Design and Construction	1,813,400
Capital Expenditures	1,345,000
Pre-Operating Expenses	426,695
Working Capital	673,305
Total Uses	**4,258,400**





Investment Terms	
Available Units	100
Price per Unit	11,000
Total Equity Financing	**1,100,000**

Design and Construction	
Construction Fees	1,494,000
Other Fees and Expenses	319,400
Total Design and Const.	**1,813,400**

Debt Financing	
Design and Construction	1,813,400
Capital Expenditures	1,345,000
Total Debt Financing	**3,158,400**

Capital Expenditures	
Medical Equipment	1,200,000
Computers and Software	45,000
Furniture and Fixtures	100,000
Total Cap Ex	**1,345,000**

range from $25 a foot to $40 a foot, though land-acquisition construction costs will vary widely depending on what part of the country you're in."

Typically, the majority of the costs associated with development, including the tenant improvements and surgical equipment, may be leveraged with debt.

"The need for equity is isolated to working capital — typically four to eight months' startup operating expenses totaling at least $1 million to $1.5 million," says Mr. Hancock. "The investment ranges from $10,000 to $15,000 for a 1 percent interest in the partnership plus assumption of pro-rata debt dependent on debt structure."

Thorough analysis of historical data and strong, realistic projections will help your cause during the current tightening of the credit market.

"You're not going to be able to get a deal financed right now," says Mr. Hancock. "Most of financing is going to require individual guarantees beyond equity, a minimum amount of cash raised and a strong, vetted financial feasibility analysis. Some of those guarantees may burn off after perhaps two years if the center hits pre-specified cash-flow targets.

"There are still lenders that can handle a certain level of debt and want to loan that money, but something that was marginal before and got financed probably would not now." ■

Four Current Issues in Real Estate Development

By Stephanie Wasek

When starting an ASC, it's easy to get caught up in the construction side — after all the building structure is the tangible element surgeons, staff and patients will have to live with day in and day out. But the choices your group makes regarding the real estate can have an equally long-lasting impact, both directly and indirectly, on the financials of the ASC business.

"I think too often, people just say, 'I'm going to go ahead and build an ASC, and it's going to cost us a million dollars,'" says Mike Lipomi, MSHA, president of RMC MedStone Capital. "Not nearly enough time is spent in thinking through the real estate component of the equation."

Here is a discussion of four key current issues in real estate development.

1. Choosing a real estate model

When physicians join together to "own an ASC," this language generally refers to the business entity that owns the operations side of the ASC. With regard to the real estate, the physician group then has three options: own the building and land as part of the already-formed entity; own the building and land as part of a separate entity that may or may not include all the physicians who are owners in the operations entity; or lease space in an existing building from a landlord. Making this decision is the top issue.

• **Own or lease.** Here, there are pros and cons to both models and, when you look at the overall financials, the decision may simply come down to your group's risk tolerance.

"In renting, you have to be careful to include all the costs so you're comparing apples to apples," says Jeff Eckert, senior principal with Kalamazoo, Mich.-based Eckert Wordell. "One of advantages in renting over owning is that not having to invest capital in real estate. We have found over the last three to five years that although real estate investments perform very well, they don't have the same return on investment as the business sides of strong surgery centers. If you have to choose between the two, based on ROI, you're better off choosing the operations over the real estate."

Further, it's not an annual return (or quarterly or monthly distributions, as you may experience with the operations side once its running full-force); it's 10 to 15 years down the road.

"It's kind of a forced savings plan," says Jerry VanderVeen, president of MW Vanderveen in Kalamazoo, Mich. "Years later, when you look at what you owe and what the building's worth, there's

some equity there that you can hopefully turn into cash. You can sell part or all of that interest to an outside investor and become a paid tenant at that point."

Mr. Eckert and Mr. VanderVeen stress that they're not negative on owning; in fact, they're "quite bullish on it. But we want to paint the right perspective," says Mr. Eckert. "Owning also has some tax advantages that renting doesn't present to the physicians. The important thing is to look at the full picture, not just the bottom line, with a 'quick, what's my return?' attitude."

For a sample pro forma comparing ownership and leasing, see "Lease Vs. Own: Cost Estimate Sample for 2-Surgery-Suite ASC Development" on p. 51.

• **Own separately or as one entity.** If you decide ownership is best for your group, there is a further choice that needs to be made.

"You actually don't have to separate the real estate and the operations ownership," says Mr. Lipomi. "You probably should have two separate, entities and the reason is the tax treatment on operations is different than the tax treatment on real estate. Whichever way physicians decide, they should make sure they have proper tax counsel on that issue."

Further, if you do it as one, "you eliminate all the potential conflicts of interest and animosity of some of the physicians being the landlords for some of the others," he says. If you have a subset that owns the real estate, there will always be a conflict of interest: If you have higher rent, there's a higher cap rate, and the real estate is worth more — but the operations make less; alternately, with a lower rent, the real estate is worth less, but the operations will make more. Signing a long-term lease up front that everyone can live with is usually the solution."

The primary reason you would want to separate the business and real estate entities is financial, and lenders are more amenable to single-asset entities, says Mr. VanderVeen.

"You're starting an ASC that has capital needs," says Mr. Lipomi. "You're going to want to have some younger surgeons, but they are maybe still paying student loans and can't invest in both. The older, wealthier surgeons can own the real estate and a piece of the operations. Keep in mind that this will create inherent conflict of interest issues; a well-worded agreement from a lawyer is necessary to keep all the issues in check."

2. Deciding on a building type

The key question here is whether to build new or take up occupancy in existing space.

• **Existing space.** Your physician group may have found space in an existing office building that is ideally located for both surgeon and patient convenience. While location is important, existing space poses a whole cadre of potential challenges.

"Quite frequently, the office building won't meet code and therefore necessitates significant upgrades in order to become ASC space," says Mr. Lipomi. "One big concern is something that recently happened to one of our facilities, which leased space on the bottom floor of an existing multi-floor building. The tenant on the floor above had a water leak over holiday weekend, and the ASC suffered over $50,000 in damages. And it's not just the damages, it's the challenge of running your business when you've got water, mold and other issues to deal with as a result.

"There are also lease-term issues with existing space: If you do have a lease, you had better be sure, because you've just limited yourself for 10 or 15 years. If you didn't plan properly and need to expand at some point, you're in rented space. There's no place to grow. You need to carefully consider your needs and the possibilities for growth and expansion."

• **New construction.** While this gives you more control over the process and the future of your business, you need to step up your due diligence and be more involved in planning efforts to ensure success.

"When building a new ASC, it's easy to overlook the real estate issues that should be involved in the decision, such as zoning regulations, CON requirements, easements and the entitlement process," says Matt Kleymeyer an associate in the healthcare development department at Lauth Property Group in Indianapolis. "It takes all those factors to get the building approved, and it's going to add a considerable amount of time and money if the physician group misjudges," either with regard to the lead time on these processes or, worse, with regard to the purchase of the building site itself.

"In a situation I recently saw, a group of docs bought a site for an ASC, and didn't do their due diligence on the land," recounts Mr. Lipomi.

"They found out after purchase that there is a six-foot easement along the front of the property, meaning they could only have and build access to the property from a side road. In this case the realtor should have informed the physicians and the easement should have been on the title policy — now they are delayed for months in court trying to get a settlement."

He recommends working with a real estate agent who has healthcare clinical real estate experience.

"Seeking professional guidance with a reputable firm is key," says Mr. Lipomi. "If you haven't been through this before, there will be a lot of questions you might not think to ask, and a quality Realtor can be of tremendous assistance."

Further, says Mr. Lipomi, when choosing a site and entering into new construction, you need to take expansion into account — do you buy a bigger piece of land than you need at present to accommodate that potential? Generally speaking, the answer is yes.

"What I usually recommend should be done is to buy the land in order to build the ASC according to the requirements you think you're going to need later," says Mr. Lipomi. "If you think you're only going to need two or three ORs now, but will need four or five later, don't landlock yourself or build the ASC and shell it out for expansion. If you're landlocked, you're stuck. If you shell the ASC, when you do undergo the expansion, you need to retrofit the entire facility to bring it up to all the new code requirements that have been enacted since the initial construction.

"My advice is, if you think you're going to want to expand, buy accordingly, build it and license it — just don't equip it."

3. Obtaining financing

The biggest issue in real estate development — and one of the biggest industry-wide (not to mention outside healthcare) — is obtaining financing to purchase the real estate.

"Financing is major challenge that many physician groups are dealing with today," says Mr. Kleymeyer. "As the capital markets continue to really tighten, lenders are more concerned with financing capacity, secondary use — who's going to occupy that facility if the ASC fails — and what supports you have in place in the business plan. Oftentimes, an ASC is a unique, single-use type of asset, so if the ASC fails, it's going to be hard to convert that center to opportune use.

"If you build the ASC to be the anchor tenant within a medical office building, that can strengthen your case with the lenders. As a result, there is a greater, more optimal mix of tenants with physician offices occupying much of the building; there's greater potential for referral sources than just among the physicians who own the standalone ASC; and because you can open up building ownership to others, you don't have to put up as much out of pocket. Lenders like to see that kind of distribution and minimization of the risk."

The terms of financing are also changing, notes Mr. Lipomi.

"You really have to work with your lenders and know where you're at," he says. "It's important that you get a real understanding of lending requirements for each potential source. Things have changed: You may end up having to give personal guarantees, whereas in the past this wasn't the case. If you have a good project, and you're smart, I think this is a good time to be buying and taking advantage of the opportunities presented by the commercial real estate market."

Finally, the experts advises, have a thorough understanding of the costs and process, or you may end up needing even more money — which the lender might not be willing to give you.

"If you are looking at a standalone ASC, work with a real estate lawyer to help with zoning and regulations, as well as with a consultant, accountant or even an attorney to guide you with respect to all the financials," says Mr. Kleymeyer.

Mr. Lipomi agrees.

"People think it's the same as buying a piece of land to put a house on, but when you take into account the cost plus the intricacy of the regulations, it's far more complex than that," he says. "This is a high-margin industry; if you make a mistake and the project is delayed, you don't just have to pay to fix the mistake, but you lose on revenues projected by the business plan. A three-month delay can cost you $600,000 of EBITDA — don't let that happen because you didn't want to spend a couple hundred on expertise."

4. Determining an exit strategy.

"Warren Buffet once said, 'The most critical question I need answered before I make an investment is how I get out,'" says Mr. Lipomi. "That's a critical question physicians need to ask on real estate development side — what is the exit strategy? Things will happen in the group as time goes on, and you need to know how you and others can get out, so you don't end up with a non-functional investment."

A good operating agreement for the real estate entity will cover various exit strategies, says Mr. Lipomi. Here are some of the options:

• **The partners will buy out the physician who is moving/retiring/cashing out.** This means you will have to be prepared to invest more if and when this happens.

• **A new physician partner (or partners) will be found to buy out the physician who is moving/retiring/cashing out.** "Ultimately, having physician partners on the real estate is generally a good thing, because then you essentially control your own environment," says Mr. Lipomi. "Just imagine a big player's coming in, he doesn't want to pay rent to the group, and three of the owners are retired and moved out of town. This guy could bring you $1 million in operations revenue, but they don't want to lower the rent. It's a big deal — you need to have a way to bring him in."

• **Sell to a real estate investment trust or other real estate investor.** "That's an excellent exit strategy, to develop then sell to an REIT; it makes the asset liquid," says Mr. Lipomi. "But when you're no longer the landlords, you might not have the flexibility to control the property the way you want to. What happens if you need to expand to keep up with the competition? Or a doctor with a great reputation comes along, and adding services would necessitate expansion? If you're not the owner, you're ultimately subject to whatever they want to do with the building." ■

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Lease Vs. Own: Cost Estimate Sample for 2-Surgery-Suite ASC Development

By Jeff Eckert and Jerry VanderVeen

This sample pro forma compares ownership versus a 15-year lease option for a sample two-surgery-suite, 8,500 square feet ASC development. It is still not quite an apples-to-apples comparison, because the leasing option would make more sense for a group going in a larger medical office building, whereas the ownership option makes more sense for a freestanding structure.

Ownership Option		Leasing Option: 15-Year Lease	
Land	$ 450,000	Land	$ 0
Base building construction	$ 1,000,000	Base building construction	$ 0
Surgery center improvements	$ 1,500,000	Surgery center improvements	$ 1,500,000
Professional fees	$ 375,000	Professional fees	$ 225,000
Development fees	$ 125,000	Development fees	$ 40,000
Legal and accounting	$ 50,000	Legal and accounting	$ 30,000
Miscellaneous costs	$ 50,000	Miscellaneous costs	$ 25,000
Financing fees	$ 165,000	Financing fees	$ 70,000
		Landlord improve. allowance	$ (340,000)
Total development costs	**$ 3,715,000**	**Total development costs**	**$ 1,555,000**
Mortgage amount	$ 2,965,000	Tenant improvement financing	$ 1,250,000
Required equity investment	$ 750,000	Required equity investment	$ 300,000
Annual mortgage payments (25-year amortization at 6 percent)	$ 229,242	Annual tenant improvement financing payments (15-year amortization at 6 percent)	$ 126,578
Annual return on equity (9%)	$ 67,500	Annual return on equity (9%)	$ 27,000
Total annual payments	**$ 296,742**	**Total annual payments**	**$ 153,578**
		Annual tenant improvement payments per sq.ft.	$ 18.07
		Annual base rental per sq. ft.	$ 18.00
Annual payments per sq. ft.	**$ 34.91**	**Total annual rent and payments per sq. ft.**	**$ 36.07**
Total cash flow over 15 years	**$ 1,012,500**	**Total cash flow over 15 years**	**$ 405,000**
Increase in building equity over 15 years*	**$ 2,173,892**	**Increase in value over 15 years***	**$ 0**

*Assumes a 1.5 percent increase in building value per year.

*Mr. Eckert (**JeffE@eckert-wordell.com**) is senior principal with Kalamazoo, Mich.-based Eckert Wordell. Mr. VanderVeen (**jlvanderveen@mwvanderveen.com**) is president of MW Vanderveen, also based in Kalamazoo.*

40 Physicians to Know

David J. Abraham, MD. Dr. David Abraham is a brilliant and entrepreneurial at The Reading Neck & Spine Center in Wyomissing, Pa. Dr. Abraham is board certified in Orthopedic Surgery and is a member of the American Academy of Orthopedic Surgeons, North American Spine Society, and the Pennsylvania Orthopedic Society.

Dale Armstrong, MD. Dr. Dale Armstrong is chairman of the board of Mason City Surgery Center in Mason City, Iowa. Dr. Armstrong is also the president of the Mason City Clinic. The most interesting fact is that he is a psychiatrist and not a surgeon who is a visionary in his center and is always looking far over the horizon.

Ken Austin, MD. Dr. Ken Austin is a practicing orthopedic surgeon in Airmont, N.Y., and is currently president of the Ramapo Valley Surgical Center in Ramsey, N.J. Dr. Austin was the founder of the surgery center along with several other physicians, but has been the key individual that has pulled together a large group of physicians to form an extremely successful surgery center on the New York/New Jersey border that is performing approximately 400 cases a month and has been extremely profitable within a very short time of its inception.

Norman Douglas Baker, MD, FACS. Dr. Doug Baker is a surgeon at the Ophthalmic Surgeons and Consultants of Ohio in Columbus. Dr. Baker is an outstanding leader. He is also a clinical assistant professor of ophthalmology at Ohio State University.

Joseph Banno, MD. Dr. Joseph Banno is the founder of the successful Peoria (Ill.) Day Surgery Center and is the past chair of the ASC Association. He is driven and smart and a tireless worker on behalf of the ASC industry. He is an outstanding person.

Tom Bombardier, MD. Dr. Tom Bombardier is a board-certified ophthalmologist, Ambulatory Surgical Centers of America's COO and one of the three founding principals. Before founding ASCOA, he established the largest ophthalmic practice in western Massachusetts, two ASCs and a regional referral center.

Nader Bozorgi, MD. Dr. Nader Bozorgi is a cutting-edge leader and pioneer in the field of outpatient surgery since 1973 when he opened one of the first ASCs in the United States, which served as the foundation for what would become a multifaceted program of ASCs, anesthesia, pain, bariatric lap band and support services, all under the Magna Health Systems umbrella. Dr. Bozorgi continues to serve as Magna Health System's CEO, overseeing the daily operations of three active multi-specialty Chicago-area ASCs and related physician and support services.

Michael Bukstein, MD. Dr. Michael Bukstein is a general surgeon who serves as the board president of the Northeast Missouri Ambulatory Surgery Center and the CEO of the Hannibal (Mo.) Clinic; under Dr. Bukstein's leadership, Hannibal Clinic expanded from nine to 50 physicians. Dr. Bukstein has also played major leading role in the planning and development of the James E. Cary Cancer Center, and he is an active volunteer and donor in the fight against cancer, making, along with his wife, a more than $1 million donation to the University of Missouri School of Medicine, establishing the Michael J. and Sharon R. Bukstein Chair in Cancer Research.

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

John Cherf, MD, MPH, MBA. Dr. John Cherf, an orthopedic physician at the Neurologic & Orthopedic Hospital of Chicago, maintains a multidisciplinary practice focusing on musculoskeletal medicine. His practice is open to non-spine general orthopedics with a special interest in disorders of the knee.

James R. Colgan, MD. Dr. James Colgan is a member, board of managers of Sierra Surgery Hospital, a hospital/physician joint-venture surgical specialty hospital in Carson City, Nev. He is also chairman of the board for Carson Ambulatory Surgery Center, founder of Physicians Managed Care, medical director and board member of Physicians Select Management and serves as a director on the board of Physician Hospitals of America.

R. Blake Curd, MD. Dr. R. Blake Curd, a leader in the physician-owned hospital field, is an upper extremity and general orthopedics physician with the Orthopedic Institute in Sioux Falls, S.D., and serves as a director on the board of Physician Hospitals of America. Dr. Curd completed his fellowship training at the Indiana Hand Center, the largest free standing center dedicated to hand/upper extremity care, research and education in the world.

Christopher Danis, MD. Dr. Christopher Danis is in his 20th year of practicing hand surgery in Dayton, Ohio. Ten years ago he initiated a hospital-physician venture ASC, Far Hills Surgical Center, where he continues to serve on the board as the organization continues to evolve.

Philip A. Davidson, MD. Dr. Philip Davidson practices orthopedic surgery in Florida, where he is the founder and CEO of Tampa Bay Specialty Surgery Center. He specializes in cartilage restoration and shoulder surgery, with extensive experience in the area of tissue transplantation, including allografts, xenografts and the usage of autologous growth factors.

John W. Dietz, Jr., MD. Dr. Dietz is an orthopaedic spine surgeon with OrthoIndy and the Indiana Orthopaedic Hospital. Dr. Dietz has served on the OrthoIndy board of directors since 2000; when OrthoIndy decided to develop the Indiana Orthopaedic Hospital, Dr. Dietz chaired the planning committee and then served as the chairman of the board of managers. He also serves as a director on the board of Physician Hospitals of America.

Stephen E. Doran, MD. Dr. Stephen Doran is chairman of the board Midwest Surgical Hospital in Omaha, Neb. This is a great facility that brought together a preeminent group of neurosurgeons, orthopedic surgeons, ENT and pain medicine physicians, all partnered with a large local healthcare system. Dr. Doran is also a clinical assistant professor of surgery at University of Nebraska Medical Center.

David S. George, MD. Dr. David George is an ophthalmologist at The Eye MDs (of George, Strickler and Lazer). His special interests include topical cataract surgery and glaucoma and diabetic eye care. He is a member of the board of directors for the ASC Association and the Outpatient Ophthalmic Surgery Society.

Tom N. Galouzis MD, FACS. Dr. Tom Galouzis is the president and CEO of the Nikitis Resource Group. Dr Galouzis is currently 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.

John R. Harvey, MD, FACC. Dr. John Harvey formed the Heart Group of Oklahoma in 1991, which later evolved into Oklahoma Cardiovascular Associates, a 40-man cardiovascular group in Oklahoma City. He is currently CEO and medical director of the Oklahoma Heart Hospital and serves as a director on the board of Physician Hospitals of America.

Michaelis Jackson, MD. Dr. Michaelis Jackson is chairman of Physicians' Surgery Center in Carbondale, Ill., who leads the physicians in a joint-venture with Southern Illinois Healthcare. Dr. Jackson views the center as a model that supports the needs of the community, providers and partner health system.

Marc E. Koch, MD, MBA. Marc Koch is the president and CEO of Somnia, where he focuses on ensuring that all efforts further the company's mission of offering high-quality and cost-efficient anesthesia solutions to

hospitals, ASCs and office-based facilities nationwide. Dr. Koch co-founded the medical practice Resource Anesthesiology Associates in 1996.

Donald Kramer, MD. With a medical practice spanning more than 25 years, Dr. Donald Kramer has developed several successful ASCs in the Houston market and, building on that success, has founded Northstar Healthcare, which develops and, in conjunction with physician partners, owns and operates significant ASCs in concentrated markets. Dr. Kramer serves as president and medical director for Northstar.

Brent Lambert, MD. Dr. Brent Lambert has revolutionized approaches to ASC management. He is the chairman of the board and a founder of Ambulatory Surgical Centers of America, and is not only has a brilliant strategic mind but also takes a hands-on approach to ASC management.

James J. Lynch, MD, FACS. Dr. James 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.

Ajay Mangal, MD. Dr. Ajay Mangal is the founder, CEO and a board member of Prexus Health Partners. He is also an ear, nose and throat physician. As a hands-on executive at Prexus, Dr. Mangal has been instrumental in developing surgery centers and assisting existing centers and hospitals to prosper.

Keith Metz, MD, JD, MSA. Dr. Keith Metz is a practicing clinical anesthesiologist and medical director at Great Lakes Surgical Center in Southeast Michigan. Dr. Metz serves on the board of directors for the ASC Association and was program committee chairman for the association's first meeting held in San Antonio.

William C. Mobley, MD, FACS. Dr. Mobley has been a practicing urologist since 1983 when he joined Iowa-based Urological Associates. Dr. Mobley is certified by the American Board of Urology and is a fellow of the American College of Surgeons.

Thomas J. Pliura, MD, JD. Dr. Tom Pliura is a doctor, lawyer and the founder and manager of several ambulatory surgical centers. Additionally, he is the founder of zChart EMR, an electronic medical records related company. In addition to these accomplishments, he is an incredibly inventive and interesting individual.

Herbert Riemenschneider, MD. Dr. Riemenschneider is founder of Knightsbridge Surgery Center in Columbus, Ohio. He is a urologic surgeon, a dedicated patient advocate, an innovator in delivering superior urologic care, and is currently a member of the faculty at Ohio State University; clinical assistant professor of Urology at OSU's College of Medicine; and director of urologic education at Riverside Methodist Hospitals. He performed the first prostate cryoablation in Ohio.

J. Michael Ribaudo, MD. Dr. Michael Ribaudo has more than 27 years experience as a surgeon, healthcare executive and real estate developer, and currently serves as CEO and chairman of Missouri-based Surgical Synergies. He is a pioneer in the development of physician-owned ASCs and has served as executive vice president of Surgical Health Corp. and HealthSouth Surgery Centers.

Michael E. Russell, II, MD. Dr. Michael Russell is an orthopedic surgeon serving on the board at Texas Spine & Joint Hospital in Tyler. He received his orthopedic training at the University of Texas Southwestern Medical School at Dallas, performs procedures at several other Texas hospitals and medical centers and serves as a director on the board of Physician Hospitals of America.

Kuldip S. Sandhu, MD, FACP, FACG. Dr. Kuldip Sandhu is a gastroenterology physician at the Sutter Roseville (Calif.) Endoscopy Center in and is president of Capitol Gastroenterology Consultants Medical Group. Dr Sandhu received his medical degree from Punjabi University, Patiala, India, completed his internship and his residency in internal medicine at MLK-Drew Medical Center, in Los Angeles, and went on to complete his fellowship training

in gastroenterology at LAC-USC Medical Center in Los Angeles.

David Shapiro, MD, CPHRM, LHRM, CHC. Dr. David Shapiro is a partner in Ambulatory Surgery Company, an ASC consulting firm, and is the chair of the Ambulatory Surgery Foundation and chair-elect of the ASC Association. Previously, Dr. Shapiro held the position of senior vice president of medical affairs for Surgis, an ASC management company, serving as the corporate medical director for over 20 facilities.

Thomas A. Simpson, MD, FACS. Dr. Thomas Simpson is chairman of the board of directors for the Iowa City Ambulatory Surgery Center, and led the board of this multi-specialty ASC as they came together to plan and develop the ASC with Mercy Hospital. He also serves as president of the board of directors for Mercy of Iowa City Regional PHO and is a former president of the Iowa Academy of Otolaryngology.

Eric J. Stahl, MD. Dr. Eric Stahl, a board-certified orthopedic surgeon specializing in sports injuries and shoulder and knee surgery, is the president of Golden Ridge Surgery Center in Golden, Colo. During his military service in France, he was the physician for the climbing school and the mountain rescue team in Chamonix, France and, as the 1972 University World Champion skier in the combined and the downhill, Dr. Stahl brings personal experience and understanding to his practice and program lectures.

Charles Tadlock, MD. Dr. Charles Tadlock is the founder of Surgery Center of Southern Nevada in Las Vegas. He is also the CEO of Epiphany Surgical Solutions.

Larry Teuber, MD. Dr. Larry Teuber, a neurosurgeon, is the founder and physician executive of Black Hills Surgery Center in Rapid City, S.D., one of the country's most successful small surgical hospitals. Due to his dynamic skills and knowledge, Larry transformed the ownership of that hospital so that now it is a publicly held company that is partially owned by the Medical Facilities Corporation, where he now is president.

George A. Violin, MD, FACS. Dr. George Violin is the founder of Medical Eye Care Associates in Massachusetts. He devotes most of his practice to cataract surgery, LASIK and related surgeries, was one of the early investigators of epikeratophakia, a precursor of current LASIK technology, and is affiliated with Caritas Norwood Hospital, Faulkner/Brigham and Women's Hospital, and Massachusetts Eye and Ear Infirmary and New England Medical Center.

Robert Welti, MD. Dr. Robert Welti is the corporate medical director and COO, western region, for Regent Surgical Health. Previously the medical director and administrator of the Santa Barbara Surgery Center, Dr. Welti also was affiliated with Santa Barbara Cottage Hospital for 20 years.

Thomas Wherry, MD. Dr. Thomas Wherry serves as medical director for the Surgery Center of Maryland and consulting medical director for Health Inventures. He has collaborated with professionals in the United Kingdom and Japan to improve the delivery of ambulatory surgery, is currently serving as a board member for Mid-Atlantic Practice Management, the management arm for First Colonies Anesthesia Associates, a large anesthesia group that employs over 120 anesthesiologists and, more recently, has joined forces with Delmarva Health Solutions to assist hospitals and major health systems in developing innovative strategies to slow the emerging anesthesia service subsidy crisis.

Richard N.W. Wohns, MD, MBA. Dr. Richard Wohns, chairman of the medical advisory board for NeoSpine outpatient spine surgery centers, is a board-certified neurosurgeon and an associate clinical professor of neurological surgery at the University of Washington, with a private practice in Tacoma, Federal Way and Puyallup. After pioneering an innovative outpatient spine surgery program, he founded Ambulatory MicroNeuroSurgery Consultants, then co-founded NeoSpine to further develop this concept. ■

The Future of Spine: Freestanding Spine Centers

By Rob Kurtz

Spine care comes from many sources — standalone practices, partners in group practices, hospital outpatient procedures, specialties in surgery centers — but the future of spine care and surgery is freestanding centers that offer "one-stop shopping," says David Abraham, MD, co-founder of the Reading Neck and Spine Center in Wyomissing, Pa.

"Right now, if you ask typical 68-year-old grandmothers with spinal stenosis what they would change about the healthcare system so they could have a better care package, their No. 1 complaint is that they tend to be bounced around from person to person to person, and no one has really orchestrated or organized their care," Dr. Abraham says.

"If you talk to family doctors, their biggest hassle is that when they send a patient to a surgeon, and the surgeon sends them to pain management, they don't want to see them back," he continues. "They want the surgeon to coordinate that care for the whole musculoskeletal-disease pattern and they are interested in referring that patient to a comprehensive service that's already set up. The days of kind of piecemealing patient care should be, I think, over because we really can't treat patients lik ethat anymore."

The solution to piecemeal care should come in the form of freestanding spine centers, he says. These centers, whether they are in the form of standalone practices, surgery centers or sub-specialties in a group practice, should provide the entire spectrum of treatment and care for patients in need of spine services.

"Yes, this stepping outside of our comfort zone, but if you can get physiatrists, pain management specialists, perhaps physical therapy, MRI … if you can be enough of a business man to organize all of that, you will never have to worry about another referral because everyone in your catch area will know that you provide comprehensive care services which is really what every family doctor wants," Dr. Abraham says.

Dr. Abraham says he frequently speaks to young spine surgeons looking to make their mark in spine but unsure how to do so with so many pressures to take on orthopedic cases.

"Let's focus on a surgeon who's fellowship-trained," he says. "They go and a join an orthopedic group, but they are wondering 'Why haven't I distinguished spine?' and 'How do I develop a spine-exclusive practice?' So many guys I talk to are not 100 percent committed to their fellowship training and that is not where a graduating spine fellow, in my humble opinion, should be. There's so much work out there that needs to be done in only spine surgery and spine care, that all these other distractions of total hips and total knees are really the reason I think spine care is in its infancy."

Dr. Abraham offers the following advice for spine surgeons in orthopedic group practices interested in devoting themselves to spine care.

1. Prepare for a challenge.

"The burden of opening a center that is something different, something new, means that you have to break down barriers between doctors, between specialists, and get orthopedic spine specialists to team up with pain management doctors, and physiatrists, and therapists — you have to want to organize these people in a way that they may have never been aware of or have any of their friends or colleagues be engaged," he says.

The workload will be heavy, but it is the stress and the anxiety of the challenge that will help make sure that business succeeds.

"That way, you don't fall into a comfort zone and become complacent; you tend to be proactive and you tend to add services to your business that you might not find necessary if you're fat, happy and supported by an orthopedic group," Dr. Abraham says.

2. Start by adding a physiatrist.

"Go to your orthopedic group and say 'I am going to bring on a physiatrist who is a musculoskeletal specialist who may have a background in pain management,'" he says. "When you think about pain management today, half are physiatry, half are anesthesia. You could easily sell a physiatrist to an orthopedic group; they will buy into this because even orthopedists want non-operative spine specialists."

3. Add other supportive physicians.

"Bring in an anesthesiologist, rheumatologist, neurologist, and get them to work to support not only the spine but also help the orthopedic group," he says.

"Family doctors are doing sports medicine fellowships — a lot of times these guys are hired to screen all musculoskeletal problems and only refer surgical cases to the surgeons. That's another kind of person who can help develop the specialty of spine care.

"Bringing in non-surgeons is the way to grow the division of spine surgery in a way that other people might not be familiar with," he says. "One of the best ways I think spine guys can really make a difference in the development of their specialty is to team up with podiatrists and pain-management specialists so that they work within the same office, side-by-side, and, more specifically, out of the same office chart. If you're only providing surgical services, you really haven't distinguished yourself from the competition."

4. Make spine a true subdivision.

"A lot of orthopedic group are subdivided — there's the division of sports medicine, spine surgery; and hand surgery," Dr. Abraham says. "I think it's a great idea because then you're giving the individual the autonomy to develop a 'center of excellence' while still remaining part of the tax ID number of the big orthopedic group."

5. Give subdivision its own identity.

While the spine subdivision is part of the orthopedic group, you will find that referrals and patients gain a better understanding of the level of care you are looking to provide if the subdivision truly becomes its own entity, he says. Give the subdivision its own name, promote the leaders within the subdivision as representing the subdivision (and not the orthopedic group), and even develop a unique, independent marketing effort around just the spine component.

6. Reap the rewards.

"When I started my practice, I went to the family doctors and said 'We're providing one-stop shopping,'" he says. "I was surprised that once I defined myself as a spine surgeon, the number of good referrals that I got from many other people was astonishing. It really has allowed my practice to grow. Stop doing ankle fractures, stop doing hip fractures. We've trained enough orthopedic surgeons to take care of those things; now you can really grow your spine business by really just focusing on spine."

7. Don't wait.

"If we private practitioners don't do this work, hospitals will do it for us because their incentive is to control spinal surgeons," Dr. Abraham says. "Their whole [angle] is if we want to grow our local hospital's revenue, we need spine surgeons. The thing that I mention about delaying this process to young guys is if you aren't the leader who does it and puts in the extra time to organize this, your hospital is going to and then you're looked at as simply a cog in the wheel and you're working for the hospital." ■

*Dr. Abraham (**abrahamatrnsc@aol.com**) is a founder of the Reading Neck and Spine Center. The facility takes a multidisciplinary approach to spine care by offering medication; epidural steroid injections and facet injections of the spine; pain management; minimally invasive spinal surgery; standard spinal surgery; physical medicine and rehabilitation; and spine-specific physical therapy. Learn more about The Reading Neck and Spine Center at **www.readingneckandspine.com**.*

Cost of Doing Orthopedic Surgery

By Susan Kizirian, RN, MBA

With the advent of the updated CMS 2008 fee schedule, orthopedic surgery now becomes an even more viable option for the ASC. 183 Orthopedic CPTs were added to the list, including a uni-compartment knee replacement (CPT 27446). In addition, ASCs can now realize up to a 92 percent increase in reimbursement from Medicare on average for all orthopedic procedures.

Commercial payors will be taking into consideration the positive reimbursement changes that CMS has made for orthopedics as they recalibrate their reimbursement schedules for ASCs. Going forward — as we negotiate future contracts — we need to educate payors and have in place the best strategy to obtain good reimbursement for our orthopedic cases.

That being said, when looking at the orthopedic service at your ASC or if thinking of adding an orthopedic service, what are the prime financial considerations that need to be addressed?

Certainly space, equipment and instrumentation are critical. Certain subspecialties in orthopedics require more equipment, instrumentation and trays than others, such as spine, shoulders and ACL repair.

Space: An assessment of your current work area for decontamination and central sterile processing and storage area is important for instrumentation, equipment and supplies that you will require. You may need a C-arm and will need ORs (especially pertinent for older facilities) that can accommodate a C-arm. If you intend to perform joint replacement procedures, the trays required are numerous and older ORs may be too cramped to accommodate.

Equipment/instrumentation: Not counting the items you need to purchase to perform orthopedic cases, you will find that a 20 x 20 chamber pre-vacuum autoclave is necessary to process the larger instruments. Usually a washer-disinfector is recommended due to the amount of instrumentation needed for efficient decontamination and cleaning. Also, many are organizations using the Neptune waste system, which requires a docking station.

Video towers can be specialty-specific and you may require a separate tower or, hopefully, can convert a current tower/camera system from another specialty for use in orthopedics. Camera inventory and processing can be an issue and you will need to assess your case mix to determine the number of items necessary to maintain efficient OR turnover. Many organizations use a liquid sterilization processing method or a gas sterilization method for cameras.

Let's look at financial considerations as far as the anticipated cost of performing orthopedic surgery and how to go about estimating costs:

Total cost of a case — how to estimate or calculate

• Overhead per case

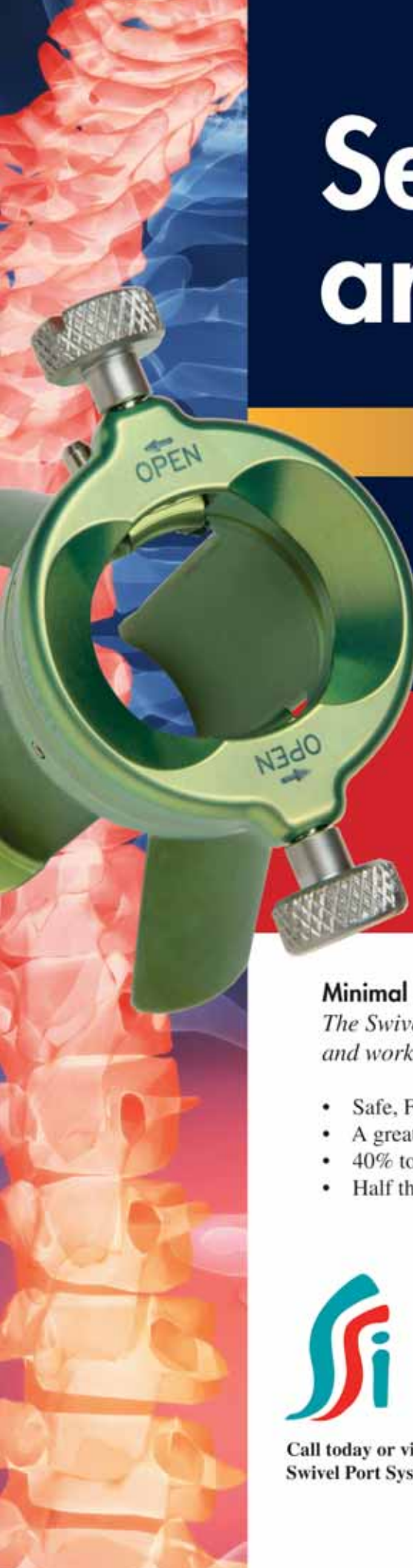
1. Take each potential case from patient in room to patient out of room and estimate OR time in minutes.
2. Multiply that estimated time by $18 to $24, depending upon your ASC's costs.
3. This will give you an average overhead (all expenses except for disposable medical supplies and implants that are costed on the surgeon's preference card).
4. $18/OR minute is an overhead cost goal to measure against.
5. To obtain your facility's overhead cost per OR minute, take your total OR minutes in a calendar month and divide into your monthly expenses minus medical supplies and implants on your profit and loss statement (cash basis). That will give you your OR/minute cost.
6. If this is less than $18/minute, you're doing great.
7. If it is more, you need to look at costs that go into your overhead and try to reduce them.

One final benchmark for the overhead category — which is the largest overhead cost — is payroll and benefits. If you are primarily performing orthopedic cases, the range of payroll and benefits per case is $280 to $400. Orthopedics is more labor-intensive if you are performing a mix of the subspecialties. If you are performing just hand or just knee arthroscopy cases, you will find your total employee costs at the lower end of the range. If going full-blown across all sub-specialties, including spine, you will be at the high end of the total employee cost range. Labor is also marketplace-dependent and changes annually.

• Disposable medical supplies and implants, prosthetics and tissues

1. This is the cost that you calculate from your surgeon's preference card. This can be as simple as OR costs or as full-blown as every disposable medical supply, including pharmaceuticals, used for the patient from pre-op, to anesthesia, to OR, to PACU.
2. You decide how detailed you wish to be. Just remember that the more-detailed the preference card, the more labor dollars you will spend to obtain the information and to keep it accurate.
3. Be sure you need that level of detail before you implement the process by asking yourself how this data improves your bottom line.
4. Implants, prosthetics and tissues: Make sure to also track this on your preference card.
5. The benchmark to measure against for disposable medical supplies and implants, prosthetics and tissues is an average of $265 to $360 per case with a typical mix of orthopedic cases. If you perform a lot of shoulder, foot and ankle, pinning and plating, ACL and joint replacement procedures, then your costs will be much higher. ■

*Ms. Kizirian (**skizirian@ascoa.com**) is COO of Ambulatory Surgical Centers of America.*



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Resources

National trade associations

The ASC Association. The ASC Association is a membership and advocacy organization that provides member benefits and services; combats legislative, regulatory and other challenges at the federal and state levels; assists state ASC associations; enhances ASC representation at the state and federal levels; and established a political action committee. The other arm of the ASC Association, the Ambulatory Surgery Foundation, is an educational and research organization. To learn more, contact Kathy Bryant, president, at (703) 836-8808 or e-mail ASC@association.org.

Physician Hospitals of America. Physician Hospitals of America offers support, advocacy and educational services to the physician-owned hospital industry. PHA envisions a healthcare system focused primarily on patient care, in which physicians are involved in every aspect of delivery. For more information, visit http://physicianhospitals.org or contact Molly Sandvig, JD, executive director at (605) 275-5349 or e-mail info@physicianhospitals.org.

Accreditation

The Accreditation Association for Ambulatory Health Care. The Accreditation Association for Ambulatory Health Care, founded in 1979, has become a leader in ambulatory health care accreditation with more than 3,800 organizations accredited nationwide. For more information, visit www.aaahc.org or call (847) 853-6060.

The Joint Commission: Ambulatory Care Accreditation Program. The Joint Commission has been accrediting ambulatory surgery facilities since 1975, and has more than 1,600 ambulatory organizations accredited nationwide. For more information, visit www.jointcommission.org/ASC or call (630) 792-5286.

Anesthesia staffing and practice management

Anesthesia Healthcare Partners. Anesthesia Healthcare Partners was established in 1997 as an anesthesia staffing and practice management company. To learn more, visit www.ahphealthcare.com or call (800) 945-6133.

Somnia. Somnia is a physician-owned and managed leading provider of anesthesia services to hospitals, ASCs, and office-based surgical facilities nationwide. Visit Somnia at www.somniaanesthesiaservices.com or call (877) 476-6642, ext. 3538.

Superior Medical Services. Superior Medical Services is a full-service medical recruitment firm specializing in permanent and locum tenens placement of anesthesiologists, CRNAs and pain management physicians nationwide. Visit SMS at www.smsanesthesia.com or call (847) 816-9296.

Back-office management, outsourcing and accounting

Credentialing Corporation of America. Credentialing Corporation of America is a credentials verification organization that provides ongoing credentialing services for ASCs and other healthcare entities. Contact CCA at (866) 222-0034 or visit www.ccacredentialing.com.

MedHQ. MedHQ provides accounting, revenue cycle, human resources and credentialing services to clients in 10 states. Learn more at www.medhq.net or call (708) 492-0519.

MediGain. MediGain helps healthcare providers to preserve profitability with improved and low cost back-office processes. Find out more about MediGain at www.medigain.com or call (214) 952-6602.

Somerset CPAs. Somerset's healthcare team is comprised of more than 20 dedicated professionals serving clients nationwide, including all types of healthcare organizations — ancillary service providers, surgery, imaging, infusion and dialysis centers, therapy facilities, other relevant ancillaries and physician groups. For more information, call (800) 469-7206 or visit Somerset CPAs online at http://healthcare.somersetcpas.com.

Billing, coding and collecting

Key Health. Key Health is a leader in providing unique financial solutions to healthcare facilities, healthcare providers and attorneys, and it funds medical services on a lien/letter of protection basis on behalf of injured patients. Learn more about Key Health at www.keyhealth.net or call (877) 633-5436.

The Coding Network. The Coding Network is committed to provide cost effective state-of-the-industry procedural and diagnostic coding support to medical groups, academic practice plans, hospitals, ambulatory, surgery centers, and billing companies throughout the United States. Learn more at www.codingnetwork.com or call (888) 263-3633.

National Medical Billing Services. National Medical Billing Services specializes in freestanding outpatient surgery center coding and billing, offering a cost-effective service, subject matter experts and integrity in business relationships. To learn more about NMBS, call (636) 273-6711 or visit www.asccoding.com.

Serbin Surgery Center Billing. Serbin Surgery Center Billing was founded in 2001 to provide solutions for ASCs' billing and collection needs. For more information, contact SCB at (866) 889-7722.

Cataract outsourcing

Vantage Technology. Vantage Technology is a turnkey service providing eye programs to both rural and metropolitan hospitals in 19 states. Visit www.vantage-technology.com or call (217) 342-4171 to learn more.

Compounding pharmacies

JCB Laboratories. JCB Laboratories is a compounding pharmacy that serves the ASC marketplace. Contact CEO Brian Williamson, PharmD, at (877) 405-8066 or visit www.jcblabs.com for more information.

Construction and architectural firms

AMB Development Group. AMB Development Group specializes exclusively in the development of ambulatory care facilities nationwide, including surgery centers, medical office buildings, clinics, imaging centers and outpatient centers. E-mail Jack Amormino at jamormino@ambdevelopment.com, call him at (800) 779-4420 or visit www.americanmedicalbuildings.com for more information.

BBL Medical Facilities. BBL Medical Facilities is a single-source business unit with plan, design, build and development capabilities, and has been developing attractive, efficient and cost-effective

medical facilities for more than 30 years. Learn more at www.bblmedicalfacilities.com or call (888) 450-4225.

Clayco. Clayco, a privately-owned real estate, architecture, engineering, design-build and construction firm, serves the healthcare industry. For more information, contact Rice A. (Sandy) Jacobs at (888) 429-3330 or via e-mail at jacobss@claycorp.com or visit www.claycorp.com.

Irmscher Construction. Irmscher is a 115-year-old national healthcare project development firm specializing in the design and construction of healthcare facilities. For more information, visit www.irmscherinc.com or call (260) 422-5572.

L3 Healthcare Design. L3 Healthcare Design is a surgery center design and research firm, focused on ASCs and clinics. To find out more, visit www.l3healthcaredesign.com or call (866) 929-5353.

Lauth Property Group. Lauth Property Group is a leader in the development, construction, management and ownership of commercial real estate throughout the United States for the past 30 years. Learn more at www.lauth.net or call (317) 848-6500.

Leopardo Construction. Leopardo Construction is a leading construction company offering preconstruction, general contracting, construction management, design-build and development services across several vertical industries. Find more information at www.leopardo.com or call (847) 783-3000.

Marasco & Associates. Marasco & Associates is a national architecture and consulting firm, dedicated to providing quality facility design and development assistance for outpatient medical facilities, private physician groups, hospitals and institutional clients. Contact the Marasco & Associates office at (877) 728-6808 or visit www.marasco-associates.com for more details.

Erdman (A Cogdell Spencer Company). For more than 50 years, the name Erdman has been synonymous with the delivery of innovative healthcare facility solutions. For more information, visit www.erdman.com or call (608) 410-8000.

McShane Medical Properties. McShane Medical Properties is an integrated design/build construction and real estate development firm offering comprehensive services for the healthcare industry. Contact John Daly, vice president, healthcare, at (847) 692-8616 or visit the firm's Web site at www.mcshane.com for more information.

MedBridge Development. MedBridge Development is a medical facility development and management company creating state-of-the-art healthcare delivery environments in partnership with leading physicians. For more information, visit MedBridge online at www.medbridgedevelopment.com or call (805) 679-7560.

Consultation and brokerage of ASCs

ASCs Inc. ASCs Inc. helps physician-owners of ASCs form strategic relationships with leading ASC management companies and hospitals, and also represents physician-owners of ASCs and medical office building real estate. For more information contact Jon Vick, president, at (760) 751-0250 or visit www.ascs-inc.com.

Debt collection

Affiliated Credit Services. Affiliated Credit Services is a Colorado-based professional account receivables management firm which focuses on increasing businesses cash flow by providing superior collection services. Learn more at www.acscollects.com or call (970) 867-8521.

Professional Finance Company. Professional Finance Company is a full-service accounts receivable management company serving credit grantors for over 100 years with integrity and results. Visit PFC online at www.professionalfinancecompany.com or call (970) 352-5000.

Finance

Bank of America. Whether your need is to expand due to growth, acquisition or merger, or make a strategic investment, Bank of America offers ASCs flexible equipment finance options with competitive rates. For more information, contact BALHealthcarefinance@bankofamerica.com or call (800) 835-8488.

CIT Healthcare. CIT Healthcare offers a full spectrum of financing solutions and related advisory services to companies across the healthcare industry. For more information, please visit www.cithealthcare.com or contact CIT Healthcare at (800) 547-7026.

CitiCapital. Whether you are looking to construct a two-room ASC, diagnostic imaging center, cancer treatment center or build a 20-bed surgical hospital, Citi's dedicated team of outpatient financing specialists can help make your plans a reality. Learn more at www.citicapital.com/medical-outpatient, or contact Ann Heck by e-mail at ann.e.heck@citi.com or call (877) 276-2249.

MarCap. MarCap puts its 30-plus years of healthcare finance experience to good use every day, working with its clients to find ways to improve patient care and increase business. Visit MarCap at www.marcapcorp.com or call (800) 621-1677.

Physicians Capital. This Nashville-based firm provides loans based solely on the future cash flow of a surgery or diagnostic center. Learn more at www.PhysiciansCap.com or call (615) 342-0824.

Physicians Financial Resource. Physicians Financial Resource is a leading advocate for physicians when sourcing capital for commercial investments and providing wealth management. Call (407) 830-7763 or visit www.physiciansfinance.net.

Health information technology providers

Alis Technology. Alis Technology is a consulting company that specializes in helping implement and manage technology to improve the operations and efficiency of outpatient centers. Learn more at www.alistechnology.com or call (312) 212-8027.

Amkai. Amkai is a software company with 20-plus years of experience delivering administrative and clinical solutions to ASCs, surgical hospitals and physician practices. Learn more at www.Amkai.com or call (866) 265-2434.

Count Me In. Count Me In provides large enterprise time tracking tools and innovative boimetric technology solutions scaled for small business needs and budgets. Find out more at www.countmeinllc.com or call (847) 981-8779.

Experior Healthcare Systems. Experior Healthcare Systems is a leading software developer specializing in practice management (ExpertPM) and electronic health records (RemedyEHR). Learn more at www.experior.com or call (260) 432-2020.

GHN-Online. GHN-Online is an industry innovator in online enterprise class healthcare transaction processing. Visit www.ghnonline.com or call (214) 696-5717 to learn more.

Laserfiche. Laserfiche offers a suite of products and services that address enterprise-wide challenges from the perspective of executives, records managers, IT staff members and end-users. Find more information at www.laserfiche.com or call (800) 985-8533.

Mednet. Mednet is a software technology company, led by a group of professionals from the ASC market who understand the core of your business practice and its unique requirements. Learn more at www.mednetus.com or call (866) 968-6638.

Medtek.net. Medtek.net is a leading provider of medical transcription solutions for healthcare providers and healthcare organizations, with clients including hospitals, ASCs, clinics and physician practices. Visit www.medtek.net or call (818) 673-2900 to learn more.

Med Images. Med Images focuses on the diagnostic and surgical arena, providing state-of-the-art, high-quality solutions to image-based surgical and diagnostic information acquisition and management. Lean more at www.emedimages.com or call (800) 366-7501.

ProVation Medical. ProVation Medical has created ProVation EHR, the first electronic health record designed for busy, cost-conscious ASCs. For more information, e-mail Laura Gilbert at Laura. Gilbert@provationmedical.com, or visit www.provationmedical.com or call (612) 313-1500.

QSE Technologies. QSE Technologies is a premiere IT systems integrator serving the ambulatory healthcare industry for more than five years. For more information, contact Marion K. Jenkins, PhD, QSE's co-founder and CEO, at (877) 236-0795, or via e-mail at info@qsetech.com or visit QSE's Web site at www.qsetech.com.

ScheduleSurgery.com. ScheduleSurgery.com offers SCOR, a multi-purpose communication and case scheduling tool that leverages the Internet to improve ASC case scheduling efficiency, customer service and ability to market services. Learn more at http://schedulesurgery.com or call (888) 463-9058.

SourceMedical Solutions. SourceMedical is a leading provider of outpatient information solutions and services, collectively serving ASCs, and surgical hospitals. For more information, visit www.sourcemed.net or call (800) 719-1904.

Surgical Notes. A preeminent nationwide provider of medical transcription, coding and other related value-added information technology services for the ASC market, Surgical Notes provides transcription, coding and practice management solutions to more than 420 surgery centers and 6,300 physicians in more than 40 states. To learn more, visit Surgical Notes online at www.surgicalnotes.com or call (214) 821-3850.

VersaSuite. VersaSuite is a comprehensive integrated software management system which consists of a number of modules, both healthcare- and business-related. Find more information at www.versasuite.com or call (512) 250-8774.

zChart EMR. zChart EMR, a first-rate, intelligent, 21st-century surgical chart, was developed by dozens of healthcare professionals — administrators, office staff, nurses and physicians — at multi-specialty outpatient surgery centers. For more information, contact Kent Barber at (866) 924-2787 or visit www.zchart.com.

Imaging

Atlantis Worldwide. Atlantis Worldwide is a full-service provider of pre-owned and refurbished diagnostic imaging systems — MRI, CT scanner, C-Arm, X-ray, bone densitometer, mammograph, ultrasound and cath/angio as well as other imaging systems. To find out more, go to www.atlantisworldwide.com or call (800) 533-3356.

Insurance

Affinity Insurance Services. Affinity Insurance Services, a part of Aon Corporation, a Fortune 250 Corporation, is a top global insurance broker with the market presence and carrier relationships unmatched by smaller brokers to ensure you the best coverage for the most reasonable cost. To learn more, call (215) 773-4600.

Heffernan Insurance Brokers. Heffernan Insurance Brokers, formed in 1988, is one of the largest full service insurance brokerage firms in California and provides comprehensive insurance and financial services products to a wide range of business and individuals. Learn more about HIB at www.heffgroup.com or call (800) 234-6787.

Keane Insurance Group. The professional liability consultants at Keane Insurance are experts in malpractice insurance with more than 200 years of cumulative insurance industry experience, serving more than 4,000 physician clients. Call (314) 966-7733 or find out more at www.keanegroup.com.

Medical Protective. Medical Protective is a national leader in primary medical professional liability coverage and risk solutions to healthcare providers. To learn more, call (800) 463-3776 or visit www.medpro.com.

Managed care contracting

Eveia Health Consulting & Management Company. Founded by I. Naya Kehayes, MPH, Eveia Health Consulting & Management is comprised of a team of seasoned professionals who are experts in reimbursement management, managed care contracting and business management with a specialization in ASCs and surgical practices. For more information, call Ms. Kehayes at (425) 657-0494 or visit www.eveia.com.

Management, consulting and strategy

TRY Health Care Solutions. TRY Health provides consulting services to large healthcare systems, group practices, independent physicians and surgery centers throughout the United States. You can contact Tom Yerden, president, at (208) 865-2400 or send him an e-mail at TYerden@aol.com.

Management, development and equity firms

Ambulatory Surgery Centers of America. ASCOA is a leader in the surgery center industry, achieving exceptional quality of care and outstanding financial results. For more information, visit ASCOA online at www.ascoa.com or call (866) 982-7262
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Blue Chip Surgical Center Partners. Blue Chip Surgical holds an equity stake in its projects and also serves as a managing partner, with several highly profitable, physician-led centers in operation around the company and a number of projects in the works. For more information, visit Blue Chip online at www.bluechipsurgical.com or call (513) 561-8900.

The C/N Group. The C/N Group is a recognized leader in the development, ownership and operation of exceptional healthcare facilities, including ASCs, medical office buildings and diagnostic imaging centers. Visit them at www.thecng.com or call (219) 736-2700.

Facility Development and Management. Facility Development and Management is a for-profit company that provides consultative, developmental and managerial services for ASCs throughout the United Sates. To learn more, visit the Web site www.facdevmgt.com or call (845) 770-1883.

Foundation Surgery Affiliates. Foundation Surgery Affiliates is a healthcare management organization specializing in project development, innovative facility design, partner recruitment and facility operations for ASCs, medical office buildings, surgical hospitals and bariatric hospitals and healthplexes. More information about FSA can be found at www.foundationsurgery.com or call (405) 608-1700.

HealthMark Partners. HealthMark Partners owns and operates single and multi-specialty ASCs throughout the United States by creating joint-ventures with physicians or physicians and hospitals. Please visit the company Web site at www.healthmarkpartners.com, e-mail Senior Vice President — Development Kenny Spitler at kspitler@healthmarkpartners.com or call him at (615) 341-0701 to learn more.

Health Inventures. A management and consulting services firm, Health Inventures has been developing and expanding ambulatory surgery care and other outpatient services since 1976. Learn more at www.healthinventures.com or call (720) 304-8940.

Instantia. Instantia is a company founded by Jack Amormino and Lisa Freeman to provide development services to surgical centers. For more information, visit Instantia online at www.instantia-health.com or call (303) 554-0046.

Medical Facilities Corporation. Medical Facilities Corporation is a publicly traded company and a leading acquirer of majority interests in high-quality specialty hospitals and ASCs. Visit MFC's Web site at www.medicalfacilitiescorp.com or contact Steven Hartley at (866) 766-3590 ext. 105.

Medstone Capital. RMC MedStone Capital combines the strength of several industry standards like Mike Lipomi, Tim Noakes and the Stanislaus Surgical Hospital of Modesto, Calif., with one of the leading real estate companies in Dallas, RM Crowe, to form a very strong team. You can see more information on MedStone at www.MedstoneCapital.com or call Mr. Lipomi directly at (209) 602-3298.

Meridian Surgical Partners. Meridian Surgical Partners aligns with physicians in the acquisition, development and management of multi-specialty ambulatory surgery centers and surgical facilities. E-mail Kenny Hancock, president and chief development officer of Meridian, at khancock@meridiansurg.com or call him at (615) 301-8142 for more information.

National Surgical Care. National Surgical Care is a nationwide owner and operator of ASCs, focuses on addressing the needs and problems confronting surgery centers across the country. Contact Rick Pence at (866) 866-2116 at rpence@natsurgcare.com.

Nikitis Resource Group. Nikitis Resource Group is a new ASC development, management and consulting firm with a team that encompasses more than 100 combined years of ASC development and management experience, HOPD and hospital consultation experience and licensure and accreditation assistance to centers. To learn more, contact Dawn Q. McLane, chief development officer, at DAQuay@aol.com or call (720) 320-6577.

NovaMed. NovaMed acquires, develops and operates ASCs in partnership with physicians. For more information, visit NovaMed at www.novamed.com or call (312) 664-4100.

Nueterra Healthcare. Nueterra Healthcare partners with physicians and hospitals to develop and manage community hospitals, surgical hospitals, ASCs and physical therapy centers including new development, joint-ventures, acquisitions and turnarounds. For more information e-mail Denise Mayhew at dmayhew@nueterra.com, call her at (888) 887-2619 or visit Nueterra's Web site at www.nueterra.com.

Orion Medical Services. Orion Medical Services offers a turnkey approach to ASC development and management by covering all aspects of a project from financial feasibility analysis to site and operational development. For more information, visit Orion Medical online at www.orionmedicalservices.com or call (541) 431-0665.

Pacific Surgical Partners. Pacific Surgical Partners was created to own and operate outpatient surgery centers exclusively in southern California, primarily in conjunction with physician partners. For more information, visit www.pacificsurgicalpartners.com or call (818) 881-1106.

Physicians Endoscopy. Physicians Endoscopy develops and manages endoscopic ASCs in partnership with practicing GI physicians and hospitals. Visit the company on the Web at www.endocenters.com, e-mail John Poisson at jpoisson@endocenters.com or call him at (215) 589-9003.

Pinnacle III. Pinnacle III specializes in the operational development, management, select management and billing for ASCs. For more information, visit Pinnacle III online at www.pinnacleiii.com or call (970) 484-2826.

Practice Partners. Practice Partners in Healthcare takes great pride in the development, management and equity ownership with its physician and hospital partners. E-mail Larry Taylor at ltaylor@practicepartners.org, visit Practice Partners online at www.practicepartners.org or call (205) 824-6250.

Prexus Health. Prexus Health is a 100 percent physician-owned company that specializes in the development and management of multi-specialty, physician-owned ASCs and small hospitals. For more information, call (513) 454-1414, e-mail Prexus at info@phcps.com or visit the Web site at www.prexushealth.com.

Regent Surgical Health. As buyers, developers and managers of outpatient surgery centers and physician-owned hospitals around the country, Regent Surgical Health is an experienced developer and specialist in turnaround situations. You can learn more by visiting Regent Surgical Health online at www.regentsurgicalhealth.com or call (708) 492-0531.

SpineMark. SpineMark partners with hospitals and physicians across the United States and globally to develop and operate comprehensive, evidence-based spine centersof excellence. Learn more about SpineMark at www.spinemark.com or call (858) 623-8412.

Surgery Consultants of America. Surgery Consultants of America is a highly regarded company offering complete ASC development and management services nationwide. For more information about SCA, visit them at www.surgecon.com or call (888) 453-1144.

Surgical Management Professionals. With a seasoned team of healthcare professionals, SMP specializes in the management and development of ASCs and surgical specialty hospitals. For more information, visit SMP's Web site at www.surgicalmanprof.com or call (605) 335-4207.

Symbion. Headquartered in Nashville, Tenn., Symbion is a leading provider of high-quality surgical services across many specialties. Visit Symbion at www.symbion.com or call (615) 234-5900 for more information.

Titan Health. Titan is a nationwide surgery center development, acquisition and management company that partners with hospitals and physicians to develop successful, multi-specialty ASCs. Please visit Titan Health online at www.titanhealth.com; you can also e-mail D.J. Hill, chief development officer, at dhill@titanhealth.com, e-mail Kristen Franz at kfranz@titanhealth.com or call (916) 614-3600.

TpHR. TpHR, a joint venture formed between Paragon Health and Texas Health Resources, is a healthcare development and management company that serves as a dedicated resource for the analysis, organizational development and operation of specialty healthcare services and hospital/physician joint-ventures. For more information about TpHR, visit www.tphrhealth.com or call (972) 392-9252.

United Surgical Partners International. United Surgical Partners International was founded in 1998 by Don Steen and the investment firm, Welsh, Carson, Anderson & Stowe, to pursue the ownership and management of ASCs in the United States and the ownership and operation of private surgical hospitals in Europe. Learn more about USPI at www.unitedsurgical.com or call (972) 713-3500.

Woodrum/Ambulatory Systems Development. Founded in 1986 by healthcare professional managers, Woodrum/ASD has offices in Chicago, Dallas and Los Angeles, and is one of oldest continuing, national ASC companies in the United States, having developed and managed ASCs in 46 states for more than 20 years. Please e-mail Joe Zasa at joezasa@woodrumasd.com, call (214) 369-2996 or visit www.woodrumasd.com for more information.

Medical devices — Implants and expedited payment options

Implantable Provider Group. Implantable Provider Group works with providers, facilities, manufacturers and commercial payors to fully manage all aspects of high-cost implantable medical devices. For more information about IPG, visit www.IPGSurgical.com or call Michael Jones at (866) 753-0046.

Medical devices — Reprocessed and refurbished

MediSISS. MediSISS is a third-party medical device reprocessing company, registered and inspected by the FDA, that serves both hospitals and freestanding ASCs. Visit www.medisiss.com or call (866) 866-7477.

Mini C Sales. Mini C Sales specializes in providing pre-owned and refurbished FluoroScan, Xi-Scan and OEC Mini C-Arms at a fraction of the cost of new systems. Visit www.minicsales.com or call (800) 356-4000.

Medical laundry

Medtegrity. The Medtegrity Medical Laundry Network is a $500 million commercial laundry network comprised of the largest and most successful independent and family-owned laundries in the United States. Contact David Potack at (888) 546-3650 or visit www.medtegrity.us.

Medication program management

Industrial Pharmacy Management. Industrial Pharmacy Management is a completely full-services in-office medication dispensing organization. For more information about Industrial Pharmacy Management, contact Michael Drobot at (800) 803-7776 or visit its web site at www.ipmrx.com.

Outsourced medical implantable device management solutions

Access MediQuip. Access MediQuip is one of the largest and most experienced providers of outsourced implantable device management solutions to the healthcare industry. For more information, call (877) 985-4850 or visit www.accessmediquip.com.

Patient financing options

CareCredit: Patient Payment Plans. CareCredit lets your patients pay their current bills in-full immediately with the use of convenient monthly payments. Call (800) 300-3046, ext. 4519, or visit www.carecredit.com for more information.

Patient satisfaction and benchmarking

CTQ Solutions. CTQ Solutions is a leading provider of healthcare satisfaction and benchmarking services, helping support ASC patient satisfaction targeting quality and process improvement initiatives, improving patient loyalty and meeting all industry accreditation requirements. For more information, visit www.ctqsolutions.com or call (877) 208-7605.

Surgical Outcomes Information Exchange. Surgical Outcomes Information Exchange (SOIX) offers services to benchmark performance and outcomes for accreditation, risk management and quality patient care in surgery centers. Learn more about SOIX at www.soix.com or call (877) 602-0156.

Real estate acquisition and real estate investment trusts

McShane Medical Properties. McShane Medical Properties is an integrated design/build construction and real estate development firm offering comprehensive services for the healthcare industry. Contact John Daly, vice president, healthcare, at (847) 692-8616 or visit the firm's web site at www.mcshane.com for more information.

Montecito Medical Investment Company. Montecito Medical is one of the nation's largest privately-held real estate companies specializing in the acquisition and development of hospitals, medical office buildings, surgery centers, long-term acute-care facilities and skilled nursing facilities. Learn more about Montecito at www.montecitomedical.com or call (805) 568-0862.

The Sanders Trust. The Sanders Trust owns, acquires and develops ASC buildings and medical office buildings nationwide. To learn more about The Sanders Trust, visit it at www.sanderstrust.com, e-mail Bruce Bright bbright@sanderstrust.com or call him at (205) 298-0809.

Recruitment and search firms

B.E. Smith. B. E. Smith has become one of the nation's leading healthcare search firms, representing hospitals across all 50 states. Contact B. E. Smith today by calling (800) 397-2078 or visit them on the Web at www.besmith.com.

Kaye/Bassman International. Greg Zoch is a partner and managing director with Kaye/Bassman International, a 26-year-old executive search firm. You can e-mail Mr. Zoch at gregz@kbic.com or call him at (972) 931-5242 ext. 5290.

Manning Search Group. Roger Manning, Cathy Montgomery and their healthcare search consultant team offer middle management and executive search and recruitment with ASC-industry-specific focus. E-mail Roger Manning at roger@manningsearchgroup.com or Cathy Montgomery at cathy@manningsearchgroup.com, call them at (636) 447-4900 or visit Manning Search Group online at www.manningsearchgroup.com.

The Spring Group. Primarily focused on the ambulatory surgery industry, Joe Feldman, who brings over 35 years of healthcare experience to the recruiting industry, and his team work with corporate, hospital-based and privately owned ASCs throughout the United States. Mr. Feldman is the owner of AmbulatorySurgery Center Careers.com, a Web-based career board dedicated to the ASC industry, designed primarily for employers, recruiters and candidates to seek each other out at a single location. For more information, visit www.ambulatorysurgerycentercareers.com. You can reach Joe Feldman at (610) 358-5675 or e-mail him at joe@thespringgrp.com.

Sleep apnea

Ion Healthcare. Ion Healthcare provides a turnkey solution for screening and management of patients with sleep apnea referred to your surgical center. Contact an Ion Healthcare professional today at (804) 433-1717 or visit Ion Healthcare online at www.ionhealthcare.com.

Surgical supply and equipment manufacturers

3M. 3M is a diversified technology company serving customers and communities with innovative products and services. Visit www.3m. com or call (888) 364-3577.

Acclarent. Acclarent is dedicated to developing innovative solutions for ENT specialists and their patients. For more information, call (877) 775-2789 or e-mail Acclarent at acclarent@acclarent.com.

Alcon. Alcon engages in the development, manufacture, and marketing of pharmaceuticals, surgical equipment and devices, and consumer eye care products to treat eye diseases and disorders. Learn more at www.alcon.com or call (800) 862-5266.

Allen Medical Systems. The newest innovation from Allen Medical Systems, a Hill-Rom Company, is the Allen Spine System, which manages patient skin pressure during four-post spine surgery, supports various body types, and enables the surgeon to flex the patient's spine using the power of the ORtable. Learn more about Allen Medical Systems at www.allenmedical.com or call (800) 433-5774.

Alpine Surgical Equipment. Alpine Surgical provides its clients with a wide array of both new and refurbished medical equipment for the entire ASC by working closely with many of the leading medical equipment manufacturers and specialty refurbishing companies nationwide. For more information, contact Matt Sweitzer at (916) 933-2863 or visit Alpine Surgical on the Web at www.alpinesurgical.com.

AVEC Scientific Design. AVEC Scientific Design is the manufacturer and distributor of fluid management products for the OR, with products that include Black Hole suction devices and Quick Wick Floor Mats. For more information, visit www.avecscientific.com or call (800) 944-2525.

B. Braun. For 150 years, B. Braun has developed a rich heritage of knowledge and expertise for delivering innovative healthcare products, medical devices and programs designed to improve both patient and health-professional safety. For more information, visit B. Braun online at www.bbraun.com or call (610) 691-5400.

Cygnus Medical. Cygnus Medical specializes in products and services for the endoscopy suite, the operating room and the sterile processing department. Learn more about Cygnus at www.cygnusmedical.com or call (800) 990-7489.

Integra LifeSciences. Through the Jarit, Miltex and Luxtec companies, Integra LifeSciences offers German-crafted quality and cost-effective surgical instruments, sterilization containers and instrument repair and refurbishment services to meet the needs of every surgery center. You can learn more about Integra LifeSciences by visiting http://integra-ls.com/, e-mailing David W. Swanson, vice president of ASCs, at david.swanson@integra-LS.com or calling (800) 654-2873.

Kimberly-Clark. Around the world, medical professionals turn to Kimberly-Clark for a wide portfolio of solutions that improve the health, hygiene and well-being of patients and staff. To learn more, visit www.kimberly-clark.com or call (888) 525-8388.

McKesson Medical-Surgical. McKesson Medical-Surgical, based in Richmond, Va., is a leading distributor of medical supplies and equipment to physician practices, surgery centers, home care and extended care facilities. You can visit McKesson online at www.mckesson.com or call (415) 983-8300.

Medline Industries. Medline Industries is a manufacturer of medical supplies serving hospitals, nursing homes and home health agencies. To find out more, visit www.medline.com or call (800) 633-5463.

Miltex. Miltex, a business unit of Integra LifeSciences, is a leading provider of surgical and dental hand instruments to alternate-site facilities including physician and dental offices, and ambulatory surgery care facilities. Visit Miltex at www.miltex.com or call (800) 645-8000.

Spine Surgical Innovation. Spine Surgical Innovation designs and markets the Holmed Swivel Port System, which is designed for ease of use and intended for posterior or lateral lumbar surgery. Read more at www.spinesurgicalinnovation.com or call (800) 350-8188.

Stryker Corporation. Stryker is one of the largest players in the $28.6 billion worldwide orthopedic market and its products are in use by medical professionals in more than 120 countries. Visit Stryker at www.stryker.com or call(269) 385-2600.

Urology and cryoablation

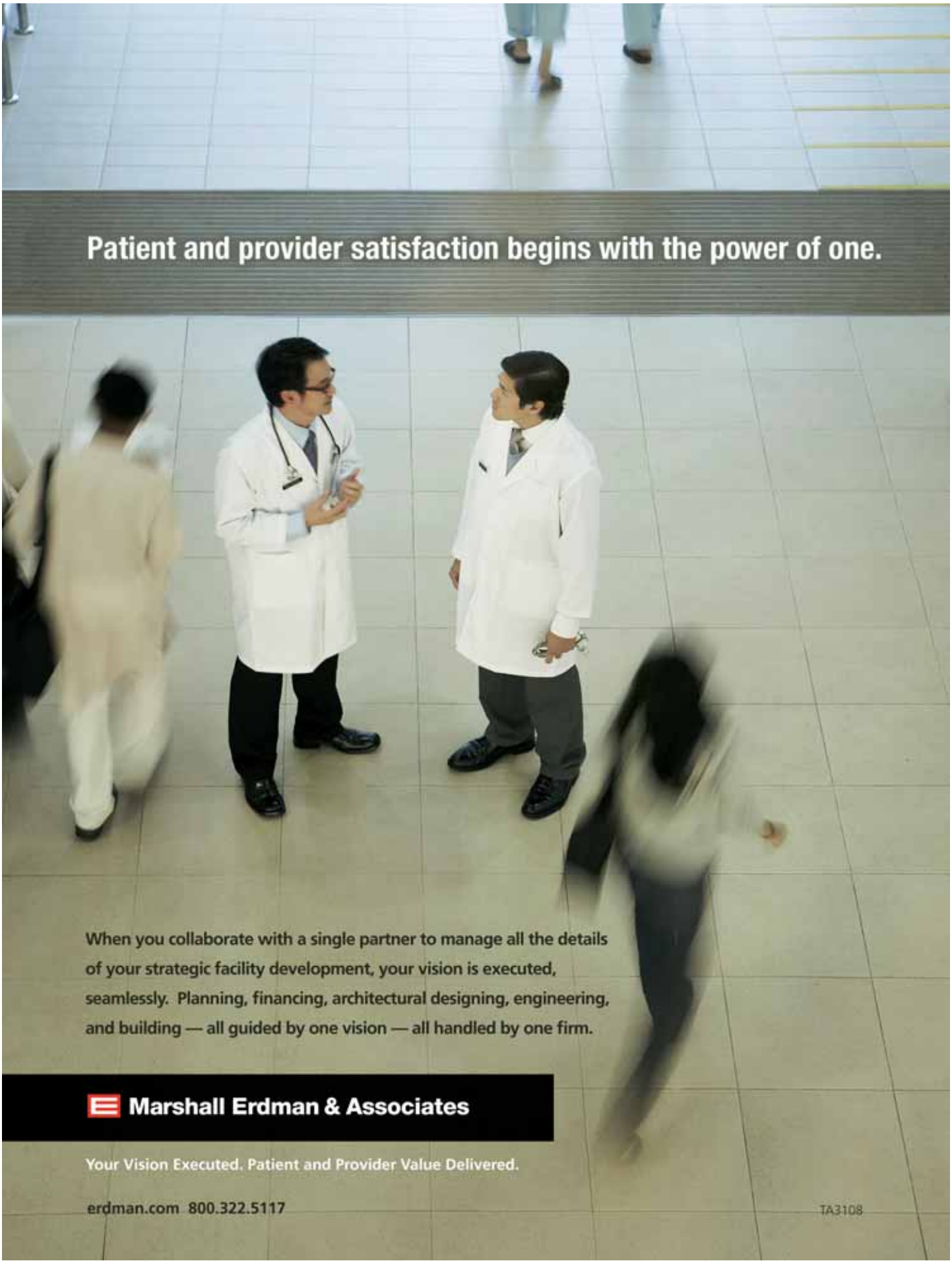
Galil Medical. Galil Medical is leading a new era of minimally invasive cryotherapy solutions that enhance patient quality of life. Learn more about Galil at www.galil-medical.com or call (877) 639-2796.

Valuation

HealthCare Appraisers. HealthCare Appraisers is a nationally recognized valuation and consulting firm providing services exclusively to the healthcare industry. Visit Healthcare Appraisers' Web site at www.healthcareappraisers.com or call the Delray Beach, Fla., office at (561) 330-3488 or the Denver, Colo., office at (303) 688-0700 to learn more.

Principle Valuation. Principle Valuation specializes in the valuation of all types of healthcare real estate including hospitals, independent-living communities, assisted living residences, skilled-nursing facilities, continuing-care retirement communities, medical office buildings, ASCs, pharmacies and rehabilitation facilities. To learn more, visit www.principlevaluation.com or call (312) 422-1010.

VMG Health. VMG Health is recognized by leading healthcare providers as one of the most trusted valuation and transaction advisors in the United States. For more information, visit VMG's Web site at www.vmghealth.com or e-mail Jon O'Sullivan at osullivan@vmghealth.com or call (214) 369-4888. ■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