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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

March/April 2012 • Vol. 2012 No. 3

What Surgery Centers Should Expect in 2012: 15 ASC Market Trends

By Abby Callard

Here are 15 trends for the ambulatory surgery center industry that will affect how ASCs do business in the upcoming year.

1. More complex and higher-end procedures will move into the outpatient setting. Sean Rambo, co-founder, Compass Surgical Partners, says 2012 will continue to see more higher-end procedures, including complex orthopedic and spine, move into the ASC setting. He predicts that as smaller procedures increasingly compete with an office-based setting — a move that many payers are driving — more complex procedures will take their place in the ASC.

continued on page 8

10 Metrics That Reveal a Surgery Center's Financial Performance

By Rachel Fields

Nick Newsad of HealthCare Appraisers discusses 10 key indicators that can help ASC leaders analyze their centers' financial performance.

Revenue

1. Average revenue per case. Mr. Newsad says surgery center leaders should track how average revenue per case trends over several years. This can provide you with insight into how your reimbursement

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10 Steps to More Profitable Managed Care Contracts for ASCs

By Rachel Fields

Managed care contracting is essential to surgery center profitability, particularly as out-of-network billing becomes less feasible in many markets. Adriaan Epps, director of contracting services for abeo Management Corporation, discusses 10 ways surgery centers can achieve substantial increases year-over-year without hurting relationships with their payors.

1. Collect as much data as possible before negotiation. Mr. Epps says surgery centers should do as much preparation as possible before sending a proposal to the health plan. "You always have to have as much ammunition and data as possible to demonstrate why your ASC or group deserves a higher rate than maybe anybody else," he says. This means understanding where you are in

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Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

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Publisher's Letter

This letter briefly discusses eleven issues facing surgery centers in 2012.

1. Out-of-Network. Centers continue to struggle with managed care contracting and with whether to stay in-network or provide services out-of-network. Certain chains and centers seem to still be making a lot of money by providing services out-of-network. However, it seems pretty clear that chains and centers must work with patients to manage or reduce co-payments significantly to still see patients. In contrast, many centers are either more conservative with out-of-network and/or have faced recoupment claims from payors or other threats to physicians with respect to out-of-network patients and the payors' efforts to push physicians to drive patients to in network providers. This is an issue that will continue to evolve, particularly as payors become tougher in their contract offers.

2. Relationships with hospitals. Surgery centers often have a love/hate relationship with hospitals. Many of their physicians need to maintain affiliations with both the hospital and the surgery center. Further, many surgery centers have moved to or investigated joint venturing with hospitals. Even with the joint venture, it remains a love/hate relationship where the sur-

gery center often is not certain if they are getting the benefit from the joint venture that they expected to receive. For example, the hospital may not be able to really help with managed care contracting. Further, the hospital may continue to employ physicians.

3. Employment of physicians by hospitals. This continues to be an evolving and challenging issue for surgery centers. As surgeons are employed by hospitals, the great majority of physicians may become unable or less able to work with surgery centers or remain owners of surgery centers. A loss of just a few physicians to hospital employment can be devastating to a surgery center.

4. Contracting with payors. This issue goes hand in hand with the out of network issues discussed above. Payors in some markets are making extremely low offers to surgery centers. Here, the surgery center almost has no choice but to deny the contract and attempt to see patients out-of-network. It is often the case that a surgery center or chain can benefit from the help of an experienced managed care contractor negotiator. However, even with help, this remains a challenging issue.

5. Hiring a great administrator. A great administrator must have a clinical and business mind, must be highly focused on results and must be recruiting physicians and cases all the time. Because surgery centers are not a static business, it requires an intelligent driven administrator to help assure that a surgery center has a chance of great success. The situation where a surgery center relies on the spouse of a surgeon or the office manager of the practice, often leads to a bad situation.

6. Recruiting physicians. Surgery centers must constantly be recruiting new physicians to the center. Here, it is harder than ever to be able to just target specific specialties. Rather, surgery centers must be looking at all available surgeons in the market. There are often not a large number of available surgeons given other ASC investments by surgeons and employment by hospitals.

7. Adding cases. Surgery centers must constantly be working with their existing partners to add cases and examine what types of other procedures can be added to the center. They also must be constantly soliciting non-owners to work at the center.

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8. Physicians leaving for other centers.

As new centers continue to develop, and certain of the centers promise large returns, it is critical to keep surgeons from leaving to join another center. This competition for a limited number of surgeons is often a zero sum game. This can also lead to different disputes over non-competes and redemption pricing.

9. Safe harbor issues. There remains tremendous debate over the appropriate use of the safe harbors. Can a center rely on the 1) one-third tests, plus the qualitative tests, to redeem physicians 2) if it does so, it should do so on a consistent basis. Further, even if the center has the right to pay the adverse price, it is often legally advisable to pay the non-adverse price. Further, it should take other actions to assure that it is clear that physicians are being redeemed for compliance reasons not case generation reasons.

10. Statistics and benchmarking; keeping costs in line. Centers and their leadership must be great users of data. They must both receive great data on costs per case and compare costs to averages, and then use that data to cajole, persuade and work with center physicians and staff to bring costs into line with bench-

marks. Expenses per case and as a percentage of revenue are impacted by numbers of cases and by reimbursement. That stated, centers really need to concentrate on the actual variable cost per case and the staff hours per case.

11. Redemptions and noncompetition disputes; without cause redemption clauses. Centers are constantly facing two kinds of disputes. Disputes relating to redemption and disputes relating to non-competes. Here, many centers have added in a "without cause" termination provision over the last few years simply to help reduce the amount of disputes over redemptions. Here, the physician is typically paid a non-adverse price versus an adverse price. The provisions is arguable not suppose to be used to redeem somebody based on volume or value of referrals.

* * *

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Should you have any questions or if we can be of assistance in any manner, please contact myself at 312-750-6016 or at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

Very truly yours,



Scott Becker

What Surgery Centers Should Expect in 2012: 15 ASC Market Trends (continued from page 1)

David Lau, managing partner, Medical Forefronts, a surgery center management company overseeing centers in San Francisco, Las Vegas and New York City, agrees.

"What used to be basic orthopedic and pain facilities are really starting to see an increase in new procedures: partial and even total joint replacement, more advanced spine procedures such as fusions as well as cardiac procedures like pacemaker insertion," he says. "In fact, one of our California ASCs recently became the world's first non-hospital facility to buy a MAKO Rio surgical robot and now offers unicompartamental knee replacement outpatient procedures. Patients used to spend days doing rehabilitation after inpatient surgery at a hospital; they are now literally walking out after the surgery the same day."

2. Healthcare reform will drastically change the ASC environment. Charles J. Militana, MD, director of NAPA Ambulatory Surgery Centers, says a center's success in the face of healthcare reform will depend on many factors.

"Healthcare costs and their effects on the economy continue to play a significant role on health systems," he says. "ASCs are most certainly not immune from such effects. What we will see over the next year will be the impacts of these economic pressures on ASCs. How ambulatory centers position themselves with respect to such forces will be key to their success. For example, as federal requirements continue to be developed with respect to ambulatory center quality care reporting, factors such as admission rates, patient satisfaction, etc., will have direct and indirect effects on the economic success of the facility."

3. Multi-specialty centers might weather healthcare reform better than single-specialty centers. Adam Frederic Dorin, MD, MBA, founder and president of America's Medical Society, says assuming that healthcare reform survives, the ASC industry will undergo a big change in the next few years.

"Let's just assume the accountable care organizations take on a life of their own," he says. "I believe there will be some major housekeeping that

will be going on. By 2020, a lot of ASCs will likely be closed or bought up by hospitals. Contrary to conventional wisdom, many multi-specialty centers are going to be more vulnerable. Unlike traditionally high-paying single-specialty centers, like orthopedics, where there can be real cost savings through efficiencies of scale, the multi-specialty facilities will become squeezed between less-acute, office-based cases and those procedures reserved for the hospital setting. ACOs will demand that hospitals be protected and preserved at all costs, as they will form the core of most ACO leadership hierarchies, and thus non-hospital owned ASC reimbursements will shift to favor the hospital masters."

Mr. Lau thinks that while a single-specialty center can improve profitability by tailoring its expenses and understanding its income stream, too much reliance on one specialty or procedure can result in disaster if reimbursement changes drastically. For example, if a center relies heavily on Medicare cataract surgeries, and the reimbursement for that code changes, the center could be in trouble. A multi-specialty center can avoid that by increasing volume in other, more profitable specialties.

"The multi-specialty center is certainly a bigger beast to manage on a day-to-day basis, but I think that diversification in the cases and subsequent revenue might be one of the best strategic defenses against the inevitable changes in reimbursement," he says.

4. Out-of-network reimbursement is becoming harder to obtain. Mr. Lau says getting out-of-network reimbursement from payors is becoming increasingly difficult.

"Without question, payors and insurance companies are getting much trickier when dealing with out-of-network facilities," he says. "They're not only reimbursing less on billed charges, but they're also just making it harder to get reimbursed at all."

The standard accounts receivable cycle for Medical Forefronts' centers used to be as short as 90 days, but Mr. Lau says A/R cycles are lengthening as the centers are increasingly getting letters requesting additional information such as full medical records, even after procedures have been authorized. Payors are putting more pressure on surgeons and patients to stay in network.

Although payors are making it more difficult, Mr. Lau says centers can continue to do out-of-network cases by making some critical changes. Specifically, they need to put more effort into collections, including possibly taking billing in-house to have more control; walk patients through the entire financial process and make sure whoever does the billing is on top of industry trends and changes.

5. Insurance companies are forcing patients and physicians to stay in-network. Mr. Lau says that insurance companies are changing their policies to restrict certain things, such as out-of-network reimbursement. The impetus behind the change is all about saving money, he says.

"A larger percentage of the insurance base is needing to be seen in network," he says. "There is certainly a growing demand for in-network facilities. Again, it speaks to what institutional payors are trying to do: They are tweaking insurance plans so people aren't able to be seen out-of-network. It's all about the bottom line, and they're going to ultimately steer people to a place where they can maintain the biggest margin for themselves."

Mr. Lau says insurance companies will continue to put pressure on patients and physicians to keep their cases in network. For years, he has seen insurance companies send letters to physicians threatening to kick them out of their professional contracts if they don't stay in network, but just recently he has started seeing insurance companies follow through on those threats.

6. Insurance companies are starting to steer patients toward ASCs. Healthcare reform has encouraged all aspects of the healthcare system to pinch pennies and cut costs. For this reason, insurance companies are looking for the most cost-effective treatments for their patients. In many cases, this benefits the ASC because they are usually less expensive than procedures done in the hospital. Mr. Lau says insurance companies have begun to approach some Medical Frontiers centers with more favorable contracts.

"This speaks to the fact that certain hospitals are expensive, and insurance companies have started to identify that those folks are making a lot of money on their backs," he says. "For once, insurance companies actually approached us with favorable contracts. We believe that's because they want to steer their patient volume to these more cost-effective ASCs rather than keep them in the hospital systems."

7. Reimbursements will continue to be cut across the board. Jimmy St. Louis, CEO of Advanced Healthcare Partners, says in general, the trend of decreasing reimbursement will continue to shape the industry. There are things ASCs can do to mitigate the damage, such as marketing directly to the consumer and performing out-of-network cases.

Mr. Rambo says that in some markets, the ASC industry has been able to offset some of the Medicare payment reductions and modifications. For example, the ASC industry in New Jersey remained highly profitable due to favorable workers' compensation, personal injury and out-of-network reimbursement. However, he says, that "is being attacked from all angles." In other states, Medicare-based fee schedules are being considered to replace more lucrative workers' compensation fee schedules — a trend that began several years ago across the country. These changes will have a significant impact on the profitability of orthopedic cases in these markets.

"We're beginning to see more and more rate compression and fewer opportunities for ASCs to offset low paying insurance or Medicare reimbursement," he says. "That trend will continue."

8. The ASC market will continue to consolidate. The consolidation trend started to heat up last year with three big deals: Surgery Partners acquiring NovaMed in January 2011, AmSurg acquiring National Surgical Care in August 2011 and United Surgical Partners International acquiring Titan Health Corp. in October 2011. Mr. Rambo believes this trend will continue in 2012 and into 2013.



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Mr. Rambo says in many cases, the investors behind these large organizations will be evaluating their exit strategy. This may include IPOs, but to accomplish this many will look toward increased consolidation to drive revenue growth. He says that in most cases, management companies aren't building new centers to fuel growth in large part due to the saturation of ORs in many markets, but rather are looking at acquisitions of individual centers in strategic markets or multiple center acquisitions that really add to the company's portfolio and near term growth targets.

Mr. Lau also sees the trend of consolidation growing as ASCs are under increased pressure.

"As a whole, with all these mounting pressures, many centers out there are in trouble," he says. "But frankly, that's when a company like mine gets approached because we can take troubled centers and help turn them around. Right now, we're busier than ever."

Mr. Lau stresses the importance of finding a partner that can offer not only capital but tested, implementable leadership, such as recruiting and supply chain strategies.

9. ASCs are increasingly partnering with acute-care and nursing facilities. One of the factors keeping some procedures out of the ASC is the inability to keep patients for longer than a few hours. Mr. Lau sees this as something that could change with strategic partnerships.

"Another reason why we could continue to see more complex cases being performed in the ASC is that in our market, we've seen an upsurge of acute rehab and nursing facility partnerships," he says.

When an ASC partners with this type of facility, the patients can be monitored for longer periods of time if the need arises. Mr. Lau says this is quite common, and he has seen an increase in the past few months, especially in the San Francisco Bay Area.

10. If done right, robotic surgery can be profitable. Mr. Lau says that although purchasing a surgical robot can cost a center upwards of \$1 million, if a center has the right cases, there's no reason it can't be successful. Ensuring enough case volume and the correct cases will allow a surgery center to compete with local hospitals that already have the equipment. If a center already does procedures that can be done using surgical robots, it's not a brand new marketing effort and the center doesn't have to bring in a whole new patient base. Another option to save money on surgical robots is to buy a refurbished unit.

"By finding refurbished equipment, an ASC is able to save significantly on capital investment," he says. "The return is quite a bit better."

11. Physician employment threatens innovation. Dr. Dorin says that healthcare re-

form will bolster the trend toward physician employment by hospitals, and that trend will hurt the healthcare industry as a whole.

"When you squeeze doctors literally or functionally into an employee model, there's less incentive to be creative," he says. "There's actually more incentive to do less cases, and efficiency inherently grinds down. People are still thinking in the mindset of independent players in the healthcare market — such as we have today with insurance companies, hospitals, and doctors/physician groups. If ACOs are allowed to take hold and flourish, there may be cost savings, but the trade-off of effectively rationed care and the creation of government-sanctioned, anti-competitive collusion

between the insurance industry and local hospital systems may very well be a dramatic and unpleasant game changer for the American public."

12. Maintaining independence as a physician will be hard. Mr. St. Louis says that one of the biggest challenges facing ASCs will be the ability of the physicians to remain independent. He says the trend of consolidation and acquisitions affects the physicians as well as the centers. Affording the infrastructure demanded by reform can be a challenge. Some things that physicians can do to boost their profit is add patient coordination functions to their services, do more out-of-network cases and market directly to the patients. Patient coordination allows phy-

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sicians to control their volume and manage their practice more efficiently.

"This can help some of these physicians maintain their independence — financial as well as practice independence," he says. "The physicians want to remain independent, but they can't. That is where our strategies of direct to consumer and efficient patient coordination comes into play. If you can go direct to consumers, you can stay out of network, which allows you to control your financial destiny."

13. Centers will add various ancillary revenue opportunities. Mr. Rambo says ASCs and ASC management companies are also stepping up efforts to target ancillary revenue opportunities such as bringing anesthesia in house, adding an in-house pharmacy or adding a sleep lab.

"The mindset is that as the rate is compressed, they will ask what are other opportunities exist to protect and boost earnings in an ASC," he says. "As an example, I have seen the development of an in-house anesthesia program be very successful, and believe this in particular is a trend that is gaining steam throughout the industry."

14. The slow adoption of EMR will start to pick up. Mr. Rambo thinks large-scale

adoption of electronic medical records is still a few years away. Because the ASC industry is still fairly fragmented, he thinks ASCs will be some of the last adopters of EMR. Mr. Rambo says the standards are currently in active discussion, and the industry is likely looking at standard approval in 2014 or beyond.

"We'll hear more about it in 2012," he says. "Things are slowly beginning to heat up, but we're still several years away from active adoption in the industry."

15. To stay independent, ASCs should market direct to consumers. One of the ways centers can stay independent is through direct-to-consumer marketing, Mr. St. Louis says. He says there are four different channels to market a center or service: advertising online through SEO and website optimization, traditional offline marketing, seminars and physician-to-physician marketing.

Online advertising includes paid advertisements and creating relevant and quality content that is placed strategically on the website to enhance a user's experience. Mr. St. Louis says a good social media strategy can go a long way in marketing to patients.

"[It] provides a nice, comfortable environment

for people looking to have a surgery done," he says. "For those existing patients, they can talk to people about how their experience is going as well as correspond regarding questions and concerns. Typically, the goal of a seminar is to find the proper geographic location as well as direct-to-patient strategy that are unique to people and then educate them as well as spend personal time with them to maximize their knowledge of our procedures," he says.

For example, one center managed by Advanced Healthcare Partners holds seminars on sleep apnea that looked at the causes and the possible unique treatments. Seminars serve as a way to build trust and credibility, especially if procedures are unique, Mr. St. Louis says. The ultimate goal of a seminar is both to educate people and to convert them to trusting customers at the seminar.

The last marketing strategy is to educate the local physicians on what the ASCs do and build a reciprocal relationship with them. This can generate a high volume of leads. If a center is effective and generating leads, Mr. St. Louis says as much as 90 percent of those the center won't be able to treat. That allows centers to refer patients to other physicians and establish reciprocity. ■

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10 Metrics That Reveal a Surgery Center's Financial Performance (continued from page 1)

is changing over time, as well as how your costs affect the amount of money you make on a case. He says you can further “drill down” into this statistic by measuring average revenue per case by specialty. This will let you know which of your specialties are losing or gaining profitability.

2. Payor mix. Surgery centers should measure payor mix in two different ways: percent of charges and percent of revenue. Percent of charges — or the percentage of total charges billed to a single payor — will tell you how reliant you are on a particular insurer for case volume. Percent of revenue — or the percentage of total revenue received from a single payor — will tell you how reliant you are on a particular insurer for profit.

When you compare these two statistics, they can show one insurer is responsible for a high percentage of your charges but receive relatively low revenue, possibly due to non-payment issues or reimbursement changes. “Your percentage of charges could stay the same, meaning that you’re seeing the same proportion of patients, but your percent of revenue could change,” Mr. Newsad says.

3. Accounts receivable. Mr. Newsad also advises looking at accounts receivable, or the amount of money on the books that the surgery center still needs to collect. He says his company generally breaks down A/R by payor, dividing payors into groups such as commercial, Medicare, Medicaid and workers’ compensation. He says you should then look for trends: Is A/R growing, shrinking or remaining the same relative to revenue? Has the proportion of A/R associated with any given payor changed over the last few years? What is your average number of days in A/R and distribution of A/R across aging buckets? Pay particular attention to increases in the older A/R buckets (such as 90-120 days) which could indicate an increase in uncollectible accounts or payor issues.

He says increases in A/R can be linked to a number of issues, including problems with a payor, internal turnover, employee re-training or surgery center growth. If the center’s total book of business is increasing and time to collect on accounts is staying the same, A/R would grow. Similarly, if the center’s total business is shrinking and time to collect on accounts is stagnant, A/R would shrink.

4. Case volume. To determine where your case volumes come from, Mr. Newsad says you should look at case volume by physician. “How much case volume is coming from physicians and surgeons who are owners in the surgery center?” he says. “You can trend by physicians and try to determine whose practices are growing, whose are shrinking and perhaps even which physicians are performing surgeries at other facilities.” If you see that a certain physician’s volume has dropped consistently over the past year, you can follow up to determine the reason.

He says it’s important to watch owner vs. non-owner volume because non-owner volume is usually more risky. “There’s a higher likelihood that a non-owner could leave the center at any time,” he says.

Expense

5. Medical supply costs per case. Keep track of average cost per case, which would include the cost of disposable supplies and implants. This is important because supplies are one of the two biggest costs for surgery centers, and high supply costs can easily eat away at case profitability. Mr. Newsad recommends drilling down and looking at average medical costs per specialty or per physician.

For example, you might look at medical supply costs per physician and discover one of your ophthalmologists is a significant outlier because he or she uses a particular type of cataract lens that the others don’t use. “You would then need to determine if you can collect a little more from the patient on that [lens] if it’s not [fully covered],” he says.

6. Inventory turnover. Mr. Newsad recommends tracking how many times inventory is turned over during the year. “It’s just a ratio — what are the total supplies bought during the year divided by how much inventory is on the shelf,” he says. He says if a surgery center orders supplies every week instead of every month, staff can avoid “leaving money on the shelf” and possibly tying up money in supplies that are not used. “If you order every week, you have smaller orders and carry less on the shelf,” he says.

7. Clinical hours per case. Mr. Newsad says the most common benchmark in terms of staffing costs is clinical hours per case. This benchmark tells you how much time your clinical staff — nurses, pre-op and post-op staff, and clinical support staff — are spending on each patient. He says the rule of thumb for procedure focused centers (such as endoscopy centers) should be 3-4 clinical hours per case. These cases have faster turnover and can be moved through more quickly.

Surgical centers will average around 8-10 hours per case because the surgery and recovery takes longer. “That’s really a measure of throughput and turnover and how long it takes the patient to get in and out,” he says. This benchmark is important because the faster your cases, the more volume you can book in the center and the lower your staffing costs will be for each patient.

8. Number of operating rooms run per day. Mr. Newsad recommends also looking at how many operating rooms the center is running each day. He says there are two staffing models in the surgery center industry: horizontal staffing and vertical staffing. Vertical staffing means one OR is staffed for more hours during the day, so the same staff is working in one OR for a longer period of time. Horizontal staffing means multiple ORs are opened at the same time and the cases are finished sooner.

“It’s more cost-effective to staff vertically, but the problem is that physicians all tend to want to start first thing in the morning,” he says. He says ideally, a surgery center should run an operating room from 7 a.m. until 3 p.m., leaving enough time after the last case to recover the patients who finish at 3 p.m. He says over the course of a year, the median benchmark is around 1,100 surgeries per operating room. Underutilization can lead to a reduction in profitability.

9. Number of days per week the center opens. Many surgery centers cut costs by closing the center on days when volume is low, which is effective because it eliminates an entire day of staffing costs while consolidating cases on other days. “It may make sense to do 10 cases on Friday instead of five on Thursday and five on Friday,” he says. He says the center should track how many weekdays a year the center closes to determine whether staffing costs could be cut by closing an extra day per week.

10. Debt to total capital ratio. Mr. Newsad says HealthCare Appraisers always looks at how much debt a surgery center is carrying. In a new surgery center, he says a typical debt-to-total capital ratio should be no more than 80 percent. Once the surgery center is established, that ratio should go down over time.

“There’s a lot of equipment that surgery centers have to buy in the beginning, and it’s a little riskier when they go out and get loans for everything because then you have to make bigger payments every month,” he says. He says while carrying debt is not necessarily bad, it does add some degree of risk relative to a center that purchases equipment with cash. ■

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10 Steps to More Profitable Managed Care Contracts for ASCs (continued from page 1)

the marketplace — maybe you're the only ASC that performs orthopedic procedures in your community; maybe you have the best physicians and the best outcomes. He says you also need to know your costs inside and out in order to negotiate profitable insurance rates. Before you submit a proposal, break down costs per case for each specialty and determine where you can afford to maintain the same reimbursement rate and where you need an increase.

He also recommends focusing on those payors that represent the majority of your business. Look at data on patient volume to determine where your volume comes from. "Maybe the Blues is the biggest payor for you, or maybe it's a medical group," he says. "You need to figure out what percentage of your business that payor represents and how important it is to you."

2. Start negotiating six months before your contract renewal date. Mr. Epps says surgery centers should start negotiating six months in advance of the renewal date — at least. "If you wait until a month before the renewal date, health plans will draw it out," he says. "They'll use a variety of different excuses

to not give you a proposal in a timely fashion." He says payors will tell you the analytics team is still reviewing your case for months or up to a year before they finalize your contract. Start talking to your payor six or eight months in advance to ensure an increase.

3. Isolate the codes that affect your profitability most significantly. Mr. Epps recommends isolating your top five payors and then looking at your contracts to determine which facets of each contract represent the ASC's "bread and butter." Look at your top volume services and determine which codes fall under each grouper. "You try to look line-by-line in the contract to see where you get the biggest bang for your dollar, and then figure out how to increase those rates," he says.

He says surgery centers can take acceptable losses on some codes, but not on others. For example, if a code is billed at your center 95 percent of the time, you should not accept a loss, compared to a code that's only billed five times a year. Try and negotiate increases on the codes that represent the largest volume for your ASC.

4. Aim for an annual increase of 3 percent — and don't ask for more than 10. As long as a surgery center is "in the

black," Mr. Epps recommends asking for an annual increase close to a cost of living adjustment — around 3 percent. He recommends using the Medical Service Index to determine a good benchmark for your increase. "The MSI typically increases by 3 percent annually, so it's a good benchmark to use," he says. He says while you might want to aim for a 5-6 percent increase in case the payor tries to negotiate down, you shouldn't ask for 10 percent or more. "Asking for a 10 percent increase sends off bells and whistles and alarms at health plans," he says.

The only exception to the "10 percent increase rule" is if your surgery center's contracts are several years old and represent a significant volume with the payor. If your contracts haven't been renegotiated in five years, you might ask for a more substantial increase.

5. Keep the payor informed when you plan to add a new service. If your surgery center plans to add a new service, you will need to negotiate a new contract to account for the new codes you'll be using. Because you won't have historical data on the new service until you start performing the cases, Mr. Epps recommends going over your plans with your insurance companies. "You can often tell them, 'We've hired a new doctor, and he specializes in this type of procedure. We're going to start this service in the next few months, and it's important that you understand our plans as a business partner even though we have no historical data,'" he says. Introduce the physician to your payor contractor if possible, and present any quality data on the physician's services from his or her time at other facilities.

6. Carve out some codes and accept percent of billed charges for the rest. Health plans hate carve-outs for codes, Mr. Epps says. "The problem that health plans have with multiple carve-out codes is that it's an administrative nightmare to pay the claims," he says. If your health plan is balking at the code carve-outs you have requested, you might want to consider a simpler contract that pays based on percentage of billed charges.

Mr. Epps recommends looking at your current contract and deciding whether you have certain codes carved-out that you don't actually bill very often. "If you notice that over the last year you don't bill those codes as often, you can remove those as a carve-out," he says. "All other services might then be paid at 50-80 percent of billed charges, which still equates to a decent reimbursement level." He says you can also sometimes compare data with the health plan itself. Ask them what their data shows as your most commonly billed codes and compare with your data to see if it matches.



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7. Make sure your contracts are up-to-date on the newest codes. If your contracts are five or even 10 years old, you may be billing with old codes that are outdated and have been retired, Mr. Epps says. "Make sure that your contracts are up to speed with the latest and greatest codes," he says. "You may be billing with old codes and, as a result, losing money."

8. Establish an ongoing relationship with your payor representative. A better rapport with your payor representative generally means a better annual increase and an easier negotiation process, Mr. Epps says. While you don't have to set up an annual meeting, he recommends inviting your payor contractors out for lunch every two years or so to keep up the relationship. "I'm an advocate of meeting face-to-face and talking about your goals or bringing them out to the surgery center for a meeting or to give them a tour," he says. "Relationships and networking are so key to our business that you're likely to get a higher rate if you have that relationship."

9. Don't accept the tactics payors use to tell you "no." Mr. Epps says there are a variety of different tactics payors will use to tell

you "no" on a negotiation. You may hear things such as, "You're already at the top of our reimbursement level for ASCs" or, "Due to the current economic environment and pending health-care reform, we're in a position where we can't do anything."

Mr. Epps says while plans will use a variety of tactics to shut you down, that doesn't mean they won't offer you an increase. "It's kind of like claims denials — there are a variety of different ways to deny claims until you fight, fight, fight and they finally pay it," he says. He says you simply have to keep pushing the value that you bring to the organization and differentiate yourself from other centers. Explain that you're not asking for an increase for all your codes, only some of them — and don't forget important codes, because the payor will not be happy if you have to come back for renegotiation.

10. Take the negotiation to your contractor's supervisor if necessary. Mr. Epps has a handy trick if your contractor isn't responding to your queries — go on LinkedIn and look up his or her boss. "I look up the VP of network management in Texas or wherever because 50-60 percent of the time, I have to es-

calate the negotiation to the regional manager because the contractor is not working in good faith or does not respond at all," he says. "If you don't receive a response in a few weeks, escalate it to the regional vice president and tell them you're seriously reconsidering your relationship with the health plan." ■

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32 GI & Endoscopy-Driven Surgery Centers to Know

By Rachel Fields

GI & Endoscopy-Driven Surgery Centers to Know

GI is the most common specialty in terms of case volume and the sixth most popular specialty with management companies, according to data from VMG Health and HealthCare Appraisers. Here are 32 notable surgery centers that perform a majority of GI & endoscopy procedures. *Note:* Surgery centers are listed in alphabetical order. Centers do not and cannot pay to be selected for *Becker's ASC Review* lists. The list is not an endorsement of any organization or individual's clinical abilities.

Advanced Endoscopy Center (Bronx, N.Y.). Advanced Endoscopy Center opened in April 2007 as a joint venture between a group of physicians, Physicians Endoscopy and a local hospital in the Bronx. Twenty-two physicians use the facility, with 10 physicians owning interest in the center. Advanced Endoscopy Center is an AAAHC-accredited center and an ASGE Center of Excellence and performed more than 10,000 procedures in 2011.

"We have a great team of physicians and staff, and they work really hard to make sure patients are processed efficiently and quickly," says administrator Steve Housberg. "Our average wait time is an hour and a half from start to finish, and we have state-of-the-art equipment." He says the surgery center just "put money back into the facility" by purchasing a million dollars worth of endoscopes and reproprocessors.

Alabama Digestive Health Endoscopy Center (Birmingham, Ala.). Alabama Digestive Health Endoscopy Center, a three-way joint venture between Tenet Healthcare's Brookwood Hospital, local physicians and Practice Partners in Healthcare, performs colonoscopies, EGDs and flexible sigmoidoscopies. The facility administrator, Jackie Harrison, RN, has been with Practice Partners since the opening of the center and has led the facility in what Practice Partners president and CEO Larry Taylor calls "incredible clinical and non-clinical work on a daily basis to provide the physicians and patients the highest care."

The center opened in March 2008 and currently employs 35 staff members, 26 of whom are RNs or LPNs. In 2011, the center achieved an excellent average turnover time of 10 minutes per case and updated its equipment with the latest scopes. The center has also continued same-store growth on an annual basis since it opened. In 2012, Mr. Taylor says the center will "continue to add physicians to our center, utilizing the combined resources of the center and the hospital to provide the finest clinical care."

Ambulatory Endoscopy Clinic of Dallas (Dallas, Texas). The Ambulatory Endoscopy Clinic of Dallas opened in April 1993 as the first licensed free-standing surgery center exclusively for GI procedures in North Texas. According to the center's site, the facility was opened by a group of physicians who wanted to create a facility that provided efficient, easily

accessible care for patients and featured a staff dedicated exclusively to GI health.

In January 1995, Healthcare Corporation of America joined the center as its general partner, and the facility is currently operated under Ambulatory Surgery Division of HCA. AECD has been accredited by AAAHC since 1995 and named a "substantially compliant" facility every year since its initial accreditation. Featuring one OR and two procedure rooms as well as nine practicing physicians, the center states its mission is "[providing] economical, high-quality ambulatory care in a manner consistent with the needs of the community we serve."

Arkansas Surgery & Endoscopy Center (Pine Bluff, Ark.). Arkansas Surgery & Endoscopy Center opened in 1995, the project of sole physician owner Syed A. Samad, MD, FACP, FACP, AGAF. The single-specialty surgery center has two operating rooms and performs approximately 1,500 cases per year. According to Ahmed Samad, MD, "Dr. Samad is a very well-educated physician who saw the great benefit to providing outpatient care in the form of an ASC." He has achieved the CASC credential as well as his board certification in internal medicine, gastroenterology and managed care medicine and serves as a full adjunct clinical professor of medicine with University of Arkansas for Medical Sciences.

In 2005, 10 years after opening his first surgery center in Pine Bluff, Dr. Samad opened a second ASC in Little Rock. The Pine Bluff location was the first GI ASC to serve southeast Arkansas, and its owner has "always strived to provide the highest level of quality care to its patients while running an efficient ASC," according to Dr. Samad. "ASEC has been in the forefront when it comes to successful GI-driven ASCs in the state of Arkansas," he says. "With the decreasing amount of single physician owner ASCs, ASEC continues to strive."

Amarillo Endoscopy Center (Amarillo, Texas). Amarillo Endoscopy Center is a Medicare-approved, GI-driven center that performs a variety of procedures, including colonoscopy, upper endoscopy, capsule endoscopy and remicade treatments. The ASC features two GI physicians — Amit K. Trehan, MD, and Srinivas Pathapati, MD. According to Freida Toler, administrator of Amarillo Endoscopy Center, physicians have input about every staff member hired at the center, effectively building cohesion between physicians, nurses and other staff members.

She says she also cross-trains employees and moves them through different departments in order to encourage collaboration and break down walls between physicians and employees. "Periodically staff members move through different areas of the ASC they haven't been in for a while to maintain competency in all areas, as well as to ensure they aren't working with the same people all

the time," she says. "Surgical teams tend to form cliques, so we try to make sure everyone gets a chance to work with different people."

Barkley Surgicenter (Fort Meyers, Fla.). Barkley Surgicenter opened in 1993 as the project of a group of gastroenterologists. The center is currently owned by seven physician-owners — Nick Sharma, MD, Brian Feiock, MD, Brian Longendyke, DO, Michael Weiss, MD, Michael Bays, DO, Ramesh Koka, MD, and Srinivas Raju, MD. The center contains one operating room and three procedure rooms and is utilized by nine physicians, all in the field of gastroenterology.

According to administrator Keri Gantt, the center leaders recently performed an entire crosswalk of the ASC's policies and procedures and made sure everything fit with Joint Commission standards and Medicare regulations. She says the success of the center can be attributed to "great communication between management, physicians and staff."

Berks Center for Digestive Health (Wyomissing, Pa.). Berks Center for Digestive Health opened in 2001 and is currently owned by 11 physicians and Physicians Endoscopy. The center includes three procedures and 13 practicing GI physicians. According to administrator John Gleason, a strong relationship between the physicians' offices and the ASC leadership has enabled BCDH to drive strong volume to the center.

"We had a slow start to the year and were off-budget in terms of volume and revenue," he says. "Thanks to some innovative scheduling through open endoscopy and a sense of urgency to fill the schedule, we were able to make up all the lost volume and revenues in the final three months of the year."

Burlington County Endoscopy Center (Lumberton, N.J.). Burlington County Endoscopy Center opened in November 2008, a partnership between a Gastroenterology Consultants of South Jersey and Physicians Endoscopy. Physicians Endoscopy had previously worked with the practice starting in 2006 and was involved with the physician group through the development process.

There are currently seven physicians with financial ownership in Burlington County Endoscopy Center, with an additional two physicians using the center for cases. In 2011, the physician GI practice added an eighth fellowship-trained GI specialist, which administrator Elaine Lang says was a significant advantage for the practice as well as the center.

Bux Mont Endoscopy Center (Sellersville, Pa.). Bux Mont Endoscopy Center was founded by Bux Mont Gastroenterology Associates and is currently owned by four physicians — Jerome Burke, MD, William O'Toole, MD, Michael Cassidy, MD, and Ira Kelberman, MD. The center averages 350 procedures a month, with colonoscopies being the most frequent procedure. The center is run by administrator Penny Jacobs, RN, BSN and medical director Dr. Burke. Since opening in April 2008, the center has opened a second room, with the possible expansion of a third room in the future. Due to the center's quality improvement program, the ASC has also been granted an exception from the state to perform procedures on ASA III patients.

The center has also added BRAVO pH monitoring and is considering adding hemorrhoid banding in the near future. The center is staffed by 16 nurses and techs, six GI physicians, one colorectal surgeon and 10 anesthesiologists. "Our physicians are very involved in the day-to-day operations of the center," says Wendy Freed, RN, DON. "Their commitment to the center is evident in their weekly meetings with the administrator. There is a true presence and concern for all aspects of the operation of the facility."

Digestive Health Center (Madison, Wis.). Digestive Health Center is a 50/50 joint venture between SSM Healthcare of Wisconsin and Dean Health System, the latter of which is 95 percent owned by physician shareholders. The Digestive Health Center opened in 2004 — initially performing only GI procedures but expanding to include pulmonology procedures in 2010. The center's primary procedures at this

time include colonoscopies, upper endoscopies and bronchoscopies.

According to Jonathan Lewis, RN, MBA, vice president of ambulatory surgery centers for St. Mary's Dean Ventures (the center's corporate name), the center implemented an endoscopic bronchial ultrasound program in 2011 and converted its colonoscopy prep protocol to the split prep for patients. The center has also fully implemented an Epic electronic medical record that includes nursing and physician documentation, computerized physician order entry and billing.

Eastside Endoscopy Center (Bellevue, Wash.). Eastside Endoscopy Center opened in 1995 and specializes in upper endoscopies and colonoscopies, which are performed in three procedure rooms. The center, which is managed by Physicians Endoscopy, has been accredited by the AAAHC since 1996 and was the first endoscopy center in Washington to achieve AAAHC accreditation. According to Michelle Steele, administrator of Eastside Endoscopy, the ASC recently implemented an electronic medical record, allowing staff to track times and easily identify areas of delays and target them for improvement.

She said the center also successfully implemented anesthesia services, contracting with a local anesthesia group to administer propofol in the facility. "One of the reasons I believe 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," she says. She calls the center "a family" and credits its success to the combination of great physicians, RNs, medical assistants, techs and its corporate partner, Physicians Endoscopy.

The Endoscopy Center at Bainbridge (Chagrin Falls, Ohio). The Endoscopy Center at Bainbridge opened in October 2007 and currently partners with University Hospitals, which owns a minority interest in the center, and management partner Physicians Endoscopy. The surgery center has six physician-owners who are



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currently the only providers to use the facility and perform colonoscopies and upper endoscopies. The center, which is an ASGE-recognized unit, received its AAAHC accreditation renewal in September and will be up for ASGE renewal this spring. Speaking on the success of the center, administrator Jean Neading says, "The nurses [at our center] have worked with these physicians for 20-25 years prior to opening our facility. When the center opened in October, the physicians brought these nurses with them, so they're all very seasoned and experienced and know their physicians very well."

Fleming Island Surgery Center (Orange Park, Fla.). Fleming Island Surgery Center was founded in January 2007 and currently performs approximately 8,000 cases per year, 65 percent of which are GI. The center features five GI specialists who routinely use the ASC and between four and five general surgeons who perform GI cases at the center. The center is accredited by the AAAHC and is affiliated with Borland-Groover Clinic, the largest gastroenterology clinic in the Southeastern United States. According to Lindsay Allen, special services coordinator for Borland-Groover Clinic, the center added an additional GI physician in 2011 and was able to decrease its expenses by 5 percent over the last year. "[This] was a huge accomplishment for us," she says.

Gateway Surgery Center (Edwardsville, Pa.). Gateway Surgery Center, which was purchased by Covenant Surgical Partners in July 2010, opened in 2007 and performs approximately 5,800 cases every year. The center is open from 6:30 a.m. until 3:00 p.m. and performs colonoscopies, endoscopies, peg tubes, bandings and dilations. The center is licensed by the Department of Health, accredited by AAAHC and recognized by ASGE for promoting quality in endoscopy. According to Kathryn M. Hummel, "The patients and families who come to the center daily tell us how warm, friendly, efficient and professional the entire staff is. We use CRNAs for our sedation, and again, the patients think this is

'wonderful.'" The center is at street-level and is handicap-accessible, with plenty of available parking. "We do think we are the best!" Ms. Hummel says.

Hackensack (N.J.) Endoscopy Center. The ownership at two-OR Hackensack Endoscopy Center has stayed relatively similar for the last 10 years, according to administrator Aaron Shechter. The center opened in 2001 and has stayed 100 percent physician-owned since then, performing an average of 7,000 procedures a year. "The center is very focused on providing high quality patient care, but also a very high level of service to the patients," Mr. Shechter says. "We offer valet parking for patients and we provide a nice, pleasant place for patients and families to come when patients require a procedure." He says the center tries to keep up with recent technological developments by purchasing new Olympus high-definition instruments and scopes.

Jacksonville Center for Endoscopy (Jacksonville, Fla.). The Jacksonville Center for Endoscopy was established in 1998 and is currently a state-licensed, Joint Commission-accredited, AHCA-certified ASC owned and operated by the physicians of Borland-Groover clinic. The center, which has two locations in Jacksonville, performs colonoscopies, upper endoscopy and sigmoidoscopy and staffs only nurses trained specifically in endoscopy. The center performs more than 32,000 procedures annually. Since its inception, JCE has been determined to implement health information technology to improve quality and safety, as well as streamline workflow, increase patient throughput and maximize revenues. JCE administrator Cindy Hall says the center aimed to "ensure that our physicians had access to patient information that was up-to-date to the minute." Since the implementation of an EMR, JCE has saved more than \$26,000 and is now completely paperless, according to Ms. Hall.

Lincoln Endoscopy Center (Lincoln, Neb.). Lincoln Endoscopy Center opened in July 1998 to house the cases of physicians from Gastroenterology Specialties, P.C. The surgery center has three suites equipped with state-of-the-art Olympus equipment, and patients have individual restrooms and lockers in the pre-op and post-op bays. Lincoln Endoscopy Center was also the first free-standing endoscopy center in the state of Nebraska.

The facility performs three procedures — colonoscopies, upper endoscopy and flexible sigmoidoscopy — and all GI physicians are board-certified by the American Board of Gastroenterology. According to clinical director Becky Johnson, the center is careful to work with physicians on needed equipment and come to a reasonable conclusion about final purchases. She says she also visits at least one conference every year focusing on GI to keep up with technological advancements in the industry. Manhattan Endoscopy Center (New York City). Manhattan Endoscopy Center was opened by a group of 17 physicians and Frontier Healthcare in January, one of New York state's largest ambulatory surgical centers. The facility expects to see more than 15,000 patients in its first year. The center provides services such as colonoscopy, upper endoscopy and endoscopic ultrasound and brings together 17 gastroenterologists from hospital systems such as Lenox Hill Hospital, New York University Hospital and New York Presbyterian Hospital.

"We are seeing the ASC setting as the future for outpatient procedures, particularly in specialties like GI," says Peter Kim, MD, board member of the center. "The center will provide a site of service that matches, if not exceeds, the stringent safety requirements and infection controls seen in a hospital setting and achieved through an efficient, cost-effective model, while providing for a thoroughly personalized patient experience."

Memorial Mission Surgery Center (Chattanooga, Tenn.). Though a multi-specialty center, Memorial Mission Surgery Center performs around 60 percent GI procedures — 6,600 out of 11,000 total cases in 2011. The center, which opened in 2003, is owned primarily by GI and orthopedic physicians, as well as two general surgeons and one ENT. The center is owned 70 percent by physicians and 30 percent by the local health system.

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According to administrator Brent McLean, the center managed to cut costs in 2011 by streamlining GI supplies so they're not located in multiple areas. In the previous set-up, GI materials were kept in all three GI procedure rooms, and staff members tended to hoard the supplies to make sure they had enough for their cases. Now, the materials are stored in a central location in the GI lab, and staff members only stock their procedure rooms for the next day's cases.

Michigan Endoscopy Center (Farmington Hills, Mich.).

Michigan Endoscopy Center opened in March 2003 as a joint venture between 16 physicians and corporate partner Physicians Endoscopy. The center includes three operating rooms and three procedure rooms and is used by 19 physicians — 15 GI physicians and 4 colorectal surgeons. According to administrator Brien Fausone, MEC is a very busy surgery center, with average daily procedures at 62 and high-demand days at more than 80. "We were a low cost/high volume provider with an outdated and cramped waiting room," he says. "In 2010, we made the decision to acquire an additional 3,000 square feet of adjacent space to build out a new waiting room and business office. The patient response — and more importantly, the physician referral response has been overwhelmingly positive." The surgery center also created an environment with Wi-Fi, HD TV and quiet areas for escorts to wait or work in comfort.

Midtown Endoscopy Center (Atlanta, Ga.).

Midtown Endoscopy Center, a center affiliated with Atlanta Gastroenterology Associates, was established in 2001 and currently performs approximately 10,620 cases a year. The physician-owned center staffs 18 physicians and recently added hemorrhoid banding (2008), liver biopsy (2009) and Bravo pH (2010). According to Steven Morris, MD, managing partner, and Jana Baker, practice administrator with AGA, the center's success can be attributed to "skilled, experienced physicians and staff" and "attention to individual patient needs." The surgery center contains four ORs and is accredited by the AAAHC.

Mirage Endoscopy Center (Rancho Mirage, Calif.).

Mirage Endoscopy Center is a single-specialty endoscopy center managed by Health Inventures that opened in March 2003. The surgery center has two procedure rooms and is used by eight gastroenterologists. According to administrator Dana Folstrom, the center was recently successful with the help of Health Inventures' contracting department in renegotiating several of its key commercial contracts, ensuring increases in reimbursement for the next three years.

"Given the current economic environment and its impact on volumes, along with recent cuts in Medicare, we consider this a key accomplishment in maintaining center revenue and maintaining our high level of service and care to the community," Mr. Folstrom says the center's key to

success is the employees' commitment to patient welfare and satisfaction. "As a single-specialty in a high Medicare environment, we have a particular need to operate very efficiently, and without the buy-in from the staff, this would be difficult, if not impossible," he says.

New York GI Center (Bronx, N.Y.).

New York GI Center is a single-specialty GI ASC in Bronx, N.Y. The center opened in March 2007 and has since earned AAAHC accreditation, implemented electronic medical records and expanded to 18 gastroenterologists on staff. The center contains five ORs and performs approximately 10,800 cases a year, according to NYGI president James. C. DiLorenzo, MD. He says the center's initiatives for 2012 include an expansion, which will involve enhanced facilities for staff and patients and two additional ORs.

He also says the center plans to expand its charity care initiative and participate in GI QuIC. 2010. A joint venture between private practice physicians and a major academic medical center, NYGI contains "safety-based technology," such as 100 percent disposable endoscopic accessories, end tidal CO2 monitoring and a video laryngoscope for emergency intubations, according to Dr. DiLorenzo.

North Memorial Ambulatory Surgery Center (Maple Grove, Minn.).

North Memorial Ambulatory Surgery Center is a multi-specialty surgery center with seven operating rooms. The center is a joint venture between physicians and the local hospital and is managed by Surgical Management Professionals. The center originally opened its doors in 2008, running four rooms with no endoscopy procedures. In August 2011, the center integrated over 400 endoscopy cases per month from a center that closed within the same building. These 400 cases account for over 50 percent of total volume performed within the center today.

"This is the most efficient place I work," says Isaac Felemovicus, MD, a partner and practicing physician at the center. "It is not only elegant and visually attractive, but is a modern example of how a surgery/endoscopy center should work. There is nowhere else in the Twin Cities I can go where I can perform 17-18 colonoscopies from 7:30-3:00 on a routine basis."

Northwest Endoscopy Center (Marietta, Ga.).

Northwest Endoscopy Center opened in Marietta in 2010 and has since received accreditation from the AAAHC. The physician-owned center staffs three physicians and contains three operating rooms, where the providers perform an average of 2,322 cases every year. According to Dr. Morris and Ms. Baker, the center is equipped with high-definition scopes and a fully functional electronic medical record, and propofol is always administered by anesthesia staff to improve patient care and quality. The surgery center expanded its list of services by adding hemorrhoid banding in 2010.

Northwest Michigan Surgery Center (Traverse City, Mich.).

In 2004, 36 Northern Michigan physicians partnered with Munson Medical Center to create Northwest Michigan Surgery Center, an ASC that performs 17,400 multi-specialty cases per year aimed at addressing the expanding outpatient needs of the region. The center contains six ORs, three endoscopy suites and one minor procedure room, and eight GI specialists and nine general surgeons performed 9,500 GI procedures in the last year. The surgery center went live with EHR on Aug. 11, 2011, a feat that was accomplished during the center's busiest month to date without disrupting patient care.

Physicians Endoscopy Center (Houston, Texas).

A joint venture with HCA Ambulatory Surgery Division, Physicians Endoscopy Center has 18 physician owners and eight procedure rooms and performs around 1,100 cases every month. The ASC was founded by several physicians who wanted "a centralized, convenient and patient-focused center to perform procedures at lower cost than hospitals," says PEC administrator Nancy Le Nikolovski. The AAAHC-accredited center opened in Dec. 2002 and performs GI procedures exclusively. Ms. Nikolovski says in 2011, the surgery center successfully added a hemorrhoid ligation clinic and propofol anesthesia. "This year marks our 10-year anniversary in serving the community and saving lives through colorectal cancer screenings, so we're planning a big celebration," she says.

Skyline Endoscopy Center for Health (Loveland, Colo.).

Skyline Endoscopy Center for Health opened in December 2004, a joint venture between McKee Medical Holdings, a hospital that owns 25 percent, and Loveland Endoscopy Enterprises, a physician group that owns 75 percent. The center was developed by Pinnacle III and has been managed by the company since its inception. Skyline is a single-specialty GI/endoscopy center that performs colonoscopies and EGDs and performed 4,163 procedures in 2011.

According the center's administrator, the center continues to increase case load incrementally by negotiating and improving payor contracts, as well as purchasing all new endoscopes and an HD video system to improve polyp detection. The center has also upgraded its electronic procedure documentation system to improve physician satisfaction and efficiency and implemented the use of CO2 to reduce patient discomfort post-procedure.

Stateline Surgery Center (Galena, Kan.).

Stateline Surgery Center started as a primarily orthopedic surgery center, until administrator Jenny Morris pursued a GI physician in the Joplin, Mo., area. "This practitioner was interested in using our center one day a week to perform GI procedures at our center," she says. "The managed care situation in the Joplin, Mo.-area is restrictive due to exclusivity arrangements with the local hospitals and large payors, which

prompted the discussions as the physician was interested in performing cases at an in-network facility.” She says the center conducted a feasibility analysis to determine whether GI would be a good fit for the center, and the board voted to add the specialty.

In May 2011, a tornado hit Joplin and severely damaged Four States Surgery Center, in which the new GI physician was an owner. The physician needed another three days a week to perform procedures at Stateline, which ramped up GI volume, and a few months later, the center added another GI physician to perform cases three afternoons per week. At this time, the center averages 60 to 70 GI procedures weekly.

Surgery Center at Tanasbourne (Hillsboro, Ore.). Surgery Center at Tanasbourne, which was opened in March 2009 by Renton, Wash.-based Providence Health and Services, is a freestanding, multi-specialty facility with four ORs and two procedure rooms. The center is managed through a joint venture with Blue Chip Surgical Partners and stands at around 17,000 square feet. The center features state-of-the-art medical technology and performs GI, general surgery, orthopedics, gynecology, plastic surgery, pain management, spine and ear, nose and throat procedures.

Center Administrator Cindy Givens said the center drives GI referrals by following up with physicians about the patient’s experience — an aspect of the relationship that ASCs might sometimes overlook. “I make sure the loop is closed,” she says. “When they send a referral over, we follow up with them to let them know the patient was scheduled on this date, or that we were not able to contact the patient, or that the patient was referred on to another provider.”

Surgery Center of Joliet (Ill.). The Surgery Center of Joliet opened in 2008 and specializes in colonoscopy, EGD and upper and lower GI diagnostics and screenings. The center houses two procedure rooms, two endoscopy rooms and three ORs and contains a portable endoscopy machine that allows patients to undergo endoscopic procedures in one of its ORs. According to Marge Schillaci, administrator of the Surgery Center of Joliet, the ASC keeps costs low by decreasing inventory of high-cost items.

“We looked at what we were keeping on the shelf and also specifically how long it took us to get the item,” she says. “Based on what our volumes were and actually looking at our usage, we no longer kept more on the shelf than we actually needed.” She said this strategy improved cash flow to the center and decreased holding costs. In addition to GI procedures, Surgery Center of Joliet also performs ENT, general surgery, pain management, plastics, podiatry and orthopedic procedures.

West Metro Endoscopy Center (Douglasville, Ga.). West Metro Endoscopy Center in Douglasville opened in 2008 and has four physicians. The physician-owned center has three ORs and performs strictly gastroenterology procedures — approximately 3,350 every year. The surgery center is accredited by the AAAHC. According to Dr. Morris and Ms. Baker, Atlanta Gastroenterology Associates’ centers are successful in part because they provide “patient convenience with eight locations [and] offer special procedures often only provided in hospitals.” The center expanded its list of services by adding hemorrhoid banding in 2008. ■

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- The Best Ideas and Biggest Threats to Orthopedics and Spine - Tom Mallon, CEO, Regent Surgical Health, Brian Cole, MD, MBA, Professor, Dept. of Orthopedics, Dept. of Anatomy and Cell Biology, Section Head, Cartilage Restoration Center, Rush Division of Sports Medicine, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, and Jeff Leland, CEO, Blue Chip Surgical Center Partners, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News
- Healthcare Reform, Politics, and The Next 4 Years - Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians, Thomas J. Bombardier, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, John Caruso, MD, Neurosurgeon, Parkway Surgery Center, and Robert Zasa, MSHHA, FACMPE, Founder, ASD Management, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News
- Evolving Clinical Developments in Interventional Pain Management - Mark Coleman, MD, CEO, National Spine and Pain Centers, LLC
- Moving Spine Procedures to ASCs - Key Business and Clinical Issues - Panel Discussion with Paul Schwaegler, MD, Seattle Spine Institute, PLLC, Richard Kube, MD, CEO, Founder/Owner, Prairie Spine & Pain Institute, Devin Datta,

MD, Melbourne Surgery Center, moderated by Jeff Leland, President & CEO, Blue Chip Surgical Center Partners

- Key Concepts to Fixing Physician Hospital Joint Ventures Gone South - Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America
- 10 Best Practices to Improve Billing and Collections - Lisa Rock, President, National Medical Billing Services
- Orthopedics Hospital Joint Ventures, Bundled Payments, 16,000 Cases and Are There Lessons That Can Be Applied to Other Facilities and Systems - James T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic Institute
- The Key Legislative Priorities of the ASC Industry - William Prentice, JD, Executive Director, ASC Association
- Hand Surgery - Key Business Issues for ASCs and Physician Owned Hospitals - R. Blake Curd, MD, Board Chairman, Surgical Management Professionals
- Developing a Spine-Driven ASC: The Essentials for Success - Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners
- The State of The ASC Industry - Andrew Hayek, President & CEO, Surgical Care Affiliates, and Chairman of The Advocacy Committee
- 7 Keys to Make Orthopedic and Pain-Driven ASCs More Profitable - Larry Taylor, President & CEO, Practice Partners in Healthcare, Inc.
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PROGRAM SCHEDULE

Pre Conference – Thursday, June 14, 2012

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

Main Conference – Friday, June 15, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:20pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:20pm – 6:30pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday, June 16, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:10am – 12:30pm	Conference

Thursday, June 14, 2012

Track A Improving Profits, Valuation and Transaction Issues

1:00 – 1:40 pm

Key Concepts to Fixing Physician Hospital Joint Ventures Gone South

Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America

1:45 – 2:15 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

2:20 – 2:50 pm

Utilizing Spine Cases to Improve the Profitability of Underutilized Poorly Performing ASCs

Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners,

2:55 – 3:25 pm

7 Keys to Make Orthopedic and Pain-Driven ASCs More Profitable

Larry Taylor, President & CEO, Practice Partners in Healthcare, Inc.

3:30 – 4:00 pm

An Integrated Approach to Introducing Direct to Consumer Marketing to Your Practice

How it Can Deliver Superior Financial Results - Jimmy St. Louis, CEO, Advanced Healthcare Partners

4:05 – 4:35 pm

What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements, Valuations and Other Issues

Jen Johnson, CFA, Managing Director, VMG Health

4:40 – 5:40 pm - KEYNOTE

Leadership and Management in 2012

Lou Holtz, Legendary Football Coach and Analyst, ESPN

Track B – Spine

1:00 – 1:40 pm

Business Planning for Spine-Driven Centers

Jeff Leland, CEO, Blue Chip Surgical Center Partners, and Devin Datta, MD, Melbourne Surgery Center

1:45 – 2:15 pm

Minimally Invasive Multi-Level Fusions in ASCs

Richard Kaul, MD, Owner, New Jersey Spine and Rehabilitation

2:20 – 2:50 pm

Moving Spine Procedures to ASCs – Key Business and Clinical Issues

Paul Schwaegler, MD, Seattle Spine Institute, PLLC, Richard Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute, Devin Datta, MD, Melbourne Surgery Center, moderated by Jeff Leland, President & CEO, Blue Chip Surgical Center Partners

2:55 – 3:25 pm

The Best Ideas for Marketing Spine and Patient Development

Daniel Goldberg, Director of Business Development, New Jersey Spine and Rehabilitation

3:30 – 4:00 pm

Bundled Contracting Initiatives for Orthopedics and Spine

Marshall Steele, MD, Orthopedic Surgery, Marshall Steele & Associates

4:05 – 4:35 pm

Minimally Invasive Spine Surgery for Degenerative Spine Conditions

Miquel Lis-Planells, MD, Michigan Head & Spine Institute

Track C – Pain Management and Spine

1:00 – 1:40 pm

Evolving Clinical Developments in Interventional Pain Management

Mark Coleman, MD, CEO, National Spine and Pain Centers, LLC

1:45 – 2:15 pm

The Best Ideas Now; Key Ways to Improve Physician Owned Hospital Profits

Larry Teuber, MD, President Medical Facilities Corp.
 Michael J. Lipomi, President & CEO, Surgical Management Professionals, Goran Dragolovic, SVP, Operations, Surgical Care Affiliates, moderated by
 Amber McGraw Walsh, Partner McGuireWoods LLP

2:20 – 2:50 pm

Managing Pain Practice Protocols, Branding and Other Tips to Improve Profitability

Vishal Lal, CEO, Advanced Pain Management

2:55 – 3:25 pm

Interventional Pain Management - New Concepts to Reduce ER Visits, Hospitalizations and Re-Admissions

Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

3:30 – 4:00 pm

Keys to Successfully Establishing and Growing a Premier Pain Center

Stephen Rosenbaum, CEO, and Robin Fowler, MD, Medical Director, Interventional Management Services

4:05 – 4:35 pm

Intradiscal Biologics Injections for Mild to Degenerative Disc Disease

Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, President & CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, American Board of Neurophysiologic Monitoring Board of Directors

Track D – Orthopedics

1:00 – 1:40 pm

5 Key Steps to Improve Profits in Orthopedic-Driven ASCs

Gregory P. DiConciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites, LLC

1:45 – 2:15 pm

Complex Hand Cases in ASCs, Business and Reimbursement Issues

Steven S. Shin, MD, Kerlan-Jobe Orthopaedic Clinic, and John Seitz, Chairman & CEO, Ambulatory Surgical Group, LLC

2:20 – 2:50 pm

Emerging Orthopedic Procedures in ASCs - Business and Clinical Issues

Michael R. Redler, MD, The OSM Center

2:55 – 4:00 pm

Orthopedic Practices – Why Merging Two Practices Can Help, What Are The Choices for Orthopedic Surgeons, Stay the Course or Sell

Leslie R. “Les” Jebson, Executive Director, University of Florida Ortho and Sports Medicine

3:30 – 4:00 pm

Hand Surgery – Key Business Issues for ASCs and Physician Owned Hospitals

R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

4:05 – 4:35 pm

Succeeding in the Face of Challenges, Dealing with Vendors, Focusing on Clinical Operations and Other Strategies from the Front Line

Charley Gordon, MD, Texas Spine and Joint Hospital

Track E – Business and Profitability Issues; Revenue Cycle; Managed Care Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm

Selling Your ASC; What Price Can You Expect; What Are The Deal Terms?

Blayne Rush, MHP, MBA, President, Ambulatory Alliances, Patrick J. Simers, EVP, Principle Valuation, LLC, Thomas J. Chirillo, SVP Corporate Development, Surgery Partners, Matt Searles, Managing Director, Merritt Healthcare, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

1:45 – 2:15 pm

Keys to Transforming Surgery Centers Into a Profitable Business

Tom Yerden, CEO, TRY Healthcare Solutions, Jimbo Cross, VP Acquisitions & Development, Ambulatory Surgical Centers of America, Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America, moderated by Barton C. Walker, Associate, McGuireWoods LLP

2:20 – 2:50 pm

How to Smartly Use Technology to Become More Efficient in Operations

Scott McDade, Vice President, Surgery Centers, McKesson Medical

2:55 – 3:25 pm

A Step by Step Plan for Selling Your ASC – How to Maximize the Price, Terms and Results and How to Handle the Process

Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America, Introduced by Amber McGraw Walsh, Partner, McGuireWoods LLP

3:30 – 4:00 pm

The Key Legislative Priorities of the ASC Industry

William Prentice, JD, Executive Director, ASC Association

4:05 – 4:35 pm

Physician Owned Hospitals - Adding Ancillaries, Reducing Costs and Legal Compliance

Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Michael Weaver, Vice President, Symbion, Inc., Amber McGraw Walsh, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track F – Quality, Infection Control, Accreditation, Management

1:00 – 1:40 pm

Developing the Right Clinical Environment for Complex Spine and Orthopedic Cases

Linda Lansing, SVP Clinical Services, Surgical Care Affiliates

1:45 – 2:15 pm

The New CMS Quality Reporting System and What a Center Needs to Do

David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

2:20 – 2:50 pm

Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs

Nancy Jo Vinson, RN, RBA, CASC, Principal, NJM Consulting, Nurse Surveyor, AAAHC, Accreditation Association for Ambulatory Health Care

2:55 – 3:25 pm

Infection Control in ASCs – 10 Best Key Practices

Jean Day, RN, CNOR, Director of Clinical Operations, Pinnacle III

3:30 – 4:00 pm

10 Great Ideas for QA Studies

Mary Sturm, VP Clinical Operations, Surgical Management Professionals

4:05 – 4:35 pm

TBD

Friday, June 15, 2012**7:00 – 8:00 am – REGISTRATION and CONTINENTAL BREAKFAST****GENERAL SESSION**

8:00 am

Introductions - Scott Becker, JD, CPA, Partner – McGuireWoods LLP

8:10 – 8:55 am - Keynote

An Outlook on Politics, Healthcare and the Election

Tucker Carlson, Contributor, FOX News, Editor-In-Chief, The Daily Caller and Senior Fellow, The Cato Institute

9:00 – 9:40 am – Keynote Panel

Healthcare Reform, Politics, and The Next 4 Years

Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians, Thomas J. Bombardier, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, John Caruso, MD, Neurosurgeon, Parkway Surgery Center, and Robert Zasa, MSHHA, FACMPE, Founder, ASD Management, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

9:45 – 10:35 am

The Best Ideas and Biggest Threats to Orthopedics and Spine

Tom Mallon, CEO, Regent Surgical Health, Brian Cole, MD, MBA, Professor, Dept. of Orthopedics, Dept. of Anatomy and Cell Biology, Section Head, Cartilage Restoration Center, Rush Division of Sports Medicine, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, and Jeff Leland, CEO, Blue Chip Surgical Center Partners, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

10:35 – 11:05 am – Networking Break & Exhibits

11:05 – 11:35 am

The State of The ASC Industry

Andrew Hayek, President & CEO, Surgical Care Affiliates, and Chairman of The Advocacy Committee

Track A

11:40 – 12:20 pm

Orthopedics Hospital Joint Ventures, Bundled Payments, 16,000 Cases and Are There Lessons That Can Be Applied to Other Facilities and Systems

James T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic Institute

12:25 – 1:05 pm

Developing a Spine-Driven ASC: The Essentials for Success

Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

Track B

11:40 – 12:20 pm

Key Concepts to Improve the Profitability and Outcomes of Spine Programs

Kenneth Pettine, MD, Loveland Surgery Center, Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Larry Teuber, MD, President, Medical Facilities Corp., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:25 – 1:05 pm

Spine Surgery: The Next 5 Years

David Abraham, MD, Reading Neck and Spine Center, Bob Reznik, MBA, President, Prizm Development, Inc., David Rothbart, MD, FACS, FACPE, Medical Director, Spine Team Texas, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track C

11:40 – 12:20 pm

The Best Ideas for Improving the Profits of Pain Management-Driven ASC Centers

Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago, Girish Juneja, MD, West Michigan Pain, Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

12:25 – 1:05 pm

The Important of Measuring Clinical Outcomes for Pain Management

Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

Track D

11:40 – 12:20 pm

The Best Ideas for Orthopedics Now

Michael Redler, MD, The OSM Center, Geoffrey S. Connor, MD, Orthopedic Sports Surgery, Alabama Orthopaedic Spine and Sports Medicine Associates, and Greg Horner, MD, Managing Partner, Smithfield Surgical Partners, LLC

12:25 – 1:05 pm

Strategies for Transitioning from Out of Network to a Contracted ASC Model

Greg Horner, MD, Managing Partner, Smithfield Surgical Partners, LLC

Track E

11:40 – 1:05 pm

An 80 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits

Robert Westergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, Ambulatory Surgical Centers of America

Track F

11:40 – 12:20 pm

Physician Engagement and ICD-10: The Role of the Physician in a Succession Transition

Christy A. May, MS, RHIA, and Kathy Lindstrom, RHIT, ProVation Medical

1:05 – 1:50 PM – Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F**Track A – Improving Profits, Valuation and Transaction Issues**

1:50 – 2:30 pm

Physician Hospital Alignment and Business Relationships

Allan Fine, SVP & Chief Strategy and Operations Officer, The New York Eye and Ear Infirmary, Charles “Chuck” Peck, CEO, Health Inventures, and Carole Guinane, Novant Health Ambulatory Care, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

2:35 – 3:05 pm

Assessing the Profitability of Orthopedics and Spine Cases

Andrea Woodell, Managed Care Manager and Matt Lau, Director of Financial Analysis, Regent Surgical Health

3:10 – 3:45 pm

How to Maintain Practice Independence While Effectively Partnering with Hospitals

Charles “Chuck” Peck, CEO, and Christian Ellison, Vice President, Health Inventures, LLC

3:45 – 4:15 pm - Networking Break & Exhibits

4:15 – 4:45 pm

The Best Ideas for Handling Out of Network Patients

Edward Hetrick, President & CEO, Facility Development & Management, Rebecca Overton, Surgical Management Professionals, moderated by Melissa Szabad, Partner, McGuireWoods LLP

4:50 – 5:20 pm

What Should Great Medical Directors, Administrators, and DONs be Paid?

Greg Zoch, Partner and Managing Director, Kaye/Bassman International Corp., Christopher Collins, RN, BSHCS, Administrator, Metropolitan Surgery Center, moderated by Rachel Fields, Editor In Chief, Becker's ASC Review

Track B – Spine

1:50 – 2:00 pm

Complex Revision Spine Surgery and ALIF's, TLIFs, DLIFs in ASCs

Lessons Learned, Mistakes to Avoid, Tips to Consider - Devin Datta, MD, Melbourne Surgery Center

2:35 – 3:05 pm

Complex Cervical Spine – Key Developments

Krzysztof “Kris” Siemienow, MD, Adult and Pediatric Spine Surgery, Lutheran General Hospital, UIC

3:10 – 3:45 pm

Everything You Need to Successfully Perform Spine Surgery in an ASC

Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm

Intraoperative Monitoring for Spine Cases in the ASC Setting “Understanding the Technology and What a Surgery Center Should and Should Not Pay For

Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, President/CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, Spalding Surgery Center, Board of Directors, American Board of Neurophysiologic Monitoring

4:50 – 5:20 pm

Minimally Invasive Outpatient Lumbar Fusions – A Study on Clinical Outcomes in the ASC

Alan Villavicencio, MD, Boulder Neurological & Spine Associates, LLC

Track C – Orthopedics, Spine and Pain Management

1:50 – 2:30 pm

The Use of Implanted Epidural Catheters for Painful Orthopedic Procedures

Tim Lubenow, MD, Rush SurgiCenter

2:35 – 3:05 pm

Developing Spine Centers of Excellence

Bob Reznik, MBA, President, Prizm Development, Inc.

3:10 – 3:45 pm

Getting Started with Spine Surgery in ASCs – 6 Key Concepts

John Pelozza, MD, Center for Spine Care

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

4:15 – 4:45 pm

Creating a Minimally Invasive Center for Spine and Orthopedics

Sev Hrywnak, DPM, MD, CEO, AASC, Inc.

4:50 – 5:20 pm

Pain Management – Is In-Office Pain Management or Investing in an ASC the Smarter Business Decision

David M. Thoene, Managing Partner, Medical Surgical Partners, LLC

Track D – Management and Development

1:50 – 2:30 pm

Physicians, Hospitals, and Management Companies – What It Takes to Make a Winning Partnership and ASC

Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

2:35 – 3:05 pm

New Developments in Orthopedic and Spine Devices and Implants

Chris Zorn, Vice President of Sales, Spine Surgical Innovation, Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center and Bryan Massoud, MD, Spine Centers of America, moderated by Helen H. Suh, Associate, McGuireWoods LLP

3:10 – 3:45 pm

23 Hour Plus Recovery Care in ASCs

Geoffrey S. Connor, MD, Orthopedic Sports Surgery,
Alabama Orthopaedic Spine and Sports Medicine Associates

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm

Third Party Device Acquisition in an Outpatient Pain Management ASC

Nameer R. Haider, MD, Spinal & Skeletal Pain Medicine

4:50 – 5:20 pm

Global Fees and Transparency in Healthcare

Nick Vailas, CEO & Founder, Bedford Ambulatory
Surgical Center

Track E – Business and Profitability Issues, Managed Care and Contracting for ASCs

1:50 – 2:30 pm

Orthopedic and Spine Contracting - A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors

I. Naya Kehayes, MPH, Managing Principal and CEO,
and Matt Kilton, MBA, MHA, Principal and Chief
Operating Officer, Eveia Health Consulting &
Management

2:35 – 3:10 pm

Orthopedic and Spine-Driven Hospitals – Best Practices

David Rothbart, MD, FACS, FACPE, Medical Director,
Spine Team Texas

3:10 – 3:45 pm

Evolving Business, Clinical and Competitive Issues in Spine and Pain

John Prunskis, MD, Bal Nandra, MD, President,
Metro Anesthesia Consultants, LLC, Ara Deukmedjian,
MD, moderated by Holly Carnell, Associate,
McGuireWoods LLP

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm

How to Improve Profits – Billing Process Improvement 101

Bill Gilbert, Vice President, Marketing, and Brice
Voithofer, Vice President Anesthesia and ASC Services,
AdvantEdge Healthcare Solutions

4:50 – 5:20 pm

Health Insurance Plans Are Taking Notice in Fraud and Abuse of Surgical Implants - What Are They Figuring Out and How to Prevent It?

Steven Arnold, MD, Chief Medical Officer, Access MediQuip

Track F – Quality, Infection Control, Accreditation Management

1:50 – 2:30 pm

10 Best Practices to Improve Billing and Collections

Lisa Rock, President, National Medical Billing Services

2:35 – 3:05 pm

Reading the Tea Leaves – Assessing ASC Valuation Trends Utilizing the Latest Industry Data

Elliott Jeter, CFA, CPA/ABV, Partner, and Colin McDermott,
CFA, CPA/ABV, Senior Manager, VMG Health

3:10 – 3:45 pm

Key Legal and Legislative Issues

Kristian A. Werling, Partner, McGuireWoods LLP,
Bobby Hillert, Executive Director, Texas Ambulatory

Surgery Center Society, Stephanie A. Kennan, SVP
Government Relations, McGuireWoods Consulting,
LLC, moderated by Scott Becker, JD, CPA, Partner,
McGuireWoods LLP

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm

Selecting the Best Staff, Preparing and Training the Staff for Complex Spine Cases in the ASC

Nancy Boyd, Administrator of Crane Creek Surgery
Center, and Gina Doleson, Vice President of Operations,
Blue Chip Surgical Center Partners

4:50 – 5:20 pm

Maximizing ASC and Anesthesia Group Relationships

Charles Militana, MD, North American Partners in
Anesthesia

5:20 – 6:30 PM - Cocktail Reception, Cash Raffles and Exhibits

Saturday, June 16, 2012

7:00 – 8:10 am – Continental Breakfast

Track A

8:10 – 8:50 am

Orthopedic, Spine and Pain Management Practices and ASCs – 6 Defining Issues

Michael Redler, MD, The OSM Center, Robert A. Vento,
SVP Operations, Quorum Health Resources, LLC, James
T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic
Institute, moderated by Scott Becker, JD, CPA, Partner,
McGuireWoods LLP

8:55 – 9:30 am

Cervical Myelopathy

Fernando Techy, MD, Adult & Pediatric Spine Surgery,
Lutheran General Hospital, UIC Chicago

9:35 – 10:10 am

Total Joint Reimbursement Strategies in the ASC

Rebecca Overton, Surgical Management Professionals

10:15 – 10:50 am

Healthcare False Claims and Anti-Trust Litigation

Jeffrey C. Clark, Partner, and David J. Pivnick,
Associate, McGuireWoods LLP, moderated by Scott
Becker, JD, CPA, Partner, McGuireWoods LLP

10:15 – 11:30 am

The Business of Spine Reimbursement and Coding Changes

Barbara Cataletto, MBA, CPE, CEO, Business
Dynamics, Ltd.

Track B

8:10 – 8:50 am

Information Technology for Surgery Centers – Achieving Positive Outcome and Avoiding Complications

Michael Rauh, MD, UB, Orthopaedics and Sports
Medicine, Marion Jenkins, PhD, Founder & CEO, QSE
Technologies, Inc., moderated by Holly Carnell,
Associate, McGuireWoods, LLP

8:55 – 9:30 am

10 Key Concepts from Top Performing Pain Management Programs

Amy Mowles, President & CEO, Mowles Practice
Management

9:35 – 10:10 am

New Advances in Sacroiliac Joint Problems

Richard A. Kube, MD, CEO, Founder & Owner, Prairie
Spine & Pain Institute

10:15 – 10:50 am

Managed Care Contracting - Tips to Succeed with ASC Contracting

Andrea Woodell, Managed Care Manager, Regent
Surgical Health

10:55 – 11:30 am

Sell Your ASC or Stay the Course - 7 Key Considerations

Helen Suh, Associate, McGuireWoods LLP, and Scott
Becker, JD, CPA, Partner, McGuireWoods LLP

Track C

8:10 – 8:50 am

Optimizing Your Revenue Cycle

Catherine Meredith, RN, BS, CASC, Vice President of
Finance, Ambulatory Surgical Centers of America

8:55 – 9:30 am

Key Practices to Improve Infection Rates and Clinical Quality

Sandra Jones, MBA, MS, CASC, FHFMA, CEO, EVP,
ASD Management

9:35 – 10:10 am

Challenges of Spine in a Multi-Specialty ASC and the Administrator's Role in Turning Around a Poorly Performing ASC – A Case Study

Nancy Boyd, Administrator, Crane Creek Surgery
Center, and Gina Doleson, Vice President, Blue Chip
Surgical Center Partners

10:15 – 10:50 am

15 CPT and Coding Issues for Orthopedics and Spine

Stephanie Ellis, RN, CPC, Ellis Medical Consulting, Inc.

Track D

8:55 – 9:30 am

HR Practices That Dramatically Improve Quality and Profits

Thomas H. Jacobs, President & CEO, MedHQ

9:35 – 10:10 am

Key Tips for Quality Assurance and Infection Prevention

Dotty J. Bollinger, RN, JD, CASC, LHRM, Chief
Operating Officer, and Nicole Gritton, MSN/MBA,
Director of Nursing, Laser Spine Institute

10:15 – 10:50 am

Key Implantable Device Benefit Management (DBM) Issues Facing ASCs

Robert W. Phipps, Pharm D., Vice President and
General Manager, Eastern Division at Implantable
Provider Group, Inc. and Lynne Stoldt, Administrator at
Melbourne Same Day Surgery Center

GENERAL SESSION

11:35 – 12:30 pm

Conducting a Compliance Review of Your ASC or Physician Owned Hospital

Holly Carnell, Associate, and Scott Becker, JD, CPA,
Partner, McGuireWoods LLP

12:30 pm – Meeting Adjourns

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Lou Holtz has established himself as one of the most successful college football coaches of all time. Born Louis Leo Holtz on January 6, 1937, Holtz grew up in East Liverpool, Ohio, just up the Ohio River from his Follansbee, West Virginia, birthplace. He graduated from East Liverpool High School, earned a Bachelor of Science degree in history from Kent State in 1959 and a master's degree from Iowa in arts and education in 1961. He played linebacker at Kent State for two seasons before an injury ended his career. He has received 4 honorary doctorate degrees.

COACH

Holtz is the only coach in the history of college football to: 1) Take 6 different teams to a bowl game. 2) Win 5 bowl games with different teams. 3) To have 4 different college teams ranked in the final Top 20 poll. Despite never inheriting a winning team, he compiled a 243-127-7 career record that ranked him third in victories among active coaches and eighth in winning percentage. His 12 career postseason bowl victories ranked him fifth on the all-time list. Holtz was recently selected for the College Football Hall of Fame, class of 2008, which places him in an elite group of just over 800 individuals in the history of football who have earned this distinction. Approximate 1 in 5,000 people who played college football or coached it make it into the Hall of Fame.

ESPN Sports Analyst

Currently, Holtz serves as a college football studio analyst on ESPN. He appears on ESPNEWS, ESPN College GameDay programs, SportsCenter as well as serves as an on site analyst for college football games.



Sam Donaldson, a 44-year ABC News veteran, served two appointments as chief White House correspondent for ABC News from January 1998 to August 1999 and from 1977- 1989, covering Presidents Carter, Reagan and Clinton. Donaldson also co-anchored PrimeTime Live with Diane Sawyer from August 1989, until it merged with 20/20 in 1999. He co-anchored the ABC News Sunday morning broadcast, This Week With Sam Donaldson & Cokie Roberts, from December 1996 to September 2002. From October 2001 to May 2004, he hosted The Sam Donaldson Show - Live in America, a daily news/talk radio program broadcast on ABC News Radio affiliates across the country. In the three hour show, Donaldson tackled the day's top stories and important issues-taking comments from newsmakers, engaging listener calls and, of course, inserting his own unique experience and opinion.

Most recently, Donaldson hosted the show Politics Live on ABC News Now, the ABC News digital network. From 1999 to 2001, Donaldson also hosted SamDonaldson@abcnews.com, the first regularly scheduled internet webcast produced by a television network. On it, he interviewed former Presidents Jimmy Carter, Gerald Ford and George Bush, along with such diverse personalities as actor Sean Connery, comedian Janeane Garofalo, tech company CEO Jeff Bezos and sports great Willie Mays.

Donaldson has covered every national political convention since 1964 with the exception of the 1992 Republican Convention in Houston. He reported on the presidential campaigns of Senator Barry Goldwater, Senator Eugene McCarthy, Senator Hubert Humphrey, President Jimmy Carter, President Ronald Reagan and Governor Michael Dukakis. He also reported as an eye-witness on Spiro Agnew's no contest plea in a Baltimore courtroom that forced Agnew's resignation from the Vice Presidency.

In 2008, Donaldson received the AFTRA Media and Entertainment Excellence Award as well as the RTNDA Paul White Award. In 1998, Donaldson received the Broadcaster of the Year Award from the National Press Foundation. The Washington Journalism Review named him the Best Television White House Correspondent in the Business in 1985 and the Best Television Correspondent in the Business in 1986, 1987, 1988 and 1989. Donaldson has won many other awards, among them four Emmy Awards and three George Foster Peabody Awards.



Tucker Carlson is a veteran journalist and political commentator, currently working for the Fox News Channel. Carlson is also the editor-in-chief of TheDailyCaller.com, a news and opinion site. Carlson joined Fox from MSNBC, where he hosted several nightly programs. Previously he was the co-host of *Crossfire* on CNN, where he was the youngest anchor in the history of that network. During the same period, Carlson also hosted a weekly public affairs program on PBS. A longtime writer, Carlson has reported from around the world, including dispatches from Iraq, Pakistan, Lebanon and Vietnam. He has been a columnist for *New York* magazine and *Reader's Digest*. He currently writes for *Esquire* and *The New York Times* magazine. Carlson began his journalism career at the *Arkansas Democrat-Gazette* newspaper in Little Rock. His most recent book is entitled, *Politicians, Partisans and Parasites: My Adventures in Cable News*. In 2006, he appeared on ABC's *Dancing with the Stars*. Carlson is currently working on his third book.

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7 Dos and Don'ts for Opening a New Surgery Center in Today's Economy

By Rob Kurtz

While the economy finally appears to be stabilizing, there's no indication that it's on a strong trajectory upward. But even just the feeling of stability is providing courage to those wishing to once again start developing new ambulatory surgery centers, says Paul Skowron, senior vice president of operations, for Regent Surgical Health.

However, he says the landscape has changed dramatically in the last year regarding the environment for starting a new ASC. "It has changed with respect to large, well-capitalized health-care systems absorbing smaller, less-capitalized healthcare systems and purchasing physician practices at an alarming rate."

With this and other industry and economic trends in mind, Mr. Skowron identifies seven dos and don'ts for entrepreneurs to consider before moving ahead with a new ASC.

1. DO more robust underwriting. Mr. Skowron says more robust underwriting is required with respect to the specialty volume commitments made by surgeons.

"In the past, ASCs have been started with 'soft commitments' made by physicians with regard to the volume by specialty," he says. "There have been some huge disappointments with the profitability of the center specifically because the commitments did not materialize, forcing the ASC after one year to be looking for a new base of investors. We are in a different economic climate now, and more robust underwriting is required to ensure that in the first year the ASC is profitable."

Note: The same sentiment applies to expanding an existing surgery center. "You need to know how much you trust the volume a physician or a new specialty group is committing," Mr. Skowron says. "Also, the bank is going to require more solid information before they're going to lend additional money for an OR expansion."

2. DO more investigation of additional ASC ownership. As you're performing the underwriting, Mr. Skowron advises a thorough investigation to help identify investments physicians may have in other ASCs in the marketplace.

"There have been too many failures in the last year or two that can be associated with small investments by surgeons in multiple centers," he says. "I am finding that it is most often the younger surgeons who don't understand the impact of that. We want to avoid the casual investors looking for an easy return."

3. DON'T rely on single specialty. "While I think we've been saying that for the past 10 years, it couldn't be more appropriate now when we don't know from year to year which specialty is going to be reduced in its net reimbursement," Mr. Skowron says. "The only thing that is predictable is that on a net basis, the government will try to have an increase of zero or negative going forward, and we don't know which specialty will take a hit in a given year."

4. DO look for a hospital partner. Finding a hospital partner is beneficial in at least two ways for a new ASC, Mr. Skowron says. It can enhance an ASC's managed care strategy and increase confidence levels of prospective physician-investors.

"We want to convince the potential surgeon-investors that there is an alignment of goals between the surgeons and the hospital — it's easier to sell shares that way these days," he says. "The physicians know their colleagues are being courted and/or purchased by the local hospital, so it's better to be in alignment with the goals of the hospital than feel like you're the man standing on the outside competing with the hospital."

Mr. Skowron says that through his experiences with Regent Surgical Health partner facilities Surgery Center of Mount Dora in Florida and Midland Surgical Center in Sycamore, Ill., two ASCs with hospital partners, he has found hospitals to employ large treasury and accounting staffs who perform a more thorough due diligence than those performed by independent surgeons.

"They ask for much tighter monthly, quarterly and annual reporting," he says. "They themselves are doing a more thorough job of understanding the volume commitments of the potential surgeon-partners."

5. DON'T rely on out-of-network. While out-of-network reimbursement hasn't disappeared yet, Mr. Skowron says there are diminishing opportunities for OON by payor, and the net revenue per case is decreasing across the board as well.

"There's also the fact that the valuation companies are reducing multiples as a center shows a higher reliance on OON," he says.

6. DO plan ahead for the technology platform. With a focus on cost consciousness, Mr. Skowron says ASCs are looking for the best "EMR lite" system they can purchase. But before they commit to a system, he advises ASC leadership to ensure the system will integrate with existing billing systems.



"My experience [with one of our partners] was that the EMR was brought in as an afterthought. It was not planned for up front, so the integration was not smooth and was labor intensive," he says. "If it had been planned ahead, it could have provided for a shorter time commitment for the training and installation of the actual billing system."

7. DO prepare for increasing quality reporting requirements. Mr. Skowron doesn't believe the increasing ASC quality reporting requirements beginning this year and becoming more labor intensive going forward in the next three years are receiving proper attention.

"I think [to meet them] will require a skill set higher than you see in an average director of nursing," he says. "The center needs to plan ahead to have those skill sets available. Why is that important? Because the government is now tying reimbursement to quality standards."

He says such a skill set will include extensive knowledge of Joint Commission standards "because the Joint Commission tends to incorporate both hospital and ASC safety standards and readmission rates," he says. "Potential hospital partners in a new joint venture will be looking for this skill set either in the DON, administrator or the clinical management team of the management company." ■

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

Contact Rachel Fields at rachel@beckershealthcare.com.

10 Steps to an Improved Hospital Joint Venture in 2012

By Abby Callard

Running an organization with multiple moving pieces is never easy, and a hospital-ambulatory surgery center joint venture is no different. "Experience has taught us that joint ventures that begin with the best of intentions can fall apart because of lack of structure, common vision and really the hard work at the beginning to make sure that the relationship is long-lasting," says Akram Boutros, MD, founder and president of BusinessFirst Healthcare Solutions, a consulting firm. "The aim is to be very specific methodically and consistent. These are the hallmarks of successful, long-lasting organizations."

Dr. Boutros and Luke Lambert, CFA, CEO, Ambulatory Surgical Centers of America, share 10 steps to create a happier hospital joint venture in 2012.

1. Ensure a shared mission and vision. The first part of any successful joint venture between an ASC and a hospital is defining the shared mission and vision. This can be problematic, Dr. Boutros says. "Sometimes physicians have views of what the organization will be like versus what the hospital thinks," he says. "A hospital may see this as an expansion of geographic area, and the physicians may see this as their primary business venture."

If both partners cannot get onboard with a shared mission, there's no need to go further, Dr. Boutros says.

2. Create a detailed and realistic business plan. Dr. Boutros says physicians can have an unrealistic idea of what a joint venture will look like. "There are some physicians who overestimate the volumes and underestimate the costs," he says. "They need to be a little more methodical in their assessments and not shoot from the hip."

It's important for both the hospital partner and the physician owners to sit down and create the business plan together. If one party created it before inviting the other, they should spend time modifying it so that all parties can give input.

3. Create a strong board of directors. Dr. Boutros says it's essential to create a board of directors that can be successful. Choosing members who can and are willing to "subjugate their personal ambition and needs to that of the greater good is absolutely necessary," he says. Measures of success for a board of directors include developing quality and financial improvement systems, hiring experienced management and putting in place a structure to deal with issues proactively instead of reactively.

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4. Clearly define everyone's roles and responsibility. Dr. Boutros recommends clearly defining the roles of the active physicians and hospital partners as well as the staff in the ASC. This ensures everyone is doing what they're supposed to do and removes ambiguity and reduces conflicts associated with undefined roles.

5. Increase physician interest in the center. Mr. Lambert says joint ventures can be turned around by increasing physician equity in the center and giving them a greater incentive to fight for the center's success. While Mr. Lambert promotes a minority interest for the hospital (26 percent or less), he said maintaining physicians' incentives is possible even under a hospital majority ownership model, which may be required if the ASC needs a certificate of need or access to the hospital's contracts. "The more the hospital owns, the more you decrease the interest the physicians have in how the center is run," he says.

6. Focus outside the hospital's primary service area. Dr. Boutros says the ASC should choose a geographic location that exposes a new area to the hospital's services rather than pulling cases from the hospital. He recommends looking for areas that are dominated by other hospitals, where the ASC can help the sponsoring hospital to get a foot in the door.

7. Look for unaffiliated physicians. Along the same lines as location, Dr. Boutros says a hospital should not transfer its core physicians to the new entity but look to recruit unaffiliated physicians in the area to practice at the ASC. This way, the ASC is not cannibalizing the hospital's cases and physicians.

8. Define ground rules for interaction. Dr. Boutros says it's essential to outline appropriate interaction between all shareholders in

the center. This includes how the staff interacts with patients, how the specialists interact with staff and how the owners interact with the manager. He says this needs to be done before the organization is set up because the process is much more difficult after the fact. At the same time, unacceptable behaviors, such as late arrival, should be explained and their consequences communicated to the staff and physicians prior to opening day.

9. Utilize metrics. Metrics are a valuable tool for ASCs, Dr. Boutros says. Centers should benchmark their financial and operational performance against their own historical performance as well as the performance of other centers. Collecting data over time can reveal trends about case volume, revenue, payor mix, staffing costs and other factors essential to profitability. These statistics are also a great way to encourage physician engagement in a center's operations. For example, a physician might be motivated to switch supplies if data shows that his case costs are significantly higher than his colleagues'.

10. Have fanatical discipline. Dr. Boutros says it's essential for an ASC to have a specific, methodical and consistent design related to center composition, staff responsibilities and measures of success. It's even more important that the center stick to that design. Dr. Boutros says even though ASCs are typically small businesses with less than 100 employees, they can also turn into big businesses with healthy revenues and even healthier profits. ■

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Getting to 18,000 Cases a Year: 8 Steps to Increase and Accommodate Case Volume

By Rachel Fields

Brent Ashby, administrator of Audubon Surgery Center in Colorado Springs, Colo., leads two surgery centers that perform a combined case volume of 18,000 cases annually. He discusses eight strategies the ASCs use to attract, accommodate and maintain robust case volume year-over-year.

1. Take advantage of a relationship with a hospital partner. Audubon Surgery Center uses a unique operational and ownership structure, with the most significant difference from typical ASCs being the operation of two separate surgery centers about 15 miles apart. The two surgery centers are jointly owned by a limited liability company and the local hospital; the hospital owns 43 percent and the physician-investors own the rest. Physicians are credentialed at both facilities and can choose to work at either or both of them, and specialties are divided between the centers so that certain specialties — such as urology — are entirely contained in one center. In the case of urology, it makes sense to keep the specialty in one center because the cost of equipment is too great to justify purchasing equipment for both locations.

Mr. Ashby says the second facility came to fruition when the local hospital decided to build another campus in a different part of town. “They decided not to build any operating rooms to accommodate outpatient surgery,” Mr. Ashby says. “We built our surgery center on the hospital campus, attached to the hospital, and we have eight operating rooms while the hospital has four. Their focus is on inpatient surgery, and the intent was that we would be the source and location of the bulk of outpatient surgery.” When the second surgery center opened, it captured all the outpatient surgery that had been going to an old hospital campus, boosting volume significantly.

2. Concentrate on specialties that will bring additional volume through sub-specialties. Mr. Ashby’s surgery centers place a large emphasis on orthopedics, partially because the largest orthopedic groups in the community were the first to drive construction of the facility. Since the first center opened, Mr. Ashby has attracted three orthopedic physician groups to the center — the bulk of orthopedics in the community.

“[The presence of orthopedic physicians] has driven some of our pain management volume as well,” Mr. Ashby says. He says controlling much of the orthopedic outpatient case volume in the community is useful because the physician-investors talk up the surgery center to related sub-specialists and then benefit from their colleagues bringing more cases to the center.

3. Establish relationships with physician practices in the community. While some physicians still maintain solo practices, most have gravitated toward large group practice or hospital employment, Mr. Ashby says. This means surgery centers must build relationships with entire practices, not just standalone physicians, if they want to maintain robust case volume over time.

In his community, he says surgery center ownership and participation generally falls down practice lines: If a certain practice uses a certain surgery center, most of the practice’s physicians take their cases there and not to a competitor. This means Mr. Ashby has worked to attract entire practices to his surgery center — for example, building a relationship with the major orthopedic groups in town.

4. Shift employees to other areas on slow days. While Mr. Ashby’s employees work at two separate surgery centers, they are all under the same employment umbrella, meaning ASC leadership can move staff members from center to center (and within areas in the same center) when volume fluctuates.

“They’re happy to work at either location, and this way, we don’t have to call them off and look for replacements if volume drops at one facility,” he says. “That’s been really effective at keeping costs down.” With 18,000 cases to perform every year, he says the surgery centers also have to staff “ample” nursing and clinical staff. Audubon Surgery Center also uses block scheduling to predict high- and low-volume days and distribute staff accordingly.

5. Accommodate increased volume by shifting cases to low-volume days. Mr. Ashby expects a volume increase of approximately 1,000 cases in 2012 — a challenge for a surgery center that’s already one of the busiest in the region. To accommodate the increased volume this year, he says he plans to move certain cases and block times to low-volume days.

“For example, on Mondays we’re not as busy, so I’ve asked some physicians to move off days that are busier to open up times for guys that really need them,” he says. “That will help to balance out the volume.”

6. Schedule more complicated cases in the morning. A busy surgery center needs to stay efficient to keep cases running on time and control costs, Mr. Ashby says. He says his surgery centers schedule more complex cases — such as orthopedic cases — in the morning to allow patients a longer recovery time. He says they also try to schedule children in the morning because younger patients don’t tolerate fasting as well as adults. The surgery center has 23-hour capabilities, so patients that might stay overnight will be scheduled later in the afternoon.

Mr. Ashby says his physicians are usually very accommodating about scheduling. “Most of the time, they give us flexibility,” he says.

7. Expand into new specialties when appropriate. Mr. Ashby says Audubon Surgery Center may expand into a specialty like spine if it can attract the necessary volume from physicians. Surgery center administrators must constantly look for opportunities to expand into new specialties, especially newly profitable ones like spine, to promote growth.

8. Ensure that volume will make up for case expenses. Mr. Ashby says surgery centers expanding their case volume should make sure that equipment and supply expenses do not exceed profits earned from increased volume. For example, one of his surgery centers performs urology cases, which generally require a C-arm and flexible scopes that can each cost \$30,000 to \$60,000.

“Dollars can go really fast for not a whole lot of stuff with urology,” he says. He says it may be easier to increase volume for specialties that don’t require such a significant capital investment. For example, general surgery physicians may perform laparoscopic procedures that use the same equipment and supplies as orthopedic cases. ■

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20 Statistics on Physician Specialties With the Most ASC Investors

By Rachel Fields

Here are 20 statistics on physician specialties that invest in surgery centers, according to Medscape's *Physician Compensation Report 2011*.

Anesthesiologists

Invested: 11 percent
Expect to invest: 5 percent

Gastroenterologists

Invested: 40 percent
Expect to invest: 10 percent

General surgeons

Invested: 19 percent
Expect to invest: 7 percent

Neurologists

Invested: 7 percent
Expect to invest: 3 percent

OB/GYNs

Invested: 12 percent
Expect to invest: 5 percent

Ophthalmologists

Invested: 27 percent
Expect to invest: 9 percent

Orthopedic surgeons

Invested: 30 percent
Expect to invest: 11 percent

Radiologists

Invested: 9 percent
Expect to invest: 54 percent

Urologists

Invested: 32 percent
Expect to invest: 8 percent

Cardiologists

Invested: 9 percent
Expect to invest: 4 percent ■

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10 Evolving Issues for Hospitals, Health Systems, Physicians & ACOs

By Scott Becker, Drew E. McCormick, Allison L. Harms, Samuel C. Bernstein of McGuireWoods

This article briefly discusses 10 emerging healthcare issues for 2012, focusing principally on hospital and physician issues.

1. Macro 2012 developments. We expect 2012 to be a very interesting year. There will be (1) a Supreme Court decision on Health Care Reform Act constitutionality, (2) a presidential election and (3) a great deal of overall uncertainty in the markets as to the direction of the country and the healthcare sector. We expect that in 2012, parties will be spending a good deal of time digesting the acquisitions they made last year and making sure that they have met their expectations. Many independent hospitals and independent practices need to take a deep breath and really assess their situation before aggressively moving forward to give up their independence.

2. Community hospital sales and consolidation. 2011 was a fascinating year in terms of pieces moving around the healthcare map. There was an uptick in the number of acquisitions by hospitals of hospitals and physician practices. HealthLeaders Media reported that in 2011, the top 10 hospital mergers were valued at \$5.6 billion, compared to \$3.8 billion in 2010, citing the "The Health Care M&A Information Source" published by Irving Levin Associates. The amount of mergers and acquisitions increased substantially in 2011 compared

with 2010, and the dollar volume of transactions also increased substantially in 2011.

Due to the changing healthcare environment, we are seeing concerned looks on the faces of the boards of community hospitals. This fear has led to an unprecedented willingness to engage in potential sales of hospitals to national chains or larger systems. (See Krist Werling and Bart Walker, "Preparing Your Hospital for Market," Governance Institute BoardRoom Press, February 2012.) On the flip side, buyers may often obtain substantial market benefits from consolidation. (See, e.g., Avik Roy, "Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About," *Forbes*, Aug. 22, 2011. Also see Katherine Rourke, "Hospital Merger Mania on the Rise Across the U.S.," *www.NextHospital.com*, April 30, 2011.)

3. Physician independence. A 2011 PricewaterhouseCoopers Health Research Institute survey reported that 46 percent of physicians are interested in hospital employment. This type of interest is consistent with the number of practice transactions we have seen in the last year.

Notwithstanding the talk of physician practice acquisitions and physician integration with hospitals, several large independent physician practice groups have indicated that they have remained very busy, despite systems they once

worked with acquiring competing practices. In orthopedics, for example, it is common that almost 12.5 percent of the healthcare budget is spent on orthopedics in total. This means that many systems must have a large orthopedic presence and compete aggressively to employ orthopedic surgeons. Despite the hospital pressure to accept employment, the independent orthopedists seem to be weathering the changes fairly well.

The PWC survey found that 56 percent of physicians want to more closely align with a hospital in order to increase their income, yet 20 percent of physicians surveyed said they don't trust hospitals, while another 57 percent only "sometimes" trust hospitals.

4. Professional services agreement. A number of health systems are considering entering into professional services agreements with physicians and physician groups. Such arrangements are a middle ground between the acquisition of a physician practice and subsequent employment of its physicians, and other kinds of relationships between health systems and physicians. As such, PSAs continue to grow in popularity as an option for increasing integration with a number of specialties, while also enabling physicians to maintain private practice. (See Karen Minich-Pourshadi, "When PSAs Are the Right Choice," *HealthLeaders Media*, July 13, 2010):

Physician compensation expert Max Reiboldt, president and CEO for The Coker Group, an Alpharetta, GA-based healthcare management consulting firm, refers to these PSA arrangements as "employment lite"—and he says they can offer a good opportunity for both hospitals and physicians. Unlike traditional service agreements, in which a person is hired for a specific function or for limited service, PSAs allow the facility to work with the doctors, [and permit] doctors to keep their independence while the hospital can build in quality measures to help create greater alignment for the physician with the hospital's goal.

"A PSA takes the shape and look of employment, but the physician or practice retains its independence, and if the deal doesn't go well, then the doctor can go back to private practice," he says.

In a PSA model, a health system will typically purchase a substantial amount or all of a physician's overall time but will not acquire the physician's practice. We will see in upcoming

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years whether or not this model becomes a sizable part of the physician-hospital universe or whether the popularity of the professional services agreement model is merely a stop-gap measure for certain systems. The challenge with the PSA model is that it is much more difficult to conform payments to physicians into various anti-kickback safe harbors and antitrust safety zones than in the practice acquisition and subsequent employment model.

5. Increased governmental investigations.

In 2011 we also witnessed significant increases in governmental investigations on a variety of fronts, including physician-hospital relationships, false claims and billing and coding claims. With increased integration of both providers and of payors, we expect additional antitrust claims. Further, with more healthcare fraud investigators on the street, we expect continued increases in Anti-Kickback and Stark acts investigations. Increasingly, recovery audit contractors are also having a material impact on hospital net income.

6. Privileges and disputes. We have observed an increase in the number of privilege and peer review disputes involving physicians and hospitals. We are not exactly sure what is driving increased clinical reviews; however, a great article was published in 2011 based on the concept that the Health Care Quality Improvement Act has resulted in abuses of the peer review system through the courts. The article, entitled "How Courts are Protecting Unjustified Peer Review Actions Against Physicians by Hospitals," by Nicholas Kadar, in the *Journal of American Physicians and Surgeons* (Volume 16, Number 1, Spring 2011), states that "[n]evertheless, the courts have disregarded the legislative history of HCQIA in the HCJ, and have interpreted and applied HCQIA in a way that protects unjustified peer review actions against physicians by hospitals, against Congress's expressly stated contrary intent." As a result, according to Kadar, the courts improperly review motions for summary judgment based on HCQIA immunity and improperly dismiss cases on summary judgment before a physician has had an opportunity to present the merits of his or her case.

7. Exclusive relationships between hospitals and payors.

Hospitals and health systems with great market positions are again looking at exclusive relationships with payors. Such relationships threaten to become a substantial issue for independent surgery centers, physician practices and competing hospitals. One of the first largely reported exclusive agreements was struck between Boston-based Partners HealthCare and Blue Cross Blue Shield of Massachusetts in 2000. BCBS gave Partners increased reimbursements in exchange for Partners' promise to seek similar pay increases from BCBS competitors. Since 2000, Partners has received a 75 percent increase in payments from BCBS, but

health insurance premiums have also risen by 78 percent since that agreement was made.

There is some evidence that the government is monitoring the anticompetitive effects of such behavior. For instance, in February 2011 the Department of Justice took an aggressive stance against a health system under Section 2 of the Sherman Antitrust Act in *United States v. United Regional Health Care System* (No. 7:11-cv-00030-O (N.D. Tex., Feb. 25, 2011)). In *United Regional Health Care System*, the DOJ alleged that United Regional Health Care System pos-

sessed monopoly power in the sale of both inpatient hospital services and outpatient surgical services to commercial health insurers.

8. Ambulatory surgery center transactions, out-of-network, going public and more.

The surgery center industry saw a great number of transactions involving national companies and hospitals buying surgery centers. For healthy in-network centers, multiples remained in the upper 6 times EBITDA range to close to 8 in some situations. The ASC industry also saw (1) big chains wholly pursue the model whereby



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they partner with hospitals to acquire centers, (2) a return of big chains buying centers without hospital partners and (3) a couple of the large chains showing continued interest in acquiring physician-owned hospitals.

In the ASC sector, we continue to see more and more aggressive action by payors against out-of-network patients and an increased effort to scramble for independent physicians to fill slots in surgery centers. We expect a few large ASC chains to test the public markets in 2012.

9. Pioneer ACOs. The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as accountable care organizations or in other similar arrangements. The Pioneer ACO Model will test the impact of different payment arrangements in helping these organizations achieve quality and cost goals. After a weak start, 32 provider organizations ultimately enlisted in the Pioneer ACO Project. Many of the enlisted ACO participants are very prestigious systems, such as Allina Hospitals & Clinics, Beth Israel Deaconess Physician Organization and the University of Michigan Health System.

The Department of Health and Human Services made a wise decision by making the process of testing the ACO model more manageable for health systems. An article entitled "Pioneer ACOs: Promise and Potential Pitfalls," posted by Steven Lieberman on Dec. 29, 2011, in Health Affairs Blog states:

The 32 Pioneer ACOs selected by CMS will operate in 18 states for up to 5-year periods. Hospitals are key players in 22 (69 percent) of the Pioneer ACOs, with 16 integrated delivery (or healthcare) systems, 4 hospital-physician partnerships, and 2 individual practice associations (IPAs) named for hospitals where the physicians have affiliations (or employment). The remaining 10 Pioneer ACOs (31 percent) are predominately IPAs, with one identified as an alliance of 5 multi-specialty medical groups. (The Leavitt Partners survey reported hospitals sponsored 99 (60 percent) of ACOs, with 38 (24 percent) sponsored by IPAs, and 27 (16 percent) sponsored by insurers, a category not relevant for Medicare ACOs.) In addition to urban entities, the selected Pioneer ACO sites include ACOs that serve rural areas.

Time will tell whether the ACO model will endure as a significant part of the healthcare landscape.

10. Opting out of Medicare. Notwithstanding the difficult economy, we hear from more physicians that they have decided to opt out of Medicare. This trend is occurring more frequently in certain specialties in which physicians are not overly reliant on Medicare business or hospital referrals. For instance, the New York Times reports that of the 93 internists affiliated with New York-Presbyterian Hospital, only 37 accept Medicare, according to the hospital's website. Further, we typically see the decision to opt out of Medicare with physicians who have built tremendous brands and franchises and who can afford to not take Medicare patients. Interestingly, despite opting-out of Medicare, many of these physicians nevertheless continue to see Medicare patients on either a pro bono basis or through other means. (See, for example, Julie Connally, "Doctors are Opting Out of Medicare," New York Times, April 1, 2009.) ■

6 Strategies to Recruit More Physicians to Your ASC

By Abby Callard

Here are six strategies to recruit additional physicians for an ambulatory surgery center in 2012 with Reed Martin, COO of Surgical Management Professionals.

1. Talk to existing partners. Mr. Martin says during regular member meetings, talking about possible physician recruits should be one of the items on the agenda. He says the current physicians, staff and hospital partners are asked about possible physician recruits. The local administration staff at the center should also watch newspapers for announcements of new physicians coming to the area.

2. Create a one-page fact sheet. One of the things that SMP does with their facilities is to ensure possible recruits have accurate and up-to-date information on the ASC. Administrators should create one-page fact sheets with the help of the corporate marketing department. These sheets contain general information about the center as well as competitive advantages such as state-of-the-art equipment, awards, block time availability, turnover times, and the possibility of investment opportunities, if applicable.

3. Have the physicians visit the center. Having the physician recruits visit the ASC is a great way for them to get a feel for the staff and the way the center runs. "The best opportunity

is when they tour our facility and see our staff and equipment and meet with some of our surgeons," Mr. Martin says.

Ideally, the physician would be able to meet with a surgeon in the same specialty to discuss advantages of the facility for that specialty. Mr. Martin suggests giving the surgeons at the center a heads up a few days before the visit so they have time to prepare.

4. Be persistent. Mr. Martin says persistence pays off. Even if a physician is not interested after the site visit, he has the ASC's executive director or administrator touch base with the physician monthly or quarterly to see if there have been any changes. "Sometimes persistence is effective in bringing that physician to the center," he says.

5. Talk about future investment opportunities. Mr. Martin says on a return visit to the center, he would usually talk to the physician about future investment opportunities. At this meeting, Mr. Martin would talk to the physician about the current share valuation and what returns or distributions have looked like in the past. "The meeting is really to discuss future opportunity, not to get into too much detail," he says. "It's important to set up expectations properly to discuss how this is a long term investment opportunity."



Trying the facility for a period of time before investment allows both the physician and the facility staff and physicians to determine if the relationship is a fit. "It's best if both parties have a waiting period before an offer is made," Mr. Martin says.

6. Enhance direct marketing. Mr. Martin says SMP has recently started enhancing the website of its centers and also strives to increase community awareness with press releases and community education. While most marketing efforts are geared toward physicians, some are aimed at the general public. Mr. Martin says the idea behind this is to make patients more aware of the ASC so they begin to ask their physicians for more information. ■

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How to Increase Efficiency at an ASC: 5 Thoughts From Dr. Ricardo Borrego of Dearborn Surgery Center

By Abby Callard

Dearborn (Mich.) Surgery Center averages 12,500 procedures every year or between 50 and 60 each day. With 75 practicing physicians in 11 different specialties, the center has to maintain efficient processes in order to function at such a high level in a multi-specialty facility.

“The efficiency that the DSC has is based upon the unified goal that the physician is a key customer,” says Ricardo D. Borrego, MD, MSBA, medical director. “Turnover differentiates us from hospital-based services, and patient satisfaction keeps us motivated. To clarify this, our patients’ satisfaction and safety are our core values, but the difference is most facilities stop short of recognizing that the physicians’ satisfaction is key to continued success. Our differentiation is always starting on time, maintaining consistent low turn over times and expediting the patients without any feeling of being rushed.”

In fact, Dr. Borrego says the center was started when a group of physicians became frustrated with the unpredictable hospital environment and founded the center to run like “clockwork.” Dr. Borrego and DCS’s executive director Linda T. Prister, RN, MSBA, offer five tips for maintaining efficiency at a busy surgery center.

1. Have schedulers meet with surgeons’ offices. Dr. Borrego says efficiency in the center starts when cases are scheduled. Quarterly or semi-annually, schedulers in the ASC meet with the schedulers in all of the surgeons’ offices to discuss issues such as types of cases and insurance coverage. This way, the schedulers in the physicians’ offices know exactly what to do when the surgeon tells them to schedule a surgery at the outpatient center.

“This encourages synchronicity within the offices,” he says. “We try to make the scheduling process easier and more understandable on both ends. A key element of our success is our ability to recognize and appreciate the value and influence a physician’s office scheduler has on our center. As in life, mutual respect fosters long term relationships.”

2. Standardize all processes. Dr. Borrego says the center has an established protocol for most patients based on best practices; however patients with co-morbidities and extenuating circumstances such as patients with pacemakers or other health issues are evaluated individually prior to surgery. Having standardized practices ensures consistent and safe surgery for patients. This way, staff is aware of what documentation is needed prior to the procedure so there are no avoidable cancellations the day of surgery.

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“Standardized care provides efficiency, however we treat each patient as a unique individual with distinct medical histories,” he says. “All our patients’ histories are reviewed by an anesthesiologist prior to surgery. All these processes are established so that there’s nothing missed along the way,” he says.

Another way DCS standardizes processes is through a surgery checklist that includes all steps of the patient experience from registration to discharge, Ms. Prister says. DSC was one of the first centers to implement such a checklist. The center implemented the checklist in spring 2009 and has “buy in” among staff which results in compliance. Surgical safety checklists are currently being recommended for implementation and usage for surgery centers by CMS, and the Dearborn Surgery Center has a long history of usage prior to being instructed to comply.

3. Synchronize staff duties and responsibilities. Each and every staff member at DSC has specific duties during the day, so the center runs with precision.

“All of the staff members at the DSC understand what is expected from them as to their roles and responsibilities for their daily duties,” Dr. Borrego says. “They have accountability for their performance and are able to function as self-directed professionals. Trusting your staff to do their job allows for efficiency as well as creates pride resulting in the staffs’ desire to exceed the expectations of our patients.”

Ms. Prister says the center has enough staff to be able to synchronize duties and responsibilities.

“What’s happening is that there’s always movement,” she says. “There aren’t these start ups and stops. There’s always fluid, forward movement. When staff know what is expected from them and share the same goal of efficiency, they can be self-directed to proactively anticipate issues and manage their time and resources.”

An example of this synchronicity is seen in room turn over, she says. After a procedure is completed, one member of the clinical team takes the patient back to the recovery area, while another cleans the OR and another interviews the next patient. The center’s average OR turn over time is under five minutes.

“They’re all going at the same time,” she says. “That’s why the turn over is so good. There’s not that start and stop. Everyone is on the same page,

going in the same direction and everyone meets at the starting gate at the same time. Most persons simply call this teamwork.”

4. Implement a flexible schedule. One common pitfall of surgery centers — and medical offices in general — is empty schedule time where staff members are just standing around. To maximize use of the center’s time, DSC uses a block schedule but adjusts that schedule on an as-needed basis, Ms. Prister says.

“We will adjust the schedule even on a daily basis,” she says. “If a physician needs to optimize the schedule or to make some changes, we can do that. We start with a framework of what we typically do, but we actually change it based on the day.”

This system does not work without dedicated staff members that are willing to accommodate their schedules to match the flow of cases at the center, Ms. Prister says. If a physician wants to start at 6 a.m., the staff has to be willing to come in early.

“Optimizing productivity of the OR schedule is a key financial indicator because large gaps in schedules carry overhead expense without any generated revenue,” says Dr. Borrego. “Being flexible in scheduling aligns resources to revenue.”

5. Have anesthesia take an active management role. One of the things that distinguishes DSC is the role of anesthesiologists in the center’s daily operations and management, Ms. Prister says.

“Our team is led by [me], as the medical director, or one of my colleagues,” Dr. Borrego says. “In this role, anesthesia takes an active role in oversight and running of the surgical schedule. Patients have to be seen and ready in order to have the cases start on time. The anesthesia team is not passive participants but active initiators of service and efficiency.”

Ms. Prister says this adds a level of accountability that is often absent from hospital programs. She recalls talking to some hospital managers who believed that a medical director lead by anesthesia would provide the necessary efficiency and consistency needed in a hospital environment. This model could mimic the “outpatient surgery arena” and improve efficiency, she says. ■

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7 Steps to Double ASC Volume by Integrating Cases From a Closed Surgery Center

By Rachel Fields

In Aug. 2011, North Memorial Ambulatory Surgery Center in Maple Grove, Minn., integrated over 400 endoscopy cases per month from a center that closed within the same building. These 400 cases account for over 50 percent of total volume performed at the center today. Reed Martin, chief operating officer for Surgical Management Professionals, which manages the center, discusses how the company helped the ASC integrate the new cases and ramp up volume in a short time period.

1. Determine whether the surgery center can handle more cases. When Surgical Management Professionals heard from their phy-

sician partners that another surgery center was closing, they looked into the possibility of integrating cases from the closed ASC into their existing center. “We had excess capacity so we thought we might be able to do it,” Mr. Martin says. SMP and Traci Albers, the facility executive director, analyzed the facility capacity and determined the surgery center would be able to double its case volume without overwhelming the center.

2. Explain financial and operational benefits to the ASC board. A surgery center board will likely have some reservations when considering integrating cases from a closed center. Mr. Martin says the most common

concerns with his board were whether the ASC could handle the extra patient flow and double the case volume. “Any board would say, ‘Can our reception area handle it, and are we ready in all areas for that volume increase?’” he says.

SMP and the executive director developed financial models of the additional volume and explained to the board that the addition of the endoscopy cases would benefit the surgery center financially and increase physician distributions. The additional cases would also use the extra time available in the surgery center’s schedule and take advantage of staff already working at the facility.

3. Analyze equipment needs. Mr. Martin says SMP and the executive director worked with the physicians at the closing center to make sure they were comfortable with the equipment at the existing facility. The physicians said they were happy with their current equipment, so the surgery center opted to buy it and incorporate it into the existing center. “We did the same thing with supplies,” he says. “We asked physicians and staff, ‘Are these the supplies that best served you and the patients?’” He says the equipment and supplies were purchased at fair market value.

4. Look at surgery center processes and make changes as necessary. Before the physicians joined the new center, Mr. Martin says SMP and the facility leadership had to determine how they would best utilize the facility for the additional cases. ASC leadership decided the physicians could use some of the center’s operating rooms and that the center would require modifications for scope processing. The ASC eventually decided to do some physical plant modifications to create a space for scope processing.

The surgery center also decided to utilize one end of the pre-operative area for endoscopy cases, with surgical cases at the opposite end. “Endo cases have different requirements than surgery cases, and this way we could keep them

both separate and together,” Mr. Martin says. He says the same was true for post-operative care; endoscopy patients were treated in the opposite end of the center’s “phase two” area.

5. Bring on staff from the old center if possible. Mr. Martin says the surgery center brought on staff from the old center that understood the physicians’ needs and could participate in the transition. He says the clinical areas were not the only areas in need of extra staff when the extra cases came in; the surgery center also had to add staff in reception and scheduling to make sure the ASC could handle the additional patient flow. “The new staff were very helpful in describing their processes to us and how best to incorporate them,” he says. “We built some good teamwork with those discussions.”

6. Integrate new physicians into the center and culture. Integrating physicians from another center can be challenging, as the physicians have to transition to working in a new space and sharing the facility with a new set of providers. Mr. Martin says SMP and the surgery center leadership team helped integrate the new physicians by involving them in discussions around ASC processes, equipment and supplies. “We also made an effort to give the physicians frequent access to the center’s executive director during the transition.”

“They were used to a separate dictation area, and we were able to provide that area adjacent to the executive director’s office,” he says. “In addition, there are some creature comforts that make an environment more pleasant, such as special coffee or a separate refrigerator.” He says the physicians were accustomed to those comforts in the old facility, so they incorporated them at the ASC to make them feel at home.

7. Emphasize efficiency to help cases run smoothly. SMP emphasizes efficiency to increase surgery center profitability, Mr. Martin says, and that culture needed to be communicated to the new physicians to make sure they wasted no time in the OR. He said it was quite simple to get them “on board” with SMP and the surgery center’s attitude towards efficiency.

“We just showed them that our staff can handle the patients and described how we were going to do it,” he says. “One of the physicians was really excited to see he could do 17-18 colonoscopies between 7:30 a.m. and 3:00 p.m. I think the proof is in the pudding once you show them how it’s going to work.” ■

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How Do ASC Management Companies Assess Value?

By Rachel Fields

Here are 8 points on how ASC management and development companies assess value, based on data from HealthCare Appraisers' 2010 ASC Valuation Survey.

1. Valuation multiples are staying relatively consistent. When purchasing a controlling interest in a multi-specialty center, 56 percent of respondents reported prevailing valuation multiples of 6.0 to 6.9 times EBITDA, while 13 percent reported valuation multiples of 7.0 to 7.9 times EBITDA. Over half of respondents believed valuation multiples had stayed consistent with the prior year, while 41 percent thought the multiples had decreased.

2. Predetermined formulas are generally used for underperforming physicians. When buying out retiring or underperforming physicians, 70 percent of companies base the redemption price on a predetermined formula. For new physician investors, 41 percent of respondents report using a formula to establish buy-in price; 18 percent allow the board to determine the purchase price; and 35 percent obtain a fair market value opinion from an independent source.

3. Most measure ASC profitability based on EBITDA. Regarding the measure of ASC profitability utilized by the respondents to determine the value of an ASC, 69 percent measure earnings based on EBITDA and 25 percent report using cash flow to shareholders as the primary earnings measure.

4. Orthopedics, ophthalmology, ENT, GI and pain management are particularly desirable in a surgery center. At the same time, respondents indicated that the majority of surgical specialties were desirable, with the sole exception of cosmetic surgery.

5. Hospital-owned ASCs are generally valued more highly. According to the survey, 50 percent of respondents said hospital ownership of an ASC would add to the value. Another 11 percent said hospital ownership had no impact, and another 11 percent said it would detract from the value of the center.

6. Out-of-network strategy significantly reduces value. Seventy-six percent of companies said that the magnitude of the reduction to the multiple for a center with an out-of-network strategy was more than 1.0x. This is in keeping with industry opinions that out-of-network increases the risk of an ASC investment and may no longer be a viable strategy for most surgery centers in the next few years.

7. Decreases in Medicare reimbursement lower ASC value. Many surgery centers rely on Medicare for a portion of their reimbursement, and governmental reimbursement rates are not up for discussion as with commercial insurance companies. This means changes to Medicare reimbursement can affect value significantly. According to the HealthCare Appraisers report, multiples of EBITDA would

be expected to decline anywhere from 0.26-0.50x if Medicare reimbursement decreased as a result of new payment methodology, based on the most popular response from those surveyed.

8. Multi-specialty centers generally command higher multiples of EBITDA. According to HealthCare Appraisers data, 56 percent of multi-specialty centers receive valuation multiples of 6.0-6.9x EBITDA, compared to 35 percent of single-specialty centers. Another 13 percent of multi-specialty centers receive valuation multiples of more than 7x EBITDA, whereas no single-specialty surgery center received a valuation multiple that high. Single-specialty centers are also much more likely to receive valuation multiples between 4.0-4.9x EBITDA, compared to multi-specialty centers. ■

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

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Starting From Scratch: Top 5 Tips on ASC Development From Manhattan Endoscopy Center

By Abby Callard

The Manhattan Endoscopy Center in New York City opened in December 2011 and is one of the largest single-specialty GI centers in the nation, with 15,000 patients expected in the first year. The center currently has 17 active physicians, and the facility is a completely renovated state-of-the-art space on the 5th floor of a historic Manhattan building. From start to finish, the process took two years, and the center opened right on schedule.

Developing a center of this size from the ground up was no easy task, says Peter S. Kim, M.D., member of the board of directors at Manhattan Endoscopy Center. But he says it was worth it in the end. "Each one of us had anxiety about transferring our procedures from the office to the ASC," he says. "Without exception, we are all very happy and satisfied."

Dr. Kim and executives from Frontier Healthcare, the development/management company hired to assist in the MEC project, share five tips about starting an ASC.

1. Form a strong board of directors. The first step to creating MEC was to form a board of directors. Many ASCs are formed with physicians from one practice so they're used to working together, but in the case of MEC, most of the physicians were solo practitioners. Board members must be able to work well together. Since the Board represents all the members of the group, it is imperative that self-interests are minimized and the concerns and interests of each member are taken into account. All the members must feel confident that the board represents the interests of every member. There is a huge time commitment that is required of each board member. "Our board is successful because the physicians are willing to put in the necessary time and we have developed a great camaraderie and mutual trust in working to achieve a common goal," according to Dr. Kim.

The board of directors consists of five physicians and Jordan Fowler, the founder and CEO of Frontier Healthcare. Dr. Kim says that in addition to monthly meetings, the board is in constant communication utilizing e-mail and telephone conference calls to immediately address any issues or problems that arise.

2. Make sure the development/management company is a good fit. The physician owners decided to hire a development/management company. "The choice is extremely important," he says. "As physician owners we interviewed several groups who were keen to work with us. There are some firms that are national in their viewpoint. Frontier manages ASCs that are predominantly in New York state. They are more familiar with our state's regulations. We felt this would provide an advantage for us. Each state has different regulations; the marketplace is unique."

Another factor in selecting Frontier was how much time, resources and energy the company was willing to devote to the project. "You really need a lot of dedication from the group you select," he says. "A good management company such as Frontier is critical in opening an ASC. They were instrumental in vetting potential members, helping us draft the operating agreement, finding real estate, obtaining a loan and a line of credit, hiring staff and analyzing our business model. We were also able to tap into the business relationships Frontier has cultivated through their experience in the opening and management of other ASCs."

3. Hire a nurse manager early. Mr. Fowler says he tends to hire a nurse manager two months before the facility is set to open. Not only can this person spot deficiencies in compliance, but he or she can help train staff before the ASC opens.

"A good nurse manager is as important as a good CEO," he says. "Qualities to look for include proficiency in staff training and noticing deficiencies. There are always deficiencies when you open a large facility. You need someone who is highly proactive and can attend to the physician members, as well as the nurses, administrative staff, plus third party service providers."

The final few weeks before the ASC is scheduled to open are critical for a nurse manager. "All the different pieces that you think about at the very end, that last 10 percent, is easy to overlook," Mr. Fowler says. "Those are the things that contractors, architects and engineers think least about. The nurse manager has to really come into their own in the final weeks prior to opening."

4. Plan early and anticipate. Mr. Fowler says people often underestimate the complexity of opening a center. "You hear anecdotally, some physicians offer the idea that it's a simple project," he says. "It's just a bunch of procedure rooms and walls. It's not that simple. A large ASC project is a major undertaking."

Because opening an ASC is a complex project, it requires time. "You really need to recognize what it takes to open a center this large and understand the time and resources it takes to get a center humming," Roy Bejarano, Frontier COO, says. "It takes more than five to six months post-opening for a large facility to go through all of its growing pains."

While MEC has experienced some growing pains, Dr. Kim sees the efficiency improving day to day. "We are trying to reproduce the efficiency of an office in an ASC setting," he says. "We've improved with each passing month. There are the inevitable adjustments. Our center is fully digitalized and for many of our physicians, this was their first experience with using electronic health records. Efficiency will continue to improve with experience."

5. Be selective with physicians the center recruits. Although well-run ASCs tend to attract physicians, Mr. Fowler stresses the importance in ensuring that every physician joining the center maintains the same high quality of care. "A well-managed facility can act like a center of gravity attracting other successful and qualified physicians who want to be part of a well-run ASC," he says. "We try to make sure that new physician have standards commensurate with the group. We've seen firsthand how attractive a well-managed site can be."

MEC already has two rounds of physician recruits scheduled to be added to the center over the next year or so. Dr. Kim says all new physicians must agree with the central mission of MEC. "Before the center opened, we tried to identify doctors who we wanted to partner with and who had similar philosophies. We wanted physicians who would prioritize quality in patient care and experience first and foremost." ■

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The Colon Cancer Screening Controversy: How Old is Too Old to Screen?

By Abby Callard

A recent study in the *Archives of Internal Medicine* found 57 percent of seniors age 75-79 had been screened for colon cancer despite the increased risks and limited benefit. The study was followed by calls to set upper age limits for colon cancer screening.

However, Andrew Spiegel, CEO of the Colon Cancer Alliance, says older patients should still be screened for colon cancer because the average age at diagnosis is 71, and 43 percent of cases are diagnosed at age 75 and older.

"I think not screening patients over the age of 75 is a really bad idea when the average age at diagnosis is 71," he says. "We are living in a world now where people are living much, much longer. Why would you stop screening at 75?"

One of the reasons Mr. Spiegel recommends screening be done for elderly patients is that colon cancer is the one major cancer that can be prevented — and the prevention method is the screening test, he says. Removing polyps during a colonoscopy prevents colon cancer. Even so, an estimated 50,000 people die every year of colorectal cancer in the U.S. About 1 in 20 Americans will get colorectal cancer.

"The thing that is so frustrating about all of those numbers is that it's an almost entirely preventable disease," he says. "You can almost certainly avoid this disease if you screen for it. If people would just get screened, you can remove polyps before they develop into cancer. The other issue on the screening side is deciding when people should be screened. If you're going to catch this cancer, you want to catch it in the earliest stages when it is far more treatable."

The Colon Cancer Alliance conducted a survey in collaboration with Quest Diagnostics earlier this year to determine colon cancer screening rates as well as interest in a blood test for colon cancer. Mr. Spiegel was surprised by the high rate of screening. Usually, he says, studies find a screening rate in the 50 percentile, but this survey found a rate of 69 percent among people age 50 and over.

"That, to me, was really startling data," he says. "People are getting the message and are finally getting screened. A year ago, the CDC conducted a similar survey and found screening rates were about 65 percent, so we do see progress."

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However, the survey also found nearly one-quarter of patients over the age of 75 had never been screened for colon cancer. The same percentage of patients age 60-70 had never been screened, while 30 percent of those age 55-64 and 47 percent of patients age 50-54 had never been screened.

Although the benefits decrease and risks increase as the invasive colonoscopy procedure is performed on older patients, Mr. Spiegel and other researchers recommend screenings for patients over the age of 75.

The current recommendations for cancer screenings vary. While the U.S. Preventive Services Task Force recommends against routine colon cancer screening of people over age 75, the American Cancer Society offers no age limit for colon cancer screenings but says men with a life expectancy of less than 10 years should not be screened for prostate cancer.

At Digestive Disease Week 2011, Ann G. Zauber, MD, principal investigator of the National Colonoscopy Study and associate attending biostatistician at the Memorial Sloan-Kettering Cancer Center in New York City, presented a model that simulated colon cancer screening in patients older than 75 who had never been screened. Based on the findings, she concluded that patients should be screened until the age of 85 depending on risks and benefits for specific patients.

Dr. Zauber also used this model to determine the life-years gained by screening different age groups. She found 155 total life-years gained for all patients screened at 65 years, 132 at 70 years, 108 at 75 years, 57 at 80 years, 27 at 85 years and 6.5 at 90 years. That works out to be one month

gained per person screened at age 75 and only 1.5 days gained per person screened at age 91.

Another study presented at DDW 2011 found that the incidence of colorectal cancer in patients over the age of 75 is high enough to necessitate screening. Vishnu Naravadi, MD, and colleagues reviewed charts of patients undergoing colonoscopy at Mt. Sinai Hospital in Chicago between 2007 and 2010. Adenomas were detected in 58.9 percent of males and 27.5 percent of females, and significant colorectal tumor was detected in 23 percent of males and 17.2 percent of females. No adverse events were reported.

Although colonoscopy is considered the “gold standard” for colon cancer screening, blood tests, including one in development by Quest Diagnostics, can also screen for colon cancer, although they won’t be able to prevent the disease by detecting or removing polyps. In the same Colon Cancer Alliance and Quest survey, 78 percent of respondents said they would be likely to take a blood test for colon cancer if it were available.

Mr. Spiegel refrains from recommending one screening method over another because “the best test for colon cancer screening is the one the patient gets.” ■

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15 New Statistics on GI/Endoscopy Revenue Per Case

By Rachel Fields

Here are 15 new benchmarks on GI/endoscopy revenue per case, according to data from VMG Health’s *Multi-Specialty ASC Intelimarker 2011*.

Average net revenue per case: \$867 Based on location

Western: \$870
Southwest: \$857
Midwest: \$778
Southeast: \$724
Northeast: \$730

Based on number of operating rooms

1-2 ORs: \$625
3-4 ORs: \$776
More than 4 ORs: \$860

Based on annual case volume

Less than 3,000 cases: \$613
3,000-5,999 cases: \$759
More than 5,999 cases: \$790

Based on annual net revenue

Less than \$4.5 million: \$648
\$4.5 million-\$7 million: \$746
More than \$7 million: \$872 ■

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Cigna to Terminate Contracts With New Jersey One-Room Surgery Centers

By Rachel Fields

Connecticut-based insurance company Cigna is in the process of removing all one-room surgery centers in New Jersey from its network, according to a Cigna contract manager.

Jeffrey Shanton, chair of the advocacy and legislative affairs committee for the New Jersey Association of Ambulatory Surgery Centers, reached out to Cigna after a surgery center physician indicated that the insurance company intended to terminate existing in-network contracts with one-room centers.

Courtney A. Bennett, contract manager for Northern New Jersey with Cigna Healthcare, responded to Mr. Shanton, “Cigna is in the process of removing all one-room surgery centers from the network.”

“I do not necessarily believe this policy is across the board, a national one,” says Mr. Shanton. “I believe that the uniqueness of the New Jersey insurance landscape has something to do with the CIGNA decision. While indeed this provision has been challenged in court, and Cigna has won, I cannot help but state the obvious: These one room centers are not breaking any law. They are doing everything they can do, and are obli-

gated to do, under current law, and indeed many would jump at the opportunity to be licensed.”

In early January 2012, the New Jersey Legislature approved a bill that would require licensing for one-operating room surgery centers. The bill makes all surgical facilities — including single-room surgical practices, multi-room ambulatory surgery centers and hospitals — subject to the same licensing by the state health department. The health department does not currently license single-room centers. In addition, new centers would have to become Medicare-certified, though currently operating centers would be “grandfathered in” to Medicare certification.

In late January, New Jersey Gov. Chris Christie used a pocket veto on the recently approved bill, “effectively [killing] the bill,” according to Mr. Shanton. The bill is up for approval again and has passed out of the Senate committee with no vote in the Senate as of yet. “We are working with [Sen. Joseph Vitale (D-Middlesex)] to get this done,” Mr. Shanton says.

While the New Jersey Department of Health currently licenses hospitals and multi-room ASCs, the department does not license surgical facilities with a single room. Under the new law, the one-

OR surgical centers will be inspected by the state health department every two to three years.

Ms. Bennett added that, “Currently, Cigna is upholding the current policy of non recruitment for one-room surgery centers. Once everything with the bill is completed, I believe that Cigna would then relook at the policy. But at this time it stands as it is.”

In response to an inquiry from Becker’s ASC Review, a Cigna media representative said, “Cigna supports [Senator Joseph Vitale’s] efforts to license one-room ambulatory surgery centers to better protect the public health. Among other pertinent findings, a survey by the New Jersey Department of Health and the New Jersey Health Care Quality Institute found that more than 40 percent of unlicensed surgical practices were not compliant with safety standards, versus 15 percent of licensed facilities. These findings demonstrate that licensure is a strong indicator of safety and quality. Beyond that, Cigna does not comment on actions — actual or speculative — as relating to specific health care providers.” ■

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The Future of Out-of-Network Reimbursement: 4 Thoughts From Industry Experts

By Rachel Fields

Out-of-network reimbursement is one of the most significant issues in the surgery center industry today. Many experts believe that dependence on out-of-network reimbursement will become unfeasible in the next few years, but some surgery centers and markets continue to buck the trend by profiting tremendously from OON. Here four surgery center industry leaders discuss the future of out-of-network reimbursement.

We want to hear from you. If you have an opinion on the future of out-of-network, please email Rachel Fields at rachel@beckershealthcare.com.

Scott Becker, JD, McGuireWoods:

Here are five thoughts on out-of-network reimbursement:

1. It poses a constant, evolving risk to centers. Out-of-network patients are very hard to wholly ignore as a revenue source even with payors increasingly scrutinizing out of network payments.
2. Given some offered contract rates, some centers have little choice

but to be out-of-network. For example, some payors offer centers contract rates very close to Medicare rates.

3. Centers face recoupment claims, new requirements such as written patient acknowledgments, threats against in-network doctors by payors, payor lawsuits, having every claim go to payor audit and non-payment of claims. Generally, we see minimal state-initiated actions.

4. There are several steps ASCs can take to reduce and assess out-of-network risk.

5. Some ASCs and chains, notwithstanding these issues, still seem to be making a lot of money from out-of-network patients and payors.

Jimmy St. Louis, CEO of Advanced Healthcare Partners:

The large majority of people going in-network are doing it to drive volume and to get some predictability around pricing and reimbursement cycles. A large majority of the businesses we work with and manage are on an out-of-

network basis, and although in network status is effective for a lot of health-care, out of network status is beneficial for emerging healthcare markets largely because more unique technologies and treatment protocols often are beneficial to patients but insurance companies are slower to adopt them. Typically, to support an out of network status for any of the companies that we manage or grow, we would create a direct-to-customer marketing strategy to drive volume to the facility. If you're not in-network, you need someone to drive referrals and patient volume, as it typically is not coming from other physicians, because you are not operating within a network.

We've also created a revenue recognition process for our out of network clients because when you bill on an out-of-network basis, your cycle time to reimbursement is going to be unpredictable and can lead to challenges. As we drive sufficient volume to the practice, we can get statistics that allow us to predict reimbursement and pricing, allowing us to better predict our clients accounts receivables cycle and cycle time. We'll look at each case from a reimbursement perspective and essentially try to establish out of network pricing according to reimbursement trends. Typically, out-of-network pays at a higher level, so as we are effective in driving volumes, we see higher facility and physician level revenues overall. If you can deliver sufficient patient volume, and maintain a superior level of quality, staying out of network certainly displays an advantage. This doesn't mean that going into network doesn't certainly have its advantages as well, such as credibility, and an expanded network of physician partners.


We also always place a heavy emphasis on research, outcomes, patient satisfaction and quality of care. That way, if insurance companies do start to push back and slow payments, we're armed with the right data to negotiate favorable contracts due to favorable outcomes, high levels of patient satisfaction, and our ability to market directly to patients.

Patients' financial responsibility can certainly be greater with out-of-network, and from that perspective, we typically recommend an in house financial services and billing team that we provide at AHP and they then work hard for their reimbursement. The patient doesn't have to pay cash and fight for their reimbursement themselves which is a great service for the patients. We're also not going to go out-of-network on services that are offered next door on an in-network basis, unless we offer a superior service or a higher quality of care. If there's a differentiator, we'll go out-of-network and work to track the highest, most credible level of data. That's the conversation we have with consumers: We say we are out-of-network, we present the quality measurement statistics and outcomes and we explain we are still providing the highest quality care. We believe that both scenarios have their benefits, but there is certainly a case to be made, in a lot of circumstances, to stay out of network.

John Seitz, ManageMyASC.com:

I'm sure you must be hearing this from other people, but insurance companies have figured out a way to deal with out-of-network by selling policies that limit out-of-network coverage. And we're seeing an awful lot of it — from Blue Cross to Aetna to Blue Shield and United — anywhere from \$389 per occurrence to an annual cap of \$1,000 or \$1,800 because they don't want you going out-of-network.


Think about it this way: If I'm the insurance broker selling a new program to a company with 500 employees, I can go in and say, "Hey, your premium is going to go up 22 percent this year, but we can knock that down to 10 percent if you limit the out-of-network benefits. Your employees don't like going out-of-network; they'd prefer to know the facility is someone we do business with." The employer is going to say, "Sign me up!" The employer



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gets the policy, and when a doctor says, "Let's go to Spalding Surgical Center for your colonoscopy," if you're out-of-network and you do the verification, you find out you're going to get \$389.

For the most part, we've chosen to go in-network. We're still seeing centers that always specialize in out-of-network cases. They do all out-of-network patients and just cherry pick the cases, and the doctors over there are saying they're getting \$20,000 for a colonoscopy because they're treating patients with plans that say the surgery center will get 70 percent of charges. You can still make a lot of money on out-of-network if you get people with the right plans.

Adriaan Epps, director of contracting services for abeo Management Corporation:

When it comes to out-of-network reimbursement specific to ambulatory surgery centers, we find that whether or not ASCs are successful in contracting with top commercial payors really makes the final determination in staying in-network or going out-of-network. The problem they run into is that if you are out-of-network, there's a tendency for payors and referring surgeons and primary care providers to potentially not refer patients to surgery centers if the surgery center is out-of-network. This is especially true if the ASC is out-of-network with a payor like Blue Cross Blue Shield, where the physician might have significant volume and significant membership. That can significantly hurt and impact the surgery center and doctors, and it's something they certainly have to consider and something we work with regularly.

What are the pros and cons of going out-of-network versus staying in-network? Do we offer discounts, and what kind of discounts do we offer

to members if we are out-of-network? Maybe we offer a 10-20 percent discount for most people and a deeper discount to those with financial hardship, to offset someone who is willing to pay all the services upfront if they are out-of-network.

In my opinion, the ideal situation is to contract with all your payors and achieve the best possible rates so that you're able to run your business effectively and make up for the loss in your business that typically occurs with Medicare and Medicaid. As far as long-term strategy, I believe that being in-network is best for the healthcare delivery system and continues to build relationships in the community — not only with consumers, but with physicians, health plans and hospitals. And not doing so can have huge ramifications, not only to cost.

If you are out-of-network, one of the problems concerns how long it actually takes to capture and collect that money. Your A/R can significantly increase if you have a lot of self-pay patients and if you don't do your due diligence and collect co-pays and co-insurance. Trying to go after the patient afterwards for that money make take months and years, and sometimes you may not ever collect that money. And payors know that and will use that against you — they'll say, "It's going to take you much longer to collect that type of reimbursement." You can potentially make more money out-of-network, but unless you are very good and have a good system in place to follow through with the collections process, you could be dealing with a significant A/R issue. ■

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13 FAQs About Surgery Center Insurance Coverage

By Rob Kurtz

I. David Gordon, president and founder of Gordon Companies, which provides a variety of services covering all aspects of the insurance market, identifies 13 frequently asked questions ambulatory surgery centers ask relating to insurance coverage, explains why they are important questions for which to have answers, and identifies other related questions ASCs will need to have the answers for.

1. What is my insurance company's "rating"?

I. David Gordon: Knowing your company's A.M. Best rating is essential when comparing insurance companies. The higher the rating, the greater the financial stability. You want a company that will be around well after your policy expires. Who else will pay for claims if not them?

2. Who are the attorneys that will represent me in the event of a negligence

claim against me? Do they have experience in medical malpractice claims?

IDG: The ability to have an experienced medical malpractice attorney shouldn't be a luxury when you're the client. When it's your license and reputation on the line, you want someone with the proper knowledge. Not a workers' compensation or Directors & Officers insurance specialist. Who will represent you?

3. Does my opinion matter when deciding whether or not a claim is settled pre-trial?

IDG: Again, when dealing with your claim, your opinion should always be taken into account. The decision whether or not to settle affects you just as much at the insurer. Making sure that you are an integral part of the process is critical when your business is on the line. Are you being heard?

4. Will my insurance company assist in risk management and quality assurance?

IDG: Having the support of experienced risk management is a key part of staying clear of any unexpected surprises and claims. Remaining claim-free means lower premiums. Does your insurance company actively try to ensure that you are taking necessary precautions to avoid errors and reduce risks?

5. How do I know how much property coverage I need?

IDG: Underinsurance is one of the biggest problems in the industry today. Annual reviews and coverage alterations should be a priority. How much would it cost to replace your building, contents, improvements and medical equipment? How do you replace your medical records? How do you reproduce your accounts receivable?

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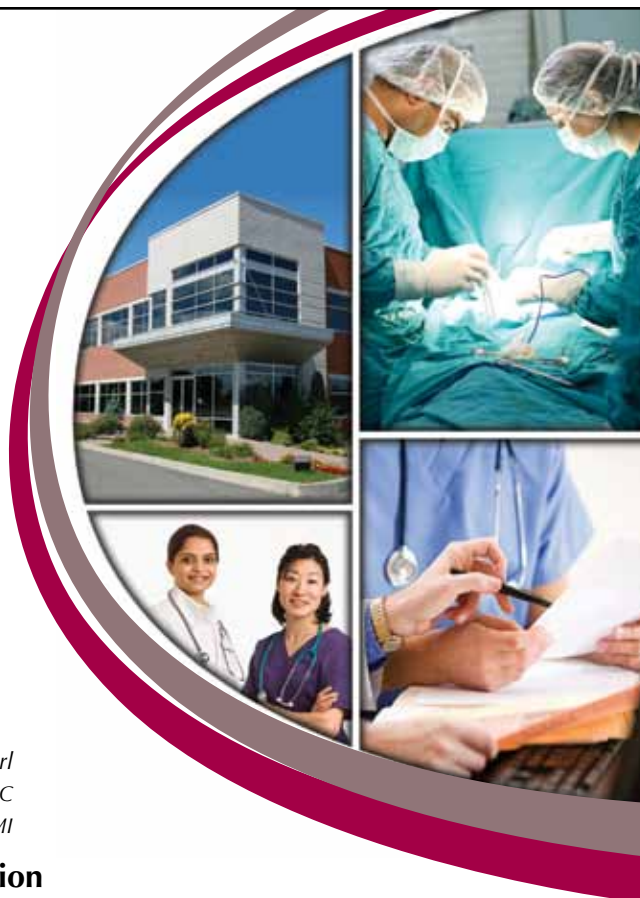
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Visit our Web site www.hfap.org for more information
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6. How much liability coverage do I need for asset protection?

IDG: There are some industry minimums. What limits of liability are required by vendors, Medicare, state licensing authorities? How do you calculate your coverage requirements on a cost/benefit bases? Are your assets protected? Many ASC owners consult local defense attorneys for input on this question. They then evaluate cost/benefit measures to reach a business decision.

7. Who can be sued?

IDG: In short, everyone. In America today claimants try their best to bring in as many “negligent parties” into the suit as they can. Potential defendants include the operating entity, the physicians, technical staff, clerical staff and billing staff. Plaintiff attorneys usually include any potential defendants.

8. Do I need a company that specializes in insuring healthcare exposures?

IDG: Like anything in business, specialties are vital. A company should always be able to closely relate to its clientele. Would you go to a hardware store for a stomach problem?

9. Is it better to divide my risk amongst a few insurance companies or group everything with one company that specializes in healthcare?

IDG: The insurance industry agrees with physicians when they say “nothing exists in a vacuum.” It is important to understand how a single claim can affect different parts of your policy. What are the ripple effects of this claim? What benefits are derived when coverages are combined in one company?

10. Should the size of my center matter when choosing an insurance carrier?

IDG: Whether large or small you want to make sure that your insurance provider is equipped to deal with your specific needs. Are there certain companies that are better equipped to help your large center? Is there a company where your small center will receive the same attention as a larger company? ASC exposures appear to be similar to other medical practices. Only a skilled underwriter will understand the complex business arrangements and contractual relationships in the ASC business model.

11. Do I need business interruption coverage?

IDG: When a blizzard or boiler problem closes your center and appointments are being cancelled, you are no longer able to practice due to the fact your credentials are location specific. Can you afford to be out of work for this time?

12. I've read a little bit about cyber liability. Is that something I need?

IDG: With new government mandated regulations, information must be kept electronically. Consequently, new liability risks arise from the vulnerability of cyber space. Are you protected?

13. What other coverages are important for me to know about?

IDG: Most ASCs are of mixed ownership and management. Therefore, it is critically important to maintain adequate Directors & Officers and Employment Practices Liability coverages to address hiring and firing issues and the selection of owner partners and termination of owner parties. These arrangements have become targets of plaintiff attorneys. ■

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8 Basic Steps for ICD-10 Implementation in Surgery Centers

By Rachel Fields

Here are 10 basic steps for ICD-10 implementation in surgery centers, based on information provided by CMS. Visit the CMS website to learn more about ICD-10 implementation.

1. Identify your current systems and work processes that use ICD-9 codes. This could include your clinical documentation, encounter forms/superbills, practice management system, electronic health record system, contracts and public health and quality reporting protocols. It is likely that wherever ICD-9 codes now appear, ICD-10 codes will take their place.

2. Talk with your practice management system vendor about accommodations for both Version 5010 and ICD-10 codes. Contact your vendor and ask what updates they are planning to your practice management system for both Version 5010 and ICD-10, and when they expect to have it ready to install. Check your contract to see if upgrades are included as part of your agreement. If you are in the process of making a practice management or related system purchase, ask if it is Version 5010 and ICD-10 ready.

3. Discuss implementation plans with all your clearinghouses, billing services and payors to ensure a smooth transition. Be proactive; don't wait. Contact organizations you conduct business with, such as your payors, clearinghouse or billing service. Ask about their plans for the Version 5010 or ICD-10 compliance and when they will be ready to test their systems for both transitions.

4. Talk with your payors about how ICD-10 implementation might affect your contracts. Because ICD-10 codes are much more specific than ICD-9 codes, payors may modify terms of contracts, payment schedules or reimbursement.

5. Identify potential changes to work flow and business processes. Consider changes to existing processes including clinical documentation, encounter forms and quality and public health reporting.

6. Assess staff training needs. Identify the staff in your center who code, or have a need to know the new codes. There are a wide variety of training opportunities and materials available through professional associations, online courses, webinars and onsite training. If you have a small center, think about teaming up with other local providers. You might, for example, be able to provide training for a staff person from one center,

who can in turn train staff members in other centers. Coding professionals recommend that training take place approximately 6 months prior to the Oct. 1, 2013, compliance date.

7. Budget for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials and training. Assess the costs of any necessary software updates, reprinting of superbills, training and related expenses.

8. Conduct test transactions using Version 5010/ICD-10 codes with your payors and clearinghouses. Testing is critical. Allow yourself enough time to first test that your Version 5010 transactions, and subsequently, claims containing ICD-10 codes are being successfully transmitted and received by your payors and billing service or clearinghouse. Check to see when they will begin testing, and the test days they have scheduled. If you submit electronic claims, you need to have completed internal testing of Version 5010 systems in time to begin external testing with your payors, clearinghouses, billing services and other business partners by Jan. 1, 2011. ■

Learn more about ICD-10 implementation at CMS at www.cms.gov/ICD10/.

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12 Critical Concepts to Know About ASC Supplies and Contracts

By Rob Kurtz

Karen Lombard, RN, used to run a 21-OR ambulatory surgery center. Now she's director of contracting solutions for Amerinet, a national healthcare group purchasing organization. She identifies 12 critical concepts about ASC supplies and supply contracts and explains why they're important to surgery centers.

1. Direct from the manufacturer. Part of Ms. Lombard's work for Amerinet is verifying all of the products the GPO contracts for are not coming from third parties, and this is a good best practice for all ASC supplies.

"You want to ensure the quality of the products," she says. "If the product you get doesn't come directly from the manufacturer, how can you guarantee it will work?"

2. High fill-rate percentage. When looking at purchasing supplies, particularly soft goods, many ASCs lack room for extra storage of supplies. This means it is critical for ASCs to know

suppliers are capable of getting supplies to them in a "just-in-time" fashion.

"We want to make sure they can at least fill 97 percent of the time," Ms. Lombard says. "We look to make sure the fill rates are there, they can honor those fill rates and that they're going to be able to deliver when they say they can deliver. Not everybody's perfect but we want a minimum of 97 percent because if you're in an OR and you don't have any [extra storage] room, you need know those products are coming."

3. Competitive pricing. While it may seem obvious that ASCs want to ensure they're getting competitive pricing on their products, it is an area that needs constant attention.

"We want to make sure pricing is competitive and remains competitive," Ms. Lombard says. "We internally benchmark products and go back and forth on pricing with suppliers a lot. You need to constantly keep at it."

4. Price protection. Ms. Lombard says in most cases she likes to have contracts with firm pricing for three years as it helps with budget planning, but that approach can bring sticker shock after those three years are over.

"If you hold your price firm for three years, you may get a big bump because you didn't take any for three years," she says. "You'll still want to budget a minimum percent increase each year rather than [being unprepared] to get hit with a 6-8 percent increase in three years."

5. Surcharge clauses. There are circumstances when the prices of materials go up or down in a matter that is out of control of suppliers, and ASCs should anticipate these changes having an impact on their prices.

"For example, [the price of] cotton recently went through the roof," Ms. Lombard says. "Companies come to us and say they need to rework and make changes to the contract or else they will need to



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cancel the contract. We don't want them to cancel the contract but we don't want to allow them an unchecked price increase. We pay close attention to the Consumer Price Index. We make sure our pricing is within that. If they're going to propose an increase because of a certain situation, we make sure that it's relevant to what they're doing."

6. Term and termination. Amerinet looks closely at the term of the contract and how it is terminated, two concepts ASCs need to understand before agreeing to a contract.

"You need to know how long is this going to be for and what are the criteria for termination of a contract," Ms. Lombard says.

7. Return policies. ASCs need to understand the precise reasons why a supplier will accept a return and whether there could be costs incurred by the ASC for returning a product.

"We always learn what the member has to do to return a product and for what reasons they can return a product," Ms. Lombard says. "We want to make sure they can return the products and return them without cost to them. That's important, especially for shipping."

But ASCs must also understand suppliers may look to include clauses that limit returns or carry

charges with returns, and sometimes these clauses are acceptable. "I just don't feel that if you ordered excess because you thought there might be a backorder that you can just return that to the supplier for free," she says. "You have to be responsible for what you're ordering."

8. Shipping. Amerinet encourages its suppliers to pay for the cost of shipping of soft goods rather than pass it on to members.

"We won't ask them to pay for overnight or special shipping, just standard ground shipping," Ms. Lombard says. "A lot of them will do that, depending on the product line. If it's heavy capital equipment, they likely won't do that."

9. Follow FDA guidelines. Ms. Lombard says Amerinet works to ensure the companies they partner with follow FDA guidelines, which she says is a good best practice for ASCs as well.

"That's very important to us as a GPO," she says.

10. Recall process. "We want to make sure that if there's a product recall, there's a mechanism in place [by the supplier] to provide that information to us and our members," Ms. Lombard says. ASCs will want to understand how their supplier partners will inform them of recalls and how these partners will help inform and educate

patients on the recall, when necessary."

11. Service after the sale. Amerinet likes to see its supplier partners provide support to its members after the sale of goods.

"That's another thing that's important to me — marketing, sales literature and samples," she says. "It's all about service after the sale, and making sure that if we're having issues, there's someone who can help us out with it."

12. New technology. Amerinet strives to work with new suppliers and identify new technology it can offer its members, and this is a practice ASCs will want to emulate, Ms. Lombard says. New technology may offer worthwhile improvements on existing technology used in the ASC, and new suppliers may offer cheaper options.

"We're always looking at new technology and new suppliers," she says. "We want to make sure we're offering the latest and greatest and we're giving suppliers opportunities to get their foot in the door." ■

Learn more about Amerinet at www.amerinet-gpo.com.

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5 Future IT Needs for Surgery Centers

By Rachel Fields

Surgery centers are increasingly adopting information technology to integrate their processes with their physician practices and keep up with hospitals and ASC competitors. Here Robert Brownd, Surgical Notes' director of business development, discusses five technologies surgery centers should consider implementing within the next few years to stay competitive.

1. Transcription services to complement a practice management system. Mr. Brownd says while surgery center's business needs do not match the functionality that a full-blown electronic medical record provides, centers could immediately benefit from a transcription product to improve quality of operative notes. "A lot of times, surgery centers consider transcription a commodity product," he says. "It's not — rather if treated as a commodity, surgery centers will likely engage with an inferior transcription service that provides poor quality, which will create time waste through unneeded management of this inferior service. This time waste and sub-par transcription quality is guaranteed to have negative impacts on your revenue cycle."

He says that in order to keep these negative impacts off your revenue cycle, it's very important to partner with an industry established transcription vendor that can provide quality and timely (next day turn-around-time) transcriptions. "Secondly, you want a vendor that can equip your physicians and business office staff with a web-based transcription management tool that is interfaced with your core practice management system," he says. "That's exactly the type of service and technology that we equip our surgery center clients with and they stay automated."

He says if a surgery center does not invest in quality transcription services, the ASC will likely submit inaccurate claims to payors and have to wait for reimbursement while they handle the appeals process. "Leveraging a transcription technology that interfaces with your core practice management system will ensure the ADT and report content is accurate the first time around," Mr. Brownd says. "Converting to a vendor that has this type of technology will shave off AR days, from your current vendor that might be providing poor quality transcriptions that lead to these submissions of inaccurate claims." He adds that using a full service transcription product might eliminate the need for a full-time employee — who costs the center salary plus benefits — and saves money. "Instead of a transcription vendor that doesn't deliver reports back for two or three days, or a full-time employee expense, you can have technology working to save you time and preserve data integrity," he says.

2. Coding and transcription handled by a single vendor to leverage their technology platforms. Mr. Brownd adds that surgery centers should look into ASC vendors that provide both transcription and coding services. He says some vendors tailor their business model to provide both services, because they can integrate both their transcription and coding platforms through one interfaced and highly streamlined system. This product arrangement works particularly well for surgery centers because it removes the need for the center to single out both their coding and transcription operations to separate vendors or in-house FTEs. If both services can be consolidated under one specialized vendor, you gain from their economies of scale and unique technologies. "Therefore, the codes are turned around the next day as well, so within 24 hours, you have the coding and the transcription turned around in a digital format for seamless charge entry," he says. "The quicker you get those claims processed, the more money you are adding to the bottom line."

He says many surgery centers may not realize they can combine transcription and coding services with one vendor. He says it's also worthwhile to contract a transcription vendor that has a great reputation for providing consistent

quality and technology, instead of viewing transcription as a commodity to save a little money by contracting with subpar vendor. "You can save \$200 a month with a cheaper company, but if you err on one claim with your insurance companies, that easily could be thousands of dollars you leave on the table," he says. "The real scenario is multiple claims start having issues, due to poor transcription quality, which further damages your bottom line much more so than spending a few hundred extra dollars a month with a transcription company that is considered the 'gold standard.'"

3. Customizable EMR. It is not a smart business or clinical decision for surgery centers to implement the same type of electronic medical records software as hospitals, because surgery centers have vastly different needs, Mr. Brownd says. For example, hospitals may need to track patient blood pressure or cholesterol levels over several days/weeks, whereas ASCs focus on outpatient type procedures and bypass most of the value and functionality points that tablet-based EMRs were intended to provide.

"What surgery centers need is software to keep their existing paper workflows that their doctors and clinical staff are so used to charting on, but eliminate the task for employees to manually prepare and store these patient charts," Mr. Brownd says. "This type of simple technology will enable their staff to remain efficient without losing the quality of patient care. The solution has to also be highly customizable to their practice and very easy to use." Overall, he says the software should not change the clinical workflows, with the exception of reducing clinical chart retrieval time.

While a hospital with employed physicians can dedicate significant time to EMR training, a surgery center may find it more difficult to allocate training hours for its surgeons. Because of this, an EMR or electronic document management system should be easy-to-use and customized to the surgery center, so that most of their workflows and forms remain the same. Mr. Brownd says a good motto with technology to have is: "you have to crawl before you walk before you run."

He says the key is to implement a solution that can achieve a moderate level of culture change. If the EMR technology requires too much change to existing workflows, physicians and staff will likely resist the change entirely, and the technology will become a quick failure or long-term struggle at a hefty expense. Fortunately, he says there are solutions tailor-made for the ASC market that have a proven track record of successfully changing business office and clinical cultures to improve operations. "You just have to get out and evaluate these solutions against your business needs," he says.

4. Scanning technology with a barcode. Surgery centers that aren't interested in adopting a full electronic medical record might consider technology that simply scans the patient chart and indexes an electronic copy. This process eliminates the need for paper record storage and retrieval, which is part of the intention of electronic medical records. "This type of product is the best of both worlds because it allows you to keep the familiar paper chart for your physicians and clinical staff, but eliminates the need to have to manually pull forms and prepare the chart with sticky labels," Mr. Brownd says. With this technology, the physicians maintain the use of a paper chart while with the patient, and postoperatively, the business office scans it to an electronic .PDF format through a proprietary barcode technology.

He says while some surgery centers have adopted tablet EMR technologies, he would recommend seriously evaluating other software options and calling at least two reference surgery center sites to see how their implementation and "go live" were executed. "Some hospitals have seen many secondary effects from implementing a tablet based system," he says. "One

of those noticed effects has been that nurses are still filling out the paper chart and then having a second layer of employees typing the information into the EMR. This workflow has slowed down the delivery of patient care and has established redundant charting practices.” He says some centers have found it very difficult for center management to achieve 100 percent physician compliance with a tablet based EMR, which leaves a half-paper and half-electronic based medical records environment.

5. Preparation for possible EMR mandates. While Mr. Brown doubts the federal government will mandate electronic medical records for surgery centers any time soon, he says surgery centers should still prepare for the possibility by familiarizing themselves with technology. “I urge facility administrators and business office managers to not be afraid to take a look at technologies readily available to them,” he says. “Some of these ‘lighter’ EMRs afford a return on your investment within the first year.” He says if the government did mandate something for ASCs in the same manner as hospitals, surgery centers would also likely be allowed a five year “grace period” to implement software before any mandates and penalties took effect. He says it’s worth evaluating these technologies now to

increase profitability and prepare your center for any mandates that might arise in 5-10 years.

He says while mandates are a possibility, he doubts surgery centers will receive incentives like hospitals have for implementing EMRs that meet meaningful use requirements. “The Budget Control Act of 2011 was passed to increase the borrowing authority of the United States to reduce the deficit and prevent default, provides \$841 billion of immediate reductions in federal spending and more than \$2.5 trillion in budget cuts over the next 10 years,” Mr. Brown says. “The likelihood that ASCs will receive incentives in this economic climate are slim.” He says since the government has not mandated EMR for surgery centers, ASCs have the advantage of evaluating and hand-picking a system that fits their needs. He says he believes on a “big picture” level, the ASC market is better off without government intervention. ■

Learn more about Surgical Notes at www.surgicalnotes.com.

Contact Rachel Fields at rachel@beckershealthcare.com.

8 Reasons for Surplus Surgical Supplies in Ambulatory Surgery Centers

By Rachel Fields

West Coast Medical Resources is preparing for a busy year in 2012. After 12 years of running a “one man show,” CEO and founder Randy Ware decided to expand his company in 2009 by assembling a strong team. By April, WestCMR will staff 20 employees and move into a new, 16,000-square-foot facility in Clearwater, Florida.

Since 1997, WestCMR has purchased surplus surgical supplies from hospitals and surgery centers across the U.S., lessening the burden of surplus inventory on materials managers. While surgical facilities typically deal with excess inventory three to four times a year, Mr. Ware says most just don’t have time to consistently address this issue and too often perfectly viable surgical supplies lose most of their value. In some cases, facility staff members want to believe they will find “other” facilities to buy up their surplus, but history has proven in more cases that not that other materials managers “don’t want to deal with anyone else’s problem.”

In the end, a secondary distributor of surplus surgical supplies is often the best option. “Companies like WestCMR are not always the best option economically, but we are the absolutely the most efficient and fiscally responsible option,” Mr. Ware says. “In a nutshell, it’s our mission to help people figure this out sooner than later.”

Surgical surplus occurs for a number of reasons, Mr. Ware says. Here he outlines eight ways surgery centers end up with excess inventory.

1. Strict return policies. Original equipment manufacturers generally do not like taking product back, Mr. Ware says. Strict return policies imposed by these OEMs and traditional distributors can work against surgical facilities and negatively impact budgets.

2. Surgeon preferences change or a surgeon departs. Surgeons may decide they prefer another OEM’s products over the supplies they have been using. If your facility has inventory of the previous product, you are often stuck with an odd assortment of supplies. This is a very common occurrence since surgeons are constantly targeted by sales representatives showing off the newest surgical supply.

3. Unused custom pack components. Surgical facilities often opt for custom packs to save money and time ordering supplies for a particular procedure. However, if you order custom packs without checking that you need every item included, you may end up wasting surgical supplies by leaving them on the shelf every time a pack is opened.

4. Poor inventory management and stock rotation. Surgical facilities face constant fiscal pressure to maintain “just in time” inventory and tight par levels. This can lead to lots of “onesies” and “twosies” that never get used. In addition, employee turnover and a host of other factors can leave surgical facilities with shelves full of supplies that constantly get pushed aside. Simple ordering errors can also be overlooked for months and lead to shelves full of products that won’t be used and can’t be returned to the distributor.

5. Discontinuance of surgical procedures. If your facility stops performing a certain surgical procedure, all the supplies for that procedure will become useless to your facility. Even if you think you may recruit surgeons to start performing the procedure again, the likelihood is that technology will change or the surgeons will not want or have the proper training to use the products in your current inventory.

6. Product enhancement or improvement. OEMs regularly release “new and improved” versions of existing products to keep their competitive edge and consistently improve upon their technology. This means your surgeons will frequently insist on the newer products and decline to use the old inventory.

7. Sales representative turnover and pressures.

8. Contract changes. GPOs and IDNs are doing fantastic work with their OEM partners to negotiate pricing and service contracts that can lead to future savings in healthcare costs by reducing supply costs. However, these contracts typically do not address what to do with the existing or leftover inventory. ■

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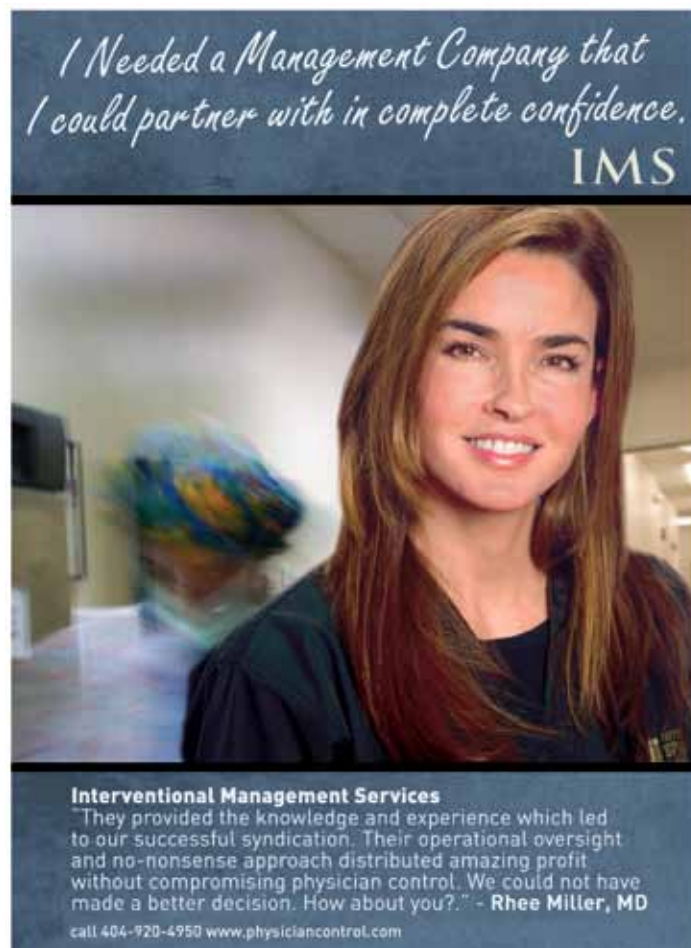
7 Serious Effects of Anesthesia Drug Shortages on Surgery Centers

By Rachel Fields

The last year and a half has seen more significant drug shortages than the last 30 years, says Meena Desai, MD, managing partner for Nova Anesthesia Professionals. The shortages have affected anesthesia and chemotherapy drugs most severely, creating problems for ambulatory surgery centers that rely on certain anesthetics to put patients to sleep and wake them up safely. Dr. Desai discusses seven ways drug shortages are affecting surgery centers — and offers some best practices for what anesthesiologists and ASCs can do in response.

1. Many drugs in short supply do not have viable substitutes. While some scarce drugs can be replaced with generic alternatives or a combination of drugs, Dr. Desai says certain drugs simply do not have substitutes. For example, surgery center anesthesiologists commonly use Atropine as a pre-medication for anesthesia in order to decrease bronchial and salivary secretions and emergently to prevent and counteract bradycardia associated with surgery.

Atropine is currently listed on the FDA shortage list, causing problems for surgery centers since there really is no viable alternative. “There are several drugs on the list for which there are no substitutes — or bad substitutes,” Dr. Desai says. If surgery centers are left without a crucial drug, they may have to cancel or reschedule cases until they can find a new supplier.



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2. Multi-dose vials may be needed in the absence of single-use vials. When one manufacturer announces a drug shortage, the demand for other manufacturers increases, Dr. Desai says. If the remaining manufacturers cannot or will not produce enough of the drug to handle the shortage, drugs are rationed in ways that endanger patient safety or profitability.

For example, a surgery center that was purchasing a drug in a single-dose vial to prevent contamination may no longer have access to single-dose vials. If the surgery center purchases multi-dose vials instead, they must now throw away and waste the remaining drug if all of it is not used with a single patient. “You have to take what you get, and you’re still supposed to follow all the infection protocols,” she says.

3. Medication errors are more likely. Dr. Desai says different distributors produce vials of different sizes and colors. When your operating room staff members is used to using a certain size and color of vial for a particular drug, they may reach for that vial without thinking about it or reading the label. When you suddenly have to switch drugs because of a shortage, medication errors are more likely. “When you multiply the increased likelihood for error with the number of drugs this is happening too, it makes errors much more likely,” Dr. Desai says.

Make sure staff members are aware of drug changes before surgery takes place. Hold meetings to discuss any medication changes and point out drugs that look similar or different than the ones they have replaced.

4. Patient side effects will likely differ. Side effects differ from drug to drug, and patients who have visited your surgery center before will probably notice if you switch them to a completely different drug for anesthesia. Dr. Desai says during the propofol shortage, surgery centers were forced to replace propofol with Brevital. “The use of Brevital had different limitations because the wakeup profile was different and the patient was left feeling [groggier],” she says. “Patients did not feel street-ready, even though they were stable for discharge. The nausea profile also increased with the use of the substitute.”

Dr. Desai says Labetalol, a drug commonly used to control blood pressure and heart rate, is currently in short supply. “It was the perfect drug because it was the right dosing with fewer side effects, and we could monitor it easily and everybody knew what to do with it,” she says. Now that Labetalol is scarce, providers have to combine two drugs — one to control heart rate and another to control blood pressure. The two drugs have different half-lives and different onset rates, which changes the rapidity and reliability at which the drug works.

5. Multiple suppliers will be necessary to tackle shortages. Dr. Desai recommends surgery centers keep multiple suppliers on hand in case of shortages. “That means some of them will be higher-costing, so you may not be able to just use your buying group,” she says. She recommends setting up contracts with suppliers ahead of time, since contracts may take some time to get into place. Setting up relationships with alternate suppliers now can be very helpful if your main supplier announces a drug shortage in a key area.

6. Surgery centers must maintain higher par levels. While she does not recommend surgery centers “hoard” scarce drugs, Dr. Desai says surgery centers should maintain higher par levels. In some cases, surgery centers may have to stop using a particular drug as they normally would because of its scarcity.

For example, she says lidocaine cannot be purchased easily anymore. Surgery centers often use lidocaine to decrease irritation and burning at the injection site during a propofol injection to help prevent the patient from experiencing stinging or burning. If lidocaine is in short supply, the surgery center may have to stop using lidocaine to prevent stinging and burning and reserve it for more crucial uses, such as the treatment of arrhythmia and the use of the drug in ACLS algorithms.

7. Anesthesiologists must decide how to substitute for scarce drugs. Surgery centers should assign an anesthesiologist to head decisions about drug shortages and determine how substitutions can be made, Dr. Desai says. "These aren't the kinds of things you want to discover after the problem has already happened and the drug is not available to you at all," she says. "The rescue is so much harder." She says the lead anesthesiologist should keep up with the FDA list of current drug shortages and use that information to plan ahead. ■

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