November/December 2009
Vol. 2009 No. 9

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

10 Steps to Increase the Life Span of a Surgery Center

By Scott Becker, JD, McGuireWoods and Rick Pence, President, National Surgical Care

A physician, years ago, informed an audience that the life span of a surgery center was exactly 13 years. We had never put an exact time frame on it. That stated, his comments and thoughts resonated as often true. If a surgery center is not refreshed and does not have an ongoing business plan, it generally suffers reduced profits as the physicians who formed the venture move into different stages of their careers and as the business climate and opportunities change. Moreover, in the accelerating times that we live in today, we view this more as less than a 13-year rule. However there

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10 ASC Salary Statistics From the ASC Association 2009 ASC Employee Salary & Benefits Survey

The ASC Association has released the results of its *2009 ASC Employee Salary & Benefits Survey*. Data were collected using a 82-question survey sent to 5,111 ASCs, including ASC Association

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47 Concepts to Consider for ASCs

By Scott Becker, JD, CPA, Rob Kurtz and Renee Tomcanin

This article highlights 47 concepts each ASC owner and operator should consider. It provides insight into general management issues, specialty issues, regulatory issues and several other issues.

General management issues

1. Great management is critical; good business fundamentals will be necessary for ASCs to remain successful. ASCs more than ever run on their profits and distributions. It is critical that ASCs have "A" level employees at every single level. Whether the scheduler, the administrator, the director of nursing or anyone else — an ASC must aim to have "A" players at every level.

An administrator must block and tackle and make sure that the trains runs on time. However,

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INSIDE

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FEATURES

Publisher's Letter

Six Quick Thoughts About the Healthcare and ASC Industry

By Scott Becker, JD, CPA

2009 has been an incredibly interesting year. Here are six quick thoughts.

1. Economic gloom and recession began the year as the biggest issue; healthcare reform ends the year as the biggest issue. This year began with tremendous paralysis in the American economy and tremendous concern. While improvement may have been fueled in part by government spending and record deficits, the economic challenges that the country finds itself in does not for the moment seem to be the biggest issue facing the healthcare economy. Rather, for healthcare providers, healthcare reform has emerged as the overriding and perhaps foreboding issue of the year.

Concerns regarding the public option. There is substantial concern that a healthcare reform package that includes any type of public option will ultimately cause a substantial migration away from better paying commercial payors to Medicare-like payment. There have been estimates that a movement to a public option structured with Medicare plus 5 percent reimbursement would include almost 120 million people within 3-5 years. As Medicare or public option reimbursement is likely to be substantially lower than commercial reimbursement, this means a great percentage of patients upon which surgery centers actually make a profit would migrate to the plan and thus reduce profits. In the long term, this should be of great concern to surgery centers and to hospitals.

Practical alternative. A great letter to the *Wall Street Journal* summarizes my thoughts on healthcare reform fairly well. There, the writer quotes Al From's op-ed piece and says:

"I (a conservative) am shocked to read Al From's (founder of the Democratic Leadership Council) "Democrats Don't Need the Public Option") op-ed, Oct. 16), which makes more sense than anything I've heard from any of the Washington blowhards. His advice to drop the public option, require everyone to buy coverage, cut the pre-existing condition trap and tax Cadillac health-care plans would get most people's support. Pass a bill like this, sign it into law and let's move on."

2. Stark Act, Fraud and Abuse and Anti-Kickback Statute developments. From a federal anti-kickback and Stark perspective, it has been a fascinating year. First, Stark Act changes which disallowed under arrangements agreements as well as disallowing pre-used leases and real estate arrangements became effective this fall. Second, there have been a number of settlements between the government and individuals and hospitals with respect to anti-kickback issues and Stark Act issues. This include settlements relating to the alleged overpayment to physician employees of a hospital in Waterloo, Iowa (in that situation, there was one gastroenterologist being paid approximately $1.8 million by the system as well as four other specialists that were being paid very well) and a fascinating South Carolina qui tam case involving hospital offers to physician specialists.

There, the government has intervened in the case against the hospital and the case is going to trial shortly.

These cases, plus recent comments by Charles Grassley stating that there is a backlog of nearly 1,000-2,000 qui tam cases for the government to review and decide whether or not to intervene in, indicate an increased sense that hospitals and centers must have very active compliance driven efforts. This is an area that, due to budget deficits and the political ease of attacking things that are "called" fraud and abuse, is extremely ripe for further government action.

3. Easy reimbursement is going away. A clear story this year has been the movement and aggressiveness of payors away from paying any sort of above-market reimbursement through out-of-network or small discounts from usual and customary charges. This movement is accelerating. ASCs can still be profitable without these big pockets of reimbursement but it is harder.

4. Physician-owned hospitals may not fare well under healthcare reform. Every healthcare reform bill still includes provisions that would substantially reduce the ability of new physician-owned hospitals to be built. This is a shame as this industry is an outstanding example of innovation in delivery of care. The strength of the model is finally being borne out by several different consumer report studies that show physician-owned hospitals as the best consumer option for patients in many states. This is a terrific validation of the efforts of the physician-owned hospital industry.

5. ASC Association and ASC Coalition. There is a great song in the Michael Moore movie Capitalism about Cleveland that says its catch phrase is "we're not Detroit, we're not Detroit." There, it alludes to the troubling but better economic situation that Cleveland is in than Detroit. From an ASC perspective, we are fortunate to have some of the best political efforts of any physician-owned directive. Between the ASC Association and the newly formed ASC Coalition, the ASC industry is represented better than any other physician constituency. The similar catch phrase to "we're not Detroit, we're not Detroit" would for ASCs be "we're not medical devices, we're not physician-owned hospitals and we're not health insurers." These are all areas that are being attacked at a level more directly and profoundly than surgery centers.

5. Spine, bariatric and retina. Aside from the ongoing core strengths of surgery centers — orthopedics, GI, and ophthalmology — we are seeing the addition of spine, bariatric and retina, more general surgery, ENT and urology procedures to ASCs. In essence, there might not be flood gates opening of new volumes and cases to surgery centers, but there are possibilities and opportunities out there that surgery centers should continue to aggressively pursue.

ASC Conferences 2010

We have two outstanding surgery center conferences planned for next year. First, we have our 8th Annual Orthopedic, Spine and Pain Management Driven ASC Conference. This will be held June 10-12 in Chicago. We will, once again, combine great and interesting keynote speakers with a terrific amount of practical and focused guidance. This year we have lined up Ron Brownstein, the political director at Atlantic Media Company, and Joe Flower, a fascinating healthcare futurist, to both speak at the June meeting.

The 17th Annual ASCs Improving Profitability and Business and Legal Issues will be held October 20-22 in Chicago. Should you have suggestions for a speaker or topic for either of the meetings, or just simply want more information about the meetings, please feel free to e-mail sbecker@mcguirewoods.com.

Hospital and Health Systems Conference — April 2010

We are also involved in hosting a conference on April 13-14 for hospitals and health systems entitled "Improving Profitability and Business and Legal Issues." This conference also highlights Ron Brownstein as a keynote speaker and will include several hospital CEOs as speakers as well as a number of terrific presentations. Should you have interest in this conference, please also feel free to e-mail sbecker@mcguriewoods.com.

We see 2010, for the healthcare industry, as a very interesting and a solid year. It is 2012 and beyond that we have greater concerns about.

Very truly yours,

Scott Becker

P.S. Please e-mail Scott Becker at sbecker@mcguirewoods.com to sign up for the free Becker's ASC E-weekly, the Becker's Hospital E-weekly or the Becker's Orthopedic & Spine E-weekly.

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10 Steps to Increase the Life Span of a Surgery Center

(continued from page 1)

are many surgery centers still performing well after 15 years in business.

There are several steps that a surgery center can take to offset the effects of aging on the business. These steps include.

1. Always be recruiting. A surgery center should always be recruiting. It is not the big offering every couple years that leads to ongoing success but constantly adding individual physicians, whether as owners or as utilizers of the surgery center. In essence, one should constantly be adding doctors. Further, it is impossible to match up the selling of shares with the buying out of physicians. Thus, do not make the two events conditioned upon another.

2. Succession planning. ASCs are active living businesses and do not perform well as partners enter the wind down phase of their medical practice. An ASC should be aggressive in discussing succession planning with key partners with a goal of getting the ownership into the hands of the younger physicians. Be a facilitator of the process.

3. Great management. It is critical that ASCs have "A" level employees at every single level. Whether the scheduler, the administrator, the director of nursing, or anyone else — an ASC must have an "A" team.

An administrator must block and tackle to make sure the train runs efficiently and on time. However, this alone does not make somebody an "A". To truly be an A administrator, he/she must do an outstanding job of marketing and recruiting doctors and cases to the center. The prerequisites of the job is great blocking and tackling. The movement to A player status requires adding cases and marketing as well.

ASCs more than ever must have the right team, which includes the number of employees and the right type of employee. Two questions to ask when evaluating your team: Is the individual capable of doing the job you expect them to do and are they willing to meet your expectations?

An A administrator understands what it costs to perform a case in relation to the revenue the case will generate. The business is a much more challenging business than it was 5-10 years ago. In a great reimbursement climate everybody looks smart. In contrast, in a challenging reimbursement environment, the difference between great managers and greatly run centers versus poorly run centers is very clear and distinct. ASCs more than ever run on their profits and distributions.

4. Long-term debt and high expenses can be crippling. We use two words to describe long-term debt and high real estate costs: cautious and crippling. Centers must be extremely cautious about taking on significant long-term debt and/or lease obligations.

When somebody says let's relocate a profitable center and spend $4 million to do so, we become very cautious. The first question is why? It will be expensive and it will take a long time. Can you predict how your volume will look in two years? It is a time to be very careful when taking on fixed expenses that cannot be varied up and down with the revenues of the facility.

5. Hospital relationships are helpful but not a panacea. In many situations, hospitals can be helpful for managed care contracts. However, they are not the absolute trigger for better contracts. Most not-for-profit hospitals are reluctant to get involved in contract negotiations of physician-owned entities. But for avoiding conflict and competition, it can be very helpful to have a hospital partner. In many situations, hospitals are employing surgeons. This often becomes a critical issue as most employed physicians will not be allowed to invest in a surgery center even if the hospital is a partner in the center.

6. Build on your strengths. If the center has an outstanding strength, the first goal is to double down on that strength. For example, an ASC with a great orthopedic program should work to accelerate its orthopedic development to become the premier orthopedic facility in the area. This could include new equipment, new procedures, rebranding the name of the center to include orthopedics, adding podiatry (very similar equipment) and pain. An outstanding staff along with quality care as demonstrated through patient and physician surveys can allow an ASC to double down on marketing, branding it as the best place to work for physicians and staff.

7. Keep it fresh. Often we see ASCs that are showing their age and look a bit run down from the lobby to the back door. Why? Are partners overly focused on distributions or are the employees and physicians simply too comfortable with their home? Is the equipment up-to-date? When the center opened it likely had the best equipment in the community. If the center no longer has current technology, it will be difficult to recruit new surgeons.

8. Develop a positive relationship with your managed care representative. Think about what you can do to help the representative look at your center's data in a way that is beneficial to you. You may have to do some of their work but you also understand your center much better than anyone else. People like to work with people they feel can help them.

9. Review your fee schedule at least annually by comparing your rates to your best managed care agreement. Most payors pay contract rates or your charge, whichever is lower.

10. Review and rebid all service contracts every few years. There may be a better deal today on maintenance contracts, laundry and linen and other outsourced services.

These are just 10 ideas on expanding the life spans of surgery centers. In the past, surgery centers could have become complacent and survive. Today, complacent surgery centers go out of business. Should you have any questions about any of the ideas in the article, please contact Scott Becker (sbecker@mcguirewoods.com) or Rick Pence (rpence@natsurgcare.com). ■

ASCOA is seeking to invest in and manage physician-owned hospitals. If you have an interest in a partnership or have a contact that may have such an interest, please contact Brent Lambert at 781-258-1533 or e-mail blambert@ascoa.com.

Learn more about ASCOA at www.ascoa.com.

10 ASC Salary Statistics From the ASC Association 2009 ASC Employee Salary & Benefits Survey (continued from page 1)

members and Medicare-certified ASCs. Participants were instructed to provide the annual salaries for positions as of Jan. 1, 2009. Responses were returned through fax or mail or completed online.

Here are 10 significant findings from the *2009 ASC Employee Salary & Benefits Survey*.

1. For most ASC positions, 2009 salaries were higher than 2008 salaries. Here are the three positions which saw the largest salary increases:
   - Operating room technicians — 4.6 percent ($40,000, up from $38,230)
   - Licensed practical nurses — 4.1 percent ($39,500, up from $37,958)
   - Receptionists/admitting clerks — 4.0 percent ($28,662, up from $27,560)

2. The only position to see a decline in salary for 2009 was radiology technician, which decreased by 1.5 percent ($47,840, down from $48,561).

3. Salaries for ASC managers did not experience the same significant growth as the salaries for the non-managerial positions. Here are the percent growth statistics and median 2009 salaries for ASC managerial positions:
   - Business office manager — 3.9 percent ($53,000, up from $51,000)
   - Director of nursing — 2.8 percent ($76,000, up from $73,913)
   - Administrator — 1 percent ($92,957, up from $92,000)
   - Materials manager — 0.7 percent ($43,975, up from $43,680)

4. Administrators who have achieved the CASC credential report higher salaries that those who did not have the CASC credential. The median salary of an administrator with the CASC credential and no clinical background was $102,000 and an administrator with the CASC credential and a clinical background was $105,000. Administrators with a clinical background and no CASC credential earned a median salary of $89,500.

5. States in Region II (New Jersey, New York and Puerto Rico) saw the highest median administrator salary for 2009 at $110,000. States in Region X (Arizona, California, Guam, Hawaii and Nevada) saw the lowest median administrator salary at $84,764.

6. Here are the average 2009 national salaries for nursing positions at ASCs:
   - Licensed practical nurse — $41,463
   - Registered nurse — $62,111
   - Certified registered nurse anesthetists — $151,365

7. Here are the 2009 median salaries for other non-managerial ASC staff members:
   - Anesthesiologist — $275,000
   - Coder — $36,000
   - Insurance clerk — $31,720
   - Scheduling clerk — $32,000

8. Sixty-three percent of ASCs surveyed reported that recruiting new employees was easier in 2009 than in 2008. In 2008, only 6 percent of ASCs reported that recruiting new employees was easier than the year before.

9. Of the ASCs surveyed, 98 percent reported that they offer healthcare benefits to their employees, and 80 percent reported offering retirement benefits.

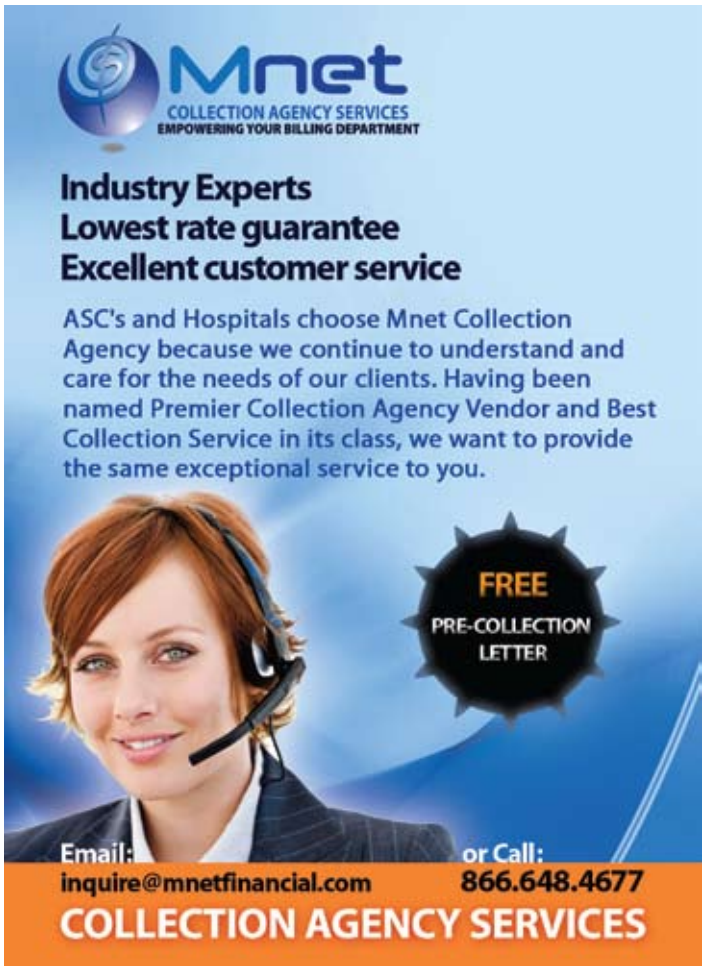
10. Most ASCs surveyed (31 percent) employed 1-10 full-time employees, and 29 percent employed 11-20 full-time employees.

About the *2009 ASC Employee Salary & Benefits Survey*

The report includes national and regional data, state-specific data for 34 states and the District of Columbia, in-state regional data for California, Florida, Illinois, Pennsylvania and Texas, selected salaries by caseload, size, ASC type, number of employees and location, benefits packages and employee bonus information, recruiting trends as well as other benchmarking information.

Copies of the report sell for $40 to ASC Association members and $195 to nonmembers.

To order a copy of the *2009 ASC Employee Salary & Benefits Survey*, call (703) 836-8808 or visit www.ascassociation.org/store. ■



47 Concepts to Consider for ASCs (continued from page 1)

this alone can make somebody a B to B+ administrator. To truly be an A administrator, someone must also do an outstanding job of marketing and recruiting doctors and cases to the center. The movement to A player status requires adding cases and marketing as well.

ASCs must have the right number of employees and be open the right number of days. They also must be able to understand what it costs to perform a case. The business is a much more challenging business than it was 5-10 years ago. In a great reimbursement climate, everybody looks smart. In contrast, in a challenging reimbursement environment, the difference between great managers and greatly run centers versus poorly run centers is very clear and distinct.

ASCs remain profitable, but unlike in the early days of the industry, it is becoming more and more necessary for ASCs to make sure they are operating using good business fundamentals, according to Rajiv Chopra, principal and CFO of The C/N Group.

"In the past, centers would say, 'We're still profitable; let's just go with it,' but that era is coming to a close due to competition and other market pressures," says Mr. Chopra. He notes that it is becoming more important for surgery centers to maintain their profitability by managing expenses, understanding case costs and watching their reimbursements, so they can adjust their business practices accordingly.

Joseph Zasa, co-founder and managing partner of Woodrum/ASD, agrees that ASCs are a "fundamentals-driven business." "ASCs will continue to find effective and proper practices to make sure that their centers are successful," he says.

2. Turnarounds are more prevalent than ever. Over the last few years, as more surgery centers have been built and fewer independent physicians are available, there has been greater growth and attention paid to turning around surgery centers rather than building new facilities.

Mr. Zasa notes that this trend has remained popular. "Most of our business is turnaround-oriented since we are focused as a management/operations firm," he says. "Turnarounds require deft management expertise and a team effort between the surgeons, management, the staff and anesthesia."

Luke Lambert, CEO of Ambulatory Surgical Centers of America, says, "Three years ago, 80 percent or more of our business was startups. Now, 80 percent or more are turnarounds."

"Turnarounds are definitely less expensive and less time-consuming than a pure startup," says Todd Mello, ASA, AVA, MBA, principal of HealthCare Appraisers. "ASCs typically have heavy investment in fixed costs (equipment and leaseholds), so obtaining sufficient volume is critical in maximizing staff efficiency and covering heavy fixed cost burdens. Once fixed costs are covered, and assuming staff is sufficient to cover the volume (i.e., staff is not purely variable and behaves in a step-wise function in that there is a certain level of minimum staffing required regardless of volume, and at various case levels, new, incremental staff may be required), incremental costs are limited predominantly to supplies (and perhaps billing if outsourced), which causes the margins on incremental cases to be significantly higher.

"New physicians added to an existing ASC is a win-win for all parties in that existing owners, while diluted, share a smaller percentage of a larger pie, and new investors are allowed the opportunity to forego a very risky start-up and expeditiously begin doing cases," he says.

3. Always be recruiting. A surgery center should always be recruiting. It is not the big offering every couple years that leads to ongoing success, rather the constant addition of individual physicians whether as owners or as users of the surgery center. In essence, one should constantly be adding

physicians one at a time as owners or non-owners. Further, it is impossible to match up the selling of shares with the buying out of physicians. Thus, do not make the two events conditioned upon another.

New surgeons can add capital and provide a transition from old or retiring surgeons to keep the ASC viable. While it is important that new recruits be productive physicians and that they meet the safe harbor tests, it is equally important that they be high-quality people and team players. One difficult physician (or staff member) can often ruin a great center.

4. RNs often make superior administrators. Experienced registered nurses often make great ASC administrators. However, the RN must study and be interested in the business side of ASCs. RNs are generally trained to be disciplined and dedicated workers, a work ethic that carries over to the administrator position.

Dawn Q. McLane, RN, MSA, CASC, CNOR, chief development officer of Nikitis Resource Group, notes that having an administrator with a strong clinical and financial background and ASC experience, particularly at a multi-specialty center, is even more crucial at this time as ASC face a growing number of regulatory issues.

"An RN or a business-trained person, like a CPA, can each make a great administrator," says Ms. McLane. "However, an RN with a business background or training makes a superior administrator. An RN with experience in the surgical clinical area, particularly the OR and especially an ASC setting, possesses an unparalleled knowledge about how the center functions should function from a clinical perspective and how it should be managed from a business perspective. A qualified and proven OR RN with clinical leadership and business training and experience would always be my first choice when recruiting for an ASC administrator."

According to the ASC Association's *ASC Employee Salary and Benefits Survey 2009*, the median salary of a CASC-certified administrator with a clinical background is approximately $105,000.

5. Hire staff members with ASC experience or who understand the ASC mindset. A good staff is crucial to the success of an ASC; however, developing a staff whose members all understand how the ASC setting works can require extra patience and time on the behalf of the administrator.

For this reason, it is important to hire, when possible, qualified staff who have prior experience in the ASC setting.

"ASCs require a different mindset than the hospital," says Melodee Moncrief, administrator of Big Creek Surgery Center in Middleburg Heights, Ohio. "It takes time to convert new staff to the new mindset, and it can require you to constantly, but gently, remind them that they are not at the hospital."

Ms. Moncrief notes that some areas may be affected as the new staff acquiesces to the ASC environment, so extra monitoring may be required. "One problem I've encountered [with staff coming from the hospital to the ASC] is their tendency to overmedicate patients, resulting in a longer recovery time," she says. "You just need to reiterate that the purpose of ambulatory surgery is to make sure patients can be treated and released so they can recover at home."

Mary Sturm, senior vice president of Surgical Management Professionals, agrees that simply knowing how to perform procedures may not be the only indication that a staff member is a good fit at an ASC. "Surgeons only care about whether a staff person knows how to do a great job assisting with a

procedure or knowing his/her routines for patient care," she says. "While competence certainly needs to be one aspect of performance measures, a competent individual with unacceptable behaviors is not a good hire."

6. Include the entire staff in ASC processes. A good staff is essential to running a successful ASC. Therefore, once you build a good team at your ASCs, it is important to keep turnaround low and staff members engaged in the ASC.

"If [your staff members] don't feel like partners, you won't be successful," Marcus Williamson, president of the NeoSpine division of Symbion, says. "Support for your staff should come not from the bottom up, but from the top down. Administrators and managers should remove obstacles and distractions that get in the way of their staff members from doing a good job."

By having staff members feel like they are part of a team, they can focus on patient care, which leads to a successful ASC experience.

7. Negotiation with vendors. Shopping around vendors to establish the best deals in medical/surgical equipment pricing is critical to managing costs at ASCs. Some vendors are interested in getting the "foot in the door" when it comes to ASCs, so it is important for surgery centers to explain the differences between ASCs and the hospitals.

"You want to get the best you can using the least amount of money, and often the vendor of choice is not necessarily the best fit or the least expensive," says Ms. Moncrief. She suggests bringing vendors into the ASC and explaining to them how the center works, including areas like reimbursements and types of patients, as they compare with hospitals. If you're interested in a product, don't hesitate to ask if vendors will let you trial their products in the center.

"You can use vendors to play against each other to get the best deal," Ms. Moncrief says. "Most of the time vendors want to work together with you to discover what will be most profitable for both [parties]."

Some vendors, however, are not interested in the ASC market, and occasionally vendors hands are tied as far what they can negotiate, Ms. Moncrief notes. She also suggests limiting the amount of trials you do in the center. Once you find a vendor that works well for physicians, you should work to settle on a deal rather than constantly trialing new products as this may frustrate and potentially turn away a good vendor.

8. Reimbursement depends on more than just billing and collections. Keeping a watch over reimbursements is crucial to ASC profitability, and receiving the correct reimbursements in a timely manner is becoming more and more difficult. However, the responsibility for getting these payments should not fall solely on the shoulders of billing and collections.

"In order to generate cash collection, all other business office staff should be involved as well," says Caryl Serbin, RN, president and founder of Serbin Surgery Center Billing. Ms. Serbin suggests the following responsibilities for members of an ASC's business office:

Schedulers — Need to request accurate and up-to-date patient demographics and insurance information.

Management — Plan ahead and provide advance notification to patients about your financial practices (brochure, Web site, flyer, etc.), perhaps through the physician's office handouts.

Insurance verification specialist — Request in- and out-of-network coverage, if applicable. Use a form so nothing is forgotten. "Full verification

of insurance coverage is a must (not just computer-generated eligibility information)," Ms. Serbin says.

Patient financial counselors — Call the patient and explain the patient's financial responsibility. Try to do this at least three days prior to procedure. Describe different payment options and get commitment from the patient. Advise admitting desk of patient's financial responsibility.

Receptionist — Collect agreed-upon payment amount from the patient at time of registration. Verify insurance for accuracy. Copy/scan both sides of insurance card.

Medical records specialist — Provide coders with a copy of the operative note in a timely manner. Also provide coders with pathology and other related reports for accurate and optimal coding.

9. Make sure that documentation and coding are accurate so that your ASC is properly reimbursed. Undercoding, or not coding for procedures performed during a patient's surgery, can cause ASCs to miss significant dollars in reimbursements. Laura Gilbert, senior director of communications for ProVation Medical, says the most money can be lost in highly complex specialties, such as orthopedics.

Other specialties also depend on accurate coding to optimize reimbursements. "Specialties like pain management and GI, which make up a high percent of ASC procedure volume, are seeing some the highest percentages of reimbursement declines," Ms. Gilbert says. "What this means is that ASCs are essentially having to do more with less — perform a higher volume of procedures (i.e., turn over rooms faster) and make sure that every detail affecting coding is included in documentation. Otherwise, [ASCs] are at real risk for simply not getting completely paid for the procedures they've completely performed."

10. Schedulers at surgeons' offices can be an ASC's best friend or worst enemy. Good, efficient schedulers help ASCs see more patients and keep physicians happy. Likewise, schedulers who make the process difficult for surgeons and their staffs can be affecting the case volume and flow at the center.

"Way too often, we hear surgeon investors admit that where they end up performing procedures is a function of where their surgery schedulers can get a case booked with the least amount of effort," says Ms. Sturm. "Surgeons need to be engaged in their role in where surgeries are performed."

Ms. Moncrief agrees. "You want to make it easier on the physician and his or her staff so they will continue to be a part of your center," she says.

Ms. Sturm offers several suggestions on how ASCs can make their scheduling the most efficient for surgeons and their staff:

Ensure that surgery schedulers are an important focus of your marketing efforts. Whenever possible, get together with office schedulers with the surgeon present in the conversation, Ms. Sturm suggests. "We all know that patients do and should have choice in where procedures are scheduled. However, ensure that surgeons and their schedulers have information ready for patients that demonstrate why the ASC is a great place to have surgery," she says.

Ensure that your ASC's scheduling processes are streamlined and customer friendly.

"'No' should be an almost absent word from scheduler's vocabulary when it comes to getting cases on the schedule," Ms. Sturm says. ASC schedulers should not be turning cases away without first involving a manager.

11. Surgery centers should not be run like convenience stores. The most profitable surgery centers are open those days and hours that they need to be open. In contrast, it makes little sense to operate a surgery center five or six days per week when case volume only supports operation on two days per week. Several surgery centers have failed due to this policy of trying to be open at all times rather than operating on days that are most profitable.

12. Paying fees plus equity to a management company is often the norm. In addition to a management fee, increasingly, the leading management companies are requiring a small portion of equity in the surgery center. Before writing off such an arrangement, evaluate how that management company compares to other management companies.

13. Market your services and expertise, not just the ASC. As with any corporation, marketing to the community is essential for an ASC's success. However, simply informing the public that your ASC is available is an ineffective way of spending marketing dollars.

"It's much more effective to market services your ASC offers rather than the ASC itself," says Mr. Williamson. He also suggests placing more focus on the expertise of the physicians who handle cases at the ASCs. "If people in the community are aware of the physicians [that use your ASC], they will see more patients in their offices, which therefore, could lead to more cases coming to the ASC," he says.

One key to this strategy is maintaining a solid Web presence for the ASC, which can provide testimonials, outcome information and benchmarking information on specific procedures and the ASC's overall performance.

"Patients and their families will have questions, and the Web site can help to educate them on their procedure and what to expect prior to and after surgery," Mr. Williamson says. Other information to include can be anatomy, the difference in procedures and definition for different medical conditions.

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"A Web site provides 24/7 information that is easy to access for patients," Mr. Williamson adds.

14. Target marketing efforts to different areas in the community. Patients are just one sector of the community on which ASCs should focus their marketing efforts. Raising awareness about your ASCs and what it offers to the community should extend beyond basic market awareness and include physicians and their offices, legislators, payors and large employers, according to William Southwick, president and CEO of Healthmark Partners.

ASCs should adjust their marketing strategies to highlight the areas of most concern to each of these sectors. Mr. Southwick offers his suggestions for each of these groups:

Physicians — According to Mr. Southwick, ASCs should focus on touting the center. "Explain the efficiency, convenience, patient satisfaction and benefits of a partnership to physicians," he says.

Legislators — "Advocacy is key, as it helps to educate and raise awareness about ASCs and protect the interests of your business," Mr. Southwick says. "The ASC Association does a good job of setting up events like open house days and creating awareness. Even if you can't get your legislator to your center, you can always set up a meeting and tell your story."

Large employers and payors — For this sector, transparency is key. "You want to explain your costs to patients, rates to payors, cases you perform and efficiency and patient satisfaction you achieve," Mr. Southwick says.

Managed care contracting and related issues

1. ASCs are facing increased pressure to go in-network. Working out of network had been a profitable strategy for ASCs in the past, but, recently, insurers in some states have made the use of out-of-network facilities less appealing to their customers. Some ways ASCs have responded to these measures are by offering discounted rates and placing a greater emphasis on collecting up-front payments.

In some cases, ASCs have approached the payor to renegotiate their rates to move in-network. Mr. Lambert suggests that ASCs should go into these conversations prepared and armed with comparative information.

"Prepare for a dollars and cents discussion. It is important to know what you are willing to accept in terms of reimbursement," Mr. Lambert says. Entering into a bad contract for some patients could be far more detrimental than continuing out of network.

"The best bargaining chip to bring to the table is a possible change of surgical venue in order to bring down cost," Mr. Lambert adds. "If you or your center's owners control where the cases are done, then providing [the payor] with a list of cases that can be moved to your center from some other high-cost venue can be a powerful lever in your negotiations.

"It is important to demonstrate the savings for the payor," he says. "If you've historically accepted reimbursement that is too low but you're doing the cases anyway at your facility, then you won't have any leverage with the payor."

2. Educating patients on financial responsibility is a necessity to maintain profitability. The recent economic downturn has made it necessary for ASCs to remain diligent in their collection practices. At the same time, the reimbursement squeeze by payors also results in added burden and out-of-pocket payments for patients. In order to help ease these difficulties, ASCs need to provide a complete and accurate picture of financial responsibility for patients so they collect more payments prior to surgery.

Mr. Chopra notes that some patients are participating in high deductible plans. "Where their deductibles were once $500, they are now $1,000," he says. "ASCs need to drive innovation throughout the revenue cycle to ensure that they can educate patients and accommodate this dramatic shift in patient responsibility.

Mr. Williamson agrees that educating patients on billing practices and their deductibles is crucial and can help them determine where to have their surgery. "We let patients and referring physicians know on our Web site our processes so they can compare," he says. "For example, the hospital typically sends a minimum of five bills: one for radiology, laboratory services, physician fees, the hospital, anesthesia, etc. The ASC will send a maximum or three: one for the provider, one for the ASC and possibly one for anesthesia. Copays are typically 20 percent of the total, so patients are able to calculate their out-of-pocket costs. For example, a lumbar procedure may cost $3,300-$7,000 at the ASC, which means the patient will be responsible for $990-$1,500."

3. Setting a bad contract for a small number of patients is not smart. In an increasing number of situations, surgery centers may sign a bad contract for a very small percentage of their patients. This contract might not be heavily negotiated and it may be at a low price. A surgery center may reason that this will have little impact because these patients represent a small percentage of its patients. However, increasingly, one preferred provider organization or insurance company sells their contract rates and leases out the network to another party. Thus, when an ASC thought they were contracting for 1-2 percent of the patients, the surgery center finds over the course of time that it is actually contracting for a great number of its patients. Therefore, surgery centers have to be increasingly vigilant about walking away from contracts that are not at profitable rates.

4. Use data to determine if it is necessary to renegotiate your ASCs managed care contracts. Once contracts are set, ASCs may get complacent regarding their reimbursements. Other times, ASCs may think they need to renegotiate their contracts when they are actually receiving a reasonable reimbursement rate. Gathering market information, as well as case

costing data from your ASC, can serve as an important benchmark for determining proper reimbursement rates.

Mr. Southwick notes that gathering this information is especially crucial when going into contract negotiations. "ASCs need to know more data than the insurance companies," he says. "You should know your center inside and out: know what cases you do, the costs, the variety of cases you perform for a particular payor, etc. Share cost information." By having this type of information, ASCs will have better leverage when coming to the table.

In addition to in-house data, Mr. Southwick suggests gathering price differential information on reimbursements. "Surgery centers should look at what the market offers in all locations and look at reimbursement in different markets and different locations within their markets. You may not know the exact reimbursements, but you can get general levels and find out if your reimbursements are on par with the market," he says.

5. Negotiating excellent implant contracts is essential for profitable spine surgery. Implants are essential to spine and orthopedic surgeries, but they can cost a surgery center any profit made on the procedure if contracts are not negotiated properly.

According to Ms. Moncrief, spinal fusion implants can range form $7,000-$15,000. Medicare does not reimburse for spinal implants, she adds, so it is important to select cases carefully.

"It is imperative to get a reimbursement or carve out for your implant costs or you will lose all of your profit," Ms. Moncrief says. "Spine can be very lucrative with the proper contract, but debilitating without one."

ASCs may want to consider outsourcing implant management services to ensure they are receiving proper reimbursement on implants, not only for spine, but for many other specialties. By investigating whether this type of arrangement is a good fit for an ASC, facilities may be able to expand their services to include more complex procedures.

"Implant management solutions offer prior authorization, acquisition, verification, billing and reimbursement services that remove the device specific financial risk of expanding an ASC's procedure portfolio. Expansion of the procedure portfolio increases the ASC's ability to attract and retain physicians and should be a fundamental component of an ASC's growth strategy." says Bill Cramer, founder and vice chairman of Access MediQuip.

Single-specialty vs. multi-specialty

1. Single-specialty centers can be profitable if groups are aligned. Single-specialty ASCs can be viable options for larger groups if the mix is right.

Larry Taylor, president and CEO of Practice Partners, says that his group has seen an increase in these kinds of development ventures. "These [large single-specialty] groups are usually aligned by similar practice goals, understand each other's strengths and weaknesses, practice patterns, financial goals and have relationships that can become leveraged in the marketplace. The group can be more easily focused and guided through the process, thus making decisions in a short time frame," he says.

Another benefit of these arrangements is that determining a no-go situation usually occurs quickly, according to Mr. Taylor.

"Single-specialty centers are both efficient and economical to operate," says Barry Tanner, president and CEO of Physicians Endoscopy, which specializes in the development of single-specialty GI centers. "In the GI space, ownership in an endoscopic ASC is becoming increasingly important. As

professional fees continue to get squeezed, participation in a portion of the technical revenue from ASC ownership is one of the few remaining ways to compensate. For GI physicians, technical revenue is becoming a larger percentage of overall medical practice income. It is getting increasingly difficult for small GI practices to survive and prosper. Increasingly we see practice coalitions being formed and even mergers of smaller GI practices partially in an effort to support/justify the development of a GI single-specialty endoscopy center."

2. Single-specialty ASCs may also consider reaching out to other specialties. Single-specialty ASCs can struggle, especially if reimbursement rates for their specialty decline, such as the case with GI procedures and their Medicare rates. According to Mr. Lambert, many single-specialty ASCs are looking to add more service lines to help counteract these possible issues.

"We haven't seen a lot of single-specialty startups," he says. "When we do see de novo ventures, they are usually multi-specialty partnerships. This could or could not mean that the group was forced to reach out."

Mr. Lambert notes that if single-specialty ASCs choose to reach out to other groups, they should make sure that the additions will improve the structure of the center and are compatible with what the center is trying to accomplish.

Mr. Tanner says that physicians' needs to participate in technical revenue have been driving single-specialty startups. "With GI centers, it is all about patient volume and efficiency. With reimbursement declines such as they are, GI centers are forced to operate in the most efficient manner possible. Staffing, purchasing, room utilization, payor contracting, etc., are all key to survival and to success. We have looked at expanding service lines in certain circumstances; however, the real key is to right-size the ASC to fit the current and expected case volume of the physician partners," he says.

3. Critical mass in a specialty surgery center should not be built around a single physician in an area. When adding specialties it is critical to take advantage of economies of scale. Thus, it is far better to have to have three of a certain type of physician than one of various different types. It makes equipment purchasing easier, supply purchasing easier and makes staff expertise much easier to obtain. In general, it is hard to be successful with one of anything.

Mr. Tanner says, "It is definitely not a one-size-fits all sort of process. In the GI space, we believe that in order to have the right risk profile and to secure financing in today's credit climate, four GI physicians with a historical case volume of around 4,000 is the minimum. We do not advise developing a one-room ASC, and, therefore, with two rooms we would like to see case volume of closer to 5,000 or more. What we have found is that once the physicians actually have an endoscopy center, additional physician recruitment becomes a higher probability."

Specialties

1. Spine is becoming more important to ASCs. New technology and innovations have generated continued interest in outpatient spine surgery.

"Spine and arthroscopic hip cases have continued opportunity in the ASC environment and more surgeons are utilizing the environment," says Mr. Taylor.

Mr. Lambert agrees that a greater push has been towards adding spine in ASCs. However, he notes that there are some barriers to moving these procedures to the ambulatory surgery setting.

"We are fighting against traditional care," he says. "Some surgeons are not excited to change, and there is some inertia from hospitals not to move some procedures to the outpatient department from hospitals."

Mr. Williamson also notes the trend of spine cases leaving the hospital. However, he says that it is important for centers who are considering adding spine to consider the scope of the specialized training required for some of these procedures.

"Anesthesia and microinstruments are the drives of this move [of spine procedures to ASCs]," he says. "With these innovations, special training is needed, such as with XLIF and spinal fusion."

2. Spine procedures and orthopedic procedures can sometimes not mix well in a surgery center. Spine and orthopedics are specialties that continue to grow and to be integrated into centers. However, just because a center performs orthopedics cases does not mean spine will be a logical addition.

This is often the case when spine procedures cannot receive reasonable contracts from managed care payors. When this occurs in an ASC that has added spine, the surgery center is faced with the situation where both the spine and orthopedic procedures have to be out-of-network or both have to be in-network. This can cause great problems because the spine reimbursement may be horribly inadequate, a forced scenario if the center wants to be in-network for its orthopedic reimbursable cases.

ASCs should take some elements into consideration before making the decision to add orthopedics or spine to the organization.

"The focus should be integrating the appropriate specialties into a center allowing for the flow of cases, equipment and scheduling to foster greater volume and diversity in centers without orthopedics," Mr. Taylor says. "Of course, the managed care environment and contracting must be addressed and negotiations to cover implants or thresholds."

3. GI/endoscopy can be profitable if volumes are high. GI, if volumes are high enough, remains profitable for ASCs, in spite of decreasing reimbursements from third-party payors and Medicare.

"There is no question that a GI-focused single-specialty ASC can be very successful," says Mr. Tanner. "GI physicians experience an increase in their productivity due to the efficiency of the facility and the dedication and experience of the staff. With facility reimbursements where they are, ASC management is key to success. Every detail must be monitored carefully, and there is little room for error."

Mr. Tanner also notes that the use of anesthesia is becoming rapidly more common in GI procedures. "Physicians generally believe that they are more efficient and in many cases can provide an even higher quality of service," he says. "Patient satisfaction is very high [in procedures performed with anesthesia], and everyone likes having an anesthesiologist present during the procedure for added safety."

Increasingly, gastroenterologists may be required to be competent at providing anesthesia in connection with GI procedures as some payors will not pay physicians separately for theses services.

Richard Jacques, president and CEO of Covenant Surgical Partners, notes that this trend may have payors reconsidering their stance. "In my opinion, the standard of care is changing, and more payors are forced to pay for anesthesia for GI procedures," he says.

4. ENT, general surgery, gynecology and podiatry continue to grow in ASCs. Many specialties can be good additions for surgery centers, although they may be seen less frequently in the market. Four specialties that are seen more frequently in multi-specialty centers are ENT, general surgery, gynecology and podiatry.

"Although these specialties have less of a presence in the market [than some other specialties], they continue to grow," says Mr. Lambert.

5. Ophthalmology, particularly cataract surgery, remains a terrific specialty for ASCs. As with gastroenterology and endoscopy, it is critical in ophthalmolgoy that volumes be substantial and the surgery center handle a good deal of volume to make it make sense. That stated, it remains an important specialty. It is also not heavily reliant on managed care contracts because it is so heavily dependant upon Medicare. Even thought it is Medicare dependent, with proper case volumes, it can be quite successful.

6. Bariatrics can be profitable, but it does not constitute a majority of ASC business. As the obese population of the country continues to grow, many ASCs may consider adding bariatrics to their centers. This can be beneficial as the patient pool will continue to grow, and recent studies have demonstrated the safety of bariatric procedures performed in the outpatient setting.

"Bariatrics can make money, but I have not typically seen it constitute a large percentage of service in ASCs," Mr. Lambert adds.

Tom Michaud, chairman and CEO of Foundation Surgery *Affiliates*, notes that some advances in surgical procedures have made bariatric procedures feasible in the ASC setting. "We have both ASC and physician-owned hospitals performing band procedures with most of the procedures being performed at our hospitals. Some (lower BMIs, no/minor co-morbidities) are performed in some of our ASCs," he says. "In some cases, a procedure known as the 'gastric sleeve' has supplanted the band; it is a less expensive, 'simpler' procedure that has had good outcomes.

"It is our understanding the both Johnson & Johnson and Allergan (the major band companies) are mounting significant marketing campaigns in an effort to bolster market share. I think you will see some growth in the number of bands performed in ASCs, mostly on the healthier patients. Don't forget, most of these patients come from 'weight programs' and these programs will not just hand the surgical intervention phase of the program to an ASC (or surgical hospital for that matter) without some involvement."

However, bariatrics, like many other cosmetic specialties, has suffered due to the recession. In any specialty where patients pay a great percentage of the bills directly, there has been a significant down turn in total business. For example, it was reported that the LASIK industry saw a down turn from 1.4 million procedures in 2007 to approximately 700,000 in 2008. Bariatrics and other cosmetic specialties that depend on patient pay face similar challenges.

7. Cosmetics/plastics are often problems for ASCs; bundling arrangements with surgeons for cash patients can be very difficult. Plastics, at least cosmetics-driven plastics, are often problematic for ASCs. In many situations where the physician bills globally, the ASC and physician can be adverse to each other and the ASC must negotiate its own rates with the surgeon.

"It is critical to use a time-based fee schedule in increments of 15 minutes with discounts built so that a case taking one hour is relatively more expensive than a three-hour case," says Mr. Zasa. "Also, if a surgeon starts late and the center incurs overtime, the overtime should be built into the fee unless the start time is not the fault of the surgeon. Finally, consistent cost tracking by physician is mandatory if a center performs plastics.

"The idea is to effectively reward faster, more efficient surgeons and penalize slower surgeons," he says.

According to Ms. Sturm, it is common for some surgeons (for example, plastic surgeons) to approach a surgical center with a suggestion to bundle fees for cash patients.

"The surgeons suggest that the patient pay the cash to the surgeon, and then the money will be allocated out to the ASC, anesthesia, etc. More often than not, the surgeon will ensure that his/her fees are covered first, and any deficits end up being borne by the other parties," she says. "The ASC needs to protect its interests with payment from the patient as a separate transaction."

Physician issues

1. An ASC can have too many physician investors. An ASC can have too many physician partners. With too many physician investors, there is often a dilution of individual physician responsibility and ownership interests. Without sufficient ownership, physician investors often lose their commitment to the ASC and look for other alternatives.

2. Loss of a few physicians is not fine. Surgery centers are increasingly becoming businesses that may profit when they hit a critical mass and perform more than a threshold number of cases. In the past, a few lost physicians could be easily replaced by other free physicians. However, there seem to be fewer and fewer independent and free surgeons available. Thus, each surgeon is starting to have more impact than each used to have.

"Many ASCs operate in mature markets where the majority of surgeons are committed to their operating facility," says Rick DeHart, CEO of Pinnacle III. "Therefore, losing a surgeon and easily replacing him is a difficult task. I believe that ASCs need to continue to work hard on customer relations to maintain their physician bases. There are too many choices in today's environment."

3. Physician buy-in is crucial. In order for an ASC to be successful, physicians need to be on board with the organization's mission and goals so that operations run smoothly.

"Physicians have to buy in, and administrators need to keep them informed," says Ms. Moncrief. "Provide them with updates on things they may not want to hear, but need to know to stay in the loop."

Communication is critical to an ASC's success, and Ms. Moncrief advises ASCs to make sure physicians understand the actual operations of the ASC compared with what may be a different view of them held by physicians. "You need show them where you are, but also understand where they are coming from," she says.

Mr. Williamson agrees that a good physician-ASC relationship is crucial. "Physician-client respect is part of the five point circle of excellence I stress at all of our centers," he says. "We try to have a daily focus on the physician as a customer and to address their needs."

One way to keep physician relationships strong is by maintaining a good, consistent staff. "Don't let a physician get familiar with just one team," Ms. Moncrief suggests. "Let them use all the teams so that they are comfortable no matter who is in the OR." She notes that by keeping turnover low, physicians will stay happy because they will cut down on the time needed to train new staff members.

4. Surgeons must commit. When a surgeon is party to multiple different surgery centers or when surgeons do a great deal of their cases in their offices, it is a sure sign of problems for a surgery center. Surgery centers built around

and planned for a small number of committed physicians are better than surgery centers built around many physicians with little commitment. Where a surgery center is built around a handful of physicians who are heavily committed to the surgery center, it is easier to standardize costs, set schedules and build an efficient surgery center. In contrast, where a surgery center has 40 different physicians each performing 20-50 cases annually, it is incredibly hard to manage costs and schedules or otherwise keep a staff in sync with the surgeons.

Establishing an ASC

1. Developing a solid business plan is more essential than ever. In the past, ASCs could be developed without a solid end goal in sight prior to looking for financing. The credit crunch and other factors, such as new state regulations, have made accessing capital more difficult for de novo centers. As a result, parties interested in developing new centers should craft a solid plan before looking for financing.

Mr. Southwick suggests working from the endpoint back, meaning developers should consider what their ultimate goal is for the center prior to creating any plans. "Write your goals down," he says. "Do you want to be a community asset? Are you looking to create more competition in the market? Are you open to partnering with other physician groups or competitors, such as the hospital or other centers? Establishing your end goal will help guide development. If you work from the front end back, you run the risk of having a pipe dream full of ambitions and run the risk of making bad decisions."

By establishing your end goals, Mr. Southwick says it will be easier to create next steps, such as assessing risk and how day-to-day operations will work. Additionally, you can gather a team of experienced developers, consultants and managers prior to looking for financing.

"[De novo ASCs at the planning stage] are vulnerable, and you can face disappointment because you may not get financing with an undeveloped plan," Mr. Southwick says. "By working from the endpoint, you avoid making some mistakes since you are forced to think things through. Through the extra work and diligence, you can have a successful center and avoid becoming a turnaround or less than successful ASC."

2. Do not overbuild. ASCs should only build to the size they need to meet expected volume and specialty needs. Overbuilding can result in a center's demise. A center with substantial fixed building and equipment costs will likely face long-term cost problems. There are not many things that can predict the long-term death of a center more than over-expenditure on fixed building costs and fixed equipment costs. These are costs that almost never go away. Where appropriate and fiscally viable, an ASC may consider building to accommodate future growth but this should be done with caution.

"The best way to make sure you do not overbuild is to let data drive the process of determining the scale of the facility," says Kenneth Hancock, president and chief development officer of Meridian Surgical Partners. "Determine the net transfer of cases from the physicians to the new center by analyzing billing reports and conducting in-depth interviews with the physicians to validate the information and gain additional intelligence."

3. Hospital partners can be beneficial. A hospital partner can make it easier to obtain contracts and recruit physicians, and offer several other benefits.

"In some cases, a hospital can contribute to securing better payor contracting," says Mr. DeHart. "This depends on the hospital's experience with ASC contracting and the amount of leverage it is willing to apply based on its other agreements. The other benefits could include supply purchase agreements and shared service

agreements (i.e., bio-med service, housekeeping, maintenance, etc.). Also a hospital partner can add benefit to efforts such as physician recruitment, physician referrals and community support.

However, it is important to note that the extent of the benefit that a hospital can provide to an ASC on managed care contracting is quickly declining.

It is also important for surgery centers when entering into partnerships with hospitals to be seen as a separate entity, not just another department in the hospital, according to Ms. Sturm. "Physician shareholders, board members and managers must protect the ASC as a separate and distinct entity. The most important reasons to be protective of this distinction are culture and efficiency," she says.

4. Many ASCs still fail. Despite their growth throughout the country (nearly 6,000 total ASCs in 2009; more than 5,300 Medicare-certified ASCs currently), a number of ASCs still fail. The failures occur mostly due to bad management, overstaffing, low volume, poor reimbursement or overbuilding. Knowing the risks involved in developing an ASC can help to ensure that your ASC will prosper and not fail. Working with experienced managers in developing a center can also help prevent failures.

5. Long-term debt and high expenses can be crippling. We use two words to describe long-term debt and high real estate costs: cautious and crippling. Centers must be extremely cautious about taking on significant long-term debt.

When somebody on your team says, "Let's relocate a profitable center and spend $4 million to do so," it is important to become very cautious. It is a time to be careful on fixed expenses that cannot be varied up and down with the revenues of the facility.

Legal and regulatory

1. Anti-kickback statute issues. Surgery centers must continue to be very careful with respect to anti-kickback issues. There continues to be great caution as to how ASCs use the anti-kickback safe harbors for potential redemptions. Generally, all surgeons should be treated the same way. The surgeons should be offered the non-adverse price, and they should be offered reasonable time to cure potential lack of compliance with the safe harbor. A great deal more thoughts can be placed on this issue; this is a very simple overview of some of the concerns.

2. Review anesthesia relationships with care. Increasingly, surgery centers attempt to profit from the delivery of anesthesia services. These agreements raise several legal and regulatory issues. These relationships should be reviewed carefully for compliance with the anti-kickback statute.

3. Leasing equipment from physician investors is often a bad idea. While it can look attractive, leasing equipment from entities owned by ASC physicians is often a legally risky business. These arrangements can be viewed as thinly veiled disguises to incentivize physicians to use the centers, arrangements generally viewed by the government as illegal. As such, these arrangements, as a rule, should be supported by a fair market value (FMV) analysis, make business sense regardless of referrals and preferably be set as a fixed annual fee and not "per-click."

But it's important to note that the use of a fixed fee can create a new set of problems, says Mr. Mello.

"For example, let's assume that the fixed fee assumes a particular level of volume/ activity (e.g. 100 procedures per year) and the FMV per click fee is determined to be $250," Mr. Mello says. "Using these numbers would result in a flat fee

of $25,000 per year. However, what happens if actual volume is only 50 (i.e., as opposed to 100)? Then assuming a fixed fee of $25,000, the equivalent 'per click' fee is now $500, which is greater than FMV. Accordingly, in the context of non-exclusive equipment/tech use arrangements, we favor a per-click fee and have performed dozens and dozens of these types of FMV analysis for lithotripsy, green light and holmium laser arrangements throughout the country.

"If, however, the equipment is exclusive use to the ASC and is not moved in and out as needed, then a flat fee reasonably consistent with what the ASC's annual lease expense would be if it were to lease it directly from a third-party equipment vendor (i.e., as opposed to an MD-owned venture) would be appropriate," he says.

4. CMS's new Conditions for Coverage will add responsibilities. CMS's new Conditions for Coverage for ASCs went into effect on May 18 and the new regulations may present some additional challenges for ASCs who wish to treat Medicare beneficiaries.

"Medicare's Conditions for Coverage present many issues that we are still working hard to understand and find reasonable ways to comply," says Ms. McLane.

"Compliance with the requirements will be more complex than it was previously," says Mr. Chopra. "The new Conditions for Coverage certainly raise the bar on collaboration with physicians to ensure timely and accurate patient communications."

The impact of the Medicare payment change on specialties such as GI and pain are just becoming as we move into the next phase of bundled rates.

5. RAC audits and Red Flags Rule. ASCs will be required to meet increasing compliance requirements from government agencies such as the RAC audits from the OIG and the FTC's Red Flags Rule, which ensures further HIPAA protection for breaches of electronic information.

In order to meet these demands and to respond to decreasing caseloads or streams of revenue, Ms. Serbin says an internal audit of an ASC's billing processes is necessary. She suggests performing audits at least on a monthly basis can help determine negative trends preventing an efficient collection process for ASCs.

"First, be sure you have clear and concise billing process guidelines (policies/procedures) and make sure employees have copies and are following these. Address each area of the process with separate audits. Randomly choose at least 5 percent of your caseload (minimum of 10 cases) each month," Ms. Serbin says.

Ms. Serbin notes the following areas which should also be addressed in internal audits:

Check for accuracy and need for additional CPTs, diagnosis codes and/or modifiers in coding. This auditing process may have to be outsourced to certified coding experts.

Audit your biller for accuracy of posting CPTs, diagnosis codes and modifiers and determine how long after receiving from coder the claim was submitted. Audit to make sure up-front adjustments are done correctly.

Audits to determine the accuracy of payment and adjustment posting, transferring of balance and sending secondary insurance claims and/or patient statements. Timeliness of refund requests and request to payers for correction of underpayments or overpayments should also be audited.

Check to see how long the first follow-up from collections takes. Check on accuracy and timeliness of appeals. Check on appropriate pre-collection efforts.

Technology

1. Leveraging Internet-based tools can help ASCs improve service and business operations. Many stakeholders are involved in a patient's care at ASCs and other healthcare facilities. As a result, many lines of communication are open and constantly transmitting information. According to Ron Pelletier, vice president of market strategy for Source-Medical, the healthcare industry, including ASCs, has not fully leveraged Internet tools available to them to streamline the extensive communications and transactions that go into patient care.

"Take, for example, the process in which an ASC must obtain insurance eligibility and benefit information for a pending case. Many facilities are still spending countless hours phoning in to insurers or manually retrieving data from a multitude of Web sites when they should be using available technology to automate that process," Mr. Pelletier says. "Similarly, high performing centers know that they must continually monitor and react to feedback from their patients, surgeons and staff members, yet the process for obtaining these data can be costly and cumbersome if a facility does so using outdated methods. Instead, smart centers are leveraging available Internet-based tools to gather actionable feedback in a very low-cost fashion."

Mr. Pelletier says that ASCs are moving rapidly to deploy the Web-based tools that are available to them, including e-billing patient portals, clinical assessment tools and surgeon portals.

2. Online patient surveys can help efficiently collect data for ASC improvements. Surgery centers have increased their use of patient survey feedback to drive quality- and process-improvement initiatives. Most ASCs use some sort of survey to gage the performance of the center's staff and the patient's perceptions of the center. In turn, ASCs can use this information to make improvements.

Historically an in-house practice, patient surveying is rapidly being outsourced to increase efficiency of staff time and improve feedback, according to Paul Faraclas, president and CEO of CTQ Solutions.

"Many of our clients had nurse executives spend significant time entering survey data in Excel," Mr. Faraclas says. "Developing reports was time consuming, and the presence of industry benchmarks was absent. The ASC's ability to reallocate this time to core leadership activities while receiving more patient feedback quickly made the transition to third-party surveying a no-brainer."

Mr. Faraclas has noted a trend in ASCs using online surveying to also assist in efficient collection of patient survey data. "Surveying online provides the advantage of immediately taking action. This contributes to the ASC's ability to mitigate risk and improve the patient experience concurrently."

3. EHR can help streamline an ASC's processes. Although implementation of an electronic health records system can be expensive, many ASCs have experienced cost savings as a result of streamlined billing processes and reduced need for paper and storage the EHR can provide.

Ms. Gilbert notes some other benefits ASCs can experience from implementing an EHR system can include streamlining documentation workflow, increasing patient throughput and eliminating the need for data re-entry and chart pulls. "One of our clients has gone completely paperless through the use of an EHR," she says. "They've eliminated two hours a day in FTE time that was previously spent just on chart pulls and three hours a day they used to spend on data re-entry, manually keying procedure information into their electronic record system."

Mr. Pelletier says EHR systems can help to reduce errors and improve quality of care overall in additions to the benefits mentioned above. "I am often asked by clients about what steps they should take in order to successfully implement an EHR. This topic warrants a book in and of itself, so I often tell users that perhaps the most common trend I see in successful projects is that the facility did a remarkable job managing change," he says.

4. Not all information technology systems are equal. Whether implementing an EHR, a scheduling program, a billing system or a fully integrated IT system, ASCs should put due diligence into determining which IT system works best for them. Although many companies offer similar products, you should be willing to research companies to learn what they offer and how their services can best benefit your ASCs.

"You have to get out there and kick the tires," Ms. Gilbert says. "Ask for references. Visit other sites that are using the software and watch it in action. Have a very clear idea going into a purchase of what your objectives are. An EHR isn't going to solve the world, but if you've identified key measures for improvement — such as compliance with AAAHC regulations, improving room turnover by a certain percent or tracking key quality indicators — you'll be able to evaluate software solutions based on how they meet your specific objectives."

Ms. Gilbert also suggests bringing clinician users in on the front end. "If physicians will be using the software, let them evaluate it and weigh in. If nurses will be using a charting solution, make sure they're satisfied with the solution you've selected. Without high clinician end-user satisfaction and adoption levels, you won't see a fast, solid return on your investment," she says.

5. Technology and familiarity drive the ASC model. The ASC model is not yet mature, as surgeries continue to move to less invasive procedures suitable for the ASC setting. According to Mr. Chopra, new technologies and innovations drive growth and prosperity for ASCs.

Additionally, more common procedures are moving from the hospital to ASCs, providing patients with a more cost-effective option for a familiar procedure, Mr. Chopra says. "As these technologies improve, ASCs will be the natural progression for more and more procedures," he says. "This makes ASCs a good place to be for the next three to five years." ■

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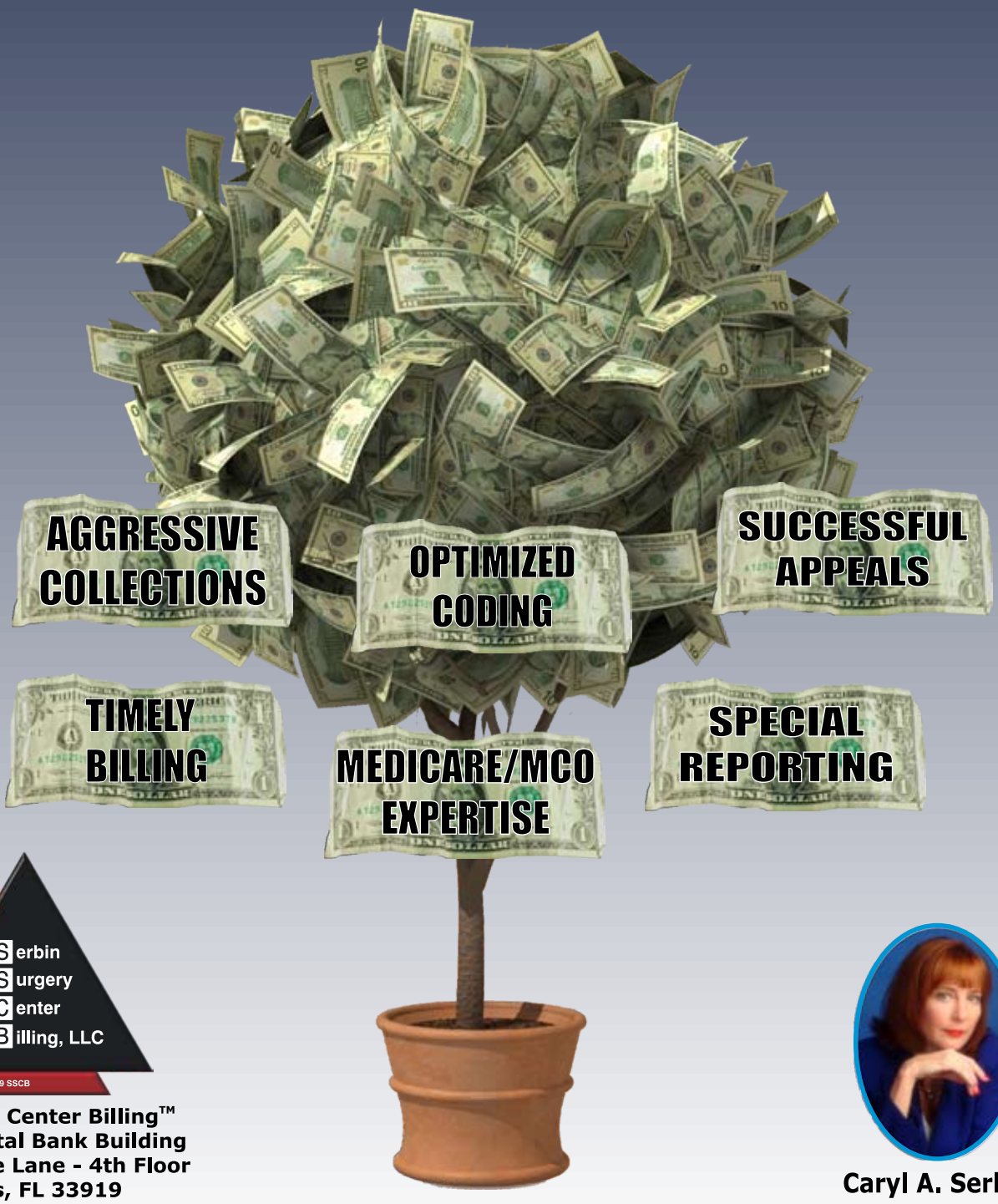

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16 Coding, Billing and Collections Best Practices

By Lindsey Dunn and Renée Tomcanin

2 Tips for Using Modifier -50

Modifier -50 is used to indicate that a procedure has been performed on both sides of the body during the same operative session. However, the modifier can present challenges to coders who are unsure about which specific procedures its use applies to.

Dawn Waibel, director of operations at Serbin Surgery Center Billing, and Laurie Spinner, compliance and quality improvement specialist at SCB, provide two tips for using modifier -50.

1. Do not add modifier -50 to procedures that are, by definition, bilateral. One of the biggest mistakes made by coders concerning the use of this modifier is adding it to procedures that are already understood as bilateral, says Ms. Waibel. For example, CPT 58671 (occlusion of oviducts by device) should not include modifier -50 as the procedure is the occlusion of both oviducts, therefore making it bilateral.

2. Make sure that how you report the modifier meets the payor's guidelines. The proper way to report a bilateral procedure varies by state and payor, according to Ms. Spinner. Although most payors call for straightforward use of modifier -50, reported after the CPT code on one line, some may prefer that the modifier is reported on two separate lines. Typically, a "1" in the unit box is used after the modifier; however some payors may require the use of a "2" in the unit box. Therefore, it is important that coders know the reporting preferences of each payor so that claims are not denied due to coding errors.

3 Questions and Answers on Handling Appealed vs. Corrected Claims When initial claims to payors are denied, billers may either appeal the claim or submit a corrected claim in order to seek reimbursement for the services rendered. In order to ensure that providers receive reimbursement, billers must be aware of the differences between appealed and corrected claims and follow state and payor guidelines for submitting both.

Ms. Waibel and Ms. Spinner address three questions regarding appealed and corrected claims.

Q: What is the biggest mistake billers make when processing appealed and corrected claims?

A: Sending a claim through the appeals processes when it could have been sent as a corrected claim is common. Also, when submitting appeals, billers must include enough documentation to support the reason for the appeal. Often, billers do not include enough documentation in these claims.

Q: What is the difference of an appealed vs. a corrected claim?

A: When appealing a claim, you are advising the carrier that the codes billed are correct, and you are providing documentation showing that the codes are reimbursable as billed. When filing a corrected claim, you are advising the carrier that you would like to amend the CPT, ICD-9 and HCPCS codes originally billed. Knowing the difference and using the correct claim form are important so that the claim is reprocessed correctly and in a timely manner.

Q: What steps should billers take when processing appealed vs. corrected claims to ensure they are correctly submitted?

A: For a corrected claim, the appropriate changes should be made to the CPT, ICD-9 or HCPCS codes, and the bill type should be changed to reflect a corrected claim. Claim form 837 is typically used for corrected claims. If the bill type is not changed, it could be denied as a duplicate bill. The corrected claim should then be submitted electronically to ensure the quickest processing.

For an appealed claim, you must supply documentation to support your appeal. Make sure to include the operative note, any relevant CCI edits, the invoice, your official letter of appeal and a copy of the original claim. There are state-specific guidelines that can be used as well as payor-specific appeal processes.

Learn more about Serbin Surgery Center Billing at www.ascbilling.com.

3 Best Practices for Reducing Electronic Claim Rejections

Lisa Rock, president and CEO of National Medical Billing Services, says that rejection of claims due to errors in the electronic submission process can be reduced by three simple practices.

1. Know the electronic pathway of claim submissions to every payor. Ms. Rock recommends that billing managers chart the path of electronic claim submissions for each payor. Electronic claims are sent from providers to the provider's EDI company and, in some cases, on to several trading partners before the claim reaches the payor. The longer the path the claim takes, the more opportunity for errors. For example, an ASC may use an EDI company that does not have a direct contract with a certain payor. If that is the case, the EDI company would send the claim to a trading partner, which may or may not have a direct contract with the payor. If the trading partner does not have a direct contract, the claim would go to yet another trading partner before reaching the payor. Knowing the pathway of claims can also give billers a better idea of how long claims will take to reach payors, says Ms. Rock.

Billing managers can begin to chart the path by following a claim from the healthcare provider to the provider's EDI company and then determine if the claim goes directly to the payor or to an additional clearing house or trading partner. "For each payor, call your EDI provider and ask if they

have a direct contract with that payor. If they do not, ask where they send the claims next," says Ms. Rock. "After you determine where it goes next, call there and ask if they have a direct contract with the payor, and so on."

Ms. Rock recommends that in order to reduce the number of steps in these pathways, ASCs should seek out EDI companies that have direct contracting agreements with most, if not all, of the facility's primary payors.

2. Review rejection reports. Ms. Rock also recommends the ASCs review all electronic claim rejection reports daily so that they can determine where in the pathway the claim was rejected. Reviewing reports will allow billers to determine if the cause for the rejection was in-house or with a certain clearinghouse and trading partner. For example, reviewing the report would allow a biller to see that a claim was rejected due to an error by the provider's billing team rather than along the pathway. If errors are made along the pathway, reviewing the report will highlight where along the pathway the claim failed to move forward.

"Maybe a claim was rejected because of an ID error by your receptionist, but if you don't read the rejection report, you don't know that it was rejected out of the first stage. It didn't even make it out of the gate," says Ms. Rock.

If errors were indeed introduced by the provider's staff, billing managers can take steps to improve processes and reduce in-house errors. If errors appear elsewhere along the pathway, billing managers should determine why the claims were rejected at that point and call the clearing house or trading partner to investigate further, if necessary.

Ms. Rock says that the most common rejections are for invalid subscriber ID numbers; missing subscriber date of birth if different from patient; invalid diagnosis code; and demographic errors, such as misspelled names.

3. Actively investigate any patterns in claim rejections. Finally, Ms. Rock suggests that if providers notice several rejections at the same point along the pathway for a particular payor, they should actively investigate the issue.

"There was one instance where there was a problem between our clearinghouse and a trading partner, and our claims weren't getting to the trading partner," says Ms. Rock. "We received confirmation that they were received by the EDI company, so we assumed they were going through. There ended up being a glitch in their system that was holding up our claims."

Ms. Rock says that without regularly reviewing rejection reports, the provider would not have been aware of the error in a timely manner as the clearinghouse did not contact the provider. By being aware of errors and actively investigating them, providers help to ensure that their claims reach payors in a timely and can take steps to change pathways or claims processes if errors continually occur.

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

3 Common Surgery Center Billing, Coding and Collection Mistakes

Simple billing, coding or collection mistakes can affect the overall profitability and efficiency of an ASC. Brice Voithofer, vice president of anesthesia and ASC services for AdvantEdge Healthcare Solutions, shares his insight on the top three billing, coding and collection mistakes he sees at ASCs.

1. There is no automated denial management system. Receiving denials from payors is one aspect of the billing and collections process surgery centers deal with on a routine basis. However, Mr. Voithofer says many ASCs fail to implement a system of tracking and trending for these denials, which is, in his opinion, the most common mistake ASCs make when it comes to their billing practices.

"Most surgery centers will fix the individual denial, resubmit the claim and in many cases eventually receive payment," Mr. Voithofer says. "But, they don't aggregate these denials in a report to see what the root causes of the denials are."

Mr. Voithofer suggests developing denial reports so that the center can look at denials by payor, surgeon, referring physician, procedure, etc. "Centers can use these reports to pinpoint where errors and omissions that most frequently result in denials occur and then attempt to reduce those mistakes through education," he says.

Gathering data on the number and dollar amounts of denials can also provide ASCs with additional information when discussing problems with payors or surgeons.

"If one payor is consistently denying claims, arrange to meet with that payor to change the activity," Mr. Voithofer says.

2. One staff member is responsible for the duties of many.
Surgery centers often only employ one or two coders and/or billers to handle all of the functions of the billing office. According to Mr. Voithofer, this can lead to errors due to the volume and variety of work the billers are required to do.

"Typically, centers find one or two employees to perform all functions, and they expect that single person to be an expert in all of them," Mr. Voithofer says. "This rarely works. We typically see that they will excel at some, but fail at others; a Jack of all trades is a master of none."

While some centers are able to work well with just a few billers and coders, Mr. Voithofer notes that in other centers something — compliance, cash collections, etc. — will usually suffer as a result. Adding staff or outsourcing some operations may be justifiable if a decrease in errors and increase in efficiency leads to improved financial results that cover these costs.

3. Inaccurate dictation can lead to underbilling or overbilling.
Coders rely on accurate dictation of procedures from surgeons so they can bill appropriately for them. Mr. Voithofer says that many times coders will bill correctly for the main procedures but miss add-ons if the report is not clear.

"Dictation and transcription are often done quickly so they can get to billing," Mr. Voithofer says. "However, ASCs can take these missed add-ons as opportunities to educate staff members and find more revenue."

Mr. Voithofer suggests having coders sit down and look over reports with the surgeons every six months.

"The coder can say to the surgeon, 'When you do this procedure, you missed these steps in the report,'" he says. "Or the coder can help to point out trends in the surgeon's procedures. By looking over the reports, the coder and the surgeon can try to create a thorough report so that centers are not over- or under-billing."

Mr. Voithofer does caution that the purpose of this analysis is to address deficiencies in documentation, not to look for an opportunity to "pile on the charges." Clinically appropriate documentation and coding is the objective.

Learn more about AdvantEdge Healthcare Solutions at www.ahsrcm.com.

5 Best Practices for Improving Your Revenue Cycle

Providers who want to improve their revenue cycle should follow the following five best practices, offered by SmartFund Medical, a complete revenue cycle management solution, for their coding, billing and collections.

1. Educate patients on their share of costs upfront. As patients' deductibles increase and more patients enroll in high-deductible health plans, healthcare providers will see more patients who will be forced to pay a significant portion of their healthcare costs out of pocket. As a result, healthcare providers should prepare for this change and work to educate patients about how much money they will owe for a procedure before the day of surgery.

"Set the expectation on the front end that they're going to owe a balance. Patients, in general, want to pay for their share of the services. However, if you send them a bill for several thousand dollars in the mail 4-5 months after a surgery, the bill is unexpected and they may not have the means to pay it," says Dennis Keaton, patient payment program manager for SmartFund Medical.

According to Jennifer McLeod, medical implementation manager, many providers try to avoid discussing costs upfront in fear that it will deter patients. However, she says that educating the patient upfront is one of the easiest ways that providers can improve their collections on the back-end.

2. Offer payment plans before services are rendered. After explaining to patients what they will owe, ASCs should offer payment plans before services are rendered. Payment plans allow patients to pay their out-of-pocket expenses over time and budget for these expenses each month.

"With payment plans, patients are set up on defined payments. They are expecting the bill each month, and they can budget for it, along with their other monthly expenses, such as a car or house note," says Mr. Keaton.

3. "Scrub" claims for errors before submitting. SmartFund Medical uses the phrase "scrubbing out claims" to describe their process of reviewing claims for errors before submitting them to payors. "Reviewing all claims for compliance issues, diagnosis issues and other possible coding errors greatly improves the chance of having a clean claim, which reduces days in A/R and increases your receivables," says Ms. McLeod.

4. Monitor the status of claims. Many healthcare providers who outsource claims fail to monitor the status of individual claims and instead rely only on monthly statements to assess their revenue cycle. "When you're turning over your billing and coding to a third party, sometimes you may not ever see a claim again until it shows up on a monthly statement," says Casey Sullivan, marketing director. "Providers should try to find outsourced solutions that allow them to see the status of claims at anytime they wish. This gives practices a much better idea about their cash flow."

5. Don't blame it on collections. Many healthcare providers are quick to blame poor collections processes for outstanding A/R. "In reality, however, issues with billing are usually the problem. If you have $500,000 in outstanding insurance A/R, you clearly have a billing problem," says Mr. Keaton. "Providers can improve their revenue cycle by not denying the problem and beginning to look at what's going wrong on the billing side." ■

Learn more about SmartFund Medical at www.smartfundmedical.com.

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

See more coding, billing and collections coverage at www.beckersasc.com/coding-billing-and-reimbursement.

10 Observations About Anesthesiologists From Incoming ASA President Dr. Alexander A. Hannenberg

Alexander A. Hannenberg, MD, who will become president of the American Society of Anesthesiologists during its annual meeting in October, discusses 10 facts that every surgeon or hospital executive should know about anesthesiologists.

1. We are very attuned to OR efficiency. Anesthesiologists are looking at the entire operation of the OR, from pre-op through post-op. Because we are personally concerned with keeping the enterprise on schedule, we have become efficiency experts. If things slow down pre-op or post-op, it affects the whole OR schedule. Since our concerns are so closely aligned with those of the hospital, hospitals are increasingly appointing anesthesiologists to manage OR operations.

2. We have unusually low Medicare and Medicaid reimbursements. Medicare and Medicaid typically pay below commercial rates, but nowhere is the difference so profound as in anesthesiology. While Medicare generally pays 80-85 percent of commercial rates for physician services, the figure is only 30-35 percent for anesthesiologists. Therefore, hospitals in communities with large numbers of Medicare beneficiaries have had to subsidize anesthesia services, paying stipends to anesthesiologists.

3. We work in increasingly more settings. In addition to the hospital OR, anesthesiologists now work in ASCs and in cardiology, endoscopy and imaging sites, to name a few. This profusion of sites increases demand for our services and, because we have to travel to different sites, diminishes our efficiency.

4. We are in tight supply. Anesthesiology residency programs are just getting back up to the numbers they had in the early 1990s, before there was a panic about an impending nationwide glut of anesthesiologists. This panic prompted the supply of new anesthesiologists to take a nosedive. We've seen a 50 percent increase in anesthesiology residents in recent years, but that's not really growth; it's a recovery.

5. We face more serious shortages in the future. Recent physician supply studies predict serious shortages not just of primary care physicians but also of specialists, including anesthesiologists. Not only will an aging population need more surgery, but health reform would greatly expand demand for anesthesiologists and other specialists. When everyone has to have insurance, the immediate effect would be a great uptick in demand for primary care physicians because the newly insured would seek out a doctor for their general care. But later, when these same people actually need care, they will be seeking out specialists and that will put our specialty in very short supply.

6. We need to continue medically directing non-physician anesthetists. Greater demand for anesthesia care should not diminish the medical role of the physician. Anesthesia care teams, including certified registered nurse anesthetists and anesthesiologist assistants, who are PAs, will be key to delivering care. Both groups are capable physician-extenders when under the medical direction of an anesthesiologist.

7. Rural hospitals need us, too. Medicare currently reimburses rural hospitals with low volumes of surgery for CRNA services without anesthesiologists. We at the ASA believe Medicare should offer similar support to anesthesiologists so that these rural communities can also benefit from physicians' care in anesthesia services.

8. We are embracing clinical outcomes data. The ASA supported the work of the Anesthesia Quality Institute, which has established a national clinical outcomes registry to identify patterns of adverse anesthesia outcomes and allow anesthesiologists to benchmark performance with peer is starting to materialize. We think it will be a valuable tool for quality improvement, using scientific investigation to establish best practices.

9. Anesthesia is ripe for information technology. Anesthesiology is even more adaptable to information technology than other areas of healthcare because perioperative information derived from anesthesia monitoring systems is basically a collection digital data. When these data are aggregated, they are a powerful tool to study patient outcomes and responses to anesthesia care. We are making great strides to achieve interoperability between different systems so that all this information can be connected.

10. We need more funding for research. Anesthesiology lags behind other specialties in research funding from the National Institutes of Health. Critical clinical issues within the specialty — such as cognitive dysfunction, chronic pain and awareness — demand aggressive investigation. ■

Operating Expense Analysis Per Case for Surgery Centers by Total Case Volume

Here are the average operating expenses per case for surgery centers organized by a center's total case volume, according to VMG Health's *2009 Intellimarker.*

1. Total operating expenses
   - All facilities — $1,293.60
   - Less than 3,000 cases — $1,711.03
   - 3,000-5,999 cases — $1,364.93
   - More than 5,999 cases — $1,193.78

2. Employee salary and wages
   - All facilities — $326.55
   - Less than 3,000 cases — $425.59
   - 3,000-5,999 cases — $380.97
   - More than 5,999 cases — $295.96

3. Medical and surgical
   - All facilities — $294.58
   - Less than 3,000 cases — $285.72
   - 3,000-5,999 cases — $307.60
   - More than 5,999 cases — $284.08

4. General and administrative
   - All facilities — $234.18
   - Less than 3,000 cases — $332.11
   - 3,000-5,999 cases — $256.48
   - More than 5,999 cases — $211.53

5. Occupancy costs
   - All facilities — $89.03
   - Less than 3,000 cases — $165.41
   - 3,000-5,999 cases — $90.98
   - More than 5,999 cases — $76.52

6. Taxes and benefits
   - All facilities — $70.51
   - Less than 3,000 cases — $82.62
   - 3,000-5,999 cases — $76.34
   - More than 5,999 cases — $63.94

7. Other medical costs
   - All facilities — $13.65
   - Less than 3,000 cases — $20.58
   - 3,000-5,999 cases — $7.24
   - More than 5,999 cases — $22.08

8. Insurance
   - All facilities — $12.19
   - Less than 3,000 cases — $16.93
   - 3,000-5,999 cases — $14.13
   - More than 5,999 cases — $9.94 ■

To receive a free copy of VMG Health's 2009 Intellimarker, visit www.vmghealth.com.

10 ASCs Performing More Than 10,000 Procedures Annually

By Lindsey Dunn

Ambulatory Surgery Center of Spartanburg (Spartanburg, S.C.). Ambulatory Surgery Center of Spartanburg is a joint-venture ASC between local physicians and Spartanburg Regional, an integrated healthcare delivery system based in Spartanburg, S.C. Physicians at the ASC of Spartanburg perform more than 11,000 procedures annually in a variety of specialties including ENT, GI, orthopedics, general surgery, podiatry, gynecology and ophthalmology. The AAAHC-accredited ASC features seven operating rooms and two endoscopy suites.

Michael Pankey, RN, MBA, administrator, says that the ASC's success can be contributed to its great staff. "The environment is one of cooperation and teamwork," he says. "In the upcoming year, the center looks forward to maintaining its reputation of excellence in the community and continuing to provide high quality care to patients.

Center for Ambulatory Surgery (West Seneca, N.Y.). Center for Ambulatory Surgery is a partnership between 15 local physicans and The C/N Group. The ASC performs approximately 14,000 procedures annually. The 18,000 square-foot ASC opened in 2001 and features four operating rooms and five GI suites. The multi-specialty ASC provides care in a variety of specialties including GI, orthopedics, ophthalmology, general surgery, urology, ENT, gynecology and podiatry.

Central Louisiana Ambulatory Surgical Center (Alexandria, La.). Central Louisiana Ambulatory Surgical Center is a multi-specialty facility with six operating rooms, two GI suites and one procedure room. Physicians at the ASC practice a number of specialties including orthopedics, interventional pain management, ENT, plastic surgery, gastroenterology, podiatry, urology, ophthalmology, neurosurgery, gynecology, general surgery and dental surgery. The physicians performed approximately 15,000 procedures in 2008. CLASC has been in operation since 1985, and expanded in 2005, transitioning from a 10,000 square-foot facility to a 30,000 square-foot facility.

Kentucky Surgery Center (Lexington, Ky.). Kentucky Surgery Center is a multi-specialty ASC that performed nearly 11,000 cases in 2008 and is on track to do so again in 2009. The ASC opened in 1986 and moved to a new facility in 2006, which features seven operating rooms and three procedure rooms. The ASC specializes in ENT, orthopedics, gynecology, plastics, podiatry, oral surgery, endoscopy, pain management, urology and general surgery.

According to Glenda Beasley, RN, administrator, the center's success is largely due to the hard work of the ASC's staff and physicians. "In an outpatient surgery center, the atmosphere is much more structured and organized, and the staff thrives on routine," she says. "The staff has the ability to deliver the best patient care that can be offered in a healthcare setting." Additionally, she considers many of her staff to be family. "I depend on these key people each day. The center would not be as successful as it is currently without the entire management team and the hard work of all the employees," she says.

Northpoint Surgery and Laser Center (West Palm Beach, Fla.). Northpoint Surgery and Laser Center is a multi-specialty ASC that performs approximately 10,000 procedures annually. The National Surgical Care-affiliated ASC features five operating rooms, two endoscopy procedure rooms and a pain management center. The ASCs more than 50 physicians specialize in a number of specialties including ENT, GI, gynecology, ophthalmology, orthopedics, podiatry, pain, and treat both adult and pediatric patients. The AAAHC-accredited center has a seasoned nursing staff and a reputation in the community for clinical excellence. Connie Casey, administrator, says that the center's success is due to its excellent and caring staff. "I am called to a patient's bedside at least one to two times weekly to answer the question: 'How do you keep your employees so happy?' My favorite answer: 'They smile because they care!" she says.

Northwest Michigan Surgery Center (Traverse City, Mich.). Northwest Michigan Surgery Center, a joint venture between local physicians and Munson Medical Center, offers outpatient surgery to patients from 12 counties in northern Michigan. Built in 2004, the 54,000 square-foot ASC features six ORs, four procedure rooms and five 23-hour stay rooms. Northwest Michigan has 68 credentialed physicians in 16 different specialties performing more than 16,500 cases annually.

Jim Stilley, FACHE, CASC, CEO of Northwest Michigan Surgery Center, says that the success of the center is even more remarkable considering the large percentage of Medicare patients in the region and the state's certificate of need requirements. He says that the ASC's "superior level of quality, patient and physician satisfaction, incredible volume and community service" have all contributed to Norwest Michigan's success.

Michigan Endoscopy Center (Farmington Hill, Mich.). Michigan Endoscopy Center is a single-specialty ASC specializing in all types of GI procedures including colonoscopy, upper endoscopy and EGD. MEC has six operating rooms and 16 physicians who perform approximately 16,900 procedures annually. According to the mission statement of the center, MEC is dedicated to promoting high-quality endoscopic services and concentrates it services on members of the local community. The center's mission also includes promoting the accessibility of its services for all persons, with particular emphasis on improving access for traditionally under-served populations.

Short Hills Surgery Center (Millburn, N.J.). Short Hills Surgery Center is one of the largest freestanding ASCs in New Jersey at 25,000 square feet, and physicians at the ASC perform more than 10,000 procedures annually. The center features six major operating rooms, two minor operating rooms and 24 beds, including four private rooms. The center's more than 70 physician partners specialize in orthopedics, general surgery, ENT, gynecology, urology, pain management, podiatry, spine, ophthalmology and plastic surgery.

According to Nancy Easley-Mack, business office manager, the center excels due to a variety of factors, including its strong organizational leadership. "Our physicians are very committed to the success of the center. This is evident through our strong organizational leadership, which includes our medical director, Dr. Edward Decter, who is avidly engaged in all aspects of our operations," she says. The center is also committed to reinvesting in its facility and staff. "Our equipment and instrumentation are state-of-the-art, which we believe helps us achieve better clinical outcomes … All our staff members are BLS-certified and the nursing staff maintain PALS and ACLS certifications."

Springfield Clinic Ambulatory Surgery Center (Springfield, Ill.). Springfield Clinic Ambulatory Surgery Center is a freestanding ambulatory facility and is associated with Springfield Clinic. The AAAHC-accredited organization performs an estimated 15,000 procedures annually and features five operating rooms and four GI procedure rooms. The ASC serves a population of approximately 300,000 residents in 12 counties. Physicians at the ASC perform procedures in a number of specialties including orthopedics, ENT, GI, urology, gynecology, vascular, ophthalmology and plastic/reconstructive surgery.

Virginia Eye Institute Surgery Center (Richmond, Va.). Virginia Eye Institute Surgery Center is a multi-specialty ASC performing nearly 16,000 ophthalmic and ENT procedures annually. The AAAHC-accredited ASC has 27 eye surgeons and nine ENT surgeons on staff, all of which utilize block time. The center treats patients referred from any of the 13 Virginia Eye Institute clinic locations, and features five ORs as well as some of the most advanced technology available including the Argon and SLT lasers for treating glaucoma, the Opal or Photodynamic Therapy laser for retinal diseases, the Yag laser for post-cataract capsule treatment and glaucoma and the bladeless IntraLase laser and Visx Excimer laser for LASIK procedures.

According to J. Eric Hays, vice president of operations for Virginia Eye Institute, the ASC's reputation and surgical mix in addition to its long-term and dedicated staff and involved physicians all contribute to Virginia Eye's success. "Our center has been accredited since 1987 and covers all ophthalmic subspecialties. We added the ENT service line in 2003, serving patients from six months of age and up," he says. "We have a great staff with long tenure that allows a level of consistency, loyalty and pride in the center." ■

Contact Lindsey Dunn at lindsey@beckersasc.com

5 Anti-kickback Cases Making Headlines

Here are five anti-kickback cases making headlines this summer. The situations involve physicians, hospitals, device makers and pharmaceutical companies.

1. University of Medicine and Dentistry of New Jersey cardiologists. The United States Department of Justice recently brought civil cases against 11 cardiologists employed by the University of Medicine and Dentistry of New Jersey for allegedly receiving kickbacks to refer cardiology patients to UMDNJ's University Hospital, which caused the submission of false claims to Medicare. Nine of the physicians involved settled the suits, agreeing to repay at least the full amount of the salaries they received from UMDNJ, with several physicians paying twice the amount of the salaries received. UMDNJ allegedly paid part-time salaries to several cardiologists in return for referrals to the hospital while they remained in private practice. Authorities from the federal government claim that the salaries were only used as kickbacks for referrals and not for the performance of any other services to the UMDNJ or the hospital.

2. Covenant Medical Center. In August, Covenant Medical Center in Waterloo, Iowa, agreed to pay $4.5 million to resolve allegations that it violated the False Claims Act. The government alleged that Covenant submitted false claims to Medicare by having financial relationships with five physicians that violated the Stark Law, which prohibits a hospital from profiting from referrals of patients made by a physician with whom the hospital has an improper compensation arrangement. The DOJ claims that the hospital compensated the physicians at rates above fair-market value in return for referrals. Although the names and compensation levels of the physicians involved were not released, the DOJ said they were some of the highest paid hospital-employed physicians in the nation.

3. Tulare Regional Medical Center. In July, Tulare Regional Medical Center in Visalia, Calif., part of Tulare District Health System, agreed to pay $2.4 million to settle a federal whistleblower case alleging that the health system offered commercial real estate and rent at rates below fair-market value to physicians in return for referring patients to the system. The whistleblower case was filed by Maria Lucy, CFO of Tulare District Health System in 2008.

4. Endoscopic Technologies. In July, San Ramon, Calif.-based Endoscopic Technologies, which manufactures devices for surgical ablation, agreed to pay a $1.4 million to settle allegations that the company paid kickbacks to healthcare providers who used the devices. The company also allegedly participated in false marketing and encouraged false Medicare claims in order to promote the use of its products. The DOJ claims that the company marketed its medical devices to treat atrial fibrillation, a use that is not approved by the U.S. Food and Drug Administration. The government also alleged that the company promoted expensive heart surgeries using its devices when less invasive alternatives were appropriate and advised hospitals to up-code surgical procedures using the company's devices to inflate Medicare reimbursements, thereby causing the submission of false and fraudulent claims in violation of the False Claims Act. Details of the kickback arrangements were not released. The suit was filed by an unidentified whistleblower, who will receive $210,000 as part of the settlement.

5. Pfizer. Pfizer agreed to pay $2.3 billion in September to settle allegations that it illegally promoted certain pharmaceuticals and provided kickbacks to physicians for using its products. The settlement is the largest healthcare fraud settlement in the history of the Department of Justice and resolves Pfizer of both criminal and civil liability arising from the illegal promotion allegations. As part of the agreement, Pfizer will pay $1 billion to resolve allegations under the civil False Claims Act that the company illegally promoted four drugs — Bextra, an anti-inflamatory; Geodon, an anti-psychotic drug; Zyvox, an antibiotic; and Lyrica, an anti-epileptic drug — and caused false claims to be submitted to government healthcare programs for uses that were not covered by those programs. The civil settlement also resolves allegations that Pfizer paid kickbacks to healthcare providers to induce them to prescribe these, as well as other, drugs. No further detail on the types of kickbacks provided were offered by the DOJ.

Additionally, Pfizer subsidiaries Pharmacia and Upjohn pleaded guilty to a felony violation of the Food, Drug and Cosmetic Act for misbranding Bextra with the intent to defraud or mislead. Pfizer will pay a criminal fine of nearly $1.2 billion for the misbranding, which allegedly promoted off-label use of the drug for uses specifically not approved by the FDA. Pharmacia and Upjohn will also forfeit $105 million for the Bextra charges, bringing the total criminal resolution of $1.3 billion. The case was brought forth by an unidentified whistleblower who will received $102 million from the settlement. ■

Contact becker@beckersasc.com.

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15 Great Single-Specialty ASCs

By Lindsey Dunn

Editor's note: ASCs are listed in alphabetical order by facility name.

Alabama Digestive Health and Endoscopy Center (Birmingham, Ala.). Alabama Digestive Health and Endoscopy Center is single-specialty ASC specializing in gastroenterology. The ASC is a joint venture between Practice Partners in Healthcare, Tenet Healthcare and local physicians. The AAAHC-accredited ASC opened in Oct. 2007, and physicians at the ASC currently perform approximately 7,700 procedures annually, including colonoscopy, EGD and flexible sigmoidoscopy.

According to Mike Rickman, COO of the center, the facility is unique because it brought together two historically competing GI groups, a large Tenet hospital and an ASC management company in order to improve patient care and efficiencies. "Everyone put aside their individual agendas and were able to see the benefit of all parties working together to maximize existing assets and combine volume where separately neither practice would be successful," he says.

Ambulatory Surgery Center of Greater New York (Bronx, N.Y.). Ambulatory Surgery Center of Greater New York is a freestanding surgery center dedicated to total eye care — from cataract and glaucoma surgery to refractive surgery and treatment for diabetic retinopathy. Jerome Levy, MD, FACS, a board-certified ophthalmologist, founded the center in 1987 and serves as the center's surgeon director. Dr. Levy is a leading expert in cataract removal and no-stitch surgery and was among the first surgeons to perform phacoemulsification more than 25 years ago. In addition to cataract surgery, the center's physicians also perform Argon and Yag laser therapy to treat glaucoma, diabetic retinopathy and retinal disorders and to open cloudy membranes that may develop within the eye. The ASC also offers refractive and ophthalmic plastic surgery.

Joanne McLaughlin, administrator of the center, says that the center's level of care is the reason why the surgery center performs well in a very competitive market. "We treat our patients like family — from the moment they arrive to the moment they leave for home," she says.

Columbia Urological Surgery Center (Columbia, Md.). Columbia Urological Surgery Center is the surgery center associated with Central Maryland Urology Associates. The Center has been rated among the best ASCs in the nation, according to the Joint Commission. The Joint Commission gave the CUSC its approval "with commendation" in 1997, an honor awarded to only 10 percent of the healthcare organizations accredited that year. The center is home to six urologists who perform approximately 3,000 procedures annually. The center offers a variety of treatments for urological conditions including laparoscopic surgery, kidney stone treatment, prostate diagnostic screening and evaluation of sexual dysfunction in both sexes. In August, CUSC moved into a brand-new surgical suite, allowing the center to double its previous size size. The new center features a complete state-of-the-art operating room and the latest technology in urological surgery.

Columbus Eye Surgery Center (Columbus, Ohio). Columbus Eye Surgery Center, which opened in 1996, was the first outpatient surgery center in the Columbus, Ohio, area dedicated to eye surgery. The physician-owned facility offers the latest outpatient ophthalmology procedures including cataract, glaucoma, eye lid, retina and laser surgery in addition to cornea transplants, diabetic eye treatment and brow lift surgery. The ASC is used by almost 30 physicians and features three licensed operating rooms. The center performed approximately 3,900 procedures last year.

According to Toni Van Horn, executive director of the center, Columbus Eye Surgery Center has remained successful because of its continued commitment to treating the eye. The well-established center has chosen to forgo adding other specialties, which it at one time considered, in order to focus only on the eye. "Our dedication to the eye has allowed us to become an efficient center. We have also been able to provide great patient outcomes and offer patients easy access to eye treatment because of this dedication," she says.

Endoscopy Center of Western New York (Williamsville, N.Y.). Endoscopy Center of Western New York opened in March 2004 and is managed by Physicians Endoscopy. The ASC performs 10,100 procedures annually and specializes in endoscopic retrograde cholangiopancreatography, upper endoscopy/EGD, colonoscopy and sigmoidoscopy. The 7,300 square-foot center features four procedure rooms and has 11 physicians on staff. The ASC enjoys strong and positive relationships with local hospital systems in Buffalo, with the physicians providing full-time clinical GI coverage for four of the hospitals in the area.

Indiana Orthopaedic Surgery Center (Indianapolis, Ind.). The Indiana Orthopedic Surgery Center opened in 2002 as a partnership between OrthoIndy and St. Francis Hospital & Health Centers. The center offers full service orthopedic care from fracture reductions to spine surgery and total knee replacement. The facility offers block scheduling to 12 orthopedic surgeons and features state-of-the-art ORs with Stryker Sidne voice activated control and Web and telecast capabilities. Indiana Orthopaedic also offers pain management procedures and has a full-time anesthesiologist on staff.

According to Jane Keller, RN, MBA, CEO of Indiana Orthopaedic Hospital, the surgery center has thrived because of its focus on orthopedics. "Our center's success is mainly due to our center being a single specialty facility. It allows staff and physicians to focus solely on orthopedics. Staff trained in orthopedics allows for efficiencies for our patients and our physician owners," she says.

Interventional Spine & Pain Management ASC (Conyers, Ga.). ISPM provides full-service pain management to patients in the greater Atlanta area, including facet blocks, radiofrequency ablation, veterbroplasty, epidurals and spinal cord stimulatory implantation. The facility, which opened in the spring of 2007 and is accredited by the Joint Commission, features two operating rooms and averages more than 7,000 procedures annually. The ASC is fully owned by four physician-owners and has two additional physicians on staff. ISPM was a recipient of a certificate of need from the state of Georgia, the first of its kind in many years, according to Stephen Rosenbaum, executive director of ISPM and CEO of Interventional Management Services, the ASC's management company.

Mr. Rosenbaum contributes the center's success to its physician ownership. "Physician ownership and control is central to the success of the center. Partners have input on every decision made at the center, which has resulted in the highest-quality patient care," he says.

Maryland Surgery Center for Women (Rockville, Md.). Maryland Surgery Center for Women is a gynecological ASC, which has been in operation since 2003. The physician-owned facility currently treats an average case volume of 1,685 cases per year and focuses on the heath and wellbeing of the female population of Montgomery and surrounding counties in Maryland. The center generates the majority of its case volume from obstetrical and gynecological surgery as well as gynecological urological procedures, and features one OR and one procedure room. The ASC is home to 23 physician investors and has a total of nearly 50 credentialed surgeons on staff.

Brooke Weaver, administrator of the ASC, says that her position in leading the center has been an "exceptional" experience. "Not only have I felt an overwhelming amount of support from our management company, ASCOA, but the knowledge base and work ethic of the staff is one that I have never had the privilege to work alongside," she says. "I am rarely disappointed with less than exceptional patient surveys often noting staff persons by name. There is nothing that makes me more proud than for my staff to have made such a personal impression on a patient for that patient to remember them by name."

Matrix Surgery Center (Saginaw, Mich.). Matrix Surgery Center is the ambulatory surgery facility for Matrix Pain Management, an interventional pain management practice in Saginaw, Mich. The Joint Commission-accredited center, a partnership between Matrix and Titan Health, allows Matrix's physicians to meet their goal of providing comprehensive pain care to patients without utilizing facilities outside the Matrix network. Matrix Surgery Center was developed as a $3 million, 3,500 square-foot expansion to the Matrix medical facility and features three state-of-the-art operating rooms and five treatment rooms.

Michigan Endoscopy Center (Farmington Hill, Mich.). Michigan Endoscopy Center specializes in all types of GI procedures including colonoscopy, upper endoscopy and EGD. MEC has six operating rooms and 16 physicians who perform approximately 16,900 procedures annually. According to the mission statement of the center, MEC is dedicated to promoting high-quality endoscopic services and concentrates it services on members of the local community. The center's mission also includes promoting the accessibility of its services for all persons, with particular emphasis on improving access for traditionally under-served populations, including ethnic minorities and persons of low-income status. Brien Fausone, administrator of MEC, says that a key to the center's success is the highly-trained and experienced clinical staff. "It's an all-star team of clinicians," Mr. Fausone says.

The Musgrove Ear Nose & Throat Ambulatory Surgery Center (Silver Spring, Md.). The Musgrove Ear Nose & Throat Ambulatory Surgery Center was opened in 1997 by local ENT surgeons interested in providing outpatient surgical care in the Silver Spring, Md., area. The center has been designed and is operated by the surgeons and a small team of professionals to provide safe, convenient surgical care in a relaxed and comfortable setting. Musgrove is Medicare-certified, and is accredited by the Joint Commission. The facility's four physicians provide all types of otolaryngology-specific care including head and sinus surgery, facial plastic and reconstructive surgery and treatment of diseases of the oral cavity, nose and paranasal sinuses. The center also offers complete audiology services including audiology testing and hearing aid services.

According to Beth Davis, RN, nurse administrator, Musgrove's success can be attributed to its excellent staff and small size. "An experienced, proficient medical staff and the patient-focused caring nursing team contribute to the success of Musgrove ENT ASC. We are able to provide safe and cost effective care to each patient and involve the family members and significant others in the entire process," she says. "Unlike larger facilities or hospitals we are able to provide each patient with individual personalized care during their visit."

New Mexico Orthopaedic Surgery Center (Albuquerque, N.M.). New Mexico Orthopaedic Surgery Center is an orthopedic-focused ASC with more than 100 physicians on staff. The Joint Commission-accredited ASC opened in 2001 and performs more than 2,500 procedures annually. The mission of the United Surgical Partners International-affiliated ASC is to provide first-class surgical service in a safe and welcoming environment and aims to be a service-oriented alternative to the hospital for patients' surgical needs.

According to Ron Rives, administrator of the center, the ASC's success relates primarily to its involved partners, which includes 18 orthopedic surgeons, three pain management physicians, one podiatrist, its staff and corporate partner United Surgical Partners International. "Many of our employees have been here from the beginning of the [ASC] in 2000, which provides for consistent delivery of care and well as strong physician/employee relations," says Mr. Rives. The ASC continues to grow and will expand with a $3.5 million renovation to add two ORs, a procedure room and expanded pre- and post-operative areas, beginning in Dec. 2010.

Orthopaedic Surgery Center of San Antonio (San Antonio, Texas). Orthopaedic Surgery Center of San Antonio is the ASC of the San Antonio Orthopaedic Group, one of the largest groups of orthopedic surgeons in South Texas. The AAAHC-accredited ASC features six operating rooms and one procedure room, and the center's 24 physicians and 50 staff members perform approximately 4,500 procedures annually. The Orthopaedic Surgery Center's physicians specialize in all areas of orthopedics including sports medicine, shoulder, knee, hand, foot, ankle and spine, and the ASC is actively involved with the ASC Association.

Lauri R. Rose, MBA, CASC, director of ambulatory services, says that the success of the ASC is due to a number of factors, including its physician ownership and excellent staff. "Our physicians are not just owners. They are partners in the total care of our patients through our physician practice, The San Antonio Orthopaedic Group, and care deeply about excellent patient outcomes," she says. "[Our staff members] show a commitment everyday to quality patient care that is unsurpassed to the care and customer service that the patients would receive in the hospital setting."

The Orthopedic Surgery Center of Arizona (Phoenix, Ariz.). The Orthopedic Surgery Center of Arizona is a physician-owned, state-of-the-art outpatient surgery center that specializes in orthopedics. The AAAHC-approved ASC was developed by 15 orthopedic surgeons and Cornerstone Surgical Partners. All of the ASC's physicians, nurses and healthcare professionals are all actively involved in the operational decision-making and aim to provide the utmost in quality care and personalized service. The Orthopedic Surgery Center of Arizona maintains a percent patient satisfaction rating above 98 percent and now uses this rating as a minimum standard.

According to Gary Throgmorton, administrator, the staff's attention to quality of care and the center's sole focus on orthopedics are two key reasons for the ASC's success. "We are a single-specialty center and focus all our expertise the orthopedics which allows us to excel in our operation, our physician care and in the high quality of patient care we provide," he says.

Piney Point Surgery Center (Houston, Texas). Piney Point Surgery Center is a highly-specialized single-specialty center focusing solely on fertility treatments and procedures. The ASC was built in 1996 by another ASC company, but became part of Houston Fertility Institute, one of the leading fertility practices in the Houston area, in 2007. The center is currently owned by HFI physicians and features two operating rooms, though the owners are currently in the process of planning an expansion. The physicians at the center perform a number of fertility surgeries including hysteroscopies, egg retrievals and egg transfers, and the center projects it will perform 2,400 cases in 2009.

According to Jimmy Gill, MD, a leading physician at the center, the center's success is due to its focus on its patients. Jason Griffith, MD, another physician at the center, agrees. "The patients are our focus. 'Turning Couples Into Families' isn't just our motto, it's our mission," he says. ■

Contact Lindsey Dunn at lindsey@beckersasc.com

Overcoming 3 ASC Crisis Scenarios

By Renée Tomcanin

Day-to-day operations typically run smoothly at ASCs. Minor problems may arise, but a well-trained staff can handle them seamlessly.

However, no matter how prepared the ASC, a crisis may occur at the least opportune time.

Alisa Fischer, administrator of the St. Augustine (Fla.) Surgery Center, describes three crisis scenarios that occurred at her center and how they were handled.

Crisis #1: Broken Sterilizer

Proper sterilization of instruments is an essential step of patient safety for all healthcare providers, including ASCs. So, what happens when a sterilizer breaks?

Ms. Fischer and St. Augustine Surgery Center faced just this problem. She describes the situation: "Both of our Steris machines, which are used to sterilize orthopedic cameras and scopes for cases, displayed warnings. We had a full day of orthopedic procedures requiring scopes."

Ms. Fischer and her staff faced some challenges. If the machine could not be fixed or if they could not come up with an alternative method, cases would have to be canceled. If the staff members proceeded with scopes and cameras that were not sterilized properly, they ran a risk of patient infection.

However, quick action eliminated some of the more serious risks, although the center did experience delays of 45 minutes.

Ms. Fischer outlines the steps the center took once the machine went down: "We immediately called the repairman and alerted the surgeons. We mixed a pan of CIDEX OPA, which is what used to be used to soak scopes prior to the invention of Steris machines. It is not state-of-art 'high level disinfection,' but for more than 20 years, it has been used successfully in ORs. We also called the equipment rep and local ASCs and hospitals to see if they had autoclavable scopes to borrow. Unfortunately, they did not.

"Thankfully, when the repairman came, one of the two machines met the criteria needed for sterilization, and we were able to continue with the cases," she adds.

Ms. Fischer thinks that by immediately calling for repairs and prioritizing alternative procedures for sterilization prevented a bad situation from getting any worse. She does note that better preparation could have helped the center reduce the wait time for patients. "If you are a busy orthopedics or urology center with a limited amount of Steris machines, you may wish to purchase back-up autoclavable scopes and sterile drapes," she says. As a result of this experience, Ms. Fischer says St. Augustine purchased two back-up autoclavable scopes with light cords and sterile camera drapes.

Crisis #2: Unauthorized prescription

When most patients leave the surgery center, they are given a prescription by their physician. Occasionally, pharmacies may call to verify a prescription or patient information. However, what should an ASC do they receive a call from a pharmacy for a prescription that could not have been issued from the surgery center?

St. Augustine Surgery Center faced this situation. Ms. Fischer says, "Wal-Mart pharmacy called asking which physician wrote the prescription for Zyban for a patient. Immediately, red flags when up: The patient's last visit was Sept. 2006, and Wal-Mart called in Jan. 2009."

Additionally, Ms. Fischer notes that Zyban is not a medication the physicians would typically prescribe post-operatively. Upon further investigation, it was discovered that the prescription was written on St. Augustine's prescription pads. The pharmacy also said that it could not read the physician's signature, and the prescription did not have a DEA number.

Ms. Fischer says the false prescription could mean a potential theft of prescription pads and potential fraud, if the patient copied the physician's signature, both of which could result in myriad problems for the ASC. "This could mean a breach in our policy of secure prescription pads and medication availability," she says. "We would have had to report potential identity theft. [The Florida Agency for Health Care Administration] could visit and impose a fine for lack of security, and perhaps this would jeopardize our pharmacy and DEA licenses."

St. Augustine Surgery Center took several steps to investigate what had happened. "We tracked down the patient through our software database to validate the patient was in the center," Ms. Fischer

says. "We had the pharmacy send us a copy of the prescription. When we received the copy, we recognized the physician signature. We called the physician and found out that he had indeed written a prescription and admitted to having two blank center prescription pads in his lab coat pocket."

As a result of this breach, St. Augustine Surgery Center has limited the number of prescription pads in its narcotics cabinet to one. "We give the prescription pads to the physician when he asks for one. Extra prescription pads are stored separately in a safe and are counted and signed for," Ms. Fischer says.

Crisis #3: Appliance failure

Staff members at surgery centers expect their equipment to be working properly, especially when it comes to appliances such as refrigerators. However, it is important not to take for granted that everything is in working condition. So, what happens when you find that the medication refrigerator isn't working?

St. Augustine Surgery Center came in on a Monday morning to find this problem as part of its refrigerator daily check. "The medication refrigerator was at 65 degrees Fahrenheit," Ms. Fischer says. "Further inspection noted that the refrigerator was unplugged."

Ms. Fischer emphasizes the importance of discovering this problem. "If the staff had not done the daily medication refrigerator check, the items could have been used on patients and caused infections," she says. "Viscoat and Contigen (which are kept in the refrigerator) are both injected in patients."

Additionally, the surgery center would have to discard any medications kept in the refrigerator and face a potential increase in replacement medications.

In order to prevent any further harm to patients, staff members at St. Augustine Surgery Center immediately isolated the medications in the refrigerator. "The medication companies were called to ascertain in writing the shelf life of each medication involved at room temperature," says Ms. Fischer. ■

Learn more about St. Augustine Surgery Center at www.sascfl.com.

Gastroenterology in ASCs: 10 Fast Facts

By Scott Becker, JD, CPA

1) Gastroenterology remains the number one single specialty for procedures in ASCs by volume.

2) It is one of the top three specialties in ASCs. The other two types of specialties are orthopedics and ophthalmology.

3) Nearly 54 percent of all ASCs are single specialty surgery centers. (See SDI's *2008 Outpatient Surgery Center Market Report.*)

4) The largest single type of single-specialty surgery center remains GI centers. Nearly 25-30 percent of all single-specialty centers are GI-specific centers. (See SDI's *2008 Outpatient Surgery Center Market Report.*)

5) This means that there are nearly 700-800 GI surgery centers in the country.

6) A typical GI case may include 1.2-1.4 procedures per case.

7) The medium reimbursement is $750-$800 per case. This includes an average of more than one procedure per case.

8) The average differential between commercial reimbursement and Medicare reimbursement is probably $200-$300 per procedure. We see GI practices, particularly those with four to five or less physicians, having increased trouble retaining all physicians. The loss of certain physicians, due to retirement, relocation or other factors, can substantially reduce the profitability of such centers and increases the cost per procedure for such centers and the overhead cost per physician for the practices.

9) We continue to see increased efforts by GI practices attempting to profit from anesthesia and from pathology. Each of these efforts has very substantial legal issues attached to it.

10) It remains generally a buyer's market for the acquisition of endoscopy surgery centers. At the current rate, prices are gravitating to a 5.5-6.5 EBITDA range with a relatively shallow pool of overall buyers. ■

Contact becker@beckersasc.com.

3 Things Wrong With the AMA's Support of the President's Healthcare Reform Plan

By Scott Becker, JD, CPA

The president has aggressively marketed the support of certain industry groups such as the pharmaceutical industry, the AMA and the AHA to help sell healthcare reform. He has used their pledges of support, which came in exchange for price protection principally in the Medicare program, in Washington, D.C., and nationally. The AMA, for example, in exchange for possible reimbursement help on the Medicare side, has lent its endorsement to President Obama. Here are three things which are horribly wrong with this support and the marketing of that support.

First, physicians on average receive 20-30 percent or better pay from commercial payors than from Medicare. The AMA has traded its support for reform in exchange for some stability in Medicare rates. However, with healthcare reform will come migration away from commercial patients to Medicare patients. The net loss to physicians has been estimated at $11 billion. The deal at first glance — better Medicare payment for support — looks good. However, when you look at this over a several year period and in its entire likely impact to physicians, it is horrible for physicians.

To add insult to injury, it is widely believed that the president won't be able to deliver to the AMA the reimbursement protections he promised.

Second, the AMA doesn't represent the physician community. At one time, AMA membership and the AMA really was the heart and soul of doctor representation. Today, the AMA represents just 15-17 percent of physicians. Despite the fact that it only represents a small percentage of overall physicians, the AMA has provided the president with an endorsement which he can use over and over again. He in effect says, "Hey if the doctors support it, it cannot be bad, can it?"

Third, there is nothing worse for a physician to be in a market where there is Medicare and just one other dominant payor. It means physicians have almost no contract leverage. Between a growing public option and Medicare, physicians will have very little negotiating power if any.

Ultimately, the lack of physician strength and the lack of a thriving healthcare sector will lead to the dumbing down of the American healthcare system. It is mind boggling and shortsighted to watch the AMA lend its support to the demise of the American healthcare system.

The AMA unfortunately has simple-minded and weak leadership at a time when it needs great leadership most. ■

ASC Financing: Sound Strategies & Proven Tactics

By Jay Rom, MBA, CPA

There's one thing that all successful and profitable ASCs have in common — effective financing strategies. Every ASC business differs in terms of specific capital requirements and local market conditions, but financing strategies should always be based on transparency in sharing projections and numbers with partners and lenders, a firm commitment to financial discipline, rigorous negotiation with financing sources and creativity in structuring contracts. These same principles are also an excellent guide to day-to-day management and overall culture because they foster trust among partners, which is another hallmark of successful ASCs.

This article will highlight best practices, proven techniques and lessons learned from ASC businesses that achieve profitability quickly and sustain it over the long term.

The basics

Joint-venture ASC partnerships are best structured as limited liability corporations, largely owned by local physicians. A business partner, like my company, Blue Chip Surgical Center Partners, and, in some cases, hospitals or health systems, take on minority stakes. Ideally, all partners should invest startup and working capital, which typically amounts to 20 percent of the total capitalization required. Hence, 80 percent of capital will be financed, usually over 5-10 years.

Some surgeons attempt to start ASCs without investing their own money, but having "skin in the game" is a strong motivator for individual partners, as it fosters physician leadership and promotes clinical excellence. In other words, it's a financing model that directly correlates to long-term success.

Understanding the options

There are many options when it comes to financing — including banks and other financial institutions, and lenders specializing in healthcare. It's important to understand the pros and cons of working with each type — their requirements for collateral and personal guarantees, for example. To find the best deal for the unique needs and goals of each partnership, investor groups must seek out competitive proposals from multiple financing sources, including both local and national lenders.

Further, partners should recommend potential sources of financing; often, the ideal source of capital is local. In some cases, physician-partners may have friends or acquaintances in the local banking community. In such instances, the strength of the local relationships may lead to attractive terms and lower interest rates. In other instances, national healthcare lenders will be most competitive. In either case, a business partner with a successful track record of successful projects can help secure favorable terms and attractive interest rates.

Wherever possible, financing sources should be evaluated in terms of their ability and willingness to provide the maximum amount of non-recourse financing. If recourse financing is required, the recourse requirement should be limited to the shortest amount of time.

There is no "silver bullet" or perfect "one-size-fits-all" financing plan. Many variables — including local market conditions, regional differences in real estate costs, varying regulations, the number of surgeon-partners, projected volume and mix of cases — must all be factored into the equation. The risk tolerance of investors should also be clearly understood; that's especially important for establishing an optimal risk-reward profile for the project.

Defining the plan

Because effective financing is essential to the overall health of ASC businesses, financing issues should be a central consideration during the business planning process. The formal business plan should very carefully specify and assess all viable financing options, opportunities and risks. It's also important to recognize that a sound business plan is a valuable tool for securing capital. Desirable lenders want to see realistic financial projections, clear-eyed competitive assessments and accurate estimates of required working capital. Demonstrated experience in the ASC industry is a plus, too, of course.

During the business planning process, a detailed matrix clearly illustrating the various costs, key terms and requirements may be useful to compare each lender's proposal. To minimize unpleasant surprises down the road — the kind which sink far too many ASCs — it's important to match the financing models to the overall business plan, especially in terms of estimated case volume. All assumptions, implications and dependencies should be quantified in scenario models and the financial obligations of all partners clearly spelled out. Again, such transparency leads to trust, better decision making and a strong foundation on which to build the business.

Making decisions

Once sufficient information has been gathered and all viable options evaluated, partnerships reach the "go/no-go" point. The partners will collectively make the final decision as to financing, though business partners can and should provide recommendations based on their experience and insights. Arranging financing quickly is a top priority. Therefore, once operating and management agreements are signed, financing should be obtained as quickly as possible.

Equipment financing

Equipment financing is an important consideration when launching new surgical centers. Financing for the facility "build-out" or "tenant improvements" can be bundled with the financing of equipment. In some instances, construction financing will be handled as recourse and the equipment as non-recourse. While surgeons select the equipment they want, business partners should take the lead in negotiating the best possible acquisition price to reduce the overall financial burden.

Once the ASC opens it doors, new equipment should be purchased with cash from operating income. In some cases, this approach will necessitate a delay in monthly distribution checks for the partners. If equipment financing is absolutely necessary and justifiable, all financing sources should once again be evaluated, not just financing or leasing offered by manufacturers or sales brokers.

The evaluation and procurement of capital equipment or technology (e.g., new instrumentation) is a governing board-level decision, supported by thorough cost-benefit analysis that seeks to quantify the number of new or additional cases the new equipment will bring and the impact on reimbursement rates, quality of care and patient satisfaction. After analysis and evaluation documents have been reviewed, the board renders final determination on capital equipment purchases. We believe this level of discipline and rigor is critical to the long-term success of the ASC business.

Once financing is secured and the business is up and running, operations and cash flow should be monitored in line with the projected financial model. Keeping a close eye on case volume, quality measures, cash flow, processed claims and accounts receivable and payable are effective tactics to avoid cash calls. By staying on top of these operational matters and promoting financial discipline from day one, the risk of re-financing is virtually eliminated.

Big picture: reducing risk, increasing rewards

A holistic, best practices-based business model views financing issues and strategies as closely linked with other essential disciplines and processes, like case costing, contracting, billing and claims management. Collectively, these activities add up to comprehensive financial and operational management. Put another way, they are important steps on the journey to profitability, and are, therefore, best managed in an integrated way.

For individual physicians, the initial investments required to develop ASCs are substantial — $30,000-$100,000 depending on the exact nature, structure and scope of the project. Business partners will also invest significant money (up to $250,000) for a minority ownership stake. While required investments are large, so is the opportunity and the likelihood of enjoying strong future ROI, provided strong business plans and financing models are in place from the start. ■

Jay Rom (jay@bluechipsurgical.com) is president of Blue Chip Surgical Center Partners (www.bluechipsurgical.com).

10 ASC Revenue Cycle Sticking Points

By Nicholas A. Newsad

Accelerating the "revenue cycle" reduces the time it takes to get paid and thereby reduces the accounts receivable balance on the balance sheet (increasing cash). This article identifies 10 sticking points in the ASC revenue cycle, each of which may represent a possible delay in the time it takes to get paid. How is your revenue cycle holding up?

1. Insurance verification — Online electronic access

Insurance verification is initiated when the surgeon's office faxes over the patient's insurance information. The surgeon's office should pre-authorize the patient for service, but the surgery center is responsible for itself. All major insurance carriers have an online system for benefit verification. This is the fastest and most efficient way to verify benefits. Calling on the phone to verify benefits consumes an inordinate amount of time. Fundamental items that need to be checked include:

- verifying that the surgery center accepts the patient's type of insurance;
- confirming patient's name, date of birth and policy number are accurate;
- ensuring coverage is active and the surgery will be performed within the enrollment period;
- checking to see if the patient has a benefit for outpatient surgery; and
- determining the patient's YTD deductible usage and any co-insurance or co-payment due for the service.

2. Preoperative call

The preoperative phone call primarily serves to verify the patient's eligibility to have an elective surgery. However, as the first contact with the patient, this is a prime opportunity to make him or her aware of their personal financial responsibility for the deductible and/or co-insurance several weeks or possible months before the operation. The goal is to provide several reminders of this responsibility prior to the date of service.

3. Financial obligation and policy letter

This practice serves to provide the patient with a written document prior to the service that describes the patient responsibility and the surgery center's financial policies in advance. This is good because it is a formal, physical document that will serve as yet another reminder of this obligation. The administrative burden of making letters for every patient is substantial, so this practice may be best served by focusing on patients with high deductible health plans. In 2009, patient deductibles of $3,000 or more have become more common and special attention is warranted for this category of patients.

4. Day of service — Registration and collection

From a revenue cycle standpoint, registration serves the purpose of allowing the patient to verify the insurance information prior to claim submission and double checking this info against the patient's insurance card. Incorrect policy numbers or patient dates of birth virtually guarantee that the claim will be rejected.

In regard to patient financial responsibility, the day of service is probably the only time that the patient is guaranteed to be face-to-face with a facility representative. The probability of eventually collecting a deductible or co-pay probably drops 25 percent or more after the patient leaves on the day of service. If the patient has been made aware of his or her obligation during the preoperative phone call and via the aforementioned letter, the day of service request for payment will be the third time they have been asked to pay or establish a financing arrangement.

5. Dictation

Dictation should be done the day the service is performed, prior to the surgeon leaving the facility. Dictation is crucial to the process because most dictation companies will guarantee a 24-hour turnaround period for the dictated operative reports. Optimally, they can be generated within a few hours. A surgeon that leaves the facility without dictating may not be back for a week or more. This often adds significant time to the time it takes to submit a claim and subsequently receive payment.

6. Coding

The operative report generated by the dictation provider is read by a certified coder and the appropriate ICD-9 diagnosis and procedural CPT codes are identified. Depending on whether this person is an in-house employee or a contractually provided service, codes can be turned-around same day or within 24 hours. Coders certified by the American Academy of Professional Coders are preferential because they have taken the Certified Ambulatory Surgery Center Credential coursework and certification exam. Coding performed by a non-certified coder is at higher risk of either not capturing all legitimate, billable procedures, or perhaps capturing more than is appropriate. A good coder may often ask for clarification or more information in regards to omissions or unclearly dictated operative reports.

7. Charge entry

Charge entry is the physical input of the billing codes and the generation of the insurance claim. Most ASC software systems (SurgiSource, Advantx, Vision, HST, etc.) will automatically generate the electronic claim with associated charges from the facility fee schedule once the codes are input.

8. Electronic claim submission — Online electronic clearinghouse

Electronic submission of claims is the preferred method of providers and insurance companies alike. Claims generated by the surgery center's software are submitted to a provider-insurance carrier intermediary called a "clearinghouse." The clearinghouse will "scrub" the claims to ensure "clean" submission by identifying errors that may cause rejections or denials. After the claim is scrubbed, the clearinghouse forwards the claim to the carrier. The clearinghouse is a key business partner is the processing of payment. Only under special circumstances are claims still faxed to the insurance carrier. The business manager and billers should have a personal relationship with the account representative at the clearinghouse and request periodic education sessions.

9. Payment: Electronic funds transfer vs. physical checks

Physical "check cutting" by insurance carriers can significantly delay the processing of payment. Normal time between the physical check cutting by the carrier and the time the check hits the ASC's bank account may be 7-10 days or more. This is because:

- some carriers do not perform daily check runs;
- checks may not physically make it from a carrier's accounts payable department to the mail room on the same day;
- checks are subject to regular mail "float";
- checks are sent via the USPS are subject to weekend and holidays delays; and
- checks sent to a lockbox service may be subject to processing backlog and possibly an extra day before they are available for deposit and online viewing.

Virtually all major carriers will set-up direct deposit remittance at the provider's request. This is an excellent way to minimize check and mail float. Imagine if you could liquidate a portion of accounts receivable valued at 7-10 days worth of cash collections. This is great way to get a one-time jump in collections if you have not done this historically.

10. Explanation of Benefits — Electronic access direct from carrier

Quick access to the Explanation of Benefits is necessary to address rejections, denials and requests for additional information in a timely manner. The sooner the problem is known, the sooner it can be fixed. Waiting for the EOB to be mailed with the remittance adds an additional 7-10 days of mail float to the time it takes to address payments that will already be delayed. All major carriers have an online portal for accessing EOBs. In many cases, the new EOBs will become available on a daily basis, even if the check or electronic funds transfer will not be cut for several more days.

Best practices to file effective denial appeals and avoid review delays

Here are some additional best practices to help you craft strong denial appeals and avoid lengthy reviews of your claims

Appealing denials

Denials most commonly occur because a fundamental coverage requirement is not met because of issues such as the following:

- patient did not have benefits at time of service;
- service was not a benefit under the patient's plan; and
- treatment was not medically necessary.

If benefit verification was completed by the surgery center, then the first two points should not be an issue. Denial for medical necessity would imply the surgeon was also not paid for his or her professional fee. When you speak to the call center representative at the insurance carrier, ask which of the Milliman's Medical Underwriting Guidelines this determination is based upon and whether they can direct you to these guidelines on their online portal. The facility and the surgeon will need to reference the guidelines when you submit your appeal.

Maximum charge edits

Individual carriers may have "edits" built into their system that "flag" or "kick-out" claims with charges that exceed preset limits. If it appears that claims with charges over a specific amount are routinely being held up or delayed for no compelling reason, you can ask a call center manager at the insurance carrier if there are such edits and whether they can remove them or at least raise the limits.

Request for additional information for processing

Large claims can have a significant impact on accounts receivable when

they are delayed for reviews. To minimize these delays, or eliminate them altogether, the ASC can send additional information "in anticipation" of the request. All carriers have a fax or mailing address specifically for sending additional information. This way, the ASC does not have to wait 30 days just to receive a notice requesting the information. There is no penalty or cost associated with sending too much supporting information to the insurance carrier.

Granted, the administrative burden of faxing or mailing additional information prohibits doing so for all claims. The business manager must develop a criteria for identifying claims that have the highest likelihood of being delayed based on experience (for example, American Insurance Carrier may often request more info for claims with charges exceeding $9,000). Information that is commonly requested may include:

- diagnosis codes and associated procedural CPTs with associated charges;
- stickers or invoices for all implants used with associated charges;
- history & physical/clinical record;
- operative report; and
- anesthesia notes.

The more information you send, they less likelihood something will be missing when it is reviewed again. It is prudent to send the packet via certified mail so record of the submission is documented. Also, make sure the appropriate identification information is attached to the packet so the carrier can attach it to the correct enrollee and claim. This may include:

- patient name, date of birth, date of service, policy/subscriber number;
- enrollee name, date of birth, date of service, policy/subscriber number; and
- ASC facility and provider number.

Conclusion

Take the time to examine each of the 10 sticking points described in this article. If your center is not using electronic claim submission or direct payment deposit, this can significantly improve the timely processing of payments. Online access to EOBs and anticipatory actions to address rejections can abbreviate the delay times. Establishing educational sessions for your billers on the various online clearinghouse and insurance carrier systems is fundamental to maximizing the use of these tools and well worth the effort. ■

Mr. Newsad is a senior business analyst for Health Inventures (www.healthinventures.com), a developer and management and services firm that has been developing and expanding ambulatory surgery care and other outpatient services since 1976.

Average Surgery Center Staff Hours Per Case

Here are the average staff hours per case for employees in ASCs by the total number of cases a surgery center performs annually and by the number of operating rooms at a surgery center, according to VMG Health's *2009 Intellimarker.*

Total case volume

1. Nursing staff
   - All facilities — 6.3 hours/case
   - Less than 3,000 cases — 6.7 hours/case
   - 3,000-5,999 cases — 6.7 hours/case
   - More than 5,999 cases — 5.8 hours/case

2. Technical staff
   - All facilities — 2.5 hours/case
   - Less than 3,000 cases — 3.1 hours/case
   - 3,000-5,999 cases — 2.6 hours/case
   - More than 5,999 cases — 2.4 hours/case

3. Administrative* staff
   - All facilities — 4.1 hours/case
   - Less than 3,000 cases — 5.0 hours/case
   - 3,000-5,999 cases — 4.5 hours/case
   - More than 5,999 cases — 3.8 hours/case

4. Administrator
   - All facilities — 0.5 hours/case
   - Less than 3,000 cases — 1.1 hours/case
   - 3,000-5,999 cases — 0.6 hours/case
   - More than 5,999 cases — 0.3 hours/case

5. Total hours per case
   - All facilities — 11.6 hours/case
   - Less than 3,000 cases — 15.5 hours/case
   - 3,000-5,999 cases — 12.8 hours/case
   - More than 5,999 cases — 10.6 hours/case

Facility size

1. Nursing staff
   - All facilities — 6.3 hours/case
   - 1-2 ORs — 4.1 hours/case
   - 3-4 ORs — 6.4 hours/case
   - More than 4 ORs — 6.3 hours/case

2. Technical staff
   - All facilities — 2.5 hours/case
   - 1-2 ORs — 2.2 hours/case
   - 3-4 ORs — 2.6 hours/case
   - More than 4 ORs — 2.5 hours/case

3. Administrative* staff
   - All facilities — 4.1 hours/case
   - 1-2 ORs — 3.7 hours/case
   - 3-4 ORs — 4.2 hours/case
   - More than 4 ORs — 4.2 hours/case

4. Administrator
   - All facilities — 0.5 hours/case
   - 1-2 ORs — 0.7 hours/case
   - 3-4 ORs — 0.5 hours/case
   - More than 4 ORs — 0.4 hours/case

5. Total hours per case
   - All facilities — 11.6 hours/case
   - 1-2 ORs — 7.8 hours/case
   - 3-4 ORs — 12.5 hours/case
   - More than 4 ORs — 11.9 hours/case ■

** "Administrative staff" can include all employees other than nurse and tech FTEs. Depending on what the ASC outsources with respect to back office functions (billing/collections, mgmt services, accounting, HR, etc.), this can include receptionists, administrators, insurance verifiers, schedulers, transcriptionists, coders, billing/collections staff, medical records staff and accounts payable staff.*

To receive a free copy of VMG Health's 2009 Intellimarker, visit www.vmghealth.com.

Co-Founder of Successful Oklahoma Surgery Center Shares Advice for Growing Your ASC

By Lindsey Dunn

Keith Smith, MD, founded Surgery Center of Oklahoma in Oklahoma City, Okla., with one other physician, Steven Lantier, MD, in 1997. Since its inception, the ASC has continually added physician partners, and the ASC now counts more than 42 area surgeons as partners.

Dr. Smith shares his advice for growing volume through attracting physician partners at your ASC.

Have a core mission and stick to it

According to Dr. Smith, his ASC's success in growing volume through the addition of physician partners is due to the center's unchanging mission of providing quality care.

Dr. Smith says that this commitment to quality and efficiency has created a strong reputation for the center, which now attracts surgeons without much active effort on his part. "I can maybe think of one or two people that I've called and visited with about joining [our ASC]," he says. "[The physician partners] contacted us because we became a brand in the community. I think that occurred because our mission of quality is really clear. The day we cannot provide high quality care at a low cost, we will close."

Be selective

ASC owners should be selective in bringing in the right physician partners, not just any physician partner, says Dr. Smith.

"Because our mission is quality, we are very picky about the surgeons and nursing and scrub staff that we allow to work here," says Dr. Smith "There have been times when we have not taken a surgeon that wanted to work here because he or she was not reputable or not kind."

Dr. Smith says that surgeons that are not a good fit for the ASC may generate profit in the short term but will hurt the center's success in the long run.

"You have to be extremely careful about bringing in people, even in lean times," he says. "It's difficult to retain really good staff that delivers the best quality if you have a surgeon that isn't cordial to them."

Dr. Smith suggests bringing in potential physician partners for a trial period before allowing them to be a full partner in the ASC, as is done at the center.

"We bring the surgeon in for a trial of usually six months to a year," he says. "If they fail the trial, they don't come back."

Have anesthesiologists as co-owners

Although many ASCs now outsource anesthesia services, Dr. Smith recommends that ASCs look for anesthesiologists who are interested in becoming co-owners. He says that having anesthesiologists as owners has been critical to the ASC's success.

"Having an anesthesiologist as a co-owner puts everyone on same boat going same direction," he says. "If there is a surgical case that financially is not good for our ASC but is financially is very good for anesthesia staff, we won't do those cases because the anesthesiologists are owners." ■

Contact Lindsey Dunn at lindsey@beckersasc.com.

Case Revenue Statistics for 11 Surgical Specialties

Here are the average gross charges and net revenue per case for 11 common surgical specialties at ASCs, according to VMG Health's *2009 Intellimarker*.

1. ENT
   - Gross charges — $6,975
   - Net revenue — $1,725
2. GI/endoscopy
   - Gross charges — $3,040
   - Net revenue — $790
3. General surgery
   - Gross charges — $5,330
   - Net revenue — $1,522
4. OB/GYN
   - Gross charges — $5,813
   - Net revenue — $1,673
5. Ophthalmology
   - Gross charges — $5,385
   - Net revenue — $1,226
6. Oral surgery
   - Gross charges — $2,669
   - Net revenue — $1,028
7. Orthopedics
   - Gross charges — $8,026
   - Net revenue — $2,453
8. Pain management
   - Gross charges — $3,873
   - Net revenue — $890
9. Plastics
   - Gross charges — $5,866
   - Net revenue — $1,487
10. Podiatry
    - Gross charges — $6,532
    - Net revenue — $1,559
11. Urology
    - Gross charges — $5,254
    - Net revenue — $1,327 ■

To receive a free copy of VMG Health's 2009 Intellimarker, visit www.vmghealth.com.

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6 Toyota Production System Concepts to Improve ASC Efficiency

By Renée Tomcanin

At first glance, healthcare and the automotive industry have very little in common. However, when looking at how both healthcare and the automotive industry conduct their daily operations, more similarities can be seen.

Steve Taninecz, a trainer, educator and coach with the Pittsburgh Regional Health Initiative, sees comparisons between the two industries in that both involve the "process of a day." "Both industries require sustaining processes and both look towards lean thinking," he says.

Joshua Manuel, industrial supervisor of IET, a full-service industrial and manufacturing engineering firm that serves healthcare providers, agrees. "We've seen a lot of former automotive manufactures now serving as healthcare leadership," he says. "There is value in hiring these professionals because they are used to cost-cutting industries."

Here is an overview of the Toyota Production System and six ways it can help ASCs improve their operations efficiency.

What is the TPS?

The Toyota Production System is a system that combines both the company's management philosophy and practices and combines rigid production activities with flexible operations to improve the flow of production. The main of objections are to design out overburden and inconsistencies and to eliminate waste.

According to a 1999 article in the *Harvard Business Review* by Steven Spear and H. Kent Bowen, the fundamentals of the system can be explained in four "rules":

- "All work shall be highly specified as to content, sequence, timing and outcome."
- "Every customer-supplier connection must be direct, and there must be an unambiguous yes-or-no way to send requests and receive responses."
- "The pathway for every product and service must be simple and direct."
- "Any improvement must be made in accordance with the scientific method, under the guidance of a teacher, at the lowest possible level in the organization."

Although originally designed for the manufacturing industry, when broken down to these rules, the principles of the system can be effective for healthcare.

Laura Mahood, a project manager, educator and coach with PRHI, says that the comparisons between the industries may seem difficult to make but when one takes a look at how both industries operate, the similarities are there. "Obviously, in healthcare, the goal is to take care of patients, not building cars," she says. "However, they both include complex systems and require looking at processes. Any work anyone does [at both a surgery center and a factory] is a series of processes designed for a specific outcome."

Six TPS applications for ASCs

1. Observation and visualization can help identify problems.

In TPS, one of the major steps to waste reduction is to eventually develop a culture that can recognize and stop problems so that it can get quality right from the beginning. According to Barbara Jennion, director of PRHI's Perfecting Patient Care℠ program, which trains healthcare providers on elements of TPS, observing processes within an ASC and then mapping them for inefficiency is crucial to the success of this program.

"After leaders observe the processes and flow at their centers, we put these observations on a value-stream map," Ms. Jennion says. "Comparing the processes to the map can help leaders understand how to identify breakdowns in the process and waste. Then, they can create programs with employees to see all forms of waste and highlight the work that needs to be done."

Mr. Manuel agrees with this process. "There's something to be said at looking at [what should happen versus what is happening] on a map," he says. "You can see the interaction between key resources and look at how to improve."

2. Communication is essential to effective processes.

Rules two and three from the Spear and Bowen article emphasize the importance of a direct customer-supplier relationship and simple pathways for products. In manufacturing, this relates directly to a physical end-product — a car seat, a door, bolts, etc. In healthcare, these concepts can apply to caring for patients with one simple concept: effective communication.

"Waste is often the result of a communication breakdown," Ms. Jennion says. "In surgery centers, this is often due to reception or surgery staff not having what they need, such as prescriptions, test results or release forms, prior to the start of surgery. As a result, the flow of the process backs up due to processing or sending out for more information, and wait times increase as a result."

Process delays and other breakdowns in flow of work often occur when patients move from one area of the surgery center to another, according to Mr. Manuel. "We have seen inefficiencies in patient hand-offs and in technology," he says. "Staff members can be stuck in rework loops with paperwork, when it can be handled more efficiently with e-mail software or electronic health records."

Ms. Mahood notes that mapping these communications between areas of your surgery center can help identify these breakdowns. "In healthcare, people are departmentalized. Mapping can help leaders see how departments connect and help to break down barriers that may be put into place as a result of departmentalizing."

3. Standardization helps simplify processes. Individual departments or surgical teams in surgery centers often perform the same work by using different processes. This variation in processes, from scheduling to equipment used for similar procedures, can be the root cause of these breakdowns of communication.

According to Mr. Manuel, standardization is the best way to keep pathways simple and direct. "Most healthcare leaders understand what it is but not how important it is," he says. "Standardization is really the only way to get control of a process. That way if a problem occurs, you can trace the issue to the step in the process and can adjust immediately."

Ms. Mahood notes that this issue with standardization is most often seen in ASCs that have patient flow problems. "Most surgery centers operate by 'pushing' patients through the system: A patient presents to registration, completes the necessary paperwork and is then pushed through to the next area regardless of if the station is ready to handle them or not," she says. "We try to modify surgery centers to move from 'push' to 'pull.' Rather than having processes driven by the front-end, we move this to the back-end."

Standardized signals that are typically visual or non-verbal can help to facilitate this movement. Ms. Mahood suggests using a light or an audible cue to signal to the front-end when the back-end is ready for the next patient. This can cut down on wait times and prevent patients from being corralled into a single waiting area.

Mr. Taninecz suggests color coding and checklists as other means of standardizing processes. "Many centers use surgical checklists to help organize their staff members before surgery," he says. "These help to ensure that a flag will be raised if you go off the path you should be on."

Standardizing the set of tools surgeons use for similar procedures can also save an ASC time and money.

Ms. Jennion says, "These processes help keep the 'pull' going. We see a flux in production if every team does it differently. With standardized practices, everyone knows when something needs to happen, where they need to be and how they need to do it."

4. Engage staff members to help with implementation. In his experience helping healthcare companies implement TPS, Mr. Manuel says that it is easier to make changes when employees are involved with the process.

"We have employees and leaders help to develop the tools necessary to train their peers in the new process," Mr. Manuel says. "For instance, [in one center], we wanted to develop a new patient information packet to send to referring physicians. We sat down as a group and came up with what should be included."

Linda Horwitz Vicaro, an educator, trainer and coach with PRHI, says developing these problem-solving tools is fairly straightforward. "Toyota uses a very scientific process. You put together a report to provide a structured way of knowing what the problem is and then you drill down to the root cause of the problem. Then you develop a very specific implementation plan."

The next step in implementation can include a pilot program for one area of your surgery center. "During this step, you need to look for problems in the new system and adjust accordingly," Mr. Manuel says. Then, the plan can be rolled-out to the entire center.

Ms. Vicaro notes that it is important to measure the new plan against the old plan to see how areas, such as patient satisfaction, have been affected.

5. Commitment from leadership is essential to changing a culture. Spear and Bowen note that in TPS, in order to make changes to improve work, guidance from a teacher is necessary to ensure that improvements are made according to the scientific method and are applied to the lowest possible organizational level. For this reason, it is important for ASC leadership to commit to changing the culture so they can guide and teach the processes throughout the ASC.

Mr. Taninecz says, "Leadership needs to be on board and focus on their role and what they need to do."

Ms. Jennion agrees: "You need to stress the importance of the leadership role in making improvements. If they are committed, they will allow the culture to blossom."

6. Changing a culture presents some challenges. As with any new policy, surgery centers will face challenges when implementing these changes. Mr. Taninecz says, "People work very hard in center, but there are many wasteful practices. It will be necessary to help them understand that just because they've always done things this way, it doesn't necessarily make it the right way."

Mr. Manuel mentions some of the challenges working with physicians in a surgery center can face when trying to implement a change in culture. "You will get some negativity from low performers. It can be a struggle because a physician is not just an employee; they are also a customer, and if they are unhappy they will take their business elsewhere," he says.

Offering physicians incentives may be one way to help ease this skepticism. "Low performers make up a small percentage of the center," Mr. Manuel says. "We try to let them reap the benefits of performing." For example, at one facility, if surgeons showed up on time for surgery 85 percent of the time in one quarter, they were allowed to keep their current schedule or take over slots of a low performer. ■

Contact Renée Tomcanin at renee@beckersasc.com.

Resources

National trade associations

The ASC Association. To learn more, visit www.ascassociation.org, contact Kathy Bryant, president, at (703) 836-8808 or e-mail asc@association.org.

Physician Hospitals of America. For more information, visit www.physicianhospitals.org or contact Molly Sandvig, JD, executive director, at (605) 275-5349 or e-mail info@physicianhospitals.org.

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The Accreditation Association for Ambulatory Health Care. For more information, visit www.aaahc.org or call (847) 853-6060.

Healthcare Facilities Accreditation Program. Learn more at www.hfap.org or call (312) 202-8258.

The Joint Commission: Ambulatory Care Accreditation Program. For more information, visit www.jointcommission.org/asc or call (630) 792-5286.

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Serbin Surgery Center Billing. For more information, contact SCB at (866) 889-7722 or visit www.ascbilling.com.

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McShane Medical Properties. Contact John Daly, vice president, healthcare, at (847) 692-8616 or visit the firm's Web site at www.mcshane.com for more information.

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Professional Finance Company. Visit PFC online at www.professionalfinancecompany.com or call (970) 352-5000.

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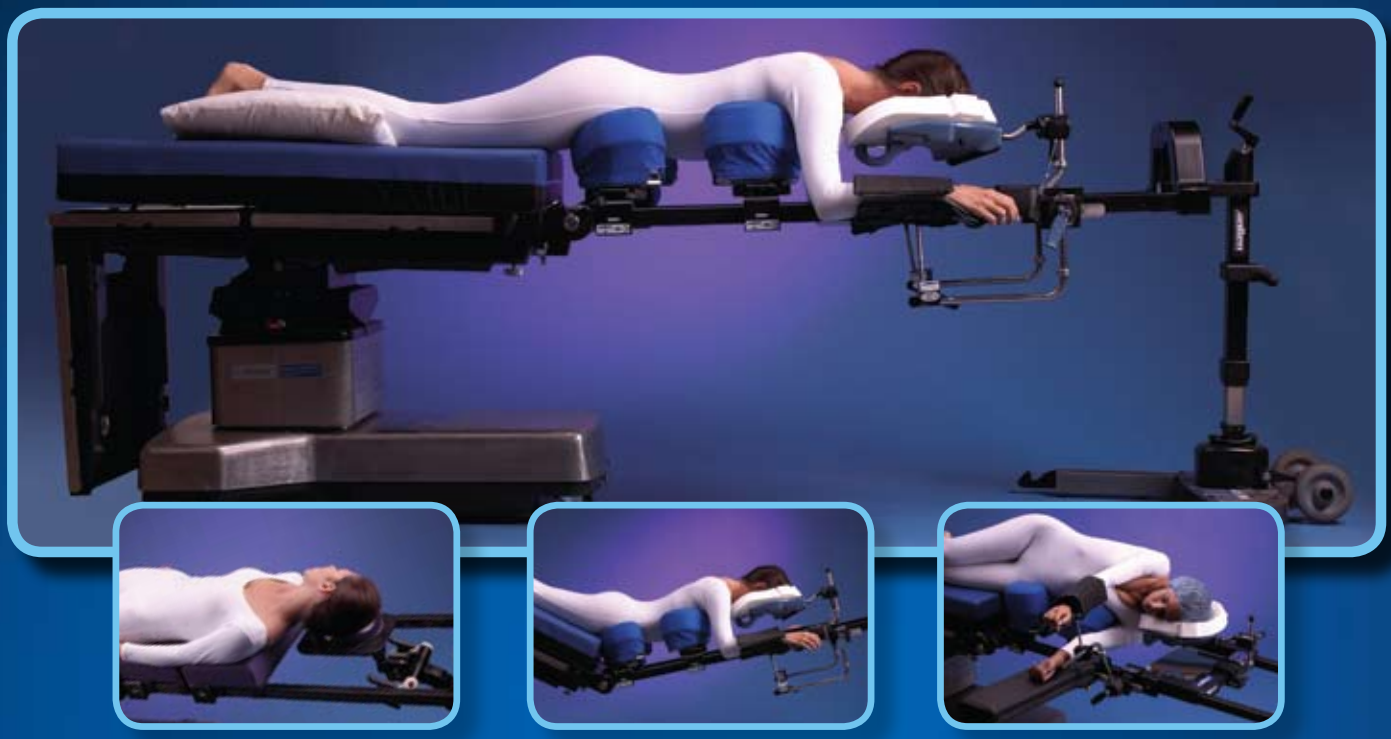

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 1. Lynch, J. (2009, May). Is It Time to Add Spine? Outpatient Surgery.

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