Inside: Orthopedic, Spine and Pain Management-Driven ASC Conference Brochure (p. 21)

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

21 Ways to Make and Save Money in Surgery Centers

By Leigh Page

1. Closely follow your market. Keep your ear to the ground. Know when competitors are attempting to get exclusive contracts with payors, says William G. Southwick, president and CEO of HealthMark Partners in Nashville. And know what physicians might be doing in terms of merger, sale or other practice transitions, he adds.

2. Use certified coders. A certified coder can help you capture the full reimbursement due your facility, says Sandy Berreth, administrator of Brainerd Lakes Surgery Center, a three-OR multispecialty center in Baxter, Minn., that logs 4,100 cases a year. The extra charges captured will be well worth the investment, she says. Her ASC employs a certified coder in addition to a biller/coder and a scheduler who does data-entry only.

continued on page 6

Top 8 Surgery Center Stories of 2009

By Lindsey Dunn

1. Medicare reimbursement. During 2009, the ASC Association and ASC industry advocates lobbied for Medicare payment rates that would protect the financial viability of ASCs that care for Medicare beneficiaries. While these efforts have achieved some success, Medicare payment rates continue to favor HOPDs.

The CMS Final Rule for 2010, which was released in Nov. 2009, includes a 1.2 percent inflation update for ASCs beginning Jan. 1, 2010. This is an improvement over 2009, as there was no inflation update in 2009 for ASCs. However, HOPD rates received a 2.1 percent inflation update for 2010. Inflation updates for ASCs remain based on the estimated change in the consumer price index for all urban consumers while HOPD updates are based on the hospital market basket, a measure of inflation that tracks the change in healthcare costs, despite attempts by the ASC Association and the ASC Advocacy Committee for the hospital market basket updates to also be applied to ASC rates.

continued on page 8

23 Things to Know About Anesthesia and Anesthesia in ASCs

By Lindsey Dunn

1. There are just over 32,900 anesthesiologists practicing in the United States. Anesthesiologists represent 5.2 percent of the 633,000 practicing physicians in the country, according to the *Bureau of Labor Statistics' Occupational Outlook Handbook, 2008-09*.

2. Many anesthesiologists are salaried employees of a healthcare facility or anesthesiology practice. Forty-four percent of anesthesiologists were salaried employees in 2009, while 32 percent were either owners or partners in some type of healthcare practice. Nineteen percent serve as locum tenens or contractors, according to LocumTenens.com's *2009 Compensation and Employment Survey – Anesthesiology*.

continued on page 13

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ASCREVIEW
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February 2010 Vol. 2010 No. 2

FEATURES

Publisher's Letter

Republican Wins Senate Seat in Massachusetts: 8 Quick Thoughts

By Scott Becker, JD, CPA

1. After President Obama won the election in 2008, the Republicans have won the last three major statewide elections — all in states that voted Democrat for President Obama in 2008 — Massachusetts, Virginia and New Jersey.

2. This is the first time the Republicans have won a Senate seat in Massachusetts in 44 years (1966). The Republicans winning Massachusetts is viewed generally as about as likely as the Chicago Cubs winning a World Series.

3. The healthcare reform bill, for various reasons, is viewed negatively to very negatively by 60 percent or more of the American public. Commentators reason this is due to concern that the plan will increase the deficit by adding a large entitlement program at a time when most Americans are concerned about the country's debt problems and other economic problems, that it is due to backroom deals with a wide variety of industry participants — unions, Senator Nelson, big pharma, Senator Landrieu, the AMA and others — or that it is due to the fact that 80 percent of Americans are generally pleased with their healthcare. In any event, the bill is very unpopular.

4. The Democratic leadership will need to make one of two choices: They can, as some commentators on the left suggest, push further left and try and jam this bill through and other legislation through. The theory, which seems incredibly misguided as a read of the American public (read: crazy) goes that President Obama and the Democrats are struggling because they have not gone hard enough left to deliver on campaign promises. Here, their concept would overwhelmingly be that the American public just doesn't understand the good we are trying to do for them yet (i.e., reform is good but the American public hasn't heard it correctly yet). If they pursue this course, they will galvanize the center and right and the midterm elections will be a debacle for the President and the Democrats. Centrist Democrats and Democrats in centrist districts will face a very tough choice: Do they upset President Obama or do they upset their district? Virginia Senator Jim Webb, a Democrat in a more traditionally Republican state, hinted last night that some Democrats will be smart enough to side with their district and not follow the party line down the proverbial plank.

5. Alternatively, as Bill Clinton did and Arianna Huffington said on the evening of the Massachusetts election, the Democrats can choose to course correct and tack center. A great deal of centrist Democrats and Democrats in balanced districts would strongly prefer this. The White House, with David Axelrod and others, has some smart people in it. It is not at all clear, however, that President Obama nor the Reids and the Pelosis of the party have an ability to tack middle. Certain of the Democrat leaders have seen this year as a once in a life time chance to redo how America does business. When the candidate Obama said last year, "the business of America is still business", it now hardly seems that he really believed that. I believe many centrist Americans who voted for President Obama feel somewhat to deeply betrayed.

6. The Republicans, for their part, can easily squander their position by, again, being a party either that pursues huge government spending as they did under President Bush (those were not my father's (Mort Becker) Republicans) or they can blow this opportunity by over-reading the mandate and allowing far right candidates to drive the party.

7. As to healthcare reform, it is not yet possible to speculate how intent the Democratic leadership in the White House is on pushing this agenda over the will of the American public. However, the longer the debate goes on and the closer this gets to mid-term elections and the more concerned centrist Democrats become, the greater chance that healthcare reform doesn't pass, at least in anywhere near its current form.

8. Many Americans want a law that doesn't allow insurances companies to be able to deny coverage to people with preexisting conditions, want to make it easier for working poor to have health insurance and want to standardize Medicaid. However, the polarizing nature of the debate and the fairly outrageous catering to special interests has caused many Americans to simply not want to touch nor hear about healthcare reform right now.

Should you have any questions, please contact me at sbecker@mcguirewoods.com or (312) 750-6016.

Very truly yours,

Scott Becker

P.S. We have an outstanding and very business-focused agenda for the 8th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference. To register, please call (703) 836-5904 or go to **www.ascassociation.org/june2010.cfm.** For a complete brochure, please see pages 21-26. For further information, please e-mail sbecker@mcguirewoods.com or call (312) 750-6016.

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21 Ways to Make and Save Money in Surgery Centers
(continued from page 1)

3. Scrutinize payor contracts. Some new ASCs accept money-losing contracts just to get patient volume, then realize they cannot sustain these payment levels, says Naya Kehayes, CEO of Eveia Health Consulting & Management in Issaquah, Wash. It's important to know how much each service in each contract relates to your costs so that you'll know it needs to be renegotiated or, if need be, dropped. When estimating the cost, keep in mind that your costs are not just your day-to-day operating costs but also include such factors as future capital requirements and debt repayments.

4. Renegotiate money-losing contracts. When you have made accurate determinations of your costs, decide what sort of payment increases you'll need to request from insurers. Ms. Kehayes advises that it is more difficult to renegotiate contracts that require large percentage increases. Payors sometimes limit the amount of increase they will allow. Be prepared for some tough negotiating, Ms. Kehayes says. Help payors understand that even though your ASC needs a large rate increase, the requested amount will probably still be below what the hospital charges. Your overall message should be, "I can help you save money," she says.

5. Know when to terminate contracts. You may have to send the insurer a termination letter if negotiations stall, but don't do so at the start of the negotiating process, Ms. Kehayes says. "You need to give the payor a certain amount of time to resolve the problem," she says. If you do terminate a contract, be prepared to survive without it for one or two years, and maybe forever, Ms. Kehayes says. It can take years for an insurer to realize how much higher surgeries cost in the hospital and to come back to you.

6. Add new specialties. Recent medical and payment advances make it possible for the ASC to bring in more specialties, such as spine surgery, retina and bariatrics. But before signing up specialists and buying expensive equipment, Ms. Kehayes advises checking with payors to make sure they will cover the new procedures at the rates you need.

7. Pursue new opportunities with APCs. As private payors shift to Medicare's Ambulatory Payment Classification groups, ASCs have opportunities to add new kinds of surgery to their repertoire, Ms. Kehayes says. APC payments are often higher than the old "grouper" rates. Sling surgeries for stress urinary incontinence, for example, involve high-cost disposable kits that groupers did not fully cover but APCs do, she says. Ms. Berreth has had the same experience. With her major payor, Blue Cross Blue Shield of Minnesota, moving to APC payments as of July 1, 2009, "I find we're getting paid a bit better," she says.

8. Engage a management company. "In a down economy, smart business skills play an important role in the success of our ASC," says Joan Zarth, business manager of Kentucky Surgery Center, a seven-OR multispecialty facility with 100 credentialed surgeons and 800-1,000 cases per month. Ms. Zarth says her Lexington, Ky., ASC realizes a substantial return on investment by working with a management firm. "It ensures that our center continues to be a leader in the ASC industry," she says.

9. Use a management company with skin in the game. Jon Vick, president of ASCs Inc. in Valley Center, Calif., advises to partner with management companies that buy a share in the ASC. Mr. Vick, whose company finds such arrangements for ASCs, says the companies then have a vested interest in making your ASC successful. Typically, he says, the management company buys a 20-30 percent in the ASC.

10. Keep tight control over billing. An ASC needs to maintain as much control as possible over the billing process, Ms. Berreth says. At her ASC, "my office is very close to my business people. We have constant conversations about the process — what works and, more importantly, what isn't working." She would not want this important function to be undertaken off-site.

11. Recruit new physicians. There are many opportunities left to recruit physicians because many physicians still perform a large part of their surgery in higher-cost settings, Mr. Southwick says. These doctors need to learn about the benefits of your ASC, including comfort, convenience and especially lower out-of-pocket costs for their patients, he says. Southwick.

12. Carve out your schedule for newcomers: To assist in recruiting physicians, persuade your core physicians to make scheduling changes so that the new physicians can have some desirable time slots, Mr. Southwick says. Get other physicians to make the argument, pointing out that it's in the interest of adding operational revenue that everyone will split.

13. Create a physician outreach effort. To recruit physicians, "you need to build relationships with physicians," Mr. Southwick says. He advises engaging physicians in face-to-face meetings, often during after-work hours. At Kentucky Surgery Center, "our goal is to meet with surgeons, perhaps over dinner, and present the benefits of using our ASC and becoming a shareholder," Ms. Zarth says. She adds that "the best recruiting tool is a happy surgeon's recommendation to a colleague."

14. Periodically contact targeted physicians. Recruiting physicians is all about timing, Mr. Southwick says. Physicians who may not at first be interested in working in an ASC may change their minds over time, so it is important to check back with them periodically.

15. Manage supply costs. Since supplies are the second highest expense in an ASC, after staff salaries, they need to be tightly managed, Mr. Southwick says. This means working closely with physicians. Provide them with side-by-side comparisons between physicians on the costs of different devices and supplies. "This will generate discussion among the doctors and will bring out their competitive streak," he says.

16. Work closely with GPOs. Mr. Southwick calls for cultivating good working relationships with group purchasing organizations. He also suggests paying line-item attention to expenses, from larger items like property taxes down to telephone bills.

17. Renegotiate loans. Mr. Southwick says renegotiating loans involves a lot of work but can be very rewarding. For example, HealthMark Partners is involved with an ASC that saved more than $15,000 in cash flow per month by renegotiating its loans.

18. Creatively manage work schedules. Alter staff duties, depending on the demands of the surgery schedule, Mr. Southwick advises. For example, a nurse who is not busy in the OR can make pre-op ad post-op phone calls. Remember that state requirements may put limits on what each employee can do.

19. Don't burn out your staff: Even though Brainerd Lakes Surgery Center has been very busy, concerns about the recession have precluded hiring new staff, Ms. Berreth says. This means it's important to make sure that staff members don't get burned out. She uses benchmarks for reasonable work hours and, as a nurse with ASC skills, she can fill in when needed.

20. Deal fairly with high deductibles. Many employers are reverting to high-deductible insurance plans. ASCs need to have established policies on handling patients with these plans — providing payment schedules for them, if necessary, says Ms. Zarth at Kentucky Surgery Center. "Prior to surgery we ask for a 50 percent downpayment on the estimated amount owed, with the balance to be paid over 90 days after surgery," she says. Her ASC also accepts credits cards and works through CareCredit, a healthcare loan company that offers reasonable interest rates for qualified applicants.

21. Remain flexible with patient payments. When creating payment plans for patients, an ASC needs to weigh the financial risk and benefits of each case, Ms. Zarth says. For example, "you would not want to cancel a case worth $1,800 if the patient isn't able to come up with the full $360 co-pay on the day of surgery," she says. Similarly, while it is always important to work your accounts receivables, Ms. Zarth advises remaining somewhat flexible about late payments. For example, her collection agency has agreed to send out letters to delinquent accounts at no charge and credit ratings are not affected if patients pay promptly. ■

Contact Leigh Page at leigh@beckersasc.com.

Top 8 Surgery Center Stories of 2009 **(continued from page 1)**

In addition to the inflation update, ASC 2010 Medicare payment rates include the graduated transition to the new ASC payment system, which pays ASCs at a percentage of HOPD rates and went into effect Jan. 1, 2008. For 2010, 75 percent of ASC payment rates will be determined using this new methodology while 25 percent will be determined using the previous system. The ASC Association estimates that, on average, ASCs will be paid 57.9 percent of HOPDs for the same services due to these changes and changes in hospital relative weights after the 2010 rates take effect.

CMS also approved 80 new procedures in the ASC setting and added 76 new CPT codes to the ASC list.

While the addition of procedures to the ASC list is beneficial for the ASC industry, the payment updates fell short of the ASC Association's expectations. "We are not pleased with the updates," says Kathy Bryant, president of the ASC Association, "We believe that the best way for Medicare to save money is to encourage services at cost-effective facilities, such as ASCs. Not using the same relative weights for ASC and HOPD payment is counterproductive to Medicare's goal of providing services as efficiently as possible."

2. Healthcare reform efforts and its impact on ASCs. Since Pres. Obama was inaugurated in Jan. 2009, he has focused on healthcare reform as a key issue for his presidency. Currently, both the House and the Senate have passed health bills, and Democratic leaders are working to merge them into a single bill that can be put to a vote. Regardless of the language of the final bill, it is almost certain some type of law will be passed to expand healthcare coverage to the uninsured. A key component of reform efforts that directly affects ASCs is how Medicare payments may be reduced to help fund an expansion of coverage, and the uncertainty surrounding this issue is making it difficult for ASCs to plan for the future.

This uncertainty is the top concern for many physician-owners of ASCs, including Neal Lintecum, MD, an orthopedic hand surgeon who practices at Lawrence (Kan.) Surgery Center. Dr. Lintecum says that these potential payment reductions would negatively impact the financial success of his ASC.

Peter Colquhoun, MD, a board-certified ophthalmologist and physician-owner of Brookside Surgery Center in Battle Creek, Mich., says that uncertainly about reimbursements from government payors are particularly threatening to specialties that treat a large number of Medicare beneficiaries, such as ophthalmology.

Uncertainty also makes it difficult for ASCs to plan strategically for growing or expanding their business. "We're all feeling very uncertain," says Bonnie Brady, RN, administrator, Specialty Surgical Center in Sparta, N.J. "You just can't predict what's going to happen, so it makes it very difficult for us to project a business. How can you do a strategic plan when you don't know what the country is going to be doing? How can you move forward with buying a piece of equipment if you're unsure of your reimbursements for it?"

3. New Medicare Conditions for Coverage. During 2009, ASCs also became required to provide new verbal and written advance notices to patients under CMS's new Conditions for Coverage. The new conditions were approved in Oct. 2008 and went into effect May, 18, 2009. These conditions require Medicare providers, including ASCs, to provide advance notice of physician financial interest, patients' rights and advance directives to patients.

CMS did not originally define what it meant by "advance notice," which led many healthcare attorneys to advise their ASC clients to provide the notice at least one day prior to the day of surgery. However, doing so created an administrative and procedural challenge for many ASCs as many do not require patient visits prior to the day of the procedure.

ASCs worked to meet these requirements in a number of ways including mailing disclosure documents and providing verbal disclosures over the phone, working with physician office staff to provide the documents and verbal disclosure and using electronic systems to provide these notifications to patients online.

On the day the new Conditions for Coverage were to go into effect, CMS issued an exception to the advance notice rule for surgeries that are scheduled on the same day they occur. In these instances, ASCs are required to provide notice prior to obtaining the patient's informed consent. According to CMS, same-day surgeries should be an infrequent occurrence as most ASCs perform elective surgery, and the frequent occurrence of such cases may represent noncompliance with the advance notice requirement.

"While most ASCs were able to successfully comply with these new Conditions for Coverage, complying adds costs to ASC services, that in my opinion, do not equate to the benefit of advance notification," says Ms. Bryant. "These regulations do not improve the quality of services ASCs provide."

4. Out-of-network reimbursement, pressures to go in-network.

Numerous lawsuits and settlements regarding out-of-network reimbursement to healthcare providers, including ASCs, made headlines in 2009. Many of these cases ended in rulings against and settlements by the insurance industry. However, despite these rulings, many ASCs continue to experience pressures to contract with insurers in their markets.

One of the first major occurrences in 2009 concerning out-of-network reimbursements was New York Attorney General Andrew Cuomo's investigation into and eventual shut-down of the Ingenix database, a database used by health insurers across the country to set out-of-network reimbursement rates for out-of-network services. The investigation revealed that the database, which was owned by UnitedHealth Group, intentionally skewed usual and customary rates downward through faulty data collection and poor pooling procedures in order to reduce payments made by insurers to out-of-network providers.

In Jan. 2009, UnitedHealth agreed to shut down the database and contribute $50 million toward the creation of new, independent database. Between January and March 2009, more than 10 other insurers, including Aetna, CIGNA and WellPoint, settled with the state of New York, agreeing to end their relationship with Ingenix and contribute to the creation of the new database. To date, more than $100 million has been collected from insurers for this cause.

In Aug. 2009, Cooper, Lundy & Bookman, a Los Angeles-based law firm, filed a national class action complaint on behalf of Downey (Calif.) Surgical Clinic and other non-contracted ASCs across the country, alleging misuse of the Ingenix database by UnitedHealth to knowingly under-reimburse ASCs by millions of dollars over many years. The case is currently entering a discovery phase in which the firm will depose UnitedHealth and Ingenix employees, says Daron Tooch, an attorney working on the case.

Another significant court decision was passed down in Nov. 2009, when the New Jersey Appellate Division of the Superior Court of New Jersey upheld a decision by the state's trial court (Garcia v. HealthNet) that Wayne (N.J.) Surgical Center and its physician-owners did not violate the state's Insurance Fraud Prevention Act by waiving out-of-pocket costs for patients or by referring to patients to an ASC in which they owned an interest without notifying these patients' insurer of these practices.

According to Thomas Gentile, partner at Lampf, Lipkind, Prupis and Petigrow, the attorney who argued the case on behalf of WSC and its physician-owners, the case stemmed from an effort by insurers in the state to pressure ASCs and other physician-owned facilities to contract with them. Contracted rates are typically much lower than out-of-network rates paid to providers.

A critical component of Mr. Gentile's argument in the case was the insurer's lack of authority to bring forward suits against healthcare providers for insurance fraud using statues that are not intended to be enforced by private parties.

While the case is a win for New Jersey ASCs, it does not completely remove all challenges to out-of-network practices by ASCs in the state or in other states around the country. Many ASCs around the country report pressure from insurers to go in-network. One tactic used by some insurers is

threatening to revoke in-network status of physicians who hold ownership interest in out-of-network ASCs.

"We are beginning to see efforts by some insurers to pressure physicians to refer to in-network facilities," says Thomas Michaud, chairman and CEO of Foundation Surgery Affiliates. "In several states, insurers, such as Blue Cross, have sent letters to physicians who have a pattern of referring to out-of-network facilities and basically threatening to revoke the physician's contract if the pattern continues."

Other tactics insurers use include bifurcating in-network and out-of-network deductibles and capping out-of-network benefits.

ASCs that opt to remain out-of-network face an increasingly difficult environment; however, they are likely remain viable and some highly profitable, at least in the short-term, due to the high level of reimbursement they receive as compared to contracted ASCs for procedures.

5. Market consolidation, growth of hospital/physician joint ventures. Due to various market dynamics, including a decrease in the number of available non-affiliated physicians for ASCs to recruit and healthcare reform efforts, the ASC industry has experienced some consolidation of ownership in 2009.

However, industry experts expect even greater market consolidation in the coming years. One of the most interesting stories regarding transactions in 2009 dealt with the growth of hospital interest in hospital/physician joint venture ASCs.

"I see a lot of mergers for surgery centers in the future, both between existing ASCs and through joint ventures and hospital acquisition of ASCs." says Tom Yerden, CEO of TRY Health Care Solutions. "Hospitals view a physician-hospital joint venture or outright acquisition of a surgery center as one way to expand/protect market share and complement their physician relationship strategy." Consolidation may also include corporate players and this, he says, is "not necessarily a bad trend."

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 physicians,

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.

"Hospitals have become much more interested in owning surgery centers," says Luke Lambert, CEO of ASCOA. "Many of our centers have been approached by their local hospitals in the past year asking whether the centers are open to accepting them as investors."

ASC industry insiders warn that numerous hospital/physician joint ventures have failed for a variety of reasons including unequal governance structures, misunderstanding or perceived inequalities in profit-sharing distributions and unclear strategic plans. Successful hospital/ASC joint ventures must carefully consider any joint-venture arrangements before moving forward.

6. Codey Law amendments signed into law. In March 2009, amendments to New Jersey's Codey Law were signed into law that included an exception for physicians to refer patients to ASCs in which they held an interest. The Codey Law prohibits self-referrals by physicians to any healthcare services in which they own an interest. Before the signing of the amendment this year, physicians generally accepted that physician ownership of ASCs was allowed under the Codey Law with some risk as the law did not explicitly exempt ASCs.

The law's recent amendment allows for physician self-referrals to outpatient surgical facilities if the referring physician personally performs the procedures, if the physician's remuneration as an owner of or investor in the ASC is not tied to the volume of patients the physician refers and if the physician's ownership interest is disclosed to the patient, among other conditions.

Although the amended Codey Law reduces risks for physician-owners of existing ASCs, the law also places a moratorium on new ASCs except for limited circumstances, such as transfer of ownership. New Jersey is the first state in the country that has a prohibition on physician ownership of surgery centers.

"When the Codey Law [amendments] passed, yes, it was a good thing for ASCs because previously, we were unsure of the status of ASCs in New Jersey," says Ms. Brady. "It did allow us to keep our ASC, but it has created more paperwork and documentation for us and essentially limits new ASCs."

7. RAC audits and an increased focus on fraudulent claims. Following a successful three-year recovery audit contractor demonstration program that initially identified $900 million Medicare overpayments to healthcare providers and suppliers in six states, a permanent, national RAC program began to roll out across the country in 2009. The permanent RAC program began operating in several states March 1, 2009, with implementation for the remaining states required before Jan. 1, 2010. The permanent RAC program will be carried out by four regional RACs and their subcontractors and will affect healthcare providers who bill federal programs, including ASCs.

The RAC audits come at a time when the federal government has increased its focus on combating improper Medicare payments including fraudulent claims. HHS estimates place the sum of improper payments to Medicare provider and suppliers at $54 billion in 2009. In May, the DOJ and HHS announced an interagency effort to combat Medicare fraud, the Health Care Fraud Prevention and Enforcement Action Team. Throughout the year, the agencies have expanded the number of sites for its Medicare Fraud Strike Force Teams from two to seven cities in the United States.

The RAC program brings greater scrutiny of ASC Medicare billing practices and creates a financial risk for centers with improper billing practices. For many ASC administrators, RACs have created another administrative and regulatory challenge for facilities. While many ASCs have responded by reexamining coding and billing procedures and increasing internal audits, administrators worry unintentional errors will put ASCs at financial risk.

"RACs are coming to find money, and they're going to keep at it until they find something that makes them money," says Ms. Brady.

In order for ASCs to prepare for the audits, billing experts suggest carrying out frequent internal audits of coding and billing procedures.

ASCs should also appeal unfavorable RAC determinations or risk becoming an "ongoing target" for auditors, who are paid a percentage of improper payments recouped, says Cristina Bentin, principal, Coding Compliance Management. "If your ASC isn't taking the time to provide documentation to support its position for each account found to be incorrect, why would RAC close the window of opportunity for future recoupment?"

Ms. Brady also reports that her ASC recently purchased insurance for billing errors, which will cover any legal costs and fines associated with RACs. The ASC, however, is responsible for paying back any overpayments to the ASC that resulted from billing errors.

8. Red Flags Rule. The expected implementation of the Red Flags Rule created another administrative and procedural challenge for many ASCs in 2009. The Red Flags Rule, part of the Federal Trade Commission's Fair and Accurate Credit Transactions Act, was approved in the fall 2008 and was originally scheduled to go into effect Nov. 1, 2008. However, the FTC soon pushed its enforcement date back to May 1, 2009 and then to Aug. 1, 2009.

The rule requires any business that could be considered a creditor, including healthcare providers, to develop, implement and administer an identity theft prevention program designed to detect signs, referred to as "red flags," of identity theft, as well as to prevent and mitigate it.

ASCs were tasked with developing and implementing these identity theft prevention policies and procedures. According to Mr. Yerden, increased compliance issues, many which were supposed to go into effect in 2009, such as the Red Flags Rule, Medicare's Conditions for Coverage and additional HIPAA guidelines, represent an increasing burden for ASCs as the number of compliance regulations continues to grow. Adherence to these guidelines requires a significant effort on the part of an ASC administrator and can take away from the time an administrator can put toward improving quality of care and financial performance, he says.

On July 39, 2009, just three days before the Red Flags Rule was set to go into effect, the FTC announced that it would delay its enforcement until Nov. 1, 2009, and on Oct. 30, 2009, the FTC again pushed back the enforcement date until June 1, 2010. ASCs now have until next summer to comply with the Rule; however many facilities still spent considerable time and effort in 2009 preparing for a Rule that was repeatedly pushed back.

According to Ms. Brady, the Red Flags Rule is another example of regulations that have created more administrative and clerical work for ASCs. "I'm still collecting information on the Rule and attempting to get everything together so that we can implement procedures that comply with the Rule," she says. ■

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23 Things to Know About Anesthesia and Anesthesia in ASCs
(continued from page 1)

3. An anesthesiologist shortage has increased competition for anesthesia providers. The number of medical students entering anesthesiology training programs dropped greatly in the late 1990s, causing a shortage of practicing anesthesiologists, according to a study 2006 by University of Michigan researchers published in *Anesthesia & Analgesia*. The shortage led to increased salaries for the specialty due to increased competition and the rise of certified registered nurse anesthetists.

According to Marc Koch, MD, MBA, president and CEO of Somnia Anesthesia, the shortage of anesthesiologists still exists and it has now spread to CRNAs. "There is a nurse anesthetist shortage of approximately 5,000, and this is expected to worsen over time and a "graying" of current practicing anesthesiologists," he says. According to some estimates, 85 percent of the approximately 30,000 practicing anesthesiologists today are 45 or older.

4. Anesthesiology is a top-paying specialty. Due in part to the shortage of practitioners, anesthesiology is one of the top-ten highest-paying physician specialties, with an average annual salary of $344,000, according to Merritt Hawkins & Associates' *2009 Review of Physician and CRNA Recruiting Incentives*.

5. CRNA salaries approach those of primary care physicians. The average CRNA salary in the United States was $189,000 in 2008-2009, according to Merritt Hawkins & Associates' *2009 Review of Physician and CRNA Recruiting Incentives*. The average salary for a primary care physician reached only $173,000, according to the same report.

6. The economic downturn has reduced the demand for anesthesia services. Despite the exponential growth of ASC-based surgeries, the economic downturn has affected volumes at ASCs across the country. The downturn that has taken place over the past year has decreased the demand for many medical services, and anesthesia is no exception. As the number of elective procedures decreases, so does the need for anesthesia coverage for these procedures. A study completed by the AAAHC Institute for Quality Improvement revealed that 67 percent of ambulatory facilities indicated a decrease in demand for anesthesia services in recent months.

According to board-certified anesthesiologist Sterling "Chip" Wood, MD, partner at Atlantic Ambulatory Anesthesia Associates, decreased volumes are definitely a concern for anesthesia practices. "With the drop in number of elective surgeries, we're looking at ways to generate more cases, whether that's more hours of service, offering services on the weekends, or other things that we can do to increase the number of patients coming in the door," he says.

7. There are three core models for the provision of anesthesia services. ASCs generally employ one of three core modes for providing anesthesia services — the traditional model, the employment model and the owner-provider model. In the traditional model, ASCs contract with independent service groups to provide anesthesia services. In the traditional model, there is usually no compensation agreement between the facility and the anesthesia group outside of perhaps a medical director agreement or stipend. The anesthesia group, then, receives all professional fees for anesthesia services. In the employment model, the ASC employs the anesthesiologists and pays them a salary. In return, the ASC retains all professional fees. In the owner-provider model, a physician-owned ASC incorporates its own anesthesia group to provide services to its facility. The anesthesia company then pays its anesthesiologists a fee, and profits from the anesthesia services go to the owners of the anesthesia group, which are assumedly the same owners of the ASC. The owner-provider model is growing in popularity, though it has been criticized by anesthesiology trade

groups as having substantial legal risks. There trade groups also argue that only anesthesiologists should profit from providing anesthesia services.

8. Outsourced anesthesia models may be a profitable option. ASCs that work with an anesthesia group may achieve greater profitability than other anesthesia models, according to Dr. Wood. While the employment-model seems to be growing in popularity as ASCs look to improve profit margin, Dr. Wood warns that employing anesthesia providers could reduce productivity. "ASCs that employ salaried anesthesiologists can fail to provide incentives for being efficient, while anesthesia groups provide incentives for efficiency because groups are compensated by the number of cases they perform," he says. Dr. Wood also says that ASCs who employ their own anesthesiologists may be tempted to use the least expensive anesthesia services possible rather than the highest-quality in order to increase profits from billing anesthesia services. As a result, ASCs should look for anesthesia providers that are high quality, first, and, then, available at a reasonable cost.

Additionally, ASCs with outsourced anesthesia services may be more able to adapt to periods of lower volumes, such as the volume dip ASCs are currently experience due to the recession. William Hoffman, MD, corporate medical director of Anesthesia Healthcare Partners, says that anesthesia groups are often willing to work with centers and adjust contracts so that the center can remain profitable. "If a center decides it's better for them to run three ORs rather than four, we can cut down on the number of CRNAs at that center and reassign that person to a new site," he says. Centers that employ their own anesthesia providers may find it more difficult to reassign these providers.

9. Most ASCs continue to contract with outside anesthesia groups. Employing anesthesiologists and other anesthesia providers can help centers improve their profits, but the challenge of negotiating employment contracts with these providers, arranging coverage, such as for when providers take vacation, and managing coding and billing for these services can outweigh the potential financial benefits for many ASCs.

Brent Lambert, MD, president and a founder of Ambulatory Surgical Centers of America, reports that none of ASCOA's centers currently employ their own anesthesiologists, though the company has done so in the past. "Anesthesia is a separate business altogether than running an ASC. It's more similar to practice management. Personnel issues are different and billing is very different," he says. "When we [managed anesthesia services] in the past, we were always negotiating employment contracts with anesthesiologists. We don't like to get involved anymore because it saves us the headache."

Dr. Lambert admits that managing anesthesia services can be profitable, but has noticed that most ASCs who do this have only done so to make up for lacking profits in surgical service lines. "Most ASCs that I've come in contact with that are employing anesthesiologists are looking for another way to profit. Typically, it's an ASC that is not doing well and thinks they can make up losses through employing and anesthesiologist and then profiting from the anesthesia payments," he says.

According to Ed Hetrick, president and CEO of Facility Development and Management, local anesthesia groups provide the best quality service with the least risk, such as staffing and other expenses required for such arrangement, especially for new ASCs just starting up. "We currently contract with local groups that our surgeons are familiar with and know their quality and their ability to service the ambulatory market," he says.

If ASCs decide to outsource their anesthesia services, Dr. Lambert recommends that ASC leaders discuss their expectations with the anesthesia group

upfront. ASCs should look for groups whose physicians will assist in timely room turnovers, are assigned only to the center (as opposed sending a new anesthesiology team every day) and "treat patients like royalty," says Dr. Lambert. "Patients should leave thinking the anesthesiologist was the nicest physician they've ever met, and when they tell others about their experience that helps market our centers," he says.

Dianne Wallace, RN, BSM, MBA, executive director of Menomonee Falls (Wis.) Ambulatory Surgery Center says that her ASC has contracted exclusively with the same anesthesia group more than 14 years. "The biggest benefit to us is that we don't have to 'manage' the physicians and/or their billing. The advantage to them is that we provide all supplies and equipment and a large volume of procedures," she says.

10. Outsourcing to anesthesia groups without the same managed care contracts as the ASC may create headaches for patients. ASCs that outsource their anesthesia services should consider selecting a group that has contracts with the same managed care organizations as the ASC. If an ASC is in-network for a certain payor, but the anesthesia group in out-of-network, patients enrolled with that payor may be unprepared for the higher out-of-pocket expenses associated with out-of-network anesthesia services, says Dr. Lambert.

11. Opinion is divided on bringing in anesthesiologists as investors. ASCs with anesthesiologists on their medical staff may improve profitability by bringing on these anesthesiologists as co-owners in the facility. Having anesthesiologists as co-owners can help ensure anesthesia staff and the owners share the same goals, and decisions regarding cases are made with the benefit to the ASC, not just the anesthesia staff, in mind, says Keith Smith, MD, founder of Surgery Center of Oklahoma in Oklahoma City, Okla. However, others believe that anesthesiologists should generally not be investors unless they will provide a significant number of pain management patients to the centers. "Anesthesiologists generally don't meet safe harbor requirements," says Dr. Lambert. "According, we don't generally bring them in as investors except in some rare cases where they would be performing pain management cases at the center."

12. ASCs that use MD and CRNAs may be best situated for anesthesia provider shortages. The anesthesia provider shortage has created competition for anesthesia services, which could result in newer anesthesia providers willing to work holidays, weekends and nights or be on-call, says Dr. Koch. Facilities that use a MD/CRNA cooperative model, where anesthesiologists and certified nurse anesthetists work together to provide services, will be best equipped to handle the anesthesia provider shortage, says Dr. Koch. Additionally, ASCs, which tend to be more efficient than hospitals and do not require physicians to be on-call, will be attractive sites for anesthesia providers.

13. Anesthesia is not reimbursed for many GI procedures. ASCs should be aware that payors are increasingly unwilling to separately reimburse for anesthesia services provided during GI procedures. According to William Hoffman, MD, corporate medical director of Anesthesia Healthcare Partners, some commercial payors refuse to pay professional fees to anesthesiologists for certain GI procedures. This refusal restricts the type of pain control that can be provided to patients undergoing GI procedures and also potentially slows the throughput of cases, he says. For example, the use of propofol during colonoscopy provides greater pain relief and quickly wears off, allowing GI patients to get out of the center quicker. Narcotics, such as Demerol, may not provide complete pain relief and take longer to wear off, says Dr. Hoffman.

Although GI physicians can direct the use of propofol, some anesthesiology groups argue that the practice is safer when directed by anesthesiologists. As a result, a number of anesthesiologists, including Dr. Hoffman, are working with payors to try to explain the benefit of reimbursing anesthesia services during these procedures. If an ASC contracts with a carrier that currently does not provide separate reimbursement for anesthesia, it is important that the gastroenterologists on staff are competent at offering various types of pain relief during these procedures.

14. Inefficient ASCs risk difficulties in securing anesthesia services. ASCs that do not employ or have anesthesiologists as investors will likely have to compete with other facilities, including hospitals, for the service of anesthesia groups. If the anesthesia group is compensated based on anesthesia unit production, and the market is experiencing anesthesia provider shortages, facilities with gaps between cases could risk increased costs in securing anesthesia services, including possible requests for anesthesia stipends to make up for down time, warns Robert Welti, MD, corporate medical director and COO, Western region, for Regent Surgical Health. ASCs with strong volumes and little downtime remain an attractive location for anesthesiologists.

15. Anesthesia reimbursement varies greatly between public and private payors. Professional fees for anesthesia services are determined by adding the time units required (one time unit typically equals 15 minutes) for a procedure with the procedure's base units, which vary according to the complexity of the anesthesia service, and then multiplying by a conversion factor, which is determined by the payor. The current average Medicare conversion factor for anesthesia nationwide is $20.92, which is about one-third the rate of managed-care contracts, according to Sharon Merrick, coding and reimbursement manager for the American Society of Anesthesiologists. For example, from Oct. 2006-Feb. 2007, conversion factors for managed care contracts ranged between $52.16 and $65.06, on average, according to the ASA's 2007 national survey of anesthesia conversion factors. At the time of the ASA's 2007 study, the average conversion factor for Medicare was $16.19. Additionally, some private payors allow coding for a qualifying circumstance or modifying factor, such as for varying degrees of comorbidity, which increase payments because of increased complexity, while CMS does not reimburse for these modifying factors, says Ms. Merrick.

16. ASCs with high levels of Medicare patients may be more at risk for subsidy requests. Medicare reimburses at a very low rate, compared to most managed care providers, for anesthesia services, says Thomas Wherry,

MD, a practicing anesthesiologist and principal of Total Anesthesia Solutions. Thus, ASCs with a large percentage of Medicare patients could be less attractive to anesthesia groups. As a result, these ASCs should be prepared for anesthesia subsidy requests and should begin to analyze if meeting the request is worth maintaining the relationship with the anesthesia group.

However, at present, the majority of facilities paying anesthesia subsidies or at risk for these requests are hospitals, says board-certified anesthesiologist Sterling "Chip" Wood, MD, partner at Atlantic Ambulatory Anesthesia Associates. "Hospitals have a much higher Medicare population, and Medicare reimbursements for anesthesia are low. In order for most ASCs to be profitable, they aren't able to do large volumes of Medicare cases. However, some ASCs, such as maybe an eye center with a huge Medicare population, could be asked for subsidies," he says.

17. Knowing anesthesia providers' needs can reduce the risk of subsidy requests. If an anesthesia group does bring up the idea of a subsidy request, ASC leaders should discuss what exactly the anesthesia provider needs to cover costs. Dr. Wherry recommends that ASCs know exactly the number of anesthesia units that the group requires to remain profitable, and work with them to determine if scheduling or other efforts, besides subsidies, could help them meet this goal.

18. Anesthesiologists also play an important role in the efficiency of an ASC. Therefore, it is important that an ASC bring in anesthesiologists that are committed to efficiency. "Our anesthesia groups to help us make our centers more efficient by being committed to helping us get rooms turnover, and they are willing to do this in order to remain the provider of anesthesia services to our patients," says Brent Lambert, MD, president and a founder of Ambulatory Surgical Centers of America.

Additionally, the use of certain anesthetics, such as propofol for sedation, reduce the time needed to perform cases, which allows an ASC to schedule more cases and schedule more efficiently, according to Stanford Plavin, MD, an anesthesiologist and managing partner of Ambulatory Anesthesia of Atlanta. The use of generic antemetics, to reduce post-op nausea, rather than name-brand medications, can also save ASCs up to $15-$20 per case, says Dr. Plavin.

Mark Schoenfeld, MD, a board-certified anesthesiologist with Columbia Anesthesia Associates who practices at Ambulatory Surgery Center of Union County (N.J.).says that he often forgoes using the "designer drugs of the day" and uses less expensive drug options in order to increase ASC efficiencies.

19. Advances in anesthesia have allowed more patients to be safely treated at ASCs. Traditionally, older and sicker patients were treated in the hospital as opposed to ASCs, but advances in anesthesia have allowed patients that once would have been turned away from the ASC an opportunity for treatment. According to Irvin Thomas, MD, medical director of Safe Sedation, Thomas, an ambulatory surgery anesthesia group, newer medications with shorter half-lives and a shorter duration of action give ASCs the opportunity to treat patients who were once designated to the hospital in the outpatient setting.

However, treating older and sicker patients at the ASC has created more of a challenge for anesthesia providers in the outpatient setting. Traditionally, ASC-based anesthesiologists and CRNAs could take comfort in the fact that they were treating the healthiest patients. Although ASC patients still tend to be healthier than hospital patients, anesthesiologists in the ASC-setting are now seeing more complicated anesthesia cases. As a result, anesthesiologists should be especially careful in determining which patients can safely be treated in the ASC as surgeons are now referring more patients to these facilities, according to Dr. Wood.

20. Offering the latest in anesthesia services may improve volume. ASCs whose anesthesiologists are willing to use innovative techniques with regard for excellent patient safety are attractive to prospective patients who may hear about the facility from other satisfied customers. According to Dr. Thomas the use of peripheral regional anesthesia alone, or in combination with general anesthesia, may provide some of these advantages, which include higher patient satisfaction scores due to excellent post-operative pain control and a lower incidence of post-operative nausea and vomiting.

The improved post-operative pain control provided by regional pain blocks is a result of their effects extending after the surgery. If a patient had undergone general anesthesia, he or she would not have that additional pain control, says Dr. Schoenfeld. Most patients also report less post-operative nausea and vomiting from regional blocks than with general anesthesia, he says. Less nausea and vomiting reduces recovery times, which allows the ASC to see more patients in a day and potentially lowers case costs.

21. Complications from anesthesia have declined dramatically despite more patients undergoing ambulatory procedures. The number of deaths attributed to anesthesia was approximately 1 in 1,500 fifty years ago. Today that number has improved nearly tenfold, despite more patients being treated in operating rooms nationwide. Currently, the chance of a healthy patient suffering an intraoperative death attributable to anesthesia is less than 1 in 200,000 when an anesthesiologist is involved in patient care, according to the American Society of Anesthesiologists.

Dr. Schoenfeld says that anesthesiologists have successfully reduced these complications in the outpatient setting by taking an active role in determining which patients can and cannot be seen at ASCs. He recommends that anesthesiology staff review patient charts and evaluate in person any questionable cases before the day of surgery. Decisions about treating patients should be made before the day of surgery so that patients do not take off work and take up time on the schedule if there is a possibility that they cannot be treated at the ASC. These situations upset patients and are costly to ASC who could have scheduled other cases during those times, he says.

22. Innovative anesthesia services may require investments in technology. ASCs that wish to offer more innovative anesthesia options, such as regional nerve blocks for orthopedic patients, may need to purchase new technology in order to make these techniques available to patients. Although many anesthesiologists use nerve stimulators to detect nerves for administrating regional blocks, new monitoring devices that use ultrasound waves to visualize nerves could grow in popularity, says Dr. Schoenfeld.

However, Dr. Wherry warns that these devices may require a significant investment — the monitors can cost around $30,000.

23. ASCs can benefit from treating anesthesia providers as true team members. According to Dr. Wherry, ASC staff members sometimes fail to appreciate contracted anesthesia providers as true members of the ASC team. However, ASCs that treat anesthesia providers as true team members and include them in the ASC decision-making may find financial benefits from doing so. Anesthesia providers may be more efficient when they feel truly a part of the ASC's success and may be able to offer ideas to cut costs and improve efficiencies.

As a result, if an ASC is outsourcing its services, they should consider using an anesthesia group that provides anesthesiologists and CRNAs that are dedicated only to serving that center, says Dr. Hoffman. ■

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4 Top Issues Facing ASC and Hospital Valuation

By Renée Tomcanin

A difficult economic climate has led many healthcare providers, including ASCs and hospitals, to make significant efforts to cut costs and improve revenues. Although providers have done well in adapting to this climate, some factors still have made an impact on the value of hospitals and ASCs.

Jon O'Sullivan, senior partner of VMG Health, discusses the following four major issues currently facing and affecting ASC and hospital valuation.

1. Physician employment. As a result of a variety of issues from lower prospective reimbursement to onerous administrative burdens, many physicians leaving medical school are looking for employment by a hospital or hospital system rather than by private practices or physician groups. Likewise, with looming cuts in professional reimbursement and expected limitations on in-office ancillary services, many practices are approaching hospitals and hospitals are purchasing private practices at an accelerating rate. According to Mr. O'Sullivan, this trend is becoming a great opportunity for hospitals but may pose a long term problem for ASCs.

"Hospitals can use this as an opportunity to align physicians directly with the hospitals," says Mr. O'Sullivan. "Many hospital systems are anticipating that payors are going to be more willing to pay for a bundled service fee, which hospitals can more effectively contract and redistribute under the umbrella of one institution, or integrated delivery network. Clearly, ASCs do not have this opportunity and the long term impact on ASCs can be negative."

ASCs, conversely, are faced with more challenges as a result of this increased trend toward physician employment by hospitals. Mr. O'Sullivan notes that this trend is decreasing the base of potential physician investors for ASCs. "This can impact ASCs and ASC valuation because they are driven by specialist reimbursements," he says. "As specialists find it more difficult to stay in private practice, ASCs will feel the impact."

Mr. O'Sullivan says ASCs must be prepared to generate more revenue off of fewer cases. "Combating this trend is hard," he says. "ASCs will have to continue to be more cost-effective to maintain their margins."

2. Corporate investors. Mr. O'Sullivan says that most ASCs have learned to adapt to the new economic climate, and over the past year or so, while corporate buyers are more disciplined in their approach to the market, not much has happened to affect the fair market value of an ASC in regards to the general economic downturn. However, corporate investors have been very prudent when entering into ownership agreements with ASCs.

"Companies have been more careful in purchasing a controlling interest in an ASC," Mr. O'Sullivan says. "Where companies previously responded to intense competition by offering higher purchase prices, often on centers that

might have underlying challenges, the current market is characterized by more rational pricing and a much more diligent review of the operating dynamics of the ASC."

3. Hospitals purchasing ASCs. Although some hospitals continue to enter into ownership agreements with ASCs in direct partnership with physicians, Mr. O'Sullivan says that the recent trend has been for hospitals to buy underperforming or market-challenged ASCs outright. In most cases, hospitals tend to focus on ASCs that can be restructured to become a part of the hospital provider entity, as opposed to centers that continue to run successfully.

"These ASCs are underutilized, poorly managed or have out-of-network contracts that are no longer viable. Hospitals look to consolidate their services and can negotiate higher rates under the hospital's provider number and the HOPD payment schedule," Mr. O'Sullivan says.

Part of this trend to purchase surgery centers is related to hospitals returning to an integrated delivery system model, according to Mr. O'Sullivan. Whereas in recent years many hospitals were stripped of their ancillaries by physicians seeking participation in ancillary revenues, now they are looking to recapture services such as imaging and outpatient surgical services as hospitals once again position themselves to deliver a full range of care.

Hospitals have also had the benefit of increased interest in physician employment to help them employ integrated care models. "Physicians are experiencing reduced reimbursements, which may lead them to align more closely with hospitals," Mr. O'Sullivan says. "For instance, cardiovascular nuclear studies are far less profitable to do in an office setting and orthopedic in-office MRI services are under attack. Hospitals are stepping in to purchase these ancillary services, and if physicians align with the hospital, they may be more inclined to perform these services as part of the provider based services."

Mr. O'Sullivan notes that hospitals are still relatively early in this cycle of increased integrated care, so the benefit or ultimate success of these strategies cannot yet be seen.

4. Restrictions on physician-ownership. Surgical hospitals face different issues regarding valuation. One major concern is any healthcare legislation that would prohibit physician-owned hospitals from obtaining Medicare or Medicaid certification after Aug. 1, 2010. Surgical hospitals may see value improve or worsen due to many factors, according to Mr. O'Sullivan.

Physician-owned surgical hospitals located in areas with a large population and affiliated with a health system stand the best chance for success if restrictive legislation passes as they will have means for replacing physicians that retire or move out of the area. "Affiliation may help to keep the hospital viable if expansion is limited," Mr. O'Sullivan says.

Hospitals located in areas where restrictive legislation on physician ownership in hospitals essentially create a certificate of need — that is, those located in areas where no other surgical hospitals can build and/or those that face little competition from acute-care hospitals — will also protect their value should the legislation pass.

Surgical hospitals that are in highly competitive areas and/or have no affiliations are at a higher risk of seeing their value decrease over time.

Mr. O'Sullivan notes that this will be a case-by-case basis, depending on the surgical hospital, competitive environment, and affiliation strategy. ■

Contact Jon O'Sullivan at osullivan@vmghealth.com or call (214) 369-4888. Learn more about VMG Health at www.vmghealth.com.

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PROGRAM SCHEDULE

Pre Conference – Thursday, June 10, 2010

11:30am – 1:00pm	Registration
12:00pm – 4:30pm	Exhibitor Set-Up
1:00pm – 5:20pm	Pre-Conference Workshop • Concurrent Sessions A, B, C, D, E, F
5:20pm - 7:00pm	Reception, Cash Raffles and Exhibits

Main Conference – Friday, June 11, 2010

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:15pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:15pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday, June 12, 2010

7:00am – 8:00am	Continental Breakfast and Registration
8:15am – 1:00pm	Conference

Thursday, June 10, 2010

Track A – Improving Profits, Turning Around ASCs, and Benchmarking

1:00 – 1:45 pm
5 Keys to Maximizing an Orthopedic-Driven ASC's Returns in a Tough Economy - Brent Lambert, MD, FACS, President & Owner, Ambulatory Surgical Centers of America

1:50 – 2:30 pm
Running Your Orthopedic Program Smarter - Benchmarking - Improving Revenues per Case, Reducing Hours per Case, Supply Costs per Case, Staffing and More - Thomas J. Bombardier, MD, FACS, Founding Principal, Ambulatory Surgical Centers of America

2:30 – 3:15 pm
The Changing Future of Health Care in the United State - Joe Flower, Healthcare Futurist

3:20 – 4:00 pm
Assessing and Improving the Profitability of Orthopedic and Spine in ASCs - Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America

4:05 – 4:40 pm
A Step by Step Guide to Recruiting Orthopedic and Spine Surgeons - Chris Suscha, VP of Business Development, Meridian Surgical Partners

4:45 – 5:20 pm
Selling Shares and Resyndication - Larry Taylor, CEO, Practice Partners in Healthcare, and Melissa Szabad, JD, Partner, and Bart Walker, JD, Attorney, McGuireWoods, LLP

Track B – Business Planning for ASCs, Spine, Orthopedics, and Pain

1:00 – 1:45 pm
Business Planning for Orthopedic and Spine Driven Centers - Tom Mallon, CEO, Regent Surgical Health, Jeff Simmons, President Western Region, Regent Surgical Health

1:50 – 2:30 pm
Building Outstanding and Profitable Pain Management Programs, Making Pain Profitable - Robin Fowler, MD, Executive Director & Owner, Interventional Spine & Pain Management

3:20 – 4:00 pm
Establishing an ASC - 10 Keys for Success - Bill Southwick, President & CEO, Healthmark Partners

4:05 – 4:40 pm
Enterprise Risk Management - Dottie Bollinger, RN, JD, LHRM, CHC, CASC, Laser Spine Institute

4:45 – 5:20 pm
Handling 5 Key Problems in the ASC Life Cycle - Joseph Zasa, JD, Partner, ASD Management

Track C – Special Procedures Issues

1:00 – 1:45 pm
Minimally Invasive Spine Surgery in ASCs - Greg Poulter, MD, Surgeon, Peak One Surgery Center, Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

1:50 – 2:30 pm
The Best Procedures to add to ASCs Now - John Hajjar, MD

3:20 – 4:00 pm
Recruiting Great Doctors - 5 Key Concepts from an Industry Veteran - Robert Zasa, MSHHA, FACMPE, Partner, Woodrum ASD

4:05 – 4:40 pm
Handling Complex Spine Cases in an ASC, Clinical and Financial Issues - Marcus Williamson, President, Neospine Services Symbion Healthcare

4:45 – 5:20 pm
Extending the Life Span of Your ASC - 10 Key Concepts - Boyd Faust, CPA, CFO, Titan Health

Track D – General Management

1:00 – 1:45 pm
How An Existing, Successful Orthopedic/Pain ASC in New Jersey is Planning for Impending Rate Compression in the State, and Adjusting its Strategy Going Forward Now That a Moratorium on New ASC Development Has Gone Into Effect - David Hall, Chairman or Sean Rambo, Vice President of Operations, Titan Health, Key Physician from Titan NJ ASC

1:50 – 2:30 pm
How to Reduce Hours Per Case, How to Hire Great DONs and Staff - Joyce Deno, Chief Operations Officer, Eastern Region, Regent Surgical Health

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3:20 – 4:00 pm
The Success, Failure and Demise of ASCs - An MD Leaders Perspective - Larry Parrish, Illinois Sports Medicine & Orthopedic Surgery Center, Dave Raab, MD, Illinois Sports Medicine & Orthopedic Surgery Center, Jeff Visotsky, MD, Illinois Sports Medicine & Orthopedic Surgery Center
4:05 – 4:40 pm
How to Effectively Measure and Track Patient Quality - David Shapiro, MD, Director of Medical Affairs, AMSURG
4:45 – 5:20 pm
5 Tips for Managing Anesthesia in Your ASC - Marc Koch, MD, President & CEO. Somnia Anesthesia

Track E - Billing, Coding and Contracting for ASCs
1:00 – 1:45 pm
Managed Care Negotiation Strategies for Orthopedic and Spine - 10 Key Concepts- Naya Kehayes, MPH, CEO, Eveia Health Consulting and Management
1:50 – 2:30 pm
10 Ways to Improve an ASCs Orthopedic Spine and Pain Coding - Stephanie Ellis, RN, President, Ellis Medical Consulting
3:20 – 4:00 pm
A 40 Minute Billing Boot Camp - What Centers Need To Do To Improve Their Billing and Coding - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing
4:05 – 4:40 pm
How to Hire Great Administrators and What Should They Be Paid? Greg Zoch, Partner & Managing Director, Kaye Bassman International
4:45 – 5:20 pm
Driving Revenues Up by Driving Denials Down - Bill Gilbert, VP of Marketing, AdvantEdge Healthcare Solutions

Track F - Buying and Selling ASCs and Hospitals, Valuation Issues For ASCs, Anti Kickback Issues
1:00 – 1:45 pm
ASC Transactions, Current Market Analysis and Valuations, Greg Koonsman, Senior Partner, VMG Health
1:50 – 2:30 pm
5 Anti Kickback and Stark Act Cases - Scott Becker, JD, CPA, Partner, Elissa Moore, JD, and Lainey Gilmer, Associate, McGuireWoods LLP
3:20 – 4:00 pm
Excelling Without Orthopedics and Spine -Key Concepts for Great ASC Performance - Joseph Zasa, JD, Partner, ASD Management, Skip Daube, MD, Founder, Surgical Center for Excellence, Panama City
4:05 – 4:40 pm
Buying, Selling and Syndication ASCs - Henry H. Bloom, Founder, and Robert S. Goettling, Esq., The Bloom Organization, Todd Mello, ASA AVA MBA, Principal & Founder, Healthcare Appraisers
4:45 – 5:20 pm
Physician Owned Hospitals - Key Concepts to Increase Profits - Tom Michaud, CEO, Foundation Surgery
5:20 pm
Cocktail Reception, Cash Raffles and Exhibits

Friday, June 11, 2010

8:00 am
Introductions - Scott Becker, JD, CPA, Partner, McGuireWoods, LLP
8:10 – 9:00 am
The Best Ideas for Orthopedic and Spine Driven ASCs Now - Brent Lambert, MD, FACS, President & Owner, Ambulatory Surgical Centers of America, Joseph Burkhardt, MD, Brookside Surgery Center, Kenny Hancock, President, Meridian Surgical Partners, James T. Caillouette, MD, Chairman, Newport Orthopedic Institute
9:05 – 10:00 am
The Politics of Health Care Reform, Ron Brownstein, Political Director, Atlantic Media Company
10:00 – 11:00 am
Networking Break & Exhibits

General Session A
11:05 – 11:45 AM
Key Developments That Will Transform the Business of Orthopedic Surgery - John Cherf, MD MPH MBA, OrthoIndex
11:50 – 12:30 PM
Key Concepts to Improve the Profitability of Spine Programs, John Caruso, MD, Jim Lynch, MD, Founder, Surgery Center of Reno, Moderator, Jeff Leland, Managing Director, Blue Chip Surgical Center Partners

GENERAL SESSION B
11:05 – 11:45 AM
A National View of Political Advocacy Efforts and ASCs, Andrew Hayek, CEO Surgical Care Affiliates, Chairman ASC Coalition
11:50 – 12:30 PM
Effective Cost Cutting and Benchmarking for Your ASC - 5 Examples - Robert Welti, MD, Medical Director & Administrator, Santa Barbara Surgery Center, Introduced by Tom Mallon, CEO, Regent Surgical Health
12:30 – 1:30 PM
Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F
A - Improving Profits, and Fixing ASCs
1:30 – 2:05 pm
10 Key Concepts for Managed Care Contracting Orthopedics, and Spine and Pain - Naya Kehayes, MPH, CEO, Eveia Health Consulting & Management
2:10 – 2:40 pm
Key Tips for Success - Orthopedics in ASCs - What Works and What Doesn't - Greg Deconciliis, Administrator, Boston Out-Patient Surgical Suites
2:40 – 3:35 pm
Networking Break & Exhibits
3:35 – 4:10 pm
10 Keys to Improve Billing and Collections - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgical Center Billing
4:15 – 4:45 pm
Out of Network - Will it Still Work? What Do I Need to Know? What is the Future? Thomas J. Pliura, MD, JD, President & CEO, Zchart
4:50 – 5:20 pm
The 5 Best Ways to Improve Billings and Collections and to Improve Revenue Cycle Management - Lisa Rock, President, National Medical Billing Services, and Michael Storch, National Client Representative, MNET Financial, Inc.

Track B – Orthopedic and Spine ASC Issues
1:30 – 2:05 pm
New Procedure Advancements for Spine Centers - Jimmy St. Louis, VP of Integrated Business Development, Laser Spine Institute
2:10 – 2:40 pm
Key Thoughts on Handling Total Joints in ASCs - James T. Caillouette, MD, Chairman, Newport Orthopedic Institute
2:40 – 3:35pm
Networking Break & Exhibits
3:35 – 4:10 pm
Hand Surgery in ASCs - Key Concepts for Clinical and Financial Success - R. Blake Curd, MD, Orthopedic Institute, Todd Flickema, SVP, Surgical Management Professionals, Kyle Goldammer, SVP Finance, Surgical Management Professionals
4:15 – 4:45 pm
Uni Knees in the Outpatient Setting - Is This Right Fit for Your ASC? - Clinical and Financial Issues - Joseph Burkhardt, D.O., Brookside Surgery Center, Sarah Martin, R.N., Regional Vice President, Meridian Surgical Partners, Becky Klein, Director of Clinical Operations, Brookside Surgery Center
4:45 – 5:20 pm
Creating a Spine Center in a Small Community, Daniel Tomes, MD, Introduced by Jeff Leland, Managing Director, Blue Chip Surgical Center Partners

Track C – Pain Management, Spine and Implant Costs
1:30 – 2:05 pm
Pain Management at an ASC: Benefits and Pitfalls - Brannon Frank, MD, Arise Healthcare
2:10 – 2:40 pm
Pain Management in ASCs - Current Ideas to Increase Profits - Amy Mowles, President & CEO, Mowles Medical Practice Management
2:40 – 3:35 pm
Exhibit Hall Break
3:35 – 4:10 pm
Negotiating Implant Payments with Payors and Payments for Multiple Procedures and Other Issues - Marcus Williamson, President Neospine Division, Symbion Healthcare, and Jamie Pearlman
4:15 – 4:45 pm
Managing Pain Practice-Protocols, Branding and Other Tips to Improve Profitability - Faisal M. Rahman, MD, CEO, APAC Group of Healthcare Companies
4:45 – 5:20 pm
Leadership in the ASC Context - What is Great Leadership and How Can it Make a Difference - Ed Hetrick, President & CEO, Facility Development Management

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Track D – Physician Owned Hospitals, Spine Cost Comparison

1:30 – 2:40 pm
The Best Ideas for Physician Owned Orthopedic and Spine Focused Hospitals Now - Tom Macy, CEO, Nebraska Orthopedic Hospital, John Rex-Waller, CEO National Surgical Hospitals, Tom Michaud, CEO, Foundation Surgical Affiliates, R. Blake Curd, MD, Orthopedic Institute, and Scott Becker, JD, CPA, Partner, McGuireWoods, LLP, Moderators

2:40 – 3:35 PM
Exhibit Hall Break

3:35 – 4:10 pm
Leveraging Engagement to Maximize the Supply Chain - Tom Macy, CEO, Nebraska Orthopedic Hospital and Anna McCaslin, CFO, Nebraska Orthopedic Hospital

4:15 – 4:45 pm
Converting an ASC to a Hospital - Russ Greene, RN, CEO, Physicians Specialty Hospital, Fayetteville

4:50 – 5:20 pm
Ambulatory Spine Surgery - ASC vs. Hospital Reimbursement Comparison - David Abraham, M.D., Reading Neck & Spine Center

Track E – Orthopedic and Spine Practice Issues, Selling Units and Implants

1:30 – 2:05 pm
Physician Practice Partnering with Medical Centers - The Good, Bad and the Ugly - Dennis Viellieu, CEO, Midwest Orthopaedics at Rush

2:10 – 2:40 pm
Key Ideas for Improving Orthopedic Practice Profits - John Martin, CEO, OrthoIndy

2:40 – 3:35 PM
Exhibit Hall Break

3:35 – 4:10 pm
Selling Units to Physicians - How Are Shares Valued - Todd Mello, Healthcare Appraisers

4:15 – 4:45 pm
Buyers Perspective on Selling Your ASC, What ASCs Need to Know Now, Acquisition Strategy, ASC Acquisitions in the Current Economic Environment, How Buyers Value ASCs - Evie Miller, CPA, VP Development, USPI, William Kennedy, SVP Business Development, CFA, Senior Partner, NovaMed, Greg Koonsman, CFA, Senior Partner, VMG Health, Moderator Scott Downing, JD, Partner, McGuireWoods, LLP

4:50 – 5:20 pm
Marketing Your ASC and Attracting Patients and Physicians - Mike Lipomi, President, RMC Medstone Capital

Track F – Clinical Quality, Governance and Profits

1:30 – 2:05 pm
The Impact of Healthcare Reform on ASCs

2:10 – 2:40 pm
Clinical and Quality Management of Newer Events in ASCs - Holly Hampe, Director, Patient Safety and Quality, Amerinet

2:40 – 3:35 pm
Exhibit Hall Break

3:35 – 4:10 pm
Improving ASC Performance Through Innovative Governance Techniques - Michael Grant, MD, Center for Ambulatory Surgery, David Myers, MD, Center for Ambulatory Surgery, Ravi Chopra, CEO, The C/N Group

4:15 – 4:15 pm
3 Great Ways to Improve Profitability - Nicola Hawkinson, CEO & Founder, Spine Search, Mel Gunawardena, Founder & CEO, Medigain, Inc., Tom Jacobs, CEO, MedHQ, Moderator, Robert Zasa, MSHHA FACMPE, Partner, ASD Management

4:50 – 5:20 pm
Building Smart in 2010 - John Marasco, Principal & Owner, Marasco & Associates

5:25 – 7:00 PM
Cocktail Reception, Cash Raffles and Exhibits

Saturday, June 12, 2010

8:00 - 8:15 am
Opening Remarks - Dr. Tom Price, US Congressman

8:15 – 8:45 am
Washington Update - Kathy Bryant, JD, President, ASC Association

Concurrent Track Sessions A, B, C, D, and E

Track A

8:50 – 9:30 am
Financial Benchmarking - Rob Westergard, Chief Financial Officer, Ambulatory Surgical Centers of America

9:35 – 10:10 am
Key Concepts to Managing an Effective Interventional Pain Management Practice and Center - Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians

10:15 – 10:50 am
An Analysis of Clinical Outcomes for Spine Procedures Performed in ASCs - Ken Pettine, MD, Loveland Surgery Center

10:55 – 11:30 am
Recruiting & Syndication of Orthopedic, Pain Management and Spine Physicians - Updates, Challenges and Strategies - Kenny Spitler, Senior VP Development, Healthmark Partners

11:35 – 12;10 pm
A Successful Spine Surgery Center That Includes Neuro and Orthopedic Spine Surgeons, Lessens Learned, Problems to Avoid - Thomas Forget, MD, Neurosurgeon

12:15 – 1:00 pm
4 Key Topics (1) Healthcare Reform and ASCs, (2) Should You Convert Your ASC to a HOPD (Hospital Outpatient Department) - The Pros and Cons and Key Issues to Consider, (3) Safe Harbors and (4) Out of Network - Scott Becker, JD, CPA, Partner, and Amber Walsh, JD, Attorney, McGuireWoods, LLP

Track B

8:50 – 9:30 am
The 7 Best Ways to Increase ASC Profits Now - Larry Taylor, CEO, Practice Partners in Healthcare

9:35 – 10:10 am
The 10 Statistics Your ASC Should Examine Each Week - Michael Rucker, COO, Surgical Care Affiliates

10:15 – 10:50 am
Surgeon Owned Implant Distrbution- John Steinmann, DO, Founder & CEO, Synergy Surgical Technologies

10:55 – 12:10 pm
Case Costing and Benchmarking for Orthopedic, Spine and Pain Driven ASCs - Susan Kizirian, COO, Ambulatory Surgical Centers of America and Anne Geier, VP, Ambulatory Surgical Centers of America

Track C

9:35 – 10:10 am
Current Business, and Clinical Thoughts on Spine Procedures in an ASC - Richard A. Kube II, MD, FACSS, Owner/CEO, Prairie Spine & Pain Institute, and Bryan Zowin, President, Physician Advantage

10:15 – 10:50 am
How Changes in the Reimbursement Market will Change the Orthopedic, Spine and Pain Management Device Market -Carl R. Noback, MD, Medical Director, Innovative Pain Solutions, LLC

10:55 – 11:30 AM
Managing Orthopedic Device Costs in the ASC - John Cherf, MD MPH MBA, OrthoIndex

11:35 – 12:10 pm
Back to the Future - Hospital Employed Physicians, How Big Will This Be? - Les Jebson, Executive Director, University of Florida, Orthopaedics and Sports Medicine Institute

Track D

10:15 – 10:50 am
Current Challenges in Financing ASCs and Financing Acquisitions and Expansions - Robert Westergard, CPA, CFO, Ambulatory Surgical Centers of America and Mike Karnes, CFO Regent Surgical Health, Moderator, Anthony Mai, SVP Healthcare Finance, Sun National Bank

10:55 – 11:30 am
Does a Captive Insurance Company Make Sense for your Large Orthopedic or Spine Practice, Pat Sedlack, SVP, Marsh McLennan, J. Brian Jackson, Partner, McGuireWoods LLP

11:35 – 12:10 pm
Uniknees in ASCs - Walter Shelton, MD, Mississippi Surgical Center

Track E

10:15 – 10:50 am
5 Steps to a More Prosperous ASC- How to Improve Billing and Coding - Kim Woodruff, VP Corporate Finance and Compliance, Pinnacle III

10:55 – 11:30 am
Key Concepts on the Smart Use of Information Technology in ASCs - Marion Jenkins, CEO & Founder, QSE Technologies, Craig Veach, SVP Operations, Amkai

11:35 – 12:10 pm
Maximizing the ROI on Technology Use and Investments - Sean Benson, Co-Founder and Vice President of Consulting, ProVation Medical

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- 5 Keys to Maximizing an Orthopedic Driven ASC's Returns in a Tough Economy - Brent Lambert, MD, FACS, President & Owner, Ambulatory Surgical Centers of America
- The 7 Best Ways to Increase ASC Profits Now - Larry Taylor, CEO, Practice Partners in Healthcare
- The Changing Future of Health Care in the United States - Joe Flower, Healthcare Futurist
- The Politics of Health Care Reform - Ron Brownstein, Political Director, Atlantic Media Company
- Key Concepts to Improve the Profitability of Spine Programs - John Caruso, MD, Jim Lynch, MD, Founder Surgery Center of Reno, Moderator, Jeff Leland, Managing Director, Blue Chip Surgical Center Partners
- ASC Transactions, Current Market Analysis and Valuations, - Greg Koonsman, Senior Partner, VMG Health
- Establishing an ASC - 10 Keys for Success - Bill Southwick, President & CEO, Healthmark Partners
- A National View of Political Advocacy Efforts and ASCs - Andrew Hayek, CEO, Surgical Care Affiliates, Chairman, ASC Coalition
- Washington Update - Kathy Bryant, JD, President, ASC Association
- Building Outstanding and Profitable Pain Management Programs, Making Pain Profitable - Robin Fowler, MD, Executive Director & Owner, Interventional Spine & Pain Management
- How to Effectively Measure and Track Patient Quality - David Shapiro, MD, Director of Medical Affairs, AMSURG
- 5 Tips for Managing Anesthesia in Your ASC - Marc Koch, MD, President & CEO. Somnia Anesthesia
- Physician Practice Partnering with Medical Centers - The Good, Bad and the Ugly - Dennis Viellieu, CEO, Midwest Orthopaedics at Rush
- Improving ASC Performance Through Innovative Governance Techniques - Michael Grant, MD, Center for Ambulatory Surgery, David Myers, MD, Center for Ambulatory Surgery, Ravi Chopra, CEO, The C/N Group
- Key Concepts to Managing an Effective Interventional Pain Management Practice and Center - Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians
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6 ASCs Turnarounds

By Lindsey Dunn

The Center for Special Surgery (San Antonio, Texas)

Background: When a group of physicians acquired The Center for Special Surgery from their former management company, they assumed full ownership of an ASC that was located in a neglected building and an "eyesore" for both patients and their physicians, according to Eric Day, MBA, ATC, LAT, the current administrator of the center. In 2006, the ASC performed an average of approximately 180 cases per month and made no distributions to physicians. The center "was on a further downhill slide," says Mr. Day.

What worked: The physicians at The Center for Special Surgery began efforts to turnaround their center by engaging a new management company, Regent Surgical Health, to aid them in improving the center's performance. Their first step was to sell the old building that housed the ASC and relocate to a state-of-the-art facility at the Texas Center for Athletes.

The team then focused their efforts on the ASC's reimbursement by re-evaluating their current chargemaster and standardizing their charges to a percentage of the Ingenix fee schedule for their market. They reevaluated and adjusted the self-pay fee schedule for both cosmetic and plastic surgery cases so that it was more in line with current market rates. The center also made a strategic decision to remain in-network for all payors in the market, though it had previously considered going out-of-network. "There had been an evolution in the market to where we found it advantageous to remain in-network," says Mr. Day. "We had long-standing relationships with many of the payors and we saw this strategy as being the best for the long-term success of the surgery center."

Next, the team began analyzing case costing reports and worked to secure better pricing for both implant and disposable products for orthopedic cases. The administration renegotiated improved rates with nearly all orthopedic vendors and switched GPOs, which led to increased margins on several sets of cases. The center also took advantage of rebate programs and maximized purchases with vendors that had such programs as well as the best pricing, says Mr. Day.

Finally, the team looked at physician referral patterns and began to focus on reasons why investors were not utilizing the center to their full potential. "Many of the surgeons had been referring to the same facility for years, and, although they were investors and located in the building, we still had an uphill climb to prove to those physicians that we could provide equal, if not better, service than they had been provided at their previous facility," says Mr. Day. The ASC's leaders emphasized putting the surgeons and patients first and assessed the needs of the surgeons to ensure that the ASC would be a comfortable, accommodating facility, he says.

Results: As a result of turnaround efforts, the ASC experienced an 85 percent growth in volume in 2009, compared to 2006. The ASC also more than doubled the number of physicians who utilized the facility in a year, adding 15 additional physicians from 2006 to 2009. The ASC is now profitable and able to produce monthly distributions to the investors. "We are now comfortable that we are maximizing utilization from our surgeons who have offices in the building and have recently began to recruit new surgeons outside the building," says Mr. Day. "Patient satisfaction scores consistently show that at least 95 percent of the patients seen in the facility would recommend the facility to their family or friends. We were only a fraction of that before the turnaround."

High Pointe Surgery Center (Lake Elmo, Minn.)

Background: When High Pointe Surgery Center opened in 1999, it was a joint venture between a hospital and physician-investors who

worked at the hospital. Its administrator lacked experience in running an outpatient facility, the center had developed a culture where add-on cases were discouraged and the anesthesiologists were uneager to stay for additional cases. The center lost nearly $1 million in its first year while performing approximately 100 cases per month when 200 cases were needed just to break even. Additionally, standard processes for collections were inexistent and, at its worst, the ASC was 180 days behind on accounts payable. "Its physician-investors had lost faith in the center," says Kyle Goldammer, senior vice president, Surgical Management Professionals, the ASC management company involved with the center's turnaround.

What worked: ASC leaders and staff from SMP began by focusing on cleaning up the center's business practices and playing catch up with accounts receivable. Additional coders were brought on site to help the center's one part-time coder and standard accounting practices were implemented. Other business procedures, including standardizing admissions processes to ensure that the center had accurate demographic information on hand, were also implemented. After the collections were in order, those functions were moved off site to SMP, and the team moved to adjust the culture of the ASC by emphasizing the importance of putting the patient first, taking additional cases and making the ASC an enjoyable and efficient place to work, says Mr. Goldammer. The physician investors were educated on the importance of bringing their cases to the center, and a new administrator was eventually hired. Additionally, the board provided profit-sharing incentives to all employees to better align the staff, and the scheduling team held meetings with physician offices to begin the new effort of marketing the center. .

Results: Eighteen months after the turnaround, the ASC turned profitable and started making distributions to its physicians. As the culture improved, more physicians brought their cases, and the center experienced approximately 30 percent growth in case volumes for nearly six years, until it stabilized. The center currently performs 400 cases per month and has average days in A/R of under 40 days. In its second year post-turnaround, the center made almost a six figure net profit. Since then, the center has made a very healthy seven figure net profit annually, especially considering the size of the facility and organization, according to Mr. Goldammer.

Melville Surgery Center (Melville, N.Y.)

Background: This Long Island, N.Y., multi-specialty ASC was on the brink of bankruptcy and destitute. It had not made money or any profit distributions in five years when ASCOA purchased it and set out to turn it around.

What worked: The center's physicians, along with ASCOA, began by restructuring the organization and working to create an environment where physicians would want to practice. The team renovated the facility, updated equipment and then went to work to employing benchmarking and best practices in staffing, supplies, case costing and accounts receivables — as well as other strategies to remedy a high rent and lagging accounts payable. After the renovation, the center was promoted as a state-of-the-art surgery center. The ASC eventually reduced its turnaround time to less than 10 minutes and was able to attract several high-volume, profitable surgeons through requesting names of unaffiliated surgeons from current partners and bringing them in to the facility for visits.

Results: Within seven months, the ASC was able to turn itself around. Staffing costs went from 52 percent to 20 percent of revenue; supply costs went from 29 percent to 14 percent of revenue; rent went from 14 percent to 5 percent of revenue; A/R went from 94 to 29 days outstanding; A/P went from three to less than one month outstanding; and average revenue per case increased threefold, from $846 to $2,586

Outpatient Surgical Center of Ponca City (Ponca City, Okla.)

Background: Outpatient Surgical Center of Ponca City was more than 20 years old and managed by physician-owners, who had not seen a distribution in seven years or an employee raise in five, when the board began to search for a corporate partner to help turn the center around. The ASC's salaries, wages, benefits and equipment costs were higher than industry averages, and fixed expenses were well above the national average for facilities of its size. Many of the physicians had become disheartened with the return on their investments, and some investors were no longer performing cases at the center and wanted to divest.

What worked: Physicians at ASC engaged Nueterra Healthcare as a corporate partner and its team worked with the ASC's administration to evaluate wages, benefits and salaries to increase net revenue without significant layoffs, says Emily McCarthy, group vice president, Nueterra Healthcare. They also completed a supply value analysis and explored GPO strategies to reduce inventory costs. After conducting a thorough review, Nueterra also moved the facility under its insurance umbrella, resulting in $16,000 in annual savings, and transferred billing operations to its regional billing office, resulting in a reduction in the average A/R days and giving the facility the ability to bill within 24 hours and collect within 45 days. Finally, Nueterra identified potential new physicians to increase volume.

Results: The changes at the facility resulted in it becoming profitable within a year after re-syndication. The operational improvements also led to improvements in employee morale and patient satisfaction, according to Ron Kregar, MD, a physician at the center. "For many years we had not been profitable and a lack of raises affected morale," he says. "[Our turnaround] has

lead to a significant improvement in efficiency and morale leading to profitability. This has resulted in improved esprit de corps that has been noticed by patients, staff and physicians."

Terrence Boring, MD, chairman of the ASC's board, says its affiliation with Nueterra and the turnaround saved his ASC. "Now we are on our way to financial recovery with a sound business footing," he says.

The center experienced a 95 percent patient satisfaction rating in 2009 and continues to conduct long-term business planning. The ASC's goals for the future include further reducing supply costs and increasing case volume, according to Ms. McCarthy.

Santa Barbara Surgery Center (Santa Barbara, Calif.)

Background: With 22 physicians on staff and a location in a well-populated, affluent market, Santa Barbara (Calif.) Surgery Center was well positioned to be a successful ASC but found itself barely breaking even. The ASC had several million dollars in debt, poor payor contracts and its partners weren't maximizing the number of cases they brought to the ASC. Additionally, the ASC had several operational issues, says Jon Vick, president, ASCs Inc., an ASC consulting firm that specializes in helping physician-owners of ASCs develop strategic partnerships.

What worked: ASCs Inc. analyzed the situation and recommended several ASC management companies to the physician-owners. After ASCs Inc. helped the center select a management-company partner with experience in turning around similar centers, the ASC and its new partner worked to renegotiate the outstanding long-term debt by agreeing to repay the loan over a longer time period at a lower interest rate. The management team also analyzed case costs and renegotiated payor contracts by requesting rates significantly higher than Medicare — increased rates that the ASC was able to secure because it still offered significant savings compared to hospital rates, says Mr. Vick.

The team then sat down with the 22 physician partners individually and asked them why they weren't bringing all of their ASC-appropriate cases to the center. "Usually the biggest reasons include scheduling and supply issues, which can be resolved by offering block time and the desired supplies for the physicians in order to create a facility that is preferred by physicians for most of their cases," says Mr. Vick.

The management company, along with the local staff, then worked to improve scheduling, turnover times and operational efficiencies that attracted new physician-partners to the ASC whose cases would be profitable.

Results: Within a year the ASC operations had become more efficient, the partners were bringing more cases, the payor contracts were generating a profit on every case, more partners were recruited and the center moved from just breaking even to very profitable. The ASC had doubled the number of procedures it performed monthly and added 13 additional physicians to its staff, says Mr. Vick. These results were possible because the ASC selected a management company that was experienced specifically in helping similarly-sized centers in like markets, he says.

Southern Indiana Surgery Center (Bloomington, Ind.).

Background: Southern Indiana Surgery Center opened in 1993 as a multi-specialty ASC and was initially profitable but later lost one of the orthopedic groups that utilized the center. As volumes dropped, numerous efficiencies were exposed. At its worst, the center had $2.4 million in A/R, according to J. Nicholas Sarpa, MD, the board chair at the center.

What worked: After becoming board chair, Dr. Sarpa and his partner, who eventually became president of the board, began searching for a company that could provide the physician owners with assistance in managing the ASC. The board eventually selected ASD Management (formerly Woodrum/ASD) as a partner, which helped the ASC turn its business office practices around. A/R was initially reduced by $800,000, despite the loss of the orthopedic group, and income went up due to refining the coding, billing and collecting procedures, negotiating more favorable payer contracts and adopting a new fee schedule. Specific processes for collections were implemented for pre- and post-surgery collections, including co-pays prior to surgery. Additional physicians were recruited to the center, and the legal and operational arrangements were restructured. Finally, the ASC reduced its inventory and updated its fee schedule, which had not been updated since the ASC's opening, 15 years prior. "No one looked under the sheets, so to say, because the center was profitable, but the loss of the orthopedic group made being more efficient necessary," says Joe Zasa, co-founder and managing partner of ASD Management.

Results: Although ASD Management estimated that it would take a year to turn the center around, the physicians saw drastic improvements in three months and saw "real results" in six months, with its largest distribution ever, says Dr. Sarpa. The ASC continues to be successful today, which is a result of very dedicated clinical and administrative leaders, who were with the ASC before the turnaround, says Dr. Sarpa. "Both our business office and clinical managers put in an incredible amount of time to turning around this center," says Dr. Sarpa. Everyone worked to quickly turn it around. It doesn't just take management, but the staff and the physician partners — everyone worked diligently together to turn the center around." ■

Visit www.beckersasc.com/asc-turnarounds/ for more information on ASC turnarounds and ideas to improve surgery center performance.

Tag Team Recruitment — 6 Steps to Drive Profitably: A Success Story From Melville, N.Y.

By Tyler Merrill, ASCOA VP, With David Benisch, MD

In order to run a truly profitable surgery center, case volume is as important an ingredient as any. The success of any turnaround or de novo project hinges on the ability to attract great surgeons to the ASC. ASCOA assumed the management and development responsibilities of The Long Island Surgery Center in Jan. 2006. The center had several problems. Once the ownership had been restructured, the name changed to The Melville Surgery Center, and the operational concerns of the business entity addressed, it was time to recruit physicians and grow the center. As in any effective partnership, cooperation and communication drove the overwhelming success of MSC. This article will examine my development efforts combined with the valuable assistance of Dr. David Benisch from the Melville Surgery Center.

Step 1: Create a working environment that your partners can be proud of. In most failing surgery centers, morale is low and, as a result, the working environment suffers. Hiring the right staff that has the same goals for success and shares the vision of the partners is crucial. In the case of MSC, the facility itself also needed a facelift and so plans were put in place to impress both patients and staff.

David Benisch: Renovating the surgery center was a key component in our recruitment efforts. By promoting the facility as a "modern, state of the art surgery center," we were able to successfully attract new physicians and patients. We also needed staff that would be able to execute on a high level. With turnaround times of less than 10 minutes, we were able to attract high volume surgeons who were disgruntled with wasting time in the hospital waiting for ORs to be turned over.

Step 2: Identify surgeons to utilize the center. The partners were asked to come up with a list of unaffiliated colleagues who would be assets to the center.

DB: The best sources of information regarding potential physician recruits are other well-known, respected and trusted colleagues. The partners have insights both personal and professional. We knew who would potentially be a good fit and who best to avoid.

Step 3: Introductions are very important. Busy surgeons are constantly being approached by vendors and sales representatives. A personal call or

conversation with a colleague is the best way to get the attention of these prospects. One example: If a surgeon is experiencing frustration with the hospital, having a partner there to advocate for his/her surgery center can provide the perfect opportunity to capture new business. Once a dialogue has been opened and interest established, it is time to set up a formal meeting to discuss the opportunities that exist at the center. Having a surgeon partner help to get a foot in the door is invaluable.

DB: If the first contact is made by a physician already utilizing the center, we found a greater success rate in attracting new physicians. A physician reaching out to a colleague will always have a greater impact than a representative from the center or from management. I've found that casually mentioning the surgery center while in conversation is a good way to gauge interest. If it seems like there is potential, I will ask that they accept a formal invitation from an ASCOA representative to discuss the details of the center. Conversations with a prospective surgeon regarding the specifics of utilization and potential ownership can be sensitive and therefore best handled by a third party. It's best to keep physician involvement on the professional level and leave the logistics to management.

Step 4: The sale or the transition into the ASC can carry with it some trepidation for the new recruit. A physician partner can share his/her own personal experience and highlight all the benefits of working at the center. Certain hospital pressure and uncertainly can be overcome by the tremendous benefits that are provided at the center.

DB: Physician to physician contact was the best initial approach to identify candidates who were frustrated with the environment in the hospital operating rooms. Once interest was established, we sold them on the short turnover time, user friendly atmosphere, low infection rate and ease of parking. We emphasized that extra office time would be a byproduct of a more efficient surgical environment and this would result in greater productivity and more free time. There were instances when the hospital threatened to take away block time. We explained that after experiencing the efficiencies at MSC, they would be happy to give away these blocks.

Step 5: The trial period is the time to prove to the new surgeon that taking their cases to the ASC is the best professional choice they have ever made. It is important to roll out the red carpet. Familiarize the staff with the surgeon, his/her preferences and any special needs of his/her patients. Whenever possible, a dry run before the first case is a good way to insure a smooth first day. Have the surgeon visit the center, meet the staff and review the instrumentation.

DB: We went to great lengths to prepare for any new surgeon and we made sure we had the equipment and materials that they would need BEFORE their arrival. We would often have another physician partner in the same specialty at the center to facilitate the first operative experience for the new physician.

Step 6: A personal follow up is a great way to further ingratiate new surgeons. Find out if there is anything the center could be doing better to accommodate them or their patients. The ability of the current partners to be flexible with scheduling is also important. Once all the needs of recruits are met, the ASC will be well on its way to having new productive members driving profits and moral to new heights.

DB: We attempt to accommodate new physicians' scheduling needs by requesting that current partners be as flexible as possible with their block time and scheduling. We want to ensure that the transition from hospital to the surgery center is as smooth as possible. We have found that surgeons have trepidation to some degree in changing their routine so ease of transition is a critical element in new physician satisfaction.

DB: A cooperative approach utilizing the trust and insight of physician to physician relationships followed by the involvement of ASCOA has produced results far exceeding our expectations.

Endnote: Since Dr. Benisch and ASCOA have made the efforts to help turn around Melville Surgery Center, its income has moved from quite negative to very positive and it has thrived as a leading ASC in the greater Long Island area. ■

Dr. David Benisch (herniadoc1@gmail.com) is a general surgeon and president of The Melville Surgery Center on Long Island, N.Y.

Mr. Tyler Merrill (tmerrill@ascoa.com) is a vice president of acquisitions & development for Ambulatory Surgical Centers of America.

8 Statistics About Anesthesiologist Compensation

Here is the median compensation of anesthesiologists for 2005-2008, according to the *AMGA 2009 Medical Group Compensation and Financial Survey*.

1. 2008 — $366,640
2. 2007 — $352,959
3. Percent change 2007-2008 — 3.88 percent
4. 2006 — $344,691
5. Percent change 2006-2008 — 6.37 percent
6. 2005 — $337,654
7. Percent change 2005-2008 — 8.58 percent
8. Dollar change 2005-2008 — $28,986 ■

To order a copy of the complete *2009 Medical Group Compensation and Financial Survey*, visit https://ecommerce.amga.org/iMISPublic/.

Extreme Makeover: ASC Turnarounds

By Brandon Frazier

When my wife and I bought our first house the year after we were married, it should have been a joyous occasion. We were fresh out of college; both had good jobs and our whole lives were ahead of us.

So why was my wife in tears? Well, it's because I had just informed her that we were buying the "fix 'er upper." It was the house that nobody else wanted. I won't go into details, but I will tell you that one of the bedrooms was used to raise pigeons. The previous owners had cut a hole in an outside wall so the birds could come and go as they pleased. Hopefully this provides a little insight into the tears … and what a lousy husband I am.

The house had potential though. It had a good floor plan, beautiful yard and was in a great neighborhood. I had experience with carpentry and knew I could make it into the house that my wife deserved.

It's now 15 years later and I find myself doing the same thing at work. As a leading turnaround expert, ASCOA has the unique ability to look past the pigeons and quickly size up the potential of the ASCs we invest in. From time to time we find centers that have "fatal flaws," which can't be overcome, but the vast majority of the ASCs I meet with can become profitable with a few changes. The best place to start your "Extreme Makeover" is with physician recruiting. The first place to look for additional cases is within your existing partnership. Chances are your partners aren't bringing every case that makes sense to be handled at the center. Meet with them individually to find out what the roadblocks are. The two most common reasons that I hear are equipment and scheduling. You have control over both of these.

Once you have met with all of the partners, estimate how much incremental profit could be generated if the center performed more cases. Present it to the group as a whole at the next board meeting. Be sure to take into account that your fixed costs are probably already covered so the additional cases will be mostly profit. For example, one of our centers in Florida realized a substantial percent increase in profits from a relatively small percentage increase in case volume. It's not uncommon to find $250,000-$500,000 or more worth of marginal revenue from current physicians who work at the center which is currently going elsewhere.

Once this has been completed, you can begin recruiting additional partners. It's best to get your financial house in order before pursuing external physicians. They'll want to be part of a winning team and see that they'll be contributing to a successful center and not just paying off your old accounts payable.

To begin this process, identify the specialties you would like to pursue and then meet with your surgeon partners to determine who the good targets are. I highly recommend having one of your partners make the initial call on your behalf to let them know that you will be following up to discuss the center. Otherwise you will likely go weeks without a return phone call, if at all. If an external physician is interested, have them trial the center for a few months before investing. Encourage your partners to be accommodating with the schedule and work with your vendors to rent or borrow equipment until a firm commitment is made. Recruiting isn't the only way to makeover a failing ASC, but it's a great place to start. Ninety-five percent of the struggling centers we acquire begin their turnaround with recruiting. As for my wife and I; we dried up the tears, rolled up our sleeves and ended up making a lot of great memories by turning our house into a home. ■

Brandon Frazier currently serves as a vice president, acquisitions and development for Ambulatory Surgical Centers of America. Learn more about ASCOA by visiting www.ascoa.com.

2010 CPT Changes for Paravertebral Facet Joint Injections & Guidance

By Lindsey Dunn

NCCI's most recent edits include significant changes for coding and billing facet joint injections. As of 2010, CPT codes for facet joint injections will include guidance for locating the injection site and will limit the number of levels that can be billed at three per day, according to Lynn Kuehn MS, RHIA, CCS-P, FAHIMA, a healthcare coding consultant with Murer Consultants.

Previous codes assigned for paravertebral joint injections did not include guidance that is used to help the physician locate the injection site, so guidance was billed separately for fluoroscopy (CPT 77003) or CT guidance (which actually did not have a code). Now, claims will be rejected if they include separate codes for the injection and guidance, according to Ms. Kuehn.

Codes for paravertebral facet joint injections, with guidance, are as follows:

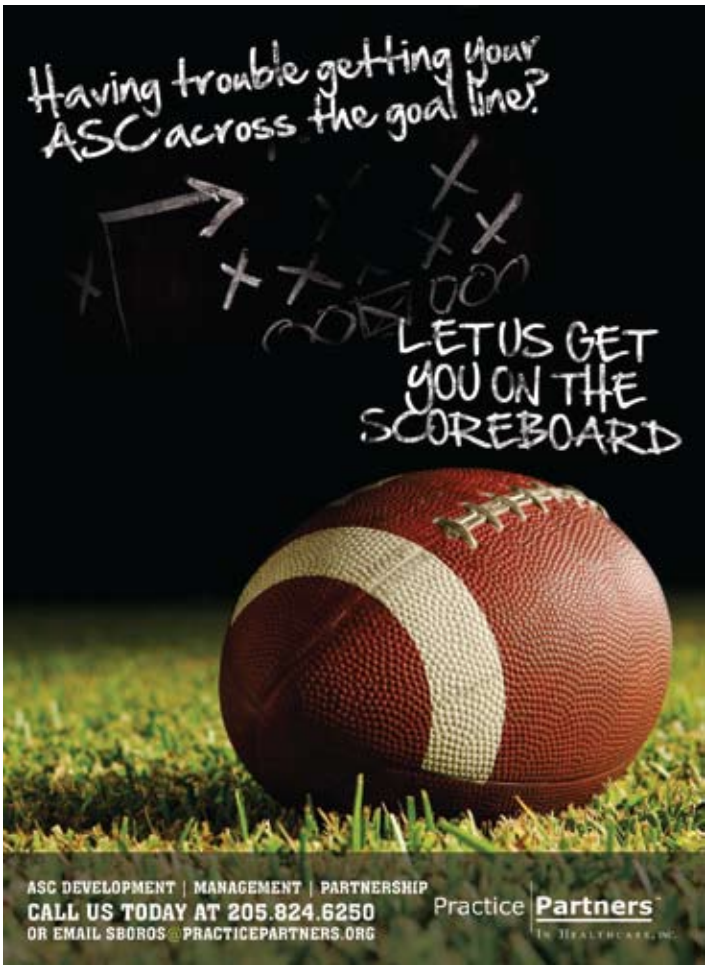
- Cervical or thoracic injections:
  - o CPT 64490 — First or single level, with fluoroscopy or CT guidance
  - o CPT 64491 — Second level, with fluoroscopy or CT guidance
  - o CPT 64492 — Third and any additional levels, with fluoroscopy or CT guidance
- Lumbar or sacral injections:
  - o CPT 64493 — First or single level, with fluoroscopy or CT guidance
  - o CPT 64494 — Second level, with fluoroscopy or CT guidance
  - o CPT 64495 — Third and any additional levels, with fluoroscopy or CT guidance

According to Ms. Kuehn, physicians who do not use guidance to perform facet joint injections cannot use these CPT codes and instead must use musculoskeletal codes, such as codes for tendon sheath or trigger point injections (CPT 20550-20553).

Ms. Kuehn also says that some physicians may choose to use ultrasound guidance for facet joint injections. In those cases, the injections should be billed using Category III codes 0213T-0218T, which mirror CPT 64490-64495. ■

The information provided should be utilized for educational purposes only. Facilities are ultimately responsible for verifying the reporting policies of individual commercial and MAC/FI carriers prior to claim submissions.

Learn more about Murer Consultants at www.murer.com.



2009 Physician Hospital Valuation Survey

By Jason Ruchaber, CFA, ASA

For the first time HealthCare Appraisers has surveyed the physician hospital industry to determine current perspectives among industry participants regarding valuation, transaction activity and management fees. With the help of Physician Hospitals of America, 30 respondents participated in our survey, representing approximately 100 physician-owned hospitals throughout the country. The following summarizes highlights of the survey.

Valuation multiples and methodologies

When purchasing a controlling interest in a physician hospital, 54 percent of the respondents reported prevailing valuation multiples of 5.0-6.9 times EBITDA. Forty percent of respondents perceive that valuation multiples have stayed consistent with the prior year, while 55 percent perceive that multiples have decreased. Only 5 percent believe multiples are increasing.

Valuation Multiples	% Respondents
< 4.0	9%
4.0 to 4.9	19%
5.0 to 5.9	27%
6.0 to 6.9	27%
7.0 to 7.9	9%
8.0+	9%

Somewhat surprisingly, 72 percent of respondents reported that political proposals related to banning or limiting self-referrals to physician-owned hospitals have no impact on the valuation process primarily because facilities currently in existence would likely be grandfathered in if the hospital had physician ownership as of Jan. 1, 2009, and had its Medicare provider agreement in effect as of such date. This grandfathering may not apply to hospitals under development that have not yet obtained their Medicare license. Even though such proposals are not new to the industry, the current focus on reform and democratic control of both the House and the Senate seem to indicate that such proposals stand a greater chance of being passed. Survey participants overwhelmingly agree that this is a risk factor, with 81 percent of respondents reporting that President Obama and the Democratic majority in Congress have a negative effect on the outlook for physician hospitals.

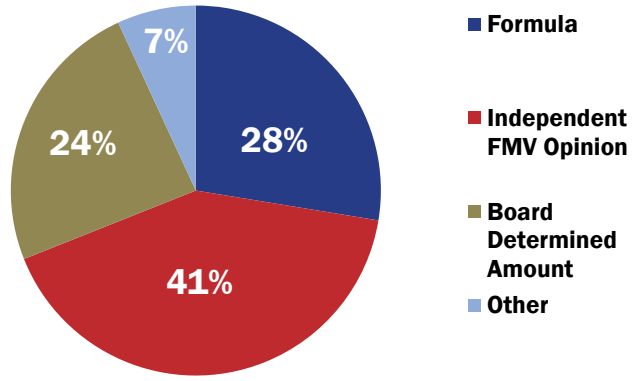
Impact on Outlook	% Respondents
No Impact	11%
Positive	4%
Slightly Positive	4%
Slightly Negative	29%
Negative	26%
Very Negative	26%

Because there exists an inverse relationship between risk and valuation (i.e., higher risk equals lower valuation) we would have expected stronger downward pressure on valuation multiples.

For minority interests it is generally accepted financial theory that valuation of such interests should trade at a discount to controlling interests. Appraisers refer to these discounts as discounts for lack of control and/or discounts for lack of marketability. Acceptance of this concept is supported by survey participants, 50 percent of whom reported that when buying out retiring or departing physicians pricing is set between 3.0-4.9 times EBITDA.

Valuation Multiples	% Respondents
< 2.0	17%
2.0 to 2.9	8%
3.0 to 3.9	13%
4.0 to 4.9	37%
5.0 to 5.9	17%
6.0+	8%

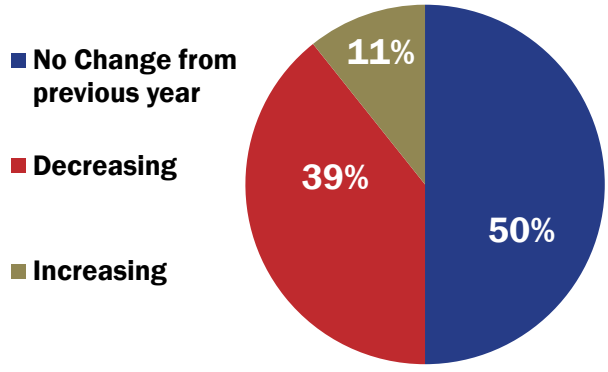
Mathematically this represents a discount from the controlling interest multiples of approximately 30-40 percent. When determining the price to pay departing physicians, 52 percent of respondents base the redemption price on a predetermined formula. For new physician investors, 28 percent of respondents report using a formula to establish the buy-in price; 24 percent allow the board to determine the purchase price; and 41 percent obtain an independent, fair market value opinion.



Regarding the measure of profitability utilized by the respondents, 88 percent measure earnings based on EBITDA. In valuing potential acquisitions, 57 percent look at trailing 12 months of financial data and 19 percent rely on the most recently completed fiscal year.

Transaction activity

With the uncertainty surrounding healthcare reform, tightening in the credit markets and overall economic distress, acquisition activity has waned over the last year with 39 percent of the respondents reporting declines.



For some this has translated into opportunity, with 32 percent of respondents reporting that competition for physician-hospital investment opportunities has declined and only 18 percent reporting that competition has increased. When bidding on acquisition targets, half of the respondents report 2-3 bidders and 30 percent report 4 or more bidders. During 2008, 63 percent of respondents reported performing due diligence for physician-hospital acquisitions but only 21 percent of respondents actually com-

pleted one or more acquisitions. For 2009, 42 percent of respondents plan to purchase between 1-3 physician-hospitals. Sixty-five percent of respondents stated that they were opportunistic with respect to selecting physician-hospital opportunities. Despite the tight credit markets, more than two-thirds of the respondents fund their acquisitions principally through debt and 71 percent of respondents will consider a purchase opportunity regardless of the magnitude of the investment.

De novo (start-up) versus purchase

One-third of the respondents report that they seek de novo opportunities; 23 percent seek turnaround opportunities; and 43 percent seek established cash-flowing centers.

Acquisition Strategy	% Respondents
Established cash-flowing centers	43%
Turnarounds	23%
De Novo (*i.e.*, start-ups)	33%

For a start-up hospital, 54 percent of respondents reported "buy-in" prices of less than $75,000 per 1 percent interest. Respondents were fairly evenly spread on the ownership interest they seek to purchase; however, 42 percent of respondents indicated that a 50-75 percent ownership interest was most desirable.

Preferred physician specialties

The respondents indicated the following strongly desired specialties for physician-investors: orthopedics, spine, general surgery, ENT, and gastroenterology. Cosmetic surgery and oncology were identified as undesirable specialties in a physician-owned hospital.

Management fees

The majority of respondents reported management fees ranging from 5-6 percent of net revenue. Seventy-three percent of respondents indicate they have an equity position in the hospitals they manage, but 68 percent of the respondents indicate that equity ownership has no influence on the level of the management fee charged. ■

(Data sorted from most desired to least desired)	Undesirable	No Preference	Desirable
Orthopedics	0	0	29
Spine	0	1	28
General Surgery	1	3	24
ENT	1	4	22
GI	3	4	21
Urology	5	3	20
Neurosurgery	1	4	19
OB/GYN	6	5	15
Cardiology	2	10	14
Interventional Radiology	5	7	12
Ophthalmology	6	9	11
Vascular Surgery	3	10	11
Neurology	2	12	10
Cardiac Surgery	5	11	8
Plastic Surgery	7	12	7
Medical Oncology/Hematology	9	10	4
Radiation Oncology	9	10	4

A copy of the *2009 Physician Hospital Valuation Survey* can be obtained by visiting the HealthCare Appraisers Web site at www.healthcareappraisers.com.

Jason Ruchaber (jruchaber@hcfmv.com) is a manager in HealthCare Appraisers' Denver, Col., office. He can be contacted at (303) 688-0700.

Becker's ASC Review, the Ambulatory Surgery Center Association and Becker's Orthopedic & Spine Review Announce 8th Annual Conference on Orthopedic, Spine and Pain Management-Driven ASCs: Improving Profitability and Business and Legal Issues

Conference for orthopedic, spine and pain management surgeons who have interests in ambulatory surgery centers and ASC owners and administrators features 112 industry leading speakers and 91 sessions on critical business and legal issues affecting orthopedics, spine and pain management in ASCs.

Chicago — Jan. 18, 2010 — Ambulatory Surgery Center Association, the national association for surgery centers, and ASC Communications, publisher of Becker's ASC Review and Becker's Orthopedic & Spine Review, announce details of its upcoming 8th Annual Orthopedic, Spine and Pain Management-Driven ASCs: Improving Profitability and Business and Legal Issues on June 10-12, 2010, at the Westin Hotel on North Michigan Avenue in Chicago.

HIGHLIGHTS INCLUDE:

- 91 sessions and 112 speakers focused on immediately useful guidance for orthopedic, spine and pain management surgeons who own ambulatory surgical centers and hospitals
- Last year's event included 600 attendees and 75 exhibitors
- Gain practical guidance that can be used immediately
- Understand the impact of healthcare reform on ASCs and physician ownership
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- Terrific pre-conference sessions
- 14.5 CME credits available
- Register before May 1 and save $100
- Additional discounts when registering 2 or more attendees

THERE ARE 4 EASY WAYS TO REGISTER:

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2. Phone. Call (703) 836-5904.

3. E-mail. Contact registration@ascassociation.org.

4. Fax. Print the conference brochure, fill-out the registration on p. 7 and fax it to (703) 836-2090.

HERE ARE JUST 15 OF THE 91 SESSIONS:

1. Minimally Invasive Spine Surgery in ASCs – Greg Poulter, MD, Surgeon, Peak One Surgery, Center, and Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

2. Key Concepts to Improve the Profitability of Spine Programs – John Caruso, MD, Jim Lynch, MD, Founder Surgery Center of Reno, Moderator, and Jeff Leland, Managing Director, Blue Chip Surgical Partners

3. Key Concepts to Managing an Effective Interventional Pain Management Practice and Center – Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians

4. The Changing Future of Health Care in the United State – Joe Flower, Healthcare Futurist

5. The Politics of Healthcare Reform – Ron Brownstein, Political Director, Atlantic Media Company

6. Hand Surgery in ASCs: Key Concepts for Clinical and Financial Success – R. Blake Curd, MD, Orthopedic Institute, MD, Todd Flickema, SVP, Surgical Management Professionals, and Kyle Goldammer, SVP Finance, Surgical Management Professionals

7. 5 Keys to Maximizing an Orthopedic Driven ASC's Returns in a Tough Economy – Brent Lambert, MD, President and Co-Founder, ASCOA

8. Business Planning for Orthopedic and Spine Driven Centers – Tom Mallon, CEO, Regent Surgical Health, and Jeff Simmons, President Western Division, Regent Surgical Health

9. An Analysis of Clinical Outcomes for Spine Procedures Performed in ASCs – Ken Pettine, MD, Loveland Surgery Center

10. The 7 Best Ways to Increase ASC Profits Now – Larry Taylor, CEO, Practice Partners in Healthcare

11. Excelling Without Orthopedics and Spine: Key Concepts for Great ASC Performance – Joseph Zasa, JD, Partner, ASD Management, Skip Daube, MD, Founder, Surgical Center for Excellence, Panama City

12. A National View of Political Advocacy Efforts and ASCs – Andrew Hayek, CEO Surgical Care Affiliates, Chairman ASC Coalition

13. A Step by Step Guide to Recruiting Orthopedic and Spine Surgeons – Chris Suscha, VP of Business Development, Meridian Surgical Partners

14. The Best Ideas for Orthopedic and Spine-Driven ASCs Now – Brent Lambert, MD, FACS, President & Co-Founder, Ambulatory Surgical Centers of America, Joseph Burkhardt, MD, Brookside Surgery Center, Kenny Hancock, President, Meridian Surgical Partners, James T. Caillouette, MD, Chairman, Newport Orthopedic Institute

15. 10 Keys to Improve Billing and Collections – Caryl Serbin, CEO, Serbin Surgical Center Billing

For further information, registration and to view the complete brochure, visit www.BeckersASC.com.

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5 Best Specialties for ASCs Now

By Leigh Page

1. Orthopedics. Rising ASC reimbursement for orthopedic surgery is transforming a sometimes break-even field into a money-making one, says William G. Southwick, president and CEO of HealthMark Partners in Nashville. For example, shoulder surgery used to be so underfunded it needed to be supplemented by income from other procedures, he says. Now, under Medicare's ambulatory payment classification system, reimbursement for orthopedic ASCs is expected to increase 100 percent.

Orthopedics, along with otolaryngology and general surgery, is on Mr. Southwick's list of specialties with enhanced value for ASCs. "These specialties are good for Medicare patients and are saving the healthcare system significant dollars," he says.

Jerry Ippolito, director of perioperative services business development at Southeast Anesthesiology in Charlotte, N.C., also puts orthopedics at or near the top of his list. "Orthopedics is a big winner under APCs," he says. "It has some lucrative cases, such as knee arthroscopies and it is not isolated to one payor population." For example, while total joint procedures focus on Medicare patients, "some of the most severe joint injuries happen to younger people who are on private insurance," Mr. Ippolito says.

2. Spine. Naya Kehayes, CEO of Eveia Health Consulting & Management in Issaquah, Wash., sees a great deal of promise for this specialty. "Spine is probably the newest, biggest most costly surgery done in the hospital that can be done outpatient," she says, but she cautions that ASCs should contact payors before deciding to add any specialty. "The biggest mistake an ASC can make is to buy all the equipment and then talk to the insurer," she says. Ms. Kehayes also sees great potential for ASCs that add cochlear implants, vaginal hysterectomies and some of the larger urology cases to their list of procedures..

Robert S. Bray Jr., MD, a neurosurgeon who runs a spine ASC in California, believes that "the future of spine surgery is in the ASC. "Spine will literally be a game-changer for ASCs in the next 10 years." He warns that ORs have to be larger than at the average ASC to accommodate spine surgery equipment and ORs have to be "ultra clean," so they cannot be shared with specialties like gastroenterology. And it takes a while to convince insurers that spine can be performed safely in an outpatient setting, he says.

3. Bariatrics. Along with spine and retina, bariatrics is on Mr. Southwick's list of specialties with growing value for ASCs because they have been slowly moving out of the hospital setting. Laparoscopic gastric band procedures, or lap-bands, are the only bariatic procedures that are typically performed in an ASC, he says. In contrast, he says gastric bypass surgery requires two or three days of hospitalization and costs a great deal more.

Mr. Southwick notes that the recession has dampened demand for lap-bands, which cost $10,000-$15,000 and are often paid by the patient out of pocket. But popularity is expected to rebound, because an estimated 5-7 percent of the population is eligible for bariatric surgery.

However, "keep in mind that bariatrics needs the whole array of services [for the ASC] to be a bariatric center of excellence," warns Ms. Kehayes. These include patient support services and features such as patient-lifting equipment, wide doorways, floor-supported toilets and sensitivity training for the staff.

4. Retina. Many ophthalmology ASCs limited to cataract surgery are adding retina surgery, which is usually handled by a separate subspecialty of some 1,300 ophthalmologists. These procedures are longer and more complicated and, until recently, were almost always done in the hospital.

While retina is now safe to do in ASCs, ophthalmology surgeons were discouraged from moving out of the hospital by low reimbursements that didn't cover costs in the ASC. However, under the new Medicare APC system, retina payments will rise 100 percent, according to Leo T. Neu III, MD, a retina surgeon who runs an ASC in Springfield, Mo. He says the average payment for a standard pars plana vitrectomy, the most common retina procedure, will rise 145 percent by 2011, to $1,540.

On the professional fee side, Dr. Neu adds that declining reimbursement for some retinal procedures will lure retinal surgeons out of the hospital and into the ASC. For example, Dr. Neu reports that the Medicare professional fee for a vitrectomy with epiretinal membrane peeling fell by 24 percent in 2008.

5. Pain management. Along with gastroenterology and ophthalmology, pain management is on Mr. Southwick's list of specialties with continued value for ASCs. "These specialties continue to be successful in ASCs, if expenses are managed carefully, even as reimbursements for them are cut," he says. While most of the cutting has been due to Medicare APCs, "private payors are beginning to reflect those cuts," he says.

Even though reimbursement to ASCs for pain management will fall 2 percent under APCs, volume is rising. A study conducted last year by KNG Health Consulting found that pain management was one of the few ASC-based specialties where most of the new procedures in centers were not simply moving out of the hospital. While 77-95 percent of new volume in orthopedics, ophthalmology and other specialties came from hospitals, the figure for pain cases was 15 percent. The new volume represents "significant changes in insurance coverage and advancement in the pain management clinical treatments [that] have evolved in the past seven years," the study said. ■

Contact Leigh Page at leigh@beckersasc.com.

17 Great ASCs to Work For

Here are 17 ASCs that are great to work for. To view profiles of and learn more about these organizations, visit **www.BeckersASC.com.** *Note:* Facilities are listed alphabetically by facility name.

Ambulatory Surgical Center of Stevens Point (Stevens Point, Wis.)

Bedford Ambulatory Surgical Center (Bedford, N.H.)

Centennial Surgery Center (Voorhees, N.J.)

Charlotte Surgery Center (Port Charlotte, Fla.)

Day Surgery at RiverBend (Springfield, Ore.)

Grand Valley Surgical Center (Grand Junction, Colo.)

Missoula Bone and Joint Surgery Center (Missoula, Mont.)

Northern Ohio Surgical Center (Sandusky, Ohio)

Northwest Michigan Surgery Center (Traverse City, Mich.)

Patients First Surgery Center (Washington, Mo.)

Reading Hospital Surgery Center at Spring Ridge (Wyomissing, Pa.)

Specialty Surgical Center (Sparta, N.J.)

St. Augustine Surgery Center (St. Augustine, Fla.)

Surgery Center of Reno (Reno, Nev.)

Surgicare of Lake Charles (Lake Charles, La.)

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