Inside: 17th Annual Improving Profitability, and Business and Legal Issues for ASCs Conference Brochure (p. 31)

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

July/August 2010 • Vol. 2010 No. 6

7 Considerations for an Out-of-Network Surgery Center Moving In-Network

By Lindsey Dunn

As pressures by health insurers on out-of-network ASCs across the country continue to increase, many of these centers are beginning to examine whether moving in-network would benefit or harm their long-term financial success. Matt Kilton, MBA, MHA, COO of EVEIA Health Consulting & Management, shares seven considerations for out-of-network ASCs considering contracting with payors.

continued on page 9

Call Coverage Payments: Trends, Regulations, Statistics and Valuation Considerations

By Jen Johnson, CFA, Managing Director, VMG Health

Establishing FMV for call coverage compensation is becoming increasingly difficult as arrangements are evolving and survey data is unreliable. The following will discuss recent trends in paying for call coverage, market statistics and the valuation considerations surrounding certain payment structures.

Growing expenses, industry trends driving call coverage payment growth

In the past, ED call coverage was typically provided by physicians in exchange for admitting privileges. Now, more physicians are demanding payments for call coverage due to:

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The 'Co-Managed' Hospital-Owned ASC: An Alternative Partnership Model

By John A. Smalley, Principal, Healthcare Venture Professionals

Over the past few years, there has been a growing trends of ASCs being operated as HOPDs. As we move through 2010, this trend toward HOPD ASCs continues.

For new ASC projects, the recent economic downturn has added deal structure complexity and an increased risk aversion on the part of many physicians when it comes to traditional equity-based ASC models. For existing equity-based ASCs, there appears to be a growing desire by physician-investors to recoup their initial investments. At the same time, more hospitals are aggressively "joining the fray" as potential ASC purchasers. As a result, we at Healthcare Venture Professionals (HVP) have become involved with a number of projects dealing with new hospital-owned ASCs or "conversion" of existing freestanding ASCs into HOPD ASCs.

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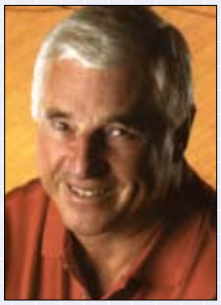
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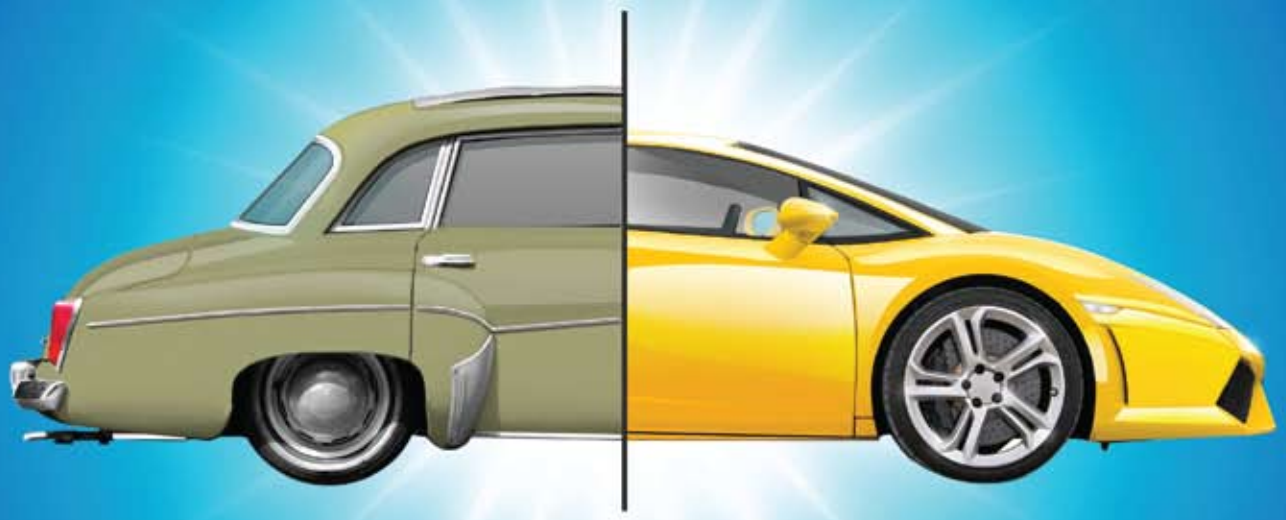

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BECKER'S
ASCREVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

July/August 2010 Vol. 2010 No. 5

FEATURES

Publisher's Letter

A Review of 100 Anti-Kickback and Self-Referral Settlements and Cases; The Erosion of Independent Medical Practice; Outpatient Trends – Six Key Issues; 10 Legal Issues Facing ASCs; Bobby Knight, Tucker Carlson, Lt. Colonel Bruce Bright and 95 Other Speakers; Co-Management Agreements; Anesthesia Models Under Attack; Streamlining Spans and Layers

1. 100 anti-kickback and self-referral cases. We recently had the chance to review nearly 100 kickback and self-referral cases and authored an article related to these findings. The cases highlight an interesting distinction between cases and settlements where the provider or company paid more than $100,000 to settle allegations and those that paid less than $100,000. The distinction often lies in the amount of improper intent involved in the incident or incidents that drove the settlement. The article is entitled "A Review of OIG Self-Referral and Anti-Kickback Cases: 6 Categories of Non-Compliant Physician Relationships and 8 Recent Cases." For a copy of this article, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

2. Erosion of independent medical practice. There is likely to continue to be significant erosion in independent medical practice. This does not generally dictate less outpatient work but it does impact the entrepreneurial outpatient side of the business. There are different statistics but generally 40-45 percent of all physicians are now employed by hospitals. There is also anecdotal discussion in the cardiology sector, for example, that while there are 30-35 percent of cardiologists currently employed by hospitals, there are 70-80 percent of cardiologists in talks to become employed.

Independent practitioners have generally been the life blood of ambulatory surgical centers, physician-owned hospitals and several other healthcare free-standing entrepreneurial ventures. Even slight changes in the total number of independent physicians have huge impacts on the economies of scale of surgery centers and physician-owned hospitals. These businesses, like most businesses, work with a fairly fixed set of costs. A great deal of the profits in these businesses is made after a base amount of cases are brought in which cover the fixed costs. Incremental cases drive a great deal of the profits. If the incremental cases are taken elsewhere through employment by hospitals and other systems, this leaves physician-owned facilities in a much tougher predicament.

Several factors are driving the trend towards employment. The top four are 1) money, 2) money, 3) money and 4) life balance.

1) Hospitals can afford to pay physicians well due to the technical fees generated by such physicians for hospitals; 2) physicians are very concerned regarding reimbursement rates; 3) many physicians were hurt significantly by the stock market and real estate crash and are seeking lower risks in their practice; and 4) many physicians who graduated over the past decade seem more focused on life balance and more predictable hours than a business owner's lifestyle.

A statement in an article by Scott Gottlieb, a former CMS official articulates the trend pretty clearly. He states in his *Wall Street Journal* article "No, You Can't' Keep Your Health Plan":

> "Doctors, meanwhile, are selling their practice to local hospitals. In 2005, doctors owned more than two-thirds of all medical practices. By next year, more than 60% of physicians will be salaried employees. About a third of those will be working for hospitals, according to the American Medical Association. A review of the open job searches held by one of the country's largest physician-recruiting firms shows that nearly 50% are for jobs in hospitals, up from about 25% five years ago.
>
> Last month, a hospital I'm affiliated with outside of Manhattan sent a note to its physicians announcing a new subsidiary it's forming to buy up local medical practices. Nearby physicians are lining up to sell — and not just primary-care doctors, but highly paid specialists like orthopedic surgeons and neurologists. Similar developments are unfolding nationwide.
>
> Consolidated practices and salaried doctors will leave fewer options for patients and longer waiting times for routine appointments. Like the insurers, physicians are responding to the economic burdens of the president's plan in one of the few ways they're permitted to."

3. 5,200 Medicare-certified ASCs. There are now more than 5,200 Medicare-certified surgery centers. There has been a significant deceleration in the growth of surgery centers. In fact one prominent commentator has said this might be the first year in which there is a net loss in the total number of ASCs across the country.

Of the nations Medicare certified surgery centers, 20-35 percent have a hospital partner. Another 20-30 percent are rumored to be not making money at any one time.

4. Revenues under pressure. Revenues for outpatient services will be under tremendous pressure due to two distinct factors: 1) the erosion of independent medical practices which reduces case numbers (discussed above) and 2) the fact that commercial paid reimbursement is under tremendous pressure. The two bigger winners in the healthcare reform bill are likely to be the pharmaceutical industry and the hospital industry. Each have for the foreseeable future solidified a substantial part of the healthcare budget and protect themselves from significant reimbursement risk. This means that if healthcare costs are actually going to be reduced or stay somewhat steady, a great deal of the reimbursement reductions will come from a whole number of other sectors.

Further, insurance companies are exercising more authority over physicians. Here, Mr. Gottlieb says:

> "One of the few remaining ways to manage expenses is to reduce the actual cost of the products. In health care, this means pushing providers to accept lower fees and reduce their use of costly services like radiology or other diagnostic testing."

5. Ten Legal Issues Facing ASCs - 2010. Elissa Moore, Elaine Gilmer and I recently completed an article titled "10 Legal Issues Facing Ambulatory Surgery Centers – 2010." Please contact me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com for a copy of this article. It outlines issues such as anti-kickback issues, healthcare reform, HIPAA, out-of-network arrangements and a number of other issues.

6. Co-Management Arrangements. Co-management arrangements for the time being seem to be the new thing as a means for hospitals to work with independent physicians. While it is not clear how long co-management arrangements will stay the new hot thing, there is likely to be some period of time in which they remain very important. Some of them appear to be done in "aggressive" ways in terms of payments. It may be that over time as government intervention occurs, these will need to be restructured. We will have three different talks on co-management relationships at our Fall ASC Conference, taking place Oct. 21-23, 2010, in Chicago (see item #10 below for more information).

7. Layers and spans. A very intelligent short article that I read recently was from Bain Consulting. Here, Bain Consulting talked about something they title "layers and spans." The article is titled "Streamlining Spans and Layers: Tuning Your Organization for Better Decisions." The core concept was that reducing the amount of layers in a company by some small degree and increasing a manager's span (for example from five direct reports to seven direct reports) can have a large positive impact on reducing an organization's costs. It was an interesting study, which included some great statistics, and was really informative. In essence, great companies must be modified at layers and spans and great managers ought to have a greater number of people they manage directly (and handle this extremely well). Of course, a key to managing a number of people well is often having "great people and engaging in great recruiting."

8. Outpatient Trends — Six Key Issues. For a copy of a brief article authored by Barbara Kirchheimer and myself titled "Outpatient Trends – Six Key Issues," please e-mail me at sbecker@mcguirewoods.com.

9. Anesthesia Models Under Attack. For a copy of an article entitled "Anesthesia Models Under Attack," please e-mail me at sbecker@mcguirewoods.com.

10. 17th Annual ASC Conference. We have completed the agenda for our 17th Annual ASC Conference. We will be at the Swissotel on Michigan Avenue in Chicago. The conference will include more than 90 sessions and keynote speakers such as Coach Bobby Knight (Thursday pre-conference), Political Commentator Tucker Carlson, and Lt. Col. Bruce Bright. It will also include nearly 95 sessions on business, legal and clinical issues for ASCs. t should be our largest and most interesting conference ever. Should you desire to receive a brochure for the conference, please contact me at 312-750-6016 or at sbecker@mcguirewoods.com.

11. Consolidation. We are seeing substantial consolidation in the hospital and surgery center areas. Consolidation discussions are occurring rapidly both amongst chains and in the acquisitions of hospitals and surgery centers. Prices seem relatively solid.

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

Very truly yours,

Scott Becker

7 Considerations for an Out-of-Network Surgery Center Moving In-Network **(continued from page 1)**

1. Compare OON vs. in-network rates. OON ASCs are generally reimbursed at higher rates than contracted centers, so ASCs should first begin by projecting the economic impact of signing a contract with a payor.

"If a center has been functioning OON with a payor and they are contemplating going in-network, the issues and consideration are very similar to a renegotiation," says Mr. Kilton.

Mr. Kilton says centers first need to determine total revenue and average reimbursement per case, by payor, under their existing OON strategy. To do this, the center must look at the annual number of cases with the payor, the case mix and the reimbursement on this case mix. Next, the center should analyze the projected total revenue and average reimbursement per case on a contracted basis. To do this, centers must look at contract rates, projected case mix and projected volume as an in-network center.

"Generally, reimbursements are less favorable when functioning in-network, but generally, functioning in-network will increase payor volumes, which can reduce cost per case as fixed costs are spread across additional cases, as well as drive incremental revenues into the center," says Mr. Kilton.

2. Project incremental volume increases from going in-network. To project volume, ASCs should meet with their physicians and their office scheduling staffs to examine how many surgeries that could have been scheduled at the center over the last 12 months were not due to the patient preferring an in-network facility. OON vs. in-network comparisons are typically done on a 12-month trailing basis, says Mr. Kilton.

"While patient acuity restricts 100 percent of a physician-owners ASC-eligible cases from being performed at the center, looking at the number of patients who were ASC eligible but went elsewhere will help forecast the incremental increase expected by going in-network," says Mr. Kilton.

If physicians and their scheduling staffs are unable to estimate these cases, a physician's office can pull a "procedures by provider" report, and then the ASC staff can count the number of times a procedure was performed by a physician in a given year compared to the number of procedures the ASC billed for that physician. This method, however, does not make adjusts for patient acuity, says Mr. Kilton.

Once a center has volume projections, it can determine a projected 12-month total revenue for the payor as well as a projected cost per case given the new volume estimates, case mix and reimbursements.

3. Estimate income as an OON vs. in-network provider. Next, centers should compare historical revenues as an OON center vs. projected revenues as an in-network center minus estimated variable costs incurred by adding incremental volume. The resulting income figures will provide centers with a clear estimate of how their profits may differ if they move in-network.

"What we generally find is the OON projection is greater than the contracted revenue given volume increases and lower variable costs," says Mr. Kilton. "At this point, it really becomes a question of economics for the center. We often find that centers have a threshold profit margin that they need to maintain and contracts falling below that threshold may not qualify for completion."

4. Understand payor methodology. As ASCs make revenue and income projections, it is very important they understand the specific methodology the payor is proposing. "No two payors follow the same methodology," says Mr. Kilton.

"Centers operating OON are commonly unaffected by payment policies and payor methodologies that reduce reimbursement. By shifting in-network and signing a contract, centers are exposed to a variety of reimbursement policies including payment reductions for multiple procedures, thresholds for implant reimbursement, restrictions on coverage for certain services, bundling of services and other factors that OON centers are not subject to," says Mr. Kilton. "ASCs need to account for these additional provisions into account when projecting case revenue as an in-network center."

5. Consider other benefits of in-network status. Even if projections suggest staying OON might provide greater income, evolution of the current payor environment has some centers considering other factors before ruling out a contract.

"We're continuing to see an emphasis by payors to frontload costs, especially for OON services, placing these responsibilities on the members. As insurance plan designs evolve and members become more accountable for OON payments, consumers will more closely evaluate whether or not the cost of going to an OON ASC is worth it to them, which could erode the OON strategy, says Mr. Kilton.

"While I don't think the OON model will completely evaporate, we are starting to see a more concentrated erosion, and an ASC may reach a point where it has lost access to meaningful volume. Furthermore, we are seeing providers struggling to capture more and more of their reimbursements from the patient, which has a negative impact on patient satisfaction and requires increased collection efforts," says Mr. Kilton. "ASCs will have to consider this when deciding their threshold for contract acceptance and how much revenue they can afford to forgo in return for shoring up volumes."

6. Start small. If an ASC is currently OON for a significant number of commercial payors, Mr. Kilton suggests the center move in-network for one of its smaller payors before trying the approach with a larger payor.

"It's risky to to suddenly change your entire business process and do so with your most meaningful payor," says Mr. Kilton. "We recommend starting with a smaller payor so in-network policies and processes can be fully vetted and understood. If the process proves less desirable than remaining OON, the ASC hasn't placed itself in a position where the impact will affect its most significant payor."

Mr. Kilton also recommends that ASCs be aware of the length of their initial contracts with a payor. "It would be advisable to secure a contract for a shorter term — 1-2 years, with one year generally preferred — if possible, which will allow for course corrections if the initial contract outcomes are not favorable," he says.

7. Don't assume a contract will improve in the next round of negotiations. Finally, Mr. Kilton suggests centers should not assume a weak contract can be improved upon in future rounds of negotiation. "One of the biggest mistakes ASCs make in their initial contracts is to assume a poor contract can be easily corrected. ASCs have the most leverage they will ever have during their initial contracting period. Once the bar is set in terms of rates, upward movement is very challenging," he says. "By accepting a contract and completing the cases under a contract's terms, the ASC is telling the payor the rates are reasonable enough to perform the services. An ASC must seriously consider the long-term impact of accepting a poor contract versus the benefit of walking away from a contract that does not meet its threshold for reimbursement."

Mr. Kilton also recommends, whether or not a center moves forward with a contract, it end negotiations on a professional and friendly note. "A center is likely to have to work with a payor again in the future, so it's important that even if they are unable to arrive at a final agreement, they end negotiations in a way that will enable the payor to consider them as having been reasonable," he says. ■

Learn more about EVEIA Health Consulting & Management at www.eveia.com.

Call Coverage Payments: Trends, Regulations, Statistics and Valuation Considerations **(continued from page 1)**

- Rising costs associated with covering the ED
    - Growth in the uninsured patient population.
    - Fear of malpractice lawsuits.
    - Higher premiums associated with emergency departments.
- Fundamental industry changes
    - Work-life balance has become more important to today's physicians.
    - There is a decreasing physician supply.
    - Physicians are less reliant on hospitals to build practice with other options for office-based procedures and outpatient facilities.
    - Physicians are seeking equity with other physicians who are being paid for call coverage.

Although the majority of call coverage arrangements are based on a daily or hourly stipend, payment structures are evolving and are more often including additional payments for the uninsured patient population.

Call coverage payments: How industry-wide is it?

The Sullivan, Cotter and Associates' *2009 Physician On-Call Pay Survey Report* states that 82 percent of the survey respondents currently provide compensation to non-employed physicians for call coverage. In addition, more than one-half of those surveyed reported their on-call expenditures have increased in the past 12 months and 20 percent of the respondents indicate they plan on implementing on-call pay within the next six months for physicians currently not receiving pay.

In addition to these recent trends, Sullivan Cotter statistics show overall expenditure for call payments have been increasing exponentially since 2006. From 2006-2009, the median expenditures increased by 546 percent for non-trauma centers and 141 percent for trauma centers.

Regulatory guidelines to consider when determining on-call payments

Since many healthcare organizations are currently considering on-call payments for the first time, a basic understanding of the regulations and payment models for on-call coverage are essential. Currently, there are two OIG opinions related to call coverage.

The OIG's opinions related to on-call payments have warned of a substantial risk that improperly structured payments for on-call coverage could be considered unlawful remuneration if the payments exceed fair market value. Therefore, when implementing an on-call arrangement, healthcare executives should start by understanding what the OIG has stipulated as factors to be considered low risk arrangements for fraud and abuse.

In determining if payments are at FMV, one should account for the burden of call. Factors affecting the burden of call include volume of call, payor mix and patient acuity. The OIG has stated that obtaining an independent third-party analysis to determine if the compensation reflects FMV for the services furnished is an important safeguard.

In addition, to ensure the arrangement does not appear to reward certain physicians for referrals, there are two important factors a hospital should consider. First, understand the history of call coverage and whether or not there is a legitimate, unmet need for on-call coverage. Second, offer compensation to all eligible physicians and make certain that physicians of similar specialties receive the same per diem payment.

On-call payment market data

Although on-call payment structures vary, the daily or hourly stipend is the most prominent model in the marketplace. There are currently two on-call industry surveys providing data for these stipends: *MGMA Medical Directorship and On-Call Compensation Survey (2009 Report Based on 2008 Data)* and Sullivan, Cotter & Associates' *2009 Physician On-Call Pay Survey*. However, essential valuation data is unavailable in these studies. Specifically, the following are important valuation factors relevant to call coverage payment data which are unknown in the surveys:

- Volume of call: in-person and via phone
- Payor mix associated with the patient population
- Physician's ability to bill and collect when seeing a patient
- Hospital's commitment to pay for the uninsured

Therefore, relying on market survey data alone will not provide a comprehensive valuation to determine fair market value. In addition, there is tremendous variance in reported on-call payment data and a low number of reported respondents in both surveys. However, the following lists the specialties for which survey data from both studies report similar median daily stipends:

- Orthopedic surgery median: $1,000 and $1,100
- Anesthesiology median: $750 and $800
- Invasive-interventional cardiology median: $775 and $800
- Ophthalmology median: $286 and $300

The above observed consistency in reported fees assists in determining a supportable valuation for these specialties. However, it is extremely important to note that factors such as volume, payor mix, acuity and specific terms of the arrangement are essential to determine if these rates are consistent with FMV. It is recommended that all of these factors be considered, as well as additional valuation methodologies.

Providing further challenges to the valuation of these arrangements is the fact that recently, more agreements are including an additional payment for the uninsured patient population.

Valuation challenges with the two payment on-call agreements

Industry observations indicate that on-call arrangements have increasingly been including an additional payment for the uninsured, or indigent patient population. This trend is expected to continue as the uninsured population is on the rise and physicians are less willing to take call.

It is important to note that when a hospital makes an additional payment to a physician for this patient population, it should be considered when determining the daily stipend. This type of arrangement guarantees the physician on-call will be compensated for his or her services when called in. From a compliance perspective, when the hospital obtains the risk of covering the uninsured for the physician on-call, the daily stipend should be less. Adjustments to the daily stipend for these additional payments should be based on the reimbursement guaranteed by the hospital and market reimbursement for professional services.

Working towards on-call compliance

If healthcare organizations are not careful in structuring call coverage arrangements, they risk non-compliance with healthcare regulations. In order to best document due diligence in ensuring the organization considered regulatory guidance in determining the on-call payment and structure, healthcare organizations should:

1. Understand FMV guidelines for determining call coverage payments.
2. Understand the OIG opinions related to on-call.
3. Document factors to show the burden of call.
4. Consider the compensation components of the arrangement.

If an on-call agreement between a physician and healthcare organization is audited by federal or state healthcare authorities, the analytical process and documentation to justify the payment at FMV will be essential in defending the compensation level.

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

Contact Jen Johnson at jenj@vmghealth.com.

The 'Co-Managed' Hospital-Owned ASC: An Alternative Partnership Model
(continued from page 1)

For the past several years, HVP has had the good fortune to work with the West Hartford (Conn.) Surgery Center (WHSC), a hospital-owned ASC. We see WHSC as an prime example of a facility demonstrating the opportunities that exist to take the HOPD model and make it an exciting, creative and effective alternative partnership model between hospital and physician through the concept of "co-management" for the ASC.

WHSC history

Due to a longstanding positive relationship and strong desire to collaborate, WHSC was initially planned as a 50-50 equity-based joint venture (a for-profit LLC) between Hartford Hospital (HH), a prominent tertiary care/teaching facility and the Connecticut Surgical Group (CSG), a prestigious 40-plus surgeon multispecialty organization. WHSC would be located in the "Blue Back Square" section of West Hartford, a rapidly growing commercial development about 10 miles from the hospital and main CSG offices. HVP was engaged in 2005 to provide development and long-term management Services for the joint-venture ASC.

While the ASC was still under development, HH and CSG decided (for a variety of business reasons) to look at alternative approaches to the ownership and operation of WHSC. After much discussion and research, the decision was made to convert WHSC to an HOPD ASC. At the same time, both HH and CSG clearly wanted to retain a collaborative approach to WHSC operations.

To support this goal of collaboration under an HOPD approach, a simple set of "partnership guiding principles" were developed for WHSC. These included:

- WHSC would be operated like a free-standing ASC vs. a hospital department.
- Emphasis would be placed on providing patients and physicians with a high quality "five-star" experience.
- HH and CSG leadership would work to minimize the bureaucracy and "red tape" inherent to a large, tertiary care facility such as HH.
- Recruitment activities would be expanded to include surgical specialties and physicians not represented within CSG.
- Key ASC functions (e.g., scheduling, pre-certification, registration and billing, medical supply and instrumentation standards, etc.) would be controlled by WHSC rather than HH.
- HH resources and relationships (e.g., group purchasing, biomedical engineering, anesthesia, laboratory, etc.) would be used to the extent possible but WHSC would also be free to pursue outside sources if justified to obtain required clinical or support services in an improved, more efficient or cost-effective fashion.

These guiding principles, together with the shared vision and ongoing commitment by HH and CSG to a collaborative relationship, resulted in the creation of a unique "co-management" approach to the future operations of WHSC.

Co-management model

The co-management model combines two approaches typically (but usually separately) seen in transactions where a hospital acquires a physician-owned clinical service and converts it to an HOPD: 1) The hospital enters into a management or professional services agreement with the previous physician-owners in order to maintain their involvement and interest in the service; or 2) The hospital engages a professional manage-

ment company to provide day-to-day management in order to ensure the service in question is operated in an efficient or "freestanding" fashion.

This co-management model was implemented in the following manner:

- HH purchased the CSG equity interest in WHSC at a formally determined fair market value.
- HH entered into a management services agreement with CSG at a negotiated and externally validated FMV rate.
- CSG entered into a "management services subcontract agreement" with HVP for defined operational and support services.

The end result of this process is a scenario wherein WHSC is effectively co-managed by CSG and HVP.

At several points in this process, the services of an external valuation company were employed to validate that all financial arrangements were consistent with a documentable FMV approach. Experienced legal counsel was also an integral part of all transactions and agreements. Finally, incentives contained in the management agreement between HH and CSG were based on defined quality, patient satisfaction and operational benchmarks vs. volume or revenue-related criteria.

The conversion of WHSC from an equity-based joint venture to an HOPD ASC also entailed the successful accomplishment of several other tasks dealing with:

- CT certificate of need
- Medicare HOPD requirements
- State licensure requirements
- Other state and federal requirements

Co-management roles and responsibilities

Under the management services agreement with HH, CSG assumed a number of responsibilities to include:

- Provision of the ASC medical director
- Provision of key leadership to the WHSC operations committee (see additional discussion to follow)
- Oversight of the management services subcontractor (HVP)
- Designation of a formal contact person to work with HH
- Establishment and maintenance of quality assurance standards
- Recommendations as to approved surgical procedures, capital equipment needs and ASC staffing and personnel
- Implementation of clinical education and training programs
- Recommendations and implementation of all quality improvement and utilization review programs
- Development of community education and outreach programs
- Other clinical and administrative responsibilities as defined in the management services agreement

Under the "management services subcontract agreement" with CSG, the major responsibilities of HVP include:

- Provision of the on-site ASC administrator
- Management of day-to-day ASC operations
- Provision of defined consultative and support resources

- Routine involvement of HVP principal and regional director of operations as an advisory and support resource to the administrator and to CSG
- Coordination of and attendance at monthly operations committee meetings
- Monitoring and benchmarking of operational performance
- Support for WHSC strategic planning efforts
- Provision of information and education related to industry trends, regulatory and safety issues
- Annual budgeting
- Monthly financial reporting
- Business analysis of proposed equipment purchases, new surgical procedures and other matters affecting future WHSC performance
- Development of operating policies and procedures
- Administrative coordination with HH on behalf of CSG (a "buffer" role)
- Other administrative responsibilities as defined in the management services subcontract agreement

Operations committee

One of the important ingredients to the success of the co-management model is the role and function of the WHSC operations committee. From the outset of the decision to convert from the equity-based joint venture model to the HOPD ASC co-management codel, this committee was envisioned as a de facto "board" for WHSC. In essence, the operations committee assumes many of the same responsibilities that would have been fulfilled by the LLC board had the joint-venture model remained in place. Key among these is serving as ongoing formal vehicle for direct physician input and involvement with all aspects of WHSC operations.

The operations committee meets monthly and is comprised of three senior leaders from both HH and CSG. The WHSC medical director, administrator and an HVP corporate representative are ex-officio members of the committee. The primary responsibilities of the committee include:

- Advisor to HH on all WHSC clinical, management and operational issues
- Review of all quality, financial and operational results
- Dealing with all licensure, accreditation, health and safety matters for WHSC
- Review of patient, physician and employee satisfaction results
- Oversight of performance of the medical director, administrator, HVP and all other professional or support subcontractors and agreements
- Establishment of performance objectives for WHSC
- Strategic planning, marketing and physician recruitment efforts
- Other key clinical and administrative matters

Hospital/surgery center integration issues

As noted earlier, one of the guiding principles for HH and CSG under the HOPD ASC approach was that WHSC would be operated like a free-standing ASC rather than a hospital department to the extent possible. The following operational areas merited special attention related to the inte-

gration of WHSC into the HH organization:

- Information systems
- Patient scheduling, registration, PAT, insurance pre-certifications, billing and collections
- Hospital support services
- Policies and procedures
- Forms/medical records
- Drug control procedures
- HR/staffing/recruitment
- Materials management
- Finance/budgeting

For each of these above areas (and others to a lesser extent), the challenge was to achieve an appropriate balance which supported the goal of having WHSC function in a "freestanding" fashion while at the same time recognizing that it must be an integral part of the HH organization in order to meet a variety of intra-organizational and external requirements (e.g., "provider-based" regulations, Joint Commission standards, etc.).

Admittedly, HH-WHSC integration is (and, to some extent, will always be) a work in progress as new questions, challenges or "turf issues" inevitably arise. Ongoing sensitivity to this potential, together with effective communication between all involved parties as issues occur has helped to minimize or prevent any long-term problems from an integration perspective. The operations committee and its members have certainly played a key role in this regard.

Benefits to physicians

There are numerous benefits to involved CSG (and other) physicians under the co-management model. Primary among these benefits are:

- Direct involvement and control of the ambulatory surgery process (especially through the operations committee)
- Ability to perform surgery and to offer a high quality ambulatory surgery experience in a non-hospital environment
- Participation in an innovative alternative form of hospital-physician collaboration
- Physician recruitment tool
- Growth of outpatient surgery market share and related revenue base
- Recouping of original investment in freestanding ASC joint venture (with conversion to HOPD)
- An additional ongoing source of revenue without the risk of a capital investment
- Professional ASC management (with HVP as co-manager)

Benefits to hospital

There are a number of similar benefits to Hartford Hospital due to the conversion of WHSC to an HOPD using the co-management model. These benefits include:

- 100 percent ownership of a dedicated ambulatory surgery setting
- Participation in an innovative alternative form of hospital-physician collaboration
- Ability to offer a high quality ambulatory surgery experience in a non-hospital environment
- Freeing up of the hospital's OR space
- Physician recruitment tool

- Growth of outpatient surgery market share
- Enhanced profitability from ambulatory surgery (vs. shared profits under ASC joint-venture model)
- Professional management (with HVP as co-manager)

WHSC today

Since its formal opening in Sept. 2007, operating results for WHSC are supportive of the benefits to physicians and hospital as discussed above and are consistent with the original partnership guiding principles developed by Hartford Hospital and the Connecticut Surgical Group with HVP's assistance. A few examples would be:

- New surgical specialties have been added to include orthopedics, GYN and pain management.
- 34 new physicians (beyond the original CSG contingent) are now performing surgery at WHSC
- Surgical volume at WHSC increased by 36 percent in 2009 over 2008
- Discussions are underway about future WHSC expansion
- WHSC recently received national recognition for excellence in patient satisfaction

Summary

The ultimate success of the HOPD ASC approach in general and the co-management model specifically hinges on a number of factors discussed in this column. To reiterate just a few, we would stress the following key ingredients to success:

- Hospital and physician commitment to a collaborative approach
- Appropriate "balance" between hospital integration vs. operational freedom for the ASC
- Meaningful physician participation
- Involvement of experienced legal counsel and professional ASC management expertise

A properly designed and professionally implemented HOPD ASC approach, together with use of the co-management model, presents a unique opportunity for hospitals and physicians to collaborate in the provision of state-of-the-art ambulatory surgery. This has certainly been the case at WHSC.

Hartford Hospital and the Connecticut Surgical Group (as well as non-CSG physicians) are integrally involved in providing an enhanced outpatient surgery delivery model hand-in-hand with an innovative form of hospital-physician collaboration. Physicians and the hospital are working together to their mutual benefit and, more importantly, to the benefit of the patients and communities served by West Hartford Surgery Center. ■

John A. Smalley (jsmalley@hvpros.com) is a principal and co-founder of Healthcare Venture Professionals, a full-service ASC management, development and consulting company with special emphasis on physician-hospital collaborative ventures.

8 Statistics About Orthopedic Surgeon Compensation

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

1. 2008 — $476,083
2. 2007 — $450,000
3. Percent change 2007-2008 — 5.08 percent
4. 2006 — $436,481
5. Percent change 2006-2008 — 9.07 percent
6. 2005 — $409,518
7. Percent change 2005-2008 — 16.25 percent
8. Dollar change 2005-2008 — $66,565 ■

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

6 Statistics About Gastroenterologist Compensation

Here are the average annual salaries for gastroenterologists by region, according to the American Medical Group Association's *2009 AMGA Medical Group Compensation and Financial Survey*.

1. Median, all regions — $389,385
2. Average starting salary, all regions — $275,000
3. East — $401,615
4. West — $385,611
5. South — $385,542
6. North — $394,417 ■

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

8 Statistics About Ophthalmologist Compensation

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

1. 2008 — $325,384
2. 2007 — $305,301
3. Percent change 2007-2008 — 6.58 percent
4. 2006 — $295,510
5. Percent change 2006-2008 — 10.11 percent
6. 2005 — $281,112
7. Percent change 2005-2008 — 15.75 percent
8. Dollar change 2005-2008 — $44,272 ■

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

8 Statistics About Urologist Compensation

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

1. 2008 — $389,198
2. 2007 — $383,029
3. Percent change 2007-2008 — 1.61 percent
4. 2006 — $365,999
5. Percent change 2006-2008 — 6.34 percent
6. 2005 — $349,811
7. Percent change 2005-2008 — 11.26 percent
8. Dollar change 2005-2008 — $39,387 ■

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

15 Statistics About General Surgeons' Compensation

Here are 15 statistics about general surgeons' compensation.

Average salaries

1. Nationwide — $328,000

2. Northeast — $302,000

3. Southeast — $330,000

4. Midwest — $331,000

5. West — N/A*

6. Five years ago — $255,000

7. 10 years ago — $189,000

Median compensation

1. 2008 — $340,000

2. 2007 — $337,595

3. Percent change 2007-2008 — 0.71 percent

4. 2006 — $327,902

5. Percent change 2006-2008 — 3.69 percent

6. 2005 — $310,736

7. Percent change 2005-2008 — 9.42 percent

8. Dollar change 2005-2008 — $29,264 ■

**Insufficient data.*

Sources:
Items 1-7: "How Much Does Your Doctor Make?" *Forbes.*
Items 8-15: *AMGA 2009 Medical Group Compensation and Financial Survey. Reprinted with permission from the AMGA 2009 Medical Group Compensation and Financial Survey. ©2009, American Medical Group Association.*

15 Statistics About Anesthesiologist Compensation

Here are 15 salary statistics about the compensation of anesthesiologists.

Average salaries

1. Nationwide — $332,000

2. Northeast — $298,000

3. Southeast — $358,000

4. Midwest — $392,000

5. West — $310,000

6. Five years ago — $303,000

7. 10 years ago — $222,000

Median compensation

8. 2008 — $366,640

9. 2007 — $352,959

10. Percent change 2007-2008 — 3.88 percent

11. 2006 — $344,691

12. Percent change 2006-2008 — 6.37 percent

13. 2005 — $337,654

14. Percent change 2005-2008 — 8.58 percent

15. Dollar change 2005-2008 — $28,986 ■

Sources:
Items 1-7: "How Much Does Your Doctor Make?" *Forbes.*
Items 8-15: *AMGA 2009 Medical Group Compensation and Financial Survey. Reprinted with permission from the AMGA 2009 Medical Group Compensation and Financial Survey. ©2009, American Medical Group Association.*

3 Key Factors Affecting ASC Administrator Compensation

By Renée Tomcanin

The ASC Association *2009 ASC Employee Salary & Benefits Survey* recorded the median base salary for an ASC administrator at $92,957. VMG Health's *2009 Intellimarker* reports the median base salary at $101,348.

Several factors can affect base salary and overall compensation for ASC administrators, leading to such variations as seen above. In this article, Greg Zoch, partner with Kaye/Bassman, discusses three key factors affecting ASC administrator compensation.

1. Bonuses have been impacted by the economy. Many surgery centers have used the recent economic downturn as an opportunity to evaluate processes and see how they can improve revenue. Part of this has been cutting bonuses or reducing compensation, according to Mr. Zoch.

ASCs have felt the real impact of the economy through a drop in procedure volume, as some patients have chosen to postpone procedures due to unemployment. Other centers are still doing well but are concerned over future impact of the economic downturn on the ASC. Administrators in this situation are not seeing their salaries cut, but they aren't receiving raises either, according to Mr. Zoch. "Some bonuses have been eliminated as a pre-emptive measure against potentially falling case volumes. The centers are also choosing to forgo raises, but if the center continues to be profitable, they will make up ground on the bonuses," he says.

2. Reimbursements have affected compensation. Similar to the effects of a down economy, unemployment and poor reimbursements have also affected ASC adminstrators' compensation and bonuses, according to Mr. Zoch. "Many ASCs are seeing lower reimbursements through Medicare and third-party payors as well as more patients who are unemployed or have no insurance," he says. "Like with the down economy, some ASCs have seen their volume affected more than others."

Common trends in how patients schedule surgery also may affect bonuses, according to Mr. Zoch. For example, ASCs often see a seasonal dip in the first quarter when deductibles are reset for many patients. Likewise, there is an upward trend in the fourth quarter as patients want to schedule surgery before the deductibles reset. As a result, many ASCs rely on compensation through bonuses.

3. Base compensation has continued to grow. Basic supply and demand has led base compensation for ASC administrators to grow. "There are not enough people who can successfully manage an ASC," Mr. Zoch says. "Competition equals increased pricing, and ASCs will continue to pay for these experienced professionals."

Healthcare reform may also drive this competition, according to Mr. Zoch. "The ASCs that are most adaptable and can meet the needs of A-list talent, including surgeons and patients, will be the ones that continue to thrive."

Tips for ASCs when setting administrator salaries

Mr. Zoch notes that there is always a slight disconnect between what a job should pay and what the market says it should pay. Therefore, ASCs should be flexible when determining base salaries and should not go below market value.

"There will always be candidates who think they should be paid more than what the market says and employers who think they should pay less," Mr. Zoch says. "The market is what the market is, and it really does no good to go against it. Likewise, in order to keep talent, ASCs should not pay 'just enough' to keep administrators there."

Mr. Zoch suggests using the ASC Association's ASC Employee Salary & Benefits Survey as a starting point, but he notes that ASC's should consider the limitations of the data of any survey. "Averages typically represent good-to-average talent and are accurate in terms of those who respond to the survey," he says. "ASCs should want to pay above average for above average talent." ■

Learn more about Kaye/Bassman at www.kbic.com.

5 Ways to Reduce Costs and Bring New Business to a Surgery Center

By Barbara Kirchheimer

Bonnie Brady, RN, the administrator of Specialty Surgical Center in Sparta, N.J., shares five tips for reducing costs at an ASC. Ms. Brady has been with Specialty Surgical Center, a multispecialty, two-OR ASC, since May 2008. Since she arrived, the center's expenses have dropped significantly, and it has drawn new physicians and reduced overtime costs.

1. Regularly review all contracts. As soon as Ms. Brady arrived at the ASC in 2008, she looked at each and every contract and requested new quotes for everything from linens to malpractice insurance. She now goes back and reviews the contracts annually. "We call it 'shopping it out,' " she says.

2. Get staff buy-in for cost savings efforts. In this area, Ms. Brady says education is key. Even so, it does not happen overnight, she says. For that reason, Ms. Brady has really worked to engage the center's staff, and even the community, in efforts to understand an ASC's costs.

One way she did this was a variation on the traditional game of guessing the number of candies in the jar. Last summer, the center held an open house and hosted an event called "The Price is What." The surgical center's employees were asked to research costs and put price tags on everything in the center. "They were given price lists," Ms. Brady says. "They and the doctors were pretty surprised to find out what things cost." Legislators and community members were invited to the open house, where both of the center's ORs were set up and labeled with price tags, one for a knee arthroscopy procedure and the other for spine surgery. The costs of each OR, with all of the equipment and devices for the procedures, topped $1 million. Guests were asked to guess how much each OR cost, and the person who came closest received a prize. Nobody's guess came close to $1 million, and most guesses were in the $200,000-$300,000 range, Ms. Brady says.

"My goal was to educate the public and to educate legislators," she says. "What I got out of that was a more cost-conscious staff." Now the center's staff members know not to approach her with a request for a purchase unless they have at least two quotes in hand.

The cost-cutting measures do not stop at medical devices and office supplies. They also apply to larger business expenses. Ms. Brady is currently engaged in looking at the center's banking relationships to find out whether it is eligible for more favorable interest rates than it is currently receiving on outstanding loans. "We are constantly keeping up on what's out there," she says. "You have to be on top of things; you have to be aware, or you're going to get lost."

The efforts at frugality are paying off. In the past year, expenses have dropped from $600,000-$700,000 annually to roughly $460,000, she says.

3. Reach out to the community for customers and physicians. Reaching out can involve sponsoring seminars, hosting educational opportunities for physicians, joining the local chamber of commerce and partnering with local educational institutions, all of which the Specialty Surgical Center has done recently.

In addition to speaking to the local chamber about what an ASC is, Ms. Brady has organized a day of CPR training for the community to bring people to the center and see what goes on there. "We're trying to show everyone that we're there, and we're good," she says. "We want to be a good neighbor and I think we are."

Building a reputation in the community also helps bring in new physicians, which is critical to a center's growth, she says. The surgical center recently added a new physician partner and is likely to add several more in the near future, she says. Ms. Brady even went so far as to hire a marketer to seek out physicians who might be interested in building a relationship with the center.

4. Invest in technology. The Specialty Surgical Center recently deployed new practice management software that has streamlined patient registration and allowed for national benchmarking. This initiative has already had an impact on profitability, she says, with nursing overtime drastically reduced from an average of 12 hours of pre-op overtime per nurse per pay period to 30 minutes or less because nurses spend less time gathering information manually.

5. Be flexible. Ms. Brady says everyone who works at the center, from physicians to staff, knows that this is part of the job description. To remain competitive, the center will open on a Saturday or remain open late in the day to accommodate new business. "If you can't be flexible," she says, "you can't work here." ■

Contact Barbara Kirchheimer at barbara@beckersasc.com.

5 ASC Practices That Can Yield Big Financial Benefits

Gina Espenschied, administrative director of Surgery Center at Brinton Lake in Glen Mills, Pa., offers the following tips to help produce substantial financial benefits.

1. Get surgeons to agree on supplies. This requires tabulating accurate data of supply costs so they can see the money being saved by consolidating orders behind one or two vendors. To keep supply costs low, it also helps to renegotiate supply contracts periodically.

2. Don't try to gouge insurers. In a market with many competing ASCs, we know that an insurer can drop us at will, so it's important to be fair when negotiating with insurers. We share with them our real costs, directly from our Excel spreadsheets, and add just a small percentage for profit. This cultivates trust and keeps us in their networks.

3. Stay on top of surgeons' scheduling. For example, an orthopedic surgeon is scheduled for surgery in the ASC at noon, but when asked what he plans to do in the morning, it turns out he has two shoulder operations over at the hospital. Knowing that there is no way that he will complete those by noon, the scheduler suggests a start time of 2 p.m. at the ASC, instead of noon.

4. Treat non-partners like kings. Non-partners have no financial incentive to use the ASC, so they need to be courted. They prefer ASCs that are convenient and willing to be flexible with scheduling. If a non-partner needs a different time slot, it could mean asking a partner to switch. Partners understand this is key to the financial health of the ASC.

5. Staff should be flexible about work. Agreeing to work flexible hours is a prerequisite for employment at our ASC. We let staff members work out scheduling among themselves, starting with a rough format a month in advance, then tweaking it as the date comes nearer. If a surgeon is running late, staff might take off to workout in the gym or go grocery shopping. ■

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Health Reform's Impact on ASCs: Commentary From Marian Lowe of ASCAC

By Leigh Page

As the new health reform law, the Patient Protection and Affordable Care Act, was debated and passed by Congress, the Ambulatory Surgery Center Advocacy Committee was working hard to make sure surgery centers' interests were included. The group, representing national and state ASC associations and all types of ASC operators and physicians, has been spreading the message that ASCs can provide the most cost-effective surgery — both for patients and payors — and thus help contain the tremendous costs of health reform for U.S. taxpayers.

"The ASCAC is committed to educating agency and Congressional leaders about the innovative model of patient care that ASCs provide as a cost-effective solution for patients, as well as the health care system as a whole," says ASCAC Executive Director Marian Lowe. Ms. Lowe provided the following summary of how the new reform law will affect the industry.

Closing the payment gap. Thanks to efforts by industry leaders and activists, ASCs were protected from the inflation update in 2010. Congress had imposed six years of Medicare rate freezes up to 2010, pushing down ASC reimbursements from 86 to 58 percent of pay for hospital outpatient departments for identical services. Moving from the Consumer Price Index, an update factor unrelated to ASC costs, to the hospital market basket will provide ASCs a higher level of resources each year than they would have received under the CPI.

"This is the first payment update for ASCs in six years and an important victory for the industry," Ms. Lowe says. "ASCs need to have the resources to keep pace with new technology, implement reporting systems, and continue to provide superior patient care."

Providing access to care. The reform bill will expand coverage to 32 million more Americans. As financial barriers to benefits and services are removed, ASCs will likely experience an increase in volume of patients treated, particularly for services like screening colonoscopies, which insured patients are more likely to use. A key provision of the bill waives patients' coinsurance for important preventive services recommended by the U.S. Preventive Services Task Force, such as colorectal cancer screenings. Currently, ASCs perform almost half of all Medicare colonoscopies. With increased access to coverage and no co-pay for this service, ASCs are expected to see a higher demand for these procedures.

About half of people getting access to care under health reform will be in Medicaid. ASCs will need to work closely with their state associations to understand their own state Medicaid program, ensure adequate reimbursement, work for inclusion in provider networks and help beneficiaries access care in ASCs.

Supporting pay-for-performance. The new law directs CMS to report to Congress on how Medicare could incorporate value-based purchasing strategies in ASCs. The ASCAC will work with CMS to ensure that the agency's recommendations are appropriate for the industry and provide plenty of time for ASCs to implement reporting before payments are at risk for performance. As with other value-based systems, the program for ASCs will likely be designed to reward health care providers and facilities achieving performance measures and demonstrating quality improvements.

Working with a new payment board. The reform law creates an Independent Payment Advisory Board charged with reducing Medicare costs. Beginning in 2014, if the Medicare growth rate surpasses its target, the board will recommend ways for CMS to cut Medicare payments to ASCs and other providers, but hospitals will be exempt from board reductions until 2020. (The reform law already imposes cuts to hospitals' Medicare payment updates and funding for uncompensated care.)

"ASCs want to be part of the solution to rising costs by providing high-quality, patient-centered care at a savings for both the patients and payors," Ms. Lowe says. "Given the impact that the review board could have on ASC payment rates, we are very focused on highlighting how improving the use of ASCs can bend the cost curve and save the government money." ■

Contact Leigh Page at leigh@beckersasc.com.

49 ASC Management & Development Company CEOs to Know

Sami Abbasi (National Surgical Care). Mr. Abbasi serves as chairman and CEO of National Surgical Care. He previously served as co-founder, president and CEO of Radiologix, a leading national provider of diagnostic imaging services, until the company's sale to RadNet in Nov. 2006. He also served as COO and CFO of Adminiquest, a web-enabled, full-service outsourcing solutions provider to the insurance and benefits industry. Mr. Abbasi was a vice president in the healthcare group of Robertson Stephens and CitiGroup. He currently serves on the board of directors of Behringer Harvard Multifamily REIT and American CareSource Holdings. Mr. Abbasi earned an MBA from the University of Rochester (N.Y.).

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

Robert J. Carrera (Pinnacle III). Mr. Carrera is the president of Pinnacle III. With more than 20 years of healthcare experience, he has spent the last 15 years developing and managing ASCs, physical/occupational rehabilitation centers, diagnostic imaging facilities and occupational medicine clinics nationally. Mr. Carrera has been active legislatively at the state level regarding issues affecting ASCs in Colorado, Minnesota and Utah. He formerly served as the Colorado Ambulatory Surgery Center Association's vice president and was one of its founding members.

Ravi Chopra (The C/N Group). Prior to founding The C/N Group in 1980, Mr. Chopra served in various executive management positions in the steel industry, including chief industrial engineer for Youngstown Steel (now International Steel Group) and director of engineering services for Wisconsin Steel (now Envirodyne Industries). He holds a BS in mechanical engineering from Punjab Engineering College in Chandigarh, India; an MS in electrical engineering from Oklahoma State University in Stillwater, Okla.; and an MBA from Xavier University in Cincinnati, Ohio. Mr. Chopra's sons, Raman Chopra and Rajiv Chopra, work as CIO and director of strategic planning, respectively, for the company.

James Cobb (Orion Medical Services). Mr. Cobb is founder, president and CEO of Orion Medical Services. With more than 38 years in management, Mr. Cobb has primarily focused the last 25 years of his career in the medical field. In the past 12 years, he has developed, constructed and managed seven high-volume ASCs. He previously served as CEO for the Pacific Cataract Laser Institute and Pacific Eye Center. He is a member of the Medical Group Management Association and began his healthcare career as an assistant business manager for a practice comprised of 25 radiologists in 1980. On a personal note, Mr. Cobb holds a private pilot's license and is a member of the Aircraft Owners and Pilots Association.

R. Blake Curd, MD (Surgical Management Professionals). Prior to accepting the interim CEO position at SMP, Dr. Curd served as chairman of the board from 2005 and vice chair from 2003-2005. He also serves as a member of the acquisition committee for Medical Facilities Corp. A hand and microvascular surgeon at the Orthopedic Institute in Sioux Falls, S.D., Dr. Curd was the chairman of orthopedic surgery at Avera McKenan Hospital and University Health Center in Sioux Falls from 2003-2004. Dr. Curd currently is a member of the South Dakota House of Representatives and is running for a Congressional seat. He is a veteran of the Persian Gulf War.

Richard DeHart (Pinncale III). Mr. DeHart has more than 20 years of experience in the outpatient healthcare industry and currently serves as CEO of Pinnacle III. He began his healthcare career as a certified athletic trainer in professional baseball. He then joined the sports medicine team at Alabama Sports Medicine and Orthopaedic Center in Birmingham. He later moved to an administrative role where he provided operational services for multiple outpatient rehabilitation facilities. Prior to co-founding Pinnacle III in 1999, Mr. DeHart oversaw the management of 14 surgery centers in five states for one of the nation's largest publicly traded healthcare companies.

Richard Francis Jr. (Symbion). At Symbion, Mr. Francis serves as chairman and CEO, overseeing the company's more than 70 short-stay surgical facilities across 27 states. Prior to the formation of Symbion, Mr. Francis served as president and CEO of UniPhy, an operator of multi-specialty clinics, independent practice associations and related outpatient services. Earlier in his career, he was the senior vice president of development for HealthTrust, where he also served as a regional vice president with responsibility for the operations of 11 hospitals in five states.

Jon H. Friesen (Foundation Surgery Affiliates). Mr. Friesen has served as president of Foundation Surgery Affiliates since Jan. 2009. He previously served as CFO and chief strategic planning officer of FSA's parent company, Foundation HealthCare Affiliates. In Jan. 2009, FHA spun off FSA in order to create a subsidiary focused exclusively on the management and development of ASCs. Mr. Friesen began his career with KPMG Peat Marwick and has spent the last 20 years in the healthcare industry where he has served in such progressive management positions as CFO, COO and CEO of various managed healthcare organizations.

Tom Galouzis, MD (Nikitis Resource Group). Dr. Galouzis is CEO of Nikitis and a practicing board-certified general surgeon in northwest Indiana. He previously was as a member of the department of surgery at the University of Chicago Pritzker School of Medicine. Since 1999, Dr. Galouzis has served as president of Lake Park Surgicare in Hobart, Ind. He has also served as president of Lake-Porter Ambulatory Surgery, a physician holding company for physician joint ventures since 1999. He is president of Lakeshore Surgicare, in Chesterton, Ind.

Gregory George, MD, PhD (SurgCenter Development). Dr. George is founding principal of SurgCenter Development and a practicing ophthalmologist. He graduated from M.I.T., received his medical degree and a PhD in ocular physiology from Duke University in Durham, N.C. Under Dr. George's leadership, SurgCenter Development has developed over 60 physician-owned ASCs.

John Hajjar, MD, FACS, MBA (Surgem). Dr. Hajjar, CEO of Surgem, is a urologist who developed one of the first ASCs in New Jersey at Fair Lawn and has been managing facilities since 1992. Dr. Hajjar also operates one of the largest private urology practices in the United States, with 17 physicians in 11 locations. He also participates in and performs surgery at two of Surgem's locations. Dr. Hajjar studied medicine at Georgetown University School of Medicine in Washington, D.C., and completed his surgical and urological training at New York University Medical Center in New York City.

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

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

Andrew Hayek (Surgical Care Affiliates). Mr. Hayek is president and CEO of Surgical Care Affiliates. Before joining SCA, Mr. Hayek served as president of VillageHealth, an insurance and care management company owned by DaVita, a leading independent provider of kidney dialysis services. Prior to his role at VillageHealth, he served as president and COO of Alliance Imaging, and worked for Capstone Consulting (an operations consulting firm affiliated with private equity firm Kohlberg Kravis Roberts & Co.), The Pritzker Organization (a merchant banking firm affiliated with the Pritzker family of Chicago, owners of Hyatt Hotels) and the Boston Consulting Group. He currently is active in ASC advocacy efforts and serves as chair of the ASC Advocacy Committee.

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

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

Jeremy Hogue, JD (Sovereign Healthcare). In addition to serving as CEO of Sovereign, Mr. Hogue manages and consults with numerous healthcare ventures and physician practices. Prior to co-founding Sovereign, Mr. Hogue was vice president of Audax Group, a $1-billion private equity investment firm where he launched and ran the firm's West Coast office and directed investments into several early-stage and middle-market businesses. Prior to Audax Group, he was an associate with Lehman Brothers, where he was a member of the firm's investment banking group. Mr. Hogue received his juris doctorate from Harvard Law School and his MBA from the University of Southern California. Mr. Hogue was an All-American offensive lineman at USC and authors a column for the website WeAreSC.com, an ESPN affiliate.

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

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

Brent Lambert, MD (Ambulatory Surgical Center of America). Dr. Lambert is the chairman of the board and a founder of Ambulatory Surgical Centers of America. He is a board-certified ophthalmologist and responsible for business development at ASCOA. Prior to the founding of ASCOA, Dr. Lambert was the developer and owner of three ASCs, including the first eye ASC in New England. He is a graduate of Harvard College, Columbia University College of Physicians and Surgeons, Harvard Medical School and the Massachusetts Eye & Ear Infirmary residency program.

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

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

Scott Leggett (Surgery One). Mr. Leggett is CEO of Surgery One, which manages four multi-specialty ASCs in the San Diego area. His has more than 17 years of experience in orthopedics and holds a master's degree in exercise and sports science from the University of Florida in Gainesville. He has also been featured on a series of educational videos on healthcare employment and interviewing on the career resource and job seeker website, www.jobing.com.

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

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

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

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

Thomas A. Michaud (Foundation Hospital Affiliates). Prior to founding Foundation HealthCare Affiliates in Jan. 1996, Mr. Michaud held the positions of COO and CFO of a regional surgery center management company. In Jan. 2009, Foundation HealthCare launched two subsidiaries — Foundation Hospital Affiliates and Foundation Surgery Affiliates. Mr. Michaud serves as CEO for the hospital company and chairman of the parent company. During his career, has also developed bariatric centers. Other experience includes that of partner in a local CPA firm, COO of a regional wholesale company, along with holding of the upper management positions of manager of management information systems as well as manager of materials at an aerospace company. Mr. Michaud is a CPA, which he earned while serving as a staff accountant with Ernst & Young.

Krystal Mims (Texas Health Partners). Prior to becoming president of Texas Health Partners, Ms. Mims served as CFO for Physician's Medical Center, a specialty hospital in Plano, Texas; Southlake Specialty

Hospital in Southlake, Texas; and Presbyterian Hospital of Rockwall in Rockwall, Texas, until August 2007. Her background in healthcare began in physician practice management. She was CFO for Texas Back Institute for three years, CFO of Practice Performance and administrator of Steadman Hawkins' Denver clinic. Ms. Mims served as secretary and CFO of Parker Road Surgery Center when Texas Health Partners formed this Dallas joint venture in 1994. Ms. Mims is also a CPA and began her career with KPMG Peat Marwick.

Kris Mineau (Constitution Surgery Centers). Mr. Mineau co-founded CSC in 1997 and has led the company's growth over the past 10 years. With surgery centers in Connecticut, Massachusetts and Rhode Island, CSC's partnerships extend to over 200 physicians and three hospitals. Prior to founding CSC, Mr. Mineau was a pilot in the United States Air Force. He commanded several different types of aircrafts flying a variety of missions worldwide. Mr. Mineau received a bachelor's degree in management from The United States Air Force Academy in 1988. He is involved in numerous professional organizations including the Connecticut Association of Ambulatory Surgery Centers, where he served as its founding president.

Fred W. Ortmann III (Ortmann Healthcare Consultants). Mr. Ortmann, founder and CEO of Ortmann Healthcare Consultants, has more than 17 years of experience developing ASCs. He received his undergraduate degree from the University of South Carolina and his MHA from Baylor University. He was then commissioned in the USAF Medical Service Corps and served in a variety of positions during a 22-year career. Mr. Ortmann retired as a colonel in 1989 and began his private career as an administrator with Presbyterian Hospital in Albuquerque, N.M. After two years, he was asked to join the initial staff of AmSurg Corp., and served as its vice president for center development. He left AmSurg in 2001 and founded Ortmann Healthcare Consultants. He has also served as a consultant to Olympus America.

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

John Rex-Waller (National Surgical Hospitals). Prior to his work as chairman, president and CEO of NSH, Mr. Rex-Waller was CFO of Hawk Medical Supply, a provider of disposable medical supplies to physicians. Previously he was the CFO and a co-founder of National Surgery Centers, which became one of the largest independent owners and operators of surgery centers in the country. He has been an investment banker, has an MBA from the University of Chicago and is a Rhodes Scholar.

J. Michael Ribaudo, MD (Surgical Synergies). Dr. Ribaudo has more than 27 years of experience as a surgeon, healthcare executive and real estate developer. He is a leader in the development of physician-owned ASCs and has served as executive vice president of Surgical Health Corp. and HealthSouth Surgery Centers. He currently serves on the board of directors for Flow International and chairs its compensation committee. He is also co-founder of Surgical Anesthesia Services. Dr. Ribaudo graduated from Louisiana State Medical School with graduate medical school training at Emory Univer-

sity, Washington University and New York University. He has received postgraduate training at Harvard Law School, Kellogg Business School and Stanford Graduate School of Business.

John Schario (Nueterra Healthcare). Mr. Schario currently serves as CEO of Nueterra. Prior to joining Nueterra in 2001, Mr. Schario spent 20 years as an executive of a major Midwestern integrated health system. His background includes building physician referral networks, managing acute-care hospitals and the development and operation of surgery centers and imaging facilities. Mr. Schario earned an MBA from Rockhurst University in Kansas City, Mo. He is also an active member of the American College of Healthcare Executives.

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

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

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

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

Barry Tanner (Physicians Endoscopy). Mr. Tanner is president and CEO of Physicians Endoscopy. Before joining PE, Mr. Tanner was the co-founder, CFO and COO of Navix Radiology Systems in Miami, which he helped found. Over a period of four years, Mr. Tanner contributed to building the company from zero to over $75 million in revenues, including the acquisition of seven professional radiology practices and orchestrating the acquisition and financing of a major diagnostics company. Mr. Tanner also served as COO of HealthInfusion, a Miami-based provider of home intravenous therapy services.

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

Larry Teuber, MD (Medical Facilities Corp.). Dr. Teuber is president of Medical Facilities Corp. and founder and physician executive of Black Hills Surgery Center, one of the country's most successful small surgical hospitals. He is a board-certified neurological surgeon and the founder and managing partner of The Spine Center in Rapid Falls, S.D. Dr. Teuber earned his medical degree from the University of South Dakota in Vermillion. He then completed his general surgery internship and neurosurgery residency at the Medical College of Wisconsin. Dr. Teuber also served for 17 years in the active and reserve Army as an aviation and medical officer, retiring with the rank of major after serving in Desert Storm.

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

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

Donald Wilson (Cirrus Health). Prior to founding one of Cirrus' predecessors in 1996, Mr. Wilson, now CEO of Cirrus Health, developed an extensive commercial real estate portfolio in various locations across Texas and surrounding states. Over the last 10 years, Mr. Wilson's focus has been exclusively devoted to the development of medical operations platforms and medically oriented real estate projects. In addition to his work in medical operations, Mr. Wilson has participated in more than 40 medical real estate development projects including ASCs, specialty surgical hospitals, acute-care hospitals, medical office buildings, primary care clinics, radiation oncology units and other complex medical facilities. Mr. Wilson earned a bachelor of business administration from the University of Texas.

Tom Yerden (TRY Health Care Solutions). Mr. Yerden has more than 28 years of experience spanning the development of 70 surgery centers and the founding of Aspen Healthcare in 1992, which he sold to a national firm in 2005. Prior to forming Aspen Healthcare, Mr. Yerden held COO and CEO positions in several healthcare systems and large physician group practices where he developed outpatient surgery centers and new outpatient surgical delivery systems. He hosts an ASC governing board retreat program in Salmon, Idaho. In addition, he is a national speaker and author on ASC issues.

Joseph Zasa, JD (ASD Management). Prior to co-founding ASD Management (formerly Woodrum/ASD) in 1996, Mr. Zasa served as corporate counsel for Premier Ambulatory Systems. He has published numerous articles on ambulatory surgery operations, development and management. He also previously served as regional director of surgery center operations for ProSurg, a division of American Ophthalmic. He received his juris doctorate from Washington and Lee University in Lexington, Va., and he is a member of the Virginia State Bar.

J.A. Ziskind (Global Surgical Partners). Mr. Ziskind, president and CEO of Global Surgical Partners, has been a healthcare attorney since 1984 and involved in Florida's healthcare industry since the 1970s. Prior to founding Global Surgical Partners, Mr. Ziskind served as CEO of Cedars Medical Center in Miami. He has also served as general counsel to the Dade County Medical Association since and was co-founder and served as general counsel to the Florida Society of Ambulatory Surgical Centers. He has also served on the board of directors for Mercy Hospital Foundation and the Pan American Hospital, both in Miami. ■

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PROGRAM SCHEDULE

Pre Conference – Thursday October 21, 2010

11:30am – 1:00pm	Registration
1:00pm – 5:30pm	Pre-Conference
5:30pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 22, 2010

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:40pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:45pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 23, 2010

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

Thursday, October 21, 2010

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

1:00 – 1:40 pm
ASC Strategies for the Foreseeable Future - A View of The National Landscape Trends Through the ASC Prism - Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, and Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America

1:45 – 2:25 pm
Selling Shares and Resyndication - Larry Taylor, CEO Practice Partners in Healthcare and Melissa Szabad, JD, Partner, and Elaine Gilmer, McGuireWoods, LLC

2:30 – 3:05 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, and Reed Simmons, Administrator, Treasure Coast Center for Surgery

3:10 – 3:45 pm
5 Steps to Have Your ASC Maximize its Profits - Chris Bishop, SVP, Acquisitions & Business Development, Blue Chip Surgical Center Partners

3:50 – 4:25 pm
What Every Surgeon Should Know; What Really Matters to Your Manager? - Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

4:30 – 5:30 pm - KEYNOTE
Leadership and Motivation in 2010 - Coach Bob Knight, Legendary NCAA Basketball Coach

Session B – Spine, Orthopedics, Pain and General Surgery

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

1:45 – 2:25 pm
Keys to Great Success with Outpatient Spine Surgery in ASCs - Richard Wohns, MD, Founder Neospine and South Shore Surgery, Introduced by Michael Weaver, VP Acquisitions & Development, Symbion, Inc.

2:30 – 3:05 pm
Assessing and Improving the Profitability of Orthopedic, Spine and Pain in ASCs - Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America

3:10 – 3:45 pm
Building Outstanding and Profitable Pain Management Programs, Making Pain Profitable - Stephen Rosenbaum CEO, and Robin Fowler, MD, Medical Director, Interventional Management Services

3:50 – 4:25 pm
General Surgery in ASCs - What you Can and Can't Do - Bob Scheller, Jr., CPA, CASC, Chief Operating Officer, and Tom N. Galouzis, MD, FACS, President & CEO, Nikitis Resource Group

Session C – GI, Ophthalmology and Management

1:00 – 1:40 pm
GI - Centers What to Expect for the Next Five Years - John Poisson, EVP & Strategic Partnerships Officer, Physicians Endoscopy

1:45 – 2:25 pm
Benchmarking for GI Centers - Barry Tanner, President & CEO, and Karen Sablyak, EVP, Management Services, Physicians Endoscopy

2:30 – 3:05 pm
Using Ophthalmology as the Beach Head of a Center - Cataracts, Retina and IOLS Ophthalmologists as Leaders - Carol Slagle, Administrator, Specialty Surgery Center of New York, John Fitz, MD, Medical Director, Precision Eye Care, Joseph Zasa, JD, Partner, ASD Management, Moderator

3:10 – 3:45 pm
Dealing With Difficult Physicians - John Byers, MD, Medical Director, Surgical Center of Greensboro, Orthopaedic Surgical Center, Introduced by Holly Ramey, Vice President of Operations, Surgical Care Affiliates

3:50 – 4:25 pm
Tomorrow is Now, Prepare Your ASC for an Uncertain Future, Rajiv Chopra, Principle and CFO The C/N Group, Inc.

Session D – General Management and Accreditation

1:00 – 1:40 pm
How to Reduce Costs and Hours Per Case - Joyce Deno Thomas, RN, BSN, SVP Operations

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& Corporate Clinical Director, Regent Surgical Health and Nap Gary, Chief Operating Officer, Regent Surgical Health

1:45 – 2:25 pm
We Don't Need a Hospital or Management Company - Thriving as an Independent ASC - Keith M. Metz, MD, Great Lakes Surgical Center

2:30 – 3:05 pm
How to Recruit and Retain Great Talent - Doug Smith, President, BE Smith

3:10 – 3:45 pm
The Most Common Accreditation Problems - Raymond F. Grundman, MSN, CASC, former President, AAASC, Edward Glinski, D.O., MBA, CPE, Heritage Eye Surgicenter of OK, moderated by Debra Stinchcomb, Progressive Surgical Solutions

3:50 – 4:25 pm
Infection Control in ASCs - Best Practices and Current Ideas - Cassandra Speier, Senior Vice President of Operations, NovaMed

Session E – Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Managed Care Negotiation Strategies - 10 Key Tips - I. Naya Kehayes, MPH, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management

1:45 pm – 2:25 pm
Information Technology - Key Ways to Improve Your Centers Operations - What are the Best Solutions? - Jennifer Brown, RN, Nurse Manager, Gastroenterology Associates of Central Virginia

2:30 – 3:05 pm
Meeting Today's Reimbursement Challenges: "A Case Study for Success" - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing, and Nancy Easley-Mack, LPN, Business Office Manager, Short Hills Surgery Center

3:10 – 3:45 pm
The Top 10 Reasons Claims are Being Denied - Lisa Rock, President, National Medical Billing Services

3:50 – 4:25 pm
EMR What Should It Cost; What System Should our ASC Adapt? Best Practices; Policies and Implementation - Patrick Doyle, VP Sales, SourceMedical

Session F – Valuation and Transaction Issues

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

1:45 – 2:25 pm
Selling Your ASC - A Process and Plan - What Can you Expect? - Evelyn Miller, CPA, VP Mergers & Acquisitions, United Surgical Partners International, Inc. Michael Weaver, VP Acquisitions & Development, Symbion, Inc., Tom Chirillo, SVP Corporate Development, NovaMed, Jon O'Sullivan, Senior Partner, VMG Health, Scott Downing, JD, Partner, McGuireWoods LLP, Moderator

2:30 – 3:05 pm
Co-Management Relationships With HOPDs - Krist Werling, JD, McGuireWoods, LLP and Scott Safriet, MBA, AVA, Principal, Healthcare Appraisers

3:10 – 3:45 pm
ASC and Healthcare Transactions - The Year in Review - Todd Mello, ASA AVA MBA, Principal & Founder, Healthcare Appraisers, Inc.

3:50 – 4:25 pm
ASC Litigation, Non Competition, Employee Litigation and Other Kinds of Litigation, Key Thoughts - Jeffrey C. Clark, Partner and David J. Pivnik, Associate, McGuireWoods, LLP

5:30 pm
Cocktail Reception, Cash Raffles and Exhibits

Friday, October 22, 2010

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

8:10 – 9:00 am - KEYNOTE
Politics, Healthcare Reform and the 2010 Election - Tucker Carlson, Contributor, FOX News, Editor-in-Chief, The Daily Caller and Senior Fellow, The Cato Institute

9:05 – 9:45 am
The State of The ASC Industry - Andrew Hayek, President & CEO Surgical Care Affiliates

9:50 – 10:30 am
Healthcare Reform and Its Impact on ASCs - Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, Tom Mallon, CEO & Founder, Regent Surgical Health, Marian Lowe, Partner, Strategic Health Care, Moderated and Led by David Shapiro, MD, Director of Medical Affairs, AMSURG

10:30 – 11:20 am
Networking Break & Exhibits

11:25 – 12:10 pm
General Session A
Developing a Strategy for your ASC in Challenging Times - Larry Taylor, President & CEO, Practice Partners in Healthcare, Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Joseph Zasa, JD, Partner, ASD Management, William G. Southwick, President & CEO, Healthmark Partners, Inc.

General Session B
Orthopedics - The Next Five Years - John Cherf, MD MPH MBA, President, OrthoIndex

11:25 – 1:00 pm
General Session C
An 80 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, Chief Financial Officer, Susan Kizirian, Chief Operating Officer, and Ann Geier, RN MS CNOR CASC, SVP of Operations, Ambulatory Surgical Centers of America

12:15 – 1:00 pm
General Session A
The Best Ideas to Immediately Improve the Profitability of Your ASC - Thomas S. Hall, Chairman, President & CEO, NovaMed, I. Naya Kehayes, MPH, Managing Principal & CEO, Eveia Health Consulting & Management, Jeff Leland, CEO, Blue Chip Surgical Center Partners, Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing

General Session B
What Works and What Doesn't in Hospital JV's - Brett Brodnax, EVP and Chief Development Officer, United Surgical Partners International, Inc. and Scott Nordlund, Vice President, Catholic Healthcare West

1:00 – 2:00 pm
Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F

Session A – Ideas to Improve Profits

2:00 – 2:35 pm
The Best Procedures for ASCs and What an ASC Should Get Paid - Matt Lau, Director of Financial Analysis, and Mike Orseno, Revenue Cycle Director, Regent Surgical Health

2:40 – 3:15 pm
Practical Tips for Recruiting Physicians - Dale Holmes, Administrator, Warner Park Surgery Center

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
10 Steps to Reduce Costs in ASCs - John Snyders, VP Operations and Anita Lambert-Gale, VP Clinical Services, HealthMark Partners, Inc.

4:30 – 5:05 pm
A Checklist Guide - 7 Steps to Take to Improve Profits Today - Kyle Goldammer, SVP Finance, Surgical Management Professionals

5:10 – 5:40 pm
Should 2 ASCs Merge? The Pros, the Cons and the Next Steps, Can 1+1 Make 3? - A Case Study Review - Tom Yerden, CEO & Founder, TRY HealthCare Solutions

Session B – Orthopedic and Spine ASC Issues

2:00 – 2:35 pm
Handling Complex Spine Cases in an ASC, Clinical and Financial Issues - Marcus Williamson, President, Symbion Neospine Division

2:40 – 3:15 pm
Orthopedics in a Changing Market - TK Miller, MD, Medical Director and Orthopedic Surgeon, Roanoke Orthopaedic Center and Joseph Zasa, JD, Partner, ASD Management

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Current Issues and Advances in Orthopedics - Jack Jensen, MD, Athletic Orthopedics and Knee Center, Michael R. Redler, MD, The OSM Center, John Cherf, MD MPH MBA, President, OrthoIndex, and Elaine Gilmer, JD, McGuireWoods, LLP, Moderator

4:30 – 5:05 pm
Key Thoughts on Urology, Orthopedics and Partners – Brian Zowin, President, Physician Advantage, Inc., Rob Carrera, President, Pinnacle III, Herbert W. Riemenschneider, MD, Riverside Urology, Inc., Moderator Barton C. Walker, JD, McGuireWoods LLP

5:10 – 5:40 pm
Key Steps to Reduce Implant Costs - John Cherf, MD MPH MBA, President, OrthoIndex and Kendra Obrist, SVP, Marketing & Product Development, Access MediQuip

Session C – GI, Opthalmology, ENT, Urology and Pain Management

2:00 – 2:35 pm
GI - How to Thrive in a Declining Reimbursement Market, Barry Tanner, CPA, President & CEO, Physicians Endoscopy

2:40 – 3:15 pm
Ophthalmology, ENT and Pain Management in ASCs - Current Ideas to Increase Profits- Tammy Ham, President, Surgical Specialty Division, and Reed Martin, Group Vice President, Nueterra Healthcare

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Taking Bold Steps to Build Case Volume - Our Direct Access, Screening Colonoscopy Program A Great Case Study - Cindy Givens, Executive Director, and Christine Corbin, MD, Medical Director, Surgery Center at Tanasbourne

4:30 – 5:05 pm
Using Anesthesia to Improve the Effectiveness of Your OR's, Marc E. Koch, MD, MBA, President & CEO, Somnia Anesthesia

5:10 – 5:40 pm
The Cost Benefit to Outsourcing Your Back Office Operations - What Can You and Can't You Outsource? - Tom Jacobs, President & CEO, MedHQ

Session D – Physician Owned Hospitals, Other Models of Physician Hospital Integration

2:00 – 2:35 pm
Healthcare Reform and Its Impact on Physician Owned Hospitals - What Does One Do Now? What are the Alternatives? - Brett Gosney, MD, CEO, Animas Surgical Hospital, and Molly Sandvig, JD, Executive Director, Physician Hospitals of America

2:40 – 3:15 pm
Adjusting to Married Life - Stories of JV Integrations with ASC Partners - Monica Cintado-Scokin, SVP Development, United Surgical Partners, Inc., and Michael Stroup, VP Development, United Surgical Partners

3:15 – 3:45 pm
Networking Break and Exhibits

3:50 – 4:25 pm
Lithotripsy Models and Current Issues with Lithotripsy ASC Relationships - Jay Sweetnich, NovaMed, Inc., Todd J. Mello, ASA, AVA, MBA, Principal, Healthcare Appraisers, Inc.

4:30 – 5:05 pm
Co-Management Arrangements - Valuation and Other Issues- Jen Johnson, CFA, Managing Director, VMG Health and Melissa Szabad, JD, Partner, McGuireWoods, LLP

5:10 – 5:40 pm
Partnership Restructuring A Case Study - Danny Bundren, CPA, JD, Symbion Healthcare

Session E – Managed Care, Revenue Cycles and Reimbursement Issues

2:00 – 2:45 pm
How to Assess if Your ASC Should be In or Out of Network - I. Naya Kehayes, MPH, Managing Partner & CEO, Eveia Health Consulting & Management, and Melissa Szabad, JD, Partner, McGuireWoods, LLP

2:40 – 3:15 pm
How to Handle New Pressure from Payors on Out of Network Issues - Tom Pliuria, MD, J.D., zChart

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Ambulatory Anesthesia - Using a Management Company versus Employing an Anesthesia Team - Gregory Wachowiak, MHA, Co-Founder & President, Anesthesia Healthcare Partners

4:30 – 5:05 pm
Key Steps to Improve Billing and Increase Collections - Bill Gilbert, VP Marketing, AdvantEdge Healthcare Solutions

5:10 – 5:40 pm
10 Ways to Improve an ASCs Coding - Document Deficiencies, Financial Impacts and How to Work with Physicians - Cristina Bentin, CCS-P, CPC-H, CMA, Founder, Coding Compliance Management, LLC

Session E – Leadership, Competition and Legal Issues

2:00 – 2:35 pm
What Great Administrators Should be Paid and What They Should Do to Excel? - Greg Zoch, Partner & Managing Director, Kaye Bassman International

2:40 – 3:15 pm
The Most Common Medical Staff Issues and How to Handle Them - Thomas J. Stallings, Partner, McGuireWoods LLP

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Medical Director 101 - What it Takes to be a Great Medical Director - Dawn McLane, RN, MSA, CASC, CNOR, Chief Development Officer, Nikitis Resource Group, and Jenni Foster, MD, The ASC at Flagstaff

4:30 – 5:05 pm
How to Develop a Successful ASC Joint Venture with a Hospital - Robert Zasa, MSHHA FACMPE, Founder, ASD Management

5:10 – 5:40 pm
How to Value and Sell an Under Performing ASC - Chris Bishop, SVP, Acquisitions & Business Development, Blue Chip Surgical Center Partners

5:45 – 7:00 pm
Cocktail Reception, Cash Raffles and Exhibits

Saturday, October 23, 2010

8:10 – 8:50 am
ASCs and Healthcare - An Overview of the Key ASC Trends and Large ASC Chains -Tom Mallon, CEO and Founder, and Vivek Taparia, Director of Business Development, Regent Surgical Health

8:55 – 9:40 am - KEYNOTE
Peak Performance - How to Achieve Peak Performance as a Person and an Organization - Lt. Colonel Bruce Bright, President & CEO, The Bright Consulting Group

Concurrent Sessions A, B, C, D, E

Session A

9:45 – 10:45 am
Physicians, Hospitals, and Management Companies - What it Takes to Make a Winning Partnership and ASC - Jeffrey Simmons, Chief Development Officer, Nap Gary, Chief Operating Officer, Regent Surgical Health

10:50 – 11:50 am
How to Start a Spine Focused Center - Jeff Leland, CEO, Blue Chip Surgical Center Partners

Session B

9:45 – 10:45 am
10 Keys to Great Performance as a DON - Sarah Martin, MBA, RN, CASC, Regional Vice President of Operations, Meridian Surgical Partners, Lori Martin, Administrator, Surgery Center of Reno, Anne M. Remm, RN, BSN, Administrator, Miracle Hills Surgery Center

10:50 – 11:50 am
Accreditation 101, Everything You Need to Know About ASC Accreditation - Marilyn K. Kay, RN, MSA, HFAP Nurse Surveyor, fomerly Vice President of Patient Care Services and Chief Nursing Officer, Henry Ford Bi-County Hospital, HFAP

Session C

9:45 – 10:45 am
Why Develop an ASC and Why Now is a Great Time to Do So? Key Steps for Development - John Marasco, AIA, NCARB, Principal & Owner, Marasco & Associates, and Rob McCarville, MPA, Principal, Medical Consulting Group

10:50 – 11:50 am
Can You Split Up Shares Based on Value of Cases; Can you Redeem 1 Non Safe Harbor Doctor and Keep Others in? Can You Amend Your Operating Agreement to Require Safe Harbor Compliance - Scott Becker, JD, CPA, Partner, Elissa Moore, JD, Gretchen Townshend, JD, and Sarah Abraham Chacko, JD, McGuireWoods, LLP

Session D

9:45 am – 10:45 am
Making the Best Use of Information Technology in ASCs - Marion Jenkins, Founder & CEO, QSE Technologies, Inc., Todd Logan, VP Sales, Western Region, Ron Pelletier, Director of Development, SourceMedical

10:50 – 11:50 am
Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues? - Stephen Peron, Partner, AVA, and Todd Sorenson, Partner, AVA, VMG Health

Session E

9:45 – 10:45 am
Billing and Coding - A 60 Minute Workshop to Maximize Reimbursement - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing

10:50 – 11:50 am
How to Improve Coding for ASC Procedures - A Discussion of Orthopedic, Spine, GI and Ophthalmology Procedures - Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting, Inc.

General Session

12:00 – 1:00 pm
10 Key Legal Issues for 2010 - 2011 - Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

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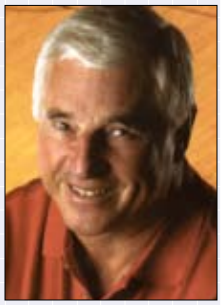
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- Brent Lambert, MD, Founder Ambulatory Surgical Centers of America
- Richard Wohns, MD, Founder, Neospine at South Shore Surgery
- Kenny Hancock, CEO, Partner, Meridian Surgical Partners
- Tom Mallon, CEO, Regent Surgical Health
- Jeff Leland, CEO Blue Chip Surgical Center Partners
- David Shapiro, MD, AMSURG
- Barry Tanner, President, Physicians Endoscopy
- I. Naya Kehayes, CEO, Eveia Health Consulting and Management


Tucker Carlson

- Tucker Carlson, Political Commentator
- Bill Southwick, President and CEO, Healthmark Partners
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6 Physician Risk Factors That Impact an ASC's Value

Certain characteristics of physician owners and non-owners of a surgery center may impact the perception of the value of that center. Here are six physician risk factors and the relative importance ASC operators place on each factor, according to VMG Health's *ValueDriver ASC Risk Assessment Survey*.

1. Number of physician investors in the ASC
   - Very low — 0 percent
   - Low — 0 percent
   - Medium — 50 percent
   - High — 36 percent
   - Very high — 14 percent

2. Average age of the physician owners
   - Very low — 0 percent
   - Low — 0 percent
   - Medium — 22 percent
   - High — 55 percent
   - Very high — 23 percent

3. Specialty mix of the physicians active at the ASC
   - Very low — 0 percent
   - Low — 14 percent
   - Medium — 23 percent
   - High — 55 percent
   - Very high — 8 percent

4. Reliance upon a few physicians to drive majority volume/revenue
   - Very low — 0 percent
   - Low — 5 percent
   - Medium — 18 percent
   - High — 32 percent
   - Very high — 45 percent

5. ASC's reliance upon non-owner physicians
   - Very low — 0 percent
   - Low — 9 percent
   - Medium — 27 percent
   - High — 50 percent
   - Very high — 14 percent

6. Level of ownership physician owners have in competing centers
   - Very low — 0 percent
   - Low — 0 percent
   - Medium — 18 percent
   - High — 27 percent
   - Very high — 55 percent ■

Information comes from VMG Health's ValueDriver ASC Risk Assessment Survey. *VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of* VMG Health's ValueDriver ASC Risk Assessment Survey, *visit www.vmghealth.com.*

4 Current Trends Driving the Value of ASCs

By Barbara Kirchheimer

As healthcare facility operators grapple with the effects of a slowed economy and prepare for possible fallout from national healthcare reform, Michael Karnes, the co-founder and CFO of Regent Surgical Health, discusses here several key factors driving ASC valuations.

1. Prices are down, with fewer deals. Many lenders have pulled back from financing healthcare deals, and those that are still in the market are including greater equity requirements to finance an acquisition, says Mr. Karnes. Previously, ASC purchasers could finance a deal by putting 20 percent down. Now lenders generally require 33 percent, which is more of a hurdle. In addition, buyers are being asked to guarantee more of the debt, often 100 percent, which makes them examine each deal much more carefully before pursuing it.

That said, Mr. Karnes believes the lending environment is likely to pick up somewhat in the future. "While we may never return to the 20-percent equity, no-guarantee environment, it will stabilize, and well-conceived projects will get financed, and the terms will get a little better," he says.

2. Overall valuations are down, driven by economy. Overall economic uncertainty has given people reasons to delay elective surgeries, which translates into lower case volumes at many ASCs, especially those that focus on elective procedures such as plastic surgery and gastric bypass. "This has lowered the financial results of ASCs that perform these types of surgery, which means they're less valuable," Mr. Karnes says. Healthcare reform might turn some of that around, but it's unclear how and where its effects will be felt the most at this point.

"Facilities located in urban areas, where a significant percentage of the population has not had any insurance, should benefit from having more cases," Mr. Karnes says. "The negative side is that you're going to get paid at Medicare or Medicaid rates."

3. Mix of specialties and geography drive valuation. The single most important factor in assessing valuation, according to Mr. Karnes, is the mix of specialties performed by an ASC's physician owners. "We look for higher-end specialties like orthopedics, spine, general surgery," On the flip side, plastic surgery, stand-alone pain management, and stand-alone ophthalmology are less valuable, he says. With a single specialty there is simply too much reimbursement risk exposure. Valuations are also enhanced when there is additional capacity not yet being used, or when it is clear that there is the potential to bring in new specialties to the center in the future.

From a geographic standpoint, ASCs already established in certificate-of-need states have higher valuations because future competition is less likely, Mr. Karnes says. The CON process is simply long and expensive, making it difficult for new competitors to enter the market unless they have a hospital partner to help shoulder the burden.

4. Higher multiples are driven by intangibles like management skill. Some aspects of an ASC's valuation can be hidden, only emerging during the due diligence process, says Mr. Karnes. One of these is management. Presenting detailed financial records that are easy to understand and having solid control over the non-financial parts of the business, such as a good grasp of a center's supply dollars per case and labor hours per case can enhance a presentation to a potential buyer. "If you have poor control over key statistics," Mr. Karnes says, "some buyers may give up and not see the true value. I think you get a better multiple if you can present your story well." ■

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

4 Facility Risk Factors That Impact an ASC's Value

Facility risks include an ASC's geographic location as well as the condition, age and replacement needs of the facility and equipment. Here are four facility risk factors and the importance of each factor as rated by ASC operators, according to VMG Health's *Value-Driver ASC Risk Assessment Survey*.

1. Age and condition of the ASC's facility:
   - Very low importance — 0 percent
   - Low importance — 18 percent
   - Medium importance — 64 percent
   - High importance — 18 percent
   - Very high importance — 0 percent

2. Facility location (patient/physician convenience):
   - Very low importance — 0 percent
   - Low importance — 18 percent
   - Medium importance — 36 percent
   - High importance — 46 percent
   - Very high importance — 0 percent

3. Age and condition of the equipment (capital expenditure requirement):
   - Very low importance — 0 percent
   - Low importance — 5 percent
   - Medium importance — 68 percent
   - High importance — 27 percent
   - Very high importance — 0 percent

4. Ability to expand existing capacity to accommodate growth:
   - Very low importance — 5 percent
   - Low importance — 50 percent
   - Medium importance — 41 percent
   - High importance — 4 percent
   - Very high importance — 0 percent ■

Information comes from VMG Health's ValueDriver ASC Risk Assessment Survey. *VMG Health is a leading valuation and transaction advisory firm in healthcare. To receive a complimentary copy of VMG Health's* ValueDriver ASC Risk Assessment Survey, *visit www.vmghealth.com.*

Michelle Steele of Eastside Endoscopy Shares Advice for GI ASC Administrators

By Renée Tomcanin

Michelle Steele is the administrator of Eastside Endoscopy Center in Bellevue, Wash., a three-room GI ASC managed by Physicians Endoscopy. Ms. Steele has been with EEC for 15 years, starting as a charge nurse, before moving into her role as administrator in 1998. Prior to coming to EEC, she worked as an office RN for a gastroenterologist in the special procedures unit and on the surgical floor at Overlake Hospital in Bellevue.

Q: GI ASCs have faced a number of challenges recently, especially due to declining reimbursements and increased regulatory demands. What have been some of the best initiatives and programs you have undertaken at your center that have added to its success and profitability?

Michelle Steele: The most recent and successful programs we have implemented here have been the implementation of our electronic medical record and anesthesia services.

The EMR allows us to easily retrieve and review a patient's chart, and with subsequent visits to the center, the information is updated rather than re-written on a paper form. The EMR also allows us to track our times so that we can identify our areas of delays and target them for improvement. Another benefit of the EMR has been in-chart storage and retrieval. Due to our limited storage space, we would have our chart storage company come at the end of each year to catalog and transfer the charts to an off-site storage center. We have eliminated this cost with the EMR and are gradually seeing our chart storage and retrieval costs decline each year.

Another successful program has been the implementation of anesthesia services. This year, we contracted with a local anesthesia group to administer propofol in our facility. Washington is an opt-out state, so we use CRNAs and are not required to have an anesthesiologist (MD) on site. The CRNAs are a wonderful addition to our team, and our patient satisfaction has increased. One of the reasons I believe the patient satisfaction is high is because our patients are now awake and alert after the procedure and are able to remember discussing their procedure results with the gastroenterologist. The added income from the anesthesia charges off-sets the cost increases and decreasing reimbursement we have been experiencing over the past few years.

Q: What do you enjoy most about EEC and serving as an administrator?

MS: My favorite part about my center has to be the people. I am lucky to work with a fantastic group of physicians, RNs, medical assistants, techs and our corporate partner, Physicians Endoscopy. Everyone works together as a team, and we are truly a family. As an administrator, I enjoy implementing new services, researching and drafting policies and continually trying to improve our processes to increase patient, physician and employee satisfaction.

Q: What is the best piece of advice you received that has helped you in your career? What advice do you have for other single-specialty ASC administrators?

MS: I think the best piece of advice I received was to never stop learning. I enjoy attending conferences and networking with my colleagues. I belong to an online network of GI nurse managers and administrators who have a wealth of information to share. I am constantly learning something new from them.

My advice for single-specialty ASC administrators would be to always try to include your staff in decisions. If you allow them input and use their suggestions, you create a sense of ownership in the facility. Don't be afraid to let your staff lead; you might be surprised at how well they do and it will make your job a lot easier! ■

Contact Renée Tomcanin at renee@beckersasc.com.

3 Tips for Coding Orthopedics Procedures in Surgery Centers

By Tamara Wagner, BS, CPC, Coding Manager, National Medical Billing Services and Lindsey Dunn

Coding meniscectomies and synovectomy during left knee arthroscopy
During left knee arthroscopy surgery, the surgeon performs both a medial and lateral meniscectomy along with an extensive synovectomy, including the patellofemoral compartment. The coding would be reported as '29880-LT' for the meniscectomies and '29875-59, LT' for the synovectomy performed in the patellofemoral compartment.

The synovectomies for the medial and lateral compartments bundle with the meniscectomies since the procedures are performed in the same compartments. The limited synovectomy performed in the patellofemoral compartment is reported with the 59 modifier since it is performed in a separate compartment.

Coding biceps tenotomy during shoulder arthroscopy

Many times during arthroscopic shoulder surgery, a biceps tenotomy is performed along with other procedures. The biceps tenotomy is reported with CPT code 29999. The AMA has not assigned a specific CPT code for this procedure.

Coding platelet-rich plasma injections

Surgeons have been performing platelet-rich plasma injections during surgeries to promote healing of the musculoskeletal tissue. An example of this procedure is when, intraoperatively, a patient has blood withdrawn, the blood is centrifuged for 15 minutes to separate the platelet-rich plasma from the platelet-poor plasma and red cells and injected into a surgical site.

The placement/injection of the cells into the operative site is an inclusive component of the operative procedure performed and not separately reported.

CPT code 86999, unlisted transfusion medicine procedure, is used to report obtaining the cells for injection. However, as of July 1, 2010, CPT code 0232T has been assigned for this procedure. ■

Learn more about National Medical Billing Services at www.asccoding.com.

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

6 Areas of Focus for Collecting Full Payment: Critical Steps to Take Prior to Billing

By Caryl A. Serbin, RN, BSN, LHRM, President and Founder, Serbin Surgery Center Billing

In today's fluctuating economy, ASCs are looking for ways to increase their reimbursement while remaining competitive and compliant. The first place to look should be your accounts receivable balances to determine if all accounts are being paid in full. To properly collect your ASC's outstanding amounts, your personnel must be meticulous in tracking all facets of reimbursement, both before and after the services are rendered. The following is a list of six areas where dollars can be won or lost before the claims have even been submitted.

Area #1: Scheduling — Acquiring necessary patient information

Let's start at the beginning. The surgeon's office calls, faxes or e-mails to schedule a procedure. The amount and type of demographic and insurance information they send is often insufficient to properly perform insurance verification. However, rather than bother the busy surgeon's office again, remember that the patient is the best source for the information you need. Even though your ASC's business office may be short-staffed and calling the patient may take a little extra time, it's a good time to make that first friendly contact and show that you are working on their behalf to verify their insurance coverage. Let them know that your office will call them back with that information as soon as you receive the necessary information from their insurance company.

Area #2: Registration — Entry of complete patient information

It's extremely important that the information received from every source is entered accurately into your computer system — after all, this is the information that is used to bill the insurance company and the patient. Remember the old adage: GIGO (garbage in, garbage out). Nowhere is it truer than in insurance billing. Medicare's #2 reason for claim denials is incomplete or invalid information, i.e., misspelling of name, wrong or missing ID number, etc.

Area #3: Insurance verification — Verifying payment by third-party payors

The best advice is to use some sort of reminder of all of the information to request. A good verification form is priceless. If the insurance section of your software is complete enough to remind you of all of the information

needed, then use it (but I have yet to see one that has areas that ask for all the pertinent information). Remember that the information you need for a commercial claim is different than what you need for workers' compensation. Don't forget to recheck the mailing address for the claim — it is frequently different from that listed on the back of the card.

Area #4: Patient financial counseling — Advising patient of fiscal responsibility

If you had to contact the patient for additional information previously, you are already a step ahead as they are prepared for your call about insurance coverage. Whether it's the first or second contact, a positive and helpful attitude go a long way in asking for payment. Explain what the facility fee is for, the amount of insurance (and secondary insurance) coverage and their estimated financial responsibility. Also let them know there will be other fees due from the surgeon, possibly the lab, x-ray, etc. Clarify differences between co-pays, deductibles and co-insurance and tell them how much is due on the day of surgery. If the amount is large and the patient expresses concern, explain the different ways to pay, i.e., credit cards, healthcare credit, credit card monthly debits, etc. Get a commitment on method of payment prior to them coming for the procedure.

Area #5: Up-front collections — Handling patient payments day of surgery

Be prepared. You have already discussed with the patient the amount of payment due on the day of surgery and the method of payment. You have documented this information in the computer system. Alert the registration clerk as to what amount of money the patient is expected to pay and provide them with any documents that the patient needs to sign. It's important that your surgery center have a semi-private area to discuss financial and clinical information, which also allows patients to sign documents and provide payments.

Area #6: Dictation and transcription — Importance of full disclosure

Accuracy and completeness of the operative note is essential in determining what you are going to be paid. The ASC should provide a quiet and comfortable area for the surgeon to dictate. Surgeon education on how certain areas of the operative note need to be clarified can also be helpful. Procedures that can provide additional reimbursement, as well as implants and ancillary procedures, are frequently not identified in the operative note. A quote attributed to CMS advised, "If it's not documented, it never happened." Areas often needing additional attention for dictation are:

- Bilateral or multiple procedures
- Identification of surgical site, e.g., fingers, toes (needed for modifiers)
- Specific areas treated, e.g., medial or lateral compartment
- Detailed implant information
- Ancillary procedures performed
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Are Hidden Costs Hurting You? A Regional Anesthesia Approach to Reduce Complications and Cost at ASCs

ASCs have long relied on general anesthesia with "breathing tube" devices, followed by narcotic-based based pain management in surgery patients. The use of opioids, however, has led many facilities to accept a high risk of PONV, excessive pain (if undertreated with opioids) and other adverse events. These side effects are highly undesirable, but largely considered "the norm," or "the way we have always done it." This kind of health care culture can translate to significant losses of both time and money for the ASC.

"Switching simple components of the anesthetic plan can reduce complications and increase efficiency in your ASC while reducing costs," according to John LaFratta, corporate training manager in pain management for B. Braun Medical. In this article, he discusses both the financial and quality benefits ASCs can reap from a regional anesthesia (RA) approach.

Financial impact of excessive pain and PONV

Post-op pain and PONV are commonly experienced outcomes of invasive surgical procedures, and are the two most common reasons for a prolonged PACU stay (e.g., greater than 30 minutes). Mr. LaFratta notes that these complications are costly for ASCs.

To demonstrate the impact, B. Braun developed a program to help ASCs project the costs of these and other post-operative complications. Centers input their experience with episodes of PONV and excessive pain to quantify the impact it can have to your bottom line. Consider, for example, what effect adverse events can make on an anterior cruciate ligament reconstruction (ACLR), one of the more common invasive orthopedic procedures performed in outpatient surgery. The results show the cost of one episode of PONV following ACLR can erode 25 percent of the revenue from that case. Ten episodes of PONV each month could cost up to $25,000 per year for treatment that tie up labor and patient flow.

"Episodes of PONV and follow-up pain management are the two most common reasons patients are held in the PACU. Shivering, itching, and lightheadedness are also important to consider, and any of these leading to patients in distress will require increased nursing interventions (e.g. dosing intravenous medications) that could lead to bottlenecks at the facility, and possibly increased over-utilized time (and/or forced overtime). Margins are tight, so all such variables need to be contained. PONV and pain are two variables that can be better managed using RA with local anesthetics for surgery," Mr. LaFratta says.

The financial burden of these delays is well documented. Costs incurred by outpatient surgery centers in managing PONV have been shown to cost a center $400 of revenue for a facility operating at

or near full capacity.[1] Even facilities performing at less than 100 percent capacity incur $200 in costs to treat a single episode of emesis when all costs are considered to manage the event including cleaning, redressing the patient, rescue medications and nursing interventions, everything down to the toothpaste.[2] And costs to manage a patient in painful distress can total $100 per incident.[3]

Difference between local anesthetic plan and a traditional GA with morphine approach

General anesthesia carries an important role in providing surgical conditions with respect to patient sedation, amnesia, paralysis and physiologic homeostasis. What we're considering is a change from the opioid component of a traditional GA plan (for perioperative pain management) to local anesthetics delivered through strategically-placed analgesic catheters (inserted by anesthesiologists or surgeons, depending on the type of catheter), both reducing the reliance on high-doses of anesthesia maintenance drugs and opioids during surgery, and reducing opioid requirements for pain management after surgery. This type of intervention is well-documented to reduce the likelihood of PONV, provide effective pain management, and increase the reliability of a fast-tracking program.

Studies show that using local anesthetics for the surgical block allows patients to emerge more rapidly than patients under GA with morphine approach. Patients are able to exit the OR achieving PACU bypass criteria, and can be fast-tracked directly to phase II PACU in preparation for discharge.[3,4] "This enables ASCs to re-examine patient flow, and take advantage of safely moving patients to more cost effective holding areas, avoiding bottlenecks that can otherwise occur," Mr. LaFratta adds.

Mr. LaFratta says, "When we help centers manage the primary endpoints of better post-op pain management and reduced PONV, a long list of secondary endpoints then become available to further reduce costs and open new revenue streams. Reduced adverse events can lead to shorter waiting times, reduced surgical variability, on-time starts and increased satisfaction. With more effective pain management, centers will experience more efficiency and high satisfaction, which can improve morale around the center."

Challenges to a new approach

RA may show significant advantages, but many centers have been reluctant to change methods for a variety of reasons. For one, GA with morphine has worked for them for decades, according to Mr. LaFratta. "GA perceptively offers an 'all-in-one' approach, with every component of anesthesia handled at once. RA adds a step to the process, and surgeons may worry this will slow cases," he says. However, evidence shows that what may take a few extra moments in pre-op will save the center time in the OR and PACU, allowing surgeons to actually see more on-time starts through improved patient flow.[5] Parallel induction models of anesthesia improve OR efficiency and can reduce staffing costs by 7 percent compared to the traditional model.[6]

From a practical standpoint, the RA component of an anesthetic for the "next patient" can be induced during anesthetic maintenance of the "current patient," and if "wake-up" (or emergence) time of the current patient is accelerated with pain management during surgery with local anesthetic nerve blocks, not only is emergence faster, but there are fewer symptoms typically caused by opioids and GA maintenance agents. A surgeon can close an incision with an awakening patient if the site of the surgery is numb.

Another limitation is the familiarity of the anesthesiologist at performing peripheral nerve blocks. "Some weren't trained in nerve block procedures; for those who want to learn, the training is out there," Mr. LaFratta says. "B. Braun Aesculap Academy is willing to design a local education workshop to provide didactic as

well as hands-on training that we can customize for your program."

Likewise, ASC or hospital administration may be concerned about the costs of new equipment needed for an RA with nerve block approach. Leading anesthesiologists on this topic, Drs. Michael Kentor and Steven Orebaugh (University of Pittsburgh), say facility owners may worry that the cost of a nerve stimulator and needles, or to purchase an ultrasound machine, will add significant costs to their overhead. "But then remember that only 10 episodes of PONV each month could cost a facility up to $25,000 a year, and the return on investment becomes significantly favorable," declares Dr. Kentor.

Patients may also add a barrier to the approach because many are unfamiliar with the procedure and may not understand the benefits. "If a surgeon tells a shoulder surgery patient, 'You will get a needle in your neck,' versus 'With GA you will be asleep through your surgery,' most are not going to respond favorably to the RA technique. The RA message needs to be delivered in a more palatable fashion to reduce patient anxiety and let them learn and weigh the potential benefits of a nerve block approach, and that patients can still sleep through surgery without airway instrumentation," concludes Dr. Orebaugh. Inadequate patient education is not a contraindication to RA.

"Bringing a new anesthesia approach to your ASC is both possible and enticing, though sharing the message throughout to the entire ASC team, from start-to-finish, is most likely to lead to your center's success in improving patient care," says Mr. LaFratta. ■

Learn more about B. Braun at www.bbraunusa.com.

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