Inside: 9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference Brochure (p. 25)

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

February 2011 • Vol. 2011 No. 2

INSIDE

INDEX

10 Key Trends for Surgery Centers in 2011

By Leigh Page

1. Continued decline in ASC volume. The decline in overall volume of ambulatory surgery center cases will not be as steep as in 2010, when volume fell by an estimated 5 percent, says Andrew Hayek, president and CEO of Surgical Care Affiliates. However, "case volume growth for the industry will likely remain negative," he says. "Modest improvements in unemployment, personal wealth and consumer confidence will overcome the continued dampening effect of rising deductibles. This will result in flat to very slight growth in overall consumption compared to the decreases we saw in 2010."

continued on page 9

ASC Transactions and Pricing During 2010: 4 Key Concepts

By Scott Becker, JD, CPA

2010 saw a significant increase over 2009 in surgery center transactions. During 2010, the pricing of transactions tended to increase from 2009. This article provides examples of pricing seen in various transactions.

1. ASC mergers and acquisitions. McGuireWoods and myself helped surgery centers complete approximately eight different transactions in the last quarter of 2010. In the ASC sector, the pricing generally ranged from six to eight times earnings for majority interest transactions with a few outliers. An interesting trend is that half of

continued on page 11

50 New ASCs Opened in 2010

Here are short profiles of 50 new surgery centers which opened in 2010, organized alphabetically by state. Visit www.BeckersASC.com to learn more about these facilities.

Alaska

Regent Surgical Health Opens Surgery Center in Anchorage

— The Surgery Center of Anchorage (Alaska) opened in December. It has two operating rooms, a dedicated GI suite and a pain suite. The ASC will initially provide services in GYN, general surgery, colorectal, ENT, pain and urology. It is a partnership between Regent Surgical Health and 18 physician partners from Anchorage, with the physicians as the sole owners of the facility.

Surgery Center in Fairbanks Receives Licensure, Opens

— The Surgery Center of Fairbanks (Alaska) opened in December. It is a 14,000-square-foot building with two ORs, six pre-op rooms and 16 recovery rooms. The center is owned by 11 physicians and private investors.

continued on page 12

McKESSON

Empowering Healthcare

Never Fill Out Another 222 Form Again

CSOS MANAGER

Save time. Avoid hassles.

Order controlled substances the easy way with CSOS Manager. Take advantage of CSOS (Controlled Substance Ordering System) – fewer errors, more items per order, faster processing – and never fill out another 222 form again.

Talk with your McKesson Account Manager or contact us at 877.4MK.CSOS (877.465.2767) or mms.csos@mckesson.com to learn how to start using CSOS Manager.

Amerinet®

to deliver

is to commit. This is our contract with you: developing new ways to lower your costs, increase revenue and stay on the job to make sure it all works. Listening, creating and delivering GPO solutions truly unique to your surgery center.

Why settle for someone else's solution?

More than 2,000 surgery centers partner with Amerinet and its dedicated employees, like Phyllis Werth, to reduce their cost per procedure and improve quality of care.

Phyllis Werth
Director, Non-Acute
Amerinet

Amerinet. Reducing healthcare costs. Improving healthcare quality.SM

877.711.5700 | **www.amerinet-gpo.com/deliver2.aspx**

Unlock Your Profits...*Start Now!*

ASC Billing Associates: The Key To Your Success.

Maximize your ASC's revenue through expert coding and aggressive claim follow-through.

One of the nation's largest ASC billing companies, Celebrating 20 years of ASC billing.

Increase your profits. Contact us today.

Montvale, New Jersey • (212) 937-4911

ASC BILLING *Associates*

www.surgerycenters.com

ASC Ambulatory Surgery Center Association

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

BECKER'S ORTHOPEDIC & SPINE REVIEW
Business and Legal Issues for Orthopedic and Spine Practices

ASF Ambulatory Surgery Foundation

9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

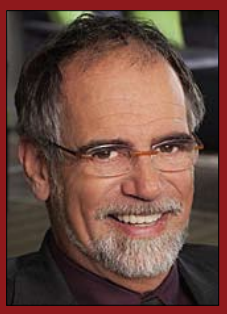
Improving Profitability and Business and Legal Issues

THE 9TH ANNUAL CONFERENCE FROM ASC COMMUNICATIONS AND THE AMBULATORY SURGERY FOUNDATION

June 9-11, 2011

Westin Hotel • North Michigan Avenue • Chicago, Illinois


Coach Mike Ditka


Joe Flower

- Keynote Coach Mike Ditka, Legendary NFL Player and Football Coach
- Keynote Joe Flower, Healthcare Futurist, CEO, The Change Project, Inc.
- Improve Your Profits Monday Morning
- Great topics and speakers focused on key business, financial, clinical and legal issues facing Orthopedic, Spine and Pain Management-Driven ASCs
- 101 Sessions, 134 Speakers
- 30 Physician Leaders as Speakers, 29 CEOs as Speakers
- Focused on Orthopedic Surgeons, Orthopedic Spine Surgeons, Neurosurgeons and Pain Management Physicians, ASC Physician Owners, Administrators and Others
- Immediately useful guidance plus great keynote speakers
- Learn How to Immediately Improve Your Golf Swing
- New and Advanced Procedures for ASCs — Spine, Total Joints, Uniknees and More
- Have an outstanding time in Chicago
- Earn Your CME, CASC, CEU Credits - 15.25 CASC credits and 15 CME and CEU credits
- Big Thoughts Combined with Practical Guidance
- Legal Issues for ASCs and Physician Owned Hospitals
- Great Networking
- Understand the Impact of Healthcare Reform on ASCs
- Orthopedics, Spine and Pain Management
- Benchmarking, Cost Cutting, Safe Harbors, Billing and Coding, Revenue Growth and more

For more information, call (703) 836-5904 or (800) 417-2035
If you would like to sponsor or exhibit at this event, please call (800) 417-2035

To register, contact the Ambulatory Surgery Foundation (703) 836-5904
or fax (703) 836-2090 • registration@ascassociation.org
Register online: https://www.ascassociation.org/june2011.cfm

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

February 2011 Vol. 2011 No. 2

FEATURES

Publisher's Letter

15 Questions for 2011; 9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference (June 9-11, Chicago) – 101 Sessions and 134 Speakers

1. 15 Questions for 2011

Here are 15 questions about ASCs for 2011, the answers to which will shape the industry.

1) Will surgery center case volumes increase or decrease in 2011?
2) Will physician employment by hospitals accelerate or slow in 2011? How will it impact gastroenterologists, orthopedists, spine physicians, ENTs and ophthalmologists?
3) Will ACO efforts negatively impact surgery centers? Will there be a place for surgery centers in ACOs?
4) Will hospitals continue to acquire surgery centers?
5) Will there be an increase in co-management agreements?
6) Will there be an increase in challenging surveys?
7) Will out-of-network regain favor in certain situations?
8) Will there be an increase in acquisition activity by the national chains?
9) Will more or less centers try to profit from anesthesia?
10) Will administrator and DON compensation increase?
11) Will more surgery centers open than close?
12) Will overall ASC profits increase or decrease?
13) Will healthcare reform be repealed, replaced, funded or not?
14) Will reimbursement increase or decrease?
15) Will there be further infection control challenges?

2. 9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference (June 9-11, Chicago) – 101 Sessions and 134 Speakers

We have included the brochure for the 9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference in this issue. We expect an outstanding event this year. We will have some of the best business speakers in the ASC industry, plus Coach Mike Ditka, Joe Flower (a great healthcare futurist), a great PGA golf pro speaker, several of the best orthopedic and spine surgeons presenting, and terrific orthopedic, spine and pain management-driven ASC business topics.

Should you have an interest in joining the conference, please register for the event with the included brochure on p. 25, register online at https://www.ascassociation.org/june2011.cfm, call (703) 836-5904 or e-mail registration@ascassociation.org.

Should you have any questions, please contact me at sbecker@mcguirewoods.com.

Very truly yours.

Scott Becker

New Head of ASC Association William Prentice Shares Thoughts on the Industry

By Leigh Page

William Prentice, a seasoned healthcare lobbyist in Washington, became executive director of the Ambulatory Surgery Center Association in Oct. 2010. He shares his thoughts on the need for political activism, ASCs' prospects in the new Congress, efforts to improve Medicare payments and other issues.

Why ASCs should join the association. About half of the nation's ASCs are members of the association, and Mr. Prentice would like to see the other half join. "We need everybody's input, not just in dues enrollment but also in intellectual capital and grassroots activities, such as contacting members of Congress," he says. He likens joining the ASC Association to taking out an insurance policy. "It insures that someone is out there advocating for you on your behalf, that someone is protecting you from outside forces that do not have your interests at heart," Mr. Prentice says. "If everyone is working together, we can be stronger."

New cost-consciousness in Washington. "We're going into a period of divided government," Mr. Prentice says, "but in both parties there is a sense that 'the bill has come due,' that government spending has got to be brought under control." He believes this viewpoint will affect every decision made in the nation's capital. "You're going to see very little happening," he says, "without being predicated upon the question, 'Where are we going to find the money for this?' "

How ASCs' interests will fare. Mr. Prentice thinks surgery centers fit well into the new cost-consciousness because they are the low-cost, high-quality choice. "We have a good story to tell about the ASC industry," he says. Since ASCs' costs are so much lower than those of hospital outpatient departments, he thinks the association has a strong case for a rate increase. "We'd like to see the payment gap between ASCs and HOPDs close," he says. "Ambulatory surgery centers cannot be expected to continue to provide the excellent service they do without being compensated fairly for it."

Plans to reintroduce payment bill. Last year, the association introduced a bill to change the payment methodology for ASCs. The bill would end tying ASC payments to the Consumer Price Index, which has no relation to ASC costs, and tie them instead to the hospital market basket. The association plans to reintroduce a similar bill this year. "We are looking for sponsors," Mr. Prentice says. "We have a number of strong advocates for ASCs in Congress." In August, for example, a letter asking CMS to fix the ASC reimbursement update was signed by more than 20 U.S. senators, more than double the number who signed a similar letter in 2009.

Demonstrating ASC quality. Through the ASC Quality Collaboration, many surgery centers have been voluntarily reporting quality measures endorsed by the National Quality Forum. The aim is to have enough data so that a valid measure of actual infection rates can be determined and then use it to compare with data on similar healthcare settings. Since 2006, CMS has had the power to require ASC quality reporting. It has been holding off, but now it is expected to implement the reporting by the end of the year, Mr. Prentice says. "ASCs provide top-notch quality of care," he says. "We want everyone to know about that."

Number of inspections may decline. The number of Medicare inspections of ASCs has been increasing due to extra funding from the federal stimulus bill, but that extra funding is about to expire. With no new source of funding identified, "we don't know if surveys will continue at the same rate," Mr. Prentice says. Also, surgery centers have been telling the association they are concerned surveys are not being implemented in a consistent manner. "We want to work with CMS to make sure there is consistency in the surveys," Mr. Prentice says.

Role of ACOs. Mr. Prentice believes accountable care organizations might well play a large role in the next few years, but at this point, "they are still a theoretical," he says. "How many ACOs will actually materialize is an open question." Everyone is waiting for CMS to release proposed regulations for ACOs, expected this month.

Aims for the future. "We can always do a better job engaging our centers in federal advocacy," Mr. Prentice says. "We will never have the sheer numbers of staff or money that other groups might have, but we can still be very successful if we all work together and maximize the advocacy of this industry as much as possible." ■

Learn more about and become a member of the ASC Association at www.ascassociation.org.

10 Key Trends for Surgery Centers in 2011 (continued from page 1)

The 2010 trend of people putting off elective surgeries will probably continue in 2011, says Jason Ruchaber, CFA, ASA, a principal at valuation firm HealthCare Appraisers. "We are not yet seeing significant improvement in the economy," he says. "The unemployment rate is still high and people are still losing their jobs."

2. Slight increase in reimbursements. Medicare payments to ASCs in 2011 will rise 0.2 percent across the board and a number of new procedures have been added for Medicare coverage. Overall reimbursement rates will increase by about 2 percent in the final year of the phase-in of the new Medicare rate structure, but GI and eye centers will face more Medicare reimbursement reductions. "Though any increase in reimbursement is better than a reduction, this increase is likely not sufficient to cover the cost inflation in most surgery centers," Mr. Ruchaber says. GI centers may benefit from enhanced Medicare cost-sharing for preventative services, which include colonoscopies, if the new Medicare waiver of deductibles and coinsurance drives higher volumes.

3. Decline in profits. Profits will continue to decline in 2011 due to lower reimbursements, some decline in volume and more aggressive payor policies, particularly for out-of-network status, according to Jon Vick, president of ASCs Inc. He says independent centers, in particular, have seen a decline in profits. However, Mr. Vick says spine-based ASCs are doing better because reimbursements are high and bariatric procedures also command high reimbursements but volume is down due to the economy.

4. Greater use of quality measures. More ASCs are expected to use NQF-endorsed quality measures. "This will allow the industry to better articulate the outstanding clinical outcomes we provide," Mr. Hayek says. He hopes the industry can gather enough data to establish a valid measure of actual infection rates so that the safety of ASCs can be compared to that of HOPDs. "We hope there will be material progress in towards reaching the point where there is a valid measure of actual infection rates, such that the safety of ASCs can be compared to hospital outpatient departments," he says.

5. Move to management companies. Mr. Vick, who helps physicians trying to sell their centers, sees "a very strong movement" toward management companies." Clients typically are looking for more partners and want help with recruitment and contracting, he says. "National companies will come to the forefront because ASCs have problems accessing capital, and a lot of the management companies have plenty of money," says Fred W. Ortmann III, founder and CEO of Ortmann Healthcare Consultants. Mr. Hayek predicts the largest ASC companies will continue to add 10 or more ASCs each in 2011.

6. Hospitals continue to acquire ASCs. This trend, which was "growing exponentially" in 2010, will continue in 2011, says Joan G. Dentler, president of ASC Strategies, who helps hospitals buy ASCs. Keith Metz, MD, medical director of Great Lakes Surgical Center in Southfield, Mich., and member of the board of the ASC Association, says the hospital-physician ASC will be favored by accountable care organizations and other arrangements under healthcare reform. Also, by partnering with a hospital, an ASC may have access to employed or integrated physicians and their associated procedures.

7. Payors becoming more aggressive. Payors are increasingly deeming some surgeries unnecessary and are refusing to pay for them, says Joe Flower, a healthcare futurist. If the peer-reviewed literature shows a non-surgical intervention or less complex surgery is just as effective, the insurer will be more likely not to pay, he says. But Mr. Flower thinks ASCs will flourish in cases where there is no real medical alternative to surgery and patients cannot forego surgery.

8. Rise of accountable care organizations. ACOs are already starting with private payors and are due to begin for Medicare patients in 2012. In theory, ACOs should seek out surgery centers as the low-cost, high-quality alternative. But Saul Epstein, co-administrator of ParkCreek Surgery Center in Coconut Creek, Fla., predicts ASCs could turn out to be a cost center for ACOs. "When an ACO is paid a lump sum for a patient's care, surgery will be seen as a cost center," he says. Mr. Flower thinks ACOs require different mindset than ASCs are used to. While an ACO will be concerned about the entire continuum of care, the ASC is used to focusing on one single niche, he says.

9. Strong federal advocacy. In Oct. 2010, William Prentice, a seasoned healthcare lobbyist, took the helm of the ASC Association. "We are very optimistic regarding the leadership of Bill Prentice," says Mr. Hayek, who chairs the ASC advocacy committee. "We are hopeful more ASCs will join ASCA and begin to participate in the political process, engaging with lawmakers, making political contributions, and staying connected to the industry's work." In 2011, Mr. Prentice says the ASC Association will attempt to expand its capacity to reach key decision-makers on policies affecting ASCs. "I believe the ASC industry offers one of the most significant opportunities to be a leader in the changes that will occur with healthcare reform," he stated.

10. More Medicare inspections. The recent increase in Medicare inspections of ASCs is likely to continue in 2011. In general, ASCs will likely do well, but "the portion of ASCs with one or more deficiencies will draw significant negative press coverage and significant attention on Capitol Hill," Mr. Hayek predicts. "This coverage is particularly disappointing, given that it implies the risk of infection is higher in ASCs than in other settings. This is an implication that we believe to be false and misleading to healthcare consumers." ■

Contact Leigh Page at leigh@beckersasc.com.

ASC Transactions and Pricing During 2010: 4 Key Concepts
(continued from page 1)

these transactions involved hospitals acquiring surgery centers, and half were national companies acquiring surgery centers. Some of the specifics on pricing were as follows:

- Orthopedic-focused surgery center that was mostly in-network, national chain purchaser for approximately 7.3 times EBITDA.
- Multi-specialty center, heavily in-network, hospital purchaser, with no co-management agreement, approximately 8 times EBITDA.
- GI center heavily in-network, hospital purchaser, no co-management agreement, approximately 6 times EBITDA.
- Multi-specialty center, entered into co-management agreement as part of the transaction, some out-of-network, hospital purchaser 5.75 times EBITDA.
- Multi-specialty center, in-network, hospital purchaser, some co-management arrangement, approximately 7 times EBITDA.
- Multi-specialty orthopedic-focused center, mostly in-network, national chain buyer approximately 7 times EBITDA.
- Multi-specialty surgery center, some orthopedic and spine focus, in and out-of-network, national chain purchaser, for 5.65 times EBITDA
- Hospital purchaser, a very high multiple, mostly due to the fact that there was a significant drop in income in 2010 and 2010, was not indicative of continued income, approximately 9 times EBITDA.

Where the hospital is also entering into a co-management agreement with the physicians, there will often be a lower price due to the reduction of the expected earnings in connection with the payments for co-management services.

Pricing is higher where there is a strong probability of continued earnings, a strong physician base and the center is heavily in-network.

2. Hospital interest in ASCs. We continue to see a great deal of physician-alignment activity, and almost everybody is looking at new and emerging physician alignment models. While here has been a slowdown in the development of de novo joint venture ASCs, 2010 experienced an increase in hospitals acquiring a 100 percent interest in ASCs. We also saw an increase in national ASC companies trying to buy into hospital-physician joint venture ASCs.

3. Co-management. On the co-management side, we are seeing a lot of activity. For co-management arrangements around a hospital-owned surgery center, keep in mind the following:

- We see some of the co-management deals done as part of an acquisition of a surgery center. Co-management agreements need to be based on fair market value and they need to be truly needed. A high quality valuation firm needs to be able to support the fair-market-value nature of the agreement and the actual need for the agreement should be documented very closely internally. There is some skepticism that certain of the agreements are entered into to help tighten relationships or lock in referrals and not that they are truly needed for management purposes.
- These relationships are often fixed, in part, with a variable component as well. It is critical that the variable component not be based on or tied to volume or value of referrals. Finally, there are significant questions as to how to split up the dollars within the groups that are providing co-management services. Much of the dollars are often allocated to actual specific services provided by individuals that are part of the co-management group. Other dollars are often paid and split by the co-management entity as a whole for the overall services being provided. In each situation, the total dollars must not be based on the volume or value of referrals and the dollars allocated to any specific person may not be based on the volume or value of referrals.

4. Healthcare economics. Over the last few years, the healthcare economy has not seen significant dollars taken out of the economy. For example, 30-40 percent of the dollars, (i.e., the Medicare dollars) have been relatively stable. Further, the shift in unemployment — which has led to an approximately 2-3 percent increase in unemployment over the last five years — has not meant a complete a shift of 2-3 percent from commercial patients to Medicaid or no pay patients. Rather, a smaller fraction of that that has shifted payors and moved to a lower payment situations. The greatest reduction in reimbursement has come from the commercial sector, but it is less the day-to-day reimbursement and more the bigger ticket reimbursement that people are finding in certain situations that is no longer readily available. Thus, the overall amount of dollars being spent in the healthcare sector remains fairly stable. Within that, there are changes in practice patterns and changes in reimbursement that are shifting dollars between sectors. In terms of prognosis, we anticipate that the total number of dollars within healthcare will stay relatively steady over the next 3-5 years. There will be, however, continued shifting between sectors. ■

Contact Scott Becker at sbecker@mcguirewoods.com.

48 New ASCs Centers Opened in 2010 (continued from page 1)

California

New Surgery Center Opens in Sacramento — The Sutter Medical Center, Sacramento (Calif.), opened a new outpatient surgery center in Sacramento in December. The Sutter Capitol Pavilion Outpatient Surgery Center features four ORs, four GI procedure rooms and an interventional radiology suite. Specialties at the ASC include general surgery, gynecological surgery, orthopedic surgery, plastic surgery, vascular surgery, urologic surgery and ENT surgery.

New Surgery Center Opens in Costa Mesa — Renaissance Surgical Arts at Newport Harbor in Costa Mesa, Calif., opened in October. The 20,000-plus square-foot ASC includes eight ORs and two procedure rooms and will perform procedures in a variety of specialties including ENT, GI, neurosurgery, orthopedics, spinal, ophthalmology, podiatry and general surgery.

Orange Coast Center for Surgical Care Opens in Fountain Valley — Orange Coast Center for Surgical Care in Fountain Valley, Calif., opened in mid-2010 and is a joint venture between Orange Coast Memorial Medical Center and physicians. The surgery center performs cases in orthopedics, gynecology, GI, pain management, weight-loss and general surgery. It has four surgery suites and three GI procedure suites.

New Surgery Center Included in Hanford Medical Pavilion — Kings River Surgical Center is part of the new 63,000-square-foot Hanford (Calif.) Medical Pavilion, developed by Adventist Health. Kings River Surgical Center is a group comprised of local surgeons.

St. Helena Hospital Opens Surgery Center — St. Helena (Calif.) Hospital opened the Trinchero Surgery Center in January. The 12,500-square-foot ASC features two surgical suites and two procedures rooms and is used for both inpatient and outpatient surgery.

Florida

Titan Health Opens Surgery Center in Titusville — Titan Health Corp. opened Titusville (Fla.) Center for Surgical Excellence, a partnership between the health system and local physicians, at the beginning of November. TCSE features two ORs rooms and one procedure room. It specializes in ophthalmology, ENT, orthopedics, general surgery, podiatry and pain management.

New Surgery Center Opened by Lee Memorial Health System — Florida's Lee Memorial Health System opened a new ASC in Fort Myers, Fla. The new Outpatient Surgery Center is a 20,000-square-foot facility featuring four ORs and two procedure rooms. Procedures performed at the surgery center include gynecological surgeries, urology procedures, bariatric surgeries, pain management procedures, plastic surgeries and general surgeries.

Georgia

New Orthopedic ASC Opens in Jesup — The Bone & Joint Institute of South Georgia in Jesup opened a new facility, which includes an ASC. The 15,000-square-foot facility also includes x-ray services and Open MRI.

Gynecological Surgery Center Opens in Cartersville — The Georgia Advanced Surgery Center for Women in Cartersville opened in mid-2010. The surgery center specializes in laparoscopic and other minimally invasive gynecological surgical techniques.

New Piedmont Surgery Center Opens in Atlanta — Piedmont Surgery Center opened at the Piedmont West Medical Office Park in Atlanta. The 15,600-square-foot center is the second surgery center of Piedmont Hospital. It features four OR and two procedure rooms and will offer orthopedic, gynecological, urological and plastic surgery services.

Hawaii

Surgical Care Affiliates' Joint-Venture ASC Opens in Honolulu — Surgicare of Hawaii, a joint-venture project between Surgical Care Affiliates, Hawaii Pacific Health Partners and Honolulu Surgery Center, opened in September. The new 17,000-square-foot surgery center offers a number of specialties including orthopedics, ophthalmology, general surgery, gastroenterology and podiatry services.

Illinois

New Surgery Center in Aurora Specializes in On-the-Job Injuries — A new ASC in Aurora, Ill., will specialize in treatment of patients injured on the job. The 4,000-square foot Ambulatory Surgical Care Facility, LLC, is a partnership with Marque Medicos. Five surgeons and an internist will provide services in orthopedic procedures.

New Ophthalmology ASC Opens in Springfield — Prairie Surgery Center, an eye surgery center in Springfield, Ill., opened in August. The $3 million ASC is attached to the back of Prairie Eye & Lasik Center. The ASC will initially perform procedures in ophthalmology.

Indiana

St. Mary Medical Center Opens New Outpatient Surgery Center — St. Mary Medical Center in Hobart, Ind., opened a new outpatient surgery center, St. Mary Medical Center Outpatient Surgery at Lake Park, as a satellite facility of the hospital's main campus. Surgical procedures

performed at Lake Park include general surgery, cosmetic/plastic surgery, ophthalmology, otolaryngology, orthopedics and gastroenterology.

Iowa

New ASC Opens in Spencer — The Spencer (Iowa) Surgery and Laser Center opened, giving Iowa its 32nd ASC. The ASC features three ORs and performs procedures in orthopedic surgery, ophthalmology, pain management, plastic surgery and laser surgery.

Kansas

New Surgery Center Opens in Galena — Stateline Surgery Center in Galena, Kan., opened in March. The freestanding surgery center was developed by orthopedic group Ortho-4-States. The physicians built a 14,000-square-foot surgery center with two ORs and four large overnight rooms.

Louisiana

Louisiana Hospital Opens New Surgery Center in Covington — St. Tammany Parish Hospital in Covington, La., opened a new 20,000 square-foot ASC. Covington Surgery Center has three OR suites and performs procedures in many specialties including orthopedics, ENT, urology, dental surgery and gynecology.

Maryland

New ASC Opens in Greenbelt — SurgCenter of Greenbelt (Md.), developed by SurgCenter Development, opened in 2010. The ASC, operated by SurgCenter and 10 local physicians, is located in the first floor of Greenbelt Ambulatory Care Center.

Massachusetts

New Surgery Center Opens for Berkshire Medical Center — Berkshire Medical Center in Pittsfield, Mass., opened a new, $20 million ASC. The Crane Center for Ambulatory Surgery performs procedures predominantly in orthopedics. It also performs ophthalmology, ENT, general surgery and eventually gynecology and plastics.

Michigan

Eye Surgery Center Opens in Fraser — A new ASC providing retina surgical services opened in Fraser, Mich. The Fraser Eye Care Center was built by Eye Care Center of Port Huron (Mich.).

Minnesota

Ophthalmology Surgery Center Opens in Blaine — A new ophthalmology ASC opened in Blaine, Minn., as part of a specialty medical office. The surgery center was developed by Minnesota Eye Consultants, which offers LASIK surgery, cataract and implant surgery, glaucoma, corneal and external disease, oculoplastic surgery and all vision correction procedures.

Missouri

Freeman Surgical Center in Missouri Set to Open — Freeman Surgical Center, an ASC developed in Joplin, Mo., by Freeman Health System, Nueterra Healthcare and local physicians, opened in June. The $5 million, 17,735 square-foot surgery center features four ORs to be used by specialists in areas including ENT, gynecology, hand surgery, orthopedics, pain management and general surgery.

Nevada

Brown Hand Center Adds Surgery Center — Brown Hand Center in Henderson, Nev., opened a new surgery center. The surgery center, called St. Michael's Center for Special Surgery, will focus initially on carpal tunnel syndrome treatment and procedures, and possibly expand services offered in the future.

New Hampshire

New ASC Opens in Lebanon — Dartmouth-Hitchcock Medical Center opened a new ASC in Lebanon. DHMC's Outpatient Surgery Center cost $31 million, has four ORs and offers orthopedics, plastics and ophthalmology, urology and ENT.

New Jersey

New Surgery Center Opened by Robert Wood Johnson University Hospital — Robert Wood Johnson University Hospital, based in New Brunswick, N.J., opened a new outpatient surgery center in New Brunswick in September. The new Ambulatory Surgical Pavilion is a 13,000-square-foot ASC with four ORs and an endoscopy room. It sees cases in general surgery, gynecology, vascular surgery, plastic surgery, podiatric and retina-vitreous surgery, endoscopy and orthopedic surgery.

New Orthopedic ASC Opens in Vineland — New Jersey's Premier Orthopaedic Associates opened a new ASC in Vineland, N.J. The $6 million, 16,000-square-foot facility includes the ASC, physician offices and a service imaging center.

Virtua Health Opens $31M Wellness Facility, Surgery Center — New Jersey's Virtua Health opened a $31 million wellness facility in Sewell, N.J., which includes a surgery center. The 256,000 square-foot center features physician offices, a surgery center, a fitness center, a spa, a cafe and an immediate care center.

New Surgery Center Opens in Somerset — Ambulatory Surgical Center of Somerset in Bridgewater, N.J., opened in mid-2010. The surgery center performs procedures in orthopedics, pain management and spine.

New Mexico

Plains Regional Medical Center Opens Surgery Center — Plains Regional Medical Center, a 106-bed hospital in Clovis, N.M., opened a multispecialty surgery center. Plains Outpatient Surgery Center is equipped for general surgery, obstetrics, gynecology, internal medicine, orthopedic surgery, ophthalmology and podiatry.

New York

ASCOA Announces Opening of Surgery Center in Bay Shore — Ambulatory Surgical Centers of America announced the opening of South Shore Surgery Center in Bay Shore, N.Y. The ASC is an 11,000-square-foot facility with three ORs and two procedure rooms. Physicians will perform outpatient surgical procedures in general surgery, orthopedics, ENT and pain management. The surgery center will be operated by area physicians, with ASCOA providing daily administrative and consulting services.

York Hospital Opens Surgical Center — York (N.Y.) Hospital completed development of a new surgical center. The new surgery center is an expansion and renovation of the hospital's existing surgery center.

New ASC Opens in Rye — Rye (N.Y.) Ambulatory Surgical Center opened in mid-2010. The $4.5 million, 14,000-square-foot ASC, owned by the physicians of WESTMED, features four ORs and 16 patient bays. The center is expected to perform 4,000 procedures annually and surgical specialties include ophthalmology, orthopedics, urology, podiatry and GYN.

Upstate New York's Largest Hospital-Affiliated GI ASC Opens — The University of Rochester Medical Center opened upstate New York's largest hospital-affiliated ambulatory GI center. The center, located on the second floor of the URMC Surgery Center, offers gastroenterology, hepatology and endoscopy services. The 10,000-square-foot GI center includes four endoscopy rooms.

United Health Services Opens New Surgery Center in Johnson City — United Health Services opened the Ambulatory Surgery Center and Pre-Admission Testing Program in Johnson City, N.Y. The surgery center performs procedures in ophthalmology, gynecology, ENT, orthopedics, general surgery and podiatry.

North Carolina

New Bariatric Surgery Center Opens in Lexington — A new bariatric surgery center opened in Lexington, N.C. Bariatric Surgery Center of Lexington Memorial Hospital was opened by Adolfo Fernandez, MD, and Stephen McNatt, MD. They are both bariatric surgeons with Wake Forest University Baptist Medical Center.

Ohio

Physician/Hospital Joint Venture Surgery Center Opens in Medina — A new ASC developed by Akron, Ohio-based Summa Health System and physicians from the Medina, Ohio, area, opened in Medina County. The Summa Health Center at Lake Medina is a 100,000-square-foot facility that includes a three-suite ASC. The center will provide outpatient surgery in ophthalmology, hand surgery, pain management, general surgery, gynecology, podiatry and plastic surgery.

Oklahoma

Surgery Center in Oklahoma City Opened by OU Medical Center — OU Medical Center opened a new $18.1 million surgery center. OU Medical Center Surgery Center has five ORs, two procedure rooms

and performs cases in specialties including orthopedics, urology, general surgery, pain management, oral surgery and sports medicine.

Pennsylvania

ENT Surgical Center Opens in Carlisle — Carlisle (Pa.) Regional Medical Center opened a new ENT surgical and medical care center in Carlisle. The MidState Ear, Nose & Throat Center provides care for general ENT disorders, including tinnitus, nasal obstructions, sleep apnea, recurrent tonsillitis, neck masses, thyroid gland disease and enlarged lymph nodes.

Heritage Valley Health System Opens Endoscopy Center — Heritage Valley Health System opened a new endoscopy center in Moon Township, Pa. The Heritage Valley Endoscopy Center provides services such as colonoscopy, esophagoscopy, endoscopic retrograde cholangiopancreatography and radiological fluoroscopy.

South Dakota

New ASC Opened by Avera McKennan Hospital — Avera McKennan Hospital & University Health Center in Sioux Falls, S.D., opened the Avera Surgery Center. The 34,000-square-foot ASC has eight operating suites and 28 private patient rooms. The ASC performs procedures in the following specialties: ENT, gynecology, urogynecology, general surgery, spine, urology, orthopedics, plastic surgery and GI.

Tennessee

New Surgery Center Opens at Jackson-Madison County General Hospital — Construction on a 106,772-square-foot medical-office building located on the campus of Jackson–Madison County General Hospital in Jackson, Tenn. was completed in early 2010. The building features an ASC, which has been leased by Jackson-Madison's parent company, West Tennessee Healthcare.

Mercy Health Partners Opens New Surgery Center in Knoxville — Mercy Health Partners opened Mercy Surgery Center West in Knoxville, Tenn. The 21,527 square-foot ASC has four ORs, two endoscopic suites and performs procedures in GI/endoscopy, pain management, plastic surgery, gynecology, ENT, orthopedics, general surgery and other procedures.

Texas

New Surgery Center Opens in Baytown — A new ambulatory surgery center opened in Baytown, Texas. The ASC, Oprex Surgery Center, is part of a 25,000-square-foot facility called Altus Medical Center.

New Surgery Center Opens in Palestine — Willow Creek Surgery Center opened in Palestine, Texas. The ASC includes two ORs and two procedure rooms and performs procedures in specialties including endoscopy, pain management, orthopedics and general surgery.

Pain Specialist Opens New ASC in Round Rock — Pain specialist Mark T. Malone, MD, opened a new ASC in Round Rock, Texas. Round Rock Surgery Center, a 9,000-square-foot ASC, opened in June and was the fifth location for the pain management chain.

Washington

New ASC Opens in Pasco Hospital – A new surgery center opened in the Lourdes Medical Center in Pasco, Wash. The $2 million ASC features 12 private rooms, three GI procedure rooms and a Mako surgery robot for knee and hip replacements.

West Virginia

Raleigh General Hospital Opens Surgery Center — Raleigh General Hospital in Beckley, W.V., opened a new $8 million ASC. The new ASC includes endoscopy and a technologically advanced OR.

Wisconsin

New Orthopedic Surgery Center Opens in Bellevue — Bellin Health Orthopedic Surgery Center and Orthopedic Sports Medicine Specialists opened an $11.9 million surgery center and clinic in Bellevue, Wis. The facility includes a 15,000 square-foot orthopedic surgery center and a 35,000 square-foot orthopedic and rheumatology clinic. ■

5 Ways to Increase Surgery Center Distributions in 2011

By Rachel Fields

Here are five ways physician-investors can increase their ambulatory surgery center distributions in 2011.

1. Expand your service lines. Look at your existing service lines and evaluate where procedures — or an entire new service line — could be added. If a particular service line lacks a profitable procedure, look to the community for physicians who can perform that procedure, says Brad Harman, MD, a founder partner at Cleburne (Texas) Surgical Center. He says this means doing a careful cost analysis to compare contracts with the generated revenue for each case. "Some specialties have a much higher profit margin than others, so before we add a service line, we need to confirm that the cost is going to come in under what we get in revenue," he says.

Bill Gilbert, vice president of marketing at AdvantEdge Healthcare Solutions, says different centers will have different needs in terms of expanding their service lines. It all depends on case costing and looking at payor contracts to determine which cases will be profitable, as well as whether there are physicians available to perform those procedures.

2. Recruit new physicians. Dr. Harman recommends two ways to recruit new physicians: a corporate marketing strategy and good outcomes. He says your corporate marketing strategy should target referring physicians as well as new physicians.

Dr. Harman says that while a corporate marketing strategy can attract new physicians, the best strategy for recruiting is publicizing your good outcomes. He says if patients want to come to your center, physicians will know about it. If your existing physicians talk to their colleagues about the efficiency, outcomes and ease of scheduling at your facility, other physicians are likely to contact you. "There's no better referral than [one physician] talking to another physician," says Mr. Gilbert.

Mr. Gilbert says this strategy can attract physician-investors whose professional fees have waned in recent years. "This is a time for centers to market themselves to new surgeons," says Mr. Gilbert. "One way is to show the center's books to new surgeons and get them excited about the financial opportunities," he says. "If another center down the road closed and the surgeons are talking about going to a center that's 20 miles away, and you have to go past your center to get there, you need to reach out. You need to show them what the upside is and use the data to show them your center will be a great financial return."

3. Review current payor contracts. To increase distributions at your ASC, Ken Pettine, MD, co-founder of Colorado's Rocky Mountain Associates in Orthopedic Medicine in Loveland, Colo., recommends adding special procedures, such as spine, and making sure to review carve-outs in your contracts. Reviewing your contracts will ensure higher-acuity cases are paid as a carve-out or on a case-rate basis. "Look at how implants are reimbursed, insuring they are paid separately and in addition to the procedure rate," he says.

4. Maintain and grow facility utilization. Dr. Pettine says the partnerships at your ASC should be reviewed and maintained on a regular basis to ensure a mix of productive physicians. If your center has older physicians looking to retire in the near future, you should be looking to redistribute their units to younger, more active physicians. Todd Mello, principal and co-founder of HealthCare Appraisers, agrees that a center's value can be significantly affected by the distribution of physicians in your ASC. If the majority of your ASC's physicians are older, you should concentrate your efforts on recruitment of active physicians to ensure your case volume doesn't lag in the coming years.

5. Control costs. Most ASC experts agree that cost-control is the number one way to maintain financial health at an ASC, as reimbursement is more difficult to affect. Dr. Pettine recommends reviewing your ASC's membership with a group purchasing organization. "If you are not a member, join [a GPO], as you will receive discounts on most products and services," he says. He also recommends looking at the products in your inventory to determine whether different products are being used for the same purpose. If you reduce the options on a specific product, you will reduce inventory and therefore save money. ■

Contact Rachel Fields at rachel@beckersasc.com.

MedPAC Calls for 0.5% Pay Rise, New Reporting for ASCs; 1 Percent Pay Hike for Physicians

By Leigh Page

The Medicare Payment Advisory Commission is asking Congress to provide a 0.5 percent increase in payments for ambulatory surgery centers and require them to report cost and quality data in fiscal year 2012, according to a report by *AHA News Now*.

MedPAC is also asking for a 1 percent increase in physician reimbursements, a 1 percent net increase in inpatient hospital payments and a 1 percent update for hospital outpatient services.

For fiscal year 2011, MedPAC recommended a 0.6 percent update for ASC payments, but CMS ended up enacting a 0.2 percent increase, based on an annual inflationary update of 1.5 percent and the productivity adjustment of -1.3 percent. ■

Contact Leigh Page at leigh@beckersasc.com.

NovaMed to Be Acquired by Surgery Partners, Go Private

By Rob Kurtz

NovaMed has announced it will be acquired by Surgery Partners, an affiliate of Surgery Center Holdings, for about $109 million.

The transaction, which will make NovaMed private, is valued at approximately $214 million, including the assumption or repayment of approximately $105 million of indebtedness by Surgery Partners.

Surgery Partners is an affiliate of H.I.G. Capital, a global private equity investment firm.

The agreement was unanimously approved by NovaMed's board of directors, including a special committee of independent directors.

The acquisition is expected to close in the second quarter of 2011.

McGuireWoods, led by Scott Becker, Geoff Cockrell and Amber Walsh, was one of the law firms which provided counsel to the buyer in connection with this transaction. For information on the McGuireWoods healthcare practice, please contact sbecker@mcguirewoods.com. ■

Contact Rob Kurtz at rob@beckersasc.com.

Irving Place Capital to Acquire National Surgical Hospitals

By Rob Kurtz

Irving Place Capital, a middle-market private equity firm, has announced it will acquire National Surgical Hospitals, an owner and operator of 14 surgical hospitals and seven ambulatory surgery centers located in 10 states.

IPC, which was advised on the deal by Cain Brothers, will replace NSH's current owners, Ferrer Freeman & Co., Charlesbank Capital Partners and JPMorgan Asset Management.

David Crane, a senior advisor to IPC, chairman of New Hope Bariatrics and former CEO for Medcath, will become chairman of NSH's Board of Directors.

John G. Rex-Waller, president and CEO of NSH, said of the acquisition in an IPC news release, "IPC's capital strength will allow us to reinvigorate our acquisition program and enhance our ability to add services and invest in the latest proven technology to empower physicians to deliver better outcomes for patients."

McGuireWoods was one of the law firms that worked with IPC on this transaction. Krist Werling, Scott Becker and Rob Marks led the McGuireWoods team.

The terms of the transaction were not disclosed. The transaction is expected to close around the end of January. ■

Contact Rob Kurtz at rob@beckersasc.com.

GELFOAM® (absorbable gelatin powder; absorbable gelatin sponge, USP)

New look,
same devices

GELFOAM Powder and GELFOAM Sponge are now available in clearly designed packaging.

For assistance with ordering GELFOAM and/or size information, contact us at **800.533.4535**, or visit **www.pfizerinjectables.com** today.

Pfizer Injectables | Solutions Are Our Business.™

10 Factors Affecting an ASC's Sales Price

By Leigh Page

Jeff Simmons, chief development officer at Regent Surgical Health, an ASC developer and manager, discusses 10 factors that influence a center's sales price.

1. Earnings. If the ASC is making money, its price can be based on a multiple of earnings, minus the debt. The typical multiple for ASCs has declined in recent years from 6-8 times earnings to 5-7 times earnings.

2. Assets. If the ASC is earning little or no money, it is evaluated based on assets minus the debt. Regent, for example, trades in centers that are losing money, breaking even or making a small profit, such as up to $500,000 a year.

3. Amount of interest sold. "The multiple would also be affected by the amount of ownership to be sold," Mr. Simmons says. If the selling physicians want to hold on to majority interest, the price would be less because the buyer would not be able to control operations. ASCs selling a minority interest have a multiple of 3-4 times the value of the assets while ASCs selling majority interest have a multiple of 5-7 times.

4. Market conditions. These factors play a smaller role in evaluations the earnings, assets or debts, but they are worth mentioning. Some examples follow.

5. Glut of ASCs in the area. If there are too many ASCs in the area, a center up for sale would have a lower value.

6. Nearby hospital buying up ASCs. If a hospital in the area is buying up ASCs, usually in partnership with physicians, this will take volume away from unaligned ASCs and thus lower their value.

7. Location in a CON state. States with tough CON laws make it more difficult to open new ASCs and thus raise the value of existing ASCs. "Centers in CON states have a higher value," Mr. Simmons says.

8. Multiple specialties. The more specialties a center has, the higher the multiple. Musculoskeletal ASCs, including spine, orthopedics and pain, are at the high end of the multiple.

9. Managed care contracts. ASCs that are fully contracted with insurers are at the high end, while out-of-network ASCs are at the low end.

10. Newer ASC. A new ASC would have a higher value in an asset-based evaluation because its equipment would be new. "If a place is brand-new and has high assets and very little debt, it would be ideal for asset purchase," Mr. Simmons says. Equipment loses value in 5-7 years. Most ASCs are more than five years old. ■

Learn more about Regent Surgical Health at www.regentsurgicalhealth.com.

Analysis of ASC Data Suggests a Mature ASC Market

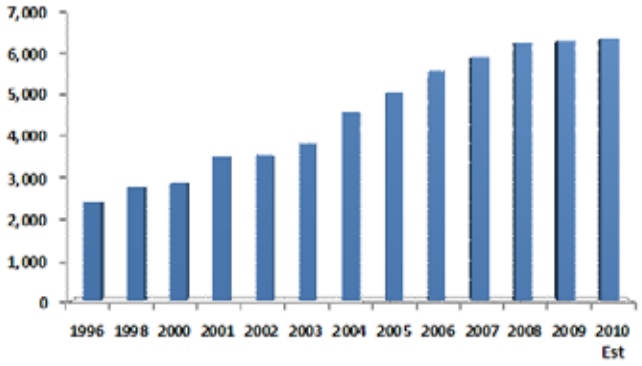
By Kevin McDonough, Senior Manager, VMG Health

Those that have been involved with this industry in recent years have heard a common theory proclaiming the ASC market as a mature industry. What does this mean and is it true? In this column we will illustrate and briefly highlight several trends that suggest this to be a valid assessment of the industry and explore the ways in which experienced ASC operators are responding.

Overall ASC growth has significantly leveled off

The number of ASCs operating in the United States expanded rapidly throughout the late 1990s through to the late 2000s (see chart below). This high growth was fueled by a number of market dynamics, including:

- physician desire to perform outpatient surgery in an focused and efficient environment;
- physician desire to participate in the management of their surgical facilities;
- physicians seeking to supplement their professional income streams;
- technological and surgical advances which made more procedures suitable for ASC setting;
- many new ASC management / development companies entering the market, providing funding, organization and expertise; and
- abundance of lenders willing to provide capital to physicians and developers.



Since 2008, however, growth in the number of ASCs has significantly declined. Essentially, what is being observed in the ASC industry is an exhibition of the economic law of supply and demand. The significant expansion in the number of ASCs was driven by a demand (from physicians and, to lesser extent, patients) that had not yet been met by the supply (of ASCs). This is no longer the case and in fact may be reversed, where supply now exceeds demand.

In addition to a decline in new ASC development, case volume levels at existing centers appear to support a maturing ASC industry.

Same-center case volume levels have significantly deteriorated

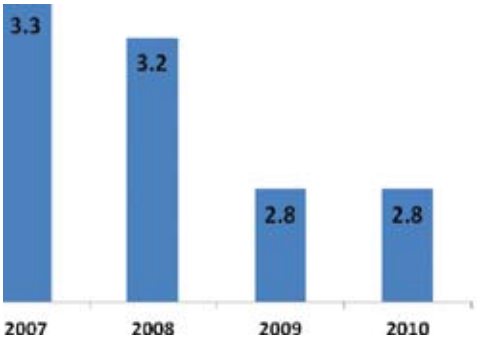
As indicated in the charts below, same center volume growth trends have turned negative. This trend is clearly evident in ASCs affiliated with the large, national ASC management companies (see chart below). Robust annual case volume growth at most ASCs has been replaced by declining same center case volume projections. Although exacerbated by the economic downturn, this trend illustrates a more profound shift in the life cycle of the ASC industry as a whole.

ASC Company	FYE 2006	FYE 2007	FYE 2008	FYE 2009	Est 2010
USPI	7.0%	6.0%	2.0%	2.0%	(1.0%)
HCA	(1.2%)	(1.1%)	(0.2%)	(0.1%)	(1.3%)
AMSURG	5.0%	4.0%	4.0%	1.0%	(1%) - 0%
NOVAMED	1.3%	9.3%	(1.4%)	(2.1%)	(5.1%)

Excess capacity is on the rise

Based on trended data compiled from VMG's *Intellimarker ASC Benchmarking Survey*, average case volume levels per OR/per day have declined materially since 2007 (based on 2006 data). This 15.0 percent drop in operating room utilization supports the trend illustrated in the prior chart regarding same center volume levels and points to the likelihood of ASC consolidation in the near future.

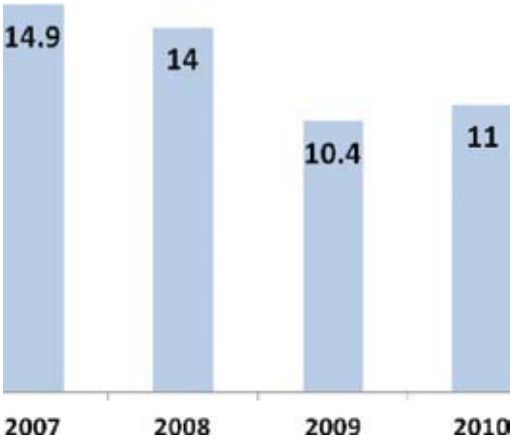
Trended Cases per OR per Day



How experienced ASC operators are responding to mature market

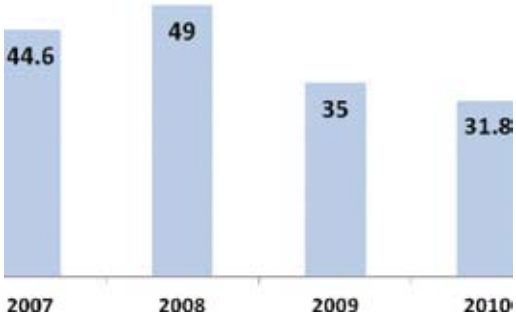
When ASC operators can no longer rely upon an ever increasingly supply of new physician investment and volume, they turn their focus on increasing operating efficiencies. The chart below illustrates trends observed in the VMG ASC *Intellimarker* related to staff hours per case. From 2007-2010 (based on 2009 data) average staff hours per case dropped by approximately 25 percent. Considering staff costs generally comprise one-quarter to one-third of an ASC's total operating expense, such a reduction is quite significant.

Staff Hrs Per Case



In addition to reducing costs by improving operating expense efficiency, many ASC operators are looking to control risk by reducing their center's debt burden. The chart below, compiled from VMG's ASC *Intellimarker* shows that the percentage of debt as compared to total assets has decline by nearly 30 percent. When faced with the challenges and uncertainty in today's ASC market, owners and operators are much less inclined to saddle their centers with significant levels of debt.

Leverage: Debt/Total Assets



In summary, our attempt with this piece was to highlight some real world data trends that validate the general opinion of the state of the ASC industry – an industry that has reached a mature state and faces significant present and future challenges. ■

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

8 Insights Into Successful Hospital-ASC Joint Ventures

By Leigh Page

Christian D. Ellison, vice president of business development at Health Inventures in Broomfield, Colo., provides eight insights for successful joint ventures between hospitals and ambulatory surgery centers.

1. Know how ASC joint ventures benefit hospitals. Such partnerships can enhance inpatient and outpatient volume, improve working relationships with physicians and encourage physicians to focus on cost management and efficiency, both in the ASC and in hospital ORs.

2. Keep in mind why physicians want to partner. "Ten years ago, the last thing physician-owners wanted was to sell to a hospital," Mr. Ellison says. But things have changed. "This is an uncertain period for physician-owned ASCs," he says. For physicians, partnering with a hospital can facilitate better payor contracting support, limit competition, augment physician recruitment efforts, and provide access to capital.

3. Consider acquiring an existing ASC. As opportunities for new ASCs decline, hospitals may want to consider acquiring an existing center. "This is a good strategy in areas where the market is already saturated and there are few physicians who are not aligned with a center," Mr. Ellison says. "Partnering on an existing ASC also allows you to get to market more quickly. You can access physician relationships and a revenue stream your hospital may have lost at some point in the past."

4. You may gain new volume. Hospitals are often concerned the surgery center will take volume away from their hospital-based ORs, but the opposite is also possible. "Through its ASC partnership, the hospital can access new inpatient and outpatient surgery volume from surgeons that once went to its competitors," Mr. Ellison says.

5. Spread your net wide at first. If you decide to acquire an ASC, thoroughly evaluate acquisition alternatives in the market and prioritize those, based on how each ASC adds value to your hospital. "The value for you might be a strong future income stream, partnership opportunity with the right doctors, keeping out competitors or gaining access to a new market," Mr. Ellison says. Once you have narrowed down your choice, contact one of the lead physicians in the ASC to determine physicians' interest in partnering.

6. Evaluate the ASC. Once you have an interested target, execute a non-disclosure agreement with the ASC so that you can evaluate basic financial and operational information. Once things get serious, you will need an independent valuation to verify price. Due to federal regulations, "you can't overpay physicians for their interest in an ASC," Mr. Ellison says. "You'll have to propose a price that you believe is fair and gets the physicians interested, but the hospital can't be seen as paying for referrals."

7. Create a business plan. As you evaluate the ASC, begin to create a business plan for the entity, focusing on a five-year forecast for the operation to see if the deal is viable. "Make sure you feel comfortable that the ASC has enough opportunity for growth to support the price you are paying," Mr. Ellison says. Examine patient volume, physician profiles and reimbursement rates. "An ASC may add additional value to a hospital beyond the incremental income stream and physician integration," he adds. "It may lower costs and add capacity to a growing hospital or one with an aging infrastructure.

8. Decide your level of interest. "There are a number of considerations in determining what percentage interest to purchase," Mr. Ellison says. If the hospital gains a majority interest, it can be easier to obtain higher reimbursement rates from payors. However, your physician-partners may want to retain majority control. Keep in mind that a controlling interest is more expensive and you may be out of reach for hospitals with capital constraints. Here is how the price for the hospital is determined for an ASC priced at a multiple of earnings. If its earnings are $1 million and the multiple is six, then the total price would be $6 million, less any long-term debt. If the hospital has a 50 percent stake, it would pay $3 million. ■

Learn more about Health Inventures at www.healthinventures.com.

10 Things to Know About Co-Management Relationships in Conversions of ASCs to HOPDs

By Leigh Page

When hospitals purchase ASCs from physician-owners and convert them into hospital outpatient departments, they may also set up co-management arrangements with former physician-owners. "The co-management vehicle allows for the development, management, efficiency and quality improvement of the HOPD by rewarding physicians for their management efforts," says Scott Safriet, a principal at Healthcare Appraisers. Mr. Safriet lists 10 things to know about such arrangements.

1. Creation of separate contracts. The co-management agreement is separate from the ASC sales transaction and conversion to an HOPD. "The arrangement may be established solely with the physicians that sold the ASC or it may also include additional physicians, medical groups or faculty practice plans," Mr. Safriet says.

2. Ownership can be split. While the HOPD remains wholly owned by the hospital, the co-management entity could either be entirely physician-owned or a joint venture with the hospital. Ownership of the joint venture is typically split 50-50 between the physicians and the hospital, but percentages vary depending on requirements of both parties.

3. Many services can be included. The services to be managed can extend beyond the HOPD. For example, the management entity could also be tasked with providing management services to inpatient surgery services and other outpatient services or locations, depending on the hospital's desired level of management integration. The amount of managed services will influence the overall management fee and the amount of work for the physicians. Services can include outpatient, inpatient and multiple locations and be structured to meet specific needs of the hospital, such as emergency call coverage.

4. Duties cannot overlap with other management services. "The duties the contract assigns to the management company cannot also be assigned to others at the hospital, whether through medical directorships or an outside management company," Mr. Safriet says. Therefore, the hospital needs to review its compensation arrangements to make sure co-management services and associated payments do not overlap with other services or payments.

5. Services must actually be provided. The management services tasked to the physicians must be performed, and the hospital needs to be able to demonstrate that it can appropriately track accomplishment of the management tasks. "Physicians must actively participate and spend significant time and effort performing their required management duties," Mr. Safriet says.

6. Clearly define responsibilities. Unlike traditional hourly compensation for medical directorships, physicians in co-management relationships are not typically required to log hours worked. However, they do need to achieve predefined goals and objectives. This means creating clear and well-defined responsibilities. "The targets can't be sandbagged metrics, such as physicians showing up on time," Mr. Safriet says.

7. Create base fee and incentive fees. The management company receives a base management fee, usually paid monthly, along with an opportunity to earn an incentive fee based on achieving certain pre-established performance targets. The base fee typically equals 30-70 percent of the total fee. "If the base fee were a higher percentage, it would erode the importance of achieving performance targets," Mr. Safriet says.

8. Payment is based on fair market value. "Establishing fair market value for the physician's services is a complicated but necessary part of setting the right payment level," Mr. Safriet says. Each co-management arrangement is unique, reflecting specific market and operational factors. The valuator assesses the relative worth of each task or objective by matching it to comparable arrangements and making appropriate normalizing adjustments.

9. Tie incentive fee to performance objectives. Tie the incentive payment to attainment of specific clinical quality objectives and other factors, such as patient satisfaction and budgetary compliance. "The calculations and weightings for the incentive payment must be part of the agreement, and should reflect aspects that are of particular service or operational importance to the hospital," Mr. Safriet says.

10. Heed compliance risks. If fair market value cannot be demonstrated and appropriately documented, co-management payments have a fairly high degree of regulatory risk," Mr. Safriet says. Ensure that the annual management fee is structured as a fixed payment, not related to the value or volume of referral needs. The hospital should also verify that it can appropriately track, monitor and document achievement of identified base management tasks and incentive metrics. ■

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

8 Factors That Make Your ASC Risky for Buyers

By Leigh Page

Vincent Kickirillo, a partner at valuation firm VMG Health in Dallas, identifies eight factors that make your ASC risky at time of sale.

1. Lack of lucrative specialties. While a really efficient single specialty ASC such as a GI-only facility can be highly desirable, it helps to include lucrative specialties like orthopedics.

2. A few physicians do most cases. Your center should not be relying on a few surgeons to bring in most of its volume. What happens if one of those surgeons is incapacitated or retires? "If your three top producers account for 50 percent or more of volume, you are too top-heavy," Mr. Kickirillo says.

3. Physician infighting. A physician group that lacks cohesiveness not only makes the ASC less productive but also raises buyers' concerns that some partners might exit the ASC and open a competing center after the sale.

4. Partners who are aging. "A center where all the physicians joined 30 years ago and are now ready to retire will appear risky to buyers," Mr. Kickirillo says. "Who will take their place?" Centers need to take the time to identity younger physicians and offer them membership.

5. Ineffective partnership agreement. The partnership agreement should include items like mandating physicians to sell all or part of their shares when they reach a certain age or when their volume drops. This will ameliorate risks to the buyer. The agreement should also have a strong non-compete covenant, stipulating that physicians cannot invest in another center within a certain radius. It should also require surgeons to bring at least one-third of their cases to the ASC, though this is also a legal safe-harbor requirement.

6. Too many cases with one payor. Buyers will view it as risky to have one large payor, such as Blue Cross Blue Shield, covering a majority of the center's volume. A center can do little about this when one payor dominates the market. It could help, however, to make sure the ASC has contracts with as many of the smaller payors as possible.

7. Too many out-of-network cases. Buyers are cautious regarding centers that rely heavily on out-of-network status because this option appears to be fading away. In the short term, however, out-of-network cases can still boost the ASC's bottom line. "Ride it as long as you can, but know that the model is going away," Mr. Kickirillo says.

8. Lack of competent management. Buyers are impressed when ASC management has demonstrated expertise with contracting, buying supplies and delivering reliable financial results. If internal management lacks these skills, a management company can step in. "Physician-owned centers can be very, very successful, but it helps to have a strong management company behind you," Mr. Kickirillo says. ■

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

ASC Ambulatory Surgery Center Association

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

BECKER'S ORTHOPEDIC & SPINE REVIEW
Business and Legal Issues for Orthopedic and Spine Practices

ASF Ambulatory Surgery Foundation

9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

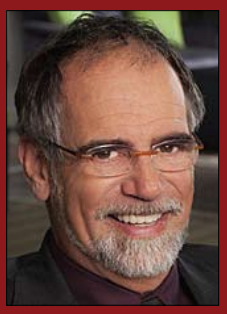
Improving Profitability and Business and Legal Issues

THE 9TH ANNUAL CONFERENCE FROM ASC COMMUNICATIONS AND THE AMBULATORY SURGERY FOUNDATION

June 9-11, 2011

Westin Hotel • North Michigan Avenue • Chicago, Illinois


Coach Mike Ditka


Joe Flower

- Keynote Coach Mike Ditka, Legendary NFL Player and Football Coach
- Keynote Joe Flower, Healthcare Futurist, CEO, The Change Project, Inc.
- Improve Your Profits Monday Morning
- Great topics and speakers focused on key business, financial, clinical and legal issues facing Orthopedic, Spine and Pain Management-Driven ASCs
- 101 Sessions, 134 Speakers
- 30 Physician Leaders as Speakers, 29 CEOs as Speakers
- Focused on Orthopedic Surgeons, Orthopedic Spine Surgeons, Neurosurgeons and Pain Management Physicians, ASC Physician Owners, Administrators and Others
- Immediately useful guidance plus great keynote speakers
- Learn How to Immediately Improve Your Golf Swing
- New and Advanced Procedures for ASCs — Spine, Total Joints, Uniknees and More
- Have an outstanding time in Chicago
- Earn Your CME, CASC, CEU Credits - 15.25 CASC credits and 15 CME and CEU credits
- Big Thoughts Combined with Practical Guidance
- Legal Issues for ASCs and Physician Owned Hospitals
- Great Networking
- Understand the Impact of Healthcare Reform on ASCs
- Orthopedics, Spine and Pain Management
- Benchmarking, Cost Cutting, Safe Harbors, Billing and Coding, Revenue Growth and more

For more information, call (703) 836-5904 or (800) 417-2035
If you would like to sponsor or exhibit at this event, please call (800) 417-2035

To register, contact the Ambulatory Surgery Foundation (703) 836-5904
or fax (703) 836-2090 • registration@ascassociation.org
Register online: https://www.ascassociation.org/june2011.cfm

Improving the Profitability of Your Orthopedic, Spine and Pain Management-Driven ASC – Thrive Now and in the Future

This exclusive orthopedic, spine and pain-focused ASC conference brings together surgeons, physician leaders, administrators and ASC business and clinical leaders to discuss how to improve your ASC and its bottom line and how to manage challenging clinical, business and financial issues.

- 101 Sessions
- 134 Speakers
- 25 CEOs as Speakers
- 30 Physician Leaders as Speakers
- Mike Ditka, Legendary NFL Football Player and Coach, and Joe Flower, Healthcare Futurist, CEO, The Change Project
- Great Participants From All Over the Country
- Business, Clinical and Legal Issues

The Becker's ASC Review/ASC Communications – Ambulatory Surgery Foundation difference:

1) Benefit from the combined efforts of Becker's ASC Review/ASC Communications and the Ambulatory Surgery Foundation to attract attendees and speakers that are among the smartest people in the ASC industry today.

2) Take discussion and thinking to the highest levels, focusing on the physician-owners, medical directors, ASC administrators and business minded directors of nursing.

3) Access expert views from all sides of the ASC world.

PROGRAM SCHEDULE

Pre Conference – Thursday, June 9, 2011

11:30am – 1:00pm	Registration
12:00pm – 4:30pm	Exhibitor Set-Up
1:00pm – 5:40pm	Pre-Conference Workshop • Concurrent Sessions A, B, C, D, E, F
5:40pm - 7:00pm	Reception, Cash Raffles and Exhibits

Main Conference – Friday, June 10, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:20pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:20pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday, June 11, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:10am – 1:00pm	Conference

Thursday, June 9, 2011

Track A – Turning Around ASCs, Ideas to Improve Performance, and Benchmarking

1:00 – 1:40 pm
Key Concepts to Fixing Physician Hospital Joint Ventures Gone South - Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, ASCOA

1:45 – 2:15 pm
How to Determine When to go In Network vs. Out of Network, Thomas J. Bombardier, MD, FACS, Principal & Founder, ASCOA

2:20 – 2:50 pm
How to Add Spine and Orthopedics to an Existing ASC - Best Practices - Mike McKevitt, Senior Vice President, Business Development and Bo Hjorth, Vice President Business Development, Regent Surgical Health

2:55 – 3:25 pm
10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them - Brian Brown, Regional Vice President, Operations, Meridian Surgical Partners

3:30 – 4:00 pm
Grow Your ASC's Profits 10% or Greater in 1 Year - Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgical Center Partners, Introduced by Melissa Szabad, Partner, McGuireWoods LLP

4:05 – 4:35 pm
ASC Turnarounds - 5 Key Steps for Success - Kenny Spitler, SVP Development and Robin Fowler, MD, Founder, Interventional Management Services, Introduced by Bart Walker, Partner, McGuireWoods LLP

4:40 – 5:40 pm - Keynote
Leadership and Management in 2011 - Mike Ditka, Legendary NFL Player and Football Coach

Track B – Spine and Orthopedics

1:00 – 1:40 pm
Business Planning for Orthopedic and Spine Driven Centers - Jeff Leland, CEO, Blue Chip Surgical Center Partners

1:45 – 2:15 pm
Developing a Spine Driven ASC: The Essentials for Success- Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

2:20 – 2:50 pm
Navigating an Orthopedic Practice and its ASCs Through a Changing Healthcare Environment - David Fitzgerald, CEO, Proliance Surgeons, Inc.

2:55 – 3:25 pm
Minimally Invasive Spine Surgery in ASCs - Greg Poulter, MD, Peak One Surgery Center, and Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

3:30 – 4:00 pm
Keys to Successfully Establishing and Growing a Premier Spine Center - Why Partner With a Management Company, Why Partner With a Hospital, Challenges and Opportunities - William Tobler, MD, The Christ Hospital Spine Surgery Center, and Michael Stroup, Vice President Development, United Surgical Partners International, Inc.

4:05 – 4:35 pm
Key Thoughts on Hand and Knee Surgery in ASCs - What Makes Sense Financially - David J. Raab, MD, President, Board of Managers, and Jeffrey L. Visotsky, MD, Member, Board of Managers, Illinois Sports Medicine & Orthopedic Surgery Center

Track C – Pain Management, Joint Ventures, Legal Issues

1:00 – 1:40 pm
Managing Pain Practice-Protocols, Branding and Other Tips to Improve Profitability - Vishal Lal, CEO, Advanced Pain Management

1:45 – 2:15 pm
Pain Management, The Best Practices in Office and ASCs - Nameer R. Haider, MD, Spinal & Skeletal Pain Medicine

2:20 – 2:50 pm
Best Practices for Pain Management in ASCs - Business and Clinical Issues - Marsha Thiel, RN, MA, CEO, Medical Advanced Pain Specialists

2:55 – 3:25 pm
Interventional Pain Management - New Concepts to Reduce ER Visits, Hospitalizations and Re-Admissions - Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

3:30 – 4:00 pm
Successful Three Party Joint Ventures - Christian D. Ellison, Vice President, Health Inventures

4:05 – 4:35 pm
6 Top Legal Issues for ASCs - Scott Becker, JD, CPA, Partner, and Melissa Szabad, Partner, McGuireWoods LLP

TO REGISTER, CALL (703) 836-5904 • FAX (703) 836-2090 • EMAIL registration@ascassociation.org
Register Online at https://www.ascassociation.org/june2011.cfm

Track D – Valuation and Transaction Issues

1:00 – 1:40 pm
ASC Transactions, Current Market Analysis and Valuations - Greg Koonsman, Senior Partner, VMG Health

1:45 – 2:15 pm
A Step by Step Plan for Selling Your ASC - How to Maximize the Price, Terms and Results and How to Handle the Process - Luke Lambert, CFA, MBA, CASC, CEO, ASCOA, Introduced by Scott Downing, Partner, McGuireWoods LLP

2:20 – 2:50 pm
Co-Management Relationships With HOPDs - Scott Safriet, MBA, AVA, Principal, Healthcare Appraisers, and Kristian Werling, JD, Partner, McGuireWoods LLP

2:55 – 4:00 pm
Selling Your ASC - A Process and Plan - What Can you Expect? - Evelyn Miller, CPA, Vice President, Mergers & Acquisitions, United Surgical Partners International, Michael Weaver, Vice President Acquisitions & Development, Symbion, Inc., Thomas J. Chirillo, Senior Vice President, Corporate Development, NovaMed, Inc., Jon O'Sullivan, Senior Partner, VMG Health, John Fennebresque, Jr. Managing Director, Fennebresque & Co., and Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

4:05 – 4:35 pm
ASC and Healthcare Transactions - The Year in Review - Todd J.Mello, ASA, AVA, MBA, Principal & Founder, Healthcare Appraisers

Track E – Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Keys to Transforming Surgery Centers Into a Profitable Business - Jim Freund, Senior Vice President, GENASCIS and Matt Searles, Managing Partner, Merritt Healthcare

1:45 – 2:15 pm
Operational Best Practices - Sarah Martin, MBA, RN, CASC, Regional Vice President, Operations, Meridian Surgical Partners

2:20 – 2:50 pm
Coding Tools to Capture, Code and Improve Billings in the High Volume Orthopedic Center - W. Harwood Runner, CEO, Kerlan-Jobe

2:55 – 3:25 pm
Supply Chain Management - How to Work with Suppliers - Scott McDade, Vice President, Surgery Center Sales McKesson Medical, Jim Ricchini, Marketing Manager, Ambulatory Surgery & Oncology Markets, B. Braun

3:30 – 4:00 pm
How to Combine in Network and Out of Network Reimbursement, Caryl Serbin, RN, BSN, LHRM, Executive Vice President and Chief Strategy Officer, Source Medical Solutions, Inc. and Nancy Easley-Mack LPN, Business Office Manager, Short Hills Surgery Center

4:05 – 4:35 pm
Value Priced Implants for Orthopedic and Spine Surgery - Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute, and Blair A. Rhode, MD, Orland Park Orthopedics

Track F – Quality, Infection Control, Accreditation, Management

1:00 – 1:40 pm
Dealing with Difficult Physicians - Michael R. Redler, MD, The OSM Center, Introduced by Holly Ramey, Vice President of Operations, Surgical Care Affiliates

1:45 – 2:15 pm
How to Effectively Measure and Track Patient Quality - David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

2:20 – 2:50 pm
Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs - Raymond E. Grundman, MSN, MPA, Senior Director, External Relations, Accreditation Surveyor, AAAHP

2:55 – 3:25 pm
Infection Control in ASCs - Best Practices and Current Ideas - Cassandra Speier, Senior Vice President of Operations, NovaMed, Inc.

3:30 – 4:00 pm
TBD

4:05 – 4:35 pm
TBD

Friday, June 10, 2011

7:00 – 8:00 am
REGISTRATION and CONTINENTAL BREAKFAST

GENERAL SESSION

8:00 am
Introductions - Scott Becker, JD, CPA, Partner – McGuireWoods LLP

8:15 – 8:55 am - Keynote
The Changing Face of Healthcare Delivery - What to Expect Over the Next Ten Years - Joe Flower, CEO, The Change Project

9:00 – 9:35 am
The State of The ASC Industry - Andrew Hayek, CEO, Surgical Care Affiliates

9:40 – 10:15 am
The Best Ideas for Orthopedic, Spine and Pain Management-Driven ASCs - Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners, Larry Taylor, President & CEO, Practice Partners in Healthcare, Jeff Leland, CEO, Blue Chip Surgical Center Partners, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

10:15 – 11:00 am
Networking Break & Exhibits

Track A

11:00 – 11:40 am
Key Priorities for the ASC Association - William Prentice, JD, Executive Director, ASC Association

11:45 – 12:30 pm
Healthcare Reform and Its Impact on ASCs and Healthcare Delivery - Paul Savoca, M.D., Fairfax Colon & Rectal Surgery, Brent W. Lambert, MD, FACS, Principal & Founder, ASCOA, William Prentice, JD, Executive Director, ASC Association, Moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track B

11:00 – 11:40 am
Spine Surgery - The Next Five Years - James Lynch, MD, Surgery Center of Reno, Introduced by Chris Zorn, Vice President, Sales, Spine Surgical Innovation

11:45 – 12:30 pm
Key Concepts to Improve the Profitability of Spine Programs - John Caruso, MD, FACS, Neurosurgeon, Parkway Surgery Center and Jeff Leland, CEO, Blue Chip Surgical Partners

Track C

11:00 – 11:40 am
Orthopedics - The Next Five Years - John Cherf, MD, MPH, MBA, President, OrthoIndex

11:45 – 12:30 pm
ACO's - An Overview of What to Expect and How to Prepare - Andrew Hayek, CEO, Surgical Care Affiliates

Track D

11:00 – 11:40 am
Keys to a Successful Turnaround of a Physician/ Hospital Joint Venture ASC - Tom Fry, MD, Board Member Lutheran Campus ASC, Karen Scremin, VP of Finance, Exempla Lutheran Medical Center, Diane Lampron, RN, BSN, CNOR, Administrator, Lutheran Campus ASC, and Director of Operations, PINNACLE III

11:45 – 12:30 pm
Hospital Within A Hospital Joint Venture - Case Study - Dennis Martin, Senior Vice President of Health Systems, Health Inventures, LLC

Track E

11:00 – 12:30 pm
A 90 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, CFO, and Ann Geier, RN, MS, CNOR, CASC, ASCOA

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

Concurrent Sessions A, B, C, D, E, F
Track A – Orthopedics and Spine

1:30 – 2:00 pm
Assessing the Profitability of Orthopedics and Spine Cases - Vivek Taparia, Director of Business Development, and Matt Lau, Director of Financial Analysis, Regent Surgical Health

2:05 – 2:35 pm
The Future of Minimally Invasive Spine Surgery - Why a Spine-Focused ASC is Important - Richard Hynes, MD, Orthopedic Surgeon, Melbourne, FL

2:40 – 3:10 pm
An Analysis of Clinical Outcomes for Spine - Procedures Performed in ASCs - Ken Pettine, MD, Loveland Surgery Center

3:10 – 3:40 pm
Networking Break & Exhibits

3:40 – 4:10 pm
How To Achieve Great Results for Spine Surgery/ Neurosurgery in an ASC - Joan F. O'Shea, MD, Neurosurgeon & Orthopedic Spine Surgeon, The Spine Institute of New Jersey

4:15 – 4:45 pm
Minimally Invasive Outpatient Lumbar Fusions and Multi-Level Outpatient Cervical Disk Replacements - Robert Nucci, MD, Citrus Park Surgery Center, Tampa, FL

4:50 – 5:20 pm
Is There a Place for Orthopedics in ACOs? - Michael Redler, MD, The OSM Clinic

Track B – Orthopedic and Spine ASC and Clinical Issues

1:30 – 2:00 pm
Current Issues in Orthopedics and ASCs - Michael Redler, MD, The OSM Clinic, and John Cherf, MD, MPH, MBA, President, OrthoIndex

2:05 – 2:35 pm
Establishing and Operating Successfully in a Small Market - Joseph Zasa, JD, Partner, ASD Management, and TK Miller, MD, Associate Professor, Dept. of Surgery, VTC School of Medicine, Medical Director, Roanoke Ambulatory Surgery Center, Carilion Clinic Orthopaedics/Sports Medicine

2:40 – 3:10 pm
Handling Complex Spine Cases in an ASC, Clinical and Financial Issues - Marcus Williamson, President, Neospine Division, Symbion, Inc.

3:10 – 3:40 pm
Networking Break & Exhibits

3:40 – 4:10 pm
Key Developments in Cartilage Restructuring - Brian Cole, MD, MBA, Professor, Department of Orthopedics, Department of Anatomy and Cell Biology Section Head, Cartilage Restoration Center at Rush Division of Sports Medicine, Rush University Medical Center

TO REGISTER, CALL (703) 836-5904 • FAX (703) 836-2090 • EMAIL registration@ascassociation.org
Register Online at https://www.ascassociation.org/june2011.cfm

4:15 – 4:45 pm
Biologic Joint Replacement: The Future of Joint Replacement Surgery Using Stem Cells Paste Grafting, Meniscus Allografts, Shell Grafting and Allo and Xenograft Ligaments - Kevin R. Stone, MD, The Stone Clinic

4:50 – 5:20 pm
Hand Surgery in ASCs - Key Concepts for Clinical and Financial Success - R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

Track C – Joint Ventures, Co-Management, Orthopedic and Pain Management

1:30 – 2:00 pm
Role of Workers' Compensation in a Spine Focused ASC - John DiPaola, MD, Orthopedist, Oregon, and Scott Gibbs, MD, Neurosurgeon, Cape Girardeau, MO

2:05 – 2:35 pm
Key Tips for Success - Orthopedics in ASCs - What Works and What Doesn't - Greg Deconciliis, Administrator, Boston Out-Patient Surgical Suites

2:40 – 3:10 pm
Pain Management in Offices and ASCs: Best Practices and Business Guidance and New Ideas - David Kadish, President, Medi-Corp, Inc., and Leslie Johnson, Director of Coding and Education for Medi-Corp and Founder of Askleslie.Net

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Co-Management Arrangements - Stuart Katz, Executive Director, FACHE, CASC, Tucson Orthopedic Surgery Center

4:15 – 4:45 pm
A Roundtable on Joint Ventures - Allen Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President Development & Acquisitions, ASCOA

4:50 – 5:20 pm
Business and Financial Relationships with Hospitals - Co-Management, Joint Ventures and Employment - Ed Hetrick, President & CEO, Facility Development Management

Track D – Physician Owned Hospitals, Orthopedic Practices

1:30 – 2:00 pm
The Best Ideas Now; 3 Ways to Improve Physician Owned Hospital Profits - Tom Mallon, CEO, Regent Surgical Health, Paul Kerens, Senior Executive Officer, Kansas City Orthopaedic Institute, Michael J. Lipomi, Surgical Management Professionals

2:05 – 2:35 pm
Reducing Implant Costs - Terry L. Woodbeck, CEO Tulsa Spine and Specialty Hospital

2:40 – 3:10 pm
Physician Owned Hospitals - A Prognosis and Plan for the Next Four Years - Brett Gosney, CEO, Animas Surgical Hospital

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Key Legal Issues Facing Physician-Owned Hospitals - Scott Becker, JD, CPA, Partner, and Amber Walsh, Partner, McGuireWoods LLP

4:15 – 4:45 pm
Key Ideas for Improving Orthopedic Practice Profits - David Wold, Chief Operating Officer, Illinois Joint & Bone Institute

4:50 – 5:20 pm
Orthopedic Practices - How to Explore Strategic Options - Stay the Course or Sell - Marshall Steele, MD, CEO, Marshall Steele

Track E – Managed Care, Reimbursement and Syndication Issues

1:30 – 2:00 pm
Orthopedic and Spine Contracting - A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors - I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting & Management

2:05 – 2:35 pm
Best Practices in Physician Syndication - Michelle Trammell, President, and Chase Neal, Vice President, The Securities Group, Larry Taylor, President & CEO, Practice Partners in Healthcare

2:40 – 3:10 pm
Key Concepts for Conducting Internal Investigations - Scott Becker, JD, CPA, Partner, David J. Pivnick, Associate, and Lainey Gilmer, Associate, McGuireWoods LLP

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Improving Managed Care, Contracting Results - A Case Study Step by Step Approach - I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting and Management

4:15 – 4:45 pm
Billing Process Improvement 101 - Bill Gilbert, Vice President Marketing, AdvantEdge Healthcare Solutions

4:50 – 5:20 pm
10 Ways to Improve an ASCs Coding - Document Deficiencies, Financial Impacts and How to Work with Physicians, - Kelly Webb, Director, ASC Billing

Track F – Reducing Costs, Market Consolidation, Hiring, and Golf

1:30 – 2:00 pm
Avoiding Critical ASC Mistakes: Hiring Great Staff, Reducing Hours Per Case, Physician Utilization - Joyce Deno Thomas, RN, BSN, Senior Vice President, Operations, and Robert Welti, MD, Senior Vice President, Operations, Regent Surgical Health

2:05 – 2:35 pm
Can an ASC Improve Profits Through Market Consolidation - William J. L. Kennedy, MBA, SVP Business Development, NovaMed, Inc., and Michael Weaver, Vice President, Symbion, Inc.

2:40 – 3:10 pm
Three Ideas to Streamline Costs and Improve Profits - Jeff Blankinship, President, Surgical Notes, Tom Jacobs, President & CEO, MedHQ, Bill Cramer, CEO, Access MediQuip

3:10 – 3:40 pm
Exhibit Hall Break

3:40 – 4:10 pm
Top Traits of ASC Leaders and How to Recognize Them - Greg Zoch, Partner, Kaye-Bassman

4:15 – 4:45 pm
How to Immediately Improve Your Golf Swing, Aaron Bergman, PGA Golf Pro

4:50 – 5:20 pm
Hiring Winners Not Whiners - Tracy Hoeft-Hoffman, Administrator, Hastings Surgical Center

5:20 – 7:00 PM
Cocktail Reception, Cash Raffles and Exhibits

Saturday, June 11, 2011

7:00 – 8:10 am – Continental Breakfast
General Session

8:10 – 8:55 am
Leveraging Ideas from Other Industries to Improve ASC Profits - W. Michael Karnes, Chief Financial Officer, Regent Surgical Health, and Michael Rucker, EVP and COO, Surgical Care Affiliates

Track A

9:00 – 9:45 am
Buying and Selling ASCs - HOPDs and National Companies, Co Management and ACOs - Current Market Trends - Scott Becker, JD, CPA, Partner, Scott Downing, JD, Partner, and Amber Walsh, Partner, McGuireWoods LLP

9:50 – 10:50 am
How and Why Might Orthopedists and Neurosurgeons Team and Partner to Create Musculoskeletal Centers of Excellence - John Caruso, MD, Neurosurgeon, Parkway Surgery Center

10:55 – 11:55 am
Lessons Learned - What Did I Do Right and What Might I Do Differently When Creating a Spine ASC? - John Caruso, MD, Neurosurgeon, Parkway Surgery Center, Scott Gibbs, MD, Neurosurgeon, Cape Girardeau, MO, Richard Hynes, MD, Orthopedic Spine Surgeon, Melbourne, FL, Moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners

Track B

9:00 – 9:45 am
New Advances in SacraIliac Joint Problems - Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute

9:50 – 10:50 am
Pain Management in ASCs - Current Ideas to Increase Profits - Amy Mowles, President & CEO, Mowles Medical Practice Management

10:55 – 11:55 am
Threats to Physicians and Strategies to Protect Your Practice and Investment - Robert M. Schwartz, Executive Director, Proliance Surgeons, Inc.

Track C

9:00 – 9:45 am
Clinical Excellence Every day: Director of Nursing 101; Lesson Learned from Overseeing 100 Plus Centers - Linda Lansing, Senior Vice President of Clinical Services, Surgical Care Affiliates

9:50 – 10:50 am
Accrediation, A 60 Minute Workshop – HFAP

10:55 – 11:55 am
Given the Economic Downturn, Why Now is Actually a Great Time to Develop a Facility - John Marasco, AIA, NCARB, Principal & Owner, Marasco & Associates

Track D

9:00 – 9:45 am
The Best Ideas to Immediately Improve ASC Profits - Sandra Jones, MBA, MS, CASC, FHFMA, Chief Executive Officer, Executive Vice President, ASD Management, Monica Ziegler, Administrator, Physicians Surgical Center, Susan Glendon-Bealieu, RN, LHRM, Administrator, Surgical Center for Excellence, Kara Vittetoe, Administrator, Thomas Johnson Surgery Center, ASCOA

9:50 – 10:50 am
Physicians, Hospitals, and Management Companies - What it Takes to Make a Winning Partnership and ASC - Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

10:55 – 11:55 am
Short and Long Term Strategic Planning and Setting Annual Goals and Objectives - John Goehle, CASC MBA CPA, Ambulatory Healthcare Strategies, LLC

Track E

9:00 – 9:45 am
Information Technology for Surgery Centers – Achieving Positive Outcomes and Avoiding Complications - Marion Jenkins, PhD, Founder & CEO, QSE Technologies, Inc., Todd Logan, Vice President Sales - Western Region, and Ron Pelletier, Vice President, SourceMedical

9:50 – 10:50 am
ASC Litigation, Non Competition, Employee Litigation and Other Kinds of Litigation, Key Thoughts - Jeffrey C. Clark, Partner, and David J. Pivnick, Associate, McGuireWoods LLP

10:55 – 11:55 am
Coding Inaccuracies That May Put an ASC or Practice at Risk With the OIG and RACs - Pain Management Medical Necessity/Over-Reporting, Orthopedic Incorrect Reporting on Knees and Shoulders, Spine Overstating Work/Unbundling - Cristina Bentin, CCS-P CPC-H CMA, President Coding Compliance Management

GENERAL SESSION

12:00 – 1:00 pm
ASC Safe Harbor Redemptions, Physician Compensation Compliance, Internal Investigations, and Increased Government Investigations - Scott Becker, JD, CPA, Partner, Gretchen Townshend, Associate, and Sarah Chacko, Associate, McGuireWoods LLP

1:00 pm - Meeting Adjourns

TO REGISTER, CALL (703) 836-5904 • FAX (703) 836-2090 • EMAIL registration@ascassociation.org
Register Online at https://www.ascassociation.org/june2011.cfm

Register by May 1, 2011 and SAVE!

9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

Improving Profitability and Business and Legal Issues

Great topics and speakers focused on key business, clinical and legal issues facing ASCs –

- 101 Sessions
- 134 Speakers

To register, contact the Ambulatory Surgery Foundation
(703) 836-5904 • Fax (703) 836-2090
registration@ascassociation.org

Register Online:
https://www.ascassociation.org/june2011.cfm

Improving the Profitability of Orthopedic, Spine and Pain Management-Driven ASC – Thrive Now and in the Future

- Coach Mike Ditka, Legendary NFL Player and Football Coach
- Brent Lambert, MD, Founder Ambulatory Surgical Centers of America
- Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners
- Tom Mallon, CEO, Regent Surgical Health
- Scott Gibbs, MD, Neurosurgeon, Cape Girardeau, MO
- Jeff Leland, CEO Blue Chip Surgical Center Partners
- David Shapiro, MD, AMSURG
- Joan F. O'Shea, MD, Neurosurgeon & Orthopedic Spine Surgeon, The Spine Institute of New Jersey• John Caruso, MD, Neurosurgeon, Parkway Surgery Center
- I. Naya Kehayes, CEO, Eveia Health Consulting and Management
- Robin Fowler, MD, Medical Director, Interventional Management Services
- Kevin R. Stone, MD, The Stone Clinic
- Joseph Zasa, CEO, ASD Managment
- Joe Flower, Healthcare Futurist, CEO, The Change Project, Inc.
- Richard Hynes, MD, Orthopedic Spine Surgeon, Melbourne, FL
- Larry Taylor, CEO, Practice Partners in Healthcare
- Andrew Hayek, President and CEO, Surgical Care Affiliates
- Brett Gosney, MD, CEO, Animas Surgical Hospital
- John Cherf, MD, MPH, President, OrthoIndex, Clinical Advisor, Sg2, Orthopedic Surgeon, Chicago Institute of Orthopedics
- Michael R. Redler, MD, The OSM Center
- Brian Cole, MD, MBA, Professor, Dept. of Orthopedics, Dept. of Anatomy and Cell Biology, Section Head, Cartilage Restoration-Center at Rush Division of Sports Medicine, Rush University Medical Center
- Terry Woodbeck, CEO, Tulsa Spine & Specialty Hospital
- TK Miller, MD, Associate Professor, Dept. of Surgery, VTC School of Medicine, Medical Director, Roanoke Ambulatory Surgery Center, Carilion Clinic Orthopaedics/Sports Medicine

To join the ASC Association call (703) 836-8808

For more information, call (800) 417-2035 or email sbecker@mcguirewoods.com

If you would like to sponsor or exhibit at the program, please call (800) 417-2035.

TO REGISTER, CALL (703) 836-5904 • FAX (703) 836-2090 • registration@ascassociation.org

TO REGISTER, CALL (703) 836-5904

REGISTRATION FORM

Photocopies are acceptable. Please print or type below. Please use a separate registration form for each attendee.

9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference

Improving Profitability and Business and Legal Issues

THE 9TH ANNUAL CONFERENCE FROM ASC COMMUNICATIONS AND THE AMBULATORY SURGERY FOUNDATION

JUNE 9-11, 2011

WESTIN HOTEL • CHICAGO, ILLINOIS

REGISTRATION INFORMATION

First/Last Name: _____

Degree (As you wish it to appear on your badge): _____

Title: _____

Facility/Company: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

REGISTRATION FEES

ANNUAL CONFERENCE & EXHIBITS

Receive multiple registrant discount(s). The more people you send, the greater discount you receive. The prices listed below are per person. Your registration includes all conference sessions, materials and the meal functions.

MAIN CONFERENCE ONLY

	FEES (Before 5/1/11)	AMOUNT	FEES (After 5/1/11)	AMOUNT
1st Attendee	$625	$ _____	$725	$ _____
2nd Attendee	$575	$ _____	$675	$ _____
3rd Attendee	$525	$ _____	$625	$ _____
4th Attendee or more	$500	$ _____	$600	$ _____

(Ask about larger group discounts)

MAIN CONFERENCE + PRE-CONFERENCE

	FEES (Before 5/1/11)	AMOUNT	FEES (After 5/1/11)	AMOUNT
1st Attendee	$825	$ _____	$925	$ _____
2nd Attendee	$775	$ _____	$875	$ _____
3rd Attendee or more	$725	$ _____	$825	$ _____
4th Attendee or more	$700	$ _____	$800	$ _____
Subtract $100 per Attendee if either a Paid ASC Association Member or Becker's ASC Review Paid Subscriber			(-$100)	$ _____
Add $100 to subscribe to Becker's ASC Review			(+$100)	$ _____

TOTAL ENCLOSED $ _____

PAYMENT INFORMATION

Enclosed is a check, payable to Ambulatory Surgery Foundation Check #: _____

I authorize **Ambulatory Surgery Foundation** to charge my: VISA MasterCard American Express

Credit Card Number: _____ Expiration Date: _____

Printed Cardholder Name: _____ Zip Code: _____

Signature: _____ CVV#/3-digit #: _____

TO REGISTER

COMPLETE REGISTRATION FORM AND MAIL OR FAX AS FOLLOWS:

Mail: **Make checks payable to Ambulatory Surgery Foundation June Conference** and mail to: Ambulatory Surgery Foundation Meeting Registration, 1012 Cameron St., Alexandria, VA 22314

Fax: Fax registration form with credit card information to (703) 836-2090

Call: Call (703) 836-5904 to register by phone

Email: registration@ascassociation.org

Web site: www.BeckersASC.com

REGISTER ONLINE AT: https://www.ascassociation.org/june2011.cfm

Cancellation Policy: Written cancellation requests must be received by May 1, 2011. Refunds are subject to a $100 processing fee. Refunds will not be made after this date.

Multi-Attendee Discount Policy: To be eligible for the discount, your ASC must be registered at one time and work at the same address. Just copy the registration form for each attendee. Employees from a 2nd location are not eligible for the discount.

GENERAL INFORMATION

HOTEL RESERVATIONS

Westin Hotel has set aside special group rates for conference attendees. To make a reservation, go to **http://www.starwoodmeeting.com/Book/ascjune2011**

The Westin
909 N. Michigan Avenue
Chicago, IL 60611
(312) 943-7200
Group Room Rates: $289

ASC ASSOCIATION

For ASC Association membership information please call (703) 836-8808, or visit www.ascassociation.org

CONFERENCE QUESTIONS

For additional information or questions regarding the conference please contact

Ambulatory Surgery Foundation
Phone: (703) 836-5904
Fax: (703) 836-2090
Email: registration@ascassociation.org

For *Becker's ASC Review* and exhibitor/sponsorship questions contact (800) 417-2035

ASC Communications, Inc.
(800) 417-2035

ADA REQUEST

If you require special ADA accommodations, please contact us at (703) 836-5904

ONLINE REGISTRATION

https://www.ascassociation.org/june2010.cfm

Register before May 1, 2011, and SAVE on registration!

For information on exhibiting and sponsorships, call (800) 417-2035

Visit www.BeckersASC.com.

4 Mistakes That Cause Surgery Centers to Fail

By Rachel Fields

Rob Murphy, founder and CEO of Murphy Healthcare Group and founder of ASC Turnaround Group, discusses four critical mistakes that spell failure for an ambulatory surgery center.

1. Too many rooms, not enough cases. According to Mr. Murphy, one of the top reasons for ASC failure involves over-building the center and failing to staff enough surgeons or bring in enough case volume. "We've been called into situations where ASCs were built with five operating rooms that only needed one or two," he says. "The ongoing costs of maintaining these large physical plants can really eat away at the profits." He says in extreme cases, partners are required to write checks to the ASC to keep it afloat financially — a major red flag that the ASC is failing and urgently needs outside help.

2. Poor managed care contracts. Mr. Murphy says many ASCs fail financially because they rely on poor managed care contracts. A center that consistently loses money on cases can approach bankruptcy rapidly. In the process of turning around a failing ASC, Mr. Murphy says his team reviews managed care contracts and often decides to re-negotiate the contracts or terminate them completely.

3. Failure to bring in complex, high-paying ASC cases. In order to succeed, an ASC needs to change and develop when necessary, Mr. Murphy says. "Failure to constantly bring in more complex, higher-paying ASC cases puts the facility behind the curve," he says. "This would be the equivalent of running a restaurant with the same limited menu year after year." He says in order to maintain strong ongoing profits, ASCs must make sure to stay ahead of the competition by adding profitable procedures that may not be available elsewhere. "Some examples include major spine cases, joints (i.e. total hips), brachytherapy, lithotripsy, ENT navigation guided procedures and, more recently, platelet rich plasma therapy," he says.

4. Out-of-control costs. Even if an ASC is bringing in profitable cases and recruiting new surgeons, the problem of out-of-control costs could still mean major financial leakage. "For example, if an ASC doesn't know its costs per minute of OR time, it can't know whether cases are profitable or money-losers," Mr. Murphy says. Much of the time, he says out-of-control costs can be attributed to a lack of professional, hands-on management, or team members who will diligently look at center data and track trends over time. If the center is losing money on unprofitable cases, sloppy supply management, staffing costs or other high-cost factors, administration needs to know immediately. ■

Learn more about Murphy Healthcare and ASC Turnaround Group at www.murphyhealthcare.com.

Owning a Surgery Center: The Best Investment I Will Ever Make

By Philip Pearson, MD, Colon and Rectal Surgery, The Surgery Center of the Mainline, Bryn Mawr, Pa.

Like a lot of younger surgeons, I considered it a very big decision when presented with the opportunity to invest in an ASC. In fact, my initial instinct was to pass on the opportunity. As a 40-year-old surgeon only three years into practice (and after 12 years of either tuition or meager pay in medical school, residency and fellowship), I really didn't feel like I had the financial resources to make the initial investment.

Looking at the business today, I'm confident that this will be the best investment I will ever make. Frankly, it's been a great professional and personal decision. I could not be prouder or happier to be a part owner of the Surgery Center of the Main Line, a multi-specialty facility in suburban Philadelphia. I love bringing my patients here because I know they will receive quality care in a comfortable environment. And the future prospects for the business are terrific.

However, looking back, my initial hesitation was understandable, given my relative lack of business expertise and the many factors to consider. I was dealing with all the common issues young surgeons face — developing a practice, creating professional networks and trying to support a young and growing family.

Let me be clear — I would encourage young surgeons to invest in ASCs, but they should also be thorough in their due diligence. Don't underestimate the upside, but be realistic about the risks. Obviously, patients come first, but you must recognize that this is a business. Ask your peers and colleagues a lot of questions and clearly assess your potential partners (both the doctors and business advisors). Do you trust these people? Take a look in the mirror to consider your personal and professional goals as well as your ability to contribute to a successful business. And definitely don't forget to talk to your spouse!

Opportunity knocks

Several years ago, when the surgery center had been open a couple of years, I had an opportunity to purchase an ownership stake at the initial buy-in rate. Initially, I was very hesitant to proceed. I really thought that the investment was too big for me to make. And there were so many unknowns about the business that I did not feel comfortable saying yes at first. Though the business was doing well, I kept asking myself, "What if it somehow goes wrong due to market forces or political shifts or just bad luck? Would I lose my house? Was I taking money away from my family to make this investment?" I have two beautiful daughters, ages seven and nine. I think about them — and think twice about them — before I do anything!

Rationally, I didn't think the business would fail, but there were still some big ifs. I didn't have the business knowledge or training to understand all the variables. So, even though I had a great deal of respect for the other surgeon-owners, I hesitated for several months, and I did not accept the invitation to become a partner immediately.

This allowed me some time to think about the positive aspects of becoming a partner. Certainly I performed a lot of cases there, and it quickly became my favorite place to do cases and scopes. Thanks to the center's excellent nursing staff and highly efficient overall operations, the environment was very comfortable for my patients. Plus, it was fun. I always enjoyed walking in the door and seeing my colleagues and co-workers in the morning. It exactly met my need for outpatient block time for anorectal surgery and colonoscopies. The fact that it is geographically positioned halfway between my two offices and hospitals makes it convenient, too.

Before making my decision to move forward with the process, I knew I needed more information and insights from knowledgeable people.

Conducting due diligence

I met with Karla German, the ASC's administrator, and Jay Rom of Blue Chip Surgical Center Partners, the management firm who'd been partners in the surgery center since day one. It was clear they wanted me to join, which was gratifying. It was just as clear they were serious about growing the business, which was already doing well. And having seen the business in action I could see why it was successful.

I reached out to several colleagues who are involved with similar centers around the country and asked their opinions. Most said, "Make sure to conduct your due diligence, but these things can be very lucrative." I asked the manager of my private practice to take a look at the numbers. When I shared details, everyone agreed that the business seemed to be on sound footing.

I reviewed financial statements with the administrator and the Blue Chip team. Some of the data was hard to grasp. Like I said, I am not a business-minded person — financial terms such as EBITDA sound like Greek to me. But everyone was patient with me and answered my questions. No one gave me the hard-sell or pressured me to make a decision. Nor did anyone talk down to me. All the scenarios were explained clearly and thoroughly. The more I learned, the more my anxiety was reduced.

I also spoke with a number of partners at Main Line before I took the leap. One of the partners finally said, "Look, there is a very strong team here and a solid operational base. Very successful and senior surgeons have invested. It's highly unlikely that your worst fears will be realized."

This was simple and solid logic, and it reflected my own experience. The place ran like clockwork — Swiss clockwork, in fact — as I'd seen with my own eyes. "Try before you buy" makes sense. It's a very good idea for young surgeons to perform cases at a center before investing in it.

So, after asking Blue Chip 10 or 15 of the same questions again and consulting with my wife a few more times, I decided to take out a loan and become a partner.

What partnership means to me

I had an advantage in that I already knew most of the surgeons and felt comfortable working with them. These were some of the top-performing physicians with great reputations in the Philadelphia area. I am fortunate

to call them partners. They welcomed me into the business, congratulating me on my decision to invest. Even though I bought in at a smaller stake than the initial partners, I feel my viewpoints are valued and heard. It's a very collegial atmosphere, which I greatly appreciate.

Still, in the end, it really isn't about the personalities of the other physicians or that everybody gets along famously. It's about the amount of business each surgeon can bring and a collective commitment to great outcomes and a quality patient experience. Given the choice between a nice guy who has no cases and a prickly guy who brings in tons of business and is a solid surgeon, I guess I'd choose the prickly guy — although that might make board meetings more unpleasant.

While the "upside potential" was made clear to me from the very first meetings, I still find the projections surprising. Actually, they're amazing. There are days I cannot believe how profitable this business will be. When I look at how much I invested, and then figure out how much can come back to me if the business does well — it's just extraordinary. And there's every reason to believe the business will continue to do well.

Translating to my personal life, my partnership means a significant financial cushion, the ability to pay back some loans and the opportunity to get ahead of my girls' educational budgets. With this investment, private education for my girls is a lot more manageable.

Bottom Line: A great decision and a bright future

These days, most physicians know that outpatient surgery centers can be terrific environments to treat patients, and that they can be very lucrative businesses, too. Looking back, my decision to invest looks like a no-brainer. But I think many development and management companies and established physicians may not realize just how big a decision it can be for up-and-coming surgeons. It's a major responsibility to take on. There are just so many things to think about.

For instance, it takes a lot of courage and foresight to invest in the development of a new center when there are a) no buildings, b) no employees and c) no patients. If you are considering investing in an existing center, you must consider the other partners and staff, and try to get a clear sense of the numbers and overall state of the business. And you have to ask yourself if you're comfortable becoming a junior partner, if that's the offer on the table. For all of these reasons, "dating" the center before "marrying" it is a very good idea; that is, you should do a good number of cases there before investing.

Obviously, nobody knows what the future will bring. But barring major policy or legal changes in the rules governing ASCs, I would wholeheartedly recommend that young surgeons invest in ASCs. Of course, I'd stipulate that the surgeon must be committed to clinical excellence and bring a solid and steady flow of cases to the center, and that their caseload contribute to a strong mix.

I couldn't be happier with the decision I made. I thought it through carefully, consulted with colleagues, asked lots of questions, did some soul searching and talked to my wife. I have a very good feeling that investing in Surgery Center of the Main Line will be the best investment I will ever make in my life. I'm serious when I say that. And, even better, it's an investment I made for all the right reasons. ■

Thank you to Blue Chip Surgical Center Partners for arranging this article. Learn more about Blue Chip at www.bluechipsurgical.com.

CMS Adjusts 2011 Medicare Conversion Factor for Physician Fees

By Leigh Page

Even though Congress approved a zero percent update for Medicare physician fees in 2011, the CMS calculation for the 2011 conversion factor represents a 7.8554 percent cut, according to a report by the Idaho Medical Association.

The reduction is necessary to account for changes to the RVUs, such as the misvalued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights.

The revised conversion factor, effective Jan. 1, 2011, is $33.9764, compared with the FY 2010 conversion factor of $36.8729. CMS has directed implementation for "no later than" Jan. 14, 2011.

The CMS announced the change in a transmission titled, "Emergency Update to the CY 2011 Medicare Physician Fee Schedule (MPFS) Database."

To read the CMS transmission on the 2011 conversion factor, go to www.cms.gov/transmittals/downloads/R828OTN.pdf. ■

Contact Leigh Page at leigh@beckersasc.com.

3 Common Complaints From ASC Physicians — And How to Avoid Them

By Rachel Fields

Augusto Alinea, MD, medical director of the Ambulatory Surgery Center of Stevens Point, discusses three common physician complaints and how to approach them.

1. Scheduling dilemmas. According to Dr. Alinea, the biggest complaint from ASC physicians generally relates to scheduling problems. "I'm one of the physicians that does procedures, so I guess I can speak firsthand: we like to do our cases at a convenient time," he says. "To do that for each and every provider in the ASC is rather difficult, so we need to have blocked time and schedule the OR efficiently, such that people are not delayed." He says problems with scheduling waste providers' time and will ultimately anger your physicians.

2. Slow turnover times. Dr. Alinea says physicians can also become frustrated if turnover times are inefficient at your ASC. ASCs, which are naturally more efficient than hospitals, must depend on their efficiency and tighten turnover time to attract and keep quality physicians. Dr. Alinea says at his ASC, physicians are involved in the process of selecting employees, so providers know from the start who will be affecting OR efficiency. He says the ASC also tracks data on turnover times and benchmarks the center's efficiency over time.

3. Efficiency decreases as volume increases. Increasing case volume is a priority for most ASCs, but physicians and administrators should keep an eye on efficiency as the center gets busier, Dr. Alinea says. "We don't want to get lackadaisical," he says. "As we get busier, there's going to be a bit more confusion." He says ASCs can prevent negative changes during busy periods by inviting physicians to sit down regularly to talk about the center's issues. The center's medical director can also invite physicians to stop by anytime and voice concerns about drops in efficiency or other problems. By keeping these lines of communication open, Dr. Alinea says your center can avoid missing a critical problem until it has significantly harmed your center's efficiency or revenue. ■

Contact Rachel Fields at rachel@beckersasc.com.

Surgery Center Benchmark for Waiting Room Times: Q&A With Ann Geier and Susan Kizirian of ASCOA

By Rob Kurtz

Ann Geier, MS, RN, CNOR, CASC is senior vice president of operations and Susan Kizirian is chief operating officer for ASCOA.

Q: What is a good benchmark for waiting room times for patients after they check-in and before they go to pre-op?

Ann Geier and Susan Kizirian: This is probably the main complaint from patients on the patient satisfaction survey, so it's something centers should not ignore. It is difficult to give a firm goal for the time, as there are several factors that affect the times allotted.

- **Physicians' request** — Many physicians want patients brought in every 15 minutes so that they don't have to wait between cases. This is usually true of ophthalmology, GI and pain management physicians. They believe that they do cases so quickly, if we don't bring patients in every 15 minutes, they will have to sit and wait between cases. The reality is that they have cases that are longer than others, and this has a domino effect. Therefore, the patients scheduled third or fourth in line may start to have a longer wait, and this snowballs. We've seen patients have to wait two hours in the lobby or pre-op because of this. There are unforeseen circumstances that occur (i.e., a cancellation) and having the patients there early allows you to move them up, so you do need to consider this.
- **Historical case times** — Most computer systems allow the center to track historical case times per physician per CPT code. This allows the cases to be scheduled more accurately in the system, and arrival times can be adjusted accordingly. Physicians don't always believe these times, but data is powerful, and this can be discussed with physicians to help them understand why the center is scheduling arrivals as they do.
- **Pre-op space may be limited** — If this is the case, bringing the patients in early may mean that they are sitting in the lobby longer. They perceive this as a waste of time. The center can accomplish some tasks before bringing them to pre-op: taking vital signs, completing the pre-assessment paperwork, etc. When the patient is brought to pre-op, they can change clothes, take pre-op meds and have an IV started.

We think the main issue is knowing how quickly patients can be admitted, and knowing this by specialty. Take that into consideration and make sure the communication between patient, physician and admitting nurses is updated frequently.

We think that when a patient arrives at the center, they should be immediately acknowledged by the receptionist and checked in within 5-10 minutes of arrival. At that point, they would be told to expect to be taken to pre-op within 15-30 minutes (depending on specialty), and if it will be longer, someone will update them. ■

Learn more about ASCOA at www.ascoa.com.

Nevada Surgery Centers See Nearly 300% Increase in Inspection Fees

By Rob Kurtz

Nevada legislators have passed a regulation which will increase ambulatory surgery center licensing fees almost 300 percent to help cover the cost of mandated facility inspections, according to a report from the *Las Vegas Review-Journal.*

The fee to operate an ASC is now $9,784, up from $3,570, following a Jan. 13 vote by the Legislative Commission's Subcommittee to Review Regulations. Rural and urban hospital fees also increased significantly as a result of the passed regulation.

The state had indicated if fees were not increased, it would be forced to lay off 13 health facility inspectors. This would have brought the Bureau of Health Care Quality and Compliance, which oversees the inspections, to a 50 percent operating capacity, according to the report. A reduction in manpower would have led to a significant drop in the number of regular inspections — which became required by law in 2009 following the 2008 hepatitis C outbreak in Las Vegas. ■

Contact Rob Kurtz at rob@beckersasc.com.

4 Ways Anesthesia Provision Will Change in the Next Five Years

By Rachel Fields

Jerry A. Cohen, MD, president-elect of the American Society of Anesthesiologists, discusses four ways the role of anesthesiologists will change over the next five years.

1. Anesthesiologists should be used as peri-operative physicians. According to Dr. Cohen, anesthesiologists are in a good position to become the "peri-operative physicians" necessary for quality patient care in the coming years. "This trend has been evolving for a large number of years," he says. "People think of anesthesiologists as the folks who just go to the OR and put patients to sleep, but the details of medical management are extensive, and the threats to patients during operation are intense as well." He says over the last 5-10 years, the American Board of Anesthesiologists has increased the length of residency for anesthesiologists-in-training and expanded the curriculum to include requirements for pain management and intensive care.

More and more, he says, patients are staying in the hospital post-operatively because a high level of care is required after surgery. Given the costs associated with surgery, efficiency and the prevention of complications will be paramount to saving money in the future. "The prevention of complications such as nausea as well as decreasing the length of stay all require a model that embraces the peri-operative pathway," he says. "Hospitalists are not a match for the surgical pathway because they don't have any contact with the sharp end of surgical care, so to speak."

He says the ability to improve efficiency and safety will become very important as global payments become related to episodes of care rather than procedures. Anesthesiologists can make a significant impact on improved efficiency going forward as managers of the "peri-operative pathway" that handle the entire process of surgical care.

2. Patients will undergo fewer referrals in the pre-operative evaluation process. Dr. Cohen says the healthcare industry will see a greater emphasis on pre-operative evaluation as facilities endeavor to improve quality and save money by conducting thorough screening and reducing cancelled case numbers. "Some of the preparation that may have been done classically by the patient's surgeon will be taken over by the anesthesiologist," he says. According to Dr. Cohen, this could mean fewer referrals during the pre-operative evaluation because the anesthesiologist will be able to complete the evaluation without the expertise of other specialists.

"If [anesthesiologists] do the pre-operative evaluation, we probably don't need to get anywhere near the number of consults other people would need in preparing the patient," Dr. Cohen says. "The patient's surgeon might need a cardiology consult and a pulmonary medicine consult, but if you send the patient to an anesthesia clinic staffed by an anesthesiologist, it's likely that all those things could be addressed by that one anesthesiologist." He says anesthesiologists have traditionally spent little time in the pre-operative evaluation area, but global payments may make the transition easier as fewer consults will mean money saved.

3. Anesthesia provision may increasingly move to the outpatient arena. As ASCs become more popular for elective and non-emergency surgeries, Dr. Cohen predicts anesthesia providers will increasingly move to ASCs. Traditionally, he says, anesthesiologists — like radiologists and pathologists — have been relatively attached to the hospital setting. "We may be moving away from hospitals more than into them," he says. "An awful lot of anesthesia and surgery is done at ASCs now, largely because patients like coming in, getting a procedure and leaving, and the complications that occur at hospitals are not as likely to happen at surgery centers."

He says anesthesia providers are also moving into office practices, where they work one-on-one with dentists, oral surgeons and others. According to Dr. Cohen, the historical "tight bond" between anesthesiologists and hospitals may diminish over the next few years as the safe, cost-effective nature of outpatient surgery becomes more attractive.

4. Rural communities will struggle to attract anesthesia providers without serious legislative changes. Rural areas across the country will struggle to attract primary care physicians and specialists in coming years as the number of insured patients increases.. "It's hard to attract both physicians and nurses to rural practices," Dr. Cohen says. "Both of them want to live in urban areas, and that's clearly the reason that rural practices have a problem recruiting." He adds that a loophole in the federal payment rule allows small hospitals to charge directly for full anesthesia costs if the care is delivered by a nurse, making nurse-administered anesthesia more cost-effective for those hospitals and disincenting physicians from moving to those areas. "[The loophole] results in unequal care, and it results in different levels of safety from rural to urban hospitals," Dr. Cohen says. He adds that data has shown this incentive for nurses, as well as state "opt-outs" of physician supervision of anesthesia, have not actually attracted nurses to rural areas — rather, numbers of rural providers have remained relatively static over recent years.

If the payment loophole and state opt-outs don't work to attract anesthesia providers to critically underserved areas, Dr. Cohen says the industry must find an alternative. He says two current ideas — increasing payment for all providers or financing medical education with the stipulation that the provider spends a few years practicing in a rural area — will likely not result in an increase of rural providers. Instead, hospitals must work to effectively transport patients to nearby urban centers, a task more difficult for states where large cities are few and far between. "Hospitals do a lot better when they do a high volume and do things they're very familiar with," he says. "One of the safety problems in a rural area is that if you don't do things very frequently, you tend not to be as good at them. We need to concentrate on not just providing care in rural areas, but getting patients from rural areas to [urban centers] when they're stabilized." ■

Learn more about the American Society of Anesthesiologists at www.asahq.org.

JOIN THE ASC ASSOCIATION TO…

MAKE YOUR VOICE HEARD IN

- Washington
- The Media
- The Industry

USE OUR NATIONAL

- Salary Survey Report, including state-specific data
- Benchmarking Program
- Membership Directory

GET EVERY ISSUE OF *ASC FOCUS* MAGAZINE

GET MEMBER DISCOUNTS FOR THE ASC ASSOCIATION'S

- Publications
- Seminars and Webinars
- ASCs 2011 in Orlando, May 11–14
- Members-Only Compliance Hotline
- Career Center

CALL OR EMAIL OUR MEMBER SERVICES TEAM SPECIALISTS FOR ASSISTANCE WITH

- Medicare
- Compliance
- HIPAA
- Benchmarking
- State Issues
- Coding/Billing

JOIN TODAY!

www.ascassociation.org/join

Phone: 703.836.8808

Email: ASC@ascassociation.org

5 Opportunities for Gastroenterologists in 2011

By Rachel Fields

2011 will be a year of change and opportunity for GI physicians. Glenn Littenberg, MD, chair of the American Society for Gastrointestinal Endoscopy's practice management committee, discusses five opportunities for gastroenterologists this year.

1. More physicians should take advantage of open access endoscopy. Dr. Littenberg predicts the next few years will see an increase in the number of physicians performing open access endoscopy, or endoscopic procedures requested by referring physicians without a prior full gastrointestinal specialty consult. Dr. Littenberg says that while open access endoscopy is becoming more popular throughout the United States, quite a few practices still fail to take advantage of the opportunity. "If you think about the efficiency loss of patients having to come to the office for a consultation, which they'd rather not even do, where are you best off spending your time?" he says. He says while physicians may not make money on patient consultations, they can use the time usually spent on consultations on more profitable procedures or more medically-necessary patient visits.

He adds that for most practices, setting up an efficient, risk-free open access program is relatively straightforward. He says the biggest barrier to open access endoscopy may be the conflict with traditional practice. "For some physicians, it's simply tradition. They've always done it that way, and they want to meet the patients and believe the patients want to meet them," he says. He adds that while some physicians worry about medical legal risk, a good OAE program involving patient education on procedures, preparation and risk can significantly decrease that concern.

2. More large GI groups will form. Dr. Littenberg says it seems inevitable that many small GI practices will link up in one form or another. He says small practices should be thinking about whether they could benefit from joining other GI groups in their region. "It doesn't necessarily require giving up your independent or small group status, but you certainly need to think about horizontally forming large GI groups in regions or across regions," he says. "There are models being developed in many parts of the country that involve large GI groups and multi-satellite offices." He says the structure of larger GI organizations will differ by region and could include involvement with a hospital or a large multi-specialty group.

In California, Dr. Littenberg says some GI practices have already had luck forming virtual groups through IPOs. "The IPOs that have been doing managed care for a long time already have fairly tightly linked groups of independent doctors, and more of them are getting on the same EHR systems," he says. "Some of the IPOs, like the one I belong to (HealthCare Partners Medical Group), are promoting and paying for a large part of the infrastructure." Dr. Littenberg says joining a larger practice or a hospital can help previously independent physicians implement EHR, which will be increasingly necessary as virtual communication becomes standard.

3. Technology could improve GI practice, though perhaps not reimbursement. Dr. Littenberg says at the ambulatory surgery center level, new GI technologies may improve quality of practice without serving as profit sources. He says researchers are developing better ways to use colonoscopes to miss fewer lesions, allowing physicians a microscopic or backward look at difficult-to-see areas of the colon. "Those technologies that pan out will help us do a better job, but it won't offer a new range of reimbursement opportunities," he says.

He says the next few years may also see evolution in obesity treatment and GERD management. "There are a whole bunch of emerging technologies for gastric restriction procedures and revisions for patients who have had gastric bypass," he says.

He says as these new methods hit the market, physicians may be able to take advantage of a wide market of patients who go outside their insurance or are covered by their insurance for the new procedures. "There will certainly be a lot of opportunities in attracting a variety of surgeons who haven't been involved in a lot of endoscopic procedures or outpatient procedures," he says.

4. Contracts due for renegotiation could be improved. Dr. Littenberg says he frequently sees ASC contracts that could be vastly improved upon renegotiation, especially for GI and endoscopy reimbursement. "If centers don't regularly renegotiate and look at the terms of their contracts, they may be losing money in the way some of the claims get handled," he says. "There are a lot of payors who don't deal with multiple endoscopy claims the same way that CMS does and may not recognize multiple procedures." He says in many cases, centers write off the loss without appealing or looking closely at the language in their contracts. "Facing the cuts in Medicare facility fees, it's more important than ever to look at every operational efficiency possible and benchmark your center against others to see where you stand," he adds.

He says as insurance companies become more aware of the cost savings ASCs offer, centers should use their efficiency as leverage to negotiate better contracts. He says the opportunity to negotiate good contracts is particularly important as out-of-network centers find it more and more difficult to maintain their OON status.

5. More physicians should hold membership in national GI societies. In the coming years, involvement in specialty societies will be even more important, Dr. Littenberg says. "Physicians need to [support and pay attention to] specialty societies because they gather a lot of valuable resources," he says. "They advocate for benefits for our patients and for us, and they serve as important information sources." He says as physicians and ASCs encounter major changes through healthcare reform, physicians must collaborate on adapting to new payment systems and quality regulations. The best way to strengthen that collaboration is to support a specialty society that connects physicians across the country and publishes clinical and operational "best practices." ■

Learn more about the American Society for Gastrointestinal Endoscopy at www.asge.org.

AMA Clarifies Fluoroscopy Coding Guidance

By Leslie Johnson, CCS-P, CPC, Director of Coding and Education, Medi-Corp., With David Waldman, CPC-H, CPC, and Deb Carr, CCS

Nov. 2010's *CPT Assistant* article states that fluoroscopy is inclusive to ESI codes and that it should not be reported: "For certain procedures, fluoroscopy is considered inclusive of the procedure (e.g., 22526, 22527, 62263, 64467, 62270-62282, 62310-62319) and not separately reportable."

It was our concern that since payors utilize the American Medical Association as an authoritative reference for their edit systems, they might target these codes and deny the fluoroscopy codes based on this article. We sent an e-mail to AMA requesting clarification because AMA has traditionally reported fluoroscopy as being separately reportable and this article seemed to deviate from prior statements.

In an e-mail response back, AMA admitted that an error was made by including these codes in the *CPT Assistant* article and printed a correction notice that can be found at www.ama-assn.org/ama1/pub/upload/mm/362/errata-nov2010.pdf.

Per this correction, AMA adheres to traditional *CPT Assistant* instruction with the following paragraph:

"The following provides correction of the inclusion/exclusion of fluoroscopic guidance: For certain spinal procedures, fluoroscopy is NOT considered inclusive of the procedure (e.g., 62267, 62270-62282, 62310-62319) and is indeed separately reportable, when performed."

It is definitely in the facility's best interest to maintain an open dialogue with the AMA if and when discrepancies are found. ■

Contact Leslie Johnson at ljohnson@medi-corp.com. Learn more about Medi-Corp at www.medi-corp.com.

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

5 Changes to CPT Codes in 2011

By Rachel Fields

Paul Cadorette, director of education for mdStrategies, discusses five changes to CPT codes in 2011.

1. New -PT modifier for screening procedures. A new HCPCS modifier took effect Jan. 1 for use in cases where a screening colonoscopy or screening flexible sigmoidoscopy was planned, but clinical findings lead to a diagnostic colonoscopy. According to Mr. Cadorette, under the Affordable Care Act, patients were not responsible for out-of-pocket payment for screening services. However, prior to Jan. 1, if the screening service turned into a diagnostic procedure in which the physician found a polyp and had to perform a polypectomy, the patient would be responsible for their deductible and co-insurance.

This financial responsibility came as a surprise to many patients who had scheduled a screening and expected not to have to pay. "By adding the -PT modifier, the Medicare claims processing system is being told to waive the deductible," Mr. Cadorette says. "CMS is saying that a surgical procedure performed in conjunction with the screening will still be considered part of the screening service."

2. Revision to guidelines for discontinued colonoscopies. In 2010, CPT guidelines told coders they should report an incomplete colonoscopy with modifier -52, which is a reduced services modifier, according to Mr. Cadorette. In 2011, those guidelines have been revised. Now, the CPT handbook states that if the service is incomplete, coders should use modifier -53 to indicate a discontinued procedure. Modifier -53 serves as a physician modifier, while the ASC should report the procedure with a -74 modifier (discontinued outpatient hospital/ASC procedure after administration of anesthesia). Mr. Cadorette says a discontinued procedure might be recorded because of incomplete preparation, an anatomical variation or a tumor located in the colon that the physician couldn't advance the scope beyond.

3. Coding threaded bone dowels. CPT 22851 was used for biomechanical devices that included threaded bone dowels. "Previously, they considered a threaded bone dowel a biomechanical device because this type of bone graft was threaded and it would be screwed it into the spinal interspace, giving it mechanical properties," Mr. Cadorette says. "This was the only bone graft you would code as a biomechanical device." Due to a revision in the parenthetical notes, starting in 2011, coders should report a threaded bone dowel as a structural bone allograft with a code from the bone graft section instead.

4. Anterior interbody technique for cervical fusion. In the past, when a physician performed a discectomy to reduce pressure on the nerve root from a herniated disc, the physician would decompress the nerve root and the coder would report a decompression procedure in addition to the spinal arthrodesis. "The AMA acknowledges that, more often than not, these two services are performed together," Mr. Cadorette says. Starting in 2011 the AMA has added two new CPT codes: 22551 and 22552.

Coders would still use CPT 22554 if the physician performs a minimal discectomy without the decompression procedure. But while last year, coders could report a cervical arthrodesis and discectomy procedure separately, now coders are required to just report one code (CPT 22551) because AMA considers both services to be components of the primary procedure.

5. Pain management injection codes. The AMA has also started adding fluoroscopy into the primary portion of the pain management injection CPT codes, so just like the facet injections, coders can no longer report fluoroscopy in addition to the transforaminal injection codes 64479-64484. "When a transforaminal injection is performed, you no longer report the fluoroscopy component (CPT 77003), since it is already included in the CPT code definition," Mr. Cadorette says. He also says that epidural, transforaminal and facet injections performed at the T12-L1 level should be reported with a code from the cervical/thoracic series of codes rather than the lumbar/sacral code set. ■

Learn more about mdStrategies at www.mdstrategies.com.

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

OIG Issues Report on Improper Billing of Surgery Center Services for Skilled Nursing Facility Stays

By Rob Kurtz

The Office of Inspector General has issued a report with recommendations concerning payments for ambulatory surgery center services provided to beneficiaries in skilled nursing facility stays covered under Medicare Part A.

Based on a sample review, the OIG estimates Medicare contractors made at least $6.6 million in overpayments to ASCs for services provided to beneficiaries during Part A SNF stays from 2006 through 2008. The OIG found all of the 100 services it reviewed were incorrectly billed to Medicare Part B even though they were also included in the SNFs' Part A payments. As a result, Medicare paid twice for these services: once to the SNF under the Part A prospective payment system and again to the ASC under Part B.

The OIG recommends CMS instruct its Medicare contractors to do the following:

1. Recover the $103,000 in overpayments for the 100 incorrectly billed services that were identified.

2. Review the 20,806 services that the OIG did not review and recover overpayments estimated to total at least $6.5 million.

3. Provide guidance to ASCs on consolidated billing requirements and the need for timely and accurate communication between ASCs and SNFs regarding beneficiaries' Medicare Part A status.

4. CMS establish an edit in the Common Working File to prevent Part B payments for ASC services that are subject to consolidated billing.

View the OIG report at www.beckersasc.com/pdfs/BeckerASCSNF.pdf. ■

Contact Rob Kurtz at rob@beckersasc.com.

4 Common Medicare Violations Found by Inspectors of Surgery Centers

By Leigh Page

One in three ambulatory surgery centers are undergoing surveys this year by Medicare, compared to a historical rate of about one in 10. Chris McMenemy, vice president for administration at Ortmann Healthcare Consultants in Columbia, S.C., discusses four common violations found in Medicare surprise inspections.

1. Patient hasn't received required materials before day of surgery. This requirement to provide the patient certain written material is relatively new, stemming from the May 2009 revision of the Medicare Conditions for Coverage. "It is an easy requirement for inspectors to verify," Ms. McMenemy says. "They need only ask patients in the waiting room if they received the material before that day." Since patients may not always remember whether they received the material and when, it helps to keep documentation, she says. Staff members can even ask patients to sign a form indicating they received the information.

2. Incomplete infection control worksheet. The worksheet must document which staff member is overseeing infection control and include the ASC's infection control plan. The person responsible for infection control cannot be a technician and has to have special training in infection control, but exact training is not specified.

3. TB tests are not up-to-date. All physicians and staff members are required to receive an annual TB test. This is an example of myriad requirements in the 75-page Medicare interpretive guidelines, updated in May 2009, and a simple requirement to tackle. But many ASC personnel have not read the guidelines or know little about them, Ms. McMenemy says.

4. Some drugs have expired. Inspectors go through drug cabinets and check expiration dates on the labels. "Every surveyor is different, but these are a few examples I've come across," Ms. McMenemy says. Surveyors have plenty of time to find deficiencies because their visit lasts one to two days.

Submitting a plan of correction. If surveyors find violations, they will inform ASC staff when they leave and a formal notice will come through the mail. The ASC then has 10 days to submit a plan of correction. The 10 days, including weekends and holidays, require fast action. Ms. McMenemy recalls a client had to submit a plan of correction on the Monday after the Thanksgiving break. ASCs that fail to meet the 10-day deadline lose their Medicare certification. Within a few weeks of submission, surveyors pay a second visit to determine whether the plan has been carried out. ■

Learn more about Ortmann Healthcare Consultants at www.ortmannhealth.com.

Medicare Clarifies Same-Day History and Physical Guidance for Surgery Centers

By Rob Kurtz

The ASC Association has announced that CMS has issued guidance clarification stating ambulatory surgery centers may perform a patient's history and physical (H&P) on the same day of surgery.

The ASC Association had expressed concern to CMS about state surveyor confusion concerning the regulatory requirement, according to a news release from the ASC Association. In response, CMS issued a memorandum stating ASCs could perform an H&P on the same day as surgery as long as it is performed by qualified personnel, is comprehensive and is placed in the patient's ASC medical record prior to surgery.

ASCs cannot perform the H&P after the patient has been prepped and brought into the OR or procedure room.

Finally, CMS stated that if the H&P is conducted in the ASC on the same day as the surgical procedure, some elements of the required pre-surgical assessments may be incorporated into the H&P; however, this does not apply to the anesthesia/procedure risk assessment, which must be performed by a physician immediately before surgery and after the H&P.

The ASC Association reminded surgery centers that "state law, the agreements an ASC has with its insurance providers and an ASC's own policies may establish other requirements for the timing of the H&P that the ASC must follow."

Read a copy of the CMS memorandum at www.ascassociation.org/hp.pdf. ■

Contact Rob Kurtz at rob@beckersasc.com.

It's 2011. Be **bold** and make a change.

Join over 450 other Ambulatory Surgery Centers in best of class transcription and coding.

- 100% Web-Based Transcription & Coding Platform
- Instantly Know which Cases Need to be Coded
- Directly Integrated with your Practice Management System
- Improve your A/R and Increase your Revenue
- No Faxing Schedules!

Be connected. Use industry standard HL7 and avoid retyping ADT, CPT and ICD-9 codes!

Be bold. Contact Surgical Notes toll-free at (800) 459-5616 or e-mail sales@surgicalnotes.com.

Surgical Notes

5 Things Every ASC Should Do to Reduce Supply Costs

By Jaimie Oh

Supply costs are a huge overhead expense for any ASC, so properly managing those costs is crucial to maintaining the financial health of your facility. Tom Wilson, managing partner of Monterey Peninsula Surgery Centers and board member of the California Ambulatory Surgery Association, explains five steps to better contain supply costs.

1. Reduce supply costs to 20 percent or less of operating expenses. Mr. Wilson says although the average percentage of supply costs could vary from facility to facility, they are usually the second highest expense item after labor-related costs and typically consume 20-33 percent. ASCs should strive toward reducing supply costs to 20 percent or less of the ASC's total expenses.

"For surgery centers to be successful under CMS payments, they need to provide the care for less than what the government is paying, so the first thing ASCs should address is the low-hanging fruit, which is medical supply costs," he says.

2. Establish a plan to reduce medical supply costs over several years. To reduce the amount of money spent on medical supplies, Mr. Wilson suggests ASCs follow a simple guideline to reduce overall medical supply expenses over a three-year period.

"What our centers have done and what centers should do is reduce the cost of medical supplies by 20 percent in year one, 10 percent in year two and another 10 percent in year three," he says. "Of course, centers can only drive medical supplies costs down so far, but this is achievable. For example, our three facilities perform over 25,000 procedures annually and spend approximately $4,000,000 in supply-related expenses. We were able to reduce this expense by $900,000 in 2010."

3. Meet with physicians to receive individual buy-in. An ASC's efforts to reduce medical supply costs are heavily dependent upon physicians' involvement, as physicians control 70-80 percent of the cost of medical care. Mr. Wilson says ASCs must first show physicians and physician-owners that reductions in medical supply costs are necessary to remain financially viable in the future.

"We'll meet with our 13 orthopedic surgeons on staff and break down eight to ten very common orthopedic procedures, such as total and partial joint replacements, shoulder repairs, ACL and other knee repairs, and [assign] each physician a letter A through M," he explains. "Then we will list by letter how much it costs each physician to perform a procedure. One physician might discover his supply costs are higher because he is the sole surgeon utilizing a $300 disposable wand. By doing peer reviews, we can discuss how to deliver quality care at a lower price."

4. Research what is clinically acceptable. Mr. Wilson says instead of opting to use medical supplies of the highest, and therefore most expensive, quality, ASCs should research what other options are clinically acceptable and are offered at a much lower cost, providing a greater value. Since the federal government continues to reimburse ASC minimally for a broad range of procedures, ASCs must be more proactive and strategic about the devices they choose to use.

"If CMS pays an ASC $1,100 for an orthopedic procedure requiring an implant and the device of choice is a plate and screw set costing a $1,000, the center will lose money," Mr. Wilson says. "This problem could be solved if the procedure could be performed with wire implants costing a $100. If the wires are clinically acceptable, medicine will move in this direction. This is a tough choice that surgeons and ASCs will need to rapidly address in the future."

5. Standardize and reduce medical supplies. Standardizing medical supplies, such as implants and expensive single use items, results in huge savings for ASCs because of the economies of scale that is achieved when negotiating prices with vendors. Providing larger volumes over fewer suppliers yields greater price points for these extremely expensive items. Mr. Wilson says an added benefit in standardizing medical supplies is time savings for materials managers, which indirectly translates into staffing costs.

"If an ASC has 13 different types of anchors, that's a huge cost because that ASC's [materials management] employees are spending more time and money in maintaining par levels, establishing re-order points and monitoring inventory," he says.

Mr. Wilson says ASCs should also strive to eliminate medical supplies that are rarely used from its inventory. In a recent orthopedic section meeting, his ASCs eliminated 15 unnecessary inventory items, including several different types of anchors and cannulas. "Of course, there are certain supplies that, even if only used a handful of times a year, are absolutely needed [regardless of frequency of use]. However, eliminating items that are not used very often or any duplicative items have saved our centers time, effort and money," he says. ■

Contact Jaimie Oh at jaimie@beckersasc.com.

Advertising Index

Note: Ad page number(s) given in parentheses

Are You Confused About Disinfectant Claims?

Well, you're not alone...

As you know, some disinfectant's list different kill times for different microorganisms / bugs simply because they can't meet all of the needs of a health care facility in a single product! All they do is to confuse things by claiming 5 minutes this bug, 1 minute for that bug, 30 seconds for this bug and they don't mention the ones they can't kill and it goes on and on and on...

New Opti•Cide³ kills bacteria, viruses, TB, and fungi with a single 3-minute contact time including the tough ones. VRE, MRSA, Norovirus, Pseudomonas, Salmonella, TB, and a multitude of others. It effectively loosens and lifts C. difficile spores for removal from surfaces...

...and, Ready to Use **Opti•Cide³** can be applied to all surfaces including vinyl, aluminum, brass, stainless steel, chrome, painted surfaces and Plexiglas®. It is the perfect cleaner disinfectant for use on all surfaces including cots, monitors, cabinets, and even laptops.

Finally, a product with no mixing, no confusing contact times, no hassles and no confusion! Available in spray, bulk liquid sizes for re-filling spray bottles and convenient wet wipes!

End of Confusion!

Protecting Your Patients
Your Staff
& Your Family

MICRO SCIENTIFIC INDUSTRIES, INC.®

Call 1.888.253.2536
www.opticide.com
Rolling Meadows, IL 60008 USA

Experts In Fair Market Value. Focused In Healthcare. Trusted by Clients.

VMG Health is the leader in the valuation of ASC's. No one has more experience and insight into the critical factors that drive the value of a surgery center.

VMG HEALTH
WE VALUE HEALTHCARE

Visit our website to download the 2010 Intellimarker ASC Benchmarking Study

1 **www.vmghealth.com**

2 Three Galleria Tower • 13155 Noel Rd., Ste. 2400 • Dallas, TX
214-369-4888

3 3100 West End Ave., Ste. 940 • Nashville, TN
615-777-7300