

ASCR BECKER'S Review

PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

11 Key Concepts From the Stark Law

By Scott Becker, JD, CPA, Ji Hye Kim, JD, and Jessica Smith, JD

The Stark law prohibits physicians from ordering designated health services for Medicare patients from entities with which the physician, or a family member, has a financial relationship unless an exception applies. This article reviews 11 key concepts under the Stark Law, in the context of changes to the Stark law made by CMS.

1. Agreements between providers and referral sources must be in writing

CMS has set forth numerous exceptions to the Stark law. These exceptions permit certain financial relationships between providers of DHS and physician referral sources, so long as certain conditions are met. These exceptions almost uni-

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44 ASC Management and Development Company CEOs to Know

Here are 44 management and development company CEOs to know. *Note:* When a company did not have a CEO, we profiled the individual holding the top leadership position, and limited our profiling to one leader per company.

Sami Abbasi — National Surgical Care.

Mr. Abbasi previously served as co-founder, president and CEO of Radiologix, a leading national provider of diagnostic imaging services, until the company's sale to RadNet in November, 2006. Mr. Abbasi served as COO and CFO of Adminiquest, a Web-enabled, full-service outsourcing solutions provider to the insurance and benefits industry. Mr. Abbasi also was a vice

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10 Best Practices for Improving GI-Efficiency in ASCs

By Mark Taylor

Outpatient GI procedures have taken a big reimbursement hit from Medicare and frequently private payors follow suit with additional cuts. That makes it even more critical for ASCs to focus on internal means of improving quality, efficiency and profitability. Our panel of expert advisors, which includes a gastroenterologist, consultant, ASC development company executive, ASC manager and an endoscopy center nurse and manager, offers these 10 ways to improve efficiency in GI.

1. Start with a good pro forma. Creating a high quality patient care environment that is both efficient and profitable begins before con-

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Coming in the May/June issue of Becker's ASC Review:

- **Specialty Focus: Spine and Orthopedics**
- **Maximize the Efficiency of Pain Management in Your ASC**
- **10 Great Orthopedic- and Spine-Driven ASCs**
- **10 Products and Devices for Orthopedics, Spine and Neurosurgery**

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Note: Editorial content subject to change.



Publisher's Letter: Consolidations Increasing - Buyouts Stagnant; 7 Key Legal Areas for 2009; ASC Communications and the ASC Association June Orthopedic, Spine and Pain Management Driven ASC Conference – June 11-13, Chicago Michigan Avenue - \$200/\$100 Discounts on Registrations Available

This letter offers a handful of observations one can make as this year starts to evolve. It discusses three papers which are available upon request. It also provides information about 27 of the 68 sessions and discounts for our June Orthopedic, Spine and Pain Management Driven ASC Conference.

I. Two overall observations

1. Consolidation of providers and businesses. This year we are seeing more transactions where two providers or several providers are consolidating operations to provide for greater revenues over a single platform. This is as opposed to transactions where a seller is cashing out at a high multiple of EBIDTA. The consolidation transactions are being done among ASCs, hospitals, (e.g., two hospitals in Rhode Island just announced their merger), group practices and healthcare companies. We are also seeing hospi-

tals increasingly acquiring and/or combining with ASCs and practices. We are currently involved in handling an ASC/ASC consolidation transaction, a hospital/hospital consolidation transaction and a hospital/ASC consolidation effort.

2. Seven key legal issues and areas for 2009. We see the following as seven key legal areas of concern for hospitals, ASCs and practices in 2009.

(i) Data mining. We expect increased enforcement as the government uses government data and data mining more fully to pursue both billing fraud and anti-kickback cases. The cases are being driven by both whistleblowers and by the government's own investigations. Here, the government is increasingly using data mining to drive enforcement and to detect patterns in billing that differ from norms. We are also seeing qui tam cases and private party complaints leading to more complete investigations.

(ii) Recovery Audit Contractors. There is substantial concern among hospitals that data entry errors and other errors will provide ammunition for RACs. The RAC program is set to recommence this March. There is a great deal of focus on items that can be picked up by the use of computers and data mining — heavy on data use as opposed to relationship-kickback type crime.

(iii) Stark Act concerns. Here, there is little wiggle room for technical violations, and a backlog of Stark cases at CMS. We are seeing more overall activity here than ever before. For a copy of a white paper on "11 Stark Issues," see below.

(iv) Medicaid enforcement. False claims and similar efforts are being unveiled at state levels to fight fraud and to drive state false claims act recoveries. We have seen states (such as Illinois) take new approaches to kickback and false claim cases and unique positions on fee splitting and kickback cases.



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(v) **Quality of care.** We see more cases being brought against providers by regulators based on substandard quality of care. We have one such investigation that is currently ongoing.

(vi) **Anti-kickback cases.** These are a variant of Stark Act cases but subject to a different standard of proof of intent and not just applicable to physicians.

(vii) **Tax-exempt compensation and community benefits.** The IRS recently completed a study that indicates that the average CEO compensation at the 500 hospitals it reviewed was \$490,000. It also found compensation on average of \$1.4 million at the top 20 hospitals. Finally, it found that approximately 10 percent of all hospitals provided nearly 60 percent of all community benefits as measured by the IRS.

II. White papers available — No charge

We have recently completed three white papers and articles that are available upon request. If you have an interest in obtaining a copy of any of the following, please contact me and we would be happy to provide you a copy of the same.

1. Developing Centers of Excellence — Strategies and Tactics. This is an article regarding developing centers of excellence. It

focuses on both developing a strategic vision and the tactics to be used in developing specialty driven centers of excellence. This was drafted from a presentation we gave at a conference in February devoted to developing orthopedic-driven centers of excellence. The talk was well received. If you would like a copy of the paper, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

2. ASC Transactions – An Overview and Primer on Key Issues.

This paper was drafted as part of a presentation for both the American Health Lawyers Association and for the February issue of *Becker's ASC Review*. It discusses pricing of surgery centers as well as the key legal agreements and legal and business issues related to such transactions. Should you desire a copy of this paper or a copy of the February issue of *Becker's ASC Review*, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com. Also, please feel free to visit www.BeckersASC.com.

3. 11 Key Concepts from the Stark Act.

As we review different Stark issues for clients, we see more different and interesting issues than ever before. These relate to such items as lithotripsy, agreements that are not in writing, per-click arrangements, the impact of the “Stand in the Shoes” rules on hospital relationships with

their subsidiaries and several other issues. Should you desire a copy of this paper, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

III. 7th Annual Orthopedic, Spine, and Pain Management Driven ASC Conference

This June we are hosting our 7th Annual Orthopedic, Spine and Pain Management Driven ASC Conference. The conference is June 11-13. For this conference, we have 94 speakers, 68 sessions, 30 CEOs and 24 physician leaders speaking. We also have great topics and should have a great turnout. Here are just 27 of the topics covered at the conference:

1. The Evolution of Healthcare and the Impact on ASCs — *Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics at Princeton University*

2. Orthopedics - The Forecast for the Next Five Years — *John Cherf, MD, Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago*

3. Using Spine as the Backbone of a Multi-Specialty ASC — *James Lynch, MD, Surgery Center of Reno*

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Amerinet is proud to be the Exclusive GPO Sponsor of the 7th Annual Orthopedics, Pain Management and Spine Driven ASC Conference, June 11-13 in Chicago. Join Karen Barrow, Amerinet SVP of Business Development, to learn about “Implant Costs: Why Facility-Physician Collaboration Makes Sense,” Saturday, June 13 at 9 a.m.

4. 7 Steps to Maximizing an Orthopedic-Driven ASC's Returns in a Tough Economy — Brent Lambert, MD, CEO, Ambulatory Surgical Centers of America

5. Case Study – Two Years Later, A Physician-Owned Spine ASC: A Frank and Open Discussion of Financial Performance, Organizational Issues, Challenges and Problems — John Caruso, MD, Parkway Surgery Center, Hagerstown, Maryland

6. A Payor's View of Orthopedics, Spine and Pain Management — Steven Stern, MD, VP Neuroscience, Orthopedics and Spine, United Healthcare

7. A Case Study Review of Current Outcomes and Issues — Marcus Williamson, MD, and George Goodwin, SVP and Chief Development Officer, Symbion Healthcare

8. Making Big Cases Profitable in an ASC — Naya Kehayes, CEO, Eveia Healthcare; and Greg Cunniff, CFO, National Surgical Care

9. Using Orthopedics and Spine to Turn Around an ASC — Tom Mallon, CEO, and Jeff Simmons, President Western Division, Regent Surgical Health

10. Capturing Your Partners' Cases; The Carrot and Stick Approach — Chris Bishop, VP, Ambulatory Surgical Centers of America

11. Key Legal Issues: Safe Harbor Compliance, Out of Network, and Other Legal Issues — Scott Becker, JD, CPA, Partner, and Bart Walker, JD, McGuire Woods

12. How Economic Conditions Impact Health Care Strategies for Success — Tom Geiser, Senior Advisor, Texas Pacific Group; and Joe Clark, Executive Vice President, Surgical Care Affiliates

13. Uni Knees and Shoulders in the Outpatient Setting: Cost, Staffing and Profitability Issues — Peter Kurzweil, MD, and Margarita de Jesus, Administrator, Surgery Center of Long Beach

14. Key Issues Faced by ASCs Today — Thomas Yerden, CEO and Founder, TRY HealthCare Solutions

15. The Pros and Cons of Total Knees in a 23-Hour Setting: Financial and Safety Issues — Eric Monesmith, MD, OrthoIndy; and John Martin, CEO, OrthoIndy

16. Pain Management: 5 Keys to a Superior Pain Management Program Surgery Center — Lance Lehmann, MD, Medical Director, and Liliana Rodriguez Lehmann, MBA, Hallandale Outpatient Surgical Center

17. Implant Costs: Why Facility-Physician Collaboration Makes Sense — Karen Barrow, SVP Business Development, Amerinet

18. Hand Surgery in ASCs – Key Concepts for Success — Ed Rudisill, MD, The Hand Center, Greenville, SC

19. Pain Management in ASCs - Current Methods to Increase Profits — Amy Mowles, President & CEO, Mowles Medical Practice Management

20. 5 Tips for Managing Anesthesia in Your ASC — Thomas Yerden, CEO and Founder, TRY HealthCare Solutions

21. How to Recruit Great Surgeons to Work at Your ASC — Robert Carrera, President, Pinnacle III

22. Turnarounds: 2 Case Studies; 5 Key Ideas for Success — Joe Zasa, President, Woodrum/ASD

23. What Does a National Company Want After a Deal? 10 Facts That Will Drive a Buyer Away — Bill Kennedy, SVP Business Development, NovaMed; Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion

24. Is Your Center too Dependent on a Single Specialty? How to Diversify and Make Change Happen — John Seitz, CEO, Ambulatory Surgical Group; Joe Zasa, President, Woodrum/ASD; and Larry Taylor, President and CEO, Practice Partners in Healthcare

25. 5 Core Concepts for Great ASC Joint Ventures With Hospital Partners — Mike Pankey, Administrator, Ambulatory Surgery Center of Spartanburg; and Caryl Serbin, CEO, Serbin Surgery Center Billing

26. Assessing the Profitability of Orthopedics, Spine and Pain in ASCs — Luke Lambert, CEO, Ambulatory Surgery Centers of America

27. 5 Core Strategies to Immediately Improve ASC and Hospital Operations — Doug Johnson, COO, RMC MedStone Capital

Should you have questions about the conference or desire to see a copy of the brochure, please contact me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com or go to www.BeckersASC.com. In addition, should you desire to register for the conference, please feel free to deduct \$100 from the registration price if registering for the main conference. Please deduct \$200 if registering for the combined pre-conference and main conference. Please note on the registration, \$100 (main conference only) or \$200 (for main and pre-conference) discount per Scott Becker.

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11 Key Concepts From the Stark Law (continued from pg. 1)

formly require that the agreement between a provider of DHS and the physician referral source be in writing. For example, the following exceptions to the Stark law require a written, signed agreement: office space and equipment rental, personal service arrangements, physician recruitment arrangements, group practice arrangements and fair market value compensation arrangements. 42 C.F.R. 411.357.

CMS has indicated that the purpose of requiring a written agreement is “so that [the agreement] can be objectively verified, and meets the terms and conditions of [the exception.]” 66 F.R. 949 (Jan. 4, 2001). The inadvertent error of not placing an excepted financial relationship in writing generally means that the arrangement will not meet an exception, even if all other requirements of the given exception were satisfied.

The key excepted financial relationship that need not be in writing is for bona fide employment relationships. 42 C.F.R. 411.357(c).

2. Per-click leasing arrangements

As of Oct. 1, physician referral sources and providers of DHS will no longer be permitted to have per-click relationships for office space and equipment leases. Four exceptions currently permit these types of arrangements: the office space

exception, the equipment lease exception, the fair market value exception and the indirect compensation arrangement exception. 411 C.F.R. 411.357(a), (b), (l), and (p).

The 2009 Hospital Inpatient Prospective Payment System final rule modified these exceptions to explicitly exclude per click arrangements for lease of equipment or real estate. 73 F.R. 48343 (Aug. 19, 2008). CMS limited per-click leasing arrangements in large part due to its concern that “such lease arrangements create the incentive for overutilization, because the more referrals the physician lessor makes, the more revenue he or she earns.” 73 F.R. 48715 (Aug. 19, 2008).

These changes that prohibit per-click office space and equipment leasing arrangements will go into effect on Oct. 1, 2009. Any existing per-click office space or equipment lease arrangement that relies on one of these exceptions will need to be restructured prior to the Oct. 1, 2009, compliance deadline.

3. Percentage-based arrangements

The revisions to Stark law made by the IPSS do not extend to percentage-based compensation formulae outside of the office space and equipment lease context. Thus, “if a compensation formula for physician compensation for items or

services — other than the rental of office space or equipment — was permissible prior to Oct. 1, 2009... that formula would not be made impermissible by this final rule.” 73 F.R. 48712 (Aug. 19, 2008).

For example, percentage-based management and billing service relationships are still permissible so long as they satisfy certain criteria set forth in the Stark law and anti-kickback statute.

CMS has indicated, however, that the prohibition on percentage-based compensation arrangements may be extended outside of the office space and equipment lease context: “although we are not extending, at this time, the prohibition on the use of percentage-based compensation formulae to arrangements for any non-professional service (such as management or billing services), we reiterate our intention to continue to monitor arrangements for nonprofessional services that are based on a percentage of revenue raised, earned, billed, collected, or otherwise attributable to a physician’s (or physician organization’s) professional services.” 73 F.R. 48710 (Aug. 19, 2008).

4. Lithotripsy arrangements

As mentioned, the Stark law prohibits physicians from ordering DHS for Medicare patients from entities with which the physician has a financial

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relationship. Lithotripsy services are not considered DHS. *Am. Lithotripsy Soc. v. Thompson*, 215 F. Supp. 2d 23 (D.D.C. 2002). The IPPS commentary confirms this analysis, suggesting that lithotripsy services are not DHS regardless of whether the services are billed by the provider or a hospital. 73 F.R. 48730 (Aug. 19, 2008). As a result, the upcoming prohibition on per-click leasing arrangements will not apply to lithotripsy lease arrangements or under-arrangement agreements. CMS draws a very significant distinction between leases of equipment which can generally no longer be per-click and services agreements which include some equipment therein, and can be per-click or per-service. In the case of lithotripsy, the distinction is critical to whether urologists can make other DHS referrals to the hospital.

A urologist who leases a lithotripter to a hospital through a leasing agreement on a per-click basis cannot make other referrals to that hospital (i.e., other referrals outside of lithotripsy). Per-click leasing agreements, in short, will not meet an exception and thus the urologist cannot make other referrals. A per-click lithotripsy agreement, in contrast, that provides overall lithotripsy services (not just equipment) may be structured to fit into the fair market value exception. Thus, the urologist would be able to arguably make other referrals to the hospital.

In the case of a local urologist providing lithotripsy services to a hospital at which he or she generally practices, the key question will come down is the agreement a lease of equipment or a service agreement.

Two key comments from CMS as to this issue are as follows:

Currently, lithotripsy is not considered a designated health service for purpose of the physician self-referral law. Therefore, if the physician owners of the lithotripsy partnership make referrals to the hospital for lithotripsy services ONLY, the physician self-referral law would not be implicated, and a per-unit or percentage based compensation formula for the compensation arrangement between the lithotripsy partnership and the hospital would be prohibited, even if the compensation arrangement is considered to be a lease of equipment (and other items or personnel).

If the physician owners of the lithotripsy partnership refer Medicare patients to the contracting hospital for any designated health services (DHS), the compensation arrangement between the lithotripsy partnership and the hospital must comply with an applicable exception to the physician self referral law. Where a compensation arrangement between the hospital and the physician-owned lithotripsy partnership is considered to be a lease

of equipment, a per-unit or percentage-based compensation formula would fail to satisfy the requirements of any of the potentially applicable exceptions for the lease of equipment found in §411.357(b), §411.357(l) or §411.357(p).

5. Professional courtesy

CMS recognized the longstanding tradition of extending professional courtesy to physicians and their family members in 2004 by promulgating an exception to the Stark law for professional courtesy arrangements. 69 F.R. 16116 (March 26, 2004). The professional courtesy exception covers free or discount services provided to a physician or his or her immediate family members, so long as certain conditions are satisfied. 42 C.F.R. 411.351.

Specifically, the arrangement must be: (i) extended to all physicians on the medical staff or in the community; (ii) for items and services routinely provided by the entity; (iii) set forth in writing and approved by the provider's governing body; (iv) unavailable to any physician or family member who is a federal health care program beneficiary; and (v) does not violate the anti-kickback statute or any billing or claims submission laws. 42 C.F.R. 411.357(s).

6. Retention payments

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11 Key Concepts From the Stark Law (continued from pg. 9)

rural health clinic may make retention payments to physicians in order to induce them to stay in its geographic service area. Retention payments may be made when a physician has a bona fide offer or presents a written certification that he or she has a recruitment opportunity that would require the physician to relocate at least 25 miles outside of the entity's geographic service area. 42 C.F.R. 411.357(t).

The Stark law recently added more flexibility to the retention payments exception by widening the "geographic service area." 72 F.R. 51065 (Sept. 5, 2007). The entity's "geographic service area" not only encompasses a Health Professional Shortage Area but also rural areas and an area with a demonstrated need for the physician, as determined by the Secretary of the Department of Health and Human Services. In addition, the geographic service area may include an area where at least 75 percent of the physician's patients reside in a medically underserved area or are members of a medically underserved population.

7. Mission support payments

Many DHS entities make mission support payments to their affiliates in order to fulfill their missions of medical research, education and healthcare services to the community.

The Stark law provides a safe harbor for those DHS entities that meet the Academic Medical Centers exception. 42 C.F.R. 411.355(e). The AMC exception is extensive as it is complicated. Each element of the exception must be satisfied when an academic medical center makes mission support payments to a faculty practice or other affiliates. The indirect compensation exception may also be available in those cases where the support arrangement constitutes an indirect compensation as defined by the Stark law. Like the AMC exception, the indirect compensation exception entails a number

of elements; each element of the indirect compensation definition and the exception must be satisfied. 42 C.F.R. 411.354(c)(2) and 411.357(p). An indirect compensation relationship may exist when at least one person or entity is interposed between the DHS entity and the referring physician. If the affiliate that is receiving the mission support payment is a physician organization and its physician employee has an ownership or investment interest in the organization, the physician-owner is deemed to stand in the shoes of the organization. As a result, arrangements that were previously treated as indirect would now be direct, and one of the direct compensation exceptions must be satisfied. 42 C.F.R. 411.354(c)(1)(ii).

A DHS entity may avoid the Stark law implications entirely if it has no financial relationship with the physician employees of the affiliate. There is no financial relationship under the Stark law if: i) a DHS entity provides mission support payments directly to its affiliate; (ii) the affiliate is not owned by any of its physician employees; and (iii) the affiliate's compensation of its physician employees does not take into account the volume or value of referrals or other business generated by the physician employees to the DHS entity. If these three conditions are met, a DHS entity may make payments to its affiliate to keep it in good financial shape and accomplish its missions without implicating the Stark law.

8. Publicly-traded company exception

The Stark law excludes certain ownership interests in a DHS entity from the definition of the financial relationship, including ownership of investment securities that could be purchased on the open market when the DHS referral was made. These securities must either be listed for trading on the NASDAQ or a similar system, or traded under an automated dealer quotation system by the National Association of Securities Dealers. Further, the securities must be in a corporation that had stock holder equity exceeding \$75 million either at the end of the corporation's most recent fiscal year or on average during the previous three fiscal years. 42 C.F.R. 411.356(a). Here, stock holder equity means the excess of the hospital's net assets over its total liabilities.

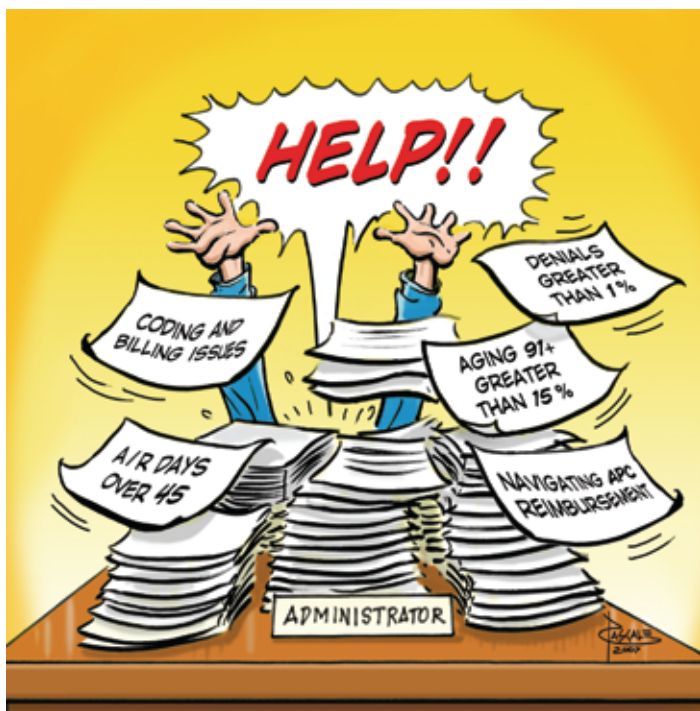
9. Isolated transactions

Physicians may engage in an isolated financial transaction with a DHS entity without violating the Stark law only if the following conditions are met. First, the amount of remuneration must be based on fair market value and not take into account the volume or value of any referrals a physician makes to the DHS entity or any other business generated by the parties. Second, the arrangement must be commercially reasonable even if no referrals are made between the parties. Finally, no additional transactions, except ones specifically excepted from the Stark law, may occur for six months after the isolated transaction. 42 C.F.R. 411.357(f). Installment payments may qualify as payment as part of an isolated transaction if the total aggregate payment is: (i) set before the first payment is made; (ii) does not take into account, directly or indirectly, referrals or other business generated by the referring physician; and (iii) is secured. 72 F.R. 51055 (Sept. 5, 2007).

10. Non-monetary compensation benefits

A physician may receive from a DHS entity non-monetary compensations up to \$300 in the aggregate a year (i.e., meals, parking, training, etc.) (This amount is adjusted annually for inflation; the aggregate amount is \$355 for 2009). Non-monetary compensation cannot take into account the volume or value of any referrals or other business generated by the physician. Further, the physician must not have solicited such compensation. The compensation must also not violate the anti-kickback statute or any federal or state law. 42 C.F.R. 411.357(k). CMS recommends that hospitals implement compliance systems, such as mechanisms to track and value the provision of gifts, complimentary items and other benefits for physicians, to ensure non-monetary compensation does not exceed the annual spending limit. 72 F.R. 51058 (Sept. 5, 2007).

The Stark law does allow a hospital with a formal medical staff to throw a local staff appreciation event once a year without adhering to the spending



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cap. Any gifts or gratuities provided in connection with the event, however, are subject to the spending cap. 42 C.F.R. 411.357(k)(4). Finally, the recent revision to the Stark law now allows an entity to stay below the spending cap when it inadvertently exceeds the cap by no more than 50 percent and the physician repays the excess within that calendar year or 180 consecutive days from receipt of the excess compensation, whichever is earlier. The entity and the physician may rely on the repayment provision no more than once every three years. 42 C.F.R. 411.357(k)(3).

11. Splitting profits from ancillary services within a practice

There are several ways to split profits from DHS within a group practice, so long as the given profit-splitting method is not related to the volume or value of referrals. Two profit-sharing methods that are not prohibited by Stark include certain profit-sharing arrangements between members of a group practice and certain productivity bonuses.

When a physician's group meets the Stark law's definition of a "group practice," its physicians may receive a share of the overall profits so long as the distribution is reasonable, verifiable and unrelated to the volume or value of referrals. The Stark law deems certain methods of profit sharing

as not relating directly to the volume or value of referrals. The profits, for example, may be divided per member of the group. The group may also distribute DHS revenues based on the distribution of the groups revenues attributed to services that are not DHS payable by any federal health-care program or private payor. Finally, the Stark law allows any method of profit-sharing if DHS revenues constitute less than 5 percent of the group practice's total revenues and no physician's share is more than 5 percent of the physician's total compensation from the group practice. 42 C.F.R. 411.352(i)(1) & (2).

CMS has explicitly stated that "all physicians, whether employees, independent contractors, or academic medical center physicians, can be paid productivity bonuses based on work they personally perform." 69 F.R. 16067 (March 26, 2004). A physician may be paid a productivity bonus based on work personally performed by that physician, so long as the productivity bonus is not calculated in a way that directly relates to the volume or value of a physician's DHS referrals. One such method of calculating productivity bonuses is to base a physician's bonus on his or her total patient encounters or relative value units. 42 C.F.R. 411.352(i)(3). ■

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44 ASC Management and Development Company CEOs to Know (continued from pg. 1)

president in the health care group of Robertson Stephens and CitiGroup. He currently serves on the board of directors of BehringerHarvard Multifamily REIT I and American CareSource Holdings. Mr. Abbasi earned an MBA from the University of Rochester (N.Y.).

David “Buddy” F. Bacon, Jr. — Meridian Surgical Partners. Mr. Bacon has more than 22 years of experience in the healthcare sector and is a founder of Meridian Surgical Partners. From 1996–2003, Mr. Bacon served in roles as CEO and previously as CFO for Medifax-EDI, a healthcare information technology company based in Nashville. In 2001, the company was acquired by Crescent Capital in Atlanta for \$117 million. At that time, Mr. Bacon was promoted to CEO of Medifax-EDI and grew the company until it was sold to WebMD in 2003, for a combined valuation of \$365 million. Prior to Medifax-EDI, Mr. Bacon worked in public accounting with Lattimore, Black, Morgan & Cain. He is a graduate of David Lipscomb College in Nashville and is a certified public accountant.

Ravi Chopra — The C/N Group. Prior to founding the C/N Group in 1980, Mr. Chopra served in various executive management positions in the steel industry, including chief industrial

engineer for Youngstown Steel (now International Steel Group) and director of engineering services for Wisconsin Steel (now Envirodyne Industries). He holds a BSME from Punjab Engineering College, Chandigarh, India; MSIE from Oklahoma State University, Stillwater, Okla., and MBA from Xavier University, Cincinnati, Ohio. Mr. Chopra’s sons, Raman Chopra and Rajiv Chopra, work as CIO and director of strategic planning, respectively, for the company.


James Cobb — Orion Medical Services. With a total of 37 years in management, Mr. Cobb has primarily focused the last 25 years in the medical field. In the past 12 years, he has developed, constructed and managed seven high-volume ASCs. He has served as CEO for the Pacific Cataract Laser Institute and Pacific Eye Center. Mr. Cobb began as assistant business manager for a practice comprised of 25 radiologists in 1980. Mr. Cobb holds a private pilots license and is a member of the Aircraft Owners and Pilots Association.

Don Cook — Pacific Surgical Partners. With more than 20 years experience in outpatient healthcare management, Mr. Cook has built and operated both private and public companies in a number of areas including surgery, cardiology, home infusion therapy and physician practice

management. Prior to his current role at PSP, he most recently served as president and CEO of Surgem and Clinicis. He has written, spoken and consulted extensively in the areas of management, strategy and operational effectiveness. Mr. Cook holds an MBA from the Kellogg School of Management at Northwestern University.

R. Blake Curd, MD — Surgical Management Professionals. Prior to accepting the interim CEO position at SMP, Dr. Curd served as chairman of the board from 2005 and vice chair from 2003–2005. Dr. Curd is board member and treasurer of Physician Hospitals of America and has been a board member of PHA since 2005. He also has served as a director of Medical Facilities Corp. since 2004. Dr. Curd was recently elected to the South Dakota State Legislature and began his term in the House of Representatives on Jan. 13, 2009. He is a practicing hand and microvascular surgeon at the Orthopedic Institute in Sioux Falls, S.D. Dr. Curd was the chairman of orthopedic surgery at Avera McKean Hospital and University Health Center in Sioux Falls from 2003–2004.

Richard DeHart — PINNACLE III. Mr. DeHart has 20 years of experience in the outpatient healthcare industry. A graduate of California



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State University at Chico, he began his healthcare career as a certified athletic trainer in professional baseball. He joined the sports medicine team at Alabama Sports Medicine and Orthopaedic Center in Birmingham. He then took an administrative healthcare role where he provided operational services for multiple outpatient rehabilitation facilities. Prior to co-founding PINNACLE III in 1999, Mr. DeHart oversaw the management of 14 surgery centers in five states for one of the nation's largest publicly traded healthcare companies.

Richard Francis, Jr. — Symbion. Prior to the formation of Symbion, Mr. Francis served as president and CEO of UniPhy, an operator of multi-specialty clinics, independent practice associations and related outpatient services. Earlier in his career, he was the senior vice president of development for HealthTrust, where he also served as a regional vice president with responsibility for the operations of 11 hospitals in five states. Mr. Francis also serves on the board of directors for the Nashville Health Care Council.

Tom Galouzis, MD — Nikitis Resource Group. Dr. Galouzis, a board-certified general surgeon, 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. Since 1999, Dr Galouzis has served as president of Lake Park Surgicare in Hobart, Ind., and is president of Lake-Porter Ambulatory Surgery, a physician holding company for physician joint ventures. He is president of both the Lake Porter Physicians Hospital and the Lakeshore Surgicare, both located in Chesterton, Ind. He is also CEO of Hoosier Healthcare and has served in many hospital leadership capacities.

John Hajjar, MD, FACS, MBA — Surgem. Dr. Hajjar is a urologist who developed one of the first ASCs in New Jersey at Fair Lawn and

has been managing facilities since 1992. Dr. Hajjar also operates one of the largest private practices of urology in the United States, with 17 physicians in 11 locations. He participates in and performs surgery at two of Surgem's locations. Dr. Hajjar studied medicine at The Georgetown University School of Medicine in Washington, D.C., and completed his surgical and urological training at New York University Medical Center in New York City.

Thomas Hall — NovaMed. Mr. Hall previously served as president and CEO of Matria Healthcare, after having joined Matria as executive vice president and COO. Matria provides disease management programs to health plans and employers. Mr. Hall has also served as president and CEO of TSH & Associates, an independent consulting and management services company; held several executive positions at ADP TotalSource, a division of Automated Data Processing; and also served in senior management positions with Riscorp, an insurance holding company, and USAir Express/Chautauqua Airlines. Mr. Hall earned an MBA from Clarkson University in Potsdam, N.Y.

Richard Hanley — Health Inventures. Mr. Hanley has been in the healthcare business for more than 30 years and has extensive experience relating to the planning, organization, development and management of healthcare services and products. He was a founding partner in 1995 of Horizon Health Services, which was acquired by Johnson & Johnson Health Care Systems. He served as president and CEO of Surgical Partners of America, a wholly owned subsidiary of Vivra. Mr. Hanley has also been responsible for development activities and operations of the Sutter Ambulatory Care Corp. and managed the day-to-day clinic operations for the Medical Center of Sacramento. Mr. Hanley is a board member for the Ambulatory Surgery Center Foundation and holds a master's degree in healthcare from the University of Minnesota.

Andrew Hayek — Surgical Care Affiliates. Mr. Hayek recently served as president of VillageHealth, an insurance and care management company owned by DaVita, a leading independent provider of kidney dialysis services. Prior to his role at VillageHealth, he served as president and COO of Alliance Imaging, and worked for Capstone Consulting (an operations consulting firm affiliated with private equity firm Kohlberg Kravis Roberts & Co.), The Pritzker Organization (a merchant banking firm affiliated with the Pritzker family of Chicago, owners of Hyatt Hotels) and the Boston Consulting Group.

Edward Hetrick — Facility Development & Management. Mr. Hetrick has over 25 years of experience in the healthcare industry, the last 15 in the ASC industry. He has held management positions in major teaching institutions in the New York metropolitan area as well as a consulting position within the healthcare division of a big six accounting firm. Prior to founding FDM, Mr. Hetrick was vice president in Healthcare Facilities Management, a firm that specializes in reimbursement consulting for physicians and outpatient hospital accounts. He continues in this position today. He was also the director of operations management and operating room administrator at a major teaching institution in New York City. Mr. Hetrick holds an MBA and an MPH in hospital administration from Columbia University.

Christopher Holden — AmSurg. Mr. Holden is a healthcare industry veteran of more than 21 years, engaged during most of his career directly in multi-facility and multi-market healthcare management. Prior to joining AmSurg, Mr. Holden served as senior vice president and a division president of Triad Hospitals, of which Mr. Holden was a founding team member and officer in May 1999. From Aug. 1994-May 1999, Mr. Holden held several officer positions with Columbia/HCA Healthcare Corp. Mr. Holden holds a master's degree in healthcare administration and a law degree from Washington University.

Jeremy Hogue, JD — Sovereign Healthcare. In addition to serving as CEO of Sovereign, Mr. Hogue manages and consults with numerous healthcare ventures and physician practices. Prior to co-founding Sovereign,

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Mr. Hogue was vice president of Audax Group, a \$1-billion private equity investment firm where he launched and ran the firm's West Coast office and directed investments into several early-stage and middle-market businesses. Prior to Audax Group, he was an associate with Lehman Brothers, where he was a member of the firm's investment banking group. Mr. Hogue received his juris doctorate from Harvard Law School and his MBA from the University of Southern California. Mr. Hogue was an All-American offensive lineman at USC and authors a column for the Website WeAreSC.com, an ESPN affiliate.

Richard K. Jacques — Covenant Surgical Partners. Mr. Jacques has over 15 years in the ASC industry, including senior management positions with both public and private health care companies. He was president and director of Surgical Health Group, a developer and manager of single and limited specialty surgery centers. Prior to that, Mr. Jacques was vice president of business development for AmSurg Corp. and was integral in the development of the system and methodology that AmSurg used to acquire or develop almost 100 ASCs during his time with them.

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

Luke Lambert, CFA — Ambulatory Surgical Centers of America. Mr. Lambert came to ASCOA, first as its CFO in 1997 and then becoming its CEO in 2002, with a broad background in finance, strategy, and operations. Mr. Lambert worked for Smith Barney in international sell side equity research. At Booz, Allen & Hamilton and Ernst & Young, Mr. Lambert consulted with entities starting new ventures, entering new markets and reengineering business processes. Mr. Lambert is a graduate of Harvard College where he studied economics, and he obtained his MBA from the Columbia Graduate School of Business. Mr. Lambert was among the first to earn the CASC designation in 2002.

Vickie Landig — Specialty Surgical Centers/Symbion Pacific Region. Ms. Landig has more than 20 years of surgical health-care experience with an expertise in orthopedic and spine procedures. Prior to her current role serving as regional vice president, pacific region, she served as director of operations for the Specialty Surgical Centers/Symbion Pacific Region, managing, developing and overseeing seven facilities. She was also administrative direc-

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tor at Fullerton Surgical Center and surgical services manager for St. Jude Medical Center. She has her RN and PHN licenses, and earned CNOR and CRNFA credentials.

Jared Leger — Arise Healthcare. Mr. Leger previously served as an executive director for a large physician group practice and ancillary services that included behavioral health and physical therapy services. He has syndicated and operated a physician-owned surgery center and a functional restoration program. Mr. Leger has a medical device sales background and currently holds a RN license as well as the CASC designation. Mr. Leger also owns a real estate holding company based out of Austin, Texas.

Jeff Leland — Blue Chip Surgical Center Partners. Mr. Leland previously served as executive director of Lutheran General Medical Group, a 260-physician, multi-specialty medical group located in Chicago. He was once a senior-level executive with Advocate Health Care in Chicago, responsible for both business development and Advocate's 225,000-member health plan. He also served as vice president with ASCOA, president of HealthSpring Medical Group and as CEO of Western Ohio Health Care, an HMO with 200,000-plus members.

Mike Lipomi — RMC Medstone. Mr. Lipomi has more than 30 years of experience in hospital and ambulatory surgery facility management. He started his career with American Medical International at El Cajon Valley Hospital in San Diego. Most recently, Mr. Lipomi was CEO of Stanislaus Surgical Hospital in Modesto, Calif., which he grew from a small surgery center into a leading specialty hospital. He spent six years on the board of directors of the organization formerly known as FASA, three terms on the board of directors and two terms as president of the California Ambulatory Surgery Association and served on the board of directors of Physician Hospitals of America for the past seven years,

including two years as president, and is the former chair the PHA's legislative committee.

Rodney Lunn — Surgical Health Group. Over the past 17 years, Mr. Lunn has developed more than 150 ASCs throughout the United States. Mr. Lunn was a founder of AmSurg Corp., where he served as a director and as the senior vice president responsible for development of de nova centers, and started Practice Development Associates. Mr. Lunn has served as controller for MEDINC, as vice president of finance and CFO of American Medical Centers, the owner and manager of acute care hospitals. He also has experience in the HMO industry, having previously served as CFO of INA (now Cigna) Healthplan of Texas and vice president of HealthAmerica of Florida.

Thomas Mallon — Regent Surgical Health. Before founding Regent in 2001, Mr. Mallon served as a founding member and remains a general partner with Gryffindor Capital Partners, a Chicago-based venture-capital fund. In 1994, he co-founded Same Day Surgery, which acquired five distressed and underutilized ASCs and a physician management company. Before his healthcare ventures, Mr. Mallon worked for 12 years in commercial office leasing for national firms. During his years as manager for the Miglin-Beitler leasing team, the *Chicago Sun-Times* selected the firm as Property Manager of the Year. Mr. Mallon received his BA in political science from Denison University in Grainville, Ohio, and a master of business administration degree from Harvard Business School.

Ajay K. Mangal, MD — Prexus Health. Dr. Mangal left the practice of medicine in 2006 to become one of the co-founders of Prexus. He previously served on staff at Butler County Medical Center, Fort Hamilton, Mercy Fairfield and Cincinnati Children's Hospitals. Dr. Mangal received his Doctor of Medicine from the University of Iowa's College of Medicine in 1984. He completed his residency in otolaryngology head and neck surgery from the University of Cincinnati in 1989 and is board-certified. He received his MBA degree from Xavier University in 1998. He is passionate about empowering his colleagues in their ability to control the quality and cost of healthcare.

Thomas A. Michaud — Foundation Surgery Affiliates. Prior to founding Foundation Surgery Affiliates in Jan. 1996, Mr. Michaud held the positions of COO and CFO of a regional surgery center management company. He has also been active in building bariatric centers. Other experience included that of partner in a local CPA firm, COO of a regional wholesale company, along with holding the upper management positions of manager of management information systems as well as manager of materials at an aerospace company. Mr. Michaud earned his CPA while serving as a staff accountant with the international accounting firm Ernst & Young.

Krystal Mims — Texas Health Partners. Prior to becoming president of Texas Health Partners, she served as CFO for Physician's Medical Center, a specialty hospital in Plano, Texas, Southlake Specialty Hospital in Southlake, Texas, and Presbyterian Hospital of Rockwall in Rockwall, Texas, until August 2007. Her background in healthcare began in physician practice management. She was CFO for Texas Back Institute for three years, CFO of Practice Performance and administrator of Steadman Hawkins Denver Clinic. Ms. Mims served as secretary and CFO of Parker Road Surgery Center when Texas Health Partners formed this Dallas joint venture in 1994. Ms. Mims is a CPA and began her career with KPMG Peat Marwick.

Fred W. Ortmann, III — Ortmann Healthcare Consultants. Mr. Ortmann has more than 17 years of experience developing ASCs. Mr. Ortmann received his undergraduate degree from the University of South Carolina and his MHA from Baylor University. He was then commissioned in the USAF Medical Service Corps and served in a variety of positions during a 22-year career. He retired as a colonel in 1989 and began his private career as an administrator with Presbyterian Hospital in Albuquerque, N.M. After two years, he was asked to join the initial staff of AmSurg Corp., and

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served as its vice president for center development. He left AmSurg in 2001 and founded Ortmann Healthcare Consultants. He has also served as a consultant to Olympus America. He is a frequent guest speaker at many national ambulatory surgery meetings and seminars and has published a number of articles on the development of ASCs.

Lori Ramirez — Elite Surgical Affiliates.

Ms. Ramirez has more than 12 years experience in surgical development, operations and management. Prior to founding Elite Surgical Affiliates in Jan. 2008, she was a senior vice president of United Surgical Partners International where she was directly responsible for developing the second-largest network of surgical facilities for USPI in Houston. In this role, Ms. Ramirez oversaw 20-plus surgical facilities. Ms. Ramirez also has extensive experience in joint venturing with health systems such as Memorial Hermann in Houston and CHRISTUS Health System in South Texas. She has a graduate degree in business administration.

John Rex-Waller — National Surgical Hospitals.

Prior to his work as chairman, president and CEO of NSH, Mr. Rex-Waller was CFO of Hawk Medical Supply, a provider of disposable medical supplies to physicians. Previously he was the CFO and a co-founder of National

Surgery Centers which became one of the largest independent owners and operators of surgery centers in the country. He has been an investment banker, has an MBA from the University of Chicago and is a Rhodes Scholar.

J. Michael Ribaldo, MD — Surgical Synergies.

Dr. Ribaldo has more than 27 years of experience as a surgeon, healthcare executive and real estate developer. He is a leader in the development of physician-owned ASCs and has served as executive vice president of Surgical Health Corp. and HealthSouth Surgery Centers. He currently serves on the board of directors for Flow International and chairs its compensation committee. He is also co-founder of Surgical Anesthesia Services. Dr. Ribaldo graduated from Louisiana State Medical School with graduate medical school training at Emory University, Washington University and New York University. He received postgraduate training at Harvard Law School, Kellogg Business School and Stanford Graduate School of Business.

John Schario — Nueterra Healthcare.

Prior to joining Nueterra in 2001, Mr. Schario spent 20 years as an executive of a major Midwestern integrated health system. His background includes building physician referral networks, managing acute care hospitals and the development and operation of surgery centers and imaging facilities. Mr. Schario earned an M.B.A.

from Rockhurst University. He is an active member of the American College of Healthcare Executives and a member of the board of the ASC Association. In addition to his business endeavors, Mr. Schario strongly believes in community service. He is an active leader of his church and has previously volunteered with the Boy Scouts of America.

Donald Schellpfeffer, MD — Medical Facilities Corp. (MFC).

Dr. Schellpfeffer has over 18 years of experience in ambulatory surgical environments and 22 years in general, cardiovascular and trauma practices. In addition to serving as CEO of MFC, he is currently medical director of Sioux Falls Surgical Center, which he co-founded, and president of Anesthesia Associates, the largest anesthesia services provider in South Dakota. As an original founder of the Sioux Falls Surgical Center, Dr. Schellpfeffer has been its medical director and a member of the management committee since 1985.

John Seitz — Ambulatory Surgical Group.

Mr. Seitz has focused in the healthcare industry for more than 25 years. Prior to co-founding Ambulatory Surgical Group, he had been a founder and either the CEO or president of three successful startup companies in the healthcare industry. Most recently, Mr. Seitz was the one of the founders and president of Surgem.

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Prior to Surgem, he was founder and CEO of Cornerstone Physicians, a medical practice management company. Mr. Seitz is a graduate of the Harvard Business School Owner/President Management Program and has attended Western State University College of Law. Mr. Seitz is a frequent presenter at conferences.

Caryl A. Serbin, RN, BSN, LHRM — Surgery Consultants of America and Serbin Surgery Center Billing. Ms. Serbin has more than 25 years of experience in the healthcare industry, with the last 18 years spent in ambulatory surgery administration and consulting. Her background includes working with one of the leaders in ambulatory care, the original Nashville-based Surgical Care Affiliates. Earlier in her career, her responsibilities included the administrative, clinical and reimbursement oversight of the outpatient department of a leading Florida hospital.

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

William Southwick — HealthMark Partners. Prior to founding the surgery center division of HealthMark, which later became the sole business for HealthMark Partners, Mr. Southwick founded Southwick Financial Associates. Through merger, Southwick Financial Associates managed over \$100 million in client assets and assisted large family businesses with succession planning for multigenerational growth. In 1996, Mr. Southwick helped start HealthMark Partners (formerly Women's Health Partners), the current parent corporation to Surgical Health

Partners. Mr. Southwick holds degrees in economics and finance and holds several advanced degrees. He currently serves on the board of DTS America, a medical transcription company based in Brentwood, Tenn.

Larry Taylor — Practice Partners. Mr. Taylor has 26 years of experience in healthcare delivery, management and physician relations. Prior to founding Practice Partners, he served as president and COO of one of the largest providers of ASC services in the United States. As a certified athletic trainer, his initial entry into healthcare was focused in the delivery of sports medicine and orthopaedic care. He has had responsibilities for multiple healthcare sites across the United States and United Kingdom over the course of his career. He also serves as an adjunct professor in healthcare at the University of Alabama at Birmingham.

George Tinawi, MD — Surgery Center Partners. Dr. Tinawi was a practicing physician in Mountain View, Calif., from 1986-2004. He co-founded Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization, with Samuel Marcus, MD, in 1997. Dr. Tinawi currently serves as president of the company. He is a graduate of the Medical School of University of Aleppo in Syria. Dr. Tinawi completed his residency in internal medicine at the University of Massachusetts Medicine Program and his fellowship in gastroenterology at the University of Southern California. He is board certified in both internal medicine and gastroenterology.

Bruce Wallace — Congero Development. Mr. Wallace has been in the healthcare industry for 24 years. His experience in healthcare started in the site placement and facility development/technical engineering of radiological imaging equipment. Mr. Wallace transitioned to senior sales and manufacturing positions including products such as laser disc storage,



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ophthalmic lasers and phaco emulsifiers, and laparoscopic and endoscopic imaging. He then developed Single Source, a company that provides services for ASCs with an emphasis on medical equipment planning, procurement, asset management and facility design. Mr. Wallace was also the co-founder of the Outpatient Partners family of companies, which developed and owned one of the largest private licensure and accreditation firms in the United States.

William Wilcox — United Surgical Partners International (USPI). Prior to joining USPI as president and a director in 1998 — he was named CEO in 2004 — Mr. Wilcox served as CEO of United Dental Care, president of the Surgery Group of HCA and president and CEO of the ambulatory surgery division of HCA. Mr. Wilcox also served as president, COO and a director of Medical Care International.

Donald Wilson — Cirrus Health. Prior to founding one of Cirrus' predecessors in 1996, Mr. Wilson developed an extensive commercial real estate portfolio in various locations across Texas and surrounding states. Over the last 10 years, Mr. Wilson's focus has been exclusively devoted to the development of medical operations platforms and medically oriented real estate projects. In addition

to his work in medical operations, Mr. Wilson has participated in more than 40 medical real estate development projects including ASCs, specialty surgical hospitals, acute care hospitals, medical office buildings, primary care clinics, radiation oncology units and other complex medical facilities. Mr. Wilson earned a bachelor of business administration from the University of Texas.

Tom Yerden — TRY Health Care Solutions. Mr. Yerden has more than 28 years of service spanning the development of 70 surgery centers and the founding of Aspen Healthcare in 1992, which he sold to a national firm in 2005. He served several terms on the FASA board of directors and was a finalist in 2003 for Ernst & Young's Entrepreneur of the Year. Prior to forming Aspen Healthcare, Mr. Yerden held COO and CEO positions in several healthcare systems and large physician group practices where he developed outpatient surgery centers and new outpatient surgical delivery systems. He hosts an ASC governing board retreat program in Salmon, Idaho. In addition, he is a national speaker and author.

Joseph Zasa, JD — Woodrum/Ambulatory Systems Development. Prior to co-founding Woodrum/ASD in 1996, Mr. Zasa served as corporate counsel for Premier

Ambulatory Systems. He has published numerous articles on ambulatory surgery operations, development and management. He previously served as regional director of surgery center operations for ProSurg, a division of American Ophthalmic, and as corporate counsel for Premier Ambulatory Systems. Mr. Zasa is the current president of the Texas Ambulatory Surgery Center Society. He received his juris doctorate from Washington and Lee University and his bachelor's degree from the University of Alabama. He is a member of the Virginia State Bar.

J.A. Ziskind — Global Surgical Partners. Mr. Ziskind has been actively involved in Florida's healthcare industry since the early 1970s, having served as CEO of Cedars Medical Center and since 1984 as a healthcare attorney. Mr. Ziskind is a board-certified healthcare attorney in Florida. He has served as general counsel to the Dade County Medical Association since 1990 and was co-founder and served as general counsel to the Florida Society of Ambulatory Surgical Centers. In 2004 he was appointed to the board of directors of Mercy Hospital Foundation and currently serves as the Chairman. From 2005-2006, he served on the Pan American Hospital board of directors and was elected vice chairman. ■

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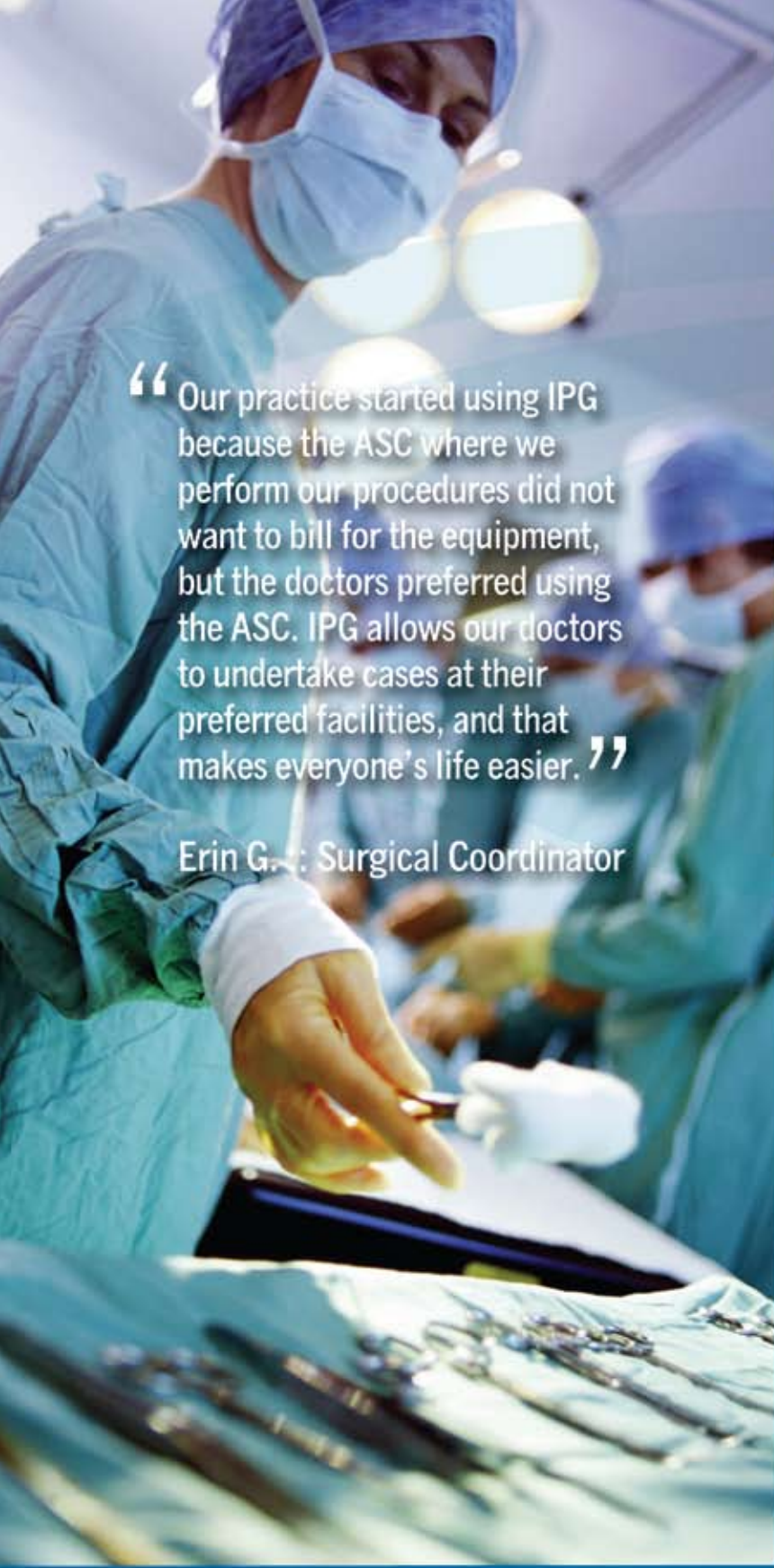
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10 Best Practices for Improving GI-Efficiency in ASCs (continued from pg. 1)

struction with the pro forma, advises Jim Reichheld, MD, board-certified gastroenterologist and director of the Northeast Endoscopy Center in Lowell, Mass.

“The pro forma is more than a budget, it’s a plan,” Dr. Reichheld says. “Included should be how much space, how to staff the ASC and fill it with equipment and patients. To me, the pro forma is a living document. Every center has one at some point, but I’ll bet fewer than half ever redo it. We redo ours at least twice each year. The pro forma can tell you where your money is going.”

2. Pick the right size space. “There are only two ways to make square footage work: either get it right in beginning, or sublet to make it work later,” Dr. Reichheld says. “There are many restrictions on subletting space for other uses, so that can be difficult. Not building a Taj Mahal is critical because your building is a fixed, recurring expense and you can’t change that. Also, with the high cost of development, it makes sense to be sage about who you choose to partner with. We chose not to give up ownership. The profit in the ASC is found in the last 25-30 percent of revenue and we didn’t want to give that away. We wanted to leave plenty of room to be cost effective and provide the very highest quality care.”

3. Invest in a good staff. An ASC’s biggest cost is staff, but paradoxically, it’s also the biggest asset.

“You staff will drive quality of medical care and patient satisfaction and the happiness of the doctors working there,” Dr. Reichheld says. “Nothing beats a good staff. Skillfully placing your staff flows from good design and can be done upfront — how you staff the rooms with how many people. I believe in investing in our staff. Even if your staff costs more, you will receive far more than that in return from really good personnel than from poor or marginal choices. Staff well with the best people, as many as you need and no more. You don’t want to overstaff, either.”

He says with cuts in Medicare reimbursement, profit margins can be tighter.

“Your schedule for each room should be full,” he says. “Your fixed costs are already there whether patients are there or not. So it’s really important to keep the place full. We discovered that doing just two more procedures a day would significantly increase revenue.”

Catherine Sayers, director of clinical operations for Pinnacle III, a national ASC development and management company, agrees that managing staff is vital to an ASC’s efficiency and profitability.

“Staff should be sent home if the center is not busy,” Ms. Sayers says. “If you take over a center without that mentality, it can be a problem. You want to be busy enough not to send people home and there is a fine line.”

She recalls one center that employs a rotating list of who was cancelled or sent home for low volume.

“You have to explain when hiring staff that that is a possibility. Hopefully, nobody is sent home more than once a month,” she says, noting the importance of good scheduling. “That center allows employees to trade and encourages flexibility.”

Consultant Ken Camerota, a Boston-based former ASC administrator who has provided development and management services to ASCs for more than 20 years, says the centers he’s worked with pay staff by the day.

“And whatever it takes to accomplish that (day’s) schedule will happen,” Mr. Camerota says. “What that means is that physicians move at a pace they’re comfortable with. People aren’t punching or watching a clock, but completing the schedule. We pay on a 10-hour day schedule. If you work 10 hours, fine, but if you can accomplish the schedule in eight hours, you can go home early and still be paid for 10 hours. Nurses can’t control the schedule, but

they can control turnaround, how quickly a patient is cared for and sent home and they are incentivized the same way our doctors are.”

4. Cross train your staff. Mr. Camerota says cross training has become a mantra.

“You hear it often, but aligning staff with the physicians, in terms of pace and worth ethic, is vital,” he says. “Cross training on equipment is key. If someone is not there, someone else needs to know how to operate the equipment and process the patients. Everyone needs to know what everyone else does.”

Pinnacle III’s Ms. Sayers concurs.

“Medicare cuts have reduced our profit margins and forced us to employ more economies of scale and become even more efficient,” she says. “We try to cross train everyone. Within GI centers there are many nurses who were trained to be flexible and understand equipment and patient needs. We train them how to clean scopes, work the front desk, verify benefits and assist. We do as much cross training as we can in our facilities. It’s exceptionally valuable and a key factor in keeping costs down and being as efficient as possible.”

Debi Chinderle, a nurse and the endo charge manager for the Surgery Center of Joliet, Ill., says she and another endo nurse share duties between her center’s OR and endoscopy rooms with two OR nurses cross trained to endoscopy work.

“If our endo schedule is low at our ASC, we go into the ORs and if the OR schedule is low, they come here,” Ms. Chinderle says. “We’re on the low end of being right-staffed, but we have not had to use any agency nurses in quite a while. We do staff a few nurses who like working part time or who are retired to fill in when we need them.”

5. Consider leasing equipment. New scopes are expensive, \$25,000-\$40,000 if purchased. Mr. Camerota recommends leasing them from manufacturers who install the equipment and charge a per procedure use fee.

“We provide a procedure count to the manufacturer and they bill us accordingly,” he says. “There’s no purchasing capital upfront and the lease agreement includes a service agreement. You can also upgrade a little easier to newer versions.”

6. Develop good relations with primary care doctors and other referring physicians. “These are the doctors who are screening their patients and referring them to gastroenterologists,” Ms. Sayers says. “Building a strong relationship with them is key to getting patients into the door.”

She says Pinnacle III centers build relations between the front desks of those doctors and Pinnacle III ASC front desk staff, making it easy to schedule patients, reducing the number of forms to complete and smoothing the process.

7. Get paid. Ms. Sayers advises ASCs to develop processes for getting paid as quickly as possible to reduce accounts receivable days and maintain adequate cash flow.

“Do a good job of getting accurate financial information in advance and make sure patients know their responsibility early on and pay on the day of the procedure,” she says. “We mail out forms detailing the patient’s insurance benefit information and financial responsibilities and confirm that by phone in advance and make sure they without any surprises.”

Also critical is billing promptly for procedures. She says Pinnacle III’s billing office typically bills on the day of the procedure or the morning after.

“GI procedures are pretty easy to code,” she says. The physician inputs the

information on the software system that creates the procedure report and assigns the correct CPT code. This is sent to Pinnacle III's billing office, which verifies that the physician has coded accurately before submitting the claim.

"We try to get a pretty fast turnaround on reimbursement," she says.

8. Manage supply costs. Ms. Sayers says securing agreement from physicians in standardizing supplies they use is important to controlling costs.

"We can't bill separately for many high dollar items (like some dilating bal-

loons) and have to absorb their costs," she says. "In some procedures you can't make any money. So it's key to rationalize your purchases. A good materials manager negotiates fair pricing with vendors, keeps an eye on inventory and talks with doctors to keep a handle on preferences."

Joliet ASC nurse and manager Ms. Chinderle says her center has computerized its entire supply list to make ordering faster and easier.

"All our materials are on a checklist on the computer, so we just have to check and order. It helps us to keep better inventory," she says. "We know immediately what supplies we've used and not used and are not paying extra surcharges on emergency deliveries or wasting money in overstocking."

9. Don't neglect pre-op. Ms. Chinderle says many potential problems faced in GI can be avoided by addressing them early in the pre-op process.

"It's important in that screening process to identify patients with defibrillators or pacemakers because they could affect the procedure," she says. "You need to know all of this ahead of time. We talk to the patients, bring them to the endo suites and apprise the staff of what to look for. It makes the work flow so much easier. If you don't know, you have to call later and that can result in delays and cancellations."

Staff prepares a checklist of drugs, previous surgeries, allergies and takes an in-depth patient history, she says, inquiring about current medications.

"If a patient is dependent, for example, on narcotics for back pain or something else, it helps us to know that because they may need more medicine," she says. "The pre-op nurse asks each patient who is taking them home and other questions. The physicians go through the charts quickly, so it's good to have something to background them with."

Ms. Chinderle says it's really helpful to have a dedicated endo team that knows the routines of the physicians and staff.

"They're familiar with the equipment, some of which is pretty state of the art scopes and it makes everything go smoother," she says. "You can train people, but it's easier to start with a well-trained and dedicated staff."

10. Coordinate care. Roseanne Silvestri, executive director of the Holy Redeemer Ambulatory Surgery Center in Huntington Valley, Pa., says that properly coordinating care is the secret to success in the GI outpatient world.

"By that I mean coordination with the physician's office, as well as coordination with the patient," Ms. Silvestri says. "With the continual decline in reimbursement from Medicare, you have to be super efficient and expedient, but also 'high touch' from the patient's perspective. The ASC staff needs to know the physicians and their idiosyncrasies, the equipment and the different procedures. The process needs to be well-planned and methodical, leaving no room for error while creating efficiencies."

She says the anesthesia component is also crucial.

"Anesthesia staff must provide appropriate coverage during the procedure, but not overdo it, since the patient needs to recover quickly so discharge can occur shortly (under an hour on average) after the procedure is completed."

She says that the physician's office must provide very clear instructions to the patient regarding the preps for the procedure. She also recommends that the ASC have copies of the various preps used by that ASC so they can review them with patients during the pre-op phone call and interaction. She says that helps to avoid rescheduling procedures because patients misunderstood or failed to properly take their preps, the products used before the procedures to "clean out" the patients. ■

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9 Best Practices for Successful Physician/Hospital Joint-Venture ASCs

By Mark Taylor

As competition intensifies and reimbursement becomes less certain, hospitals and physicians are increasingly exploring partnering in joint-venture ASCs. Both are finding numerous economic, marketing and clinical reasons to join forces. Hospitals are seeking ways to align incentives with doctors, staunch physician defections and retain the outpatient business increasingly leaving their doors, while pleasing their most loyal physicians. Physicians often seek the access to capital and greater market clout hospitals possess.

But experts in the ASC industry point to numerous failures of physician/hospital joint ventures, with numerous landmines at every stage of ASC planning, development and operation. Here are nine tips from veterans of physician/hospital joint ventures to improve the likelihood of a partnership ASC.

1. Pay attention to ownership structure and governance.

The doctors, hospital and

any third-party manager must be sure the ownership structure is fair to all parties and protects the hospital's not-for-profit (501c3) status under IRS rules, advises Michael Weaver, vice president of acquisitions and development for Symbion, a national ASC development and management firm that partners with physicians and hospitals.

"But the structure must also be fair to the doctors, who need enough ownership and power to direct the ASC," he says.

His advice? "One word: listen. The more you listen the better you can affect the documents and accommodate them to meet the parties' needs," Mr. Weaver says.

2. Pay attention to profit sharing.

Mr. Weaver says many partnerships have dissolved because of misunderstandings or perceived inequities in profit-sharing distributions.

"You have to be fair and once distributions are prepared, they have to be pro rata (in proportion),"

he says. "They also must meet fraud and abuse law requirements and laws and can't be based on performance, volume or referrals. They must be solely on percentage of ownership."

3. Implement and create short- and long-term strategic plans for exploring ASC new growth opportunities.

"Nothing will prevent an ASC from being successful like sitting on your laurels," says Mr. Weaver. "Every day you have to be working on how to grow it and develop and create a strategic plan everyone buys into."

4. Plan for adequate funding.

Be sure to have enough working capital to keep a reasonable debt-to-equity ratio, he says, a figure that will vary from center to center.

"I've seen too many surgery centers in bankruptcy cases dying of too much debt," Mr. Weaver says. "You should always have enough cash to take care of payroll a few months worth of accounts payable and any anticipated capital expenditures coming

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down the pike. A brand new surgery center should plan for enough working capital to sustain the ASC for 18 months of operations. A reasonable return should be 20-25 percent annually year in and year out."

5. Set your standards high. "You should begin with an absolute philosophy of the very highest quality and that should start from the janitor cleaning the place to the surgeons operating there and embody everyone in between," Mr. Weaver says. "Start with a goal for high efficiency and excellent quality and good supporting protocols, policies and procedures to support that."

6. Discuss, agree and document the role of the hospital in the joint venture. Robert Carrera, president of Pinnacle III, said early in the planning stages it's wise to determine what the hospital is bringing to the ASC joint venture.

Mr. Carrera says typical hospital contributions can include access to covered lives, capital, land, buildings and greater purchasing power and volume discounts from suppliers, pharmaceutical companies and medical equipment manufacturers. He says it's also wise to learn the level of involvement the hospital wants, ranging from the leasing of staff and selling of services to some form of management.

Harrison Solomon, MD, a board-certified orthopedic surgeon, hand specialist and owner/officer of a Maryland physician/hospital joint-venture ASC, suggests asking and exploring the real questions for the hospital's interest in the ASC.

"Because every operation performed at the ASC is one that otherwise would have been done at the hospital," observes Dr. Solomon, board vice president of the Surgery Center of Maryland in Silver Springs. "So you have to ask: What is the hospital's motivation? It should be a better practice environment



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for their doctors and a better environment for patients and better prices and quality for insurers — a triple win — but where is the positive for the hospital in that?”

Dr. Solomon says there should be bona fide reasons for the doctors and hospitals to make the deal.

“Just because it’s positive for the hospital doesn’t necessarily mean it will be good for the entity,” he says. “The hospital partner needs to contribute to the business model. If they can’t, they can’t and some hospitals can’t. But if additional capital is the only contribution, is that enough? In the long-term picture, each owner must contribute something valued by all partners. That’s crucial for success.”

7. Do your homework. “Don’t assume the project will work,” Mr. Carrera cautions. He recommends developing a business plan, market analysis, financial pro forma, payor analysis and securing a buy-in from potential investors. Once the partnership is secured, he also advocates crafting an operating agreement and by-laws that need to be communicated and enforced.

8. Seek hospital support in contract negotiations. Suzanne Wienburg, vice president of operations for Ambulatory Surgical Centers of America, says hospitals can be very useful in managed care contracting.

“They already have contracts with local payors, greater muscle and a stronger negotiating position than most ASCs. But that needs to be resolved on the front end of the joint-venture formation,” Ms. Wienburg says. “I’ve seen physicians who’ve gotten into contractual agreements with hospitals that seemed too good to be true and were. Be sure to have clearly defined expectations of what the hospitals are bringing to the joint venture.”

Symbion’s Mr. Weaver says knowing your business is critical to securing the best contracts.

“Don’t want to go into a knife fight with rocks,” he says. Compile all the necessary information on equipment and supply costs, net revenue per procedure and costs for all CPT costs, especially dominant CPT codes.

“And don’t forget implant costs in particular, because that can sink your per procedure margins,” Mr. Weaver says. “If hospitals already have strong relationships with payors, try to leverage those in your contracts.”

Dr. Solomon agrees that hospitals have the potential to improve managed care contracts.

“Hospitals have bigger seats at the table with the private insurers you’re negotiating with and having hospitals can help you in those negotiations,”

he says. “But frankly, it didn’t work out that way for us. It was more of a theoretical benefit. Clearing this early on can resolve later misunderstandings.”

9. Think ahead. Dr. Solomon advises ASC physician owners to look beyond the present and ask themselves: “One year from now, if we’re profitable, what kind of support do we want from our hospital investors and what do we expect?”

He says it’s difficult to think long term initially.

“But you have to because your goals may change,” he says. “You need to think about not just the initial investments, but what you may need to remain successful and the role that you want the doctors and your hospital partners to play.”

He says the key is actively involved physician ownership.

“The more passive investors you have, the worse it is,” he says. “It could be a low volume or inactive physician, a hospital that isn’t contributing very much or a third party. Only when everyone is on the same page working on the same goals can you rely on each other to make it a successful investment.” ■

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Case Study: Successful Joint-Venture Turnaround

By **Renée Tomcanin**

In Aug. 2008, Joseph Zasa, co-founder and managing partner of Woodrum/Ambulatory Systems Development, arrived at the Surgical Center for Excellence in Panama City, Fla. Like many centers, the Surgical Center for Excellence was facing some difficult challenges. It was losing money, around \$10,000-\$40,000 a week, and the bank was calling the ASC's loan on Jan. 1, 2009. The business office systems were weak, the center owed money to several vendors and although the physician partners were bringing in patients, there were not enough cases to be profitable.

Seven months later, the ASC is on the upswing and very profitable, the vendors are paid and current, the loan was re-financed and the center will pay dividends in Spring 2009.

How did the facility achieve such a drastic turnaround?

According to all involved, it was truly a team effort. Management, physicians and staff worked together to make the necessary changes to make the center successful. Below is the story of the Surgical Center for Excellence and how it was turned from a struggling facility into a profitable one.

Numerous challenges from the start

The Surgical Center for Excellence started off as the idea of three ENT physicians who were looking to offer better quality of care and see more patients in their area. The ASC opened after difficulties with state regulatory issues, but there was no opportunity to recruit new physicians outside of the ones already working at the center or to bring in more cases.

In Aug. 2008, Woodrum/ASD performed an analysis of the surgery center and identified 30 areas in need of improvement to fix the center. With this list, the ASC and Woodrum/ASD identified the most critical problem areas and prioritized fixing those first, says Daniel Daube, MD, FACS, a physician at the Surgical Center for Excellence. In addition, Mr. Zasa says an important step was defining a structure and a chain of command so that everyone at the center could understand how they were going to run "the offense." With the plan and leadership structure in place, the management and physician team could install the "offense" and follow a plan for the ASC's turnaround.

The five main areas that had the biggest effect on the ASC's operations and turnaround were the following:

- improved business office systems (billing, coding and collection procedures);
- implementation of a new fee schedule;
- renegotiation of managed care contracts;
- retraining staff and addressing operating room turnover time; and
- developing staff incentives and bonuses.

After addressing problems in these areas, the center saw drastic improvement. These changes set the stage for the ability of the center to recruit new physicians and gain physician confidence.

Areas of improvement

Here are some of the major changes the ASC underwent in these areas that helped to make this a successful turnaround.

1. Accounting (payors, contracts, etc.)

As is the case with many struggling centers, the business office at the Surgical Center for Excellence was not running at maximum efficiency, according to Mr. Zasa. To overcome this challenge, Woodrum/ASD made these four significant changes:

- **New policies and procedures for collection.** The ASC instituted pre-op collection procedures, which encouraged patients to pay their balance before the procedure was performed.
- **Integration of managed care contracts into the management information system.** By putting their managed care contracts into the system, the ASC determined its receivables and work the aged A/R properly.
- **Collections based on aging.** By following-up on old accounts and denied claims from the insurance companies, the ASC brought in more revenue.
- **Accrual accounting.** The facility started using a monthly accrual accounting system with a professional healthcare accounting firm. By using this system, staff members were able to keep better track of A/R and match their revenues.

Dr. Daube admits that the ASC had entered into some "horrible" contracts with payors. "Most doctors don't know contracts," he says, which is why it was critical for this ASC to use the services of an outside company that was able to negotiate new contracts and renegotiate old ones was profitable.

Having a business staff who understood specific areas of business was also beneficial, according to Dr. Daube. "Some [centers] have managers who do it all," he says. "Having one person head up each area was helpful to us."

Bart Walker, JD, an attorney with McGuire-Woods, worked with the ASC prior to and during its turnaround. He says that the ASC's success was due to "good fundamental business advice." Mr. Walker says that Dr. Daube should be credited for his tenacity in keeping the facility up and running. "[Mr. Zasa] took it that extra mile, and I think that [the turnaround] is tremendous," he says.

2. Recruiting and case mix. One of the areas Dr. Daube says the ASC struggled with was recruiting new surgeons. The physicians had tried to recruit on their own, but efforts were not successful. "It was better to release control [of recruiting] to an objective group," he says.

With the new management system in place and showing results, Mr. Zasa says that his group focused on the local community rather than surrounding areas. From there, they made two very subtle, but effective, changes:

- **Limited specialties.** As this is a small ASC, they chose specialties that would do best in this type of environment: orthopedics, pain management, ENT, general surgery and endoscopy. By concentrating on five areas and doing these five areas well, the ASC was able to become more efficient and bring in just those specific types of cases, allowing the ASC to excel in its space.
- **Boutique atmosphere.** To become an appealing alternative to the larger hospitals, the ASC redeveloped itself and created a boutique atmosphere, creating a high-end, exclusive feel to the ASC. Rather than recruiting a large group of physician-investors due to the limited size, the facility has a select group of 8-10 investors who carry the surgery center and can focus on its needs. This boutique approach results in more personalized service to the physician, the patient and their families.

By taking this approach, the Surgical Center for Excellence was able to increase its caseload by 25-30 percent. Additionally, bringing in cases that are profitable from a reimbursement standpoint is important in improving revenue. Michael Gilmore, MD, an orthopedic surgeon at the center, said that once these improvements were made, physicians felt better about bringing their cases to the center.

3. Physician confidence. As a result of all of the hard work improving accounting and recruiting cases, the physicians at the Surgical Center for Excellence regained confidence in their facility and its operations. Mr. Zasa notes that getting physicians on-board with the new plan was essential in making it work as they are essential in running the ASC.

Dr. Daube says, "[Mr. Zasa] was excited [about the project], so that got me excited." Once excite-

ment grew, the proposed changes were adapted with the backing of everyone on staff, making for a smooth transition from old policies to new ones.

The physicians began to see positive results as a result of the new systems and policies in place. Dr. Gilmore credits the team atmosphere to the success, noting that “a surgical center is more than just cases.” He mentions the importance of having the business, financial, management and clinical sides of the business working together. “If one person does well, the others will want to do well,” he says. “No one person wants to be the weak link.”

In addition, Mr. Zasa notes that there was an alignment of incentives among the physicians, staff, anesthesiologists and management.

Results

Within five months, the ASC was in the black and generating strong returns. According to Mr. Zasa, the facility was able to consolidate its loans, clean up its payables and make all bills current, and now it is stabilized and able to pay dividends going forward.

“I knew this center could be a winner, but its success amazes me and my staff,” says Mr. Zasa. “It is such a pleasure working with this group and having it succeed together as a team.”


In addition, Dr. Gilmore feels that the surgery center will continue to maintain its standards of patient care and expertise. He says that physicians are attempting to “be as efficient as they can be with the [new] framework” and trying to “keep the volume high and the overhead low and under control.”

Dr. Daube has some advice for ASCs who find themselves in a similar situation as the one faced by the Surgical Center for Excellence. “My biggest mistake was not finding a corporate partner sooner,” he says. He also notes that today it can be hard to run a center “on your own.”

Dr. Daube also warns against complacency once a center is improving. He warns ASCs not to let go of good management even when things are running smoothly. “Don’t take that step,” he says, noting that it is very easy for operations to fall back into old habits if a center tries to handle too much on its own.

“It’s not an investment in the business,” Mr. Walker says. “It’s an investment in the key physicians and owners and their commitment and vision. You can’t teach that.” ■

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- Handling Complex Spine Cases in an ASC, High Level Fusion and 23-Hour Cases
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- New Trends in Ambulatory Spine Surgery
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- Orthopedics – The Forecast for the Next Five Years
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CONFERENCE PROGRAM

THURSDAY, JUNE 11, 2009

12:00 – 1:30 pm – Registration

12:00 – 4:30 pm – Exhibitor Setup

Pre-Conference Workshop – Concurrent Sessions A, B, C, D, E
1:30 – 2:30 pm**A. Developing a Highly Successful Orthopedic-Driven ASC***Brent Lambert, M.D., CEO, Ambulatory Surgical Centers of America; and Tom Mead, M.D., Surgery Center of Allentown***B. Using Orthopedics and Spine to Turn Around an ASC***Tom Mallon, CEO, and Jeff Simmons, President Western Division, Regent Surgical Health***C. Sequencing an Orthopedic Start-Up ASC – Tactics for New and Ramp-Up ASCs to Optimize Their Operations***Larry Taylor, President and CEO, Practice Partners in Healthcare***D1. (1:30 – 2:00 pm) Valuing ASCs for Syndication – A Presentation of Current Market Multiples and Question and Answer***Greg Koonsman, Principal, and Jon O'Sullivan, Principal, VMG Health***D2. (2:00 – 2:30 pm) The Impact of the Financing Market on Valuations***Jon O'Sullivan, Principal, VMG Health; Doug Lewis, Managing Director and Shannon LeRoy, CEO and Managing Director, Physicians Capital***E. A Year Later – The Successful Turnaround of a Failing Hospital-Physician Joint Venture ASC***George Trajtenberg, M.D., Mark Beaungard, M.D., and Lisa Shriver, Administrator, Turks Head Surgery Center*

2:30 – 3:20 pm

A. Managed Care Negotiation Strategies for Orthopedic and Spine-Driven Centers*Naya Kehayes, CEO, Eveia Health Consulting and Management***B. Uni Knees in the Outpatient Setting – Is This the Right Fit for Your ASC? Clinical and Financial Issues***Blaine Farless, M.D., and James McGehee, RN, Administrator, Cleburne Surgical Center; and Sarah Martin, RVP of Operations, Meridian Surgical Partners***C. Physician-Owned Hospitals – Key Factors for Success and Core Challenges***Molly Sandvig, Executive Director, Physician Hospitals of America; John Thomas, EVP, HC REIT; and John Res-Waller, CEO, National Surgical Hospitals***D. Are Stark and Self Referral Laws Going to Close Down ASCs and Physician Owned Hospitals?***Scott Becker, JD, CPA, Partner, and Amber Walsh, JD, McGuireWoods LLP***E. Spine ASC – An Important Element in a Health System's Spine Center of Excellence***Jeff Leland, Managing Director, Blue Chip Surgical Center Partners*

3:20 – 4:10 pm

A. How to Recruit and Retain Great Administrators and Directors of Nursing*Greg Zoch, Partner, Kaye Bassman***B. A Case Study and Strategies to Achieve Excellent Results for an ASC***Kenneth Austin, M.D., Ramapo Valley Surgery Center; and Bob Zasa, Founder, Woodrum ASD***C. Handling Complex Spine Cases in an ASC, High Level Fusion and 23 Hour Cases***John Seitz, CEO, Ambulatory Surgical Group***D. Key Strategies for Controlling Implant Costs in ASCs and Surgical Hospitals***Randi Pisko, CEO, North Carolina Specialty Hospital; and Richard F. Bruch, M.D., Triangle Orthopaedic Associates***E. The Acceleration of Physician-Hospitals Collaboration – Trends and Strategies***Bill Woodson, SVP, Sg2; Tom Stallings, Partner, Kristian Werling, JD, and Elisa Moore, JD, McGuireWoods LLP*

4:15 – 5:00 pm

A. Physician Recruitment in 2009 – Some Key Thoughts and Challenges on Recruiting Orthopedics Neurosurgeons and Pain Management Physicians*Kenny Spitzer, SVP Development, HealthMark Partners*

THURSDAY, JUNE 11, 2009

B. New Trends in Ambulatory Spine Surgery*David Abraham, M.D., Reading Neck and Spine Center***C. Ten Keys to Improving Billing and Collections in a Challenging Economy***Caryl Serbin, CEO, Serbin Surgical Center Billing***D. Healthcare Valuations – Current Trends and Perspectives in Majority Interest Valuations***Todd Mello, Principal and Co-Founder, Healthcare Appraisers***E. Physician Owned Hospitals – Key Concepts to Increase Profits***Tom Michaud, CEO, Foundation Surgery Affiliates*

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

FRIDAY, JUNE 12, 2009

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

Main Conference – General Session

8:00 am

Introductions

Scott Becker, JD, CPA, Partner, McGuireWoods LLP

8:00 – 8:55 am

The Evolution of Healthcare and the Impact on ASCs*Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics at Princeton University*

9:00 – 9:40 am

Orthopedics – The Forecast for the Next Five Years*John Chorf, M.D., Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago*

9:45 – 10:20 am

Using Spine as the Backbone of a Multi-Specialty ASC*James Lynch, M.D., Surgery Center of Reno*

10:20 – 11:20 am – Hall Break

11:20 – 11:55 am

7 Steps to Maximizing an Orthopedic-Driven ASC's Returns in a Tough Economy*Brent Lambert, M.D., CEO, Ambulatory Surgical Centers of America*

12:00 – 12:30 pm

Case Study – Two Years Later, A Physician-Owned Spine ASC – A Frank and Open Discussion of Financial Performance, Organizational Issues, Challenges and Problems*John Caruso, M.D., Parkway Surgery Center, Hagerstown, Maryland*

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

Concurrent Sessions A, B, C, D, E

1:30 – 2:05 pm

A. A Payor's View of Orthopedics, Spine and Pain Management*Steven Stern, M.D., VP Neuroscience, Orthopedics and Spine, United Healthcare***B. Spine Centers – A Case Study Review of Current Outcomes and Issues***Marcus Williamson, M.D., and George Goodwin, SVP and Chief Development Officer, Symbion Healthcare***C. Making Big Cases Profitable in an ASC***Naya Kehayes, CEO, Eveia Healthcare; and Greg Cunniff, CFO, National Surgical Care***D. Capturing Your Partners' Cases, The Carrot and Stick Approach***Chris Bishop, VP, Ambulatory Surgical Centers of America***E. Key Legal Issues – Safe Harbor Compliance, Out of Network, and Other Legal Issues***Scott Becker, JD, CPA, Partner, and Bart Walker, JD, McGuireWoods LLP*

2:10 – 2:45 pm

A. Hand Surgery in ASCs – Key Concepts for Success*Ed Rudisill, M.D., The Hand Center, Greenville, SC*

CONFERENCE PROGRAM

FRIDAY, JUNE 12, 2009

B. Pain Management in ASCs - Current Methods to Increase Profits*Amy Mowles, President & CEO, Mowles Medical Practice Management***C. 5 Tips for Managing Anesthesia in Your ASC***Thomas Yerden, CEO and Founder, TRY HealthCare Solutions***D. How to Recruit Great Surgeons to Work at Your ASC***Robert Carrera, President, Pinnacle III***E. Turnarounds – 2 Case Studies – 5 Key Ideas for Success***Joe Zasa, President, Woodrum ASD***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 Business Development, NovaMed; Kenneth Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion***B. Is Your Center too Dependent on a Single Specialty? How to Diversify and Make Change Happen***John Seitz, CEO, Ambulatory Surgical Group; Joe Zasa, CEO, Woodrum ASD; and Larry Taylor, President and CEO, Practice Partners in Healthcare***C. 5 Core Concepts for Great ASC Joint Ventures with Hospital Partners***Mike Pankey, Administrator, Ambulatory Surgery Center of Spartanburg; and Caryl Serbin, CEO, Serbin Surgery Center Billing***D. Assessing the Profitability of Orthopedics, Spine and Pain in ASCs***Luke Lambert, CEO, Ambulatory Surgery Centers of America***E. 5 Core Strategies to Immediately Improve ASC and Hospital Operations***Doug Johnson, COO, RMC MedStone Capital***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 Business Development, NovaMed; Kenneth Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion***B. Ulnar Collateral Ligament Reconstruction: "The Tommy John Surgery"***Timothy Kremchek, M.D., Medical Director, Cincinnati Reds; Larry Taylor, President and CEO, Practice Partners in Healthcare***C. The Development & Integration of Orthopedics into a Multi-Specialty ASC***William Jacobson, M.D., President, West Lakes Surgery Center; Rob McCarville, Principal, Medical Consulting Group; and John Marasco, Principal and Owner, Marasco and Associates***D. 2 Key Issues: Working with Implant Brokers and Out-of-Network Issues***Dan Connolly, Vice President, Pinnacle III***E. Turnarounds – Lessons of the Last Five Years – Expectations of the Next Five Years***Bill Southwick, President and CEO, HealthMark Partners***4:55 – 5:30 pm****A. Orthopedics in ASCs – What Works and What Doesn't From a Business and Clinical Perspective***John Chorf, M.D., Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago***B. Physician Owned Hospitals – What Should You Do Now?***Ajay Mangal, M.D., CEO, Prexus Health; and Brett Gosney, CEO, Animas Surgical Hospital***C. How to Work Successfully with Generation Y***Lt. Colonel Bruce Bright, Director of Business Development, The Sanders Trust***D. The 5 Best Ways to Improve Billings and Collections and to Improve Revenue Cycle Management***Lisa Rock, President, National Medical Billing Services; and David Hamilton, President & CEO, MNET Collections***E. Common Litigation Issues in ASCs – Antitrust, Non Competes and More***Jeff Clark, Partner, and Richard Greenberg, Partner, McGuireWoods LLP***5:30 – 7:00 pm – Networking Reception & Exhibits**

SATURDAY, JUNE 13, 2009

7:30 – 8:15 am – Continental Breakfast**8:15 – 9:00 am****How Economic Conditions Impact Health Care Strategies for Success***Tom Geiser, Senior Advisor, Texas Pacific Group; and Joe Clark, Executive Vice President, Surgical Care Affiliates***9:05 – 9:50 am****A. Uni Knees and Shoulders in the Outpatient Setting – Cost, Staffing and Profitability Issues***Peter Kurzweil, M.D. and Margarita de Jesus, Administrator, Surgery Center of Long Beach***B. Key Issues Faced by ASCs Today***Thomas Yerden, CEO, Founder, TRY HealthCare Solutions***C. The Pros and Cons of Total Knees in a 23-Hour Setting – Financial and Safety Issues***Eric Monesmith, M.D., OrthoIndy; and John Martin, CEO, OrthoIndy***D. Pain Management – 5 Keys to a Superior Pain Management Program Surgery Center***Lance Lehmann, M.D., Medical Director and Liliana Rodriguez Lehmann, MBA, Hallandale Outpatient Surgical Center***E. Implant Costs: Why Facility-Physician Collaboration Makes Sense***Karen Barrow, SVP Business Development, Amerinet***9:55 – 10:35 am****A. Key Concepts to Managing an Effective Interventional Pain Management Practice and Center***Lax Manchikanti, M.D.***B. An Analysis of Clinical Outcomes for Spine – Procedures Performed in ASCs***Ken Pettine, M.D., Rocky Mountain Surgery Center***C. Making the Best Use of An ASCs IT System***Jeff Blankinship, President, Surgical Notes***D. Tracking and Improving Patient Satisfaction and How to Apply the Measures to Improve Results***Paul Fanaclas, President and CEO, CTQ Solutions***10:40 – 11:20 am****A. The 10 Statistics Your ASC Should Examine Each Week***Shannon Blakeley, VP Operations, National Surgical Care***B. 7 Keys to Successful Physician Hospital Joint Ventures***Edward Hetrick, President and CEO, Facility Development and Management; and Christian Ellison, VP, Health Ventures***C. Practical Case Costing and Benchmarking for Orthopedic, Spine and Pain-Driven ASCs – Strategies You Can Use Monday Morning***Susan Kizirian, COO, and Anne Geier, VP, Ambulatory Surgical Centers of America***D. 2009 Pain Management Coding Update and Pain Industry Business Trends***Linda Van Horn, MBA***11:25 am – 12:05 pm****A. Buying and Selling ASCs – 5 Key Concepts***Scott Becker, JD, CPA, Partner and Scott Downing, Partner, McGuireWoods LLP***B. Cost Justifying an EHR, What Is The ROI?***Todd Logan, Regional VP, Source Medical; Daren Smith, Administrator, Fremont Surgical Center***C. Practical Case Costing and Benchmarking for Orthopedic, Spine and Pain Driven ASCs – Strategies You Can use Monday Morning (continued)***Susan Kizirian, COO, and Anne Geier, VP, Ambulatory Surgical Centers of America***D. 10 Keys to Improve Coding for Orthopedic, Spine and Pain in ASCs***Christina Bentin, Founder, Coding Compliance Management***12:10 – 1:00 pm****Legal Q & A; Safe Harbors; War and Peace with Hospitals***Scott Becker, JD, CPA, Partner, McGuireWoods LLP***1:00 pm – Meeting Adjourns****To Sign Up for Becker's ASC Review E-Weekly, go to www.BeckersASC.com**

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23 Gastroenterologists to Know

By Renée Tomcanin

Fernando Bermudez, MD, FACP, FACG.

Dr. Bermudez is currently the medical director of the Eastside Endoscopy Center and a physician with G.I. Medicine Associates, both located in St. Clair Shores, Mich. He specializes in diseases of the gastrointestinal tract, the liver and pancreas with special interest in inflammatory bowel disease and motility disorders of the esophagus. A native of Bogota, Colombia, Dr. Bermudez received his medical degree from Javeriana University in Bogota and completed his training at St. John Hospital in Detroit. He completed his fellowship in gastroenterology at Michael Reese Medical Center in Chicago.

Dr. Bermudez is board certified in internal medicine and gastroenterology. He is a member of the American Gastroenterological Association, the American Medical Association, the American Society for Gastrointestinal Endoscopy and the American College of Executive Physicians. He is also a fellow of the American College of Physicians and the American College of Gastroenterology. Dr. Bermudez previously served as division head of the department of gastroenterology at St. John Hospital, medical director of the endoscopy unit and chairman of the endoscopy committee at St. John Hospital and medical director of the International Institute of Rural Reconstruction in Bogota. He was also a clinical assistant Professor at Wayne State University in Detroit.

Robert "Bruce" Cameron, MD, FACG.

Dr. Cameron is the medical director of the Endoscopy Center at Bainbridge in Chagrin Falls, Ohio. He is also a clinical professor of medicine at Case Western Reserve University in Cleveland. He completed his internship in internal medicine and his residency in gastroenterology at the University Hospitals of Cleveland. His areas of special interest are colonic neoplasia, esophageal diseases, gastroenterology and general gastroenterology.

Dr. Cameron is a fellow of the ACG and served as chair of the Practice Management Committee. He is certified by the American Board of Internal Medicine and the American Board of Gastroenterology. In his spare time, Dr. Cameron enjoys golfing.

Stephen Deal, MD, FACG. Dr. Deal is a member of the Carolina Digestive Health Associates, which operates five endoscopy centers in the Charlotte, N.C., area. He specializes in gastroenterology with a subspecialty in pancreatic biliary tract diseases. He has served as a member of the ACG/ASGE Quality in Endoscopy Task Force and helped to write the new practice guidelines for quality in endoscopy. He also served as an advisor on the 2005 University of North Carolina

Colonoscopy Study. Dr. Deal has been a member of the ACG National Affairs Committee and the ACG Practice Management Committee.

Dr. Deal is active in CME through the Practice Management Course and served as the co-course director in 2007 and 2008. He is a fellow of the ACG and the ACP. He is also a member of the ASGE. His interests include family time, the Christian faith and travel.

Thomas Deas, MD. Dr. Deas is the medical director of the Fort Worth Endoscopy Center and the Southwest Fort Worth Endoscopy Center, which were developed to provide a quality, safe and convenient endoscopic environment for its patients. He is board certified in internal medicine and gastroenterology. He received his medical degree from Louisiana State University School of Medicine in Shreveport, La., while serving in the U.S. Air Force and completed residency in internal medicine and his fellowship in gastroenterology at Wilford Hall USAF Medical Center in San Antonio, Texas. He is a fellow of the ACG and the ASGE. He has served in leadership positions with ASGE and North Texas Specialty Physicians. Dr. Deas is a frequent speaker at national meetings and has published articles on achieving efficient, high-quality gastroenterology practices and endoscopy centers. Dr. Deas enjoys teaching third grade Sunday school, travel and leisure time with his family.

James T. Frakes, MD, MS, FASGE, MACG, AGAF, FACP. Dr. Frakes is clinical professor emeritus of medicine at the University of Illinois College of Medicine at Rockford and is in private practice at Rockford Gastroenterology Associates. He is an expert in the fields of therapeutic pancreaticobiliary endoscopy, practice management and endoscopic ASCs. Dr. Frakes has authored more than 100 publications in distinguished scientific journals, edited four books and written 13 book chapters dealing with gastrointestinal endoscopy. He has presented approximately 300 invited lectures at national and international gastroenterology meetings and has directed 30 national or international courses.

In 2007, he received two major awards from organized gastroenterology; he was recipient of the Distinguished Service Award from the ASGE for long-term contributions to the field and was designated a Master of the ACG for stature and achievement in clinical gastroenterology and teaching and contributions to the ACG. Dr. Frakes is a past president of the ASGE and has served on numerous ASGE committees and several committees of the American Gastroenterological Association and ACG and the World Gastroenterology Organization. He is a fellow of

the ASGE, AGA and the ACP. In addition, he serves on the University of Illinois Foundation and the Athletic Board and is a past member of the board of directors of the University of Illinois Alumni Association.

Robert M. Gannan, MD, PhD. Dr. Gannan is a nationally recognized expert in endoscopic procedures and is a regular speaker at nationwide meetings of gastrointestinal physicians regarding practice and development trends. He received his medical degree from University of Rochester and completed his internship and residency at University of California, San Francisco. He is currently in private practice in Bellevue, Wash., and is the director of gastroenterology at Overlake Hospital Medical Center in Bellevue. Dr. Gannan is a renowned expert in gastro-endoscopy and has written or presented more than 20 research publications and has participated in more than 50 research trials in his field.

Pedro "Joe" Greer, Jr., MD. Dr. Greer is the founding chairman of the Bayside Ambulatory Center which provides gastrointestinal and surgical care to approximately 20,000 patients each year. He is also chief of gastroenterology at Mercy Hospital in Miami. In addition to his practice, Dr. Greer is active in community service and serves as medical director for Mercy Mission Services.

Dr. Greer is a member of numerous professional organizations including the AGA, the Florida Gastroenterology Association, the ASGE and the AMA. He is a fellow of the ACP and the ACG.

J.A. Ziskind, president and CEO of Global Surgical Partners, says that there are few GI doctors who are more accomplished than Dr. Greer. "In addition to being a highly competent specialist, Dr. Greer's activities and contributions to the community and society at large are, in one word, incredible," Mr. Ziskind says.

Reed B. Hogan, MD. Dr. Hogan is a gastroenterologist at GI Associates and Endoscopy Center in Jackson, Miss. He is board certified in gastroenterology and internal medicine. Dr. Hogan is both an accomplished speaker and writer in the field of gastroenterology and has published numerous articles on the subject. He received his medical degree from the University of Mississippi School of Medicine, completed his residency and internship in internal medicine at University of Mississippi Medical Center and completed a fellowship in gastroenterology at Baylor University Medical Center. Dr. Hogan is a member of the Mississippi State Medical Association, the AMA, the ASGE and the AGA.

David A. Johnson, MD, FACP, FASGE. Dr. Johnson is professor of medicine and chief of gastroenterology at Eastern Virginia Medical School in Norfolk, Va. His primary research interests are esophageal and colon disease. He has been involved extensively in committees of the national GI societies and is a past president of the ACG. He is co-editor of *Reviews in Gastroenterologic Disorders* and is section editor for the *Medscape Gastroenterology Viewpoints* series and *Journal Watch Gastroenterology*. He is co-editor of the ACP's book *Dyspepsia* and editor of the 2005 Gastroenterology Clinics of North America issue "Obesity and the Gastroenterologist."

Dr. Johnson worked to enact the historic first legislation to mandate colon cancer screening with colonoscopy as the preferred standard. He has served as a primary advisor for national Medicare GI issues on endoscopy (CMS advisory committee) and has co-chaired the national Gastroenterology Medicare advisors. He is a co-author of the US Multisociety Task Force on Colorectal Cancer guidelines for colon cancer screening and surveillance, the ACG colon cancer screening guidelines and the joint guidelines from the American Cancer Society, the U.S. Multisociety Task Force on Colorectal Cancer and the American College of Radiology on screening and surveillance for the early detection of colorectal cancer and adenomatous polyps.

Louis La Luna, MD. Dr. La Luna is medical director of the Berks Center for Digestive Health in Wyomissing, Pa. He also is the gastroenterology liaison for the Reading Hospital Cancer Committee. Dr. La Luna received his medical degree from the University of Medicine and Dentistry of New Jersey in Newark, N.J., and completed his residency and gastroenterology fellowship at Thomas Jefferson University in Philadelphia.

Dr. La Luna is a member of several professional organizations including the AMA, the Pennsylvania Medical Society, the Berks County Medical Society, the ACG, the ASGE, the Pennsylvania Society of Gastroenterology and the

Central Pennsylvania Society for Gastrointestinal Endoscopy. He is also a board member for the Pennsylvania Society of Gastroenterology and is the editor of its journal, *Rumblings*.

James S. Leavitt, MD. Dr. Leavitt is an assistant clinical professor at the University of Miami School of Medicine Department of Gastroenterology and a physician at the Miami Endoscopy Center and the Gastroenterology Care Center in Miami. He is a graduate of Dartmouth College and the State University of New York Downstate Medical School. He completed his medical internship and residency and his gastroenterology fellowship at Jackson Memorial Hospital in Miami. Dr. Leavitt is board certified in gastroenterology and internal medicine. Dr. Leavitt was a member of the ACG's practice management committee.

Klaus Mergener, MD. Dr. Mergener is a physician with Digestive Health Specialists, based in Tacoma, Wash., which oversees four endoscopy centers. He went to medical school in Frankfurt and Heidelberg, Germany, and completed his residency in internal medicine and a fellowship in gastroenterology, including additional training in interventional endoscopy at Duke University Medical Center in Durham, N.C. Dr. Mergener is board certified in gastroenterology and a fellow of the ACP and the ACG. He is a member of the ASGE and serves as a representative to the AMA. Dr. Mergener enjoys spending time with his family, and his hobbies include classical music, hiking and reading.

Steven J. Morris, MD, JD, FACP. Dr. Morris is CEO and co-founder of Atlanta Gastroenterology Associates, a 47-physician GI group based in the Greater Atlanta Metropolitan area. Last year, more than 40,000 cases were performed in the group's seven endoscopy centers, and an eighth is scheduled to open in 2009. Dr. Morris is also chairperson of the National Coalition for Quality Colorectal Cancer Screening and Care.

Dr. Morris is a member of many professional organizations including the

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ACP, the AMA, the AGA, the Medical Association of Atlanta, the Medical Association of Georgia and the Georgia Gastrointestinal Society. Dr. Morris is also co-founder of Galen Advisors, a medical consulting firm, and a clinical associate professor at the Emory University School of Medicine.

Henry "Hank" Nance, Jr., DO, PA. Dr. Nance is a physician with Cleburne (Texas) Surgical Center and is certified by the Board of the American College of Osteopathic Surgeons. After earning his medical degree at Kansas City University of Medicine and Biosciences in Kansas City, Mo., he performed his internship and residency at Dallas-Fort Worth Medical Center in Grand Prairie, Texas. He was chief of surgery at Walls Regional Hospital in Cleburne, Texas, from 2000-2002. He was president of the Johnson County Medical Society from 1999-2000.

James McGehee, administrator of the Cleburne Surgical Center, says, "Dr. Nance is not only thorough in his clinical practice, he is exceptionally patient-care driven. He is kind and gentle with the patients and demands the best of care for them."

Dr. Nance is a member of the Texas Medical Association, American College of Osteopathic Surgeons and the American Osteopathic Association. Outside of his practice, Dr. Nance is an avid outdoorsman, enjoying his hobbies of hunting and fishing.

Bergein Overholt, MD, FACP, MACG. Dr. Overholt is a physician with Gastrointestinal Associates in Knoxville, Tenn. He served in the Cancer Control Program of the U.S. Public Health Service and developed the flexible fiberoptic sigmoidoscope-colonoscopy, which earned him the Schindler Award from the ASGE and the William Beaumont Award from the AMA. He has published numerous articles, written several chapters for books and recently co-edited the book *Office Endoscopy*.

Dr. Overholt has served as president of the ASGE and the American Association of Ambulatory Surgery Centers and is a founding member and past president of the Tennessee Society for Gastrointestinal Endoscopy. He was the chief of staff at St. Mary's Medical Center from 1981-1983. Dr. Overholt serves as the medical director of the laser department of the Thompson Cancer Survival Center. Dr. Overholt received his medical degree from the University of Tennessee Medical School and completed his internship, residency and fellowship in gastroenterology at the University Hospital in Ann Arbor, Mich. In addition to practicing medicine, his interests include professional writing, farming, beekeeping, the outdoors and his six grandchildren.

Irving Pike, MD, FACP, FASGE. Dr. Pike is president of Gastroenterology Consultants in Virginia Beach, Va. His special interests are endoscopic management of biliary and pancreatic disease, inflammatory bowel disease and the prevention of colon cancer. Currently, he is working collaboratively with other members of the ACG and the ASGE to develop measures of quality for gastroenterology practice and implement tools to benchmark performance based on these measures. He is a member of the ACG Board of Trustees and the current co-chair of the ASGE Ambulatory Endoscopy Center Special Interest Group. On behalf of these two societies, he serves as chair of the National GI Endoscopy Quality Indicator Benchmarking project.

From 1994-2005, he served as an executive council member, a physician member of Re-inventing Sentara and was the medical director for continuing education and business education for physicians for Sentara Healthcare as well as vice president of medical affairs for Sentara Bayside Hospital. He is a member of the American College of Physician Executives, the AGA, the ASGE, the Medical Society of Virginia and the Virginia Beach Medical Society.

Dr. Pike's non-professional interests include photography, hiking, fishing and travel with family and friends.

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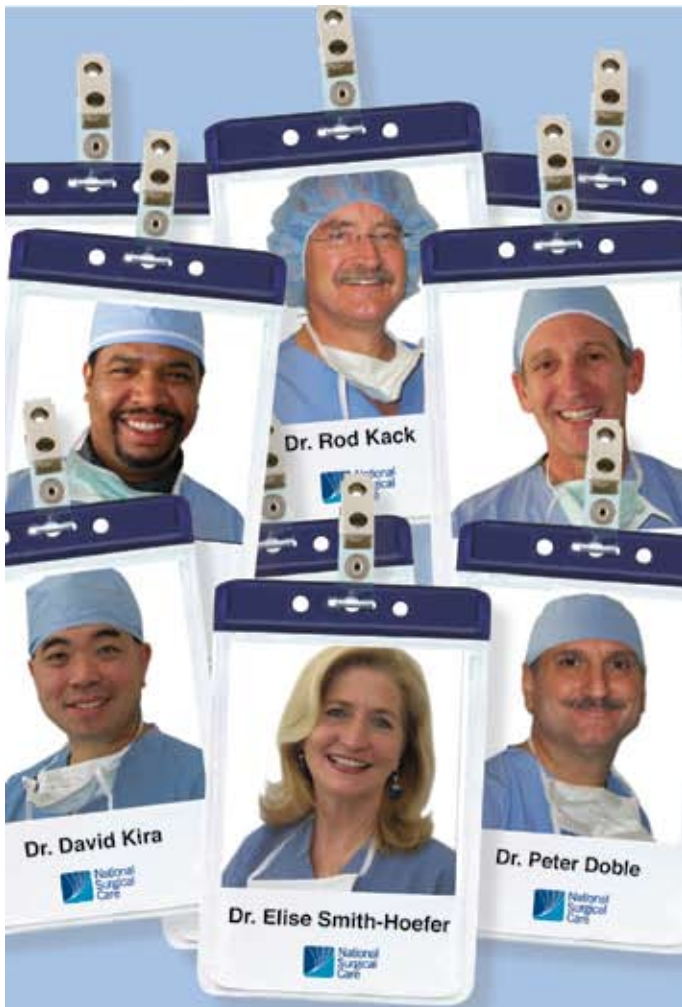
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Douglas Rex, MD. Dr. Rex is the chancellor's professor of gastroenterology and professor of medicine at Indiana University. He is also director of endoscopy at the Indiana University Hospital in Indianapolis. His research areas of interest have been colorectal disease and, in particular, colorectal cancer screening and the technical performance of colonoscopy. He co-authored the colorectal cancer screening recommendations of the ACG and those of the Gastroenterology Consortium. He has authored more than 110 original research papers, 50 book chapters, 100 invited papers and editorials and 15 guideline papers. He is an associate editor of *Journal Watch Gastroenterology* and *Reviews on Gastroenterological Disorders*, and is a member of the editorial boards of *Clinical Gastroenterology and Hepatology*, *Journal of Clinical Gastroenterology*, *World Journal of Gastroenterology* and *Gastroenterology and Hepatology*. He was the chairman of the U.S. Multi-Society (ACG, ASGE, AGA, ACP-ASIM) Task Force on Colorectal Cancer. He was chairman of the board of governors, secretary and treasurer of the ACG and is a past president.

Robert Sable, MD, FACP, FAGG, AGAF. Dr. Sable is a physician with Riverdale Gastroenterology and Liver Diseases in Bronx, N.Y., and specializes in gastroenterology. He is a clinical assistant professor of medicine at the Albert Einstein College of Medicine. From 2007-2008, he served as lead medical director at the Advanced Endoscopy Center in Bronx, N.Y., where he is currently the information technology liaison with ProVation Medical. He is also an attending physician at Montefiore Medical Center and St. Barnabas Hospital, both also located in Bronx, N.Y., and is a physician advisor for the Documentation Improvement Project at Montefiore Medical Center. He is a member of the committee working on the National Benchmarking Project for Gastrointestinal Endoscopy.

Dr. Sable is a member of the AMA, the AGA, the ASGE, the New York Society for Gastrointestinal Endoscopy, the Medical Society of the State of New York and the Bronx County Medical Society. He is also a fellow of the ACG and the ACP.

Dr. Sable enjoys teaching, reading, swimming, stamp and coin collecting and sports. He is an avid fan of the New York Yankees and the New York Jets.

Robert S. Sandler, MD, MPH. Dr. Sandler is currently the president of the AGA. He is also the Nina C. and John T. Sessions distinguished professor of medicine and chief of the division of gastroenterology and hepatology at the University of North Carolina, Chapel Hill. He is also the longstanding director of the Center for Gastrointestinal Biology and Disease, an NIH-funded Digestive Disease Research Core Center that is based at UNC and North Carolina State University.

Dr. Sandler is a nationally known scholar and lecturer and has given hundreds of talks on a variety of gastroenterology-related topics. He has published numerous articles in nationally circulated journals, and served as an associate editor of the journal *Gastroenterology* and on the editorial boards of



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Inflammatory Bowel Diseases and the *International Journal of Gastroenterology*.

Dr. Sandler credits his successes to his former division chief Don Powell, MD, and his wife, Dale Sandler, PhD. He places value on efficiency, fiscal responsibility, exceeding expectations, innovation, hard work and planning.

Harry Sarles, Jr., MD. Dr. Sarles is a gastroenterologist with the Digestive Health Associates of Texas, located in Garland, Texas. His areas of clinical interest include colon cancer screening, pancreato-biliary problems of the GI tract, gastro-intestinal bleeding problems and gastroesophageal reflux disease. Dr. Sarles currently serves numerous roles in many professional societies and is chairman of the finance committee for the Digestive Health Associates of Texas and the chairman of the Legislative Affairs Committee for the Texas Society of Gastroenterology and Endoscopy. In addition, he is the governor of the North Texas Region of the ACG and also is a member of the College's National Affairs Committee and on the board of trustees.

Dr. Sarles is a member of several professional societies including the AMA, the AGA, the ASGE and the Texas Society for Gastroenterology and Endoscopy. He is a fellow of the ACG. Dr. Sarles completed his internship and residency in internal medicine at the University of Texas Medical Branch at Galveston and his gastroenterology fel-

lowship at the VA Hospital in Phoenix through the University of Arizona.

Leonard Stein, MD, FACP, FACC. Dr. Stein is the medical director at the Long Island Center for Digestive Health, an ambulatory endoscopy center Garden City, N.Y. The facility, opened in 2006, is AAAHC-accredited and performs approximately 6,000 procedures per year. Its endoscopists are physician members of Gastroenterology Associates, PC, a single-specialty group also located in Garden City.

Dr. Stein completed a gastroenterology fellowship at Temple University Hospital in Philadelphia. He has been an active participant in the internal medicine residency and gastroenterology fellowship programs at Winthrop-University Hospital in Mineola, N.Y., and has been honored with the "Outstanding Attending of the Year" award. He is a diplomate of the American Boards of Internal Medicine and Gastroenterology and a fellow of the ACP and the ACG. He also serves as a clinical assistant professor of medicine at the State University of New York at Stony Brook.

Lewis Strong, MD. Dr. Strong is the president of the Skyline Endoscopy Center in Loveland, Colo., and has contributed to the success of the facility. He earned his medical degree and completed his internship, residency and fellowship at Case Western Reserve University. He is certified by the American Board of Internal

Medicine and the AGA. He has been an active member of the Loveland, Colo., medical community since the early 1990s. Dr. Strong was a founding member of the local physician's health organization and served as its president for four years. He later served as president of the expanded, regional PHO for one year. Dr. Strong has served on numerous committees at McKee Medical Center and currently is a member of the hospital's credentialing committee.

Catherine Sayers, director of clinical operations for Pinnacle III, says, "Dr. Strong and his family are an integral part of the Loveland community, and he is well respected for his contributions throughout Northern Colorado."

James J. Weber, MD. Dr. Weber is president of Texas Digestive Disease Consultants, which has 17 offices around the Dallas/Fort Worth area. He received his medical degree from the University of Texas Southwestern Medical School in Dallas, and he completed his residency at Parkland Memorial Hospital and his gastroenterology fellowship at Baylor University, both located in Dallas. He specializes in colorectal cancer prevention and irritable bowel disease.

Dr. Weber is an active member of several professional societies including the AGA, the ACG, the ASGE, the Texas Medical Association and the Tarrant County Medical Association. When not in the office, he enjoys spending time with his family at

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4 Key GI Trends in 2009

By John Poisson

This is an exciting time to be in the endoscopy center business. Although there are many pressures on the industry, there are also some terrific opportunities to be gained by the consistent focus in a few key areas. Below are four key trends we at Physicians Endoscopy see for 2009, along with some helpful hints to improve your practice and center.

1. Offset CMS declines by bold third-party payor renegotiations. In the last six months of 2008, I met with probably about 20 potential GI centers in which our company was considering purchasing a minority equity position. Being relatively new to the acquisition business, we didn't quite know what to expect — however, we often found what we clearly did not expect: Many of these centers hadn't actively negotiated their third-party payor contracts in years. Even in those ASCs that did, many of the practices affiliated with the respective facilities often didn't renegotiate their professional fees at all.

Renegotiating your fees isn't about being greedy — it's simply about receiving the compensation you deserve for the quality, safety-focused patient care you provide. Medicare will continue to decline in reimbursement over the next several years — and on top of that there's probably a good chance that further cuts are ahead to help pay for the multi-trillion dollar governmental bailouts occurring these days. Third-party payors clearly have a different view of the contracting world. Most, but not all, are willing to increase their fees when pressed — particularly if the facility can demonstrate it runs a quality-focused service program. Be assertive, even aggressive in your re-contracting efforts. Show the quality data you've harnessed to prove you are good. Expect increases — don't take no for an answer.

2. Ancillary revenue streams can be captured. Gastroenterology services are an inbound pathway into the healthcare system. An

amazing array of ancillary revenue streams stem from a simple colonoscopy. In a recent analysis of a coalition of 10 GI physicians in a major northeast urban area, we determined that more than \$3 million dollars of radiology business is generated from the physician coalition annually. Another \$1.5 million in pathology revenue is generated. Various other revenues from oncology, anesthesiology, surgery as well as inpatient admissions are recognized as well.

For today's GI physician, there is a focus on legally capturing some of these revenue streams. Two common methods focus on the pathology and anesthesiology portions of the outpatient visit. There are a number of models in the market that allow the GI physician to enjoy a financial benefit, in a legally compliant fashion, in the anesthesia revenue stream. Hiring the MD anesthesiologists and CRNAs and billing for their services is one approach. Other non-employee models exist as well — consult your healthcare attorney for their advice and direction as to the best model for you.

The pathology revenue stream can also be attractive to today's GI physician. Many models exist in the United States, all of which tie back to the "in-office ancillary exception" regulations. All these models have one common thread — they operate exclusively through the professional practice, not the ASC. Pathology is a Stark-regulated designated health service, so keep it out of your ASC financials.

A word of strong caution for those ASCs in which a hospital joint venture exists: Tread lightly. The ancillary revenue streams may look attractive at first; however, these services may be very important to your hospital partner — and partners need to work together, not against each other.

3. There's a new emphasis on quality.

Quality has always been the cornerstone of almost every GI center but sometimes the message emphasizing this quality got lost in the mix in past years. It is so rewarding to see the momentum of a renewed focus on quality and quality measurement gaining such a strong foothold in our marketplace. Many people deserve a tremendous amount of thanks and appreciation — folks like Irving Pike, MD, down in Norfolk, Vir., who took it upon himself to be one of the many town criers of this important message.

As another example, scope reprocessing has got to be one of the most tedious jobs in the endoscopy center. That said, it is probably also the most important responsibility for any of your staff members. Every scope must go through a distinct, multi-step process to ensure it is clean and safe for

patient care. If your ASC board hasn't reviewed your reprocessing protocols recently, it's time you hold your next meeting in the decontamination room and get acquainted with the most important room in the house.

We firmly believe that quality will someday allow those that can live it, demonstrate it, measure it and report it to receive increased financial benefits. Pay for performance isn't ready for primetime yet in most markets, but preparing your practice and center for the future can improve your local reputation today while positioning you for better reimbursement in the future.

4. Basics deliver. A focus on implementing strong business fundamentals is now, more than ever, vital to your continued success in today's GI center. Let's face it: There's plenty of pressure on reimbursement, increasing staffing costs, higher supply costs and a parade of other horrors that could begin to degrade your profitability. Maybe that is already happening.

Now is the time to institute strong business rules in your center. A focus on driving utilization while aggressively renegotiating payor contracts will deliver positive results on the revenue portion of your financial statements. On the expense side, evaluate all vendor agreements annually and selectively re-bid contracts even if you are happy with a vendor's current services — the end result generally is you retain the same vendor but at a lower cost per unit. Ensure your staff is "right sized" and the amount of staff each day is tailored to your caseload. Staffing expenses are typically the largest expense item in the facility — generally 25-30 percent of your budget. Reward employees that come forth with cost saving ideas — no matter how small the savings; reward the behavior and this culture.

Critical footnote

Patient safety is top priority at your ASC and this must never be forgotten or sacrificed. In reviewing any financial, operational or other possible change at your ASC, always implement the "sniff test" to ensure the modification will have no negative impact on patient safety (and satisfaction). One bad patient outcome is a horrible thing and could also rip apart years' worth of your hard work, taking down your ASC business in the process. Be safe. ■

Mr. Poisson (jpoisson@endocenters.com) is executive vice president and strategic partnerships officer for Physicians Endoscopy, which develops and manages endoscopic ASCs in partnership with practicing GI physicians and hospitals. Learn more about Physicians Endoscopy at www.endocenters.com.

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25 Interesting Statistics About Gastroenterology in Surgery Centers

1. Gastroenterology was the most common specialty of single-specialty surgery centers in 2008, representing 28 percent of all ASCs.

2. GI practices in multi-specialty centers performed the highest number of procedures annually with an average of 3,710. In single-specialty centers, this number was higher, with an average of 5,379 cases annually.

3. More than one-third of multi-specialty surgery centers offer GI services, which is up 26 percentage points from 2000. It is the third highest at 37 percent, behind plastics and ophthalmology.

4. Gastroenterology represents the highest volume of total procedures in ASCs at 42 percent. Ophthalmology is second at 16 percent.

5. The average net revenue per case for gastroenterology is \$780, with the highest average revenue in the Southwest (\$869/case) and the lowest in the Southeast (\$616/case).

6. The average net revenue per case changes with the number of operating room in a center. The average net revenue per case by number of operating rooms is as follows:

- 1-2 ORs: \$630
- 3-4 ORs: \$740
- More than 4 ORs: \$798

7. The average net revenue per case changes with the number of cases that a center performs in a year. The average net revenue per case by number of cases is as follows:

- Less than 3,000 cases: \$790
- 3,000-5,999: \$835
- More than 5,999: \$758

8. The average net revenue per case changes with the total net revenue of the surgery center. The average net revenue per case by total net revenue of the surgery center is as follows:

- Less than \$4.5 million: \$683
- \$4.5-\$7 million: \$724
- More than \$7 million: \$870

9. GI procedures hold the highest percent of the total case mix in the Midwest (34 percent) and the lowest in the Southwest (24 percent).

Medicare charges and payments

Here is the average 2007 Medicare sub charge (submitted charges divided by allowed services), average allow charge (Medicare-allowed charges divided by allowed services, including co-pays and deductibles paid by patient), and average payment (Medicare payments divided by allowed services, not including co-pays and deductibles

paid by patient) for common upper- and lower-GI procedures commonly performed in ASCs.

Upper-GI procedures

10. Upper stomach-intestine scope, simple (CPT 43234)

- average sub charge: \$817
- average allow charge \$303
- average payment: \$237

11. Upper stomach-intestine scope for diagnosis (CPT 43235)

- average sub charge: \$1,064
- average allow charge \$318
- average payment: \$249

12. Stomach-intestine scope, inject intestine wall (CPT 43236)

- average sub charge: \$1,218
- average allow charge \$343
- average payment: \$271

13. Upper stomach-intestine scope for biopsy (CPT 43239)

- average sub charge: \$1,406
- average allow charge \$424
- average payment: \$334

14. Stomach-intestine scope ultrasound guided biopsy (CPT 43242)

- average sub charge: \$1,959
- average allow charge \$443
- average payment: \$352

15. Stomach-intestine scope for foreign body removal (CPT 43247)

- average sub charge: \$1,405
- average allow charge \$421
- average payment: \$331

16. Stomach-intestine scope with ultrasound exam (CPT 43259)

- average sub charge: \$2,018
- average allow charge \$508
- average payment: \$402

17. Scope of upper small intestine (CPT 44360)

- average sub charge: \$1,468
- average allow charge \$433
- average payment: \$343

18. Scope of upper small intestine with biopsy (CPT 44361)

- average sub charge: \$1,409
- average allow charge \$414
- average payment: \$327

Lower GI-procedures

19. Scope of colon thru ostomy for diagnosis (CPT 44388)

- average sub charge: \$1,203

- average allow charge \$323
- average payment: \$253

20. Scope of colon with biopsy thru ostomy (CPT 44389)

- average sub charge: \$1,338
- average allow charge \$308
- average payment: \$240

21. Scope of sigmoid colon only with biopsy (CPT 45331)

- average sub charge: \$945
- average allow charge \$287
- average payment: \$225

22. Scope of colon for diagnosis (CPT 45378)

- average sub charge: \$1,403
- average allow charge \$442
- average payment: \$345

23. Scope of colon with biopsy (CPT 45380)

- average sub charge: \$1,463
- average allow charge \$407
- average payment: \$319

24. Cancer screen colon scope, high risk patient (HCPCS G0105)

- average sub charge: \$1,272
- average allow charge \$441
- average payment: \$339

25. Cancer screen colon scope, not high risk patient (HCPCS G0121)

- average sub charge: \$1,327
- average allow charge \$443
- average payment: \$340

Sources: Items 1-4: SDI's 2008 *Outpatient Surgery Center Market Report*.

Items 5-9: VMG Health 2008 *Intellimarker*.
Items 10-25: CMS.

Note: CPT codes are copyrighted by the AMA.

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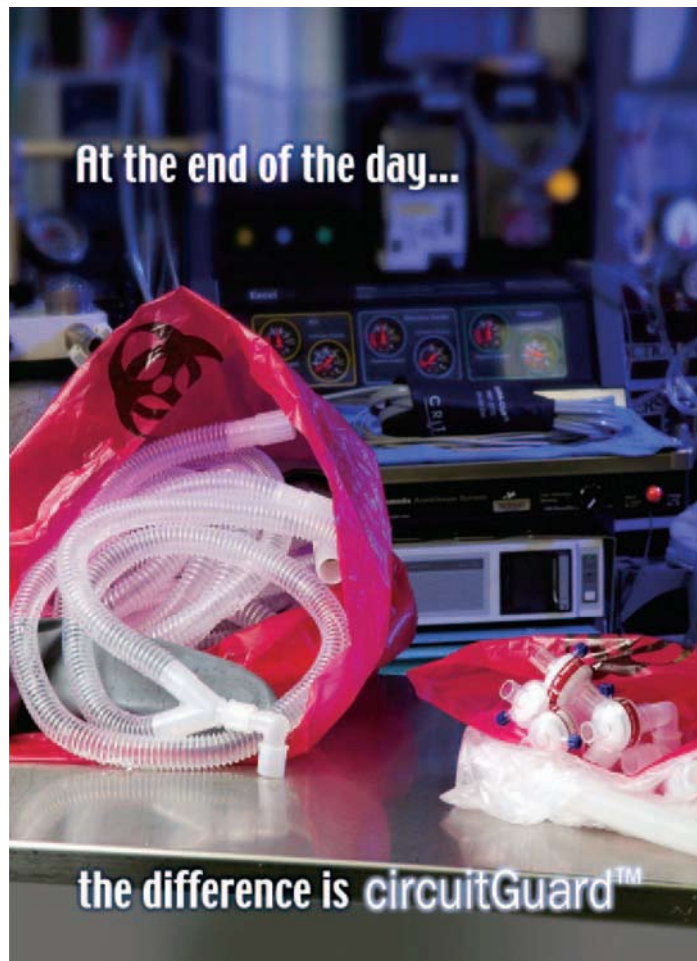
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10 GI and Endoscopy Managed Care Best Practices

By Matt Kilton

Over the past several years, GI and endoscopy services have been targeted for decreased reimbursements. Already a high volume specialty, it is anticipated that utilization will continue to increase as baby boomers become Medicare beneficiaries. In spite of lowering reimbursements, incorporating a best-practice approach to managed care can lead to ongoing success when providing GI and endoscopy services.

From a business perspective, the foundation of the optimal managed care strategy is remaining cognizant of the fact that endoscopy remains a high volume, lower reimbursement service. Therefore, any managed care strategy must include an emphasis on preserving rates for existing services and pricing new services at appropriate levels, as opposed to allowing reimbursements to decline. Furthermore, a continued awareness of operating efficiency and coding accuracy is necessary to maximize on the revenue opportunities associated with these services.

Here are 10 best practices followed by successful endoscopy centers.

1. Remain attentive to annual changes in CMS reimbursement for high volume procedures. Medicare rates for commonly performed services are being modified, with some procedures increasing while others are decreasing (see Table 1). Due to the fact that most existing or planned endoscopy centers (or those multi-specialty facilities delivering endoscopy services) experience a significant Medicare patient mix, these rate changes are meaningful.

Table 1

CPT	Description	2008 Medicare National ASC Rate	2009 Medicare National ASC Rate	Change
43235	Upper GI endoscopy; diagnostic, with or w/o collection of specimen(s)	\$337.76	\$336.97	Unch.
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s)	\$551.35	\$660.05	Up
43239	Upper GI endoscopy; with biopsy, single or multiple	\$422.51	\$392.07	Down
43248	Upper GI endoscopy; with insertion of guide wire	\$422.51	\$392.07	Down
45378	Colonoscopy; diagnostic, with or w/o collection of specimen(s)	\$426.09	\$398.85	Down
45380	Colonoscopy, with biopsy, single or multiple	\$426.09	\$398.85	Down
45385	Colonoscopy, with removal of tumor(s), polyp(s), or other lesion(s)	\$426.09	\$398.85	Down

Further modifications to rates are expected again in 2010 and 2011 and should also be monitored for their expected impact to operating revenues.

2. Check in on the terms of your existing managed care contracts, especially around the start of a new year.

If your commercial payors are linked to CMS, the start of the new year may result in changes to your contract allowables. For instance, at the beginning of 2009 you may have seen changes similar to those illustrated above. 2009 is the second year of CMS's planned four year transition. However, if your commercial contracts are linked to Medicare's previous, grouper-based reimbursement system, you may find it more advantageous to continue contracting under this methodology if possible. Analysis of the two different systems is advisable, and the decision to modify a contract may ultimately depend on your procedure mix.

3. Ensure managed care contract terms include a provision for adding new codes or adjusting with coding changes as they are released by CMS and/or the AMA. Payors deal with newly added CPT codes in different ways, and understanding the methodology for how each contract addresses new codes is important. Understand whether new codes default to a non-grouped rate, a percent of billed charge or are not covered. As it relates to endoscopy centers, 2009 saw limited changes in CPT codes. New 2009 CPTs which were also added to CMS's procedure list include:

43273 – Endoscopic cannulation of papilla
46930 – Destruction of internal hemorrhoids by thermal energy

Incidentally, the following codes were removed and replaced with new codes: 46934, 46935 and 46936. The question for commercial payors is how will they be paying for these newly created codes? Centers must remain committed to monitoring annual changes and communicating to billing staff at the start of the year to prevent errors and/or rejections by commercial payors and CMS.

4. Monitor trends in physician reimbursements whenever possible. Professional reimbursements are often impacted by changes to facility compensation, and increases to facility payments can result in offsets to professional compensation. Commercial payors' continued use of site-of-service adjustments (already common in endoscopy) further illustrates this concern. Facilities should remain aware of payor adjustments to professional rates, which may impact near and long-term referral patterns.

5. Understand the use of payor-defined "incidental-to" procedures. Commercial payors are free to create their own reimbursement systems and methodologies. While many utilize what we all know as "groupers," it is very common for payors to use modifications to standard grouping methodologies to their benefit. Some commercial payors designate codes as incidental and assign a classification to these incidental procedures which provides no incremental reimbursement when these codes are billed in conjunction with other codes considered primary. Some examples of common endoscopy procedures labeled as incidental-to by a regional Blues plan include 43200 (esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen) and 43234 (upper GI endoscopy, exam). Of course, each plan is different and centers need to request copies of grouper assignments from payors with whom they have contracted to determine specific exposure to incidental-to procedures. Understand each payor's grouper assignments, whether any codes listed are considered incidental to another code, and if so what impact will it have on payments.

6. Remain attentive to how payors reimburse multiple procedures. Many commercial payors do not follow CMS guidelines. What may appear as CMS rates in terms of allowables could actually result in reimbursement that is less than equal to CMS if multiple procedure reimbursement terms result in further devaluation of secondary procedures. Many commercial payors will modify multiple procedure reimburse-

ment terms, lowering the allowable percentage or discontinuing payment after a certain number of procedures. As is the case with incidental-to-procedures, payor-specific modifications to multiple procedure reimbursements can have the undesired effect of reimbursements that are below even area adjusted CMS allowables.

7. Recognize the value of correct billing and coding.

A common mistake in facilities involves undercoding and/or missed opportunities to code for services performed. Attention to coding and frequent coding audits to ensure accurate billing for occurs and captures all eligible services. When in doubt it's generally advisable to code and bill commercial payors and let them apply their internal multiple procedure of incidental-to rules. It is generally inadvisable to assume commercial carriers use identical claims editing rules. Endoscopy services include a broad range of codes that progressively detail the description and documentation of services provided. Success begins with understanding the differences and documenting the services accurately.

8. Proceed cautiously when considering relationships with payors calling themselves networks.

Large national networks, often referred to as "rental networks" or "PPO networks," exist to lease access to contractual discounts and many offer these networks to any payor willing to pay a fee to access the discounts. Furthermore, it is common to find clauses contained within contracts that suggest a discount from state fee schedule for Medicaid, CMS, and other payors. These discounts will generally result in further reductions in allowables. These contracts often take the approach of suggesting a fee schedule for services provided to commercial members and

discounts from state rates on all other products, for these are generally payors who are seeking those state and CMS contracts for re-pricing.

9. Understand the impact of Medicare Advantage Products.

Endoscopy centers deliver a large volume of services to a senior population, so Medicare Advantage agreements can have a significant impact on reimbursements. Commercial payors frequently include Medicare Advantage products with their commercial contract negotiations. Confirm that the Medicare Advantage contract is clear that it will pay at least 100 percent of Medicare. There are always opportunities to request more, especially from upstart plans that are attempting to enter into a new market. Endoscopy providers should anticipate increased exposure to Medicare product contracting requests as CMS continues to outsource claims management via Medicare Advantage plans.

10. Consider that it may not be the optimal business practice to enter into a contract with every willing payor.

A managed care contract is, by its very nature, an agreement to discount the cost of the services you provide. Logically this makes sense for payors who represent volume. For payors without substantial patient volume, the time and effort it takes to review, negotiate and administer a contract may quickly offset the benefit of having the contract in place. Administering dozens and dozens of contracts is a challenge to say the least, and generally results in confusion and an inability to audit and monitor payments. Also, out-of-network reimbursement rates may actually be higher than potential contracted rates. And, as mentioned above, it isn't always beneficial to enter into agreements with rental network payors. Ac-

cepting contracts with a limited number of your payors is remarkably easier and more efficient to manage. Then, some centers utilize an "all other" contracting philosophy. For smaller payors, you could request a percent of billed charge contracting format. Every payor can administer percent of billed charges; the only limitation is whether or not they will agree to it.

Strategic plan can yield strong benefits

With a finely-tuned managed care strategy in place, the anticipated changes to endoscopy utilization and reimbursement can be optimized. As the general population continues to age, the resulting need for endoscopic services is expected to affect the business of running an endoscopy center. Increasing demand and fixed budgets could result in reductions in CMS allowables per service beyond 2011, and it stands to reason that if the demand side increases and CMS budgets are required to remain neutral, the payments per service could decline. Monitor CMS and your commercial payor agreements closely to stay ahead of changes and anticipate an ongoing need causing downward pressure on reimbursements. By incorporating a best-practices approach to managed care, endoscopy practices can continue to achieve ongoing success. ■

Note: CPT codes are copyrighted by the AMA.

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5 Common GI/Endoscopy Coding and Billing Mistakes

By Stephanie Ellis, RN, CPC

1. Control of bleeding not separately billable. The control of bleeding is included in biopsy (and most other) endoscopic procedures, and is not separately billable unless the patient comes into the facility with a GI bleed, which is the reason the procedure is being performed — which rarely occurs in the ASC setting.

Control of bleeding can be obtained through means of injections, as well as cauterizations. Injections of epinephrine through an upper endoscopy are coded as 43255. This injection would be included in the ASC facility fee and would not be reimbursed separately from an esophagogastroduodenoscopy or colonoscopy procedure unless the endoscopy case is completed and the patient is in the PACU/recovery area when the bleed occurs, necessitating a return to the OR to treat the hemorrhage.

The control of bleeding by colonoscopy is coded 45382. Append the -78 modifier to the CPT code for the return to the OR for control of bleeding procedures.

2. Only bill for successful surgery. If the physician performing a colonoscopy attempts — but fails — to remove a polyp by snare technique, but he/she is successful at removing the polyp via another technique (such as hot biopsy forceps), only bill the CPT code for the technique/procedure which **was** successful (use code 45374 for a hot biopsy forceps polypectomy in this case).

For either a colonoscopy or EGD procedure, if a lesion is biopsied and then subsequently the **same** lesion is removed during the same operative session, code the removal of the lesion only — the biopsy would be considered incidental and not separately billable.

For either a colonoscopy or EGD procedure, if one lesion is biopsied and a separate lesion is removed during the same operative session, code both the biopsy of the lesion and the removal of the separate lesion.

Append a -59 modifier to the biopsy procedure if it is unbundled in the CCI unbundling edits.

3. Don't get tripped up by "cold" v. "hot" snare. For colonoscopy procedures performed involving biopsies and/or the removal of a polyp using the cold biopsy forceps method, bill the 45380 CPT code once for any of the following situations:


- The physician takes a single biopsy or multiple biopsies of lesions.
- For the removal of *portions* of a polyp by cold biopsy forceps.
- For the removal of an *entire* polyp by cold biopsy forceps technique.

The cold biopsy forceps method is referred to as "cold" since electric current is running to the instrument and no cauterization of bleeding takes place during the removal of tissue.

If the physician performs a snare polypectomy and refers to the technique as "cold snare" or "hot snare," the mention of temperature does not change the coding — the 45385 snare polypectomy code would still be used in either case.

4. Use proper modifiers for incomplete colonoscopies. For both EGD and colonoscopy procedures, a "separate site," for definition


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purposes, can be a separation between lesions as small as one centimeter. To qualify for billing a colonoscopy code, the scope must move beyond the splenic flexure of the colon. If the scope is not able to move that far, and is only used to examine as far as the sigmoid colon and a portion of the descending colon, it should be coded as 45378 with a -52 or -74 modifier — depending upon the payor's modifier requirements.

In a colonoscopy, if the patient has a particularly long GI tract and the physician runs out of scope before viewing the entire colon (for example, the scope goes past the splenic flexure but does not extend all the way to the cecum), these procedures should be coded with a -52 modifier appended for billing purposes.

Failed colonoscopies may also be referred to as "incomplete." Sometimes the physician states the procedure is not completed due to a "poor prep." This occurs when the scope is not able to be advanced past the splenic flexure.

Causes of this problem include incomplete preps, unusual patient anatomy, the patient has an obstructing lesion or the provider performing the procedure is inexperienced.

These procedures are coded as 45378, with the -52 or -74 modifier indicating a discontinued procedure — the choice of modifier depends on the payor's requirements.

5. Follow proper, current rules for screening procedures. The latest Medicare guidance for the situation where a colonoscopy is scheduled as a screening procedure but a polyp is removed and/or a biopsy is taken, is to not bill the G-code for a screening study but bill the appropriate CPT codes for the procedure(s) performed (45385, 45380-59, etc.).

On the claim form, list the diagnoses in field 21 with the screening V-code (V76.51) first followed by the 211.3 polyp or other applicable diagnosis code(s). When linking the diagnosis to the procedure in field 24E of the CMS-1500 claim form, only link the 211.3 polyp code with the 45385 or other colonoscopy code and do **not** link the screening V-code in field 24E to any procedure code billed. If your Medicare carrier specifically directs billing these procedures in another manner, follow its guidance. ■

Note: CPT codes are copyrighted by the AMA.

Ms. Ellis (sellis@ellismedical.com) is president of Ellis Medical Consulting, a healthcare consulting firm providing chart audits for coding and documentation issues, business office operational assessments, research of coverage issues, fee and coding revisions, litigation support, reimbursement research, coding/billing training, and the development and implementation of billing compliance programs for healthcare providers. Learn more about Ellis Medical Consulting at www.ellismedical.com.

14 GI-Driven ASCs to Know

By Renée Tomcanin

A successful ASC requires the cooperation of all members of its staff — from physicians to administrators to nurses and ancillary staff. In the field of gastroenterology, this sense of teamwork permeates through flourishing centers.

Here is a list of gastroenterology-driven ASCs and a few of the reasons why they have been so successful.

Gail Wells, administrator and nursing manager for the Berks Center, says that the organization's success is due to the "great group of people who work here." Ms. Wells describes the environment of the facility as "a culture of leadership." "We have great leadership," she says. "It works from the top down."

Eastside Endoscopy Center (St. Clair Shores, Mich.). Eastside Endoscopy Center opened in 1996 as the first endoscopy center in Lower Michigan. Currently, EEC has six procedure rooms in two locations and specialize in general GI procedures, including upper and lower endoscopy and routine care. The ASC 16 physicians performed 11,000 procedures in 2008. In addition to performing endoscopies, EEC hosts meetings for primary care physicians on GI problems as well as community education events. It also provides CME activities for its medical staff twice a year.

Fernando Bermudez, MD, medical director of EEC, says that the success of this ASC is measured in more than just revenue. "We have good control of our practice," he says. "Because we own the center, we can determine how to run [it]."

The staff and physicians make safety and patient satisfaction a top priority.

"If we find an issue, we address it quickly," says Dr. Bermudez. "If there is no issue, we ask ourselves 'what else can we do?'" In 2006 and 2007, EEC received the Press Ganey Summit Award for 99 percent patient satisfaction.

Beth Miller, administrator of EEC, says that the center is constantly looking for new ways to prove that it is a center of excellence. "We've always been in the forefront," says Ms. Miller, the first CASC-certified administrator in Michigan. In addition, EEC was the first ASC in Michigan to receive a recognition award from the American Society of Gastrointestinal Endoscopy for quality and patient safety.

Eastside Endoscopy Center (Bellevue, Wash.). Eastside Endoscopy Center opened its doors in 1995, and its team of 11 physicians performs around 10,400 procedures annually. The

center specializes in upper endoscopies and colonoscopies, which are performed in three procedure rooms. Eastside Endoscopy also uses the capsule endoscopy procedure in which patients swallow a capsule containing a camera that transmits pictures of the intestinal tract that can then be downloaded and reviewed by the physician. Eastside Endoscopy was the first ASC in Washington to be accredited by the AAAHC.

In addition to performing endoscopies, Eastside Endoscopy provides outreach and colon cancer education to the community. It is a sponsor for the Mercer Island Half Marathon for Colon Cancer Awareness, and this year it is raffling off a free colonoscopy for charity.

Michelle Steele, clinical nurse manager of Eastside Endoscopy, credits the success of the center to an excellent working relationship between physicians and staff. Because of this comfortable relationship, the center's staff uses humor to make patients more comfortable in what is often a pretty uncomfortable situation, according to Ms. Steele.

"They have a great rapport with one another," she says, "and this spills over to how we deal with patients."

The Endoscopy Center at Gateway (Kingston, Pa.). The Endoscopy Center at Gateway specializes in endoscopy procedures related to GI, including colonoscopies and EGDs. Of the five GI physicians in the Kingston region, three work at the facility. The physicians perform around 7,000 procedures in two procedure rooms. In addition, the ASC had eight recovery beds for its patients. The center is accredited by AAAHC and is recognized nationally through the ASGE for promoting quality GI endoscopy care.

The physicians at the center have well-established reputations in the community, and the retention rate of staff is high. Both of these result in a high level of patient satisfaction, which the ASC evaluates based on monthly customer surveys. According to Denise Calomino, administrator of The Endoscopy Center at Gateway, if a survey comes back with an area for improvement, the facility addresses it right away. In addition, the staff is kept up-to-date on changes in policies, such as billing and coding, so that they can maintain a high level of efficiency. Also, the center reaches out to its referring physicians to make sure that it addresses their needs as well.

Ms. Calomino notes that a being a single-specialty center helps the staff maintain its efficiency. Also, she says that the center "benchmarks everything."

"This is so we know where we stand," she says, "and it helps us understand our business."

Most importantly, Ms. Calomino credits the organization's success with making sure it stays on top of patient care and maintaining a positive work environment.

"The staff is happy to be here," she says. "Our patients can tell that. Overall, it's a great place to work."

Endoscopy Center of Western New York (Williamsville, N.Y.). Endoscopy Center of Western New York opened in March 2004 and is run by Gastroenterology Associates. The ASC performs 8,500 procedures annually and specializes in endoscopic retrograde cholangio-pancreatography, upper endoscopy/EGD, colonoscopy and sigmoidoscopy. The center has four procedure rooms. The Endoscopy Center of Western New York enjoys strong and positive relationships with both local hospital systems in Buffalo, with the physicians providing full-time clinical GI coverage for four of the hospitals in the area.

G.I. Associates Endoscopy Center (Wausau, Wisc.). G.I. Associates Endoscopy Center opened as a single-specialty ASC in Sept. 2008. It is wholly physician-owned. The center received its accreditation by the AAAHC in Dec. 2008. The three physicians on its staff perform endoscopies in its four procedure rooms.

Cathy Rohling, operating officer of G.I. Associates Endoscopy Center, says that the single-specialty nature of the center is one of its biggest assets. She also credits her great staff for its success, among other aspects of running the ASC.

"We use professional benchmarking tools, which have been a great help [in running our center]," she says.

Lone Star Endoscopy Center (Keller, Texas). Lone Star Endoscopy Center is a freestanding endoscopic ASC developed by the physician partners of Texas Digestive Disease Associates. The eleven physicians at the ASC perform approximately 8,000 procedures annually. The center has one operating room and four procedure rooms and specializes in colonoscopies, EGD and flexible sigmoidoscopy. Lone Star opened in May 2006 and aims to serve its patients with compassion, quality and proven technology.

Long Island Center for Digestive Health (Garden City, N.Y.). Long Island Center for Digestive Health provides endoscopies and colonoscopies in a comfortable atmosphere. Its team of seven physicians performs between

6,000-6,500 cases annually. This single-specialty ASC opened its doors in June 2006 and was developed by Gastroenterology Associates. It is licensed by the state of New York, is Medicare-certified and is accredited by the AAAHC.

Leonard Stein, MD, medical director of the Long Island Center for Digestive Health, credits the facility's skilled staff of nurses, technicians and anesthesiologists for the center's success.

"They provide the patient with a safe, careful place to have procedures," he says. In addition, he finds that a positive experience at the center can encourage a patient's friends and family members to come in for colon cancer screening.

"If we can provide our patients with a positive experience, we feel that we can reach out to those who need to be screened but have not been," he says.

Michigan Endoscopy Center (Farmington Hill, Mich.) Michigan Endoscopy Center specializes in all types of GI procedures, including colonoscopy, upper endoscopy and EGD. MEC has six operating rooms and 16 physicians who perform approximately 16,900 procedures annually. According to the mission statement of the center, MEC is dedicated to promoting a high quality of endoscopic services by maintaining an

environment that is conducive to the provision of safe, efficient endoscopic procedures by ensuring that safe and effective equipment and supplies are available for physicians and staff, by maintaining relationships with qualified, skilled physicians and staff and by providing an effective program of quality assurance and quality improvement.

Brien Fausone, administrator of MEC, says that a key to the center's success is the highly-trained and experienced clinical staff. "It's an all-star team of clinicians," Mr. Fausone says.

Physicians Endoscopy Center (Houston, Texas) Physicians Endoscopy Center is dedicated to providing its patients with the highest standard of endoscopic services available in an efficient, cost-effective environment. Its team of physicians performs around 1,100 procedures monthly in its eight procedure rooms. The organization specializes in endoscopies and colonoscopies. In addition, it provides colon cancer screenings. The facility is designed with the patient's comfort, privacy and safety in mind, and relaxing music and aromatherapy are used to minimize the anxiety patients may feel. In addition, the ASC offers Saturday hours for those who cannot come in during the week.

The facility is technologically advanced, and recently purchased state-of-the-art endoscopes and high definition televisions for the procedure rooms. It is accredited by the AAAHC. For Colon Cancer Awareness Month, PEC offers gifts to those who come in for screenings, and the staff provides colon cancer outreach to primary care physicians in the area.

Staff members are certified in Advanced Cardiac Life Support. Past medical directors and the current administrator have been recognized by the community for their achievements.

Pioneer Valley Surgicenter (Springfield, Mass.) The Pioneer Valley Surgicenter specializes in gastroenterology procedures and also performs ENT, orthopedics, general surgery and some plastics. The facility's 17 physicians perform around 7,200 procedures and 2,000 operating room cases annually in its four procedure rooms and two operating rooms. Physicians at the center work as a team to provide the best patient care possible. The goals of Pioneer Valley are to provide outpatient surgical services in a non-hospital setting in order to decrease or curtail spiraling healthcare costs, to provide quality, individualized patient care in a comfortable, non-threatening atmosphere and to provide a service of convenience, availability and efficiency for both patients and physicians in the community.

Linda Rahm, administrator of Pioneer Valley Surgicenter, says the ASC is successful because the doctors are actively involved in issues related to patient satisfaction.

"The staff is highly trained and put caring for the patient first," she says.

Skyline Endoscopy Center (Loveland, Colo.) Skyline Endoscopy Center began operation in Dec. 2004. The center provides open-access endoscopies, and it performs approximately 3,800 procedures annually. The center specializes in colonoscopy, sigmoidoscopy and upper endoscopy (gastroscopy). Currently there are four physicians on staff.

The center provides outstanding patient care and customer service as measured by its patient satisfaction surveys. According to Catherine Sayers, director of central operations of Pinnacle III, "Much of the patient satisfaction can be attributed to the dedicated and enthusiastic staff; only one staff member has left in the four-plus years it has been open. The center has been financially sound since the day it opened its doors and has consistently produced a 26-32 percent profit margin."

Surgery Center of Joliet (Joliet, Ill.) The Surgery Center of Joliet opened in 2008. The facility houses two procedure rooms, two endoscopy rooms and three operating rooms. To accommodate the rising capacity of the endoscopy rooms, the center purchased a portable endoscopy machine

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which allows one of the operating rooms to be used for endoscopic procedures. The ASC performs more than 3,000 procedures annually and specializes in colonoscopy, EGD and upper and lower GI diagnostics and screenings. In addition, it performs feeding tube insertions and hemorrhoid banding. Of the approximately 35 physicians on staff, there are five who specialize in endoscopy and an additional 3-4 general surgeons who perform endoscopies. In addition to GI procedures, the center has practices in ENT, general surgery, pain management, plastics, podiatry and orthopedics.

Marge Schillaci, administrator of the Surgery Center of Joliet, credits the success of the ASC to her skilled and efficient staff. She notes that the facility has a high level of patient satisfaction due to its surgeons and recovery room staff.

"Feedback from customers who have had procedures done in the hospital say that it is no comparison to the care they receive at the center," she says.

In addition, she says that the pre-op, operating and post-op rooms are all very close in proximity, which always for a quick turnover time in the procedure rooms and requires less movement of the patients. Most patients are under intravenous sedation, which is administered by a skilled

staff of nurses. There is no staff turnover at the center.

"Surgeons are very satisfied with their patient care," Ms. Schillaci says, which is a result of the loyal and skilled staff. Also, at least one member of the staff is assigned to clean scopes during the day, which speeds up procedure times.

Ms. Schillaci mentions that the surgery center was able to satisfy its lease early and is keeping the center equipped with state-of-the-art equipment. In addition, due to increasing case volume, it is looking to purchase new scopes and cleaning equipment to help the ASC run as efficiently as possible.

United Medical Endoscopy Center (Lancaster, Calif.). The 100 percent physician-owned United Medical Endoscopy Center specializes in all types of GI procedures, including upper endoscopy, biopsies and endoscopic ultrasound in its two endoscopy rooms. In another procedure room, pain management services are provided such as epidurals, lumbar pokes and fluoroscopy. The ASC performed approximately 12,500 procedures in 2008.

Dr. Raman Patel, president of the United Medical Endoscopy Center, credits the center's success to his very experienced team of physicians, nurses and administrators.

"Teamwork has made a difference," Dr. Patel says. "[Our staff] believes in us, and that makes a big difference in running a smooth operation."

The ASC invited all private practice gastroenterologists in the area to join in a partnership with the center. "All shareholders are on the board of directors, and each has an equal voice in management," says Dr. Patel. "Nobody takes advantage of anybody; the first [priority] is the clinic." ■

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8 Devices and Products GI-Driven ASCs Should Know

Susan Curran, a nurse and manager of the Merrimack Valley Endoscopy Center in Haverhill, Mass., and James Reichheld, MD, a gastroenterologist and director of the Northeast Endoscopy Center in Lowell, Mass., offer their advice on products they say add value to their centers and improve quality and efficiency.

1. Boston Scientific's Radial Jaw Biopsy Forceps. Ms. Curran says the single use (not reusable) stainless steel tipped forceps cost the ASC about \$10 apiece, but saves the cost of cleaning and reprocessing the reusable Merrimack formerly used. Single use accessories also eliminate the risk of cross-contamination.

"Many companies make them and each has its own beneficial features, but we like the design of the Boston Scientific model, which takes a very clean, adequate size bite of tissue and doesn't rip it away," she says. "It's easy to use and works well."

2. Carr-Locke Injection Needles by US Endoscopy. These needles are used in endoscopy procedures for injecting medications during the procedure. They are named after their inventor, Dr. David Carr-Locke, and manufactured by US Endoscopy.

"We inject medications to stop bleeding, we tattoo lesions by injecting ink and we inject mucosa

with saline solution to raise polyps, making them easier to remove," Ms. Curran says.

She points out that some needles don't function well, particularly if there is twisting in the scope. "This one opens and closes regardless of the twisting in the colon," she says. "Some other needles have a plastic sheath and the needle can poke through and damage the scope or injure the patient. The Carr-Locke is radiopaque and can be seen under the fluoroscope. It is one of few needles that work well in a side viewing scope."

She says her ASC pays about \$35 for the needles.

3. Cold snare forceps. Dr. Reichheld says cold snare polypectomy has been recommended over the electrocautery method of polyp removal for smaller polyps, excising polyps under 10 mm in size with a low risk of bleeding and perforation.

"Hot snaring (biopsy polypectomy) can burn or char right through the colon wall and cause pain, localized infection or perforation," he says. "With cold snaring, this never really happens. The cold snaring method gets small polyps more completely, is equally safe with better efficacy. It also costs less and avoids the cost of a cautery pad and use of a cautery wire and machine."

4. Guardus Overtube by US Endoscopy.

This product is used over a gastroscope to protect the airway when removing a foreign body from a stomach, such as a food impaction or a swallowed object.

"We've had cases where people have swallowed coins, and even a toothbrush," says Ms. Curran. "We recently removed a dental drill from the stomach of someone who was having a root canal. But food impactions are more common."

"The overtube is used to keep objects from falling into the trachea when removing them from the stomach or esophagus. We also use overtubes for placing a small bowel camera capsule in patients with swallowing problems. If they are unable to swallow the camera capsule, we can place it in the stomach for them, protecting the airway by using the overtube."

5. High-definition endoscopes. Dr. Reichheld calls these high-end products "a new standard everyone should strive to meet. They likely reduce the time it takes to get into the depths of colon and produce a higher quality exam. The key point is this is something patients are becoming savvy about as the latest big thing in endoscopic technology and will ask for them."

He says Olympus, Pentax and Fuji, best known for their cameras and lenses, but long known for their high-quality scopes, produce the best of these new products.

"It will take a few years to show that these new technologies are having a huge impact, but I

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believe they will be shown to improve quality of care and efficiency.”

He points out that new model scopes by Olympus and Pentax offer specialized imaging through specified wave lengths of light that can highlight features not as visible to the naked eye. Olympus calls it “narrow band imaging.”

“I believe it will improve polyp detection and has been proven to detection of abnormalities within esophageal disorders,” he says.

The new colonoscopies cost \$35,000-\$40,000.

6. MD Technologies Environ-Mate DM6000 Suction-Drain System.

Endoscopy units require continuous suction of bodily fluids during endoscopies. Suction is connected to the endoscope to remove any excess bodily fluids to obtain better visualization. Ms. Curran says unlike the suction systems in hospitals and some endocenters, this system drains directly into a sewage system.

“Most suction systems in hospitals have disposable containers which need to be changed after each procedure,” she says. “Exposure to those fluids in the containers could be hazardous. And these plastic containers when full must be disposed in hazardous waste areas, which can be expensive. But we’re not exposed to any fluids at all with this system. Everything goes into a

canister in the wall, which empties into the sewage system, similar to a toilet plumbing. There’s no risk of exposure to bodily fluids and a huge savings on the cost of disposal and the time and effort to change the containers.”

She says the initial investment of \$35,000 in the system, including a central vacuum system, saves the ASC about \$16,000 annually. “The lack of exposure is the real benefit, though,” she says.

7. Olympus180 Series FlushingScopes.

Ms. Curran says many gastroenterologists used to wash away blood or stool particles by using a syringe to irrigate through the biopsy channel. That tends to be inefficient and increases the chance of exposure to bodily fluids. She says the Olympus flushing system attaches a bottle of sterile water and tubing to the endoscope.

“Anytime the doctor wants to irrigate, washing away blood or stool to get a better visual, he or she can step on the foot pedal to flush and clean the area,” she says. The system costs around \$1,600.

“The doctors love it,” she says. “It definitely allows the physician to do a much more thorough examination and it’s a time saver. The cost of the Olympus flushing system can easily be justified by the benefits of a better exam.”

James Reichheld, MD, agrees. Dr. Reichheld says an automated lavage (wash) machine can

improve procedures.

“It washes the lining of the colon to offer a better view,” he says. “This used to be done manually by staff. But in the last several years he has routinely used this machine, which plugs into the scope and provides a nice firm jet of water. It’s freed a staff member from doing manual washes and you get a better exam in less time. I use it with every colonoscopy.”

8. Polyp traps. Ms. Curran prefers MD Technologies’ polyp trap. This \$1.99 product collects snare-removed polyps that have been suctioned through the endoscope.

“The polyps are very easy to retrieve using this system and almost impossible to lose,” she says. “They’re simple and inexpensive with a great design.”

Dr. Reichheld recommends using a simple baleen trap to retrieve excised polyps, such as the version produced by NM Beale Company, which arrive in trays.

“It’s a small pocket of net in the suction tubing so when the polyp is retrieved, it’s caught in the net,” he says. “So there’s no worry about losing a polyp in the suction system. It’s easy to use and very inexpensive.” ■

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Should You Sell Your ASC: Assessing Your Value and the Pros and Cons

By Kenneth Hancock

Thinking of selling a piece of your ASC? There are certainly a number of advantages to aligning with a corporate partner: professional management, access to capital, greater focus on growth and realizing a return on your investment. If these benefits pique your interest, the first step is to assess the value of your ASC. This article explores the various stages in the life of an ASC, along with the pros and cons of selling equity shares to a management company or corporate partner during these various stages.

ASC lifecycle

The lifecycle of an ASC includes periods of initial growth (start-up phase), sustained growth, slowing growth and a plateau to decline phase. The various stages of growth during the lifecycle generate differing amounts of profitability defined as earnings before interest, taxes, depreciation and amortization (EBITDA). Your ASC's stage of growth will have a major impact on the price a buyer is willing to pay to invest in your center.

Initial growth. The initial growth phase is normally short in duration but critical, as this phase lays the foundation for the business's future growth. The physician-partners' first impressions of operations will determine how aggressively they begin to shift cases to the ASC.

Planning must be thorough during this phase as it determines important aspects about the future of the ASC. Here are critical things to consider when developing your business:

- Accurately assess the surgical cases and case mix
- Recruit strong physician partners
- Don't overbuild the physical plant
- Raise enough working capital
- Determine what, how and when you get paid
- Don't overstaff

EBITDA growth will lag volume growth due to fixed operating costs that must be covered during this time. The initial goal should be to break even as quickly as possible. The ASC should focus on receiving the surgical cases identified in the business plan and efficient operations and cost containment to achieve this goal. During this phase it will take between 6-12 months for the business to become cash flow positive. At 12-24 months, your center should begin to build cash flow.

Sustained growth. During the sustained growth phase, case volume and solid operations yield positive results. Operating performance is deemed effective, and physicians have gained

confidence in the clinical and business staff. Cases continue to shift to the ASC as a result of their confidence.

Fixed costs are now covered and profitability is increasing during this phase. Returns are being realized through distributions and EBITDA margins are expanding with incremental volume increases. Growth is driven by the core partners. This is an ideal time to sell an interest in your ASC to a corporate partner as the business exhibits an upward EBITDA growth trend, which may yield a higher valuation.

Slowing growth. A period of slowing growth is possible at any time during the lifecycle of your ASC, but it is likely to happen as the business captures the bulk of the initial physician partners' surgical cases. Once this volume is captured, it is important to recruit new partners. The recruiting process is fraught with challenges including valuation of share price, partnership dynamics, dilution and personality considerations.

During this phase, some business aspects may be overlooked. For example, payor contracts may be out of date and in need of renegotiation; staffing levels have crept up and so have supply costs. Efforts to control costs may have been neglected. As a result, cash flow levels off and profit margins begin to suffer. Partner distribution versus partner contribution may also become an issue.

Although growth has slowed, this may be a good time to bring a corporate partner aboard — if cash flow is still relatively stable, recruiting prospects are good and out-of-network revenue is low.

Plateau to decline. At this point in the life of your ASC, growth has stalled. Business fundamentals begin to break down. The partnership begins to fracture. Older partners start to retire, and the partnership may be unable to repurchase shares without adequate protections in the operating agreement/governance structure. Ownership no longer reflects contribution, and apathy begins to set in.

Efforts to control costs in this stage may be ineffective because it is difficult to change the established operating cost levels experienced during its growth periods. The center often becomes overstaffed and capital expenditures increase. Unfortunately, the opportunity to capture the best value of the center has likely been missed. Your center may now be recognized as a turnaround opportunity for corporate partners or management companies.

Factors affecting valuation

So, what are the factors that most significantly affect the value of your ASC to an outside investor like a corporate partner or management company?

First, EBITDA represents the cash flow that a business generates and is an important factor when figuring out the price of your ASC. The main concern of a potential buyer is the stability of that cash flow. The value of an ASC with a positive EBITDA can be determined using a formula. The time period used to determine the EBITDA is typically the trailing 12 months of financial data. The formula takes into account the EBITDA for the trailing 12 months times a multiple (current range is 5-7 times for a majority interest purchase) less partnership debt plus some level of working capital times the percentage a buyer is purchasing.

An example of the formula and resulting purchase price: \$2.0 million in EBITDA (trailing 12 months) times a 5 multiple equals \$10 million enterprise value minus debt of \$500,000 plus \$100,000 cash/working capital equals a \$9.6 million dollar equity value times a purchase of 55 percent equals a purchase price of \$5.28 million dollars.

The 2009 ASC Valuation Survey, conducted by HealthCare Appraisers, representing 18 buyers and 500 surgery centers, showed that 50 percent of buyers who purchased a controlling interest in an ASC reported multiples of 6.0-6.9 times EBITDA. An additional 38 percent reported multiples of 7.0 or higher. Forty-five percent of respondents perceived that valuation multiples stayed consistent with 2008, while 38 percent perceived that multiples decreased.

4 main pricing criteria

A buyer must be critical of the stability of the center's cash flow, the growth prospects of the center and its underlying operations. Valuation multiples are determined by the outlook for future performance and, therefore, are extremely sensitive to growth prospects and risk factors. There are four main pricing criteria that have either a negative or positive impact on price.

1. Competition/barriers to entry. The multiple will decrease if there are few barriers to entry for other ASCs in the area, if there are several competing partnerships within your center or if physicians have ownership in multiple facilities. If it's unlikely that you'll experience success recruiting new partners or users, the growth prospects are diminished, driving a discount in valuation of the business.

The multiple will increase if there are significant barriers to entry for other ASCs (such as requiring a certificate of need), if there are few competing partnerships or if physicians do not have investment interests outside of your ASC. These factors create multiple recruiting/growth opportunities for the partnership and receive credit in valuation.

2. Reimbursement risk. The multiple will decrease if your center has high out-of-network revenue, if it has a specialty concentration facing significant Medicare changes or if there is other exposure (such as workers' compensation reform). Out-of-network payments can boost net collections, but centers with high levels of out-of-network payments are generating a level of cash that's not sustainable in the future. The historical trends of the business are important, but what you are really buying into is the future cash flow. If you expect that to decline, you're going to discount its value.

The multiple will increase if your center has contracted with major payors, if your center's specialty is in a "positive" Medicare concentration (such as ENT or orthopedics) or if there are no other exposures.

3. Partnership profile. The multiple will decrease if a significant number of your physician partners are nearing retirement and your center has no contingency plan to replace them. Another factor is partner concentration. Having too few partners sharing sale proceeds may create incentive for them to slow down or eliminate their surgical case production. Also, having a dominant partner creates risk that there is too much reliance on a single individual.

4. Growth prospects. The multiple will decrease if there is limited growth opportunity from existing partners, if there are few recruiting prospects or if there are capacity concerns.

The multiple will increase if your center consists of partners with growing practices, if there are excellent recruiting prospects, capacity to grow and a diverse case mix.

Buyers consider two types of growth when making these determinations — organic and external. Organic growth depends upon the maturity of the individual partner's practices. Each partner is interviewed individually to determine their objectives and ability to bring additional surgical cases to the ASC. External growth is analyzed based on the probability of recruiting new physicians to the partnership.

Determining when to sell your ASC

So, when should you sell your ASC? The answer is simple: sell when an outside investor can add the most value to your partnership.

This can occur at different stages for different partnerships, and buyers exist at all stages. It is important to assess the current and future needs of the partnership and to create realistic valuation expectations. It is difficult to anticipate a future decline in business, so it is necessary to determine where the partnership is and where it is headed. Always remember that valuation is not solely determined by past results but by the expectations of future performances.

Once an assessment is made, finding a corporate partner that can best meet your needs is critical. You should research companies to understand their track record in the industry, as well as get references to determine if they will be a good fit for your partnership. There should be chemistry between you and the potential corporate partner to ensure your goals are met. Price is likely the number one consideration when picking a corporate partner, but you should consider that it may be better to accept a slightly lower offer from a company that can create future value than a higher bid from one that cannot.

Valuations should fall in range, and you should be careful of wide variations in price. If it comes down to two possible partners and the money is equal

or close, pick the best partner for your ASC. Remember not to burn bridges with those corporate partners you choose not to pick — you may not close the transaction the first time you are engaged in this process.

Consider that incremental value can be generated from a corporate partner focused upon growing and extending the life cycle of your business. The future value perspective of the buyer is focused upon maximizing existing partner volume, recruiting new partners in order to extend the growth of your business, renegotiating payor contracts and expense management in order to expand EBITDA margins.

In the end, choose the right corporate partner based upon what the needs of your business are and the benefits that the partner can offer to you.

Finally, it is wise to retain a single lawyer to represent the partnership, ideally a healthcare lawyer who understands how to structure these transactions and will ensure that the process goes smoothly. ■

Mr. Hancock (khancock@meridiansurg.com) is the president and chief development officer of Meridian Surgical Partners, a company that aligns with physicians in the acquisition, development and management of multi-specialty ambulatory surgery centers and surgical facilities. Learn more about Meridian at www.meridiansurg.com.

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Establishing an Ambulatory Surgery Center — A Primer From A to Z (Part 1)

By Scott Becker, JD, CPA, Bart Walker, JD, and Renée Tomcanin

This article summarizes several issues that are critical to establishing an ASC. The article focuses on business and planning issues and does not focus on legal and regulatory issues for ASCs. In addition, industry experts offer their advice on some of these areas.

Financial planning issues

1. Financial feasibility; a comprehensive feasibility study. A group of physicians (or physicians and management company or hospital) must first examine their outpatient case numbers to determine whether an ASC will be financially feasible. The formula for this is easy: ASC revenue is equal to the number of procedures the group can perform multiplied by the expected reimbursement for the type of procedures expected to be performed. As a general rule, in a reasonable reimbursement market, a center focusing on higher reimbursement procedures can be profitable with as little as 2,000 procedures per year. With lower reimbursement cases, this number can jump to 3,000-3,500 procedures. Further, in low reimbursement markets, it can be very hard to be profitable in some specialties at almost any case level. Financial prudence dictates that one should only begin a project with a case level that is substantially higher than the threshold or break-even amount.

A pro forma analysis and feasibility study can help you determine if establishing an ASC is possible. You should rely on sound physician data regarding projected case volumes, case mix, scheduling preferences and expected reimbursement rates.

The case volume and reimbursement rate data that are collected are the key assumptions upon which the revenue part of pro formas are built. The greater the accuracy and certainty of these two types of information, the greater the accuracy and reliability of the final pro forma projections. In one center we helped to develop, the viability of the project itself was threatened when one or two of the key assumptions changed, resulting in the prospective loss of several hundred cases per year.

In addition, the physician partners involved in the project should be fully committed from the outset. There are few things that will negatively impact the financial outlook for a new center as much as the departure of a core physician during the later stages of development. Although a project can recover from a minor setback or challenge during the early planning stages, it is more dif-

ficult to correct more severe problems that occur later in development.

Here is a sample summary pro forma from the VMG Health 2008 *Intellimarker*:

\$'s in Thousands	Mean
Patient Revenues	
Gross Charges (procedures multiplied by revenues per procedure)	\$21,764
Adjustments	(14,926)
Net Revenue	6,940
Operating Expenses	
Employee Salary & Wages	1,541
Employee Taxes & Benefits	337
Occupancy Costs	421
Medical & Surgical Supplies	1,360
Other Medical Costs	224
Insurance	77
Depreciation & Amortization	315
General & Administrative Bad Debt	145
Management Fees	309
Other G&A	609
Total G&A	934
Total Operating Expenses	5,027
Operating Income	1,915
Other Expenses (Income)	127
Net Interest Expense	104
Earning Before Taxes	1,474
EBITDA	\$1,862

Case-counting is an essential part of the development process. "Regardless of which specialties you develop the center around, it's critical to understand the surgical case volume represented by each," says Catherine Kowalski, executive vice president and chief operating officer of Meridian Surgical Partners. "Determine the universe of surgical case by physician and always calculate the net case transfer to the ASC, factoring in issues that discount volume including insurance contracts, regulatory, politics, convenience, scheduling, surgeon behavior, etc. A good rule of thumb is about 50 percent of the surgical case universe for a conservative analysis."

Attendance at planning meetings is another crucial part of the development process. "If after two meetings to investigate and develop a project your key physician members' attendance of remains strong, then it is time to get excited," says William Southwick, CEO of HealthMark Partners. "Every surgeon likes the concept of developing a center;

it is the core group that remains after two initial meetings that tells you whether the excitement is real or not."

2. Reimbursement by market differs significantly; out-of-network concerns.

Throughout the country, centers have had difficulty contracting with certain insurance companies. Therefore, in assessing case volumes, it is important discount the number of cases, to a certain extent, in order to reflect the fact that certain insurance plans may not contract with the ASC. Moreover, certain insurance plans and geographic regions reimburse at levels below national standards. Therefore, the center may not be able to provide services to these patients covered by such plans or in such regions. A mediocre ASC located in an area with strong third-party reimbursement may do better than a great ASC in a bad reimbursement market. There is almost no way to fix a center that is built in a market with poor reimbursement from third-party payors.

In the planning stage, the center should attempt to discuss contracting with payors and obtain a real sense of whether contracts will be available and at what price. Payors have increasing power in many markets and are becoming harder to work with on an out-of-network basis. Payors and state regulatory agencies are increasingly scrutinizing out-of-network reimbursement strategies. In recent months, more insurers are attempting to recoup amounts they have paid on an out-of-network basis. Similarly, state agencies have been more aggressively policing this area. In one recent case in New York, state auditors alleged that several surgery centers improperly waived patients' out-of-pocket payments in connection with the care they received at the centers. In all, the state alleged that about \$8 million was overpaid by the state employee insurance plan, the Empire Plan, and United HealthCare, the state's insurance administrator.

I. Naya Kehayes, MPH, managing principal for Eveia Health Consulting and Management, warns that insurance companies are taking more aggressive approaches to target out-of-network ASCs and encourage in-network participation.

"They are actively pursuing surgeons who practice in non-contracted ASCs and are sending notices to surgeons who use non-contracted ASCs that indicate they are in violation of their professional contracts by directing patients to a non-participating facility," she says. "Some payors are demanding from surgeons copies of the ASCs'

out-of-network billing practices, policies and procedures. They are threatening to terminate their professional contracts as a result of taking patients to an out-of-network facility.”

In its 2008 annual report on ASCs (dated Feb. 4, 2008), the Deutch Bank reports that for ASCs, “out-of-network situations typically result in greater overall costs to the system because both the patient and the third-party payor have higher outlays.” The report also notes that, in the long-term, “any ASC that builds its business model around unsustainable out-of-network reimbursement levels is bound to fail.”

One of the benefits of a hospital partner is that it is able to jointly negotiate reimbursement rates or to include the center in on the hospital's own payor agreements. However, this is often legally restricted as it is subject to certain antitrust rules and regulations that require the hospital to have a sufficient amount of control over the venture on whose behalf it is negotiating. In many situations, the hospital will be unable to force the payors to negotiate on a joint basis. To further complicate matters, some hospitals fear that by seeking to negotiate the ASC's rates with a particular payor, they will be exposing themselves to renegotiation of their current hospital outpatient department rates.

As out-of-network practices continue to raise concerns, and there is increasing pressure due to the economic environment for providers to be contracted with payors in order to reduce out-of-pocket responsibility to the patient, Ms. Kehayes advises ASCs to develop an in-network strategy.

“A new ASC should evaluate the contracts that their physician-users have in place at their practices and determine the most critical payors,” she says. “It is important that the ASC align its contracts with the surgeons that will be using the center. Products offered by the insurance company should also be evaluated. Often, payors sell HMO as well as PPO products or they have

products that are very restrictive with respect to out-of-network benefits. Therefore, if there are product limitations to out-of-network access, these payors are typically more important to get in place soon after an ASC opens.”

Ms. Kehayes suggests that ASCs start making inquiries to payors at least six months prior to the opening of an ASC in order to evaluate access to contracts and to speed up the negotiation process. “The initial contracts an ASC secures with a payor are the baseline for the future of all contracts as well as the relationship with the payor,” she says. “The initial contracts present the most opportunity for negotiation especially if the surgeons working at the ASC are moving volume from a more costly environment, the hospital, and to the ASC setting.”

She also warns ASCs against signing contracts just to boost volume as it actually reduces the power of the ASC to renegotiate its contract. Once the ASC signs an initial contract to attain access to volume, and surgery is performed at a contract rate that is below the cost of providing the surgical service, it demonstrates to the payor that the ASC can afford to perform the case for that rate. In reality, the ASC is often subsidizing the insurance company by paying to perform surgery on their members because the contract rates are below cost. The payor is unlikely to make significant changes to rates after the initial contract has been signed and there is a contractual term in place, which can range from 1-3 years.

Some ASCs may find it more advantageous to provide services as an out-of-network provider, when out-of-network benefits are available, for a period of time when the center first opens and while the center is in active negotiations with a payor, according to Ms. Kehayes.

“This helps to demonstrate the cost-savings opportunity to the payor and its members of contracting with the ASC,” she says. “The payor will have

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claims data showing their opportunity to reduce cost by moving the ASC in-network. In addition, if a center does not provide any services to a particular payor out-of-network while in the contract negotiation process, it is often devalued and it lowers the ASC's importance on the payor's contracting priority list. This can prolong the already lengthy contracting process."

Hiring a third-party contracting consultant is another alternative to consider. A consultant can provide insight and advice with respect to the planning stages of reimbursement contracts. In addition, these consultants ultimately can be used to negotiate the contracts on behalf of the center. Some management company partners employ their own in-house contract negotiators whereas others outsource this function.

3. Capital requirements. The typical development of a standalone ASC with tenant improvements costs approximately \$220-\$250 or more per square foot to become operational. Additionally, money is needed for equipment. Of the total budget amount, a substantial portion can be provided through debt financing without guarantees; however, a certain portion of the debt may require personal guarantees (such as tenant improvements, working capital, etc.). Moreover, a substantial cash capital contribution is usually

required in an ASC venture. Typically, anywhere from \$500,000-\$1.5 million is required as an equity cash contribution in total by the owners.

An ASC will typically initially issue 100 ownership units to members based on the amount of capital that each member contributes. For example, if each unit costs \$10,000 and a member owns 15 units, he or she contributes \$150,000. The amount of capital required depends on the size of the project, the amount of debt to be secured and whether the ASC will be a "tenant" or own and develop the real estate. The equity plus the debt borrowed from lenders equals the total amount of money needed to develop the project. If a single-specialty ASC, such as an endoscopy ASC, leases the space in which it operates, total initial equity capital contributions are often around \$400,000-\$800,000; however, the members may be able to contribute less money upfront if a more substantial working capital line of credit is obtained. For a multi-specialty ASC that leases space rather than owns the building, initial equity capital contributions are often between \$700,000-\$1.2 million. One option, even when all of the investors want to invest in both the surgery center and the real estate, is to hold the ownership of the real estate and the ownership of the surgery center in separate entities. This allows for additional investors to own a portion of the real estate holding com-

pany, thus making it less expensive for the investors in the surgery center entity. By separating the real estate from the surgery center entity, investors can choose where they would like to invest: in the real estate, the surgery center or both. However, there are significant benefits to fully congruent ownership.

The operating agreement sets forth the dates on which the capital must be contributed. Typically, all or a significant portion is due at signing. In some situations, part of the capital is due at a later date, such as upon receipt of a certificate of need or at six months after the initial signing. Additional capital contributions may be required upon the vote of the board of managers and often a vote of the holders of a certain percentage of the units. The group will need to assess the total equity to be contributed.

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 better handled by an experienced lender than by a friend. For the best result, look for a lender with specific ASC financing experience.

The current state of the economy is something that should be considered heavily when deter-



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mining financing for your new ASC. Robert Westergard, CPA, CFO of Ambulatory Surgical Centers of America, says that banks are currently looking to see as much as 30-40 percent of the total cost contributed by partners, compared with the 20 percent or lower seen previously.

"In the past, we used our cash only for working capital," he says. "Some back are asking that we now use some of it in lieu of bank financing for some capital expenditures."

Mr. Westergard also notes that the banking environment has changed dramatically over the last year. "In the past, banks seemed to be looking for reasons to lend money," he says. "Now, they're often looking for reasons *not* to lend money." This changed environment also has affected the amount of time it takes to obtain a loan. "We've doubled the amount of time we tell our partners to expect obtaining a loan to take. Some banks suggest this may still be a somewhat optimistic view," he says.

4. Expense management. Surgery centers tend to have a level of fixed costs that generally require at least \$3-\$5 million in revenue to be significantly profitable and to cover the necessary expenses. Centers with \$5-\$10 million in annual revenues can, on average, expect to have an EBITDA of around 20 percent or earn about

a 20 percent operating margin before deducting interest, taxes and depreciation. The three biggest costs for an ASC typically include staffing costs (about 25 percent of revenue), supply costs (about 20 percent of revenue) and general and administrative costs (about 14 percent of revenue). With staffing costs making up most of ASC's expenses, it is critical to benchmark the hours per case to those at other similar centers in order to ensure that your staff is working efficiently. Generally, multi-specialty cases take between 13-15 hours and single-specialty cases take 6-8 hours. This number is often translated in simple terms to approximately five full-time equivalents per 1,000 patients. To control staffing costs, staff must be used efficiently by cross-training where appropriate, by staying open only as many hours as cases require and, if possible, by sending staff home when they are not needed.

Supply costs may be reduced by the use of a group purchasing organization or a hospital or management company partner that is able to aggregate expenses over a number of facilities and, as a result, benefit from volume pricing with vendors. Another common way to reduce supply costs is to standardize certain common surgical supplies and reduce the use of nonessential supplies. A seasoned management company can help a surgery center to achieve greater operational efficiency in

both of these areas. Although staffing and supply costs can be modified over time, facility costs are much more difficult to change once a lease has been signed or construction has begun. It is very important to obtain expert advice relative to these three cost items early and often.

Equity ownership, physician partner issues and hospitals and management companies as partners

1. Management and equity ownership. It is important to determine whether or not your ASC will have a management company as an equity partner. An experienced manager can help with myriad aspects of the project, such as financing, financial planning and analysis, Medicare certification, equipment planning, construction planning and physician recruitment. A good management company can significantly reduce the likelihood of problems in completing the project, operating the center, financing the project.

Working with an experienced partner can help add focus to the project and help in areas such as efficiency and cost management. "Management teams allow physicians to focus on their core business, patient care and surgery," says Larry Taylor, president and CEO of Practice Partners in Healthcare. "Since management companies



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take a lead role in the process, having their success linked directly to the success of the facility often leads to a minority ownership. By having the management company tied to the success of the center, incentives are aligned with the partnerships. Experienced firms sequence processes and the ramping of employees to reduce cost.”

Mr. Taylor says that the management team should produce results that are valuable to the partnership in both the financial and clinical areas.

“If a management company is an owner in an ASC, the financial performance of the ASC has a more significant impact on the management company than the size of their fee,” says Christian Ellison, vice president of Health Inventures. “Requiring a management company to put their capital at risk alongside the other investors appropriately aligns incentives among all of the stakeholders that drive value in the ASC business.”

The key downside to having a management company as a long-term equity partner relates to the disparate quality of companies that provide services to ASCs and the profits that are shared in bringing in a management company. Physician ownership alone can be very attractive under the right circumstances. However, an experienced management team substantially lowers the risks and, in most situations, can provide substantial benefits and improve profitability. Further, an equity owner/advisor often will have a much greater level of concern regarding the project’s success, even when it owns only 15-30 percent of the center.

The 2008 ASC Report from the Deutsch Bank says that the 25 largest management companies own interests in aggregate in about 1,000 of the country’s 4,700 Medicare-certified ASCs.

Critical items to negotiate with the management company include the percent of ownership, management fee, services provided, personnel employed or provided, length of the management contract, board rights and reserve or veto rights of the management company. A group should interview 3-5 management companies and talk extensively to other centers managed by the company.

In addition to a management fee, the leading management companies are increasingly requiring equity in the surgery center. Before rejecting such an arrangement, evaluate how that management company compares with other management companies. Mr. Ellison says that hospitals and physicians are increasingly requiring that management companies make an equity investment in the ASC to ensure that there is increased focus on the value creation that the risk creates.

A solid management company partner can also substantially improve the financing prospects of a

center. Some finance companies will not finance an entity without an experienced management company being involved.

2. An ASC can have too many physician investors. Determining the right number of physician investors requires significant forethought and planning. With too many physician investors, there is often a dilution of individual physician responsibility and ownership interests. However, with too little ownership, physician investors often lose their commitment to the ASC and look for alternatives. Further, a great deal of resentment can develop between productive and less productive parties. Of course, with too few physician investors, the price of buying-in will be greater, there will be more risk of case volume losses with a smaller number of investors and the overall case volume of the center can suffer. The average number of physician owners in an ASC is approximately 15.1, according to the Deutsche Bank 2008 ASC report.

3. Single- or multi-specialty center. Single-specialty centers can be more efficiently staffed and built than multi-specialty centers. Moreover, a single-specialty center avoids competition relating to sharing space, profits and revenues with other specialties that is often present in multi-specialty centers.

However, changes in reimbursement can affect single-specialty centers more dramatically than multi-specialty centers. For example, Medicare has instituted significant cuts in ASC reimbursement for gastroenterology, pain management and, to an extent, ophthalmologic procedures. These cuts can disproportionately impact a single-specialty GI or pain management ASC’s overall revenue and financial health.

On the other hand, a multi-specialty center can help reduce reimbursement reduction risk through a diversification of reimbursement sources and a mix of physicians. In addition, a multi-specialty center can provide for greater staff and physical plant economics of scale, which may be needed if single-specialty volumes are insufficient. In many cases, the operating margins in single-specialty ASCs are much higher than multi-specialty ASCs.

Barry Tanner, president and CEO of Physicians Endoscopy, says there are several things to think about when considering a single-specialty center as compared with a multi-specialty center.

“With single-specialty ASCs, no one specialty is subsidizing the costs associated with performing another specialty,” he says. “In other words if GI physicians working in a multi-specialty ASC are highly efficient and productive in terms of patient volume, they may perceive, rightly so, that they are subsidizing the higher costs (such as inventory, equipment, etc.) associated with performing orthopedic procedures.”

Mr. Tanner also says that there are the advantages to a single-specialty ASC. “We like to believe that because we do one thing, we do it very well,” he says. “When a patient goes to a single-specialty ASC, we know who you are and why you are there. This can improve both the patient experience as well as the overall quality of care.”

Mike Lipomi, president of RMC Medstone, says there are several important factors to consider between operating a single- versus multi-specialty ASC. “As a single-specialty facility, your ability to syndicate to additional physicians will be restricted to the practicing physicians in that specialty,” he says. “You will limit your ability to spread the overhead costs between specialties and to fully utilize the resources available in your facility.”

Mr. Lipomi also notes the areas of crossover in surgery centers, regardless of whether they are single- or multi-specialty. “Areas of the business office like reception, billing, collections and management can perform the same or similar functions for one specialty as well as multiple specialties,” he says. “The issue of rate fluctuations in a single-specialty center is a major concern. In a multi-specialty center, reducing reimbursement for one specialty is absorbed by other specialty reimbursement. This is better for the center as a whole and at the same time hurts those physicians who are getting better reimbursement.”

Specialty net revenues per case, according to the VMG Health 2008 *Intellimarker*, for several specialties are as follows:

Specialty	Net Revenue
ENT	\$1,855
GI/Endoscopy	\$859
General Surgery	\$1,696
OB/GYN	\$1,907
Ophthalmology	\$1,409
Oral Surgery	\$1,438
Orthopedics	\$2,426
Pain Management	\$1,127
Plastic Surgery	\$1,653
Podiatry	\$1,884
Urology	\$1,649

The number can be heavily influenced by sample size and several factors such as out-of-network considerations. ■

Note: Look for part two of “Establishing an Ambulatory Surgery Center — A Primer From A to Z” in the May/June issue of *Becker’s ASC Review* and online at www.BeckersASC.com.

Contact Scott Becker at sbecker@mcquirewoods.com; contact Bart Walker at bwalker@mcquirewoods.com; contact Renée Tomcanin at renee@beckersasc.com.

Industry Leaders Discuss Top Trends in ASC Startups

By **Renée Tomcanin**

We surveyed several ASC management and development companies to get their observations and opinions on the current trends and developments in de novo (startup) ASCs

Q: Over the past year, would you say that you are seeing many new, startup ASCs or have there been more turnarounds or improvements with struggling ASCs?

Of the companies surveyed, most say that turnarounds are more prevalent, although de novo projects are still happening but on a much more limited frequency.

Thomas Michaud, chairman and CEO of Foundation Surgery Affiliates, says, "We have seen less and less 'quality' (projects that should happen) de novo projects each year over the past 2-3 years and expect this trend to continue. There are a larger number of distressed properties needing re-syndication and new management."

Barry Tanner, president and CEO of Physicians Endoscopy, says the economy has caused ASC startups to slow down. "Since last summer and even more so since the fall of last year, the economic climate has had a huge negative impact upon physicians' willingness to invest and banks' willingness to extend credit to new unproven ventures," he says. "We do see more consolidation in the ASC market; however, there is a disconnect between the physicians' perception of ASC values and the market. When leverage was available at 3.5-4.0 times, cash flow purchase multiples were higher. Today, with leverage multiples between 1-2 times lower than a year ago, multiples should have also retracted. Physician perception of purchase multiples have not contracted for the most part."

Tom Mallon, CEO of Regent Surgical Health, says that Regent has seen about an even split between turnarounds and de novos for their current projects. Going forward, he says, the company's prospects are leaning more toward turnarounds.

Larry Taylor, president and CEO of Practice Partners, says, "We continue to see startup opportunities as well as an up-tick in turnaround situations. De novo situations continue to have strong inquiries and interest from surgeons."

Jeff Leland, managing partner of Blue Chip Partners, says, "We see a combination of de novo and underutilized ASCs — the number of de novo projects seem to be fewer in number than in the past."

However, some companies have not seen startup projects in quite some time. Richard Pence, president and chief operating officer of National Surgical Care, says that his company has not been involved in a de novo project since 2007.

Q: Of the start ups you have seen, what kinds of management have you seen (such as, joint-venture, physician-owned, hospital-owned, etc.)?

Most of the companies surveyed say that their projects have tended to be joint ventures, either between a management company and a group of physicians or a hospital. However, some companies see a variety of projects, including physician- and hospital-owned.

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Bill Southwick, president and CEO of HealthMark Partners, says, "We have seen slightly more physician and management company opportunities, but physician, hospital and management company transactions are a close second."


Luke Lambert, CEO of the Ambulatory Surgical Centers of America, says that most of ASCOA's projects have been joint ventures between physicians and a management company. Dan Connolly, vice president of development and payor contracting for Pinnacle III, agrees that his company has seen mostly physician-owned and joint-venture projects.

Q: Of the ASC startups, have they been mostly single- or multi-specialty? What kinds of specialties are most common to new ASCs?

Among the companies surveyed, there is no clear trend between single- and multi-specialty ASCs. Some management and development companies focus solely on single-specialty ASCs, whereas others have seen a wide variety of multi-specialty centers opening in recent years. Still others say that their companies have seen an even amount of single- and multi-specialty centers opening up.


Kenneth Hancock, president and chief development officer of Meridian Surgical Partners, says, "We've seen a few single-specialty centers (mostly orthopedics), but most have been multi-specialty with the usual specialties including orthopedics, pain, ENT, ophthalmology, GI and general surgery." ■

Contact Renée Tomcanin at renee@beckersasc.com.



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Resources

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Physician Hospitals of America. PHA 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 www.physicianhospitals.org or contact Molly Sandvig, JD, executive director at (605) 275-5349 or e-mail info@physicianhospitals.org.

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The Accreditation Association for Ambulatory Health Care. AAAHC, founded in 1979, has become a leader in ambulatory health care accreditation with more than 4,000 organizations accredited nationwide. For more information, visit www.aaahc.org or call (847) 853-6060.

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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. Learn 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 Tech-nologies 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 www.scheduleurgery.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.

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Atlantis Worldwide. Atlantis Worldwide is a full-service provider of pre-owned and refurbished diagnostic imaging systems — MRI, CT scanner, C-Arm,

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.

Ambulatory Surgical Group. The Ambulatory Surgical Group team has been involved in the syndication, development and management of some of the most successful centers in the country. Learn more about ASG at www.ambulatorysurgicalgroup.com or call (973) 729-3276 (East Coast) or (310) 531-8231 (West Coast).

Blue Chip Surgical Center Partners. Blue Chip 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 country and a number of projects in the works. For more information, visit Blue Chip online at www.bluechipsurgical.com or call (513) 561-8900.

Cirrus Health. Cirrus Health is a health services organization, specializing in the development and acquisition of ASCs, short-stay and community hospitals, serving local communities by partnering with physicians and other healthcare providers to deliver excellence in patient care in effective, caring environments. For more information, visit www.cirrushealth.com or call (214) 217-0100.

Congero Development. Congero provides management and development services to surgical centers and other types of healthcare facilities; Congero is a minority owner in its centers and helps with the syndication and all aspects of the operating company. Visit Congero at www.congerodev.com or call (949) 429-5107.

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 States. To learn more, visit the Web site www.facdevmgt.com or call (845) 770-1883.

Foundation Surgery Affiliates. FSA 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.foundationurgery.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 Spitzer at kspitzer@healthmarkpartners.com or call him at (615) 341-0701 to learn more.

Health Ventures. Health Ventures provides strategic and business planning, joint venture formation, facility development and operations management for ASCs; since 1995, it has provided support to hospitals and health systems throughout the United States and currently manages nearly 40 ASCs. Learn more at www.healthventures.com or call (720) 304-8940.

Medical Consulting Group. MCG is a national firm specializing in medical consulting, both at the surgical practice and corporate levels; MCG provides ASC development and management solutions for single, multi-specialty and hospital joint-venture facilities. Learn more at www.medcgroup.com or call (417) 889-2040.

Medical Facilities Corp. MFC 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@meridian-surg.com or call him at (615) 301-8142 for more information.



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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 McLane, chief development officer, at daqunay@aol.com or call (720) 320-6577.

NovaMed. NovaMed acquires, develops and operates ASCs in partnership with physicians. For more information, visit Novamed.com 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.orionmedicalsolutions.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.

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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@phps.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.

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Surgical Care Affiliates. Surgical Care Affiliates is one of the nation's largest providers of specialty surgical services; through its affiliation with 18 health systems and more than 2,000 physician partners, it operates 128 surgical facilities across the country. Learn more about Surgical Care Affiliates at www.scasurgery.com or call (800) 768-0094.

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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.

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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.

Texas Health Resources. 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 Texas Health Resources, 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.

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Implantable Provider Group. IPG 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.

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ImageFIRST Healthcare Laundry Specialists. ImageFIRST is a leading provider of laundry services for medical practices throughout the continental United States and Puerto Rico, with products including patient apparel, scrubs, lab coats, surgical gowns, bed and bath, and more. For more information, contact Michelle Loiederman, marketing coordinator, at (800) 932-7472 or visit ImageFIRST at www.imagefirstmedical.com.

Medtegrity. The Medtegrity Medical Laundry Network is a \$500 million commercial laundry network comprised of one 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.

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Caris Diagnostics. Caris Diagnostics (Caris Dx) offers pathology-related services providing diag-

nostic services for GI, dermatopathology and oncologic pathology. For more information and to get the contact number for your region, visit www.carisdix.com or call (800) 979-8292.

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.

Med-Care Solutions. Med-Care Solutions offers accounts receivable purchasing of lien-based accounts primarily for patients involved in vehicle accidents, working primarily with ASCs, hospitals, and diagnostic centers. For more information, visit www.medcaresolutions.us/index.htm, e-mail kabdo@medcaresolutions.us or call (702) 870-4013.

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. 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.

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PharmASC-e Consultants. PharmASC-e is a pharmaceutical waste management consulting company that works with facilities on regulatory compliance, cost control and staff satisfaction to ensure organizations are proper stewards of the environment. Learn more at www.pharmasc-e.com.



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ASC Quality Collaboration. The ASC Quality Collaboration a cooperative group of organizations and companies, interested in ensuring that ASC quality data is measured and reported in a meaningful way has taken an active role in developing quality measures for ASCs. For more information, visit www.ascquality.org or call Donna Slosburg, executive director, at (727) 867-0072.

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 www.sanderstrust.com, e-mail Bruce Bright at bbright@sanderstrust.com or call him at (205) 298-0809.

Recruitment and search firms

B.E. Smith. B. E. Smith is a leading healthcare executive search and consulting firm, supporting ASCs across the nation. To learn more, call (877) 802-4593 or visit www.besmith.com.

Kaye/Bassman International. Greg Zoch, a partner and managing director with Kaye/Bassman International, a 26-year-old executive search firm, specializes heavily in the ASC world and has served many of the industry's largest players by finding top talent at the facility and corporate level. 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 AmbulatorySurgeryCenterCareers.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.

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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.

Advanced Medical Optics. Advanced Medical Optics (AMO) is focused on providing the full range of advanced refractive technologies and support to help eye care professionals deliver optimal vision and lifestyle experiences to patients of all ages. For more information, visit www.amo-inc.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.

AliMed. Since its inception in the early 1970s, AliMed has grown to become a leading designer, manufacturer and distributor of patient care, rehabilitation, OR/critical care and diagnostic imaging, orthopedic and ergonomic products, now distributing more than 70,000 products to healthcare facilities, veterinarians and businesses worldwide. To learn more, visit www.alimed.com or call (800) 225-2610.

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.

ARC Medical. ARC Medical, founded in 1990 by Hal Norris, provides ASCs and anesthesia, ICU, long term acute care and emergency areas of hospitals with products such as its ThermoFlo System, a hygroscopic condensing humidifier. Learn more at www.arcmedical.com or call (800) 950-2721.

Aspen Medical Products. Aspen Medical Products is a leader in the design, development and marketing of upper and lower spinal immobilization products. Learn more at www.aspenmp.com or call (800) 295-2776.

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.

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Cybertech Medical. Cybertech is the brand name of orthotic products offered by Bio Cybernetics International; its patented Mechanical Advantage products are the result of advanced technology that creates biomechanical support, patient comfort, and compliance. Learn more about Cybertech Medical at www.cybertechmedical.com or call (800) 220-4224.

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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 www.integra-ls.com, e-mailing David W. Swanson, vice president of ASCs, at david.swanson@integra-ls.com or calling (800) 654-2873.

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PENTAX Medical Company. PENTAX, an industry leader offering detection and efficiency solutions for video and fiber endoscopy equipment and computer technology/imaging products for diagnostic, therapeutic and research applications in the GI, ENT and pulmonary fields, offers a full range of endoscopes, accessories, carts, computer hardware and software platforms, video equipment and computer software for image and data management. Learn more at www.pentaxmedical.com or call (800) 431-5880.

Progressive Dynamics Medical. Progressive Dynamics Medical manufactures six different types of warming covers to meet various requirements for the operating and recovery rooms. Learn more at www.progressivedynamicsmedical.com or call (269) 781-4241.

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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. ■



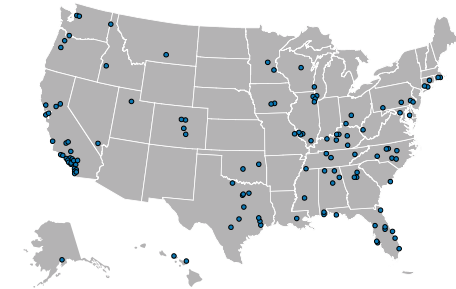
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