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

Which ASC Model is Best-Equipped to Deliver Spine Surgery: Multi-Specialty or Spine-Focused

By Mark Taylor

ASC executives and back specialists say that spine surgery is the last, great, untapped frontier — the final medical specialty and potential ASC business line remaining relatively unexploited.

Like every other specialty that has made the transition from hospital-only to outpatient, reimbursement, or the lack of it, is cited as the primary restraint to spinal surgery's rapid conversion to ambulatory settings.

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3 Core Models for Delivering Anesthesia Services — Trends, Legal Issues and Observations

By Scott Becker, JD, CPA

This article briefly describes three different methods of delivering anesthesia services. Then, it discusses a few legal issues related to anesthesia services. Finally, it provides several different observations related to trends in anesthesia services.

Introduction

The American Society of Anesthesiologists sent a letter to the Office of Inspector General dated Mar. 19, 2009. In the letter, the ASA argues that only anesthesiologists should own, control and

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28 Interesting Facts About Orthopedics in Surgery Centers and Orthopedic Surgeons

Here are 28 interesting facts about orthopedics in ASCs and orthopedic surgeons.

1. Orthopedics was fourth among identified specialties represented at single-specialty centers, tied with pain management, and was represented in 5 percent of all single-specialty ASCs.

2. Orthopedics was the fourth most-represented surgical specialty and was represented in 36 percent of all (single- and multi-specialty) centers in 2007, behind plastic surgery, ophthalmology and gastroenterology.

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FEATURES

Publisher's Letter

ASCs in 2009: 14 Quick Observations; Improving ASC Profitability in a Down Economy — 7th Annual Orthopedic, Spine and Pain Management Driven ASC Conference; Discounts Available — Must Register by May 1

1. **Core Trends in ASCS — 14 Quick Observations.** A number of the current trends we see in ASCs are as follows:

   A. ASCs are holding up, overall, fairly well compared to the rest of the economy.

   B. ASCs are seeing decreases in overall procedures; commonly we are seeing reductions of 5-7 percent as opposed to dramatic reductions.

   C. ASCs are seeing flat to slightly reduced reimbursement with less opportunities for big reimbursement (i.e., less big out-of-network payments, less high paying commercial payors).

   D. Spine continues to move to ASCs with an increasingly positive impact on surgery centers overall.

   E. GI and orthopedic volumes remain generally fine to slightly down without huge negative impacts from the economy. Orthopedics is slightly more down than endoscopy. For both GI and orthopedics, there seem to be significant geographic variations as to results (i.e., some regions of the country are holding up better than others, generally aligned with the economics of the area).

   F. There has been a slow down in the growth of bariactrics procedures and a dampening in the pricing of bariactrics.

   G. Ophthalmology seems to be doing fine.

   H. Pain management reimbursement and the total number of procedures seem to be holding up well.

   I. Cosmetic surgery appears down significantly.

   J. Great management together with the benchmarking of supply costs and the managing of staffing costs has become more important than ever.

   K. Negotiations with payors are becoming more challenging overall. This is very dependent upon market and access issues. There are some markets where payors are under more pressure to limit reimbursement. However, there continues to be opportunity to work with payors and enhance ASC contract rates if the ASC demonstrates a cost savings alternative. For example, if the ASC is offering a new line of business, especially spine and high cost orthopedics, there is often an opportunity for substantial negotiation.

   L. As patients are faced with layoffs and potentially new jobs with new employers, there are substantial shifts in the payor mix which impact net revenue per case. In addition, there are increases in flexible spending accounts and high deductible benefits that require a larger portion

of the overall payment to be from the patient. Hence, patient collections and up-front collections are becoming more critical.

M. ASCs are reexamining opportunities to reduce full-time employees and increasingly outsourcing certain functions such as revenue cycle management, and billing and collection services, particularly where the center can realize savings and/or improve collections.

N. We are seeing an increased interest in the willingness to buy refabricated and refurbished equipment as opposed to new equipment.

2. **Improving ASC Profits in a Down Economy: 7th Annual Orthopedic, Spine and Pain Management Driven ASC Conference.** The 7th Annual Orthopedic, Spine and Pain Management Driven ASC Conference is scheduled for June 11-13. The conference is focused on providing practical advice to ASCs that can be used immediately. It will be held at the Westin Hotel in Chicago. We have approximately 94 speakers, 68 different sessions and, overall, outstanding presenters. We expect an outstanding conference. To obtain a brochure, visit www.beckersasc.com.

If you would like to attend the conference, please take a $100 discount off of registration to attend the main conference and a $200 discount if attending the main plus preconference. Please note on your registration form discount per Scott Becker. **These discounts must by taken by May 1. These discounts are in addition to other discounts, such as ASC Association member discounts and early registration discounts, to which you may be entitled.** To register, either fax in the registration form found on the conference insert to (703) 836-2090, or register online at https://www.ascassociation.org/june2009.cfm or call the ASC Association at (703) 836-5904.

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

Very truly yours,

Scott Becker

SpineFeature: Which ASC Model Is Best-Equipped To Deliver Spine Surgery: Multi-Specialty or Spine-Focused
(continued from page 1)

While inpatient hospital spinal surgery cases were predicted to increase only 10 percent by 2013, outpatient spinal surgery cases are expected to rise 342 percent by then, according to a 2003 survey by the Healthcare Advisory Board that was updated in 2006.

A confluence of factors — including increased safety, new and improved preoperative and postoperative drugs, including pain medication, better and less invasive instruments and surgical procedures and better imaging devices — have pushed the drive from inpatient hospital to ASC settings. Improved anesthesia has reduced nausea and other side effects and diminished the need for overnight stays and extended hospitalization. All of these factors have led to improved outcomes and greater patient comfort and satisfaction, ASC owners assert. As payors like Medicare and private health plans have crunched the numbers and documented the lower costs of ASC spinal procedures versus the more expensive hospital inpatient bills for the same services, they have encouraged in growing numbers the move to ASCs.

Physician specialists, such as fellowship-trained orthopedic surgeons and neurosurgeons, who were slow to embrace the transition from hospital ORs, are performing more procedures in ambulatory settings. They appreciate the faster turnarounds, greater efficiencies and control over their environment that ASCs offer.

Neurosurgeon James Lynch, MD, an owner and board chairman of the Surgery Center of Reno (Nev.) and the founder of SpineNevada, a surgical medical practice, says spinal procedures at his ASC account for only 3.5 percent of total cases but comprise 18 percent of total gross charges and 22.5 percent of total revenue.

While most spine surgeons continue to perform the vast majority of their procedures in hospital settings — from 65-80 percent — they agree that the percentage of outpatient surgeries is rising. Today the most common spinal CPT code services offered in ASCs are microdiscectomies with decompression, single and multi-level anterior discectomies, laminectomies and laminotomies, use of microscope, anterior instrumentation, allografts for spine surgery and arthrodesis anterior interbodies. Some surgeons are performing even more complex procedures in ambulatory settings.

What ASC model works best?

There continues to be debate over the best model for delivering spinal surgery services in ASCs. Some argue that single-specialty ASCs focusing on spine offer the best opportunities for physicians, patients and investors, while others contend that multidisciplinary ASCs offer a better model that further spreads the risk and assures greater longevity.

While representatives present compellingly divergent arguments for both models, spine surgeons and ASC chain executives say it's more like "different strokes for different folks," respectfully agreeing to disagree.

Here industry experts make the cases for each model.

Spine-focused ASCs: Planning and seeking market-based reimbursement critical to success

Neurosurgeon John Caruso, MD, is sold on the spine-focused ASC model and helped found spine-only The Parkway Neuroscience & Spine Institute in Hagerstown, Md., a comprehensive spine treatment center and integrated practice model. While a variety of different physicians practice there, the focus of their efforts are directed toward the spine. Taking a 'Center of Excellence' approach has worked for Parkway, Dr. Caruso says.

"We're a pure spine center. We're not a multi-specialty ASC but an integrated specialty practice. We don't do colonoscopies or cataracts, but we included neurosurgeons, neurologists, physical therapists, rehabilitation physicians (physiatrists), pain management specialists and chiropractors. The model makes sense," he says. "Since we opened in 2006, business has been great."

Dr. Caruso says organized medicine has dropped the ball in treating back and neck pain. "If you look at who provides care to those patients, it's been a hodgepodge of professionals ranging from chiropractors and pain management physicians to spine surgeons, each chipping away at the problem," he says. "We went away from that scattershot, uncoordinated model by growing and integrating that. Here they all overlap. We employ an electronic health record. A patient can have different points of entry and still be seen by a variety of specialists in the practice."

He says the center offers flexible hours and a

convenient location in which physician offices are located in the same facility in which they perform procedures. Dr. Caruso, one of four neurosurgeons who operate there, concedes that the bulk of his procedures continue to be performed in hospitals.

"But we've positioned ourselves to have an outpatient spine center to maximize efficiencies and improve quality of care. We can see more patients and make it a better experience for them," he explains. He notes that spine procedures aren't performed at the ASC every day, but on those days the center offers pain procedures.

He says each pain physician works during defined blocks of time, but points out that Maryland law prohibits him from keeping Parkway open overnight, necessitating that the most complex procedures be performed in hospitals.

In spite of those restrictions he believes his ASC model will continue to grow because of the pervasiveness of spine problems in America today and the maturing of the baby boomer generation. "Of all the back patients, only about 3 percent will ever need back surgery. However, they will continue to need the kinds of comprehensive back services we offer."

Multiple spine services under one roof improve patient satisfaction

Dr. Caruso described a recent out-of-state worker's compensation patient who had not worked in three months after a back injury. "A physician assistant saw the patient, who received an MRI scan across the hall that revealed a large disc herniation. I saw him and arranged an epidural injection in our center, and he was back to work in days after being off for months," he recalls. "It's an efficient model of integration that gives quick and easy access to multiple providers in a comfortable and convenient setting. It's not all about the surgery but getting people seen effectively and efficiently. We're looking at it from different aspects."

Dr. Caruso, whose Parkway ASC partners with Blue Chip Surgical Center Partners, says he hopes to expand to add a neuromuscular focus as well. The ASC originally planned to partner with an orthopedic surgical group, but he says a local hospital learned of the planned deal and broke it up. "Our hospital saw this as a threat against the hospital and fractured our relationship with the orthopedic group. Muscular skeletal conditions bring about 20 percent of all people to see a physician. And we're hoping to add that to our center."

He says patients get to know the care team and appreciate the experience.

"Instead of shifting between doctors in distant locations and struggling to get early appointments, we offer everything under one roof. As sub-specialists, we create a lot of chaos in patients' lives. But in an integrated center, it can work. We've seen patients at 6 a.m. and even on weekends and do house calls if we need to. We have care extenders and do clinics on everyday. We fit them in and work them through."

Dr. Caruso says many patients are surprised by the number and complexity of procedures that can now be performed in an outpatient setting.

"I've been doing outpatient spine surgery 15 years through hospital outpatient facilities. We're doing it in the exact same way, but it's more comfortable for patients and more efficient for physicians. We employ the best nurses and our anesthesiologists give me great ability to take care of my patients in a patient-friendly controlled fashion that does not exist in a standard hospital stay."

Dr. Caruso says spine-focused ASCs struggle against the perception that they will over-utilize the facilities. "Hospitals and providers and payors think we're just going to do more. I explained

to one insurer that I would be able to see more patients in a better setting, thus providing better care to their members."

He says because ASCs operate faster and more efficiently, he can now perform five procedures by 1 p.m. and see patients the rest of the day. Because of the longer turnaround times in hospitals, he says it would often take until 6 p.m. to complete the same number of surgeries.

Getting paid remains challenging

"Our bills are always less than a hospital's, but it's a struggle to get paid," Dr. Caruso says. "Medicare and Medicaid are the death knell to physicians seeking to try anything innovative. But you can't cover your overhead, let alone make any profit, on what Medicare and Medicaid pay you. Unfortunately, the problem with commercial insurers is that they think if you accept Medicare, then that's what they'll pay you. I can't do a Medicare disc in my center; CMS doesn't recognize that as an appropriate place."

According to Dr. Caruso, CMS has now released more CPT codes for ASCs. "CMS realized it would have saved more than $1 billion if the same procedures had been performed in ASCs instead of hospitals," he says. "They're slowly releasing restrictions, and commercial payors are starting to follow. They look at the last 50 cervical discs they've paid to hospitals and look at our outcomes and costs and see I can do it better and more efficiently. The patient satisfaction is much higher with lower infection rates and improved results. But you have to understand the model, too. One-third of ASCs will fail. This is a huge economic undertaking."

He says his practice left a 7,000 square-foot facility to merge with the orthopedic group committing to a 26,500 square-foot building. The merger unraveled, leaving Parkway to fill the facility, which includes 18 physician exam rooms, one OR and eight recovery rooms. Physical therapy and rehabilitation are available on site, along with imaging and chiropractic. "We have the ability to expand to another 30,000 square-feet," he says.

Dr. Caruso says at first Parkway remained out of most payors' networks until it developed a track record of quality and efficiency. "They saw that their members were well cared for and eventually came around," he says. "Nobody wants to pay for services. They always begin by saying, 'We'll pay 105 percent of Medicare.' But that doesn't work for us. My partners and I have been in practice for quite a while, so we waited them out and negotiated a much more favorable rate than if we'd signed their initial contract offers. We had a very good return on our investment in the first year. We've been successful from the get go."

He concedes that most of his work is still done in hospitals, but predicts rapid changes.

"Things are coming to ASCs," the 44-year-old surgeon says. "When I first started doing cervical discs we kept people in the ICU for two days with drains. Now in my center they're in and out in two hours. This model works. I can go directly to employers. One-third of worker's compensation is back pain and problems, and we're providing a model of efficient and effective care where people can be engaged in their own recovery."

Hospital changes from enemy to friend

Dr. Caruso says the local hospital, Washington County Hospital in Hagerstown, went from seeing him as a "rogue entrepreneurial physician" to an ally. "I'm working with the hospital to bring in inpatients," he says. "Their case volume didn't go down, and the hospital is still making money. We've made them better. They're getting involved in improving their efficiency and effectiveness as well. Now they're seeing this model as beneficial to the community and not a threat to them."

Dr. Caruso says scheduling, a hallmark for every ASC, is also vital to spine-focused ASCs.

"My hospital's turnover time between procedures was 68 minutes, compared to seven minutes at my ASC," he says. "I sometimes spend more time waiting for the case than in doing the case. We're showing them how to be more efficient. We're controlling pharmaceutical costs and schedules and organizing care into patterns. We're always asking, 'Can we do better?' If you keep asking that question, the answer will be 'yes, we can.' You just need the willingness and determination to do it."

Careful planning important

Jeff Leland, managing partner of Blue Chip Surgery Center Partners, says spine-focused ASCs can become successful if efficiency is a primary focus.

"In my view the way you build a successful spine center is by choosing partners correctly and sizing the facility appropriately," he says. "Our spine surgery centers may be only open two-and one-half days a week, but surgery centers are largely fixed-cost businesses. So if you can keep your total cost downs, it can work. At the end of the day, the trick is figuring out how to obtain proper reimbursement. In our spine surgery centers, we can do far fewer cases but have to be properly reimbursed to make this a win-win. The competition for a spine surgery center is the hospital, not other ASCs. Successful spine ASCs position reimbursement on what hospitals get paid while capturing some of that savings for the partners."

Mr. Leland says a typical spine surgeon brings 60-120 cases annually to an ASC.

"That's not so many cases compared to some specialties, and because the case volume is relatively low, the successful spine ASC must be reimbursed properly," he reiterates. "There's an art form to getting proper reimbursement. You have to stay "out of network" for a while to help the payors appreciate how much they're paying that they don't have to. In every instance, our eventual goal in all centers is to be largely 'in-network.'"

He says in a multi-disciplinary ASC, the other non-spine doctors will often not want to remain out-of-network very long. " It creates challenges they're not willing to accept. The competition for typical multi-specialty surgery center is not in-patient hospitals, but other ASCs. It really gets down to ability to contract effectively," Mr. Leland explains. "Most contract negotiators in the ASC business use cost information when they think of contracting, however, with spine cases, they ought to be reimbursed higher than some nominal mark-up on cost. In Blue Chip managed spine ASCs, it's based on value, on what is the market rate for spine cases. We don't talk about costs at all. We look at what the market is paying. It's not rocket science."

He says the biggest problem Blue Chip and its spine ASCs face is that payors don't have cell-designed and well-understood algorithms for understanding the payor's costs and often the payors do not understand how to evaluate value.

"Reimbursement is critically important and one must also know how to manage costs and design for a low volume of cases. Knowing we'll only do 1,500 cases, not 4,000, helps us to plan and price our services correctly," he says. "We turn out the lights."

Staffing appropriately keeps costs manageable

Mr. Leland says Blue Chip's spine-focused ASCs are able to staff with only two to three full-time staff and a handful of per diem employees. He says the spine surgeons each work in the surgery center only one day a week or a few days a month so the surgery center will often recruit the surgeon's hospital-based nurses and staff to work in the spine ASC on a per diem basis.

"That allows us to keep our fixed costs really low. Three years ago, we formed this business with the idea of doing outpatient spine right from the beginning. It was the game plan from day one," he says. "We have to train staff and choose our markets well. The reason we're successful with outpatient spine is we do it in an organized and methodical way. And we're careful to do it well."

Mr. Leland says the spine center referrals come from doctors. "People don't call us directly to request spine surgery," he says. "The physician practice is the portal. We don't even have to advertise. All of our patients come from other doctors. We don't have walk-ins. It's all based on relationships with doctors. We don't view ourselves as competing with pain management centers and chiropractors. Most of our partners are neurosurgeons and orthopedic spine surgeons."

Beth Ann Johnson, RN, vice president of clinical systems for Blue Chip, says six of the company's nine ASCs offer spine surgery.

She says one of the most critical things to doing spine surgery effectively in an outpatient environment is anesthesia.

"That can be a real deal-breaker," she says. "An ASC doing spine needs great anesthesia delivered by anesthesia providers experienced in giving anesthesia in outpatient settings. That's crucial. Patients need to feel good enough to go home in a few hours. It's important that they have not been given the impression that they will need extended care in a medical setting. We educate everyone, from the staff in the physician offices to the receptionists at the ASC that the patient can expect to go home within a couple hours of their procedure."

One ASC's answer to the outpatient limitations on spine surgery

Ken Pettine, MD, a board-certified orthopedic surgeon specializing in spine surgery and co-owner of the Loveland (Colo.) Surgery Center, says his ASC is spine-focused and offers pain

management, orthopedics, urology, ENT, podiatry and anesthesiology services in a state-of-the-art facility with three operating rooms.

While acknowledging challenges with the spine-centered model, Dr. Pettine says he's figured out a way to make it work.

"We have a unique situation. We are an ASC with a convalescent license," he explains. "Most states only allow an ASC to keep a patient for 23 hours; Colorado allows a convalescent license. And that's the key. It allows us to transfer patients from our recovery room and enables me to do 90 percent of my spine surgery at the ASC. Anybody in the country can do what we're doing, subject to state regulations."

Because of the adjoining convalescent center, in which he holds an ownership stake, Dr. Pettine says he can more perform more difficult and complex surgeries at his ASC for less money than hospitals charge.

However, securing good contracts is vital. "We were non-participating (out of network) for about one year," he recalls. "You're paid more out of network, but insurers recognized our high quality and lower costs, and we got the contracts we needed. There's no way any hospitals can compete with us."

He says eight physician partners own the ASC with National Surgical Care, which manages the center.

"If you ask most spine surgeons whether they would rather operate under my conditions in an ASC or in a hospital, they would choose an ASC," he says. "We have a 12-minute average turnaround, compared to an hour to an hour and a half for hospitals. We have no staff turnover and offer experienced personnel, and I can do an operation at least 20-30 percent faster because I have the same personnel working with me everyday. There's a lower infection risk, patients spend less time under anesthesia and we have better pain control with a one-to-one nurse/patient ratio. In hospitals these patients would spend three to five days recovering, but in ours they're out in 48 hours."

Taking a leadership role

Dr. Pettine says that Loveland currently is conducting 10 FDA-approved studies of spinal implants. "We're doing more spine surgery research in our ASC than all the Colorado hospitals combined," Dr. Pettine says. "We probably do more than 400 major artificial disc replacements and major spine procedures per year. Anybody can do what we're doing. You either build an ASC next to a rehab hospital or nursing home or establish a relationship with an existing facility nearby. We arrange to have our patients transferred there from our recovery room."

Dr. Pettine says his ASC was named a Blue Cross and Blue Shield Center of Excellence. "We're presenting outcomes data at a conference this summer on over 500 instrumented spine cases and demonstrate how we have improved safety and efficiency," he says. "At the same time, we've saved BCBS 60 percent over hospital charges on the same procedures."

He says healthcare in the United States will change, and the winners will be providers who can do spine surgery with safety, efficacy, high quality and cost savings. "That's what President Obama is looking for, and I think we're an example of that new model of care," he says.

Dr. Pettine says there are no spinal procedures he would not perform at Loveland.

"We're busy five days a week. My partners perform about 70 percent of their spine work here, because they do more Medicare and Medicaid and do that in the hospital. But I'm spoiled now and don't want to work at the hospital anymore."

Multi-disciplinary ASCs offer spine surgery, but hedge bets

David Abraham, MD, a board-certified orthopedic surgeon fellowship trained in spine surgery with the Reading (Pa.) Spine and Neck Center, says opening a spine-centered ASC in a state like Maryland may make sense there because of restrictive laws requiring ASCs to focus on a single specialty.

"But it wouldn't work here [in Pennsylvania]," says Dr. Abraham. "I've always said a spine-only ASC would flop. The problem is Medicare does not recognize nor reimburse for all outpatient spine procedures and Medicare beneficiaries make up one-third of my cases. If one-third of my cases are with Medicare beneficiaries and can't be done in my ASC, I'm going to need three other spine guys to fill that gap to keep the ASC busy. I've heard some of these spine-only places don't do enough cases to keep their ASCs open. It doesn't seem like a viable business model."

He says many older spine surgeons still believe that doing spine procedures in an ASC is risky business because it wasn't done when they were undergoing their training. "Back then, everything was done in hospitals, and really good outpatient anesthesia wasn't available," he says. "It's different today. There has been an evolution of technology and comforts that have brought many more spine cases to ASC settings."

He says the Reading ASC is a multi-specialty ASC that opened nine years ago and partnered with Ambulatory Surgery Centers of America. He says that while it offers a full range of spine services, he chose to team up with other types of surgeons to produce a multi-specialty center that offers greater opportunity for institutional longevity and spreading the economic risks.

"If the work I do can only keep the center busy two days a week but others working there can expand its use to five days a week, my investment is better protected by that outside revenue stream," he says.

Payors slow to embrace spine-focused ASCs

Dr. Abraham points out that some insurers don't like spine-focused centers. He says a typical spine surgeon performs 70 percent inpatient and 30 percent outpatient surgery. Some spine surgeons who do surgery may also do pain injections or refer to a colleague within the center with a pain management practice across town.

He says the limitation of a spine-only center is that the majority of spine surgery is still done in inpatient settings, with Medicare and some large insurers only agreeing to reimburse some procedures in a hospital setting.

"In a best case scenario if all payors allowed me to perform spine procedures in ambulatory settings, I would probably only be able to do 40 percent of the ASC's case volume. And if you factor in Medicare and insurers, it might be down to 20-25 percent. Therein lays the problem," he says.

That contrasts with hand and foot surgeons, who can do 90 percent of their work in outpatient settings. "I think the multi-specialty model works the best by including sports medicine, orthopedics, ophthalmology, pain management, GI and ENT," he says.

He believes a multi-specialty spine center should include different types of medical specialists covering the entire gamut of spine care, including non-operative spine specialists, pain management physicians and fellowship-trained spine surgeons.

Dr. Abraham says medicine is to blame for the confusion surrounding how to treat back pain. "We have done a poor job of organizing protocols for managing back pain," he says. "We didn't get a lecture in medical school about spine care, but they did take two weeks to learn about sub-Saharan diseases you'll never see in real life. We didn't spend any real time learning about the number two reason people see a doctor: back pain."

In that absence, other healing professions began focusing on back care, he says, including chiropractors, homeopaths, acupuncturists, osteopaths and others.

"That's been very confusing to the public," he says. "Historically, we haven't managed spine care well. We're trying to introduce scientific rigor and organization to what is a very disorganized area of medicine."

Dr. Abraham says he performs the surgeries the same way whether in a hospital or ASC setting. "The concept of doing something less or differently argues against quality of care," he suggests. "If you mess with the foundation of good results, you will have a lot of failed procedures.

Spine-focused ASCs a 'risky business'

The Surgery Center of Reno's Dr. Lynch also believes it's a risky proposition for an ASC to rely on a single medical specialty. "It places the ASC in a vulnerable position, particularly with the uncertainty of our current economic climate," he says. Like Dr. Abraham, he says going out of network to obtain higher reimbursements can adversely impact patients.

"Insurers are clamping down on this. Patients are having more difficulty with out-of-network benefits and it's asking a lot of them to pay that much extra money," he says. "People don't have the extra money to match these big out of network co-pays."

Dr. Lynch also directs spine services for Regent Surgical Health, the Surgery Center of Reno's managing partner. He says outpatient spine has great growth potential. "Spine is the last specialty to catch up and go outpatient. It's a hot topic with huge projected growth."

The Surgery Center of Reno has 30 physician owners who perform 50 percent of the ASC's cases. It includes three neurosurgeons, two pain management specialists, three ENT specialists, four orthopedic surgeons, a general and bariatric surgery program with four surgeons, two ophthalmologists, two podiatrists and a urology/lithotripsy group.

Single-specialty spine may be a risky proposition

Dr. Lynch says Regent won't even start an ASC now with a single-specialty focus.

"It's a one trick pony, a high-risk proposition, regardless of where you are located. When you are only open two and one-half days a week, you're more likely to have higher staff attrition," he says. "And it's hard to get part-time staff, pay them well and retain them. They want the guaranteed hours."

"Most ASCs are not successful focusing only on spine," Dr. Lynch says. "You can't know what's happening five years down the road. And you can't predict what's coming next in reimbursement, so you need to diversify."

He says spine or high-end orthopedics can lose money if done incorrectly.

"Our ASC's small minority ownership prevents us from making big mistakes, like dealing with implants, carve outs and equipment purchases," Dr. Lynch says. "We have such an overlap, setting up pain injections, referrals back and forth. It's gravy. It's insane not to do that. Why would you do a single-specialty when it doesn't make sense? It's like putting all your eggs in one basket, and just because you focus on one spec doesn't mean you do it better than anyone else."

He says bringing ENT and spine together can generate big profits for ASCs. "ENT is high volume. Spine procedures fluctuate in volume but offer high reimbursement."

Sometimes partnering with hospitals is a wise decision

Dr. Lynch encourages ASCs to explore partnering with local hospitals as a way to grow the spine business.

"So many people see hospitals as adversaries, but aligning with them can work. They can be one of your best anchored tenants," he says, "and partnering with them can help you get loans. They won't disappear overnight either."

"Hospitals have insurance contracts and better rates," Dr. Lynch says. "There are other advantages as well. Because of them we have intraoperative monitoring. We make money off partnering with hospitals. It's the same thing with implants, because of our relationship with both Regent and St. Mary's Regional Medical Center (a Catholic Healthcare West hospital in Reno). The old relationship paradigm was adversarial. But by the nature of spine surgery, we have to do cases in the hospital. This is a give and take. So it makes sense to have to have a good working relationship."

Dr. Lynch says his ASC has a presence on the hospital campus. "I operate at the hospital two days a week. We market with them. What we're doing is a win-win. That's how you keep everyone happy," he says. "It's an ideal model for us. I call it a triple crown if have good corporate and hospital partners. Our ASC returns 30-40 percent ROI on cash investment year to year. Pain, GI and ENT are the high-volume procedures that keep people coming in, pay the bills and keep staff employed. Everything else on top of that is profit." ■

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3 Core Models Delivering Anesthesia Services
(continued from page 1)

arguably profit from anesthesia and that arrangements by which surgeons and gastroenterologists profit from anesthesia are not legal. The following paragraphs from the ASA letter highlights some of the ASA's views as well as the models being used and certain of the issues raised by such arrangement.

The letter states:

Traditional model
"The overwhelming majority of anesthesiologists are organized as independent group practices that contract with hospitals, ambulatory surgical centers (ASCs) or other outpatient providers to provide anesthesia services.

"Other than perhaps leasing space, equipment and/or administrative personnel services from the facility or office, there is usually no compensation agreement between the group and the facility or office."

Employment model
"A limited number of anesthesia providers operate under an employment model whereby the facility directly pays the anesthesia providers a salary. In exchange for the salary, the anesthesia provider either assigns billing and collecting for professional fees to the facility or handles billing himself/herself and then turns over collections to the facility."

Owner provider model
"A third model, the 'company model,' has grown in popularity in various areas of the country and is the impetus for this letter. Trade press articles increasingly note the popularity of this model amount ASCs (e.g., "Can Surgery Centers Profit from Anesthesia?" *Outpatient Surgery*, April 2004, and "Five Ways Your ASC Can Profit from Anesthesia Services," *SurgiStrategies*, May 2005). Under the 'company model,' a physician-owned facility, such as an ASC, establishes and incorporates a separate anesthesia company under the same ownership as the facility. The anesthesia company employs anesthesia provides and exists to provide anesthesia services to the facility. The establishment of the separate corporation allows for billing of facility fees and anesthesia services fee, which is usually handled through the same billing/administrative company. After the anesthesia providers' salaries, billing expense and other costs are extracted, the anesthesia company's profits are distributed back to the owners of the facility. Some estimate these distributed profits as 40 percent or higher of the anesthesia fees. In most cases, the fees paid to the anesthesia providers are less than they could earn if they billed independently.

"As healthcare dollars become increasingly scarce, healthcare facilities are looking to areas, including anesthesia services, to enhance their profitability. The 'company model' is gaining traction across the country and is especially prevalent with endoscopy centers owned by gastroenterologists. We have learned of gastroenterologists establishing or proposing the company model in a number of states, including Tennessee, Florida, Pennsylvania, Oklahoma and North Carolina."

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

"However, under the 'company model' the facility owners, who also own the anesthesia company and have a stake in the anesthesia profits, have an incentive to increase utilization of anesthesia services and thus, increase costs to the system and federal healthcare programs."

ASA's alleged kickback concerns
"Given the increased opportunity for profits from anesthesia services, the 'company model' is likely to result in corruption of professional judgment. In the example of the endoscopy center, a gastroenterologist performs the procedure as a physician and owner of both the center and the anesthesia company. He/she will receive income from the performance of the procedure, facility fee and administration of anesthesia. Now that he/she has a stake in the game in regard to anesthesia services, it does not take a leap of logic for one to surmise that he/she could pressure anesthesia providers, who are employees of his/her company, to administer anesthesia or administer a deeper level of anesthesia to patients who might be able to tolerate the procedure without such anesthesia services. The resulting increase in referrals for anesthesia services could amount to a violation of the self-referral laws. More important, they could have a detrimental impact on patient safety and quality of care."

"Finally, the 'company model' requires anesthesia providers to pass back to the facility a substantial portion of the fees for the services they provide to patients. As previously stated, some have estimated 40 percent of the anesthesia fee is distributed to the physician owners of the facility. Further, anesthesia groups cannot economically compete with such a model unless they are willing to provide a similar illegal kickback to the facility."

ASA's request for action
"Given the fact that several anesthesiology group practices have seen their contracts terminated for failing to agree to the company model, and out of concern for patient safety and quality of care, we respectfully request the Office of Inspector General to issue a Special Advisory Bulletin clarifying the merits, implications and legality of the company model described."

A. Models of delivering service
There are multiple different models of arranging for anesthesia services. Three of the most prevalent include the following:

Under the traditional model of delivering anesthesia services, a local anesthesia group contracts with a center, and the local group keeps and bills for the fees. Some of the most critical issues that are determined and negotiated with respect to the traditional model include whether the agreement will be exclusive or nonexclusive, whether there will be a stipend or no stipend (including any sort of guarantee), whether the agreement will be short or long term, whether there will be termination rights and what the termination rights will be and whether the parties will be aligned for managed care purposes (i.e., will one be in-network and the other out-of-network).

Under the second core model for providing anesthesia services — a model which is increasing in its use — is the model whereby ASC owners or the ASC itself attempt to profit from anesthesia services. Under this model, the ASC may employ the anesthesiologist directly. In such situation, the ASC will bill for the professional fees and pay the anesthesiologist a salary or percentage of fees collected. Under the alternative model, the ASC owners themselves would establish a related professional corporation that provides services to the ASC. Some or all of the ASC owners may be owners of the related PC.

In the third basic model, an ASC will engage an anesthesiology management company to assure that services are provided to the ASC. This may take the form of a simple independent contractor agreement whereby the anesthesia management company simply provides services and keeps the fees from such services, or in a situation where the management company has a related PC, the PC provides services to the center. This model may or may not include some local anesthesiologists, and like other models, there may or may not be a stipend or fee or guaranty.

1. Key legal issues. The anesthesia models can raise corporate practice of medicine issues — such as state laws that allow the ASC employ anesthesiologists or state antikickback issues. It is important to ask several questions regarding anesthesia practices and ASCs: Is the ASC requiring kickbacks in the form of rental, equipment or other types of agreements from the anesthesiologist? Or, as to newer types of kickback concerns, is the ASC forcing the group to hand over fees or share fees with it? Is it allowing its top producers to "own" anesthesia, or is it paying stipends to pain management physicians or others in exchange for anesthesia services but that may be disguised as really a payment for pain management services? Professional liability issues also raise critical legal issues in the ASC anesthesia services context.

2. Trends and observations.

- There are probably more exclusive agreements than nonexclusive agreements. However, some of the best centers/companies push hard for nonexclusive agreements. The exclusivity generally does not extend to pain management.
- Stipends still remain less the rule for anesthesia groups in ASCs. However, where an ASC is in its early stages or where it is doing less than 120 cases per month, stipends are more common.
- Many anesthesia contacts still have relatively short without cause termination provisions.
- The profitability of anesthesiology remains heavily dependant upon the volume, case mix, payor mix and many of the same factors that impact whether the surgery center itself is profitable.
- The surgeon partners often prefer local anesthesiologists, but an outside management company may be particularly needed if there is local shortage of anesthesiologists, the local anesthesia group is highly dysfunctional or the local anesthesiologists are not outpatient focused or have non-compete problems with the hospital.
- Outside management firms will generally require exclusive and longer term agreements. They may or may not require a stipend or guarantee.
- Medical director stipends tend to be rising.
- Many of our clients prefer the anesthesiologist not be owners of the surgery center. The anesthesiologist generally won't meet a safe harbor, there can be resentment of the profits being shared with such anesthesiologists and overall we estimate that more centers view it as negative than positive. In contrast, one company president states, "I feel strongly the medical director (anesthesiologists) ought be an owner.""
- Managed care coordination between the anesthesiologists and the centers is becoming increasingly critical. This causes a great deal of tension where one party is handling patients out of network and the other is not.
- Some parties see a definite trend towards ASC owners attempting to seek profit from anesthesiology. Here, one executive has termed it "rocket-like growth."
- Here is an example of the potential profitability of anesthesiology. Assuming 3,000 cases and costs, reimbursement of $300-$325 per case and CRNA and medical doctor anesthesiologist costs total $730,000 annually, this would represent a cost per patient of approximately $240-$250 and provides a profit of approximately $70-$80 per patient. In the costs, one needs to also account for vacation coverage, working capital, billing, collections, practice management, malpractice and other expenses. As a second example, assuming a daily cost of $2,000, an ASC would need approximately seven to eight cases to break even. ■

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28 Interesting Facts About Orthopedics in Surgery Centers and Orthopedic Surgeons
(continued from page 1)

3. Orthopedics represented 8 percent of the total case volume at surgery centers, ranking it fourth behind gastroenterology, ophthalmology and pain management.

4. The average net revenue for an orthopedic procedure was $2,192 in 2008.

5. Here is the average net revenue for orthopedic procedures by region:
- West: $2,265
- Southwest: $2,312
- Midwest: $2,182
- Southeast: $1,865
- Northeast: $1,813

6. Here is the average net revenue for orthopedic procedures by an ASC's number of operating rooms:
- 1-2 ORs: $1,935
- 3-4 ORs: $2,155
- More than 4 ORs: $2,261

7. Here is the average net revenue for orthopedic procedures by an ASC's total number of cases:
- Less than 3,000: $2,136
- 3,000-5,999: $2,313
- More than 5,999: $2,031

8. Here is the average net revenue for orthopedic procedures by an ASC's total net revenue:
- Less than $4.5 million: $1,645
- $4.5-$7 million: $2,179
- More than $7 million: $2,512

9. In surgery centers with more than 50 percent of cases in orthopedics, the average net revenue for an orthopedic procedure was $2,328.

10. Here is the 2008 cash compensation earned by orthopedic surgeons by percentile and region:

20-25th percentile
- National: $335,000
- North: $360,000
- South: $282,000
- East: $294,000
- West: $356,000

50th percentile
- National: $437,000
- North: $475,000
- South: $369,000
- East: $383,000
- West: $444,000

75-80th percentile
- National: $561,000
- North: $606,000
- South: $562,000
- East: $518,000
- West: $530,000

90th percentile
- National: $706,000
- North: $730,000
- South: $668,000
- East: $669,000
- West: $699,000

Medicare charges and payments
Here is the average 2007 Medicare sub charge (submitted charges divided by allowed services), average allow charge (Medicare-allowed charges divided by allowed services, including co-pays and deductibles paid by patient), and average payment (Medicare payments divided by allowed services, not including co-pays and deductibles paid by patient) for 14 orthopedic procedures commonly performed in ASCs.

11. Obtaining small amount of bone for graft (CPT 20900):
- average sub charge: $2,060
- average allow charge: $294
- average payment: $231

12. Open surgical partial removal of collar bone (CPT 23120):
- average sub charge: $3,793
- average allow charge: $477
- average payment: $376

13. Partial repair or removal of shoulder bone (CPT 23130):
- average sub charge: $4,027
- average allow charge: $478
- average payment: $377

14. Open repair of rotator cuff, recent (CPT 23410):
- average sub charge: $4,947
- average allow charge: $671
- average payment: $530

15. Open repair of rotator cuff, old (CPT 23412):
- average sub charge: $5,556
- average allow charge: $984
- average payment: $777

16. Reconstruction rotator cuff, old (CPT 23420):
- average sub charge: $5,653
- average allow charge: $984
- average payment: $777

17. Open repair elbow fracture involving ulnar bone (CPT 24685):
- average sub charge: $3,965
- average allow charge: $502
- average payment: $396

18. Wrist fracture pinning through skin (CPT 25606):
- average sub charge: $2,886
- average allow charge: $487
- average payment: $386

19. Open surgical treatment wrist fracture (radius) (CPT 25607):
- average sub charge: $4,240
- average allow charge: $706
- average payment: $560

20. Shoulder scope, repair cartilage tear (CPT 29807):
- average sub charge: $4,426
- average allow charge: $309
- average payment: $241

21. Shoulder scope, partial removal collar bone (CPT 29824):
- average sub charge: $4,605
- average allow charge: $562
- average payment: $442

22. Shoulder scope, bone shaving (CPT 29826):
- average sub charge: $4,680
- average allow charge: $409
- average payment: $244

23. Shoulder scope, rotator cuff repair (CPT 29827):
- average sub charge: $5,272
- average allow charge: $693
- average payment: $547

24. Injection of lower back joint (HCPCS G02060):
- average sub charge: $1,290
- average allow charge: $281
- average payment: $222

Average implant costs for four orthopedic procedures in hospitals
Here are four interesting statistics about orthopedic implants from a study presented at the May 2008 IHA CHA Medical Device Conference that was carried out by James C. Robinson, PhD, a professor of health economics at the University of California, Berkeley.

25. Average total knee replacement (DRG 544) implant cost per case ranged from $3,321-$8,987, according to information from 11 hospitals (the national benchmark is about $4,700).

26. Total knee implant cost as a percentage of average reimbursement ranged from 25-51 percent, according to information from 11 hospitals.

27. Average lumbar fusion (DRG 498) implant cost per case ranged from $6,959-$14,689, according to information from 11 hospitals (the national benchmark is about $7,600).

28. Lumbar fusion implant cost as a percentage of average reimbursement ranged from 15 percent-52 percent, according to information from 11 hospitals. ■

Note: CPT codes are copyrighted by the AMA.

Sources:
Items 1-3: SDI's *2008 Outpatient Surgery Center Market Report*. Learn more at www.sdihealth.com.
Items 4-9: VMG Health *2008 Intellimarker*. Learn more at www.vmghealth.com.
Item 10: Integrated Healthcare Strategies *2008 Healthcare Executive Compensation Survey* and supplementary IHS statistics. Learn more at *www.ihstrategies.com*.
Items 11-24: CMS.
Items 25-28: IHA CHA Medical Device Conference.

31 Spine Surgeons

Gerald Alexander, MD — Dr. Alexander is an orthopedic surgeon, specializing in disorders of the spine, who practices at Fullerton (Calif.) Orthopaedic Surgery and Fullerton Surgery Center. Dr. Alexander attended medical school and completed his orthopedic surgery residency at Loma Linda (Calif.) University. He completed a fellowship in spine surgery at UCLA Medical Center in Los Angeles.

John Atwater, MD — Dr. Atwater is a spine surgeon at the Downstate Illinois Spine Center in Bloomington, Ill., and practices with McClean County Orthopedics, also in Bloomington. Dr. Atwater treats a wide range of spinal conditions and performs many types of spinal surgery. He currently serves as a medical consultant to several medical device companies. He received his medical degree from the University of Virginia in Charlottesville and interned at John Hopkins University in Baltimore. He completed an orthopedic residency at Howard University in Washington, D.C., and a spine fellowship at the University of Louisville. During medical school, he was a member of the "Spinal Chords," an all-male chorus that performed for patients at local hospitals.

David Abraham, MD — Dr. Abraham is the founder of The Reading Neck and Spine Center in Wyomissing, Pa. He is also a partner at The Reading Surgery Center in Wyomissing and at the Surgical Center of Pottsville (Pa.). Dr. Abraham, whose interests center around ambulatory and minimally-invasive spinal surgery, attended Jefferson Medical College, performing his internship at Thomas Jefferson University Hospital in Philadelphia and his residency at the Rothman Institute in Philadelphia. He completed a fellowship in adult spine surgery at William Beaumont Medical Center in Detroit.

Scott Blumenthal, MD — Dr. Blumenthal is a spine surgeon with the Texas Back Institute and the first surgeon in the United States to devote his practice solely to the research and application of artificial disc replacement. Dr. Blumenthal is a leader in spinal arthroplasty working with a large number of discs currently on the market and in trials. He serves as a clinical assistant professor of orthopedic surgery at the University of Texas Southwestern in Dallas and as an ongoing contributor to the first non-profit created for arthroplasty patients, ADRSupport.org. He also currently serves as a spine consultant for the Dallas Mavericks. Dr. Blumenthal graduated from Northwestern Medical School in Chicago and completed his general surgery internship and orthopedic surgery residency at the University of Texas Health Science Center in Dallas. His fellowships include work at the Rehabilitation Institute of Chicago for physical medicine and rehabilitation and at Midwest Regional Spinal Cord Injury Care System at Northwestern Memorial Hospital in Chicago for spinal trauma surgery. Dr. Blumenthal was recently featured in *ON Magazine* in the publication's "ON Personality" section.

Charles Branch, MD — Dr. Branch is a neurosurgeon who specializes in the spine and is currently president of the North American Spine Society. He practices at Wake Forest University Baptist Medical Center in Winston Salem, N.C. Dr. Branch attended medical school at the University of Texas Southwestern Medical School in Dallas. He completed his residency in neurological surgery at Wake Forest University Baptist Medical Center and a fellowship at the University of California, San Francisco. Dr. Branch has been published in numerous medical journals and once served as editor-in-chief for *The Spine Journal*. He recently was profiled by *Spinal News International,* where he discusses his family's involvement in the field.

Two of his children are currently enrolled in medical school and his oldest will pursue neurosurgery. His father, Charles Branch, Sr., was awarded the Humanitarian Award from the American Association of Neurological Surgery in 2004 for his medical mission work in Nigeria.

John R. Caruso, MD — Dr. Caruso is a neurological surgeon with more than 16 years experience. He currently practices with Neurosurgical Specialists in Hagerstown, Md., where he has performed numerous spinal procedures including minimally invasive procedures to complex instrumentation of the cranial, thoracic and lumbar spine. He also serves a chairman of the board and medical director of Parkway Surgery Center in Hagerstown. Dr. Caruso attended Eastern Virginia Medical School in Norfolk, Va., and completed residencies at the Eastern Virginia Graduate School of Medicine in Norfolk and at the University of New Mexico, Albuquerque.

Leonard Cerullo, MD — Dr. Cerullo is a neurosurgeon with more than 30 years experience and the founder and medical director of Chicago Institute of Neurosurgery and Neuroresearch. He helped pioneer the use of lasers in neurosurgery and has published several articles and books on this subject. He also serves as a professor in the Department of Neurosurgery at Rush Medical College in Chicago. Dr. Cerullo attended medical school at Jefferson Medical College in Philadelphia and completed his residency training in neurosurgery at Northwestern University Medical School in Chicago. Dr. Cerullo held fellowships at the Neurological Institute of New York and Columbia-Presbyterian Medical Center, both in New York City, and at Hôpital Foch in Surenes, France. Dr. Cerullo has been featured repeatedly in *Chicago Magazine*'s "Top Doctors" issues.

E. Jeffrey Donner, MD — Dr. Donner is an orthopedic surgeon, fellowship-trained in the management of spinal disorders. His specialties include spine surgery and general orthopedics. He is a co-founder of Rocky Mountain Associates in Loveland, Colo., and also works at Loveland Surgery Center, a spine center of excellence for Blue Cross/Blue Shield. Dr. Donner is recognized internationally as an expert in the diagnosis and surgical treatment of chronic cervical whiplash disc injuries. His orthopedic residency included rotations through Shriner's Hospital for Children in Philadelphia and St. Christopher's Hospital for Children in Philadelphia. Dr. Donner's fellowship in spine surgery was completed at the Hospital of the University of Pennsylvania and Temple University Hospital, both in Philadelphia. Dr. Donner has published articles in several scientific journals and is the past president of the Larimer (Colo.) County Medical Association.

Stephen Doran, MD — Dr. Doran is a neurosurgeon and chairman of the board and medical director of Midwest Surgical Hospital in Omaha, Neb. This facility brought together a preeminent group of neurosurgeons, orthopedic surgeons, ENT and pain medicine physicians and partnered with a large local healthcare system. Dr. Doran is an active lobbyist for physician involvement in healthcare. He is also a clinical assistant professor of surgery at University of Nebraska Medical Center. Dr. Doran's areas of interest include spinal instrumentation, stereotactic and functional neurosurgery, deep brain stimulation and disorders of the spine. He has received national recognition for his research in gene therapy related to the central nervous system and his research has been published nationally. Dr. Doran received his medical degree from the University of Nebraska Medical Center in Omaha and completed his internship and residency at the University of Michigan Medical Center in Ann Arbor. According to Todd Flickema, senior vice president at Surgical Management Professionals, "Dr. Doran is a very articulate, intelligent and caring physician. He has a vision that is beyond his practice and hospital that encompasses his community and healthcare in general with extremely high ethical standards. He is one of the finest people I have ever had the pleasure of working with."

Wesley H. Faunce, III, MD — Dr. Faunce practices with the Southwest Florida Neurological Associates in Cape Coral, where he focuses on degenerative spine disease of all areas of the spine. He has been involved in a variety of medical research studies and is an accomplished author or coauthor of numerous studies, publications and presentations. Dr. Faunce received his PhD in biochemistry and molecular biology from the University of Florida in Gainesville. He then earned his medical degree at the same university. He also completed an internship at the university's department of surgery and residency training at its department of neurosurgery. While at the University of Florida, Dr. Faunce served as president of the University of Florida's AMA Medical Student Section and was awarded the Lyerly Neurosurgery Award.

Thomas Forget, MD — Dr. Forget is a St. Louis-based neurosurgeon focusing on cerebrovascular disease, stroke and general neurosurgery. He is an owner and medical director of The St. Louis Spine Surgery Center, a spine-focused ASC in Creve Couer, Mo. He also leads the Division of Neurosurgery at Neurological Specialists of West County. Dr. Forget has co-authored two books, as well as multiple book chapters, articles and presentations. He attended medical school at Georgetown University School of Medicine in Washington, D. C., and completed his residency at Saint Louis University School of Medicine. He completed a fellowship in neurosurgery at Thomas Jefferson University Hospital, Jefferson Medical College in Philadelphia.

James Hansen, MD — Dr. Hansen is a spine surgeon with the Spine & Rehabilitation Center in Austin, Texas. He has affiliations with 10 hospitals and surgery centers, including the South Austin Surgery Center. Dr. Hansen has pioneered the expansion of outpatient spinal procedures utilizing minimally invasive methods at the South Austin Surgery Center. He attended medical school at Michigan State University in East Lansing and completed his internship at Michigan State's Butterworth Hospital in Grand Rapids. He completed his residency at Medical University of South Carolina in Charleston.

Richard Harrison, MD — Dr. Harrison is a spine surgeon focusing on the comprehensive management of spine conditions, including minimally invasive surgery to spinal reconstruction and fusion procedures. He practices at the Bay Care Clinic in Green Bay, Wis., among other locations in Wisconsin and Illinois. Dr. Harrison attended medical school at Texas Tech University in Lubbock, Texas, and completed his residency at Loyola University Medical Center in Chicago. He completed a fellowship at the National Hospital for Neurology and Neurosurgery in London, England. He has been featured by his local ABC news station, *Action 2 News*, for his work.

Richard Kube, II, MD — Dr. Kube is a spine surgeon at the Prairie Spine & Pain Institute in Peoria, Ill., which he owns and operates. He regularly performs procedures at the Peoria Day Surgery Center. He previously practiced at St. Anthony's Memorial Hospital and with the Bonutti Clinic in Effingham, Ill. Dr. Kube attended medical school and post-graduate training in orthopedic surgery at Saint Louis University. He completed a spine fellowship at Spine Surgery PSC in Louisville, Ky. Dr. Kube's research on motion preservation has been presented on an international level at several different venues. Dr. Kube is a clinical assistant professor of surgery at the University of Illinois College of Medicine at Peoria. According to Bryan Zowin, business manager of Peoria Day Surgery Center, "Since joining Peoria Day's medical staff, he has been instrumental in assisting staff and management with cost-effective equipment needs along with working with us to provide high-quality spine treatment surgery services for our community. This is a new service line for our center and his knowledge and assistance to the center has been outstanding."

Michael Janssen, MD — Dr. Janssen is a surgeon at the Center for Spinal Disorders in Thornton, Colo. He founded the Spine Education Research Institute, a non-profit dedicated to clinical research, physician education and youth science and community education. Dr. Janssen also serves as a clinical associate professor at the University of Colorado. He received his medical education at the University of Health Sciences in Kansas City, Mo. His internship and residency were completed at the Medical College of Georgia in Augusta, and he completed a spine fellowship at Lakewood Orthopaedic Clinic in St. Gallen, Switzerland.

Iain H. Kalfas, MD — Dr. Kalfas is a neurosurgeon who works for Cleveland Clinic's Center for Spine Health. He is also the head of spinal surgery for the clinic's department of neurosurgery. His specialties include complex spinal surgery and reconstruction including instrumentation and fusion, image-guided spinal navigation, neck and back disorders and minimally-invasive surgery. Dr. Kalfas attended medical school at Northeastern Ohio Universities College of Medicine in Rootstown, Ohio, and completed his internship and residency in neurological surgery at the Cleveland Clinic. He completed fellowships at Barrow Neurological Institute in Phoenix and at Allegheny General Hospital in Pittsburgh, Pa. Dr. Kalfas recently edited the book, *Spinal Reconstruction: Clinical Examples of Applied Basic Science, Biomechanics And Engineering,* and has written numerous book chapters.

Jordi Kellogg, MD — Dr. Kellogg is a neurosurgeon who has published more than 40 professional articles and abstracts since 1997. He is also a regular speaker at neurosurgery conferences. In private practice in Portland, Ore., since 2001, Dr. Kellogg is an investor-owner in the highly successful East Portland Surgery Center. Dr. Kellogg attended medical school at the Unversity of Southern California in Los Angeles and completed his residency and fellowship at Oregon Health Sciences University in Portland.

James Lynch, MD — Dr. Lynch a neurological surgeon who specializes in complex spine surgery, as well as minimally-invasive spine surgery. He is director, spine services, for Regent Surgical Health, where he directs Regent's program to help physicians develop spine-focused ASCs and specialty spine hospitals. He is the founder and CEO of Spine Nevada and chairman and director of spine at the Surgical Center of Reno. He is also on staff at St. Mary's Hospital and Renown Regional Medical Center, both located in Reno. Dr. Lynch is a frequent lecturer at national meetings on spine topics related to ASCs. He earned his medical degree from Trinity College in Dublin, Ireland, followed by a residency at the Mayo Clinic in Rochester, Minn. Dr. Lynch completed three spine fellowships at the Mayo Clinic, National Hospital for Neurology and Neurosurgery in London, England and the Barrow Neurological Institute in Phoenix. His work has been published in several professional publications including *The Journal of Neurosurgery* and *Neurosurgery and Spine.*

James Macon, MD — Dr. Macon is a neurological surgeon with Framingham-Wellesley Neurological Surgery in Framingham, Mass. In addition to being a member of several neurological associations, Dr. Macon is a member of the American Pain Society, International Association of the Study of Pain and American Academy of Pain Medicine. Dr. Macon attended medical school at Harvard Medical School and completed his internship at Stanford University Medical Center. He completed his residency in neurosurgery at Massachusetts General Hospital in Boston. Dr. Macon worked as a clinical associate for the National Institutes of Health's Institute of Neurological Disorders and Stroke in Bethesda, Md., and received a Fulbright Scholarship to study neuropharmacology in Paris, France. According to Chris Zorn, vice president of Spine Surgical Innovation, "Dr. Macon is companionate, innovative, reputable and patient-focused professional."

Paul McCormick, MD — Dr. McCormick is a neurosurgeon at Columbia-Presbyterian Neurosurgery in New York City, specializing in disc disease, spinal stabilization and instrumentation, spinal tumors and spinal cord injury. He attended medical school at Columbia University College of Physicians and Surgeons and completed his residency at the Neurological Institute of New York. He completed a fellowship in spinal surgery at the Medical College of Wisconsin in Milwaukee. He currently serves as a professor of clinical neurosurgery at Columbia's College of Physicians and Surgeons and has published more than 70 peer-reviewed articles.

Greg McDowell, MD — Dr. McDowell is an orthopedic surgeon specializing in adult and pediatric spine care. He currently practices with Ortho

Montana in Billings and is co-director for the Northern Rockies Regional Spine Center. Dr. McDowell completed medical school and his residency at the University of Virginia in Charlottesville.

Kenneth A. Pettine, MD — Dr. Pettine is a co-founder of Loveland, Col.-based Rocky Mountain Associates and a surgeon at Loveland Surgery Center, a spine center of excellence for Blue Cross/Blue Shield. He has an extensive background in spinal surgery, research and rehabilitation. He is co-inventor and co-designer of the Maverick Artificial Disc, a patented disc replacement device for the neck and back, currently the subject of a clinical trial. Dr. Pettine is currently the chief investigator for eight FDA IDE studies involving non-fusion spine technology. He is a distinguished speaker at national and international symposiums and the author of nearly 20 research publications. Dr. Pettine completed his residency and his master's degree in orthopedic surgery at the Mayo Clinic in Rochester, Minn. His medical degree was awarded from the University of Colorado School of Medicine, and he completed a Spine Fellowship in Minneapolis.

Joan O'Shea, MD — Dr. O'Shea is a dually-trained neurological and orthopedic spine surgeon. She has concentrated her training and dedicated her career to the treatment of spinal disorders. She helped found the Spine Institute of Southern New Jersey and previously practiced neurosurgery at Cooper Medical Center in Camden, N.Y. She received her medical degree at the State University of New York Upstate Health Center in Syracuse. She completed a residency in neurosurgery at Mount Sinai Medical Center in New York, N.Y., and completed an additional orthopedic spine surgery fellowship at the Hospital for Joint Disease and the Spine Institute of Beth Israel Medical Center, both located in New York City. She has been an invited lecturer for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons annually since 1996. Ms. O'Shea has been described by a colleague as "very sharp and entrepreneurial. She is excellent at working with and marketing to workers compensation case nurses."

Carlton Reckling, MD — Dr. Reckling is a spine surgeon at the newly formed Spine Center Cheyene (Wyo.). He attended medical school at Creighton University in Omaha, Neb., and completed his internship and residency at the University of Minnesota Hospitals & Clinics in Minneapolis. He completed a fellowship in spinal surgery at Queen's University Medical Center in Nottingham, England. According to Richard Slater, attorney, friend and patient of Dr. Reckling, "Carlton is the only orthopedic spine surgeon in in our community. Like his father and grandfather who were also physicians, Dr Reckling performs major reconstructive spine surgeries for scoliosis and other deformities. He is also a regional leader in minimally invasive techniques and non fusion technology."

Mike Russell, II, MD — Dr. Russell is a spine surgeon at Azalea Orthopedics in Tyler, Texas. He holds hospital privileges at the Texas Spine and Joint Hospital, Trinity Mother Frances Hospital and the East Texas Medical Center, all in Tyler. Dr. Russell attended medical school and completed his orthopedic training at the University of Texas Southwestern Medical School in Dallas. He completed a fellowship in spine surgery at the Carolinas Medical Center in Charlotte, N.C.

Larry L. Teuber, MD — Dr. Teuber serves as director of Medical Facilities Corp. and as the physician executive of Black Hills Surgery Center in Rapid City, S.D., which he founded in 1997. Dr. Teuber is also the founder and current managing partner of The Spine Center in Rapid City. He provides consultative services and frequently speaks to physician organizations concerning the development of surgical facilities for neurosurgical and spinal care. Dr. Teuber earned his medical degree from the University of South Dakota in Vermillion. He completed his general surgery internship and neurosurgery residency at the Medical College of Wisconsin in Milwaukee. Dr. Teuber served for 17 years in the active and reserve Army, retiring with the rank of major after serving in Desert Storm.

Daniel Tomes, MD — Dr. Tomes, a neurological and spine surgeon, practices in Lincoln, Neb., where he sits on the Board of Directors of the Madonna Rehabilitation Hospital and serves as medical director of the Gogela Neuroscience Institute. Additionally, he led the development of the Southwest Lincoln Surgery Center, a multi-specialty ASC that includes spine and is slated to open in April 2009. Dr. Tomes attended medical school at the University of Nebraska College of Medicine in Lincoln and completed postgraduate training at the University of Nebraska Medical Center.

Ensor Transfeldt, MD — Dr. Transfeldt is a staff surgeon at Twin Cities Spine Center in Minneapolis, Minn., specializing in deformities and tumors of the spine. He also serves as an associate professor at the University of Minnesota. Dr. Transfeldt attended medical school at the University of Witwatersrand in Johannesburg, South Africa; completed an internship at Baragwanath Hospital in Johannesburg; and completed his residency at the University of Toronto, Canada. He completed a spine fellowship at the University of Toronto and held the John H. Moe Spine Fellowship at the Twin Cities Scoliosis Spine Center in Minnesota.

William Watters, III, MD — Dr. Watters is an orthopedic surgeon who specializes in spinal surgery. He is the current research council director for the North American Spine Society and is the chairman of the American Academy of Orthopaedic Surgeon's Guideline and Technology Assessment Oversight Committee, which oversees all clinical practice guideline development and technology assessments produced by the AAOS. Dr. Watters attended Harvard Medical School and completed two residencies, one in internal medicine and one in orthopedic surgery at the University of Pennsylvania in Philadelphia.

Jeffrey C. Wang, MD — Dr. Wang is currently chief of the University of California Los Angeles Spine Service and director of the UCLA Spine Surgery Fellowship. In addition to a busy clinical practice, Dr. Wang runs a science laboratory where he develops new methods for treating spinal dis-

orders. Dr. Wang has received numerous research grants and is currently involved in many clinical trials in the treatment of spine problems. Dr. Wang attended medical school at the University of Pittsburgh School of Medicine. He completed a residency in orthopedic surgery at UCLA and a fellowship in spine surgery at Case Western Reserve University in Cleveland.

Richard Wohns, MD, MBA — Dr. Wohns is a spine surgeon and one of the first physicians involved with the development of ambulatory spine practices. He is the founder of South Sounds Neurosurgery in Puyallup, Wash. He also founded Neospine, a spine ASC development company, currently part of Symbion Healthcare. His areas of expertise in the field of neurosurgery include brain tumor and skull base surgery, numerous complex minimally invasive spinal surgical techniques, teleradiology, computer-based neuronavigation and stereotaxis. He was one of the first neurosurgeons in the United States qualified to perform the revolutionary XLIF technique for minimally invasive lumbar fusions. Dr. Wohns attended medical school at Yale University School of Medicine and completed his neurosurgery residency at the University of Washington in Seattle. Dr. Wohns also holds an executive MBA from the University of Washington and is currently pursuing a law degree from Seattle University School of Law. Dr. Wohns has advanced the knowledge of outpatient spine surgery and minimally invasive techniques through the Mazama Spine Summit, an educational meeting which has organized for the past six years. According to Hiroshi Nakano, CEO of South Sound Neurosurgery in Puyallup, Wash., "Dr. Wohns has been a pioneer in the development of the ambulatory spine world, stressing clinical excellence and business performance. In addition, he has dedicated a great deal of his time to the improvement of the profession and continues to be a voracious learner." ■

9 Surgical Equipment Products for ASC Spinal Procedures

By Mark Taylor

Neurosurgeons and nurse/ASC executives discuss nine valuable products for ASCs performing spinal procedures.

1. Allen Flex Frame Operating Table. Dr. Lynch, a board-certified neurological surgeon and fellowship-trained spine surgeon who chairs the board for the Surgery Center of Reno, says he recommends an Allen operating table, which folds up — an advantage in space-challenged ASCs — and costs $100,000 less than some commonly used hospital operating tables. Dr. Lynch says the typical hospital OR table is too large and doesn't swing easily between the smaller spaces occupied by ASCs. "Hospitals have space for storage, but most ASCs have little extra room and rent space for their ASCs. Storage costs money. This works well for us."

2. Leica Operating M520 F40 Surgical Microscope. Dr. Lynch says the Leica scopes can also save ASCs money and deliver great quality and value. They cost $80,000-$90,000. But he says high end microscopes with image guidance abilities can cost up to $250,000.

Beth Ann Johnson, RN, vice president of clinical systems for Blue Chip Surgical Center Partners, says her company tries to purchase refurbished microscopes. "There's a company called Prescott's, Inc., that reconditions surgical microscopes for between $60,000-$70,000. Neurosurgeons will give you the names of $200,000 microscopes when you actually can get a top model refurbished. Prescott's doesn't just dust them off, but takes them apart, reconstructs them and produces and sells great microscopes for a good price."

3. Anspach Pneumatic Surgical Drills. These devices cost around $15,000-$28,000 apiece. "You will need two for each operating room," Dr. Lynch advises. "You'll need one for backup in case the first one breaks down or is sent out for repair. You don't want to be dependent on just one and have it go out on you."

Ms. Johnson says her firm negotiates loaner drills and a limited number of drill bits needed. "We agree to minimum numbers to purchase to drive down the cost of the bits."

4. Intraoperative fluoroscopy unit (C-arm). The imaging units are manufactured by General Electric, Siemens and others and cost $140,000-$150,000. Dr. Lynch recommends investing in a new or refurbished high-end model to provide intraoperative imaging for lumbar and cervical visualization. "The older versions often provide poor visualization and require extensive repair. And surgeons will go nuts if they see that you're using equipment that breaks down. Some will say the equipment is not on par with the hospital and will refuse to do surgery there," Dr. Lynch says. "If you're going to do it, do it right."

5. Bipolar Medical Coagulation and Cauterizing Instrument. Anne Roberts, administrator for the Surgery Center of Reno and a former hospital ER nurse and executive, says the COAG machine, which costs about $12,500, is essential to ASC spine procedure. It is used to stop bleeding.

6. Retractors and instrument trays. Ms. Roberts says ASCs offering spine surgical services need lumbar ($21,500) and cervical ($16,730) instrument trays and Shadowline ($14,500) and McCulloch ($16,650) retractors. "This is surgeon-specific," she says. "You need physician buy-in. They need to be a part of the decision-making process. Typically we identify what procedures will be performed and then get a list of what our neurosurgeons want. Then you discuss it with them to try to standardize the products."

Ms. Johnson says Blue Chip often uses TeDan Surgical Innovations for spinal retractors. "They produce them for $9,000-$15,000 instead of $20,000-$25,000 for the same quality," she says. "It's important when adding a specialty to an ASC to keep capital equipment costs to a minimum."

7. Spinal implants. "We've had great success in working with DePuy, BioMet and Medtronic's Sofamor Danek Division on price and standardization for plates and screws," says Ms. Johnson. "It's important that the ASC ask the manufacturer to loan the instrumentation needed to install the plates and screws. Each set of implants requires instruments, and you don't want to have to buy that. You also want them to agree to have an inventory of plates and screws on consignment, so you're not holding thousands of dollars in inventory you'll seldom use. Depending on the volume you do with them and the relationship you share, they're usually agreeable."

Implants typically cost $5,240-$13,000.

"Be cautious about the dollar amount spent on disposables or implants used," she advises. "Unless those items are carved out of a global reimbursement methodology, many health plans and payors will not pay for them," Ms. Johnson says. "Hence, your high expenses can significantly affect your profit margins."

She says it's important to standardize purchases so the ASC doesn't staff a different set for each surgeon. "That's not a wise use of inventory. ASCs need to get around the table with their physicians and decide on one manufacturer. Once you have agreed to do that, you have much more negotiating power with the company as well," Ms. Johnson says.

8. One Headlit Surgical Head Lamp. Plano, Tex.-based medical equipment producer, L.I.T. Surgical makes these surgical lights, which sell for around $6,000. Neurosurgeon Ken Pettine, MD, a spine surgeon from Loveland, Colo., says they represent the latest in LED technology and never decrease in brightness. Dr. Pettine says he prefers them to some of the top brands because after 200 hours many of the top brand lights begin to lose up to 40 percent of their brightness. Many other brands are connected to boxes, which are attached by cables, and may cost up to $12,000. "I don't have to wear lead with the One Headlit, which weighs 8-10 pounds and starts to fatigue you after 5-6 hours. And there are no cables attached either."

9. Haemonetics Cell Saver 5 Blood Processing System. Dr. Pettine says several companies produce cell savers, which are autologous blood filtering, storage and recovery machines that allow surgeons to filter patients' blood and return half of what they lose intraoperatively. "You need it if you're doing big time spine surgery," he says. He says his Loveland Surgery Center bought a refurbished cell saver for $4,000, but said new models can cost around $12,000. ■

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5 Best Practices to Help Address Increasing Patient Out-of-Pocket Expenses

By Lindsey Dunn

The number of Americans enrolled in health plans with high deductibles is on the rise and is expected to continue as employers look for ways to cut costs in this tough economy. This trend creates challenges for ASCs and hospitals as they begin to see more and more patients who are responsible for significant out-of-pocket expenses for treatment.

More than 17 percent of Americans 65 and under with private health insurance are enrolled in a high deductible health plans (defined as a private health plan with a deductible of $1,100 or more for self-only coverage or $2,200 or more for family coverage), according to the NCHS. Additionally, 95 percent of insured individuals face significant cost-sharing expenses, even after their deductibles have been met, for inpatient and outpatient procedures.

The prevalence of HDHPs will continue to grow; 37 percent of employers in a survey by the Kaiser Family Foundation indicated that they would likely increase their deductibles in the next year.

So what can ASCs and hospitals do to ensure that this trend does not affect their ability to receive payment for services?

Here are five best practices for healthcare providers to help address the increase in patient out-of-pocket expenses.

1. Verify any and all insurance coverage. Experts agree that thorough insurance verification is the first step in ensuring that patients are able to pay out-of-pocket expenses required for a procedure.

According to Lisa Rock, president and CEO of National Medical Billing Services, it is imperative that healthcare providers such as surgery centers are properly verifying patient insurance coverage.

"ASCs collectively aren't doing their due diligence on insurance verification," she says. "When things get busy, and they get behind, maybe they skip over this step. When the economy was strong, centers were okay if they let this slide. Now, however, ASCs must make sure they are following the verification procedures they have put into place."

Donna Smith, an administrator at The Surgery Center in Oxford, Ala., agrees that insurance verification is extremely important in today's economy. She estimates that one-third of the patients that present to her center have HDHPs. Her facility, which averages 16 days in accounts receivable, follows strict verification and patient education procedures to help ensure that the ASC receives payment for services provided.

"I've found that some surgery facilities only verify primary insurance," says Jennifer Bailey, business office manager at the Oxford facility. "Our center verifies all insurance coverage. Having this information helps us better inform our patients of their responsibilities," she says.

Experts also recommend that insurance verification should be done by qualified staff with knowledge about accounts receivable and experience working with insurance providers.

The Surgery Center in Oxford employs two staff members who are able to verify patient insurance. "It is crucial that your verification staff is knowledgeable and has an extensive background in insurance," says Ms. Bailey.

Ms. Rock agrees. "At some facilities, you may find a nurse making these verification calls. That nurse may get the information, but it may not make sense to her. Having staff that understands the information and can translate it for patients is becoming more and more important," she says.

2. Educate patients about their coverage and financial obligations. Patients who are educated about their financial obligations before a procedure are more likely to fulfill those obligations, sources say.

"Patients may not realize what their estimated responsibility may be for their procedure, so we contact them before the date of service to prepare them for these costs. It seems to be really appreciated," says Ms. Bailey.

Lindsay McQueeney, director of product management for SourceMedical, adds that healthcare providers should begin this process as soon as possible. "It is fundamental that centers work with both the insurance company and the patient as far in advance as possible so that the patient really has a chance to understand his or her coverage and so that the patient is prepared to meet his or her portion of the obligation," she says.

3. Move collections to the front end. The best way to ensure that patients pay their out-of-pocket expenses for a procedure is to require payment before the procedure.

Ms. Smith says, "It is standard practice at our facility to ask that our patients pay in full, on the date of service, for any out-of-pocket costs. That said,

we are still always willing to work with patients who may need payment arrangements or financial assistance."

Ms. Rock agrees with the merits of this policy. "Upfront collections are definitely preferable. However, we must have professional courtesy with front-end collections," she says. "We have to remember why it is we're doing these procedures."

Everyone interviewed for this article agreed that patient care should never be compromised due to financial circumstances or a patient's ability to pay.

If patients have a large deductible that they cannot pay upfront, Ms. Smith says that her facility will require them to pay half upfront or work with them to set up payment plans before the procedure.

Occasionally, a patient may be charged more on the day of service than what the patient actually owes due to lag-time in billing clearance. If there are accounts with overestimated patient responsibilities, Ms. Smith recommends that facilities refund any overpayments made by the patient immediately. "Our patients are willing to pay if they can be assured their money will be refunded quickly and without a hassle. We strive to get the money refunded to these patients before most even realize that they are owed a refund," she says.

4. Take a retail approach toward payment. Hospitals and surgery centers should start to see billing and payment as retail transactions rather than just the transfer of funds between a facility and a private or public payor.

Earl Winter, CEO and founder of nTelagent, a company that provides self-pay management systems to healthcare providers, says that providers have to take a retail approach toward their billing and collections in order to be successful.

"Healthcare providers have systematically approached billing as an issue between the healthcare facility and some type of public or private payor," he says. "All computer systems that the facilities use for billing were built to bill private and public insurers, not actual people. Now that has switched. More and more responsibility for payment lies with the individual patient, and many facilities haven't yet figured out how to think like a retailer in their payment options."

Thinking like a retailer means that healthcare providers should evaluate each patient individually and offer different payment options based on that evaluation. For example, a facility may offer a discount to encourage a patient to pay upfront for services; however, a facility would probably not want to offer that discount to a patient who would be willing to pay the full price upfront.

"Solutions are out there to help providers determine a patients' ability to pay. This information can help business managers offer payment options that are most appropriate for each patient," says Ms. McQueeney.

Mr. Winter, whose company offers one of these solutions, says that providers need to be careful in how they determine ability to pay. "When determining patients' ability to pay, providers should be most concerned about predicting the likelihood that they'll pay healthcare bills, which can be tricky," he says. "Some facilities use credit scoring, which alone can be legally problematic. Plus, credit scores only show how patients have paid in the past. You have to use other predictors, such as demographics, to figure out the likelihood that they'll pay in the future."

Ms. McQueeney recommends that facilities develop business rules for offering discounts, credits or payment plans to patients after they have determined their ability to pay. Facilities may also benefit from offering payment plans regardless of the patient's ability to pay. "Centers may increase patient satisfaction by offering automated monthly withdrawals

from the patient's bank account or a recurring charge to their credit card. These types of payment plans offer flexibility while ensuring that the facility receives the entire payment," she says.

Mr. Winter, however, warns that some facilities may not have enough information to develop sound business rules or lack the technology to offer certain payment options, such as automatic reoccurring billing from a patient's credit or debit account.

"I see a lot of facilities that either have trouble figuring out where it makes financial sense to provide discounts or have trouble offering the ones they've implemented," he says. "You might have an employee with a bunch of post-its on her computer screen trying to figure out what to offer to which patients. Or you have a front-office employee who has to call a business manager to approve every discount. Neither of these processes is efficient."

5. Do everything you can to keep unpaid bills from going to collections. While sending bills to collections is an option, sources say that facilities should do everything possible to avoid this last resort.

"I've seen statistics that say that less than 15 cents on the dollar is recovered during back-end collections," says Mr. Winter.

Ms. Smith concurs. "Once a patient leaves a facility, the chances of receiving any payments from them decreases drastically," she says.

According to Mr. Winter, healthcare providers need to do everything they can to keep even relatively small bills from going to a collection agency. "Most people think that outliers with huge bills cause the biggest problems for facilities, and that just isn't true," he says. "The average bill in collections is usually around $700-$1,100 dollars, depending on the services offered by the facility"

Providing other payment options are also a good alternative to help ensure that money is collected upfront, sources say. Ms. Bailey says her facility occasionally allows patients to post-date checks if necessary. The ASC also offers patients financial assistance through CareCredit, which extends some loans with no interest for 12-18 months, according to Ms. Smith. "This assistance allows us to collect on the date of service , and the financial provider works with patients directly on any defaults," she says.

Healthcare providers must anticipate the increasing prominence of patient out-of-pocket expenses. By moving collections to the front-end and using sound business principles to offer payment options to patients that will keep bills out of collections, facilities can prepare themselves for the business challenges caused by this trend. ■

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13 Orthopedic- and Spine-Driven ASCs

By Lindsey Dunn

Here is a list of 13 orthopedic- and spine-driven ASCs and a few of the reasons why they have been so successful.

Beacon Orthopaedics & Sports Medicine (Sharonville, Ohio). Beacon Orthopaedics & Sports Medicine, with three locations in the northern Cincinnati area, is home to 13 physicians specializing in orthopedic surgery, including total joint replacement and arthroscopic procedures, and sports medicine. The group recently introduced a spine center, which provides surgical and non-surgical treatments for disorders of the spine. The flagship 33,000 square-foot facility in Sharonville performs around 4,800 procedures annually and features two large surgical suites and two smaller procedure rooms.

According to Jayne Walker, the center's corporate marketing director, the ASC's success is due to its outstanding services and patient care. "Our [program] is known for many things, but one element that is outstanding is our capability to serve the patient from start to finish under one roof," she says.

The single-specialty center is appealing to the physicians who affiliate with it as well. "For overall patient care and cost-effective delivery, a single-specialty ASC is a must for any busy orthopedic sports surgeon," says Tim Kremchek, MD, a board-certified and fellowship-trained orthopedic surgeon at the facility. "Working within this tremendously motivated environment is rewarding to the patients, physicians and staff."

The ASC offers teaching programs for medical students and is directly involved with sports teams, including the Cincinnati Reds and the Cincinnati Cyclones, a local professional hockey team. Beacon Orthopaedics & Sports Medicine has successfully treated a number of professional athletes including Ryan Dempster, pitcher for the Chicago Cubs; Scott Rolen, third baseman for the Toronto Blue Jays; and Rondell White, outfielder for the Minnesota Twins.

East Portland Surgery Center (Portland, Ore.). East Portland Surgery Center is a multi-specialty, freestanding surgery center, which features a strong orthopedics program. The ASC boasts state-of-the-art medical technology making it possible for physicians to treat patients more efficiently and comfortably. According to John DiPaola, MD, an orthopedic surgeon at the center, the ASC provides outstanding patient care. "EPSC provides excellent service, excellent equipment, and their well trained staff always treats my patients with exceptional skill," he is quoted as saying on the ASC's Web site.

Houston Orthopedic Surgery Center (Warner Robins, Ga.). Houston Orthopedic Surgery Center is home to four orthopedic and sports medicine specialists and one spine surgeon. The ASC consists of two operating rooms, a sub-sterile area, four preoperative rooms and five PACU beds. The center performs a variety of orthopedic procedures, including anterior cruciate ligament reconstruction, carpal tunnel release, trigger finger release and surgery for tennis elbow. The center's spine program performs cervical disc replacement, multi level anterior cervical disc fusion, endoscopic spine procedures and minimally invasive spine fusions, among other procedures.

Becky Mann, director of Houston Orthopedic, attributes the center's success to its dedication to patient care and cost-consciousness. "Our goal at Houston Orthopedic Surgery Center is to always put our patient first. We make their visit with us as timely and pleasant as possible," she says. "Service is given with professional competence and a smile. No one in the center is too busy to stop and answer a question or lend a helping hand."

Ms. Mann warns, however, that even with the best care available, a successful surgery center must be aware of cost. "We know to the penny what a case costs to perform. We strive daily to save money by researching products and prices. We waste nothing," she says. "Knowing your area's reimbursement is critical to the bottom line."

The center is also active in the communities of Houston County, Ga., providing physicals for school athletes for a $10 fee, all of which is returned to the schools' athletic programs to purchase equipment.

The center's great patient care and commitment to the community has lead to the financial success of the center and to patient referrals. "Our patients recommend us to their friends and family," says Ms. Mann. "Word of mouth is more valuable than any billboard, and we are proof of it."

Illinois Sports Medicine & Orthopedic Surgery Center (Morton Grove, Ill.). The Illinois Sports Medicine & Orthopedic Surgery Center is the surgery center of the Illinois Bone & Joint Institute, an orthopedic practice group in the Chicago area with more than 20 locations. The 100-percent physician-owned surgery center has four operating rooms and one procedure room and is home to 18 orthopedic surgeons, eight podiatrists, three pain management physicians and 14 anesthesiologists. ISMOSC performs a wide variety of orthopedic ambulatory surgical procedures, including arthroscopies, ACL reconstructions, arthroplasties, carpal tunnel releases, meniscectomies, open reduction internal fixations, arthroscopic Bankart procedures and rotator cuff repairs as well as spine procedures such as laminectomies, microdiscectomies and anterior cervical discectomies and fusions. In 2007, the ASC's first year of operation, ISMOSC performed 2,500 cases. The center performed 3,250 cases in 2008, according to Larry Parrish, administrator of the center.

Robert Patek, MD, a physician and board member of the center, attributes the ASC's success to its outstanding staff. "A dynamic, adaptive and forward thinking leadership team comprised of talented facility administrator, outstanding nurse leaders and a skilled medical director has been empowered to create, maintain and nurture an environment of professionalism, mutual respect and teamwork," he says.

Loveland Surgery Center (Loveland, Colo.). Loveland Surgery Center performs approximately 3,400 orthopedic, spine, pain management and ENT procedures annually. The ASC, which is jointly owned by physicians and National Surgical Care, features two operating rooms and a procedure room that is equipped with anesthesia. The center's spine program was the first facility in the United States to perform a level-three Prestige cervical artificial disc replacement, utilize the Coflex device, perform a multi-level NeoDisc replacement and the first to utilize the Dynamic Stabilization System for a posterior lumbar fusion, according to Sue Sumpter, administrator of the center. Additionally, Loveland has participated in five FDA Investigational Device Exemption studies and is enrolled to begin three more.

The surgery center holds a convalescent license, which allows the facility to complete more complex surgeries such as lumbar and cervical spine fusions, which require multiple overnight stays, while remaining an outpatient facility. The offering of these complex surgeries at the center provides an economical surgery option for patients and third-party payors, says Ms. Sumpter.

The center also provides a variety of payment and cost-saving opportunities to its patients whose procedures are not covered by insurance. "For artificial disc procedures not covered by patients' insurance, we have developed a cash-pay price, which includes the surgery center facility fee, the fee for the implant and physician and anesthesiologist charges," says Ms. Sumpter. Spine surgeons at the center also recently provided a free clinic for patients without insurance coverage.

Ms. Sumpter credits the physicians and staff for the center's success. "We are fortunate to have surgeons who truly care about their patients. Our physicians are on the cutting-edge of their specialty. A combination of our physicians, staff and our convalescent center is what makes the Loveland Surgery Center so successful and allows us to provide excellent patient care," she says.

Mayfield Spine Surgery Center (Cincinnati). The Mayfield Spine Surgery Center, which opened in early 2007, is the first freestanding surgery center in the region to provide same-day spine procedures. The center performs both pain management and spine procedures including lumbar laminectomies, anterior cervical diskectomies and fusions, spinal cord decompression, ulnar nerve surgery, carpel tunnel surgery and minimally invasive spine procedures. The 23,500 square-foot facility features three operating rooms and a pain management suite.

Missoula Bone & Joint Surgery Center (Missoula, Mont.). Missoula Bone and Joint Surgery Center has been an AAAHC-certified center since 2002. The surgery center's eight physicians perform a number of orthopedic and sports medicine procedures, including joint replacements, arthroscopies, hand and microvascular surgeries, spine procedures and general orthopedic surgeries. The Missoula Bone & Joint Surgery Center is part of Missoula Bone & Joint clinic, an orthopedic practice serving Western Montana for more than 50 years. The surgery center features a one to one nurse-to-patient ratio and has performed more than 12,000 procedures since opening its doors in 2001.

The surgery center also actively works with Missoula Medical Aid, a nonprofit organization which began in 1998. Physicians from Missoula Bone & Joint travel to Honduras twice each year with a group of volunteers to provide orthopedic care to residents of the country. In addition to their time and expertise, the physicians of Missoula Bone & Joint donate medical supplies and durable medical equipment to the cause, according to Sami Spencer, CEO of the surgery center and clinic.

Ms. Spencer attributes the center's success to the dedication of its staff. "What makes Missoula Bone & Joint so special is the caring physicians and staff that work here," she says. "We are very proud of the care we provide our patients by incorporating both team effort and team spirit. Patient care and satisfaction are the number one priority for us."

Orthopaedic Surgery Center of La Jolla (La Jolla, Calif.). The Orthopaedic Surgery Center of La Jolla is the orthopedic ASC of Surgery One, a network of four outpatient surgery centers located in and around San Diego. The center offers a full range of surgical services from minimally-invasive spine surgery and arthroscopic and reconstructive orthopedic surgery to cutting-edge treatments for chronic pain. Ten spine surgeons, 24 orthopedic surgeons and six pain management physicians are affiliated with the center. The surgery center is driven by its goals, which include offering the best and most current state-of-the-art technology, impacting the industry, pursuing an outstanding reputation and maintaining profitability.

Parkway Surgery Center (Hagerstown, Md.). Parkway Surgery Center offers comprehensive spine treatments and non-invasive spine surgical procedures in a state-of-the-art outpatient facility. The physician-owned surgery center, which is part of the Blue Chip Surgical Center Partners network of physician-led surgery centers, features four neurosurgeons specializing in the spine, and three pain management specialists. The center prides itself on providing world-class care and using the latest technology at an affordable cost.

Tucson Orthopaedic Surgery Center (Tucson, Ariz.). Tucson Orthopaedic Surgery Center specializes in orthopedic and pain management procedures, performing more than 6,400 procedures annually. The center performs more than 1,000 knee scopes and around 500 carpal tunnel procedures annually, according to Tracey Kruse, RN, director of nursing for the surgery center. The 11,500 square-foot facility features four operating rooms and serves 17 surgeons. The accredited center sought accreditation not because it was required by law or other governing bodies, but because the staff believed it would improve patient care and safety, according to Ms.

Kruse. "The entire staff has worked very hard to build a team that is constantly looking for ways to improve patient outcomes, cost of care and staff satisfaction," she says.

The surgery center is also committed to providing care to those who need it most. "Our center, as well as the Tucson Orthopaedic Institute, continue to provide services to the Medicaid population and those without insurance while many other physicians have withdrawn from the Arizona Healthcare Cost Containment System [Arizona's Medicaid program]," says Ms. Kruse.

The center recently worked with Continental Airlines and its Continental Cares program to bring a young girl from Belize, along with her mother, to Tucson for a surgery to repair a fracture of her distal humerus. "The girl and her mother stayed at the guest house of a surgeon from our center for four weeks until the pins could be removed and they could then return to Belize," says Ms. Kruse. That surgeon, Brian Nielsen, MD, a board-certified orthopedic surgeon, learned of the girl on a vacation to Belize and helped to organize the effort surrounding her surgery.

Ms. Kruse says that staff members attribute the center's success to the cohesiveness of the team. "Our entire staff — from housekeeping to management and everyone in between — has a committed interest and desire to assure that we provide excellent support not only to our patients but to each other as well," she says. "I believe that our ASC stands out from the crowd for multiple reasons, but most importantly due to the outstanding patient care delivered by the staff."

Surgical Institute of Lake of the Ozarks (Osage Beach, Mo.). Surgical Institute of Lake of the Ozarks, an 8,400 square-foot multi-specialty surgery center, features three operating rooms. The center's orthopedic program is led by Chris Leslie, DO, and Thomas G. Hoeft, DO. Dr. Leslie is the co-designer of the popular knee replacement device, the 3-D Knee. The center's orthopedic program specializes in knee arthroscopy, rotator cuff surgery, carpal tunnel procedures and pain management. The surgery center opened less than a year ago, in July 2008, and is continuing to grow its patient volume, according to Steve Henry, administrator of the ASC. The new center is also successful in patient satisfaction ratings, with a 96-percent-positive patient satisfaction rate in the first three months of operation.

Surgical Institute of Lake of the Ozarks is the first surgery center in its community and is finding success in offering outpatient procedures to area residents. "We are the first ASC in Camden County, Mo., and offer patients a low cost, high-quality alternative for their outpatient procedures," says Mr. Henry.

Wildwood Surgical Center (Toledo, Ohio). Wildwood Surgical Center is an 18,000 square-foot multi-specialty surgery center with five operating rooms. The center is home to 50 physicians in addition to 44 clinical and administrative staff. The center performs approximately 6,000 orthopedic, ENT, plastic surgery, and ophthalmology procedures annually. The center's orthopedic program is particularly known for procedures involving the knee, shoulder, foot and ankle, according to Kelly Shirer, manager of finance and contracting at the center.

Ms. Shirer points to efficiency as one critical reason for the center's success. "We have rapid room turnover, cost-effective supply ordering, cross-trained staff, scheduling flexibility, state-of-the-equipment and an excellent preoperative screening process," she says. Ms. Shirer also says that the center's staff greatly contributes to the center's success. "We have a courteous, respectful and kind staff that treats all patients like a 'member of the family,'" she says.

St. Louis Spine Surgery Center (Creve Coeur, Mo.). The St. Louis Spine Surgery Center is a freestanding, pain management and spine surgical facility. The 6,000 square-foot center, part of the Blue Chip Surgical Center Partners network of physician-owned surgery centers, is home to six pain management physicians, two

orthopedic surgeons and two neurosurgeons. The center features two operating rooms and offers a variety of outpatient pain management, orthopedic and neurological procedures. The center aims to offer personal attention and the highest quality surgical care using the latest technology, at an affordable cost.

Angie Ford, administrator, attributes the center's success to its single-specialty focus. "I believe our program is so successful because we are, at this point, a single-specialty center with spine and pain management," she says. "Our staff is focused on the patients, and they are familiar with the patient's needs and the doctor's needs."

The staff is so confident in the center that they have even referred their own family members. Karen Lloyd, business office manager at the center, referred her mother for a consultation after working at the center for only a short time. "What better show of confidence as to trust someone with the care of your family member," she says. "[My mother's] surgery was a huge success and has greatly improved her quality of life."

Thomas Forget, MD, a spine surgeon at the center, says that facility's wide-ranging spine services enhance patient care. "The St Louis Spine Surgery Center houses a variety of pain specialists and spinal surgeons under one roof. This has given us the ability to efficiently tailor treatments for all spinal pain disorders," he says. "[The] open collaboration between all team members has provided us with better outcomes and a very satisfied patient population." ■

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10 Great Knee Specialists

Brian J. Cole, MD, MBA — Dr. Brian Cole is a professor in the department of orthopedics with a conjoint appointment in the department of anatomy and cell biology at Rush University Medical Center in Chicago. He is the section head of the cartilage research program at Rush University Medical Center and the Cartilage Restoration Center at Rush, a multidisciplinary program specializing in the restoration of articular cartilage and meniscal deficiency. He also serves as the head of the orthopedic Master's program and trains residents and fellows in sports medicine. Dr. Cole is the team physician for the Chicago Bulls basketball team, and co-team physician for the Chicago White Sox baseball team and DePaul University in Chicago.

Dr. Cole specializes in arthroscopic shoulder, elbow and knee surgery. He has a specific interest in arthroscopic reconstruction of athlete's shoulder (rotator cuff, instability and arthritis), elbow and knee. He is the principal investigator for numerous FDA clinical trials and regularly performs basic science research.

He has authored and edited several hundred peer-reviewed publications, including highly recognized orthopedic textbooks on arthroscopy, sports medicine and cartilage transplantation. His publications also include nearly one thousand book chapters, technique papers, and presentations describing the techniques and results of shoulder, elbow and knee surgery. Dr. Cole lectures and teaches the techniques of cartilage restoration and shoulder arthroscopy on a national and international level. He is a member of numerous national societies and serves on the board of the American Academy of Orthopedic Surgeons and assumes many high level positions on society organizing committees.

John D. DiPaola, MD — Dr. John DiPaola is founder of Occupational Orthopedics and a partner at East Portland Surgical Center in Portland, Ore. After 12 years practicing general orthopedics, Dr. DiPaola established Occupational Orthopedics, the only specialty practice in the United States providing personalized care exclusively for injured workers. He is the current medical director for Oregon Health Systems and Montana Health Systems. Dr. DiPaola regularly speaks about injured workers' care at regional and national meetings.

Jack Farr, MD — Dr. Jack Farr is the medical director for the Cartilage Restoration Center of Indiana. Over the past 20 years, following his completion of his orthopaedic surgery residency at Indiana University Medical Center, Dr. Farr has continued to focus his practice in sports medicine and knee restoration. His numerous appointments and affiliations include a clinical associate professorship in orthopaedic surgery at Indiana University Medical Center and a board position with the Cartilage Research Foundation.

Freddie H. Fu, MD — Dr. Freddie Fu is the David Silver Professor of Orthopaedic Surgery and chairman of the department of orthopaedic surgery at the University of Pittsburgh School of Medicine and University of Pittsburgh Medical Center, where he was previously the department's executive vice chairman. Dr. Fu has been the head team physician for the University of Pittsburgh Department of Athletics since 1986 and holds secondary appointments at the university as professor of physical therapy and health physical and recreational education. Dr. Fu is known worldwide for his pioneering surgical techniques to treat sports-related injuries to the knee and shoulder and his extensive scientific and clinical research in the biomechanics of such injuries.

Scott Gillogly, MD — Dr. Scott Gillogly is founder of the Atlanta Knee and Shoulder Clinic and formed a sub-specialty group of the clinic, the Atlanta Sports Medicine & Orthopaedic Center. Dr. Gillogly specializes in cartilage restoration, complex knee disorders, biologic knee reconstruction as well as sports and shoulder injuries and serves as the head team physician and orthopaedic surgeon for the Atlanta Thrashers hockey team and the Atlanta Falcons football team. Dr. Gillogly completed a distinguished military career in the Army Medical Corps with the rank of lieutenant colonel. He is currently the director of sports medicine training for the Atlanta Medical Center Orthopaedic Residency Program.

E. Marlowe Goble, MD — Dr. Marlowe Goble has been a pioneering knee surgeon for the past 30-plus years and is perhaps best known in orthopedics as one of the top surgeons in ACL reconstruction and meniscal allograft transplants. He performed what may be the first minimally invasive knee replacement procedure and holds more than 70 patents. He currently practices at Salt River Orthopedics in Afton, Wyo., serves as the director of the Utah State University medical device testing laboratory in the department of animal science and is an adjunct professor in the department of orthopedic surgery at the University of Utah. His previous work included founding several companies, including MedicineLodge, an orthopedic technology development firm; Facet Solutions, a facet arthroplasty device company; and Frontier Biomedical, a leader in comparative medicine. Dr. Goble has had several other notable achievements including serving as a lead surgeon for Zimmer on the prosthetic ACL development and as Utah State University team physician.

Timothy E. Kremchek, MD — Dr. Timothy Kremchek serves as the Cincinnati Reds baseball team medical director and chief orthopaedic physician. He performs the bulk of his surgical practice at the Summit Surgery Center in Cincinnati. He currently serves as the director of sports medi-

cine for the TriHealth System of Good Samaritan and Bethesda hospitals. Dr. Kremchek began private practice in orthopaedic surgery and sports medicine in Cincinnati in 1993, when he completed a one-year orthopaedic sports medicine fellowship at the Alabama Sports Medicine Institute in Birmingham, Ala.

Frank R. Noyes, MD — Dr. Frank Noyes is founder of the Cincinnati Sportsmedicine and Orthopaedic Center and director of The Noyes Knee Center. Dr. Noyes is an internationally recognized authority on the diagnosis and treatment of complex knee problems. In 1975, he joined the department of orthopaedic surgery at the University of Cincinnati and started Cincinnati's first sports medicine program. He also established the Noyes-Giannestras Biomechanics Laboratories within the University of Cincinnati College of Aerospace and Mechanical Engineering, and today serves as a clinical professor with the school's department of orthopaedic surgery and an adjunct professor with the department of biomedical engineering.

Michael B. Purnell, MD — Dr. Michael Purnell is an orthopedic surgeon at Orthomed Center in Modesto, Calif. He specializes in sports medicine with a focus on the knee and shoulder and has more than 19 years of clinical practice experience. His clinical interests and expertise include computer-assisted knee arthroplasty, complex reconstruction of knee instabilities including ACL, PCL and dislocations, treatment of meniscus and cartilage abnormalities. He also has extensive experience in shoulder arthroscopy and reconstructive shoulder surgery. He is a graduate of University of Iowa College of Medicine, did his residency at Boston University Affiliated Hospitals Program and completed a Sports Medicine Fellowship in Sydney, Australia. Dr. Purnell is the team physician for the *Modesto Nuts*, the Class A affiliate of the Colorado Rockies baseball team, and a team physician for California State University, Stanislaus and Modesto Junior College. He serves as a consultant for DePuy Orthopaedics and Advanced Bio-Surfaces and is a member of the editorial staff for the *American Journal of Sports Medicine*.

David Raab, MD — Dr. David Raab is a senior partner and one of the founding members of Illinois Bone and Joint Institute, one of the country's largest orthopaedic and musculoskeletal practices. He has been in practice for 17 years as a board-certified orthopaedic surgeon in suburban Chicago. His practice is focused on surgical and non-surgical management of the knee, shoulder and hip, as well as sports medicine and work-related injuries. Dr. Raab's surgical specialties include arthroscopic knee, shoulder and sports medicine surgery, as well as total knee and hip replacement. He also serves as the president of the Illinois Sports Medicine and Orthopaedic Surgery Center. Dr. Raab completed his medical training and residency at Northwestern University Medical School and completed a fellowship in sports medicine at the Minneapolis Sports Medicine Center in Minnesota. ■

{ healthcare challenge no. 247 }

IF DR. NELSON THE SURGERY CENTER OWNER AND MEDICAL DIRECTOR NEEDS TO REDUCE COSTS ON PHARMACY PURCHASES BY TEN PERCENT SO THAT HE CAN FIND THE CAPITAL TO PURCHASE NEW EMR TECHNOLOGY, HOW CAN HE INSTITUTE QUALITY MEASUREMENT AND ASSURANCE PRACTICES?

5 Challenges Facing Orthopedics in Surgery Centers and Best Practices to Overcome Them

By Renée Tomcanin

Orthopedics is usually a breadwinner for surgery centers, but the specialty is facing a number of challenges that can reduce its profitability.

Here are five of the major challenges currently facing orthopedics in ASCs and some expert advice on how to overcome these obstacles.

1. Economy

As with most industries today, the state of the economy has a significant impact on orthopedics in surgery centers. A struggling stock market and the growing rate of unemployment have trickled down into healthcare.

As the economy continues to struggle, copays and deductibles on many patients' healthcare plans also continue to rise. This directly impacts orthopedics.

Marie Lee, surgical services administrator for the Ambulatory Surgery Center at Northwest Health in Springdale, Ark., has seen the effects first-hand.

"The economic downturn has postponed elective surgeries for many patients," she says.

Greg Roberts, MD, an orthopedic surgeon at Upper Cumberland Orthopaedic Surgery and Upper Cumberland Physicians Surgery Center in Cookeville, Tenn., also sees the effect of the economy on orthopedics.

"In our area we have seen a significant loss of industry," he says. "With these companies, many people are becoming uninsured or underinsured. Certainly this will put more pressure on the medical system as a whole but also lead to decreasing volumes and revenues."

Alan Davidson, executive director of the Orthopedic Institute of Pennsylvania in Camp Hill, says that this trend can lead to many patients not paying their copays at the time of their procedures.

Don Love, administrator of an orthopedic practice in Roanoke, Va., mentions several ways in which ASCs can better ensure payment from patients, including prescreening each patient's insurance benefits prior to the surgery to determine coverage eligibility and collecting copays at the time service is rendered. "It is important to help patients understand and be aware of what their copays and deductibles will be," he says.

Mr. Davidson agrees that increased attention to the workings of the revenue cycle will help combat this problem. "Staff must be trained to collect these payments at the time of service," he says. "Some insurance contracts provide obstacles to timely collection, and these clauses must be negotiated out of payor contracts."

Ken Austin, MD, an orthopedic surgeon in Airmont, N.Y., also notes that insurance companies can "place obstacles in the way of healthcare for both the patient and the practitioner." These obstacles include underpayments for procedures and excessive paperwork.

In addition, Dr. Austin notes that many patients have employers who constantly switch healthcare providers, and oftentimes the patients are not aware of what their requirements are as they change from plan to plan. "Insurers make it as difficult as possible for patients to understand," he says.

In the face of these economic troubles, a "quick-fix" solution to what seem to be mounting issues is not viable. Rather, many ASCs are working to ensure they maintain their standard of care as they weather the storm. "At present, we continue to strive to provide top-notch medical care as efficiently as possible," says Dr. Roberts.

2. Cost of implants

Another area of concern related to the economy for orthopedics in surgery centers, is implant costs and reimbursement for them, says Dr. Roberts.

"Many procedures that we could do well and probably save the patient and insurance company money — such as open reduction internal fixation of a distal radius fracture — are currently not possible at our center," he says. "Currently, Medicare and some other insurers will not pay for implants, only the center fee. Most of the time, the total payment is less than the cost of the implant, making these case impossible to do from a financial standpoint."

Expensive implants that surgeons want to use also can be a hindrance to profitable orthopedics. Sandy Berreth, administrator of the Brainerd Lakes Surgery Center in Baxter, Minn., sees this as a significant challenge for not only her center, but most centers.

Chris Metz, MD, an orthopedic surgeon at the Brainerd Lakes Surgery Center, agrees that centers should regularly consider and review what types of implants could be most cost-effective for the center. "New surgeons like to try the 'new and fancy' things," he says. "It is important to look at the benefits and prove that it is worth the expense. If it improves outcome (shorter recovery time, shorter surgery time), then it's worth it. If it's just like the ones that are already on the market, then you'd be hard pressed to make the change."

3. Compensation and disclosure

Recent reports in the media have shown that the industry and the government have become increasingly strict on surgeons receiving any type of compensation from device manufactures and drug companies. In addition, more and more companies are disclosing compensation information to the public.

As a result, it has become important for administrators and surgeons at centers to become and remain aware about what kinds of activities could fall under this umbrella.

Nancy Burden, director of BayCare Ambulatory Surgery Centers in Tampa Bay, Fla., says her ASC takes proactive approaches to minimize conflicts of interest.

"We are attentive to and concerned about compliance issues and legal requirements and the avoidance of any financial gain," she says. "For example, we might help the orthopedic surgeon plan a lecture and give ideas for advertising, but the surgeon would pay for any ads or fliers, not the ASC. Any assistance with an associated cost (such as providing a luncheon for meet and greet) fits into strict allowance guidelines and is documented and tracked."

In addition, Ms. Burden says that her ASC requires any physician in a leadership or decision-making role to sign an annual disclosure of any conflicts of interest.

4. Scheduling

Keeping track of surgeons' schedules can often be a challenge for centers. In addition, finding a schedule that makes the most sense and is the most efficient is important for administrators and surgeons.

Ms. Lee suggests sitting down with surgeons to figure out their best schedules. "Collaborate with surgeons and establish block time or surgery days that promote productivity," she says. "We reviewed a surgeon's schedule — he changed

his clinic days and we assigned him specific OR time, and ultimately he gained a half-day per week to see clinic patients, schedule additional surgery or add to family time."

Ms. Berreth also offers the following advice for administrators to help them determining an efficient schedule:

Scheduling should be monitored. "Procedure lengths should be based on experience, not on the orthopedic surgeon's memory," she says.

She suggests that centers not start the day with a large case (such as shoulder, ACL) as these types of cases require more time for prep work for anesthesia and often utilize regional blocks before the procedure. "Have the orthopedic surgeons working on smaller procedures that can start on-time, while the larger-procedure patient is being prepped," she says.

Start on time. "Define the 'start time' with the surgeons, and keep them honest," she says. She suggests monitoring each doctor and showing them, in minutes, how much it costs the center when cases start late.

Dr. Metz notes the importance of having an efficient schedule. "We take it for granted," he says. "A good scheduler is a huge part of making sure that the center runs smoothly."

He also notes the importance of keeping turnaround time low. "We try to schedule all right-side procedures in a row, then all lefts," he says. "This is so you don't have to change all of the equipment from one side to the other between every procedure."

Dr. Roberts notes that his facility tries to schedule all-day block time for their surgeons rather than half day. "This allows us to achieve better flow to our schedule and decrease down time," he says. "We also try to arrange all cases with a C-arm need together to cut down on the X-ray time needed."

By taking the time to assess these issues, ASCs should find it easier to develop a schedule that works best for their centers.

5. Equipment

Finding the best kind of equipment at the best price can be a challenge for orthopedic practices. The surgery center setting lends itself to creating a situation where every surgeon may want to use a different product, but doing so can quickly drive up costs and reduce an ASC's ability to make bulk, discounted purchases.

"We got all of our orthopedic surgeons, as much as possible, to agree on the appropriate equipment and supplies," says Dr. Roberts. "We attempt to standardize equipment when possible, allowing better price negotiation."

Ms. Berreth says it is important to keep track of pricing. "All new products at our center meet agreed on pricing before they can be used and purchasing orders are issued," she says.

Additionally, Ms. Berreth suggests preventing one equipment challenge before the center faces it. "Although expensive at startup, you must have the right amount of equipment to be efficient," she says. "If your orthopedic surgeons are successful and have the expectation to do many cases in a day, the center should have equipment to facilitate how that will look. In other words, the faster turnovers are facilitated by the availability of equipment."

She also notes that most vendors are typically looking to sell their product at the best price. "Big institutions that purchase lots and lots often can purchase the same product for much less than a small surgery center; that is why group purchasing organizations are so important to the small ASCs," she says. "They provide purchasing power."

She also suggests appointing designated material managers. "They are worth every penny, and I try to tell mine that all the time," she says. ■

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4 Great Growth Opportunities for Orthopedics in Surgery Centers

By Renée Tomcanin

In spite of the current state of the economy, with many companies downsizing and cutting services, there are still some opportunities out there for businesses. This is true for orthopedics in surgery centers.

Here are four best practices your ASC can follow to best take advantage of growth opportunities.

1. Reach out to the medical and local community and boost volume

Improving case volume is an essential step for any growing profitability surgery center and in orthopedics in particular.

"Everything in a surgery center is driven by volume," says Sandy Berreth, administrator of the Brainerd Lakes Surgery Center in Baxter, Minn. "If you don't have patients, it does not matter if you have the latest and greatest technology. Elective surgery is how ASCs are driven, and unless the surgeons (whether partners or not) bring their patients to you, it just doesn't matter about anything else — it is all about the patient!"

A good opportunity for growing your case volume is to find willing and experienced surgeons who would like to partner with your center. In addition, in-community recruitment is also an excellent chance for your current surgeons to become more aware of the medical community around them and what the needs this community has.

Nancy Burden, director of BayCare Ambulatory Surgery Centers in Tampa Bay, Fla., says that one way to accomplish this is to introduce your surgeons to local primary care physicians. She offers the following suggestions on how administrators can facilitate this meeting:

- Take your surgeons or their internal office marketing representatives on ride-alongs for a day or half-day with pre-planned primary care office visits.
- Provide advice to orthopedic office marketing representatives, such as building a marketing plan, insights into the local medical community, sharing community demographic information sources such as public access county/state databases, etc.
- Help facilitate private physician-to-physician meetings, such as lunches in a physician's office.
- Take the surgeon's business cards to referring physicians.

In addition, surgeons can benefit by reaching out to members of the community — those who are current or may be future patients. Chris Metz, MD, an orthopedic surgeon at Brainerd Lakes, suggests that education is a good way to generate more interest in the center.

"We've done presentations on arthritis, hand procedures, carpal tunnel and other types of procedures we perform at the surgery center for the community," he says. "It gives a chance for people to come down and see the center."

These types of events can help raise community awareness, not only about health conditions but about the surgery center as well. According to Dr. Metz, the hope is that patients will think of the surgery center the next time they have to have a procedure. As result of these presentations, he says case volume at his center has increased.

In addition, Dr. Metz says that at the end of each day at the center, he receives a list of the patients and procedures he has performed that day. Either that evening or the next day, he or a nurse will call the patient to check in and see how they are doing after the surgery.

"It takes no more than two or three minutes," he says, "but it means a lot." These calls have helped patient satisfaction rates go up, which encourages more word-of-mouth referrals. "You can spend all the money on ads and marketing," he says. "The 'good word' spreads must faster."

2. Take proactive approach to move cases from inpatient to outpatient

As technology advances, it may be possible to move more and more cases from the inpatient setting to the outpatient setting.

Dr. Metz notes that over the past 10 years, most shoulder surgeries are performed at surgery centers. Most of this movement is due to advancements in surgical technology, especially in pain management. He mentions the need for an ASC to have an "aggressive, well-trained anesthesia staff."

Therefore, in order to move more cases from the inpatient setting to the surgery center, it may be important to establish an excellent pain management program. According to Dr. Metz, many centers are trying to "treat pain before the patient has it" by using oral medications before surgery to treat pain after surgery.

Ms. Burden mentions that some of her anesthesiologists perform anesthesia blocks prior to the surgery to reduce post-op pain.

Marie Lee, surgical services administrator for the Ambulatory Surgery Center at Northwest Health in Springdale, Ark., notes the benefits of using anesthesia blocks. "Patients who are eligible via health/medical status/clearance, and are given anesthetic blocks, have shorter recovery time and less post operative pain," she says.

Donna Quinn, director of the Orthopaedic Surgery Center in Concord, N.H., suggests that orthopedic ASCs should consider expanding their practices to include outpatient spine procedures. "We now perform lumbar microdiscectomy and anterior cervical fusion procedures on an outpatient level," she says. "Reimbursement for these procedures can be very good. That being said, patient selection (health wise and insurance payor) is crucial to success."

Another opportunity to grow volume is to handle cases that require longer stays. "Many centers are performing all orthopedics cases at surgery centers," says Ms. Berreth. "The key to cases that require longer hospitalization and rehab is to have 23-hour care beds available. Another option is to make an agreement to transfer these patients to a rehab center, not an acute-care facility," as Medicare does not allow this.

Ms. Quinn also sees including total joint replacement as possible area of growth for orthopedics in surgery centers. However, she sees problems with patient transfer to rehab facilities that are far from a center. "I guess in the right setting this could work — where the ASC has a 23-hour facility and maybe the rehab center is attached," she says.

"I am not convinced that I personally would want to have a total joint procedure and then be sent home or to a rehab facility within 23 hours," she says. "I guess in the right setting this could work — where the ASC has a 23-hour facility and maybe the rehab center is attached."

However, there are some stumbling blocks when it comes to moving more cases from inpatient to outpatient settings. One such area involves insurance reimbursement for implants, says Greg Roberts, an orthopedic surgeon at Upper Cumberland Orthopaedic Surgery and Upper Cumberland Physicians Surgery Center in Cookeville, Tenn.

"Many of our cases that we could do well and probably save the patient and insurance company money are currently not possible at our center," he says, because many insurers only cover the center fee, not the implant, making some procedures not yet financially practical in the surgery center setting.

"If we could get this corrected, I feel that the patient, the center and the insurance company would benefit," Dr. Roberts says.

3. Associate with sports medicine programs

Ms. Lee notes that building a relationship with sports medicine programs can be a great asset to a surgery center.

"A close relationship with area schools and sports programs, including injury prevention programs, promotes confidence and support of your orthopedic program," she says. "When sports injuries are treated successfully at your facility, the extended family will also consider your services."

In order to make of the most of this affiliation, she suggests making major public relations efforts to inform the community about the partnership.

4. Avoid bad contracts

An ASC can hinder growth in a number of ways, including signing unprofitable contracts with payors. Ms. Berreth suggests that "going" non-participating, or out of network, when it comes to managed care contracts can often be a successful alternative for ASCs.

"Private payors can make or break surgery centers," she says. "They set reimbursement rates to centers and often are inflexible and because of their size versus a surgery center's size. Negotiations can be difficult, and additionally, contracting needs due diligence to be successful."

If negotiations fail to produce a better, more profitable contract for the ASC, sometimes it is wiser not to sign the contract rather than agreeing to a contract just to boost patient volume that could lead to losses.

She notes that "going non-participating" can be a "battle" with members of your ASC that is difficult to fight and win as many may be skeptical of moving from in-network to out of network. "The governing board needs to lend its support to whatever the decision," she says.

Ultimately, there are benefits to going out of network. "The primary benefit is higher reimbursements and less write-offs," Ms. Berreth says. "It is all about cash-flow and revenue." ■

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5 Best Practices for Improved Coding of Orthopedic and Spinal Procedures

By Cristina Bentin, CCS-P, CPC-H, CMA

The reporting of orthopedic, spinal and pain management procedures continue to provide challenges for many ASCs regardless of whether the coder is a novice or a seasoned veteran. Below are five best practices to help ensure your facility captures reimbursement opportunities while adhering to coding guidelines.

1. Expertise in coding specialty procedures. Simply because an ASC employs a certified coder does not denote the coder has a good working knowledge of the facility's various specialties. For example, let's consider newly added specialties. When a facility explores the possibility of adding new specialties, it assesses the costs to perform these procedures versus the reimbursement it receives once the procedure is performed. Often, the facility doesn't consider the coder's expertise or lack thereof in relation to these new procedures.

Would you expect your dentist to be able to perform an arthroscopic ACL reconstruction or your orthopedic surgeon to perform a four quadrant alveoloplasty for the preparation of dentures? Likewise, your ASC should not assume that coders, while certified, will be experts in orthopedic procedures if the only specialty they have been coding previously is ophthalmology. It is necessary for the facility to verify the coder's knowledge and provide education *prior* to bringing these specialties on board.

2. Credible and current resources. Your surgeons and OR staff have certain instrumentation preferences based on the type of procedure(s) being performed. Why would a facility expect anything less of its business office, particularly the coder? Provide the coder with current tools/resources from credible sources. Current coding books (CPT, ICD-9-CM, HCPCS), coding software, Medicare edits, local coverage determinations, AMA guidelines, individual specialty societies, and/or written carrier guidelines will assist the coder with accurately reporting procedures and maximizing reimbursement. Coders should avoid online "coding chat rooms" in which "opinion" is common and specific citations from Medicare and AMA are sparse.

The orthopedic specialty tends to generate an abundance of coding questions particularly in the areas of shoulders and spinal procedures. One recent challenge is spinal arthrodesis coding, not routinely performed in an ASC, as it pertains to crossing anatomic levels. Confusion arises when a multiple level arthrodesis is performed in which there is a crossover of anatomic regions.

For example: T10-L2 arthrodesis. Some coders and physicians attempt to code one primary code for the initial T level and one primary code for the initial L level with the add-on code reported for the additional levels. This is incorrect. Both the American Academy of Orthopaedic Surgeons (AAOS)

and the North American Spine Society recommend reporting one primary arthrodesis, CPT 22612 (*arthrodesis, posterior or posterolateral technique, single level, lumbar*) and CPT 22614 for *each additional level(s)*. The most extensive procedure is reported as primary with the additional levels reported with CPT 22614. Both CPT and CMS indicate that an arthrodesis at the lumbar level requires more work value than in the thoracic area.

3. Detailed clinical documentation. Nothing says "cha-ching" like a detailed operative report. Deficient documentation practices may result in a lack in reimbursement opportunities, not to mention the additional time spent by both the coder and the physician with regards to querying or being queried for additional information. While facilities are encouraged to implement an acceptable query process, some coders erroneously undercode a procedure in order to get the claim billed. This practice is unacceptable.

Take, for example, an arthroscopic, knee, surgical, abrasion arthroplasty. There are specific guidelines regarding the documentation required to report CPT 29879 (*arthroscopy, knee, surgical; abrasion arthroplasty or multiple drilling or microfracture*). The AAOS states CPT 29879 is "appropriate when the procedure exposes bleeding subchondral bone." The physician may describe debriding to bleeding bone or microfractures/drilling holes.

The surgeon's operative statement, "I performed an arthroscopic abrasion arthroplasty" without describing the procedure does not warrant CPT 29879. If the surgeon states, "I performed a three compartmental arthroscopic abrasion arthroplasty," without any additional description of the procedure, the coder will need to query to confirm reporting a three compartmental chondroplasty, CPT 29877 (*arthroscopic, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)*) x 1 versus a true arthroscopic abrasion arthroplasty, CPT 29879 x 3. Recall, when it is the only procedure performed in the knee, CPT 29877 is reported once regardless whether it is performed in one or three compartments ($900.78 x 1 approximate Medicare reimbursement). CPT 29879 is reported three times when performed in all three compartments ($842.28 + $842.28/2 + $842.28/2 approximate Medicare reimbursement).

4. Knowledge of Medicare vs. commercial reimbursement guidelines. It is essential for the coder to be familiar with the facility's various carrier contracts and reimbursement guidelines. The coder should be well versed in the utilization of Medicare edits and policies as well as the facility's commercial carrier reporting policies and guidelines. Not all payors follow Medicare reporting policies allowing for more aggressive reporting. Facilities that follow Medicare across the board for all payors could be leaving money on the table. Regardless, the facility should establish a consistent protocol for the coder to follow.

5. Utilization of applicable modifiers. In addition to understanding Medicare guidelines, the coder should be quite knowledgeable in regards to modifier usage. Mastering the Medicare edits can prove challenging. Coders tend to err on the side of caution when reviewing the edits or they don't understand "when" modifiers should be appended to the CPT code to indicate a "separate" and "distinct" procedure that would otherwise be considered bundled. In this instance, the coder's knowledge of the procedure(s) will assist in determining whether a modifier is applicable.

Medicare edits bundle CPT 63030 (*laminotomy, with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically assisted approaches; 1 interspace, lumbar*) into CPT 63047 (*laminectomy, facetectomy and foraminotomy, single vertebral segment; lumbar*) at this time but allows for a modifier if CPT 63030 is performed at a different *level* than CPT 63047 (i.e. CPT 63030 is performed at L5-S1 and CPT 63047 is performed at L4-L5).

Medicare edits bundle CPT Code 29823 (*arthroscopy, shoulder extensive debridement)* into CPT 29824 (*Arthroscopy, shoulder, surgical; distal claviculectomy*) at this time but allow for a modifier if the debridement is performed separate and distinct from the distal claviculectomy. A coder's unfamiliarity with the Medicare edits and its conventions might lead to the coder reporting only CPT 29824 since CPT 29823 is listed in the Medicare edits as an integral component despite operative documentation to the contrary. On the flip side, a coder's comprehension of the detailed operative description coupled with an understanding of "when" to apply the -59 modifier will result in the reporting of both CPT 29824 and 29823-59 and ultimately capture additional reimbursement.(CPT 29823 = $1241.87 + CPT 29824 = $943.20/2 approximate Medicare reimbursement). It is important to reiterate that documentation must describe extensive debridement in significant areas/sites other than the area/site of the distal claviculectomy in order to report both codes. ■

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Adopting Bylaws That Address Disruptive Physicians: Q & A with Tom Stallings of McGuireWoods

Thomas J. Stallings, JD, a leading legal expert on medical staff issues and partner at McGuideWoods, discusses medical staff issues of concern for surgery centers and hospitals, and offers his suggestions for dealing with these challenges.

Q: What medical staff issues should surgery centers and hospitals be most concerned with right now?

Tom Stallings: I am increasingly being consulted about the problems created by disruptive physicians. Unfortunately, healthcare has had some history of tolerating physicians who exhibit intimidating or disruptive behavior; however, accrediting bodies are taking more and more of an active role in requiring that healthcare facilities confront these behaviors. The Joint Commission and other accrediting and regulatory bodies are placing increased emphasis on the management of disruptive physicians. This emphasis is arising because of the recognition that disruptive conduct jeopardizes quality and safety, which require teamwork, collaboration and communication. Additionally, disruptive conduct, of course, can interfere with staff retention and recruitment and consume critical resources that are better focused elsewhere.

Let's say, for example, there is a disruptive surgeon at your facility whose behavior administration and co-workers have kept quiet about or let slide. Patient care can be compromised if nurses are afraid to ask the surgeon a question because they fear the doctor will berate them. As a result, we see an increased emphasis from accrediting and regulatory bodies on this issue.

All too often, this issue overlooked until a problem arises. I'm seeing more and more disputes involving disruptive physicians and facilities, and the facilities run into problems when they haven't put procedures into place to discipline or deal with these disruptive behaviors before they become a problem. The Joint Commission has recently required all accredited facilities to have a code of conduct and create a formalized process for managing disruptive and inappropriate behaviors. Having a clear code of conduct and a process for addressing and disciplining these behaviors is critical for all facilities, even if they are not accredited by the Joint Commission.

Q: What should surgery centers and hospitals do about this concern?

TS: The most important thing for hospitals and surgery centers to do is to update their medical staff bylaws to include a formal process for managing any inappropriate behaviors that arise. In particular, administrators should review the corrective action and hearing sections. The key is getting your system in place before a problem arises. What you don't want to do is try to invent or revise a process after a problem arises. This can create a host of problems for everyone involved.

Unfortunately, the tendency is for facilities to focus on these sections of the bylaws only at the time they need to implement them. However, by the time you need to implement them, it's too late to change them. Typically, no one reads the sections that deal with corrective action until there is a full-blown problem at the facility. Adopting some other facility's bylaws years ago, and then never updating them, is a recipe for trouble. When you have a genuine problem on your hands, you want your medical staff bylaws to comply with applicable state and federal law to maximize the immunity and privilege available to peer review proceedings. That way, the final actions of the facility's governing body can stand up in court, if it is challenged later.

Q: What do surgery centers and hospitals need to include in their bylaws to ensure they are prepared if issues involving disruptive physicians arise?

TS: There is no one-size-fits-all policy or process, especially since the applicable state laws will vary. Therefore, it is critical that facilities customize their bylaws in light of applicable state law. However, as the Joint Commission recommends, a code of conduct, a process for managing disruptive behavior, protection for those who cooperate in investigations regarding this behavior and information on how and when to begin disciplinary actions are all critical elements. Medical staff bylaws should strike an appropriate balance between protecting and promoting patient safety and providing due process for the physician in question.

I've seen a lot of a facilities model their bylaws after others they've seen and judge to be good. While there's nothing wrong with starting with a good model from another state, doing so should be a starting point, not the end of the process. Or, conversely, just because you have a model from a facility in your own state, you can't assume that it's a good model or that it has been customized in light of your state law. I've seen many bylaws that don't even come close to meeting state requirements, and this is often discovered, unfortunately, only when you are in the middle of the corrective action process.

Q: How should surgery centers and hospitals approach bylaws?

TS: The most important thing is that these facilities need to approach bylaws differently. I have seen a good number of surgery centers adopt bylaws written for hospitals without customizing them for their facilities' needs. For surgery centers, standard hospital bylaws may not be applicable.

The last thing a facility should do is adopt bylaws that it cannot follow. Surgery centers typically have much smaller medical staffs. In a hospital setting with a larger medical staff, it may be perfectly appropriate to have rules restricting who can serve in certain roles. For example, some bylaws provide that members of the governing board may not be involved in the investigation process. While these are good principles, they are typically not mandatory. In the surgery center setting, the same rules may be too restrictive, because they don't leave enough individuals available to fill the needed roles. When facilities adopt rules that are too restrictive, those facilities either end up ignoring the bylaws or following them and getting poor results. It's never a good position for a facility to be violating their own bylaws. It is also complicated to try to change the bylaws in the middle of a situation. The best approach is to anticipate problems and ensure that your bylaws satisfy accreditation as well as federal and state law requirements and are appropriate for your facility before dealing with problems, such as a disruptive physician. ■

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10 Interesting Statistics and Facts About Pain Management in Surgery Centers

Here are 10 interesting stats and facts about pain management in ASCs.

1. Pain management was fourth among identified specialties represented at single-specialty centers, tied with orthopedics, and was represented in 5 percent of all single-specialty ASCs.

2. Pain management was represented in 30 percent of all ASCs (single- and multi-specialty), ranking fifth behind plastic surgery, ophthalmology, gastroenterology and orthopedics.

3. Pain management represented 9 percent of the total case volume at surgery centers, ranking it third behind gastroenterology and ophthalmology.

4. Pain was the third highest in number of average procedures in all ASCs with 1,359 procedures annually, behind gastroenterology and ophthalmology.

5. In 2007, an average 3,920 pain procedures were performed in single-specialty centers. This was the second-highest number behind gastroenterology.

6. The average net revenue for a pain management case was $868 in 2008.

7. Here is the average net revenue for pain management cases by region:
- West: $916
- Southwest: $864
- Midwest: $925
- Southeast: $790
- Northeast: $950

8. Here is the average net revenue for pain management cases by an ASC's number of operating rooms:
- 1-2 ORs: $939
- 3-4 ORs: $879
- More than 4 ORs: $805

9. Here is the average net revenue for pain management cases by an ASC's total case volume:
- Less than 3,000: $959
- 3,000-5,999: $822
- More than 5,999: $813

10. Here is the average net revenue for pain management cases by an ASC's total net revenue:
- Less than $4.5 million: $807
- $4.5-$7 million: $851
- More than $7 million: $892 ■

Sources:
Items 1-5: SDI's *2008 Outpatient Surgery Center Market Report. Learn more at www.sdihealth.com.*
Items 6-10: VMG Health *2008 Intellimarker. Learn more at www.vmghealth.com.*

Grow Pain Management Through Diversification, Expansion and Marketing

By Lindsey Dunn

Although pain management practices have recently faced considerable reimbursement challenges, ASCs can take steps to overcome these challenges by focusing on growing services and patient volume.

Here are three recommendations for growing pain management in ASCs in both single- and multi-specialty surgery centers.

1. Diversify pain treatment options. Pain management physicians and facility administrators recommend that ASCs offer a wide range of treatment options in order to be attractive to an equally wide range of patients while considering the costs to the facility that come with offering the procedures.

"I think exclusive pain centers will need to focus on increasing volume for the next few years," says Christine Yoder, director of Wyomissing (Pa.) Surgical Services. "Since we have been hit by reimbursement cuts pretty strongly, we need to figure out how to do what we do more economically without compromising quality."

Diversification of procedures is also an option ASC should consider, says Julien Vaisman, MD, physician-owner of New England Pain Care in Peabody, Mass.

"Facilities must diversify their treatment options and have a large number of different procedures available to patients," says Dr. Vaisman. "You've got to stay ahead of the game and be innovative," he says. Dr. Vaisman recommends that centers consider offering procedures such as implantation of peripheral and spinal stimulators and verterbroplasty, if these procedures are not already offered.

Pain centers should use an evidence-based approach when adding new pain management procedures to their offerings.

"Procedures that have support in the scientific literature to be effective in a majority of cases are the ones that facilities should look to offer," says Robert Wills, MD, of Austin (Texas) Pain Associates and physician-owner of Stonegate Surgery Center in Austin. "For example, facet medial branch radiofrequency thermocoagulation (RFTC), which has been shown to be quite effective in reducing neck, back, leg and arm pain, is worth exploring if not already offered by your pain management center." RFTC is one of the few pain procedures which actually received a payment increase from Medicare in 2008-2009.

2. Expand your offerings beyond pain management. Pain management ASCs should consider expanding their center's offerings to include neurology and orthopedics, both of which are closely related to pain management and can lead to increased referrals, says Jared Leger, RN, CASC, managing partner of Arise Healthcare and executive director of Stonegate Surgery Center in Austin, Texas.

"The synergy that is generated between the cross-referral of pain management and neuro/ortho/spine has huge growth potential," says Dr. Leger.

3. Aggressively market your services. Administrators and owners of pain management practices say that marketing is crucial to growing patient volume.

"Pain management centers need to aggressively market to primary care physicians," says J. Lowell Haro, MD, owner of Pain Management Consultants in Austin, Texas. "Pain practices need to market their services in order to ensure that primary care physicians are aware of pain management options."

Joel Haro, administrator of Pain Management Consultants, agrees. "Having a marketing department that actively targets referring physicians is crucial for growth," he says. "A marketing person is a 'must have' in every pain practice."

Other pain management physicians choose to market directly to patients. Dr. Wills' private practice, Austin Pain Associates, advertises directly to potential patients in an attempt to make them aware of pain management services. Mr. Leger says, "Dr Wills' practice has developed a direct marketing program to patients, via high-end local and regional magazines, in an effort to inform their patients about their choice to come to see a pain management doctor prior to considering surgery, and it appears to be working." ■

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6 Best Practices for Maximizing Efficiency in Pain Management

By Lindsey Dunn

Here are six best practices for maximizing efficiencies in pain management, according to industry leaders and owners of pain management ASCs across the country.

1. Benchmark. Pain management centers, whether standalone or within a multi-specialty surgery center, should benchmark various data from their practice with those of other pain practices. Benchmarking is necessary in order for pain centers to see how they "measure up" against various industry averages for care. Although data for standalone pain centers can be difficult to come by, administrators of pain centers say it is critical enough that ASC should work to find good figures.

"Pain centers should benchmark their staff dollars per case and staff hours per case against ASCs with similar case volume and similar specialty mix," says Jared Leger, RN, CASC, managing partner of Arise Healthcare and executive director of Stonegate Surgery Center in Austin, Texas. "They should also benchmark turnover time. If your ASC is 100 percent pain management, benchmarking data may be hard to find. Call other 100 percent pain management centers and mutually agree to share data. If that fails, use the average of GI and ophthalmology since the turnover time should be similar, and data is easier to find on these specialties."

2. Hire wisely. Hiring the right staff is crucial to ensuring that a pain center is run as efficiently as possible.

"Hire knowledgeable employees who understand pain management procedures," says J. Lowell Haro, MD, owner of Pain Management Consultants in Austin, Texas.

Joel Haro, administrator at Pain Management Consultants, agrees. "You have to hire smart," he says. "Hire employees that can multi-task and will perform job duties other than their responsibilities."

Julien Vaisman, MD, owner of New England Pain Care in Peabody, Mass., adds that hiring a strong director of nursing is also important. "The attributes for a strong director of nursing would be somebody who can coordinate the daily staff activities, makes sure all the supplies are available and has a vision about future trends in the ASC," he says.

3. Focus on teamwork and communication. Once a pain center has hired the right employees, it is important that it focuses on cultivating a culture of teamwork and participation.

"Teamwork is an essential key to success," says Dr. Vaisman. "Communication between all the healthcare providers is of utmost importance. The pain management physician needs to actively involve both the nurses and the radiology technician in the thought process and patient management options. Those employees have to understand not only how we are doing the procedures but why we are doing a certain intervention."

Staffing decisions should be made to maximize teamwork. "Pair the same staff members in the room with the same physician every time," says Mr. Leger. "This allows your C-arm technician and nurses to become familiar with the physician's preference, style of practice and C-arm positioning. Over time this will save you countless hours and make your physician's job easier and quicker."

4. Work to align physician preferences for procedure materials. Pain centers can also improve efficiency by streamlining purchases.

"Get your pain physicians to agree on uniform needle type and pharmaceuticals," says Mr. Leger. "Make custom trays for nerve blocks and ESI's. This is less expensive than pulling everything separately. Make sure your medical supply vendor and pharmaceutical vendor are [with] your GPO."

In addition, centers should use preference cards for each operation performed at the center, says Christine Yoder, director of Wyomissing (Pa.) Surgical Services.

"Use procedure preference cards so you know you have what you need every time," she says.

5. Educate physicians about the importance of turnover time. Ensure that physicians are aware of the importance of turnover time and what types of patient care should and should not occur in the surgery center. ASC administrators should consider educating their physicians about the importance of emphasizing to patients that follow-up and patient education will occur at the doctor's private practice, not at the surgery center.

"There needs to be an emphasis on patient education and follow up at the physician's office to avoid turning the ASC procedure time into an impromptu office visit or prescription refill opportunity, which dramatically slows down efficiency and turnover," says Robert Wills, MD, of Austin (Texas) Pain Associates and physician-owner of Stonegate Surgery Center in Austin.

6. Be prepared for reimbursement challenges. One of the biggest challenges for pain management within surgery centers is reimbursement. This issue, while not unique to pain management, poses significant challenges to ASCs offering pain management. It is critical to take steps before the day of the procedure to ensure the center receives full reimbursement for each procedure it performs.

"Pain management is relatively inexpensive to actually 'do'; the majority of the costs involved are for the personnel, such as the pain specialist and the staff, and the costs of the equipment," says Sandy Berreth, administrator at Brainerd Lakes Surgery Center in Baxter, Minn. "However, with reimbursement being cut dramatically, it has made pain a 'pain.' Therefore, success in pain management is all about the numbers and payor mix." Surgery centers should verify insurance thoroughly and request payment upfront, if possible. "Verify insurance information prior to the patient coming to your centers and make sure the patient is aware of their financial liability," says Ms. Yoder. "Collect it the day of service if your contract allows" you to do so.

Administrators need to be careful that physicians never perform procedures that have not been pre-approved by the payor. Because the types of procedures that payors will cover vary by insurer and state, it is important that physicians perform only those procedures that have been previously approved by the billing department.

Staff and physicians also need to work together to ensure billing is completed in a timely manner. "You need to work toward same-day completion of operative reports, which are available to both the physician and ASC billing office," says Dr. Wills. "Doing so allows for accurate matching and coding of claims submissions." ■

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Industry Leaders Share Insight on ASCs in the Current Economy

By Renée Tomcanin

ASC industry experts discuss three critical issues concerning ASCs in this challenging economy.

Q: What impact is the economy having on ASCs?

One area that experts felt the economy was significantly affecting surgery centers was in case volume. Tom Mallon, CEO of Regent Surgical Health, says, "We are seeing lower case volumes by 7 percent overall compared to the budget. It is too early for cash to be affected."

Many of respondents confirmed this trend of decreasing volume, which could be attributed to many causes.

Caryl Serbin, president of Serbin Surgery Center Billing, says, "Patients are choosing to have less elective surgeries."

James McGehee, administrator of Cleburne (Texas) Surgical Center, says, "We are in a business where we do truly 'elective' cases. When customers have to choose between paying the mortgage and having their knee scoped or their hernia repaired or dealing with the pain for a little longer, they have to take care of their basic needs first. We have seen a high number of cancellations at the last minute because of this exact scenario. I would say the cancellations are one of the biggest indicators of the impact on ASCs due to the recent downturn in the economy."

Brad Lerner, MD, of Chesapeake Urology Associates and Summit ASC in Baltimore, says, "We have noticed a decrease in the volume of fee-for-service cases, such as vasectomy reversal and genital cosmetic surgery."

As a result of lower case volume, growth within the ASC market is likely to shrink.

William Southwick, president and CEO of Healthmark Partners, says, "Without additional physician members to drive case volume, growth is likely to be anywhere between flat to down 5 percent. Higher deductibles and job loss inevitably will hamper growth from existing partners."

Todd Flickema, senior vice president of Surgical Management Professionals, says, "I think that recent articles regarding layoffs may be a hint this storm has already hit our shores. What will be interesting to watch is how centers that have historically enjoyed very comfortable profit margins will react."

On an optimistic note, some ASCs have not seen the effects of the struggling economy. Susan Olis, administrator of the Surgery Center of the Woodlands in The Woodlands, Texas, says, "Interestingly enough, we are not experiencing any downturn in our volume or reimbursement at this time. We are cautiously optimistic but also think that this is due to the fact that our center is in an affluent, diverse area where no large impact has been felt from this downturn."

Q: What is the most important thing an ASC can do in 2009 to preserve profits?

Most industry experts surveyed said that watching expenses is critical to control spending and preserve profits.

In addition, they offered some areas in which their centers and companies have seen positive results.

Dr. Lerner says that ASCs can attempt to boost revenue by increasing case volumes and bringing in new lines of service to the center. "We try to analyze cases performed in our ASCs and the hospital and educate physicians that are performing cases in the hospital from a 'convenience standpoint' about the benefits of performing those cases in an ASC setting," he says. He also suggests decreasing expenses by reassessing disposable product usage, negotiating with vendors and reevaluating staffing needs.

Marc Koch, president and CEO of Somnia, emphasizes the importance of understanding how a patient's life can be changed by the economy while at the same time doing what is in the best interest of the ASC. "Surgery centers and patients are permitted to write-off co-payments or deductibles, but they should clearly document economic hardship and, in addition, not make this a matter of routine on each and every patient but only for patients who are facing genuine economic hardship," he says. "In addition, understanding that a patient's life may have been turned topsy-turvy, kindness, empathy, understanding and concern go along way. For instance, a patient may have forgotten to be NPO and enjoyed a breakfast the morning of surgery. Understanding that recent unemployment, failed mortgage payments and depleted 401K may have gained more mindshare than your preoperative instructions will go along way to developing patient loyalty."

Mr. McGehee says, "The largest two largest [cost areas to look at] are supplies and labor. On the supply side, it is more important than ever to only order what you need for the week. If a center doesn't have a contract that allows them to do that, it would be a great time to renegotiate. We are able to order Monday for an early morning Tuesday delivery. I meet with my materials person on Monday and go over the order for Tuesday. We only order what is needed for the week's cases. On the salary side, we have cut way back on our PRN employees' hours to assure our full-time employees of their needed hours. Employees are nervous during this crisis, with good reason. As someone who has a large hand in their immediate future, I have the responsibility to look at each financial piece of the puzzle and see where cutbacks can be made to assure profitability for my center."

Doug Peter, vice president of operations for Healthmark Partners, says, "Manage the margin, and focus on being more efficient with same store volume."

Q: Are there currently any opportunities in the ASC market?

In spite of the struggling economy, there are some opportunities for ASCs and other companies within the industry.

Dr. Lerner notes that the new lines of service can generate growth for a surgery center, and it has worked for his center. He says, "Within the past eight months, we have introduced microsurgery, genital cosmetic surgery and cryoablation of the prostate. The first two did result in increased expenses due to equipment needs but should eventually prove to be high revenue generators with the majority of the costs being fixed."

Ms. Serbin says, "There are a few opportunities in the market. Most involve turnaround cen-

ters. In addition, opportunities for management services are available, including evaluation of a center's business practices, efficiencies, managed care negotiation and outsourced coding and billing services."

Management and development companies have also found opportunities in this market that can benefit ASCs.

Mr. Mallon says, "More centers are in trouble, and more hospitals are in trouble. Both need assistance from management companies. So prospects are out there."

Barry Tanner, president and CEO of Physicians Endoscopy, says, "I believe that the opportunities in the ASC market lie in the unprecedented need for professional management. The value of professional management services has never been greater than they are today. Purchasing, staffing, contracting, utilization analysis, billing and collections and customer service training are all areas that can add substantial value to an ASC. Effective management requires focus, experience and action. These are very often things that physicians simply don't have the time address."

Richard Pence, president and COO of National Surgical Care, says, "There should be opportunities assuming seller (price) expectations are adjusting down with the overall market. The potential prospect of the government becoming a payor for half of the population makes projections over the next five years challenging and very conservative. It would be almost impossible to project an increase in net revenue per case."

Note: Visit www.BeckersASC.com to find more insight from industry leaders on ASCs in the current economy. ■

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Practical Guidance to Help You Understand and Plan for On-Call Coverage Payments

By Jen Johnson, CFA

Adequate on-call emergency coverage is a real issue for hospital emergency departments and inpatients requiring urgent specialist consultation. *Sullivan Cotter's 2008 Physician On-Call Pay Survey Report* states that 85 percent of survey respondents have experienced difficulty finding physicians to provide on-call coverage. The problem has been so severe in some instances that 16 percent of respondents reported the discontinuation of service lines due to lack of call coverage; these specialties included neurosurgery, orthopedic surgery, urology, obstetrics/gynecology and vascular surgery. These statistics help support and explain the recent, growing trend in providing payments for on-call coverage.

In fact, 86 percent of the survey respondents reported they currently provide compensation to non-employed physicians for call coverage, and 70 percent of the respondents stated they provide additional pay for on-call services, or consider call duties in determining total compensation for employed physicians. These numbers are a result of recent growth, as nearly two-thirds of those surveyed reported their on-call pay expenditures have increased in the past 12 months, with 15 percent of these respondents reporting increases of more than 50 percent. In addition, growth is expected to continue as 28 percent of the respondents indicate they plan on implementing on-call pay within the next six months for physicians not currently receiving pay. With physician payment activity such as this, it is no surprise the OIG has brought call coverage payments to the spotlight recently by issuing its first advisory opinion related to call coverage. The following discusses the reasons for the growth of call coverage payments, compensation options and what organizations should consider when determining how to ensure the arrangement meets the fair market value (FMV) requirements.

Reasons for the rise of on-call payments

There is a shortage of physicians willing to take call for several reasons, including reluctance to go without pay for uninsured patients, fear of malpractice lawsuits, disruption of personal lives and practice, and the fact that less physicians are working for hospitals. Here are four other issues contributing to the shortage.

1. Decrease in physicians. There is a pure physician supply issue, which is expected to worsen. The Health Resources and Services Administration in the U.S. Department of Health and Human Services released a report in 2006 projecting a shortfall of approximately 55,000 physicians

by 2020. A similar study in 2005 by the Council of Graduate Medical Education projected a shortage of 85,000 physicians by 2020. Even more alarming, Richard Cooper, MD, director of the Health Policy Institute at the Medical College of Wisconsin in Milwaukee and a national expert on physician-workforce issues, projects a shortage of 50,000 physicians by 2010 and up to 200,000 physicians by 2020.

2. Aging physicians. Adding to the shortage of physicians' availability for call is the fact that the physician workforce is aging and many medical staff bylaws allow older physicians to opt out of call. From a demand perspective, there is no relief in sight as the elderly population is expected to double by 2030 and the number of doctor visits per elderly person is on the rise.

3. Fundamental change in the industry. Historically, physicians provided call coverage in exchange for privileges at a hospital which allowed them to help build their practice. Today, many physicians are shifting away from hospital settings to freestanding ambulatory surgery centers or specialty hospitals that don't have emergency departments (ED). Specialists no longer need privileges at a hospital to build their practice. The growth in physician owned surgery, imaging, diagnostic and other facilities is expected to continue, which will provide more alternatives to physicians that don't require call. In 2005, The American College of Emergency Physicians survey poll of 4,444 U.S. hospital ED medical directors revealed that 51 percent of respondents attributed their call coverage problems were due to physicians relinquishing privileges to pursue practices elsewhere.

4. Economic contributors. There are several other economic reasons attributing to the shortage of physicians willing to provide call coverage and need for call payments. Payments from patients seen in the ED are often inadequate due to the uninsured patient population which is on the rise. In addition, malpractice insurance for those providing ED coverage is higher than for those strictly in private practice. This is because there is a higher probability of a lawsuit when working in the ED. Surveys by the American College of Surgeons and the American Association of Neurological Surgeons revealed more than one-third of respondents have been sued by a patient that was first seen in the ED.

Other reasons cited by hospitals for the need to provide on-call payments to physicians include physicians threatening to cease coverage if payment arrangements are not made and the desire to create equity among all physicians. Finally, work-life balance is more important to the newest generation of physicians. A front-page story in the April 8, 2008 *Wall Street Journal* reported that young physicians are intent on balancing work and family. As a result, practice options are ranging from small, primary-care facilities to many other options that keep doctors on predictable schedules.

Types of on-call payment models

Here are several types of on-call payment methods used by organizations in hopes of retaining physicians to provide call coverage

1. The most common financial solution is by providing a stipend or hourly rate. The *Sullivan Cotter's 2008 Physician On-Call Pay Survey Report* notes that 90 percent of organizations use this methodology for employed physicians and 97 percent use this methodology for non-employed physicians.

2. Other compensation options used in the industry include:
- Providing payments for "excess call" (over 3-5 shifts per month)
- Fee-for-service payments
- Paying professional fees for uninsured patients (typically based on Medicare rates), and
- Paying the physician's malpractice insurance

3. Some organizations have set up unique compensation plans, including 457fs which are deferred compensation plans allowing eligible employers to contribute money on a pre-tax basis into investments that provide physicians with a retirement benefit, while other organizations have provided company owned life insurance (COLI) plans to physicians participating in call coverage

4. There is also a trend of hiring physicians dedicated to call coverage and unassigned patients. These new roles are often referred to as laborists (obstetricians) and surgicalists (general surgeons and orthopedists). This year, for the first time, Sullivan Cotter surveyed these emerging specialties, including laborists, surgicalists and nocturnists. While the data for these specialties is still somewhat limited, it does let us know that physicians providing these services are beginning to emerge in the market.

"Based on the data received by Sullivan Cotter, the total cash compensation levels paid to these physicians appears to be slightly lower than the compensation levels paid for physicians within their respective specialties. This may be because these specialties tend to attract newer physicians just out of residency," said Kim Mobley, principal of Sullivan Cotter and the director of the survey.

Some research shows the use of these new specialties can benefit the patients by providing higher quality care in a timelier manner, benefit the hospital by providing cost savings and benefit the local physicians by enabling a better work-life balance.

5. Other organizations are finding it easier to contract with an entire physician group to provide call coverage. This guarantees coverage and allows both parties to budget a fixed amount. Low cost options which may not be available to all organizations include utilizing residents and physician extenders, while a more expensive option is utilizing locum tenen agencies. Finally, with emerging technology, some organizations are turning to technology-driven call. This is where the physician calls in remotely and through live video/audio feed, they can review imaging scans and on-site reports, and direct the on-site physician.

The following discussion addresses the strategies and struggles with determining appropriate compensation under the most common model for on-call compensation, the hourly rate, or stipend. Before analyzing the appropriate methodology for determining on-call compensation under this payment model, it is important to understand the on-call coverage opinion issued by the OIG in September of 2007 and other regulatory guidelines related to physician compensation.

First on-call opinion by the OIG

On Sept. 20, 2007 the OIG issued Advisory Opinion no. 07-10 ("Opinion") that expressed a favorable opinion of an arrangement between a hospital program and medical staff physicians concerning payment for on-call and uncompensated care physician services. This was the first advisory opinion issued by the OIG that addressed this type of hospital and physician arrangement

The Opinion provides guidance to healthcare organizations considering paying physicians to take call since it stipulates several guidelines for organizations when considering compensation for on-call coverage. Specifically, the OIG found the subject arrangement to be low risk for fraud and abuse based on several factors, which included:

1. An independent third-party analysis concluded that the compensation reflected FMV for the services furnished.
2. The per diem rate was designed to compensate each physician for the burden of being on-call and it considered the likelihood that the physician would be required to provide subsequent inpatient services.
3. On-call physicians were obligated to provide continuing care to ED patients, regardless of their ability to pay.

4. Physicians in each specialty received the same per diem payment without regard to the individual physician's referrals to, or business generated for, the hospital.
5. The medical center had a legitimate, unmet need for on-call coverage and indigent care services as demonstrated by the fact that the medical center was previously forced to outsource emergency care and related treatments to other facilities.

The OIG's opinion warned that there is a substantial risk that improperly structured payments for on-call coverage could be considered unlawful remuneration where the payments exceed FMV or for services not actually provided. Based on *Sullivan Cotter's 2008 Physician On-Call Pay Survey Report*, 9 percent of organizations modified their arrangements since the OIG opinion by either incorporating language into contracts and/or conducting a formal FMV analysis.

FMV guidelines

In addition to the Opinion discussed above, the federal government has presented guidelines which should be considered when determining the FMV for on-call payments. Most notably, the Stark regulations state specific methodologies for determining FMV. Although the Stark regulations may not be directly applicable to an on-call arrangement, they provide insight to what federal authorities consider appropriate methodologies in determining FMV within the healthcare arena:

> We will continue to scrutinize the Fair Market Value of arrangements as Fair Market Value is an essential element of many exceptions. Reference to multiple, objective, independently published salary surveys remains a prudent practice for evaluating Fair Market Value. (STARK II, PHASE III, FR Vol. 72, No. 171)
>
> The methodology must exclude valuations where the parties to the transactions are at arm's length but in a position to refer to one another. (STARK II, PHASE II, FR Vol. 69, No. 59)

Based on the above regulatory language, reference to multiple, objective, independently published salary surveys and limited reliance on information produced from referral relationships should be guidelines in determining the FMV for on-call payments.

Currently, the market does not offer multiple surveys for on-call compensation, only the Sullivan Cotter survey. In addition, this survey data is based on referral relationships. Therefore, it is prudent to look to other methodologies in determining the FMV for on-call compensation.

Methodologies for determining on-call payments

Although relying on *Sullivan Cotter's 2008 Physician On-Call Pay Survey Report* alone has its drawbacks, it does provide the most relevant data available and valuable information related to on-call coverage payment trends. In addition, based on VMG Health's experience, a national healthcare valuation firm for which I oversee the valuation of professional service arrangements, the median per diem payment data for certain specialties, such as orthopedic surgery, are in line with what VMG Health has observed in its experience in conducting FMV analyses for on-call coverage. Specifically, a review of the Sullivan Cotter survey data for orthopedic surgery call coverage compensation shows the median per diem payments for 2006, 2007 and 2008 were $975, $968, and $1,000, respectively. VMG has concluded similar results in valuing on-call arrangements in the specialty of orthopedic surgery.

However, it is important to note that a FMV analysis considers other factors, such as additional valuation methodologies and burden of call. For example,

if an arrangement's circumstances included exceptionally poor payor mix or very low volume, market indications could warrant an adjustment up or down. The Sullivan Cotter data alone does not consider these factors.

Another issue with relying on *Sullivan Cotter's 2008 Physician On-Call Pay Survey Report* is reliability. Specifically, of the 36 reported specialties, two-thirds of those specialties have less than 20 respondents for on-call compensation. In addition, some specialties show questionable year over year growth, such as anesthesiology, for which per diem median payments jumped 50 percent from $500 to $750 in 2008, and gastroenterology, for which per diem median payments rose 42 percent from $300 to $425 in 2008. Other red flags with certain data included in the survey include the decrease of median per diem payments for specialties such as neurosurgery, which dropped 15 percent to $1,000, and Psychiatry, which dropped 50 percent to $200 in 2008.

Fortunately, the Medical Group Management Association, a leading provider of healthcare survey data, is currently conducting an on-call compensation survey which is expected to be released in the spring of 2009. Although survey data alone does not appear to be enough to fully support payments for on-call coverage as FMV, considering two surveys will be a step in the right direction.

Locum tenens and beeper rates as alternatives

Alternatives for determining FMV on-call payments include calculating adjusted locum tenens rates and beeper rates. The locum tenens approach provides a proxy for the cost of on-call coverage by adjusting a market locum tenens quote by an industry margin and patient contact time. The beeper rate methodology is based on what a provider would earn, as a percent of base pay, for being on-call. If conducted appropriately, this methodology can utilize multiple surveys for the specialty and provide an on-call rate based on non-referring provider data.

Once the various market costs for on-call coverage are understood, it is important to consider the OIG's Opinion. Specifically, organizations should ensure there is a written agreement and consider stipulating low risk factors as detailed in the Opinion, such as the requirement for the physician to follow the patient. It is also important to show the agreement terms and burden of call was considered in determining the on-call payments. This will document due diligence in ensuring the organization considered regulatory guidance in its compliance policies. ■

Note: This article is not to be construed as legal advice; it is to provide insight to valuation guidelines related to FMV.

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Endnotes:

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Establishing an Ambulatory Surgery Center — A Primer From A to Z (Part 2)

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

Note: Part 1 of "Establishing an Ambulatory Surgery Center — A Primer From A to Z" appeared in the May/June issue of *Becker's ASC Review*. You can find the complete article online at www.BeckersASC.com.

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

4. Hospitals as partners. Approximately 25 percent of ASCs in the country have a hospital partner. In many situations, a hospital can add value by helping with managed care contracting, making it easier to recruit physicians or otherwise reducing physician concerns regarding being excluded from privileges or having other types of retaliatory action taken against them by the hospital. On the other hand, it is critical for surgery centers that physicians own a significant amount of the equity and that they remain interested and excited about the venture. We have seen hospital partners own 10-30 percent of the venture on the low end to 60-70 percent on the high end. A number of lawyers representing hospitals believe that physicians have to own 51 percent or more. In contrast, many lawyers believe that hospitals can own a smaller interest and either agree to treat the income as taxable income or otherwise have separate special powers to help ensure that the venture serves exempt purposes. From a business perspective, having a hospital partner has been helpful in many circumstances. However, it is not a panacea for surgery centers, and there are a great number of surgery centers that have hospital partners that still under-perform.

"Some hospital-physician joint ventures never survive the transition form a 'spirit of negotiation' to a 'spirit of partnership,'" says Tom Yerden, CEO of TRY Healthcare solutions. "Regardless of the strength of the projections (business plan), those joint ventures that I have seen fail [do so] due to lack of trust among the parties."

Mr. Ellison believes that physician-hospital joint ventures can create a significant competitive advantage for surgery centers if structured properly and done for the right reasons. "It is critical that regardless of the level of hospital ownership, ASCs should be physician-led businesses," he says. "Legal frameworks exist for this to happen in a way where the physicians still feel that they have control over their future."

5. Ophthalmology procedures can still be profitable. Do not make a blanket decision to exclude ophthalmology as a specialty. ASCs can still profit from ophthalmology procedures if the ASC has significant volumes and effective internal cost control; in other words, the ASC must run very efficiently.

According to Luke Lambert, CEO of the Ambulatory Surgical Centers of America, most ma-

ture eye practice are already participating in ASCs, noting that the quick nature of most eye cases play to the strengths of surgery centers. "When ophthalmologists start working in an ASC they never want to go back to the hospital," he says.

According to the 2009 HealthCare Appraisers Surgery Center Valuation Survey, 89 percent of respondents believe that ophthalmology is a desirable specialty to have at an ASC. Ann Deters, from the cataract division of Vantage Outsourcing, suggests several reasons why this is so.

"Ophthalmic procedures represent steady caseloads, consistent revenue and added profits to a center," she says. "Plus, these cases don't fluctuate with the economy, like elective specialties. At the same time, the majority of ophthalmic cases are cataract procedures, which are low-risk surgeries." In addition, she says that ophthalmology increases the surgeon-user base at an ASC and can increase the number of physician investors for a surgery center.

"Senior citizens have proven to be a great marketing tool for a surgery center [with an ophthalmology specialty]," Ms. Deters says. "Minimizing travel time for senior citizens and their families is a 'plus' and much appreciated by [this] population."

6. Pain management and anesthesiologists. Centers are increasingly concerned that physician-investors will perform their pain management procedures in their own offices rather than at the ASC. Medicare's site-of-service differentials, which often pay more for in-office procedures (along with other incentives), may very well encourage this practice. ASCs should plan accordingly and diversify their services to accommodate a potential loss of pain management revenue. CMS has also implemented relatively large reductions in pain management reimbursement for ASCs. In order to control the flight of pain cases from the surgery center to physician offices, it is necessary to engage in a frank conversation with pain physicians fairly early in the planning process to clarify which procedures will likely be performed in their offices versus those that will likely be performed in the surgery center. For financial planning, it is critical that both parties fully understand the expectations for these types of cases.

Notwithstanding these concerns, "Efficient pain specialists can be a pillar of strength in a successful ASC," says Mr. Lambert. However, he does advise against inviting anesthesiologists to be owners in ASCs. "We feel it is better to be the consumer and contractor of anesthesia services than to be partnered with them," he says.

7. Gastroenterology can still be profitable. In a 2006 study, gastroenterology was the largest surgical specialty, representing 25 percent of all surgical cases performed at ASCs. Medicare has implemented decreased reimbursement for gastroenterology procedures performed in an ASC. This can hurt an ASC because gastroenterology/endoscopy centers typically rely on Medicare for about 20-40 percent of their cases. Fortunately, because these centers still generate 60-80 percent of their gastroenterology business from outside Medicare, the specialty can still be profitable if they have significant volumes and the "non-Medicare" business continues to grow.

"This is a specialty characterized by high volumes," says Mr. Lambert. "ASCs are important to enhancing productivity. Profits per case are low and declining but given sufficient volume it can be attractive."

Gastroenterologists will increasingly have to minor in anesthesiology. Increasingly, payors will not pay physicians separately for anesthesia procedures provided in connection with gastroenterology procedures. Thus, gastroenterologists should be competent at offering all types of anesthesia procedures.

8. Plastics. In multi-specialty surgery centers, plastics, particularly cosmetic procedures, often are very challenging. Here, the physician often bills

globally, and the ASC and the physician are adverse to each other in that the ASC must negotiate its rates with the surgeon as opposed to charging a third-party payor.

9. Bariatrics are booming, but do not count on bariatrics as a long-term profit center. Bariatric procedures are growing rapidly and are increasingly performed in ASCs. Initially, ASCs will earn outsized profits from these procedures; however, as the number of bariatric providers increases and price competition evolves, the prices on these procedures will eventually normalize and become less profitable. For this reason, and because substantial concerns remain regarding the safety and risks related to bariatric programs, ASCs should use caution and be conservative when developing bariatric programs.

Thomas Michaud, chairman and CEO of Foundation Surgery Affiliates, notes the "patient acquisition" syndrome he sees as a common trend in bariatrics. "Many bariatric surgical patients come from 'obesity programs' that include seminars, continuing education, postsurgical support, etc.," he says. "Many of these programs, which are very costly to operate, are sponsored by hospitals, and the hospitals are not likely to let their surgical candidates leave 'their program' to have surgery performed elsewhere without effort to retain these patients in 'their program.'"

10. Lasik. Lasik surgery, for reasons akin to why plastic surgery is problematic, is often best left to practices.

11. Orthopedic procedures remain great procedures for ASCs. "How well you do with orthopedics depends — to a great deal — on how successful you are in negotiating payor contracts," says Mr. Lambert. "Medicare's new fee schedule phase-in is making it possible cover costs and setting a reference point that is helpful when negotiating with other payors."

12. Neurosurgery and spine. Spine procedures are increasingly performed at ASCs and remain a popular and growing specialty for ASCs. Orthopedics profits from the new CMS surgery center rates. These are likely to remain good specialties for ASCs for a substantial period of time. In the best situation, the center has a base of cases from both specialties.

Despite the promise of these specialties, it is important to consider the costs.

"Spine service costs up to $360,000 to set up," says Tom Mallon, CEO of Regent Surgical Health. He says that it can cost $80,000 for microscopes, $80,000 for trays, $120,000 for a C-arm and $80,000 for a Jackson table, and he says that costs should not be taken on frivolously. "However, if the surgeon uses loops instead of a microscope and if you have a C-arm, the entry cost is much less, [around] $160,000," he says.

In addition, Mr. Mallon mentions some caveats in this specialty. "Spine often cannot be performed on contracted patients," he says. "So in order for you to begin even a small program (five cases per month), you need at least some out-of-network patients. However, the surgeon will love the efficiency, and the patients will love the facility. This will grow over time and as payors recognize the benefits, you will be able to negotiate reasonable reimbursements."

13. ENT continues to be strong. Ear, nose and throat procedures continue to be a strong specialty for surgery centers. This specialty continues to be reimbursed reasonably well in many markets.

"We see ENT as an attractive specialty if the cases in your area are not overly dependent on Medicaid," says Mr. Lambert. "Special considerations for this specialty include requiring skilled pediatric anesthesia and having a private recovery area for children."

14. Urology. Urology can be a profitable specialty for ASCs.

Dr. Herb Riemenschneider, founder of Knightsbridge Surgical Center says, "Many procedures are short and can pay well on a time of utilization basis. Of those that are longer, some reimburse well." He notes that longer procedures, for urinary tract stone disease (such as extra corporal shock wave lithotripsy and ureteroscopic stone work with laser), urinary prosthetics (such as penile prosthesis and artificial urinary sphincter), prosthetic slings for treatment of female incontinence and most recently, cryoablation for the treatment of prostate cancer, have the most potential if they are performed correctly.

"Urology can be profitable when it involves lithotripsy and female incontinence surgery," Mr. Mallon says. Both are predominantly commercial populations. Serving Medicare men with prostate cancer can often be break even at best."

"The surgery center has allowed our urologists to remain more efficient doing outpatient surgery than they could be by performing the same procedures in an outpatient hospital setting," says Bill Monnig, the president of a large urology group. "The single-specialty designation allows us to gain maximum benefit of the special endoscopic equipment that urologic surgery requires and, therefore, may be more financially advantageous than a multi-specialty center where this equipment may not be used as much." He also notes that the number and type of procedures that can be performed at a surgery center continues to grow yearly.

Building issues

1. Do not overspend on real estate. Physicians planning centers should purchase property that is cost appropriate. Normally, a second- or third-tier commercial property that is level, safe, accessible to your physicians and patients and has easy parking will be sufficient. Make sure that the less expensive land will not ultimately cost you more due to unknown variables. If a property has setbacks, zoning restrictions or a lack of utilities, it may ultimately cost more in the long term. A site should be evaluated by an experienced ASC architect to ensure that it can meet the ASC's requirements. This includes performing a thorough analysis of state and municipal codes and regulations in regards to health and zoning issues prior to purchasing the land. Do not assume, for example, that a space that has been used previously as an ASC is automatically qualified to fit your needs. In many cases, existing structures may not be up to standard code, and a change in ownership or management of the facility will trigger a need to update it to current specifications.

A visible, expensive parcel is often an unnecessary cost. It is not important that the ASC be visible in order to attract drive-by or foot traffic. This is significant because premier commercial lots can cost considerably more than otherwise equally appropriate, yet less visible, lots.

2. Do not overbuild. A building should meet the group's volume and specialty needs, as well as the financial parameters. The space plan should be integrated with your staffing and equipment plans. Knowing your case numbers, how many technicians, nurses, schedulers, business office and administrative staff and other staff you will need and your equipment requirements should determine your space needs.

3. Lease or build from the ground up; lease or own the real estate. A center needs one operating room per every 1,000-1,500 cases. A typical two-room ASC can be built in 7,000-8,000 square feet. An average size ASC is approximately 14,000 square feet. VMG Health's *Intellimarker* also indicates that the median ASC includes four operating rooms and two procedure rooms. Centers can be leased from a third party or built from the ground up. Often, it is quicker and less expensive to lease space and operate as a tenant. On average, rental rates are approximately $28 per square foot each year. The disadvantage to this approach is that one does not ultimately own the real property nor completely control the project. At the same time, the long-term capital costs can be substantially lower.

Mr. Lambert says that leasing is preferable because it is possible to lease without personal guarantees and to avoid putting cash or equity into real estate. "Surgery centers, if conceived and managed properly, can offer returns that are superior to that of the typical ASC real estate investment," he says.

4. Equipment budget and planning. As you develop a center, you have to decide whether or not you are going to use an equipment planner. It costs approximately $200,000-$500,000 to set up a single operating room and is one of the largest expenses at the surgery center. Employing an expert can help you save costs, plan more efficiently and coordinate better through design, development and construction. However, a center may be able to do this on its own or it could use a management or development company. In fact, many people resent the extra cost of using an equipment planner coupled with management fees. Further, there are situations where the equipment planning firm may have such close ties with equipment manufacturers that using an equipment planner might not get you some of the benefits that you expected to get from the process.

5. Other building issues. Early in the design process, an ASC should examine how information technology systems, fluid management systems and anesthesia systems will be incorporated into the design. Bill Merkle of MD Technologies says there are a number of factors to consider with fluid management systems.

"ASC design should consider fluid waste management, since disposal systems require plumbing, drains and medical gas piping most easily installed during construction or remodeling," he says. "Procedure room layout should address fluid management to ensure that utilities and piping are conveniently located near the patient bed as well as near medical equipment (such as an endoscopy cart with light source). System size and floor space requirements should be assessed, particularly if suctioned fluid must be transported to disposal sites. Today, most (around 80 percent) fluid management costs are for canisters, with the remaining cost for waste disposal. Tremendous cost savings can be realized if both costs are eliminated. Advance planning can improve room efficiency, reduce turnaround time and minimize fluid management costs."

Miscellaneous

1. Accreditation and state licensure. Many surgery centers are state-licensed, Medicare-certified and accredited. For example, in 2005, more than 4,500 of 6,000 ASCs in the United States were Medicare-certified. Many states require ASCs to be licensed. In addition, ASCs should attempt to become accredited by the Joint Commission, the AAAHC or another reputable accrediting agency such as the AAAASF. Accreditation often enables ASCs to be deemed Medicare-certified, to serve certain payors and to measure their services and performance against national recognized standards, thereby helping them to improve the quality of their care.

Speak with your state health department early on in your development process. Each state has different ASC licensing requirements. In all cases, you will want to speak with them very early on to access state requirements and processes, and to help avoid unexpected delays in licensure requirements.

2. Hire strong leadership. High-quality management is critical to an ASC's success. All management companies are not equal. Many management companies offer superior services; however, many are of little value. For this reason, it is important to work with an experienced management company that has a proven track record of success. Working with a low-quality, inexperienced company will do more harm than good. You will need to start by hiring an administrator and director of nursing.

Greg Zoch, a partner with Kaye/Bassman, says that hiring top-rate leadership is critical to setting up a new ASC for success. "Leadership (administrators and clinical directors) will attract (or repel) great staff, manage the budget, negotiate payor and vendor contracts, manage inventory, mange staff, build the culture [of the ASC] and can be the determining factor in not just profitability, but in physician and patient satisfaction as well," he says.

Mr. Zoch suggests having your administrator and clinical director on the job six months prior to opening. This allows them to build a good working relationship with one another and to make any changes to work-flow or design before the center opens. They can also deal with the processes that are necessary to handle so that your center can be online and on-budget when it opens. He advises ASCs to start their recruiting process for an administrator or clinical director nine months before opening. He also advises ASCs to use an executive search firm to find good leadership. "Most top talent rarely, if ever, reads employment want-ads and can only be reached by a proactive approach," he says.

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

Experienced RNs often make superior ASC administrators. Generally, RNs are trained to be disciplined and dedicated workers; a work ethic that carries over to the administrator position. As such, RNs are often vibrant and willing to contribute in myriad ways to improve the surgery center. The RN must study and be interested in the business side of ASCs.

There are several important things to remember when determining salaries. Roger Manning, founder of the Manning Search Group, says that base salaries vary depending on geographic location, with California and certain areas of the Northeast (such as Boston) being the highest. He says that the average salary for an administrator ranges from $70,000-$110,000 annually, based on experience. Salaries for multi-site management positions range from $110,000-$125,000 on the low-end, to $150,000-$175,000 on the high end. This difference is again due to experience, according to Mr. Manning.

For directors of clinical services (directors of nursing), base salaries also vary depending on the geographic location. "Owners should expect to pay on the average $75,000-$88,000 [annually]," says Mr. Manning. "Recruiting a doctor with experience from a national competitor will probably coast you [upwards of] $90,000 because of the highly competitive nature of the ASC industry, coupled with the nursing shortage (especially in California)."

Mr. Manning advises physician-investors to consider hiring an administrator with prior ASC development experience who will stay on as administrator. He suggests hiring this person at "the conception of the deal."

3. Establish MIS and billing systems early. An ASC should establish its management information system and other operational systems — such as billing, materials management and marketing — as early as three months prior to your ASC's opening. The MIS is a critical part of an ASC's organizational backbone and can support the effective management of the ASC. If established early and populated with appropriate information, upon opening, your clinicians, front office and management will have immediate efficiencies scheduling surgeries, billing, performing collections, case-costing and taking inventory, among many other tasks.

According to Laura Gilbert, director of marketing communications for ProVation Medical, it takes around 90 days to set up an electronic documentation system, but she advises new ASCs to take as much as 6-9 months to evaluate systems and to see them in use. She recommends evaluating vendors for MIS and other systems by considering each system's features and functionality. A site visit can give you a feel for how the system works. "If [a provider] is proud of their product, they will give you access to other end users so that you can have an honest discussion as to the pros and cons of their product," she says.

Ms. Gilbert also recommends finding systems that have intuitive user interfaces on the clinical side of operations. Flexibility is also a priority, she says, and it is important to find a system that can be configured to your ASC's needs and a provider that is willing to do the "heavy lifting" and make the modifications for your company.

Caryl Serbin, CEO of Serbin Surgery Center Billing, implores those planning ASCs to decide early whether to outsource billing or handle billing internally; an ASC should decide at least 4-6 months prior to becoming operational.

An ASC should also set up its billing office early so that it can start billing (and collecting) reimbursements from day one. Another option is to outsource billing and collections services. If you choose to use an outside provider, it is advisable to also get them involved early in the develop stage in order to expedite implementation of their systems. ■

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

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

Accreditation

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

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

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

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

Raymond Fox & Associates. Raymond Fox & Associates is a full-service medical architectural firm that has completed over 4,000 projects ranging from small, single-specialty offices to large, multi-specialty medical office buildings and has been involved in over 400 surgical centers. Learn more at www.raymondfox.com, call (619) 296-4595 or e-mail Raymond Fox at ray@raymondfox.com.

Consultation and brokerage of ASCs

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

Debt collections

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

Mnet Collection Agency. Mnet Financial, the preferred collection agency service vendor to United Surgical Partners and Health Inventures, is a receivables management company offering cost-effective ways to increase cash flow and reduce debt for professional services. Contact Mnet Financial at (949) 680-3335 or learn more at www.mnetfinancial.com.

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

Finance

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

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

GE Healthcare Financial Services. GE Healthcare Financial Services' outpatient finance team offers flexible solutions for physician-owned hospitals and outpatient centers. Learn more at www.gehealthcarefinance.com or call (312) 441-7705.

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

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

Group purchasing organizations

Amerinet. As a leading national group purchasing organization, Amerinet strategically partners with healthcare providers to reduce costs and improve quality through its Total Spend Management solutions and operational performance improvement programs, tools and services. To learn more about Amerinet, visit www.amerinet-gpo.com or call (800) 388-2638.

Health information technology providers

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

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

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

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

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

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

Mavicor. Mavicor is an ASC technology management company specializing in ASC application services, systems integration and consulting services, as well as the procurement and management of hardware and software. Learn more about Mavicor at www.mavicor.com or call (888) 387-1620.

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

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

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

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

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

Managed care contracting

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

Management, consulting and strategy

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

Management, development and equity firms

Ambulatory Surgery Centers of America. ASCOA is a leader in the surgery center industry, achieving exceptional quality of care and outstanding financial results. For more information, visit ASCOA online at www.ascoa.com or call (866) 982-7262.

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

Blue Chip Surgical Center Partners. Blue Chip holds an equity stake in its projects and also serves as a managing partner, with several highly profitable, physician-led centers in operation around the country and a number of projects in the works. For more information, visit Blue Chip online at www.bluechipsurgical.com or call (513) 561-8900.

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

For more information or an introduction to any of the following companies, e-mail sbecker@mcguirewoods.com, call (800) 417-2035 or fax with the company circled to (866) 678-5755.

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

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

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

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

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

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

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

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

Imaging

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

Insurance

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

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

Covenant Surgical Partners. Based in Nashville, Tenn., Covenant Surgical Partners is a privately-held owner and operator of ASCs; it was founded in 2008 by a group of successful, experienced investors, including several seasoned healthcare and financial executives, along with a prominent physician who owns his own surgery center. For more information, contact (615) 345-6903 or visit www.covenantsurgicalpartners.com.

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

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

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

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

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

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

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

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

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

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

National Surgical Hospitals. NSH acquires and builds freestanding, specialty surgical hospitals concentrating in orthopedic surgery, neurosurgery, and more complex general surgery cases; under the hospital license, these hospitals can also provide related services such as pain management, imaging and physical therapy. To learn more, visit www.nshinc.com or call Dennis Solheim at (312) 627-8428.

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

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

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

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

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

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

Pinnacle III. Pinnacle III specializes in the operational development, management, payor contracting, coding, billing, and collecting for ASCs..For more information, visit Pinnacle III online at www.pinnacleiii.com or call Dan Connolly, vice president of development and payor contracting, at (877) 710-3047.

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

Medical devices — Implants and expedited payment options

Block Imaging International. Block Imaging International is a worldwide provider of refurbished imaging equipment, featuring refurbished digital x-ray, C-arm, MRI, CT, cath/angio, mammography and bone densitometry systems as well as CR, PACS and imagers from all major manufacturers. Learn more at www.blockimaging.com, e-mail info@blockimaging.com or call (888) 694-6478.

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

Medical devices — Reprocessed and refurbished

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

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

Northern Scientific. Northern Scientific specializes in high-end rebuilt surgical tables and surgical lighting systems, and also offer stainless instrument tables and surgical table accessories. Learn more at www.northernscientific.com, e-mail med@northernscientific.com or call (800) 669-9568.

Medical laundry

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

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

Medication program management

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

For more information or an introduction to any of the following companies, e-mail sbecker@mcguirewoods.com, call (800) 417-2035 or fax with the company circled to (866) 678-5755.

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

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

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

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

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

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

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

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

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

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

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

Outsourced medical implantable device management solutions

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

Pathology services

Caris Diagnostics. Caris Diagnostics (Caris Dx) offers pathology-related services providing diagnostic services for GI, dermatopathology and oncologic pathology. For more information and to get the contact number for your region, visit www.carisdx.com or call (800) 979-8292.

Patient financing options

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

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

Patient satisfaction and benchmarking

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

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

Pharmaceutical waste management

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

Quality

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

Real estate acquisition and real estate investment trusts

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

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

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

Recruitment and search firms

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

Kaye/Bassman International. Greg Zoch, a partner and managing director with Kaye/Bassman International, a 26-year-old executive search firm, specializes heavily in the ASC world and has served many of the industry's largest players by finding top talent at the facility and corporate level. You can e-mail Mr. Zoch at gregz@kbic.com or call him at (972) 931-5242 ext. 5290.

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

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

Surgical supply and equipment manufacturers

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

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

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

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

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

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

Medtronic. Medtronic develops and manufactures a wide range of products and therapies with emphasis on providing a complete continuum of care to diagnose, prevent and monitor chronic conditions. Learn more about Medtronic at www.medtronic.com or call (800) 328-2518.

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

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

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

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

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

TransMotion Medical. TMM designs, manufactures and distributes a line of specialty medical procedure chairs including the TMM3 Video Fluoroscopy Chair, TMM4 Multi-Purpose Treatment Chair and TMM5 Surgical Stretcher Chair. Learn more about TMM at www.transmotionmedical.com or call (866) 860-8447.

For more information or an introduction to any of the following companies, e-mail sbecker@mcguirewoods.com, call (800) 417-2035 or fax with the company circled to (866) 678-5755.

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

AliMed. AliMed is a designer, manufacturer and distributor of healthcare products that works with hundreds of vendors to supply more than 70,000 products to healthcare facilities and businesses all over the world. To learn more, visit www.alimed.com or call (800) 225-2610.

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

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

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

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

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

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

CONMED Corp. CONMED specializes in arthroscopy, electrosurgery, endoscopy, endosurgery, imaging, integrated systems, patient care and powered instruments that are sold worldwide through its family of companies (CONMED & Linvatec). Learn more about CONMED at www.conmed.com.

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

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

Viscot Medical. Highlights of the product line from Viscot Medical, a provider of disposable medical products since 1974, include sterile and non-sterile surgical skin markers; sterile and non-sterile medication labels and kits for compliance with the Joint Commission requirement for labeling medications on and off the sterile field; male and female urinals; minor surgery drapes; and towels. For more information, visit www.viscot.com or call (800) 221-0658.

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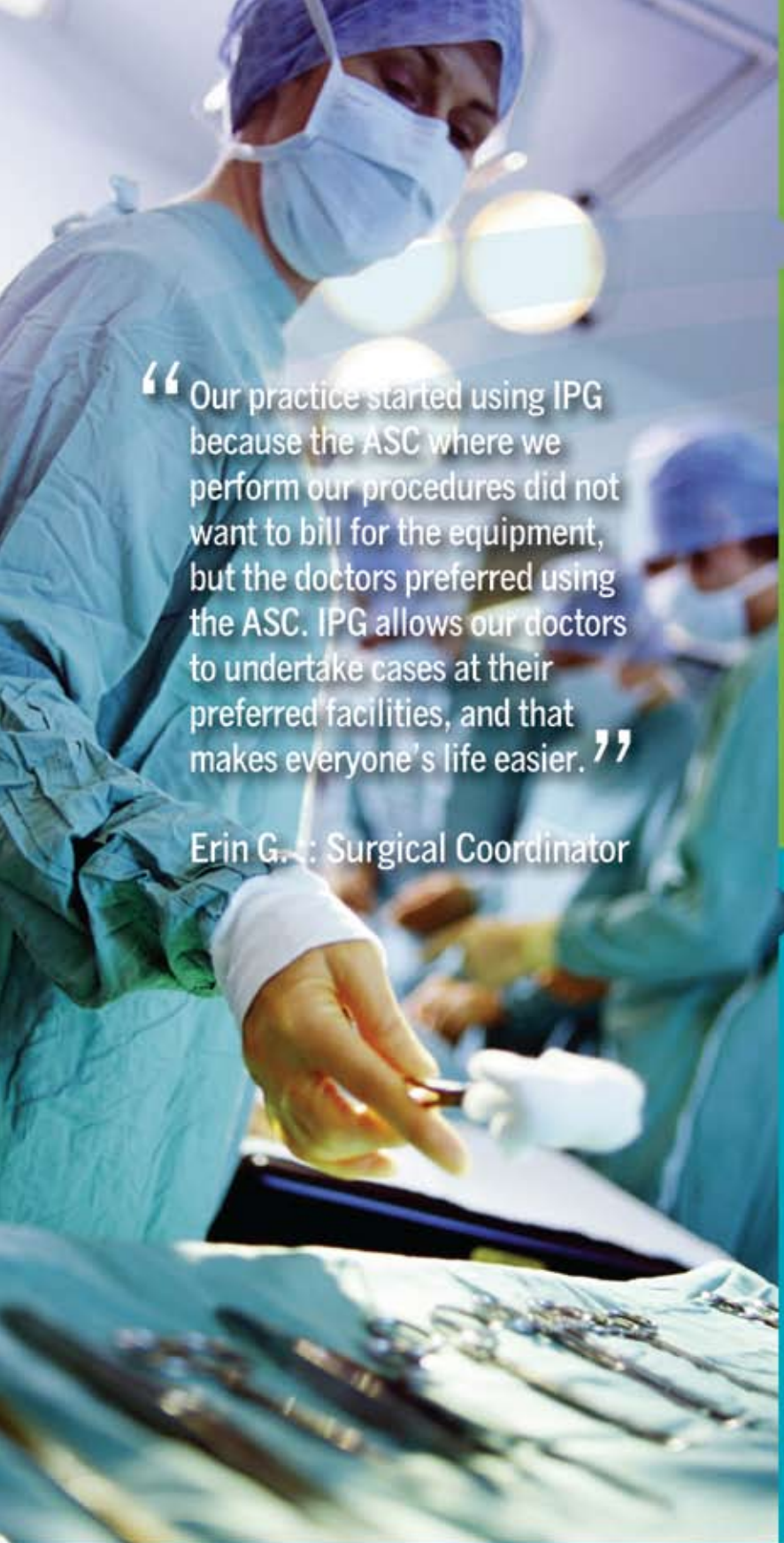
VMG Health. VMG Health is recognized by leading healthcare providers as one of the most trusted valuation and transaction advisors in the United States. For more information, visit VMG's Web site at www.vmghealth.com or e-mail Jon O'Sullivan at osullivan@vmghealth.com or call (214) 369-4888. ■



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