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BECKER'S

ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

November/December 2010 • Vol. 2010 No. 9

18 Top ASC Stories for 2010 — A Look at the Biggest Issues Shaping the Industry

By Leigh Page

1. Mature market. The ASC industry hit a watershed this year. "The number of ASCs will decline this year for the first time in the history of our industry," says Andrew Hayek, president and CEO of Surgical Care Affiliates. "We have gone from 8-10 percent growth to negative growth. This is a fundamental shift, reflecting that ASCs are now a mature market."

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CMS Issues Stark Act Voluntary Self-Referral Disclosure Protocol — 9 Key Concepts

By Julie Ann Sullivan, JD, and Scott Becker, JD, CPA, McGuireWoods

The Patient Protection and Affordable Care Act (PPACA) requires the Secretary of the Department of Health and Human Services, with the Office of the Inspector General of HHS, to establish a protocol for healthcare providers and suppliers to disclose actual or potential violations of Section 1877 of the Social Security Act (the "Stark Act"). Under the Stark Act, healthcare providers and suppliers may not refer

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10 Statistics From the ASC Association's 2010 ASC Employee Salary & Benefits Survey

By Rob Kurtz

The ASC Association has released the results of its *2010 ASC Employee Salary & Benefits Survey*. 1,260 ASCs participated in this year's survey.

Here are 10 significant findings from the survey.

1. The median salary of an administrator increased by 1.0 percent between 2009 and 2010, to $93,870.

2. Medical director salaries were the only ones to decrease in 2010. These salaries decreased by 4.0 percent to a median salary of $28,800.

3. Registered nurse salaries increased 1.1 percent over 2009 to a median salary of $60,500.

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

November/December 2010 Vol. 2010 No. 9

FEATURES

Publisher's Letter

Accountable Care Organizations – 9 Observations; Increased Integration Efforts; Increased Mergers and Acquisition Efforts; Call for Speakers: 9th Annual Orthopedic, Spine and Pain Management Driven ASC Conference & 2nd Annual Hospital Conference — Improving Profits, ACOs, Physician Hospital Integration and Key Specialties

Currently, there is a great deal of discussion relating to Accountable Care Organizations (ACOs) and physician-hospital initiatives. The movement by some systems to embrace ACO-type efforts is accelerating catch-up efforts by other systems to compete with such systems including an increase in the acquisitions of practices by hospitals. The ACO efforts are also raising concerns regarding the long-term independent practice of medicine. On a separate note, we are seeing increased merger and acquisition activity in the ASC area, the physician-owned hospital industry and the dialysis industry. We are also seeing an increased number of healthcare industry qui tam/false claims cases.

This letter provides brief observations regarding the development of ACOs. The letter also includes a call for conference speakers and a note regarding signing up for E-weeklies.

(I) ACOs

1. ACOs were established by the Health Care Reform Act to encourage greater coordination of care under Medicare. The concept is that different providers join together to coordinate care, share clinical information and report on quality measures and are financially rewarded for meeting certain performance guidelines and cost-saving benchmarks. The intended result is that greater coordination will lead to improved quality of care, prevent costly hospital visits and ultimately produce a more cost-effective healthcare system.

While ACOs have been promoted as part of the Healthcare Reform Act for Medicare patients, and pilot programs are being established, the real movement with ACOs seems to be with commercial payors at the moment. Further, the accelerated efforts by some systems to pursue ACO-type contracts is leading to a reaction by competing systems who are attempting to then accelerate the development of their own ACOs and integrated delivery systems. We are just starting to see very aggressive actions between integrated delivery systems and payors using the phraseology of ACOs to try and develop substantial steering of business by one system away from another.

2. Integrated delivery systems that control both the physician and the hospital side of care seem to be best situated to approach payors with ACO types of deals (in essence, deals that allow a system or ACO to share in savings below a baseline as long as certain quality targets are met). Because an ACO needs to contract with a broad range of parties to be successful, an integrated delivery system that already includes a lot of the needed components will be able to get to market quicker. Because the ACO movement favors integrated delivery systems as a cornerstone piece of the effort, it is

likely to cause a further acceleration of the acquisition of practices and employment of healthcare practitioners by hospitals and other health systems. ACO efforts will also put a new premium/value on primary care physicians who control patient populations. A key challenge in accelerating integration efforts relates to whether systems can aggregate resources/providers in a manner than makes sense in both a fee-for-service model and in a shared risk environment.

3. The ability to actually measure and control utilization depends on significant information systems, great nurse and physician leadership, tracking capabilities as well as having a good number of the medical coverage costs under control. To the extent an ACO has contracts with a great number of the providers that are necessary to provide healthcare services, the better it should be able to control costs. ACOs that truly invest in services and in infrastructure and provide a true value in managing costs will have a much greater likelihood of long term success.

4. The political proposition in the Healthcare Reform Act, as well as rhetoric from Washington, D.C., tends to favor the development of ACOs over Medicare Advantage plans. The overall concept of pushing down responsibility for the entire cost of care is a very similar concept in Medicare Advantage plans as it is in ACOs. Thus, it is no surprise that organizations like Humana that were major players in the Medicare Advantage plan business are now examining ways to be in the ACO business with partners.

5. An ACO can be co-owned by multiple parties or it can be owned by one party. Moreover, an ACO can be developed by a wide range of healthcare provider groups from multispecialty physician groups to integrated physician hospital organizations. This flexibility extends into payment arrangements, which may take the form of the traditional fee-for-service with a percentage return on savings or a flat rate per patient, among others. Whether an ACO is managed by one party or co-owned by multiple parties, it will need contracts with providers that will allow for controlling costs, utilization and quality. Providers who contract with ACOs will be skeptical of the potential financial benefits to them and how closely these financial benefits relate to their own efforts. The ACO model may start to remind providers of the HMO and PPO withhold contracts of a decade ago.

6. In the ACO environment, surgery centers, like many other providers, are more likely to simply be a cost center rather than a manager of patients and costs. If an ACO is really driven by a hospital system, notwithstanding the lower costs of surgery center services, there is a high likelihood that the hospital system will gravitate towards using or rewarding its own operating rooms as a strong preference and reward providers who steer business to its operating rooms rather than towards surgery centers.

7. There is no real proposition currently in healthcare reform as to single-specialty ACOs. However, we will likely see significant developments around chronic high-cost diseases.

8. Where two competitive systems contract together to either form an ACO or offer services through an ACO (or an ACO includes both independent and employed physicians), there is a risk (reality) of sharing pricing information and/or a risk of price-fixing allegations. This risk is prompting the discussion of the need for an anti-trust exemption for ACOs. While the Association of Health Insurance Plans discourages an anti-trust exemption for ACOs, providers are pushing for such an exemption. Absent this exemption, many efforts will fall into an anti-trust gray area and further encourage complete consolidation and less competition.

9. The financial arrangements that are used in ACOs, such as shared savings, raise the possibility of impermissible payments under the Anti-Kickback Statute or the Stark Act. ACOs can attempt to structure their relationships to meet the personal services or fair market value exceptions or other exceptions under the Stark Act. However, these exceptions are often not a perfect fit for these financial arrangements. There is also not a simple ability to take advantage of safe-harbors under the Anti-Kickback Statute. The integrated delivery system model generally provides greater legal comfort from an antitrust, Stark and Anti-Kickback perspective.

(II) Save the Date; Call for Speakers

1. 9th Annual Orthopedic, Spine and Pain Management Driven ASC Conference — June 9-11, 2011. Should you have a suggestion for a speaker or topic or if you have an interest in speaking, please e-mail me at sbecker@mcguirewoods.com.

2. 2nd Annual Becker's Hospital Review Improving Profits, ACOs, Physician Hospital Integration and Key Specialties Conference — May 19-20, 2011. Should you have a suggestion for a speaker or topic or if you have an interest in speaking, please email me at sbecker@mcguirewoods.com.

3. 18th Annual Ambulatory Surgery Centers Conference – Improving Profitability and Business and Legal Issues — October 27-29, 2011.

4. E-Weeklies. If you would like to be added to any of the following free electronic publications, please email sbecker@mcguirewoods.com and specify which E-weekly.

- Becker's ASC Review;
- Becker's Hospital Review;
- Becker's Orthopedic and Spine Review;
- Becker's ASC Quality, Safety and Infection Control; and
- Becker's Spine Review.

• • •

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

Very truly yours,

Scott Becker

18 Top ASC Stories for 2010 — A Look at the Biggest Issues Shaping the Industry
(continued from page 1)

Mr. Hayek says successful ASCs will need to continue adding volume in the face of rising costs and flat, even declining reimbursements. "Achieving distribution growth will require a deep focus on systems, efficiencies and processes," he says. "The growth years are over," says Jon Vick, president of ASCs Inc. "Most of the good doctors are already affiliated with ASCs." As the nation climbs out of the recession, he predicts a growth rate of about 1 percent a year.

2. Disappointing reimbursements. In CMS's transition to the new ASC payment system, based on HOPD rates, Mr. Vick says ASCs had hoped reimbursements would be greater than 60 percent of the HOPD rate, but they turned out to less than 60 percent of HOPD. ASCs received a 1.2 percent inflation update in 2010, compared with a 2.1 percent update in HOPD rates. Reimbursement updates for ASCs are now based on the consumer price index, which has been rising slowly because inflation is very low.

Mr. Hayek says next year will also be disappointing, with ASCs getting a zero percent increase in Medicare rates, which many private payors use as well. Starting in 2011, the healthcare reform law provides healthcare facilities with a "productivity adjustment," a reduction in annual reimbursement updates, based on the estimated amount that labor productivity improves in the general economy, Mr. Hayek says. The productivity adjustment for 2011 is 1.6 percent, canceling out ASCs' estimated reimbursement increase for 2011, based on the CPI. Stagnant reimbursements come at a time when labor and supply costs are growing by 2-4 percent a year, he says.

Mr. Hayek says things could get worse. Beyond 2011, "there may also be additional cuts to provider rates, as the federal deficit worsens, and there may continue pressure on surgical volumes with more plans raising co-pays and deductibles," he says. "It's a very different industry than it was 10 years ago."

3. Slightly lower profits. Mr. Vick sees a slight overall decline in profitability this year, caused by the lower reimbursements and some decline in volume. However, spine-based ASCs are doing better because reimbursements are high. Bariatric procedures also command high reimbursements but volume is down due to the economy. Mr. Vick says independent centers, in particular, have seen a decline in profits. For example, he says one Michigan ASC went from $2 million in profits last year to only $500,000 in 2010, reducing its worth from $12-$14 million to less than $4-$5 million. But he adds that high-performing centers have been able to make up for the losses by contracting for better rates, bringing in higher-priced cases and increasing volume.

Mr. Hayek sees a similar picture. "As we evaluate acquisitions, we see that most ASCs have flat to declining profits," he says. He attributes this to the new Medicare reimbursement structure and "a very difficult managed care rate environment." Most publicly traded companies generally report outpatient surgical volumes down 3-5 percent, and several reports suggest physician office visits are down 4-6 percent this year, he says.

4. Patients assume more financial risk. The rapid growth of health savings accounts and, more recently, high-deductible plans, means patients are highly incentivized to look for less costly alternatives, says Joe Flower, a healthcare futurist. To save money, patients are choosing less complex operations or no surgery at all, even if the medical literature calls for surgery. "The patient may choose just to endure the pain, to just to live with it," Mr. Flower says.

5. Administrators have more business acumen. The typical ASC administrator used to be a nurse promoted from inside, with no experience with contracting, recruiting and cost-accounting, Mr. Vick says. But as volume and reimbursement issues worsen, "ASCs have to be better managed to maintain their profitability," he says. "Now you see administrators with degrees." Mr. Hayek agrees. "Their job is becoming more and more complex," he says.

6. Management companies on a shopping spree. Mr. Hayek says at his management company, Surgical Care Affiliates, acquisitions have more than doubled over 2009 and they will be even greater next year. SCA now manages 130 centers. Mr. Hayek says physician-owners sell because they are concerned about more regulations, more personal taxes and lower reimbursements.

"There is a very strong movement toward management companies," says Mr. Vick, whose company represents physicians seeking to sell their centers. Clients typically are looking for more partners and want help with recruitment and contracting, he says. They can choose from among at least 40 companies that want part-ownership in the ASC. Companies have had a lot of access to capital because investors see ASCs as a good investment. "This trend is going to continue," says Fred W. Ortmann III, founder and CEO of Ortmann Healthcare Consultants. "National companies will come to the forefront because ASCs have problems accessing capital, and a lot of the management companies have plenty of money."

7. Hospitals also acquiring ASCs. "This is the biggest story of the year," says Ms. Joan G. Dentler, president of ASC Strategies, who usually represents hospitals in ASC sales. "It's a trend that is growing exponentially." She says ASCs that sell to hospitals have watched their out-of-network payments evaporate, need to start contracting with payors and realize they have no clout. A hospital may have that clout. Mr. Vick says hospitals are more interested in ASCs because they have lost a lot of business to surgery centers and continue to lose business in areas like spine and bariatrics.

Mr. Ortmann, a former hospital administrator, says ASC owners should not be bought by hospitals because hospitals do "a notoriously horrible job" of managing ASCs. "It's an issue of focus," he says. The ASC becomes just one of many sections within the hospital. Mr. Vick says hospitals tend to want control in the form of majority interest or the opportunity to convert the ASC into an HOPD. "Hospitals are taking advantage of the increasing payment disparities between ASCs and HOPDs," Mr. Hayek says. "As the payment disparity widens you'll see more of these conversions."

8. Rise of hybrid ownership. The most successful joint ventures with hospitals are hybrids, Mr. Vick says. That is, a management company manages the ASC, the hospital is a minority partner and physicians retain the largest interest. The most common arrangement is 40 percent ownership by physicians, 30 percent hospital and 30 percent management company, he says. Physicians can refer patients and share in revenue and profits.

Some management companies, however, still want a 51 percent share, which wouldn't fit into the hybrid model because the 49 percent remainder, split between the hospital and physicians, is not enough. In a three-way deal, Mr. Vick recommends first selling to the management company, because the management company pays a higher price than what the hospital would pay. "This establishes a fair market value that the hospital has to follow," he says.

9. Some specialty-specific ASCs stay independent. While hospitals gobble up orthopedic and ENT surgery centers, ophthalmology and GI centers have retained their independence. Hospitals lose money on ophthalmology, making ASCs with a focus in the specialty unappealing as an acquisition target, says Mr. Ortmann.

10. Physicians employed by hospitals. Half of physician practices in the country are now owned by hospitals or health systems, Mr. Hayek says. Primary care physicians and cardiologists have highest proportion of employed physicians, while surgeons are more likely to remain independent. But surgeons may still feel the consequences of hospital employment, Mr. Vick says. In some cases when primary care physicians are employed by the hospital, they may insist to the surgeons they refer to that any surgeries be performed in the hospital, he says.

11. Independent physicians won't die out. In almost every community, Mr. Hayek says, a strong group of independent physicians remain and they are committed to remaining independent. He thinks the pendulum might eventually swing back to independent practice. "We will learn a lot in the next few years about whether this trend will continue, as many of the employment agreements come up for renewal," he says. Mr. Ortmann says hospital employment is not something most surgeons would like. "They are a very independent group of people," he says.

12. Payors becoming more aggressive. Increasingly, health insurers are refusing to pay for surgery they deem unnecessary, Mr. Flower says. If the peer-reviewed literature shows a non-surgical intervention or less complex surgery is just as effective, the insurer will be more likely not to pay, he says. However, when there is no real medical alternative to surgery and patients cannot forego surgery, he thinks ASCs will flourish.

13. Retreat from out-of-network. At Surgical Care Affiliates, Mr. Hayek says less than one-half of one percent of revenue comes from out-of-network payments. "The strategy of being out-of-network is sun-setting over the long term," he says. "Payors are implementing a variety of strategies to limit out-of-network benefits across many states."

Mr. Vick agrees. "Any center than depends on out-of-network business for revenue is seeing a significant decline in value," he says. "You can get away with it still in most places but it's considered a short-term strategy." He also says patients frequently object when they see the high out-of-network rate on the bill, even if they don't have to pay it, and that harms the ASC's image.

Mr. Vick says an ASC moving away from out-of-network status has to start negotiating contracts, which is a key factor in why ASCs are linking up with a management companies and hospitals.

However, just when many surgery centers are walking away from out-of-network status, recent legal victories for ASCs suggest there might be some hope left for the approach. In April, for example, an Illinois trial court's decision to award a podiatric ASC almost $3 million in damages against Blue Cross Blue Shield of Illinois for refusing to pay an out-of-network claim, even though the center had obtained preauthorization. Blue Cross is appealing parts of Chatham Surgicore v. Health Care Service Corporation, but two related cases against Blue Cross are making their way through the courts.

Tom Pliura, MD, JD, a legal counsel for some Illinois surgical centers and manager of several ASCs in central Illinois, believes the Chatham ruling should embolden ASCs across the country to use the out-of-network option. "This case highlights that if you're willing to challenge an aggressive insurer on out-of-network status, you can win," he says.

14. More and tougher Medicare inspections. CMS has beefed up enforcement of its Conditions for Coverage for ASCs, This year, Mr. Hayek says, "we are seeing four times the rate of CMS surveys over last year, and the surveys have become more difficult and complex." The Conditions for Coverage were revised in 2009 and now include, for example, a 12-page checklist for infection control process. In addition, the 2009 economic stimulus bill stepped up funding for more on-site surveys. HHS Secretary Kathleen Sebelius stated that one in three ASCs would be surveyed this year, compared to historical rate of about one in 10. The new actions show that "when people on Capitol Hill say ASCs are unregulated, they could not be further from the truth," Mr. Hayek says.

15. Specter of healthcare reform. A common concern is that the direction the new reform law is taking healthcare may not benefit ASCs much. "In general, healthcare reform means greater regulation, greater cost cutting, greater personal taxes," Mr. Hayek says. The reform law will expand coverage to some 30 million people by 2014, but half of them will be on Medicaid, which is not profitable for ASCs, he says. "Now that there is a stake in the ground, the government will take a bigger role in healthcare, which means volume with a zero to negative margin," Mr. Hayek adds. "We have this issue of the federal deficit. To combat it, government will have to reduce rates. There will be greater cuts in Medicare just to finance the healthcare reform law." For all of its unpopularity, however, Mr. Hayek believes the law will stick. "The odds of repealing healthcare reform are low," he says.

16. Rise of accountable care organizations. One possibly positive consequence of the reform law is the introduction of accountable care organizations. In theory, at least, surgery centers are the low-cost, high-quality alternative, which is exactly what ACOs want. However, Mr. Hayek notes many ACOs will be hospital-led and hospitals would have to agree to shift volume from their own HOPDs to ASCs. "The question is," he says, "Will there be enough of a benefit from savings at ACOs to outweigh the hospital's potential loss in revenue? As a hospital leader, you have to weigh the relative benefit of this shift as it impacts the financial health of your institution."

Mr. Flower says ACOs require different mindset than ASCs are used to. "A surgery center is pretty much the opposite of an ACO," he observes. While the ACO is concerned about the entire continuum of care, the ASC is used to focusing on one niche. "A surgery center does certain kinds of procedures efficiently and well," Mr. Flower says. "But in an ACO, providers are incentivized to have a longer-term relationship with the patient." He adds that as ACOs drive for lower costs, non-surgical options may become more common. While many take ACOs very seriously, Mr. Vick doesn't think they'll amount to much. "I have been in this business since 1984," he says. "Every other year there has been something new that creates a threat. Healthcare reform is in the same category."

17. Increased lobbying. This year, as some key healthcare reform regulations are being drafted and the November elections may well change the balance of power in Washington, the industry has been stepping up its lobbying presence. The ASC Advocacy Committee, launched in mid-2009, has doubled the lobbying dollars behind surgery centers by picking up extra contributions from companies and state societies in addition to what they contributed to other ASC organizations.

This new wave of lobbying has to contend with a perception in some quarters that ASCs are on the defensive in Washington. "ASCs don't have that much political force today," Mr. Ortmann says. "The hospital lobby got a ban on physician-owned hospitals, which is a sign of their strength. If they could do that, why couldn't they go ahead and ban ASCs?"

But Mr. Hayek, who chairs the advocacy committee, says ASCs' power in Washington is rising, although it may take years for the current lobbying efforts to fully pay off. In August, for example, more than 20 U.S. senators signed a letter asking CMS to fix the ASC reimbursement update, more than double the number of senators who signed a similar letter last year. "We are doing a better job as an industry in tackling the issues," Mr. Hayek says. "In this past year, there has been more coordinated work in Washington than we did previously."

18. New executive director at ASC Association. The ASC Association has a new executive director. As of Oct. 4, the organization will be headed by William Prentice, a seasoned healthcare lobbyist, well schooled in the ways of Capitol Hill. Mr. Prentice, who has been senior vice president for government and public affairs at the American Dental Association, succeeds Kathy Bryant, who also had a great deal of Washington experience. "I'd like to broaden our advocacy and work for new and creative ways to advocate for regulatory changes that can benefit ASCs," Mr. Prentice said when his appointment was announced. "I believe the ASC industry offers one of the most significant opportunities to be a leader in the changes that will occur with healthcare reform." ■

CMS Issues Stark Act Voluntary Self-Referral Disclosure Protocol — 9 Key Concepts (continued from page 1)

patients to any entity for certain services if the physician has a financial relationship with that entity unless an exception for such referral applies.

On Sept. 23, CMS released its self-referral disclosure protocol (SRDP). The SRDP provides guidance for healthcare providers and suppliers to self-report actual or potential violations of the Stark Act in exchange for potentially (although not guaranteed) informal and more lenient settlement proceedings. Providers and suppliers should be cautious in self-disclosing through the SRDP.

This article highlights nine key concepts and considerations regarding the SRDP.

1. SRDP for Stark violations only. CMS points out that the SRDP is only to address actual or potential Stark Act violations; if the disclosing party's conduct raises potential liabilities under other federal criminal, civil or administrative laws, the provider or supplier should self-disclose through the OIG's Self-Disclosure Protocol. If CMS reviews a SRDP and determines that other violations in addition to the Stark Act may be implicated, CMS will refer the matter to the appropriate law enforcement agency (i.e., the OIG or the Department of Justice).

2. Conduct an internal investigation before filing a SRDP. It is vital to conduct a thorough internal investigation of all related compliance issues prior to filing a SRDP because violations other than the one being reported that are discovered by CMS through the SRDP may be used by the appropriate government agency to bring charges against the disclosing party. Thus, it is important to have a full picture of all potential compliance problems or risks before opening the door to government scrutiny of an organization's operations.

3. Good faith cooperation necessary. A SRDP must be made in good faith, meaning that a disclosing party that attempts to circumvent an on-going investigation or fails to fully cooperate in the self-disclosure process will be removed from the SRDP, and as noted earlier, information learned in a SRDP that is terminated for any reason may be used by CMS or another law enforcement agency to pursue legal action against the disclosing provider or supplier.

4. SRDP is distinct from the Stark advisory opinion process. A disclosing party may not use the SRDP to obtain a CMS determination as to whether an actual or potential violation of the Stark Act occurred. A SRDP is only appropriate where the disclosing party is prepared to accept responsibility for a violation or potential violation of the Stark Act and is prepared to work with CMS to come to a resolution regarding such violation.

5. Participation in SRDP conditioned on certain terms; waiver of appeal rights. One condition of disclosing a matter pursuant to the SRDP is that the party waives all appeal rights attached to claims relating to the conduct and agrees to have the reopening rules (i.e., rules pertaining to remedial actions to change a final determination that resulted in either an overpayment or an underpayment) apply from the date of the initial disclosure to CMS. Similarly, although CMS has the authority to reduce the overpayment amount owed by the disclosing party as a result of the Stark violation, CMS has no obligation to reduce any amounts due and owing. As CMS states:

CMS will make an individual determination as to whether a reduction is appropriate based on the facts and circumstances of each disclosed actual or potential violation. The nature and circumstances concerning a physician self-referral violation can vary given the scope of the physician self-referral law and the health care industry. Given this variability, CMS needs to evaluate each matter in order to determine the severity of the physician self-referral law violation and an appropriate resolution for the conduct.

CMS further advises that "a disclosing party should make a submission to the SRDP with the intention of resolving its overpayment liability exposure for the conduct it identified."

6. Other discovered violations in CMS verification process of SRDP fair game. Any matters uncovered during CMS's verification processes and investigation pursuant to the SRDP which are outside of the scope of the matter disclosed to CMS may be treated as new matters outside of the SRDP and prosecuted accordingly. In other words, self-reporting a Stark Act violation could potentially lead to additional criminal, civil or administrative liabilities under statutes such as the False Claims Act or the Anti-Kickback Statute.

7. Need to act quickly. Given the 60-day time limit to return or report potential overpayments pursuant to Section 6402 of PPACA, providers and suppliers need to act quickly in order to get a SRDP on file if the provider or supplier believes he or she has violated the Stark Act or has potentially violated the Stark Act. Note, however, that the 60-day period to return or report overpayments is tolled once a valid SRDP is filed.

8. Complex disclosure requirements. The SRDP submission is a tedious process requiring complete legal and financial analyses related to the violation or potential violation. Some of the components of the SRDP submission include:

A detailed description of the actual or potential violation, including a complete legal analysis of the application of the Stark Act to the conduct and any exceptions to the Stark Act that may apply;

A description of all past, present and future compliance programs that the disclosing party has implicated, why such programs failed in preventing the violation, and what efforts have been taken to avoid violations going forward;

A detailed financial analysis of the violation, itemized by year, for the entire period of non-compliance (referred to by CMS as the "look back" period), as well as a description of the methodology used for the financial analysis; and

Certification by an authorized representative of the disclosing party that all information contained in the SRDP is truthful and based on a good faith effort to bring CMS's attention to the Stark Act violation.

9. Secure appropriate representation and counsel. Because a SRDP is a tedious process involving careful legal and financial analyses of a provider or supplier's business, providers and suppliers are urged to seek immediate counsel if they suspect they have violated the Stark Act. ■

For more information, please contact:

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10 Statistics From the ASC Association's 2010 ASC Employee Salary & Benefits Survey (continued from page 1)

4. Salaries for certified registered nurse anesthetists experienced the largest increase between 2009 and 2010 — an increase of 4.0 percent to $156,000.

5. Salaries for four positions remained constant in 2010: business office manager ($53,000), anesthesiologist ($275,000), instrument technician ($33,280) and operating room technician ($40,000).

6. Administrators with the CASC credential earned higher salaries. Administrators with the CASC credential and no clinical background had a median salary of $110,000. The median salary of an administrator with the CASC credential and a clinical background is $105,000.

7. The majority of managers are eligible for bonuses:

- Administrators – 75 percent
- Business office managers – 63 percent
- Directors of nursing – 64 percent
- Materials managers – 53 percent

Only 10 percent of medical directors, however, are eligible for bonuses.

8. Ninety-six percent of ASCs offer their employees health benefits.

9. Sixty-seven percent of ASCs reported recruiting new employees in 2010 was neither easier nor more difficult than in 2009, while 17 percent reported it was easier and 16 percent reported it was more difficult.

10. Twenty percent of administrators were CASC certified, an increase of 3 percent from 2009, the biggest jump since these data reports started being collected.

About the 2010 ASC Employee Salary & Benefits Survey

This publication provides national salary and benefits data for 17 ASC positions. Publication includes bonus data for several managerial positions, salary comparisons of selected positions by number of employees, rooms, patient encounters, ASC type and ASC location. State-specific data available for 33 states. Regional data is available for five states and the Washington D.C. region. ■

To order a copy of the *2010 ASC Employee Salary & Benefits Survey*, call (703) 836-8808 or visit www.ascassociation.org/store.

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Illinois Court Orders Blue Cross to Pay Almost $3M to Surgery Center in Out-of-Network Case

By Leigh Page

Becker's ASC Review has learned of a recent decision in the Illinois courts regarded as an important step forward in ASCs' efforts to achieve reasonable out-of-network payments.

A trial court in Chicago has upheld a local podiatric surgery center's claim for out-of-network payments from the largest payor in the state, Blue Cross Blue Shield of Illinois, awarding the center almost $3 million in damages.

The case, Chatham Surgicore v. Health Care Service Corporation, involves Blue Cross' refusal to pay for out-of-network services even though Chatham had made sure to get preauthorization approval for services and submitted claims on time.

Ruling will embolden ASCs

The ruling, made in late April but not publicized until now, will embolden ASCs across the country to use their out-of-network option and be paid at fair market rates, says Tom Pliura, MD, JD, a legal counsel for some Illinois surgical centers and manager of several ASCs in central Illinois.

"This case highlights that if you're willing to challenge an aggressive insurer on out-of-network status, you can win," says Dr. Pliura, who is not involved in the case. Other aspects of Illinois Blue Cross reimbursement policies are being challenged in two related Illinois lawsuits. Dr. Pliura encouraged ASCs in other states to launch similar legal challenges against insurers attempts to reduce payments for out-of-network ASCs or not recognize them at all.

Blue Cross is appealing parts of the Chatham Surgicore ruling to the state appellate court. The higher court had earlier directed the trial court to hear the case, which a trial judge had originally refused to hear in 2002. If Blue Cross loses its appeal, Dr. Pliura says the insurer is likely to ask the Illinois Supreme Court for a hearing, but that higher legal body grants very few requests, he added.

What it means for ASCs nationwide

The trial court decision in April recognized that if a surgery center makes a preauthorization call to an Illinois insurer and the insurer verifies coverage, the insurer must pay the claim. The ruling is based on the legal

concept of "promissory estoppel," which enforces an oral promise even when there is no written contract between the parties. Dr. Pliura says courts in at least 13 states recognize some form of promissory estoppel, and the rest of the states have other legal concepts that might be used to challenge insurers' treatment of out-of-network status.

The Chatham Surgicore case was outlined in a 2005 Illinois Appeals Court decision, Chatham Surgicore v. Health Care Service Corporation, clearing the way for the 2010 trial. Because the trial court decision did not go into details of the case, the appeals decision is the only public document to lay out the facts of the case.

Chatham Surgicore made many preauthorization calls to Blue Cross to verify coverage for each of its Blue Cross patients and "Blue Cross' agents repeatedly represented to Chatham that those individuals were covered for services rendered at Chatham," the court stated. The insurer did not disclose any limitations on coverage. After providing treatment, Chatham sent in its claims on time. However, "Blue Cross refused altogether to pay Chatham for the treatment," the court noted.

The court stated, "Blue Cross' promises to pay were unambiguous because they were both definite and complete." It continued, "When Blue Cross made its assurances, it knew who would be providing the services, what services would be provided and who would be receiving those services." The opinion then directed the lower court to hear the case.

Appeal to stay out-of-network

Dr. Pliura says payors across the country have been pressuring ASCs to sign contracts and go in-network, signing agreements where they sometimes make even less than Medicaid rates. However, centers are now reaching a point where they have go out-of-network to survive, he says. While staying out-of-network is a little more difficult, because centers have to make a preauthorization call to the payor and get confirmation of coverage for each case, they can in some cases get double or triple the reimbursement compared with in-network, he says.

Even if ASCs decide to stay in-network, they may still want to renegotiate rates, Dr. Pliura says. In Illinois, "Blue Cross will tell you we don't negotiate rates, but it will negotiate. Blue Cross caused its own problems because it was greedy," he says. "It ratcheted its rates down so low that the providers have no choice but to go out-of-network."

More Illinois cases to come

Two entities related to Chatham Surgicore are plaintiffs in two other cases that are awaiting trial in the Illinois courts:

* Rosner Podiatric Services v. Health Care Service Corporation involves both in- and out-of-network payments and alleges promissory estoppel and breach of contract. It is scheduled for trial on Dec. 1.

* Chatham Foot Specialists v. Health Care Service Corporation involves in-network payments to a podiatric practice. In this case, the Illinois Supreme Court has directed the trial court to address fraud and breach of contract complaints against the insurer. No date for trial has been set yet, but it is expected to take place next summer or fall. ■

Contact Leigh Page at leigh@beckersasc.com.

106 Physician Leaders in the ASC Industry

By Rachel Fields

Here is a list of 106 physician leaders who have made significant contributions to the ASC industry. To read their complete profiles, visit www.beckersasc.com.

David J. Abraham, MD. Dr. Abraham is one of the entrepreneurial leaders at The Reading Neck & Spine Center in Wyomissing, Pa. He is board certified in orthopedic surgery and is a member of the American Academy of Orthopedic Surgeons, North American Spine Society and the Pennsylvania Orthopedic Society.

Amir Arbisser, MD. Dr. Arbisser is an ophthalmologist and co-founder of Eye Surgeons Associates in the Quad Cities in Iowa, where he also serves as board chairman. He recently finished a six-year gubernatorial appointment on the Board of Regents, the governing body of Iowa's public universities, including University of Iowa Hospitals and Clinics and Carver College of Medicine in Iowa City.

Dale A. Armstrong, MD. Dr. Armstrong is chairman of the board of Mason City (Iowa) Surgery Center and the president of the Mason City Clinic, where he has visionary ideas for his center. Dr. Armstrong received his medical degree from the University of Oklahoma College of Medicine in Oklahoma City, Okla., and completed his residency in adult psychiatry and his fellowship in child and adolescent psychiatry at the University of Oklahoma Health Sciences Center.

Ken Austin, MD. Dr. Austin is a practicing orthopedic surgeon with Rockland Orthopedics & Sports Medicine in Airmont, N.Y., and is the president of the Ramapo Valley Surgical Center in Ramsey, N.J. His expertise includes treating traumatic and sports-related injuries of the upper and lower extremities and joint replacements of the hip and knee. Dr. Austin was named one of "America's Top Physicians" by the Consumers Research Council.

Norman Douglas Baker, MD, FACS. Dr. Baker is a surgeon at the Ophthalmic Surgeons and Consultants of Ohio in Columbus. He is board certified in ophthalmology. Dr. Baker is clinical assistant professor of ophthalmology at Ohio State University.

Joseph Banno, MD. Dr. Banno is the founder and co-owner of the successful Peoria (Ill.) Day Surgery Center and is past chairman of the ASC Association and a current executive committee member. During the last few years, Dr. Banno has been involved in developing the world's first mobile ASCs, which have been purchased by the U.S. Army for breast cancer research.

Scott Bateman, MD. Dr. Bateman is an otolaryngologist practicing at Sheridan Ear, Nose & Throat in Wyoming. He has served the Sheridan area in private practice since 1995. He is affiliated with the American Medical Association, the Texas Medical Association and the American Academy of Otolaryngology.

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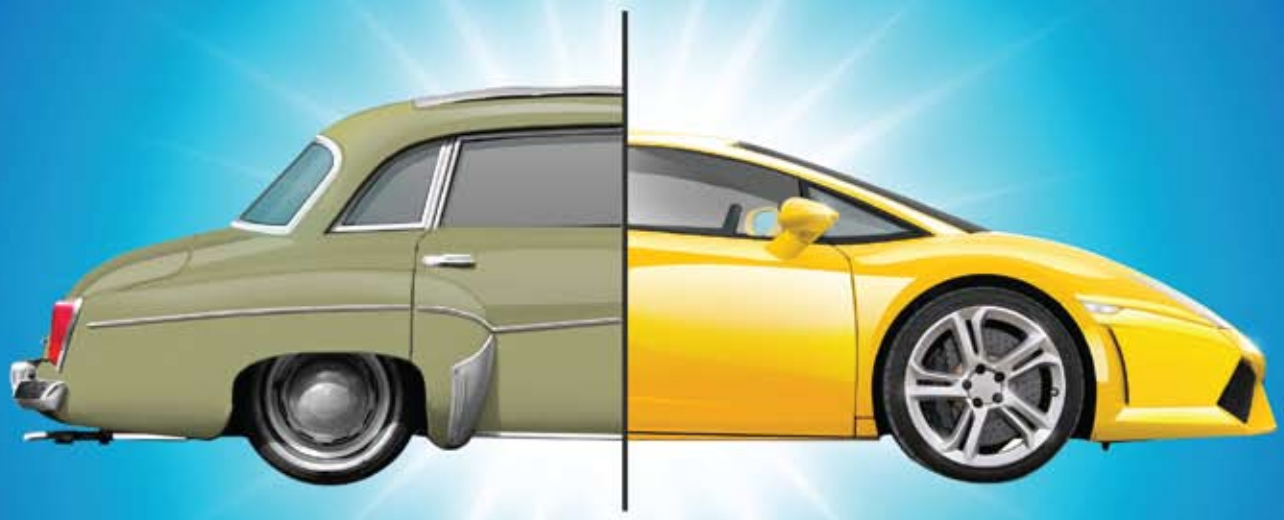

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Robert A. Berger, MD. Dr. Berger is a general and bariatric surgeon practicing with Flagstaff (Ariz.) Medical Center. He has special interest in minimally invasive procedures and bariatric surgery. Dr. Bermudez is a board-certified general surgeon with affiliations with the American College of Surgeons, the American Society of Bariatric Surgeons and the Society of American Gastrointestinal Endoscopic Surgeons.

Fernando Bermudez, MD. Dr. Bermudez is the medical director of Eastside Endoscopy Center and the medical director of G.I. Medicine Associates in Michigan. Dr. Bermudez has served as division head of the department of gastroenterology at St. John Hospital, former medical director of the endoscopy unit at St. John Hospital and former clinical assistant professor at Wayne State University. He specializes in diseases of the gastrointestinal tract, the liver and pancreas.

Tom Bombardier, MD. Dr. Bombardier is a board-certified ophthalmologist and is the COO and one of the three founding principals of the Ambulatory Surgical Centers of America. Prior to founding ASCOA, he established the largest ophthalmic practice in Western Massachusetts, two ASCs and a regional referral center. Over the past 17 years, he has been a real estate developer in Cape Cod, Mass.

Nader Bozorgi, MD. Dr. Bozorgi has been a leader and pioneer in the field of outpatient surgery since 1973, when he opened one of the first ASCs in the United States. This paved the way for a system of ASCs that provide anesthesia, pain, bariatric lap band and support services, under Magna Health Systems. Dr. Bozorgi continues to serve as Magna Health System's CEO.

Richard F. Bruch, MD. Dr. Bruch is a physician with Triangle Orthopedic Associates, the North Carolina Specialty Hospital and the James E. Davis Surgery Center, all located in Durham, N.C. Dr. Bruch has served as team physician for the Durham Bulls baseball team since 1980 and specialized in problems of the foot and rheumatoid arthritis.

Michael Bukstein, MD, FACS. Dr. Bukstein is a general surgeon who serves as the board president of the Northeast Missouri Ambulatory Surgery Center in Hannibal, Mo and practices general surgery at Hannibal Clinic. Dr. Bukstein served as chief resident in surgery and surgical oncology at University of Missouri Medical Center and Ellis Fishel Cancer Center in Columbia.

James T. Caillouette, MD. Dr. Caillouette is a board-certified orthopedic surgeon with Newport Orthopedic Institute in Newport Beach, Calif., specializing in joint replacement and adult reconstructive surgery of the hip and knee. He has been on staff at Hoag Hospital and in private practice for 22 years. He is the immediate past president of the California Orthopaedic Association.

Peter A. Caprise, MD. Dr. Caprise works as an orthopedic surgeon at The Orthopaedic Center of Central Virginia in Lynchburg, Va. He specializes in arm, hip, knee and shoulder surgery and provides joint replacement, arthroscopic surgery and sports medicine surgeries to his patients. Dr. Caprise is affiliated with Lynchburg (Va.) General Hospital and Virginia Baptist Hospital, also in Lynchburg, as well as The Surgery Center of Lynchburg.

John Caruso, MD. Dr. Caruso has more than 16 years of neurological surgery experience and currently practices at Parkway Neuroscience and Spine Institute in Hagerstown, Md. Dr. Caruso has been in private practice with Neurosurgical Specialists, LLC, in Hagerstown. He is actively involved in the national affairs of Blue Chip Surgical Partners.

Peter Cimino, MD. Dr. Cimino practices orthopedics at Omaha Orthopedic Clinic and Sports Medicine in Nebraska, a center with over 70 years of experience in orthopedic service. He specializes in orthopedic surgery of the foot and ankle, hip, knee, shoulder and elbow, as well as sports medicine.

James R. Colgan, MD. Dr. Colgan is a member of board of managers of Sierra Surgery Hospital, a hospital/physician joint-venture surgical specialty hospital in Carson City, Nev. He is also chairman of the board for Carson Ambulatory Surgery Center and the founder of Physicians Managed Care.

R. Blake Curd, MD. Dr. Curd, a leader in the physician-owned hospital field, is an upper extremity and general orthopedics physician with the Orthopedic Institute in Sioux Falls, S.D., and serves as a director on the board of Physician Hospitals of America. He also serves as the interim executive director of Surgical Management Professionals.

Christopher Danis, MD. Dr. Danis is in his twentieth year of practicing hand surgery in Dayton, Ohio. Ten years ago, he initiated Far Hills Surgical Center, a hospital-physician joint-venture ASC in Dayton where he continues to serve on the board. Dr. Danis is currently affiliated with Dayton Children's Medical Center of Dayton, and from 2006 to 2007, he served as chief of staff at Miami.

Daniel C. Daube, MD. Dr. Daube is the director and CEO of the Surgical Center of Excellence in Panama City, Fla. He also practices with the Gulf Coast Facial Plastics and ENT Center in Panama City and is on the clinical faculty at Tulane University Medical Center. Dr. Daube is board certified in otolaryngology and facial plastic and reconstructive surgery and is a member of numerous professional societies.

Philip A. Davidson, MD. Dr. Davidson is the founder and former CEO of Tampa Bay (Fla.) Specialty Surgery Center and now practices orthopedics with Heiden Orthopaedics in Park City, Utah. He specializes in cartilage restoration and shoulder surgery and is an official consultant of Major League Baseball and the National Football League.

John W. Dietz, Jr., MD. Dr. Dietz is an orthopedic spine surgeon with OrthoIndy and the Indiana Orthopaedic Hospital in Indianapolis. Dr. Dietz has served on the OrthoIndy board of directors since 2000 and currently holds the position of secretary. When OrthoIndy decided to develop IOH, he chaired the planning committee and then served as the chairman of the board of managers. Dr. Dietz is an inventor and has been awarded patents on surgical instruments used in endoscopic spine surgery.

Douglas R. Dodson, DO. Dr. Dodson practices orthopedics at Alamogordo Orthopaedics and Sports Medicine in New Mexico. His special interests include hip and knee reconstruction, back pain, arthritis, foot and ankle disease, work-related injuries and anterior cruciate ligament injuries. Dr. Dodson is the former chief of staff of Gerald Champion Memorial Hospital.

Stephen E. Doran, MD. Dr. Doran is chairman of the board of Midwest Surgical Hospital in Omaha, Neb., and practices with Midwest Neurosurgery & Spine Specialists, also based in Omaha. His special areas of interest include spinal instrumentation, stereotactic and functional neurosurgery, deep brain stimulation and disorders of the spine. He has received national recognition for his research in gene therapy related to the central nervous system.

Ken Drazan, MD. Dr. Drazan is a physician and managing director of healthcare services investments for Bertram Capital Management based in San Mateo, Calif., which includes GENASCIS among its portfolio companies. He was a leading academic liver transplant surgeon and basic scientist at Stanford University and UCLA.

James P. Emanuel, MD. Dr. Emanuel is an orthopedic surgeon practicing with Parkcrest Orthopedics in St. Louis, a center that specializes in upper and lower extremities. Dr. Emanuel specializes in the care of the upper extremity and has extensive experience in arthroscopic shoulder reconstruction.

John Fitz, MD. Dr. Fitz is the founder of The Surgery Center of Farmington (Mo.), a 10-year-old, multi-specialty surgery center, where he works as a physician. He has been in the private practice of comprehensive ophthalmology for 23 years and also started Precision Eye Care in Farmington, Mo., in 1986. Dr. Fitz was the first Crystalens-certified surgeon in southern Missouri and eastern Illinois.

Donald W. Floyd, MD. Dr. Floyd is an orthopedic surgeon practicing with Texas Surgical Center in Midland. He has been in private practice since 1982 and serves as team physician for Midland College and Midland Rockhounds AA Baseball Team, the Oakland Athletics' affiliate. Dr. Floyd has worked with the U.S. Olympic Committee Sports Medicine Program in several Olympic Games.

John A. Foster, MD. Dr. Foster is an otolaryngologist practicing with Spartanburg Ear, Nose and Throat in South Carolina. He has been with the center since 1991. While Dr. Foster's main interest is in general otolaryngology, he also specializes in pediatric otolaryngology, nasal and paranasal sinus disease and the treatment of snoring and obstructive sleep apnea.

John Fontana, MD. Dr. Fontana is an obstetrician/gynecologist practicing at Beaufort Ob-Gyn in Beaufort, S.C. He also serves on the staff at Beaufort Memorial Hospital. Dr. Fontana has held faculty positions at Hershey Medical Center at Penn State University and Dunham Army Hospital.

Robin Fowler, MD. Dr. Fowler is the medical director of Interventional Spine & Pain Management, based in the Atlanta area, and he has developed several different surgery centers in Georgia, Texas and New Mexico. He is also an active staff member at the Newton and Rockdale Medical Centers. During his tenure as a pain practitioner, he has performed more than 5,000 epidurals and pain procedures.

James L. Fox, Jr., MD. Dr. Fox is the founding leader of the Ravine Way Surgery Center in Glenview, Ill., and practices at the Illinois Bone & Joint Institute. He is a board-certified orthopedic surgeon who has been practicing for more than 20 years. His clinical interests include general orthopedic surgery, including fracture care and arthroscopy, as well as orthopedic oncology.

Eric J. Freeh, DO. Dr. Freeh practices orthopedics at Alamogordo Orthopaedics and Sports Medicine in New Mexico. Dr. Freeh specializes in trauma surgery, shoulder injury and osteoporosis and has successfully treated thousands of fractures. In addition to his clinical work, he serves as an examiner for the American Osteopathic Board of Orthopaedic Surgery.

Robert Gannan, MD, PhD. Dr. Gannan is the founder and clinical strategies advisor for Doylestown, Pa.-based Physicians Endoscopy. Dr. Gannan established Eastside Endoscopy Center as one of the first outpatient endoscopy centers in Washington State. He retired from clinical practice in Dec. 2006. Dr. Gannan is a regular speaker at national meetings of gastrointestinal physicians regarding practice and development trends.

David S. George, MD. Dr. George is an ophthalmologist with The Eye MDs of George, Strickler and Lazer, based in Marietta, Ohio. His special interests include topical cataract surgery and glaucoma and diabetic eye care, as well as refractive surgery. He is a member of the board of directors for the ASC Association.

Gregory George, MD, PhD. Dr. George is the founding principal of SurgCenter Development, which partners with local surgeons to create physician-owned and operated ASCs. Under his leadership, SurgCenter Development has developed over 60 profitable, physician-owned ASCs.

Scott E. Glaser, MD, FIPP. Dr. Glaser is a well-respected pain specialist and founder of the Pain Specialists of Greater Chicago in Burr Ridge, Ill. He serves as director on the national board of the American Society of Interventional Pain Physicians and was heavily involved in the lobbying efforts required to ensure passage of the NASPER bill and still works closely with the Illinois Department of Health and the chief pharmacist to implement the program in Illinois.

John H. Hajjar, MD. Dr. Hajjar is the CEO of Urology Specialty Care in northern New Jersey. After spending time researching the genetic aspects of kidney cancer, Dr. Hajjar turned his focus to clinical urology and patient care. He has held appointments as chief of urology at St. Joseph's Hospital in Paterson, N.J., an associate professor at NYU Medical Center and an urologist at The Valley Hospital in Ridgewood, N.J., and The Englewood Hospital in Englewood, N.J.

John R. Harvey, MD, FACC. Dr. Harvey formed the Oklahoma Cardiovascular Associates (formerly the Heart Group of Oklahoma), a 40-man cardiovascular group in Oklahoma City, Okla. He is currently president and medical director of the Oklahoma Heart Hospital in Oklahoma City and serves as a director on the board of Physician Hospitals of America.

Scott Holley, MD. Dr. Holley is the president and founder of Great Lakes Plastic & Hand Surgery in Portage and Battle Creek, Mich. He is board certified in general surgery, plastic surgery and holds the certificate of added qualification as a specialist in hand surgery. Dr. Holley is president of the Michigan Association of Hand Surgery and is a member of numerous professional societies.

Stephen Holst, MD. Dr. Holst practices urology at Big Horn Urology in Sheridan, Wyoming. He earned his MD from the University of Colorado and also completed his residency in surgery and urology at the university. He is affiliated with the American Board of Urology, the American Lithotripsy Society, the American Urological Association and Rocky Mountain Urological Society.

Young B. Huh, MD. Dr. Huh is a gastroenterologist with Gastroenterology Associates, P.C., in Bettendorf, Iowa. He has published work in the Annals of Internal Medicine. Dr. Huh is board certified in internal medicine and gastroenterology and hepatology. He practices at the Center for Digestive Health, which was established in 2004 as a joint venture between Gastroenterology Associates, P.C. and Genesis Medical Center.

Jack E. Jensen, MD, FACSM. Dr. Jensen is a board-certified orthopedic surgeon and medical director of Athletic Orthopedics and Knee Center, an integrated healthcare plaza specializing in the care of knees, and the founder of a surgery center in Houston. Dr. Jensen has been distinguished with the title Fellow of the American College of Sports Medicine.

Douglas D. Koch, MD. Dr. Koch is medical director of Baylor Vision, the refractive surgery clinical and research group at Baylor College of Medicine. He is also professor of ophthalmology at the Cullen Eye Institute at Baylor College of Medicine. He is editor of the Journal of Cataract and Refractive Surgery and was named one of the top 10 refractive surgeons in the United States in a survey by *Ophthalmology Times*.

Marc E. Koch, MD, MBA. Dr. Koch is the president and CEO of Somnia Anesthesia Services based in New Rochelle, N.Y., where he focuses on ensuring that all efforts further the company's mission of offering high-quality, cost-efficient anesthesia solutions to hospitals, ASCs and office-based facilities nationwide. Dr. Koch co-founded Resource Anesthesiology Associates in 1996.

Satish Kodali, MD. Dr. Kodali is an ENT physician and one of the physician owners of The Surgery Center in Franklin, Wis., a joint venture between Associated Surgical & Medical Specialists and Aurora HealthCare Ventures. He currently serves as president of The Surgery Center's board of managers.

Donald Kramer, MD. With a medical practice spanning more than 25 years, Dr. Kramer has developed several successful ASCs in the Houston market and is the founder of Northstar Healthcare, which develops and, in conjunction with physician partners, owns and operates significant ASCs in concentrated markets. He serves also as president and medical director for Northstar.

Timothy Kremchek, MD. Dr. Kremchek is one of the leading shoulder surgeons in the country and is a physician with Beacon Orthopaedics & Sports Medicine in Sharonville, Ohio. His professional interests range from advanced arthroscopic repair of the shoulder and knee injuries to total joint reconstruction. Dr. Kremchek serves as medical director and chief orthopedic physician for the Cincinnati Reds.

Peter R. Kurzweil, MD. Dr. Kurzweil is the founder of the Surgery Center of Long Beach (Calif.) and is an internationally recognized orthopedic surgeon with expertise in arthroscopic and reconstructive surgery of the knee and shoulder and the treatment of athletic injuries. He serves as chairman of the department of orthopedics at Long Beach Memorial Medical Center.

Brent Lambert, MD. Dr. Lambert has revolutionized approaches to ASC management. He is the chairman of the board and a founder of Ambulatory Surgical Centers of America and takes a hands-on approach to ASC management. He is currently responsible for business development at ASCOA. Prior to the founding of ASCOA, Dr. Lambert was the developer and owner of three ASCs, including the first eye ASC in New England.

Gregory Lauro, MD. Dr. Lauro is the president and medical director of Laurel Surgical Center in Greensburg, Pa. Dr. Lauro is a board-certified orthopedic surgeon who opened the center in 2004 with a group of surgeon-investors. The center grew from around 25 cases per week in 2004 to nearly 150 cases per week in four years. The center has been in partnership with Meridian Surgical Partners since 2007.

Jeffrey Leider, MD. Dr. Jeffrey Leider is a co-owner of Great Lakes Surgical Center in Southfield, Mich., as well as a physician and surgeon at the American Ear, Nose and Throat Institute in Farmington, Mich. He has published numerous research articles, including one on the effect of head position on Eustachian tube function.

Lance J. Lehmann, MD. Dr. Lehmann is an interventional pain physician who spends a tremendous amount of time studying business and healthcare. He is a physician with the Pain Consultants of Florida in Hollywood, Fla. He is board certified in pain management by the American Board of Anesthesiology and the American Board of Pain Medicine.

Jay R. Levinson, MD. Dr. Levinson serves as medical director of Michigan Endoscopy Center in Farmington Hills, Mich. An accomplished gastroenterologist, Dr. Levinson was recognized by his peers as one of the region's most respected gastroenterologists in Detroit Magazine's Top Doc survey in 2005 and 2008.

Marshall S. Lewis, MD. Dr. Lewis is an orthopedic surgeon practicing in Bakersfield, Calif., where he has established medical privileges at every major hospital in the area. He serves as chief of orthopedic surgery for several different hospitals and also runs a private practice, where he focuses on combining the latest technology with his decades of orthopedic experience.

Stephen Lloyd, MD, PhD. Dr. Lloyd is a board-certified internist who has practiced in the Midlands in South Carolina for nearly 30 years. Lloyd currently practices at South Carolina Medical Endoscopy Center, where he has trained over 100 physicians in colonscopy.

Thomas Lorish, MD. Dr. Lorish is the medical director of the Providence Brain Institute in Portland, Ore. He is a physiatrist and tremendous leader of their efforts to move towards an ASC effort and philosophy. With his help, Providence has become one of leaders in ASC joint ventures in the country.

James J. Lynch, MD, FACS. Dr. Lynch is the president, founder and CEO of SpineNevada based in Reno, Nev., and he also serves as the director of spine service for Regent Surgical Health. He specializes in complex spine surgery, cervical disorders, degenerative spine and spinal deformities. He is one of only a handful of spine surgeons with three fellowships in the specialty of spine surgery.

Laxmaiah Manchikanti, MD. Dr. Manchikanti is the medical director of the Pain Management Center of Paducah (Ky.) and Ambulatory Surgery Center in Paducah. He is the CEO and chairman of the board of the American Society of Interventional Pain Physicians. Through his work with various organizations, Dr. Manchikanti has been instrumental in the preservation of interventional pain management through specialty designation, mandatory Carrier Advisory Committee representation, reimbursement and the passage of NASPER.

Ajay Mangal, MD, MBA. Dr. Mangal is the founder, CEO and a board member of Prexus Health Partners, and is also a board-certified ENT physician. As a hands-on executive at Prexus, he has been instrumental in developing ASCs and assisting existing centers and hospitals to prosper. He is on staff at Butler County Medical Center, Fort Hamilton, Mercy Fairfield and Cincinnati Children's Hospitals.

Thomas D. Meade, MD. Dr. Meade is a senior partner with the physician group that drives the Surgery Center of Allentown (Pa.), OAA Orthopedic Specialists. He specializes in knee surgery, both sports injuries and joint replacements (with the rare exception of displaced clavicle fractures, where he is recognized as a leading expert in surgical treatment).

Keith Metz, MD, JD, MSA. Dr. Metz is a practicing clinical anesthesiologist and medical director at Great Lakes Surgical Center in Southfield, Mich. Dr. Metz serves on the board of directors for the ASC Association and was program committee chairman for the association's first meeting held in San Antonio.

Jeffrey Michaelson, MD. Dr. Michaelson specializes in orthopedic surgery at the Porretta Center for Orthopaedic Surgery in Southfield, Mich, as well as Providence and Providence Park Hospital in Novi, Mich., and DMC Surgery Hospital in Madison Heights, Mich. He was recognized by his peers as one of Detroit's most respected orthopedic specialists in HOUR Detroit magazine's annual "Top Docs" ranking in 2008.

Thomas K. Miller, MD. Dr. Miller is an orthopedic surgeon at the Roanoke (Va.) Ambulatory Surgery Center and the Roanoke Orthopaedic Center. He has specialty experience in sports medicine, arthroscopy and knee and shoulder reconstruction. Dr. Miller has been team physician for the U.S. National Triathlon Team and the Salem Red Sox baseball team.

Thomas Miller, DPM. Dr. Miller is a board-certified podiatrist at the Surgery Center of Beaufort in South Carolina. A member of the Podiatry Associates of Beaufort, Dr. Miller earned his MD from Ohio College of Podiatric Medicine in Cleveland and completed his residency in podiatric surgery from Northwest General Hospital in Knoxville, Tenn. He is also affiliated with Beaufort Memorial Hospital, a Duke Medicine affiliate.

William C. Mobley, MD, FACS. Dr. Mobley is a practicing urologist with Davenport, Iowa-based Urological Associates. He is certified by the American Board of Urology and is a fellow of the American College of Surgeons and is a member of the Iowa Medical Society, the American Urological Association, the American Association of Clinical Urologists, the American Fertility Society and the American Medical Association.

Eric Monesmith, MD. Dr. Monesmith has performed extensive studies on total knees performed in surgery centers and hospitals and is a practicing physician with OrthoIndy in Indianapolis. He specializes in the treatment of arthritic knees and hips. Dr. Monesmith is a past president of the Indiana Orthopaedic Society.

Daniel B. Murrey, MD. Dr. Murrey is CEO of OrthoCarolina and a spine surgeon practicing at the OrthoCarolina Spine Center in Charlotte, N.C. He specializes in treatment of both surgical and nonsurgical spinal disorders, with special interest in cervical spine surgery, spinal deformities and disk replacement.

Bergein Overholt, MD, FACP, MACG. Dr. Overholt is a physician with Gastrointestinal Associates in Knoxville, Tenn. He served in the Cancer Control Program of the U.S. Public Health Service and developed the flexible fiber-sigmoidscope-colonscope, which earned him the Schindler Award from the ASGE and the William Beaumont Award from the AMA. Dr. Overholt has served as president of the ASGE and the American Association of Ambulatory Surgery Centers and is a founding member and past president of the Tennessee Society for Gastrointestinal Endoscopy.

Paul D. Pace, MD. Dr. Pace is a hand surgeon practicing at the San Antonio Orthopaedic Group in San Antonio, where he has worked since 1998. He previously practiced with the Hand Associates of South Texas in San Antonio from 1982-1998. Dr. Pace's special interests include carpal tunnel syndrome, care of wrist and hand fractures, tendon repair, nerve repair, trigger finger and pediatric hand and wrist injuries, among others.

Greg Parsons, MD. Dr. Parsons is the medical director of the Carolina Surgical Center, a joint venture with Tenet Health Systems in Rock Hill, S.C. He has been on the staff of the center since its beginning in 1989 and has been the president of the physician group for more than 10 years. Dr. Parsons was named one of North Carolina's best doctors in 2009 by Boston-based rating company Best Doctors.

Kenneth Pettine, MD. Dr. Pettine is the co-founder of Rocky Mountain Associates in Orthopedic Medicine in Loveland, Colo. He has an extensive background in spinal surgery, research and rehabilitation and is board certified. Dr. Pettine co-invented, designed and patented the Maverick Artificial Disc, a new technology for neck and back intervertebral disc replacement.

Stanford R. Plavin, MD. Dr. Plavin has served as a member of Ambulatory Anesthesia of Atlanta since its inception and has been the managing partner for the last four years. During his career with Ambulatory Anesthesia of Atlanta, Dr. Plavin has advocated for improved patient safety, saying that appropriate licensed and trained providers are essential during administration of anesthesia.

Thomas J. Pliura, MD, JD. Dr. Pliura is a physician, healthcare lawyer and the founder and manger of four ASCs, with a potential fifth under development. Additionally, he is the founder of zChart EMR, an electronic medical records related company. He is a member of the American Medical Association, the Illinois State Medical Society and the McLean County Medical Society. In 1998, he sought and received the first favorable Medicare Advisory Opinion in the country, certifying that a proposed ASC was exempt from Stark Laws under a rural provider exemption.

William A. Portuese, MD. Dr. Portuese is the current president of the Washington State Chapter of Facial Plastic Surgeons, as well as a clinical instructor in the department of otolaryngology in head and neck surgery at the University of Washington in Seattle. Dr. Portuese is an active advocate for facial plastic surgeons in his state and has supported the move toward health savings accounts that would reduce the number of uninsured Americans.

Thomas E. Price, MD (R-Ga.). Dr. Price is an orthopedic physician who now serves in the U.S. House of Representatives, representing the sixth district of Georgia. Dr. Price has been an

outspoken advocate for patient-centered healthcare reform in Washington, D.C., and developed the Comprehensive HealthCARE Act, designed about positive changes to provide access for all Americans to affordable, quality healthcare.

David J. Raab, MD. Dr. Raab is the founder, president and CEO of the Illinois Sports Medicine & Orthopedic Surgery Center in Morton Grove, Ill., and an orthopedic surgeon with Illinois Bone and Joint Institute in Des Plaines, Ill. He specializes in orthopedic surgery in sports medicine, total joint replacement and arthroscopy, among other areas of interest.

Michael Redler, MD. Dr. Redler is an orthopedic surgeon at Surgery Center of Fairfield County in Bridgeport, Conn., as well as a founding partner of the Orthopaedic and Sports Medicine Center, which has five locations in Connecticut. He is also the orthopedic consultant to major league lacrosse and serves as head team physician for Sacred Heart University.

Wallace Reed, MD. Anesthesiologist Dr. Reed is credited with co-founding the nation's first ASC in Phoenix, Ariz., and has been recognized for his "vision and tireless advocacy on behalf of ASCs," according to a 2010 statement by ASC Association President Kathy Bryant. Dr. Reed and his late partner, John L. Ford, founded Surgicenter in 1970 to provide patients with high-quality, affordable and accessible healthcare, setting the standard for ASCs all over the country.

J. Michael Ribaudo, MD. Dr. Ribaudo has more than 27 years of experience as a surgeon, healthcare executive and real estate developer and currently serves as CEO and chairman of Ballwin, Mo.-based Surgical Synergies. He is a pioneer in the development of physician-owned ASCs and, in 1982, developed the largest freestanding outpatient surgery center in the country in a city with 28 other competing hospitals.

Herbert Riemenschneider, MD. Dr. Riemenschneider is the principal physician at Riverside Urology and the founder of Knightsbridge Surgery Center, both in Columbus, Ohio. A local pioneer in cryosurgical ablation for treatment of prostate cancer, he performed the first prostate cryoablation in Ohio.

Steven Robinson, MD. Dr. Robinson is a board member and practicing plastic surgeon at Riverside Outpatient Surgery Center in Columbus, Ohio. He is also an active member of the Aesthetic Society and the American Society of Plastic and Reconstructive Surgeons. His ASC, Riverside Outpatient Surgery Center, has more than 20 co-owners and hosts a variety of specialties, including plastic surgery, ophthalmology, ob-gyn and urology.

Paul L. Rohlf, MD. Dr. Rohlf began practicing at Urological Associates in 1969 and retired in 2007. During his career, Dr. Rohlf served as president of the American Association of Ambulatory Surgery Centers. He was the initial urologist who obtained the first surgery center certificate of need for a center in Iowa and remains a strong leader in the ASC industry following his retirement.

L. Edwin Rudisill, Jr., MD. Dr. Rudisill is one of the leading hand surgeons in the country and practices with The Hand Center in Greenville, S.C. Dr. Rudisill holds a certificate of added qualifications in surgery of the hand and is a member of the American Society of Surgery of the Hand, American Society of Reconstructive Microsurgery and is board certified by the American Board of Orthopaedic Surgery.

Michael E. Russell, II, MD. Dr. Russell is an orthopedic surgeon with Azalea Orthopedics and is a board member at the Texas Spine & Joint Hospital in Tyler, Texas. He specializes in the treatment of spine injury, deformity and degeneration and serves as a director on the board of Physician Hospitals of America.

James W. Rust, DPM. Dr. Rust has been in private practice since 1988. In 1991, he joined Atlantic Podiatry Associates in Daytona Beach, Fla., where he currently practices. He also works with Twin Lakes Surgical Center in Daytona Beach and serves on the faculty at Florida Sate University College of Medicine.

Kuldip S. Sandhu, MD, FACP, FACG. Dr. Sandhu is a gastroenterologist at the Sutter Roseville (Calif.) Endoscopy Center in and is president of Capitol Gastroenterology Consultants Medical Group. He received his medical degree from Punjabi University, Patiala, India, and completed his internship and his residency in internal medicine at MLK-Drew Medical Center in Los Angeles.

Kent Sasse, MD, MPH, FACS. Dr. Sasse is one of the leading bariatric physicians in the country, serves as the director of the Western Bariatric Institute in Reno, Nev., and is an attending surgeon at several hospitals in the area. He is the founder of the International Metabolic Institute. Dr. Sasse is the author of two recent books titled Life-Changing Weight Loss and Doctor's Orders: 101 Medically Proven Tips for Losing Weight.

Hooman Sedighi, MD. Dr. Sedighi is a physical medicine and rehabilitation physician who has practiced as a private practice physician in Dallas since 1997. Dr. Sedighi is an equity partner in two Gulf States long-term acute care hospitals in Dallas and DeSoto, Texas, where he was responsible for the development and formation of the physician partnerships for both hospitals.

David Shapiro, MD, CPHRM, LHRM, CHC. Dr. Shapiro is a partner in Ambulatory Surgery Center, an ASC consulting firm, and is the chair of the Ambulatory Surgery Foundation and chair-elect of the ASC Association. Previously, Dr. Shapiro held the position of senior vice president of medical affairs for Surgis, an ASC management company, serving as the corporate medical director for more than 20 facilities.

Joshua A. Siegel, MD. Dr. Siegel is the sports medicine director at Access Sports Medicine & Orthopaedics in Exeter, N.H., and the founding partner and managing member of Northeast Surgical Care. Dr. Siegel has treated professional, national and Division I collegiate athletes and has mastered the latest techniques in arthroscopic surgical treatments of the knee, shoulder and elbow.

Thomas A. Simpson, MD, FACS. Dr. Simpson is chairman of the board of directors for the Iowa City Ambulatory Surgery Center and led the board of this multi-specialty ASC as it came together to plan and develop the ASC with Mercy Hospital. He serves on the staff for ENT Medical Services and belongs to numerous academic societies and associations. He also serves as president of the board of directors for Mercy of Iowa City Regional PHO.

Eric J. Stahl, MD. Dr. Stahl, a board-certified orthopedic surgeon specializing in sports injuries and shoulder and knee surgery, is the president of Golden Ridge Surgery Center in Golden, Colo. He also specializes in sports medicine at the Panorama Orthopedics and Spine Center and serves as vice president of the Colorado Ambulatory Surgery Center Association.

Steven Stern, MD. Dr. Stern is a Harvard-trained orthopedic physician. He is the medical director and the vice president of neurosciences orthopedic and spine of United Healthcare. Prior to coming to United Healthcare, he was a leading surgeon at Northwestern Memorial Hospital in Chicago and has developed a very successful surgery center.

David W. Strege, MD. Dr. Strege specializes in orthopedic surgery at Mid County Orthopaedic – Bellevue in St. Louis, Mo. He works with St. John's Mercy Health Care, St. Mary's Health Center and Missouri Baptist Medical Center, all in St. Louis. Dr. Strege specializes in hand and upper extremity surgery, general orthopedic surgery, reconstructive surgery and elbow and shoulder surgery and has served as a member of the Tissue Advisory Board for Mid-America Transplant Services since 1995.

Charles Tadlock, MD. Dr. Tadlock is the founder of Surgery Center of Southern Nevada in Las Vegas. He is also the CEO of Epiphany Surgical Solutions and an avid developer of surgery centers.

Larry Teuber, MD. Dr. Teuber, a neurosurgeon, is the founder and physician executive of Black Hills Surgery Center in Rapid City, S.D., one of the country's most successful small surgical hospitals. He also serves as the president of Toronto, Canada-based Medical Facilities Corp., medical director of Sioux Falls Surgical Hospital, which he founded in 1985, and founder and current managing partner of The Spine Center in Rapid City.

George M. Tinawi, MD. Dr. Tinawi is the president of Surgery Center Partners and its management subsidiary, Endoscopy Management Services Organization, which he founded with Samuel Marcus, MD. He was a practicing physician in Mountain View, Calif., from 1986-2004. He is board certified in both internal medicine and gastroenterology.

Vasudevan Tiruchelvam, MD. Dr. Tiruchelvam — Dr. Tiru to his colleagues and patients — has been a leader in the York, Penn., medical community for many years, have served as chief of the division of surgery at the York Hospital. He currently serves as vice-chairman of the York Hospital department of surgery, as well as the president of the York County Medical Foundation, the charitable arm of the York County Medical Society. As president of YCMF, he has led teams of physicians in providing free medical care to underserved patients in his local community and many foreign countries.

Arnaldo Valedon, MD. Dr. Valedon is the chief ambulatory division and managing partner of First Colonies Anesthesia Associates in Baltimore, Md. He is a diplomate of the American Board of Anesthesiology and currently serves on the ASC Association's Program Committee for ASCs for 2011. He is also a member of the search committee for the next president of the Ambulatory Surgery Foundation and ASC Association and a member of the Ambulatory Surgery Foundation board.

George A. Violin, MD, FACS. Dr. Violin is the founder of Medical Eye Care Associates in Massachusetts. He devotes most of his practice to cataract surgery, LASIK and related surgeries and was one of the early investigators of epikeratophakia, a precursor of current LASIK technology. Dr. Violin is one of the three founding principals of the Ambulatory Surgery Centers of America.

Jeffrey L. Visotsky, MD, FACS. Dr. Visotsky is a member of Illinois Bone and Joint Institute and founder of the Morton Grove (Ill.) Surgery Center. He is a board-certified orthopedic surgeon and specializes in conditions of the hand, elbow and shoulder, arthroscopy shoulder/elbow, shoulder reconstruction and replacement, among other areas.

Robert Welti, MD. Dr. Welti is the corporate medical director and COO, Western region, for Westchester, Ill.-based Regent Surgical Health. He served as the medical director and administrator of the Santa Barbara (Calif.) Surgery Center and was affiliated with Santa Barbara Cottage Hospital for 20 years. He has worked in both hospital-based surgery centers and smaller physician-owned ASCs.

Thomas Wherry, MD. Dr. Wherry is co-founder of Total Anesthesia Solutions, a company dedicated to addressing the emerging anesthesia subsidy crisis and developing innovative anesthesia service solutions for practitioners, hospitals and major health systems. He is currently a member of First Colonies Anesthesia Associates, a large anesthesia group that employs over 140 anesthesiologists, and he serves on the board for the group's management arm, Mid-Atlantic Practice Management.

Richard N.W. Wohns, MD, MBA. Dr. Wohns is a spine surgeon and one of the first physicians involved with the development of ambulatory spine practices. He is the founder of South Sounds Neurosurgery in Puyallup, Wash. He also founded Neospine, a spine ASC development company, which is currently part of Symbion Healthcare. He was one of the first neurosurgeons in the United States qualified to perform the revolutionary XLIF technique for minimally invasive lumbar fusions. ■

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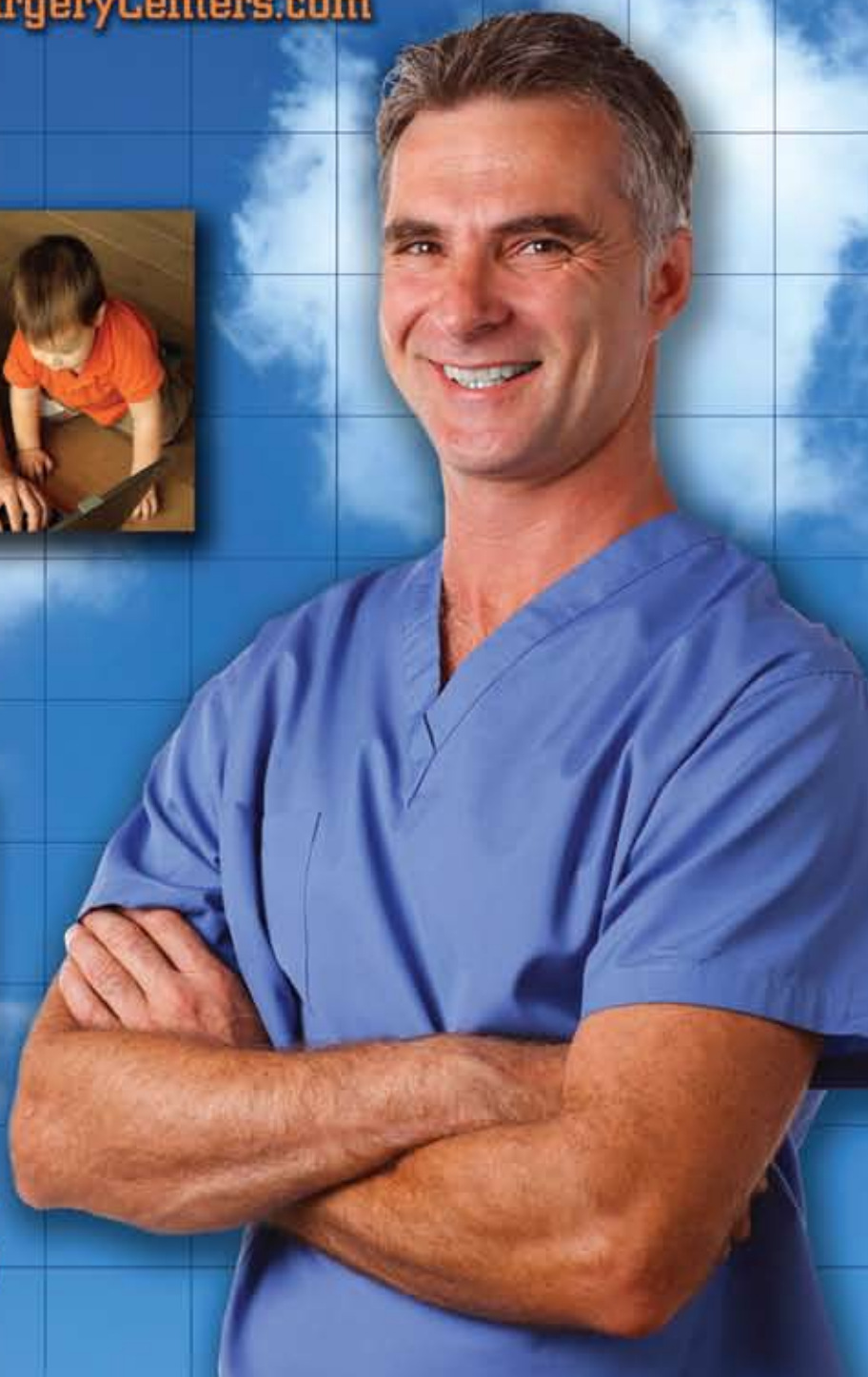

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3 Most Important ASC Specialties Resisting the Trend of Movement to Employment by Hospitals: A Quick Look at Orthopedics, Ophthalmology and Gastroenterology

By Scott Becker, JD, CPA, and Rob Kurtz

The three most important specialties to ASCs are orthopedics, ophthalmology and gastroenterology, based on case volume and revenue statistics. Many of these specialties can still excel in group practice due in part to significant control over the generation of their own business. The specialties do however face both short- and longer-term reimbursement challenges. Economic challenges are pushing many other specialties toward the security of hospital employment. This generally turns the physicians away from investing in and using ASCs.

In a report entitled "Hospitals Employing Physicians in Greater Numbers" by Merritt Hawkins:

> "According to Hawkins, physicians are accepting employed positions with hospitals in order to avoid the hassles of private practice, which include high malpractice premiums and struggles for reimbursement. Younger physicians in particular, he notes, are less willing to "hang up a shingle" and practice on their own. Hospitals, which went through a phase of employing mostly primary care physicians in the 1990s, are employing both primary care doctors and specialists today. Employment helps secure physician loyalty to hospitals, Hawkins says, and reduces direct competition between physicians and hospitals for medical procedures and tests."

The report indicates that the financial incentives offered to recruit physicians continue to increase, reflecting robust demand in most specialties. Specialties seeing the greatest increase in income offers over the past year, according to the report include urologists, otolaryngologists, cardiologists, orthopedic surgeons, emergency medicine physicians and family practitioners.

1. Orthopedics. Orthopedic specialists are autonomous by nature, says Brandon T. Frazier, vice president of acquisitions and development at ASCOA. "They want control of scheduling, equipment, interaction with the patient and they are turned off by the perceived bureaucracy of hospitals," he says. These specialists can make significantly more money if they stay in private practice and use an ASC and are typically confident in their ability to do so, he says. Orthopedic procedures yield the highest revenue per treatment of all ASC specialties, according to the Astor Group's "Investment in the Healthcare Industry" white paper.

High income potential is the major reason young specialists are more like to join a practice right out of school, Mr. Frazier says.

"Young orthopedic specialists often join an existing orthopedic practice which provides a sort of middle ground between solo practice and hospital staff," says Mr. Frazier. He adds that this move is in line with the potential income the specialists can make and the fact that they don't like to take orders from others, as would be the case in hospital environments. Joining an orthopedic practice will often naturally lead to performing procedures in an ASC if other physicians in the practice do so already.

Joshua A. Siegel, MD, director of sports medicine for Access Sports Medicine & Orthopaedics in Exeter, N.H., says a good reputation is an orthopedic specialist's main ammunition to develop a successful orthopedic practice and ASC. "Our main way of resisting hospital employment is to establish a reputation and good will that supersedes even our own center and make ourselves known in the community as the place to go for exemplary service," he says.

We should note that there are an increasing number of markets where specialists, including orthopedic surgeons, are aggressively being employed.

In an article entitled "Physician Alignment" by Ken Terry which appeared in the September 2009 issue of *HHN Magazine*, he provides a lengthy discussion as well as examples of employment trends involving specialists, and states:

> "Methodist Medical Center of Peoria, Ill., and its cross-town rival, OSF St. Francis Medical Center, already employ most of the primary care physicians in their market. Now they're going after specialists. Michael Bryant, Methodist's president and CEO, believes that in five to seven years, "Most of the doctors in Peoria will be employed by either our system or St. Francis."
>
> Something similar is happening in Greenville, S.C. Local hospitals are snapping up specialists, and for certain disciplines, they employ nearly every local physician. "There are no private-practice general surgeons left in Greenville County," notes Jerry Youkey, MD, vice president of medical services and dean of academic services for Greenville Health System University Medical Center. Other specialties in which a majority of doctors work for hospitals, he says, include cardiac surgery, colorectal surgery, neurosurgery, endocrinology, pulmonology and some pediatric subspecialties.

The article continues on as follows:

> ## Why Specialists Are in Demand
>
> The HSC survey, conducted before the recession was officially declared, found that many hospitals were employing physicians to compete with other hospitals. Some were hiring specialists to direct profitable service lines. Others decided that it was more cost-effective to employ specialists than to pay them large per diems to be on call. Some hospitals recruited outside physicians to fill gaps in their staff, "or to compete with physicians who were uncooperative with hospital initiatives." In some cases, they bought out specialists who might have otherwise built competing ambulatory surgery centers or specialty hospitals. They also hired physicians to increase hospital leverage with health plans. And many said they had to employ physicians to gain their cooperation in pay-for-performance and quality reporting programs.

The article also noted certain trends among specialties.

David Scroggins, a health care consultant based in Cincinnati, cites a pair of orthopedic surgeons who moved from Hawaii to Iowa because compensation was higher there. A recent MGMA survey found that experienced physicians were migrating to Texas and Florida, perhaps because those states have no income tax.

Despite these trends and decisions by some other orthopedic specialists, Dr. Siegel says he has no intention of selling his practice to a hospital.

"Although I believe there are many fine hospital-based and hospital-employed physicians, I believe that a doctor may give up the ability to establish his/her reputation as a doctor to that of the institution," he says. "For instance, there are many patients who would say I am going to the Cleveland Clinic, rather than to the specific doctor at the clinic, misunderstanding that the physicians are what makes the team and care so exemplary.

"I believe in a few instances that the institutional excellence may trump that of the individual doctors or groups such as at Mayo or Cleveland to name just a couple, but a vast majority of community hospitals who employ physicians cannot and do not look or even know exactly who they need to hire to create excellence whereas a small group that understands the medical field intimately will," he says.

2. Ophthalmology. According to Christopher Regan, managing director of The Chartis Group, many ophthalmologists do not find value in working at a hospital. "Physicians can afford to do it on their own and they often want to keep their money instead of partnering with a hospital," he says.

Hospitals may also put unnecessary restrictions on ophthalmologists, says David M. Kwiat, MD, FACS, of the Kwiat Eye and Laser Surgery in Amsterdam, N.Y..

"I am not likely to sell my practice to a hospital due to the constraints on efficiency and the decreased access to advanced technology," Dr. Kwiat says. "While this model may work well for primary care and its specialties, it falls short for the surgical practice. To offer the best care for our patients it is vital to stay current. In a hospital-owned setting there are large bureaucratic barriers to this and little incentive to do so.

"Selling to a hospital is analogous to government run medicine where the doctor is truly an employee and has the resulting decision-making power," he says. "I understand the desire of certain physicians to sell their practice for various reasons (retirement, illness, financial difficulties, etc.). However, the best medicine will almost always be provided by private practices. There is a much larger incentive for quality outcomes and patient care when your name is on the building instead of the hospital's."

John Narcross, senior engagement manager at The Chartis Group, has found that hospitals also aren't very interested in employing these specialists. "The only time I hear about hospital involvement in an employee situation with ophthalmologists is in trauma coverage," he says.

According to William L. Rich III, MD, medical director of health policy for the American Academy of Ophthalmology, ophthalmology thriving in ASC is helped by the fact that the specialty is not attractive financially to hospitals. "Hospitals aren't buying ophthalmology practices because they want specialties that generate more revenue for hospitals."

Ophthalmologists were some of the first adopters of ASCs because they typically don't embrace the hospital model, says Mr. Frazier. "They become frustrated with hospitals because of lack of procedure time and efficiency of turnover between cases that their specialty demands." Ophthalmologists tend to be very entrepreneurial and risk tolerant, and as long as they can market themselves, patients will beat a path to their doors, he says.

3. Gastroenterology. Hospitals need gastroenterologists more than GIs need hospitals. "Hospitals always have a need for GI procedures, but much of them can be done out of an outpatient setting," says Mr. Narcross. Even some third-party-payors are also helping to keep the procedures in ASC. In Massachusetts, for example, some payors are encouraging GIs to do procedures in an outpatient setting because it is so much cheaper, says Jeff Peo, a vice president of acquisitions and development at ASCOA.

There's no question that an ASC is a higher quality, lower cost environment for providing service, says John M. Poisson, executive vice president and strategic partnership officer at Physicians Endoscopy. More and more of these specialists are recognizing this fact. According to SDI's *Outpatient Surgery Center Profiling Solution,* from 2000 to 2009, gastroenterology had the most growth of any ASC specialty at 23 percent.

Mr. Frazier says GIs are making a shift away from being dependent on patient referrals from hospitals to self-referrals. "More patients are having colonoscopies for preventative measures and they are savvy enough to find their own physician instead of relying on a hospital referral," he says.

James Weber, MD, a gastroenterologist and president of the Texas Digestive Disease Consultants, says gastroenterologists have to be careful about giving up too much control to the hospitals or other large organizations or else they will have little control of their own future regarding how they practice medicine. This is the reason Dr. Weber says he and the group of physicians he works with have no interest in selling their practice to a hospital system.

"We enjoy our autonomy, with the ability to work at any facility and with any referring doctors," he says. "We feel that independently we can provide the best quality of care while maintaining a better work environment. The pride of ownership is reflective in one's work." ■

12 Sound ASC Financial Practices

By Kim Woodruff, VP of Corporate Finance & Compliance, PINNACLE III

ASCs run lean operations and typically can afford to employ only a small office staff to conduct its business office operations. Problems can be created when one or two individuals are entrusted with the ASC's financial health. Due to limited resources, it is not unusual to discover that the employee who posts the payments to patient accounts also generates the deposit, delivers the deposit to the bank and/or generates the daily receipts report. This closed environment creates unnecessary risks for embezzlement, identity theft and deceptive business practices. Here are 12 key steps ASC owners and administrators can take to minimize these financial risks.

1. Begin with separation of duties in the business office. Take the cash control out of the hands of a trusted few and utilize outside resources to ensure security. Create an effective system of checks and balances by actively separating the cash flow processes associated with over-the-counter collections, phone receipts and mail receipts. One person handling multiple aspects of the finances of an ASC can create opportunities for fraudulent activities, which can end up being difficult to detect.

2. Establish a "lock box" through a banking institution to ensure mail receipts from patients and third-party payors are handled in a secure financial environment. Lock box services include retrieval of the mail from a post office box, scanning of the receipts and same-day deposit of the funds to the ASC's designated account. A lock box system is often perceived as an unnecessary expense but its value is in moving the mail receipts function out of the office to free up staff while simultaneously adding a necessary layer of security. Additionally, money deposited via a lock box is more quickly available for use by the facility and creates a seamless funds accounting process. In efforts to "go green" and create greater efficiency on their end, more and more third-party payors are offering the reimbursement option of electronic funds transfers. EFTs function effectively as direct deposits into a facility's designated account. Remittance advice information is typically facilitated through retrieval of reports from the payor's website or mailed to the ASC's remittance address. Create more rapid access to your reimbursement by utilizing a lock box and EFTs.

3. To handle bank deposits from point of service payments, set up a courier service. This way, facility employees are not handling both receipt of the payments and deposits of the collected cash to the facility's financial institution. It is worth it to pay someone who is bonded and insured to pick up cash and checks collected directly at the facility to minimize losses and avoid liability that could occur should an employee be involved in an accident or criminal attempt by an outside party to confiscate the funds intended for deposit.

4. Next, set up a system of checks and balances in your revenue cycle management. Before closing the month, ensure charges have been entered for all cases performed. If there are discrepancies, investigate. Was a cancelled case erroneously reported as performed? Has the documentation required to enter charges been received?

5. Ensure dollars deposited to the bank tie out to the payments posted. If they do not, explore why.

6. Routinely review credit balance reports to ensure refunds are being processed in a timely manner. Do not let credits sit. They create inaccuracies in your stated A/R days and knowingly retaining an overpayment constitutes fraud. Federal payors (e.g., Medicare, Medicaid, Federal BCBS and Tricare) expect providers to self-report credit balances. Failure to do so creates significant liability for an ASC.

7. Perform routine review of A/R over 60 days. Know the timely filing requirements for each of your payor contracts. If a claim is not worked within the designated timeframe, you may be denied the right to pursue reimbursement. When A/R accounts are older than 90 days, know why and how each account is being worked.

8. Track denials from payors. Make sure you trend denials over time to identify glitches in your system and processes. If you have a high initial claim rejection rate, determine what type of information is being routinely missed during the registration process and educate intake personnel to reduce processing delays.

9. Get into the habit of performing internal reviews to ensure adherence to your established policies, procedures, and processes. Notify business office personnel that internal reviews are being conducted to identify if work processes seem to be working for or against them. Fix those areas that are broken.

10. Audit staff compliance with HIPAA Privacy and Security Rules. Listen to how and where staff members discuss patient information. Are employees speaking about patients in the hallways or break room? Are computer screens positioned to prevent viewing by facility visitors? How is credit card information protected?

11. Check the accuracy of insurance verification and registration. Does your system contain data entry errors? Are payments posted in a timely manner? Are your policies related to point of service collections being followed? Are contracts loaded into your system and underpayments/overpayments worked accordingly?

12. At routine intervals, arrange for external audits. At least once a year have an audit of your coding conducted by an experienced coding firm. A good accounting audit will look at your financial practices with the intent of detecting whether or not you are observing sound financial practices. Often external coding and/or accounting audits will reveal small shifts in current practices are needed to close loops appropriately and to thoroughly protect your ASC's assets. ■

Learn more about PINNACLE III at www.pinnacleiii.com.

Distribution of Facility Profits to Owners & Should Same Corporation Own ASC and Practice: Q&A With Scott Becker

By Rachel Fields and Rob Kurtz

Scott Becker, JD, CPA, is a healthcare attorney and a partner in the national law firm of McGuireWoods.

Q: What are the most common ways ASCs determine and distribute the ASC facility profits among owners — do owners buy/have shares and are profits distributed by percentage of ownership?

Scott Becker: ASCs distribute facility profits based on the percentage of ownership the owners have in the facility. It is generally not legal to split the profits based on the value of business generated instead of the ownership. It is also highly suspect to split up or reallocate the ownership either based on expectations of referrals or past history of referrals.

Q: Should my ASC be owned by the same corporation as my practice?

Scott Becker: Generally an ASC is owned by a different corporation than the practice. There may be situations where ownership under the same entity may make sense due to a CON exemption or safe harbor situation. ■

If you have further questions, please contact Scott Becker at sbecker@mcguirewoods.com.

Critical ASC Mistake: Accepting Highest Bidder but Not Best Long-Term Partner

By Rob Kurtz

Kevin McDonough, senior manager at the Dallas office of VMG Health, discusses why an ASC looking for a partner shouldn't base its decision solely on who is offering the most upfront money.

Kevin McDonough: Some ASCs appropriately send out their ASC to bid, get a number of bids on it and then ultimately select who offers the most money upfront as opposed to who would be the best long-term partner. It may not be an insignificant amount of money, however when you look at it from a long-term perspective, oftentimes the appropriate and superior long-term partner — who may offer a lower initial bid — should be able to make that money back many times over in the way of enhanced distributions after the sale.

That's one thing we see particularly now that acquisition activities have started to pick up and most of the bids out there are relatively competitive. Oftentimes you have certain firms that aren't necessarily bound by fair market value opinion — smaller companies or those that aren't involved with a not-for-profit health system. They may often offer a higher multiple however they may be somewhat unfamiliar with the market which can result in the inability to capture additional volume and enhanced financial performance on the backside of the transaction.

ASCs need to ask potential partners what they could bring to the table after the transaction. How are you going to help us besides just taking money off of the table? That's obviously one goal, and an important goal for the group, but almost more importantly is what can you do to put us in a better position in the market than what we did entering into this transaction? Examples include enhanced managed care contracts, successful recruitment efforts, improved vendor supply contracts, recruitment of a well-trained staff and identifying potential long-term strategic opportunities. ■

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

Washington Hospital Receives ASC CON After State Supreme Court Ruling

By Rob Kurtz

Swedish Health Services in Seattle has received a certificate-of-need to build a five-OR surgery center after the Washington Supreme Court ruled the state's department of health appropriately determined there was a need for such a facility, according to a copy of the ruling filed Sept. 23.

Swedish Health Services applied for the CON to build the ASC in Bellevue, Wash., in Nov. 2002, which was opposed by Overlake Hospital Association and Evergreen Healthcare. The Washington DOH determined there was a need in East King County for the ASC and issued the CON to Swedish.

Overlake and Evergreen challenged the decision, working through the courts until the Washington Court of Appeals reversed lower court rulings on the basis that the DOH's decision to issue the CON "was arbitrary and capricious because it was based on an erroneous interpretation of the governing statutes and a misapplication of its own regulations," according to the ruling.

Swedish and the DOH challenged this ruling on the basis that "the Court of Appeals failed to accord sufficient deference to the Department's interpretation of its own regulation."

The Washington Supreme Court reversed the decision on the basis that the DOH made the correct decision to issue the CON to Swedish for several reasons including that the DOH did not ignore the state legislative goal of controlling costs and the DOH properly interpreted regulations to assure a sufficient supply of publicly available ASCs.

View a copy of the ruling about the Swedish Health Services surgery center at www.beckersasc.com/pdfs/Swedish%20ASC.pdf. ■

20 ASCs Performing More Than 10,000 Cases Annually

By Jaimie Oh and Rob Kurtz

Allied Physicians Surgery Center (South Bend, Ind.)

Annual case volume: More than 10,000 since 2003

Specialties: Orthopedics, podiatry, ophthalmology, pain, ENT, general surgery, gynecology, urology

Details: The Allied Physicians Surgery Center is an AAAHC-accredited facility that opened in Feb. 2000. Just three years after opening, the center started topping 10,000 cases a year. There are seven ORs and two minor procedure rooms with 82 physicians on staff. More than 20,000 procedures have been performed each year since 2007.

Keys to maintaining/building volume: Executive and Clinical Director Chuck M. Strasser, RN, CASC, says much of the ASC's success stems from the commitment by surgeons and staff to maintain high patient satisfaction and excellent clinical outcomes and below benchmark reported infection rates.

"We have a strong commitment to providing excellent surgical care with an economic focus," he says. "We strive to make available most insurance contracts as well as Medicare and Medicaid recipients. We are successfully recruiting surgeons and investigating new procedures (joint replacement and spine surgery)."

Ambulatory Surgery Center of Spartanburg (Spartanburg, S.C.)

Annual case volume: More than 10,000 in the last four years

Specialties: Gastroenterology, ophthalmology, general surgery, orthopedics, ENT, podiatry, pain, gynecology

Details: The ASC of Spartanburg is a joint venture between Spartanburg Regional Medical Center and a group of 34 physicians. It was opened in April 2002 and now has 50 surgeons on staff. The center has seven ORs and two endoscopy procedure rooms, with a bulk of its procedures being GI-related.

Keys to building/maintaining volume: On building and maintaining case volume, Administrator Mike Pankey, RN, MBA, says fast turnovers, a competent staff of busy surgeons and ease of scheduling keeps the volume of cases high.

Mr. Pankey comments that the ASC is actively recruiting new physicians and optimizing scheduling and room utilization in order to further develop the center's growth.

Berks Center for Digestive Health (Wyomissing, Pa.)

Annual case volume: More than 10,000 cases since 2005

Specialties: Gastroenterology

Details: Berks Center for Digestive Health opened in Dec. 2001 and has since been accredited by the AAAHC. The center feature three procedure rooms entirely dedicated to GI-related procedures. It is currently a joint venture with 10 physician owners and a management company called Physicians Endoscopy. In total, the staff has 13 physicians, who performed more than 13,000 procedures in 2009 alone.

Keys to maintaining/building success: Administrative Director John Gleason stresses creativity and adaptability as the key components to operating a successful ASC. Since the opening of the facility, hours have been extended to allow cases to end at a later time, schedules have been readjusted and turnover of procedures has been kept up in order to facilitate more procedures.

"We are constantly considering ways to add additional procedures to the schedule so as to increase volume," says Mr. Gleason. "And our staff and doctors have been adaptable enough to change to meet the center needs for the schedule." Mr. Gleason also says the facility is looking to move to a bigger facility to keep up with increasing case volume.

Centennial Surgery Center (Voorhees, N.J.)

Annual case volume: More than 10,000 since 2004

Specialties: Orthopedics, general surgery, urology, gastroenterology, colon/rectal, plastics, pain management, podiatry

Details: The physician-owned Centennial Surgery Center was established in Sept. 1999 by a group of 16 physicians. Since then, the center has grown to more than 60 physician users with four ORs, two endoscopy rooms and two short procedure rooms.

Keys to building/maintaining volume: Margaret T. Atkinson, BS, CPC, RMC, business manager of the AAAHC-accredited center, says a number of factors play into the center's high case volume. State-of-the-art equipment, the staff, constant physician recruiting ,quick turnaround times and patient satisfaction all play into the growth of the center.

Center for Ambulatory Surgery (West Seneca, N.Y.)

Annual case volume: More than 10,000 cases since 2002

Specialties: Gastroenterology, ophthalmology, orthopedics, general surgery, gynecology, plastics, podiatry, urology and pain management

Details: The Center for Ambulatory Surgery opened in June 2001 and has since been accredited by AAAHC and expanded to include four ORs and five GI procedure rooms. The facility is a joint ownership between 16 physicians and The C/N Group and has more than 100 credentialed physicians on staff.

Keys to maintaining/building success: Rajiv Chopra, principal and CFO for The C/N Group, says the surgery center focuses on building strong physician relationships and tried to identify and respond to clinical or operational issues on a timely basis. "As a result, physician participation in the center's governance is enthusiastic," Mr. Chopra says. Other factors contributing to the surgery center's success include focusing on hiring and retaining experienced staff, working with high quality anesthesia team and maintaining efficiency to drive operations. "For example, endoscopy and surgical operations have separate locations within the building due to the velocity of GI cases," he says.

Mr. Chopra also acknowledges the facility's emphasis financial discipline in order to make resources available over the long haul to support new specialties and physicians.

Central Utah Surgical Center (Provo, Utah)

Annual cases volume: More than 10,000 since 2003

Specialties: Orthopedics, gastroenterology, ophthalmology, otolaryngology, urology, general surgery, podiatry, pediatric dental, pain, OB/GYN, plastics

Details: Central Utah Surgical Center was opened in 1995 by Central Utah Clinic. The facility was syndicated in 1997 with a management company and several dozen physician partners. The facility has since been accredited by The Joint Commission and Medicare. The ASC has six ORs and two procedure rooms.

Keys to maintaining/building success: Administrator Jill Andrews, RN, BSN, CNOR, says several factors have contributed to the continued success of the surgery center, including the board of managers, which allows staff to manage the facility on a daily basis, flexibility with time and scheduling, and maintaining a staff that works well together. "We have good communications with physicians, our own staff and the physicians' office. [We also] have an anesthesia group that works as a team with the facility staff and physicians," she says.

Cincinnati Eye Institute Surgery Center (Cincinnati, Ohio)

Annual case volume: More than 10,000 since 2007

Specialties: Cataract, retina, plastics, glaucoma, cornea, YAG laser, argon laser

Details: The AAAHC-accredited Cincinnati Eye Institute Surgery Center opened in 1985 and now features six ORs and three procedure rooms in a 17,000-square-foot surgery center, with plans to open up two more ORs sometime in the future. A majority of their more than 10,000 surgeries performed annually are cataract surgeries, which make up approximately 7,000 of the cases. The physician-owned facility has 25 physicianusers on staff.

Keys to building/maintaining success: Todd D. Albertz, director of surgical services, says that training and educating staff has helped to maintain success at the Cincinnati Eye Institute. In regards to maintaining volume, he says managing block time has been essential. "[Another key to our success] has been properly managing the surgeons' expectations for block time versus their true needs for block time," he says. Using technology to strategize open block time has been essential in utilizing open OR time with other surgeons.

Cypress Surgery Center (Wichita, Kan.)

Annual case volume: More than 10,000 procedures since 2008

Specialties: Orthopedics, gynecology, ENT, ophthalmology, gastroenterology, urology, general surgery, plastics, oral and maxillofacial, and pain management

Details: Opened in Nov. 2000, the AAAHC-accredited Cyrpress Surgery Center was founded by Medical Director David Grainger, MD; Michael Brown, MD; and Bruce Tjaden, DO. The facility currently has 38 physician-owners and 28 non-investors that work on staff. The surgery center features six ORs, three procedure rooms and two GI suites.

Keys to building/maintaining volume: Judy Graham, administrator at Cypress Surgery Center, says the ASC market is deeply saturated, which makes it important to make sure the physicians stay happy. "We work very hard to meet their needs by accommodating their schedules, having the equipment that they use and not wasting their time," she says. A part of their marketing program in order to bring in and retain staff members is recruiting new surgery and GYN residents from the KU residency program.

Eastside Endoscopy Center (St. Clair Shores, Mich.)

Annual case volume: More than 10,000 since 2008

Specialties: Gastroenterology

Details: AAAHC-accredited Eastside Endoscopy Center opened its doors in April 1996 as a joint venture between eight physician owners and St. John Hospital and Medical Center in Detroit. Between two locations, the center collectively has six procedure rooms and 12 physicians performing procedures. As a center that was founded by a gastroenterology private practice, it is dedicated to GI endoscopy.

Key to building/maintaining volume: Administrator Beth Miller, RN, CASC, says paying special attention to patient and referral physician satisfaction, being patient-oriented and offering cost-effective services have all facilitated the growth of the facility.

Fernando Bermudez, MD, Medical Director, says the continuing frequent interaction with primary care physicians, offering continuing education events and marketing are all part of the plan to promote growth in the

future. "It has been a team effort among our staff, our physicians and our administrator who has played a significant roll in our success".

Kemp Surgery Center (Everett, Wash.)

Annual case volume: More than 10,000 cases since 2001

Specialties: Gastroenterology, ENT, orthopedics, urology

Details: Kemp Surgery Center was opened in Nov. 1997 by the Everett Clinic. To this day, it is owned by the 300-physician multi-specialty clinic and is now accredited by Medicare. With its primary focus being on GI procedures, the clinic houses four ORs and four GI rooms. The facility has performed more than 16,000 procedures performed in 2009.

Keys to building/maintaining volume: The center offers services that are not immediately available in its community, such as continuous peripheral nerve blocks for orthopedic procedures. Medical Director Nick Marassi, MD, says the focus of the ASC is not only on providing service to patients but also to surgeons and physicians. The center also offers state-of-the-art equipment for surgeons in the facility to utilize in order to maintain high quality care.

"[We plan to] keep one step ahead of the competition, provide a better, cheaper alternative and continue to follow our guiding principle of doing what is right for each patient," he says.

Kentucky Surgery Center (Lexington, Ky.)

Annual case volume: More than 10,000 cases since 2007

Specialties: Orthopedics, ENT, gastroenterology, general surgery, plastics, podiatry, dentistry, pain management, urology, vascular, colorectal, and pulmonary

Details: The Kentucky Surgery Center, which opened Dec. 1986 and is accredited by AAAHC and Kentucky Medicare, is a 28,000-square-foot center with seven ORs and three procedure rooms. This physician-owned facility was started by a handful of surgeons and anesthesiologists and now has more than 100 surgeons on staff.

Keys to building/maintaining volume: Administrative Director Glenda Beasley, RN, says maintaining high case volume stems from the staff and physicians jointly providing quality patient care with excellent patient outcomes. "Raising the bar with expectations of only providing care that can be parallel to none is the goal of the center on a daily basis," she says. "Every team member must buy into the notion of bringing their top performance and positive attitude everyday to maintain success on every level."

Lakeland Surgical and Diagnostic Center (Lakeland, Fla.)

Annual case volume: More than 10,000 cases since 2001

Specialties: Endoscopy, pain management, eye, cosmetic surgery, reconstructive surgery, general surgery, eye, gynecology, orthopedics, urology, radiation oncology, podiatry, otorhinolaryngology

Details: The AAAHC-accredited Lakeland Surgical and Diagnostic Center, which is owned by the two largest physician groups in the area and the largest regional medical center, opened in April 1996 as a joint venture by the Watson Clinic and the Lakeland Regional Medical Center. The facility has three locations with a collective six ORs. The main campus houses five procedure rooms. Lakeland Surgical and Diagnostic Center is projected to exceed 20,000 cases for the first time this year.

Keys to maintaining/building volume: The success of the ASC is largely attributed to the facility's leadership and a focused aim for high quality patient care and satisfaction from both patients and physicians.

"We have strong, capable management and attention to every possible operational detail," says CEO David G. Daniel, FACHE. "We plan to continue our past winning formula for success and to settle for nothing less than the very best in every aspect of our operations. If you do that, volume issues seem to take care of themselves."

Menomonee Falls Ambulatory Surgery Center (Menomonee Falls, Wis.)

Annual case volume: More than 10,000 since 2002

Specialties: Gastroenterology, general surgery, orthopedics, pain, ENT, gynecology, podiatry, ophthalmology, urology, plastic surgery

Details: The Menomonee Falls Ambulatory Surgery Center is a joint venture between a community hospital and two large medical groups which started in April 1994. The AAAHC-accredited ASC has five ORs, four GI rooms and a laser room. Approximately 45 surgeons work in the facility on a day-to-day basis. Since 2002, the center has performed over 12,000 procedures every year.

Keys to building/maintaining volume: Dianne Wallace, RN, BSM, BMA, executive director, says that the center's success partly has to do with seeking out new physicians to join and retaining highly skilled staff.

"The latest merger between our hospital owner and a large local academic medical center brings with it many new opportunities," Ms. Wallace says. "Many of the physicians associated with this new partner have never experienced what an ASC has to offer them and their patients. Our plan for continued growth includes recruiting many of these physicians and introducing them to this exciting surgical venue."

Michigan Endoscopy Center (Farmington Hills, Mich.)

Annual case volume: More than 10,000 since 2004

Specialties: Gastroenterology

Details: The Michigan Endoscopy Center is a gastroenterology-only specialty center with 13 GI physicians and three colorectal surgeons on its staff. It was opened in Jan. 2003 as a 65 percent physician and 35 percent Physicians Endoscopy joint venture. It has since been accredited by the AAAHC and grown to average 16,000 procedures annually over the past six years.

Keys to building/maintaining volume: Administrator Brien Fausone, MA, MBA, highlights the keys to the center's success were in providing an efficient wok environment for physicians with a clinical support team that prioritizes both the patient and the physician. Mr. Fausone says the future growth plans include recruiting new physicians and negotiating prime vendor arrangements with physician networks.

Northpoint Surgery and Laser Center (West Palm Beach, Fla.)

Annual case volume: More than 10,500 since 2006

Specialties: ENT, gastroenterology, gynecology, ophthalmology, retina, oral/maxillofacial, orthopedics, pain management and podiatry

Details: Northpoint Surgery and Laser Center opened in Sept. 1996 as a limited partnership with 13 physician owners. In 2003, they formed a joint venture with National Surgical Care. The center houses five ORs, two endoscopy suites and a pain management center with its own waiting room, preoperative and postoperative room as well as a procedure room. This AAAHC- and AHCA-accredited facility now has 32 physician owners and 25 other physicians on staff and has performed over 20,000 procedures a year since 2006.

Keys to building/maintaining success: Administrator Connie Casey, RN, CNOR, LHRM, suggests starting with well-known active physicians

in the community and recruiting hospital staff that the physicians are familiar with and trust. "Most physicians are drawn to the fact that they have worked with the same staff and know what to expect," Ms. Casy says. She adds that having physicians add partners to his or her practice is a perfect opportunity for them to recruit for the facility as well.

She says that the center is also considering opening up to different specialties, such as lap banding and other insurance procedures.

Northwest Michigan Surgery Center (Traverse City, Mich.)

Annual case volume: More than 10,000 since 2005

Specialties: Gastroenterology, eye, general surgery, orthopedics, urology, podiatry

Details: This AAAHC-accredited center was opened in April 2004. It is now a joint venture between physicians and Munson Medical Center with 35 physician investors and 83 physician users. The center itself houses six 800-square-foot ORs, three GI suites and one minor procedure room for pain, lithotomy and GI overflow.

Keys to building/maintaining volume: Lisa Warren, quality assurance manager, attributes physician commitment and flexibility of staff and physician schedules to the success of the ASC's high case volume.

Springfield Clinic Ambulatory Surgery & Endoscopy Center (Springfield, Ill.)

Annual case volume: More than 10,000 since 2004

Specialties: Orthopedics, ophthalmology, general surgery, urology, eyes, ENT, plastics, gynecology, pain, endoscopy, colon/rectal, neurosurgery, gastroenterology, podiatry, vascular surgery

Details: The Ambulatory Surgery and Endoscopy Center, opened in April 1994 by Springfield Clinic, is a physician-owned center operating under 159 partners. The AAAHC-accredited ASC houses five ORs and four endoscopy procedure rooms and is currently considering adding other specialties, such as retina and spine. In 2009, the facility performed more than 16,000 procedures.

Keys to building/maintaining volume: Ginny Forrest, RN, director of the ASC, says the center offers great efficiency and attributes consistent patient satisfaction ratings of 98 percent or more to the ASC's success.

To achieve efficiency, the facility audit's operative times for accuracy twice a year, implements staff competency requirements and assures patient readiness for an "on-time" start.

Summit Surgical Center (Voorhees, N.J.)

Annual case volume: More than 10,000 in the last few years

Specialties: ENT, pediatric urology, general surgery, gastroenterology, pain, orthopedics

Details: The AAAHC-accredited Summit Surgical Center was opened in 1985 as part of Virtua Health, a comprehensive health system in southern New Jersey, and became a joint venture in Feb. 2006. It was established with a group of over 40 physician investors currently has an active medical staff of 195 medical professionals. The facility includes seven ORs and two

procedure rooms. In 2009 alone, the facility performed more than 25,000 procedures.

Keys to building/maintaining volume: Vice President of Virtua Surgical Services Jo Ann Dower, RN, BS, MGA, notes that physician relationships, alignment with Virtua and its reputation for excellence in care of pediatric patients, which makes up 25-30 percent of total volume of cases, is what helps Summit Surgical Center maintain and grow its high volume of cases.

In efforts to grow and expand, Summit Surgical Center is planning to relocate to a new site on the campus of the new Virtua Voorhees hospital, align the center with Virtua's strategic growth plan and market the center's growth to physicians' interests.

Virginia Eye Institute Surgery Pavilion (Richmond, Va.)

Annual case volume: Approximately 13,000

Specialties: Ophthalmology and ENT

Details: The physician-owned Virginia Eye Institute surgery center opened in May 1987 and is accredited by the AAAHC. With roughly 70 percent of cases specializing in ophthalmology and 30 percent in ENT, the institute offers five ORs, one laser room and one LASIK suite for its 36 privileged physician users. Approximately 16,000 procedures are performed each year at the facility.

Keys to building/maintaining volume: Vice President of Operations J. Eric Hays says safe and efficient operation of the operating rooms is critical for physicians to feel their time is being well spent in the facility. He adds that the aim to accommodate surgeons and focus on organizational objectives is always a focus.

"We always plan with growth in mind," Mr. Hays says. "Our processes and supporting ancillaries are designed to be adaptable and expandable. New clinical geographies and additional specialties are other growth strategies we consider."

United Medical Endoscopy Center (Lancaster, Calif.)

Annual case volume: More than 10,000 cases for the past four years

Specialties: Gastroenterology and pain management

Details: The United Medical Endoscopy Center, which opened in June 2005, is a physician-owned facility that has since been accredited by the AAAHC. The surgery center currently has 12 different physicians users, including ASC founders from High Desert Gastroenterology, two GI rooms and one pain management room. The ASC performed approximately 12,500 procedures in 2008 and 2009.

Keys to maintaining/building success: The ASC has strategically marketed itself as a GI-driven ASC, as all GI physicians in the area work from out of the facility. The facility also relies on physician recruiting and patient referrals to maintain high volume. ■

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25 New ASCs Opened or Announced in 2010

1. New Georgia Orthopedic ASC Opens in Jesup. The Bone & Joint Institute of South Georgia in Jesup has opened a new facility which includes an ASC, according to a news release from the organization. The 15,000-square-foot facility, formerly Kenerly Orthopaedic Center, also includes x-ray services and Open MRI.

2. Orthopedic ASC Opens in Green Bay, Wis. Bellin Health in Green Bay, Wis., has announced the opening of Bellin Health Orthopedic Surgery Center and partner Orthopedic Sports Medicine Specialists. The $11.9 million project facility has a 15,000-sqaure-foot orthopedic ASC and 35,000-square-foot orthopedic and rheumatology practices. It was completed in March. The surgery center provides treatment and care for orthopedic and musculoskeletal conditions including ACL and rotator cuff tears to fractures and bunions and meniscal tears.

3. Indiana Spine ASC to Open in Carmel. A new 60,174-square-foot spine surgery and treatment center that includes an ASC will open next year in Carmel, Ind., according to a report by *The Indianapolis Star*. The new center — owned by the physicians of the Indiana Spine Group — will feature the ASC, 16 patient exam and treatment rooms, CT and MRI imaging and a physical therapy suite. It is scheduled to open in fall 2011, according to the report.

4. Iowa ASC Opens in Spencer. The Spencer (Iowa) Surgery and Laser Center has opened, giving Iowa its 32nd ASC, according to *The Daily Reporter*. The ASC features three ORs and performs procedures in orthopedic surgery, ophthalmology, pain management, plastic surgery and laser surgery. The primary surgeons at the center are Dennis D. Gordy and Alexander Pruitt, according to the report.

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

6. Illinois Ophthalmology ASC Opens in Springfield. Prairie Surgery Center, an eye surgery center in Springfield, Ill., opened in August, according to a report by *The State Journal-Register*. The $3 million ASC, with $2 million for building costs and $1 million in equipment costs, is attached to the back of Prairie Eye & Lasik Center. While the ASC will initially just perform procedures in ophthalmology, primarily cataract surgery for Medicare

patients, owner Dr. Sandra Yeh intends to seek approval to offer orthopedics as well, according to the report. Dr. Yeh estimated the ASC will perform 2,500 procedures annually. Plans for Prairie Surgery Center were approved by the Illinois health planning board in Jan. 2009.

7. New York ASC Opens in Rye. Rye (N.Y.) Ambulatory Surgical Center has opened, according to a report in *The Journal News*. The $4.5 million, 14,000-square-foot ASC, owned by the physicians of WESTMED (formerly called the Westchester Medical Group), features four ORs and 16 patient bays. The center is expected to perform 4,000 procedures annually and surgical specialties include ophthalmology, orthopedics, urology, podiatry and GYN, according to the report. Plans for the Rye surgery center were announced in Jan. 2009.

8. Iowa's Wright Medical Center to Build ASC. Wright Medical Center in Clarion, Iowa, will undergo an $18 million expansion which will include a new ASC, according to a report in *The Wright County Monitor*. The expansion project will center around the ASC, which will feature three ORs and 13 outpatient surgery bays. The new construction is anticipated to take about a year, according to the report.

9. New Hampshire ASC Opens in Lebanon. Dartmouth-Hitchcock Medical Center has opened a new ASC in Lebanon, N. H., according to a report in *The Dartmouth*. DHMC's Outpatient Surgery Center cost $31 million, has four ORs and offers orthopedics, plastics and ophthalmology, urology, and ENT. There is room for expansion into four other ORs. This will likely take place over the coming year to accommodate general surgery and GYN, according to the report.

10. United Health Services Opens New York Surgery Center in Johnson City. United Health Services has announced the opening of the Ambulatory Surgery Center and Pre-Admission Testing Program in Johnson City, N.Y. The surgery center will perform procedures in ophthalmology, gynecology, ENT, orthopedics, general surgery and podiatry.

11. Upstate New York's Largest Hospital-Affiliated GI ASC Opens. The University of Rochester Medical Center has announced the opening of the largest hospital-affiliated ambulatory GI center. The center, located on the second floor of the URMC Surgery Center, offers gastroenterology, hepatology and endoscopy services. Features of the 10,000-square-foot GI center include four endoscopy rooms, 12 private admitting/recovery bays and 12 examination rooms.

12. Surgical Care Affiliates' Hawaii Joint-Venture ASC Opens. Surgicare of Hawaii, a joint-venture project between Surgical Care Affiliates, Hawaii Pacific Health Partners and Honolulu Surgery Center, has opened, according to ABC's KITV. The new 17,000-square-foot surgery center offers a number of specialties including orthopedics, ophthalmology, general surgery, gastroenterology and podiatry services. SCA will provide day-to-day management for the center.

13. South Dakota ASC Opens in Sioux Falls. The Avera Surgery Center in Sioux Falls, S.D., opened in July, according to a report from KELOLAND TV. The eight-OR surgery center is housed in the Avera McKennan Hospital's new Avera Cancer Institute.

14. Wisconsin's Aurora Health Care to Build ASC in Same Town as Competing Facility. Aurora Health Care in Milwaukee, Wis., plans to build an ASC in Wauwatosa, Wis., which would place the facility only a few miles from a competing surgery center, according to *The Business Journal of Milwaukee*. Wheaton Franciscan Healthcare has its own ASC in Wauwatosa. The planned 60,000-square-foot Aurora Health Care ASC will cost $18 million and offer orthopedics, GI and other specialties, according to the report. Wheaton Franciscan Healthcare-Wauwatosa ASC offers similar services and also provides physical therapy, radiology and urgent care.

15. Surgery Center Planned for Colorado's Vail Valley Medical Center. Vail (Colo.) Valley Medical Center has announced plans to start building a new surgery center in Edwards, Colo., this year. Tentative plans for the ASC show 4-6 ORs, with specialty types to be determined. The hospital is expecting the ASC to cost $9-$12 million and open in 2012.

16. Newton-Wellesley Hospital in Massachusetts to Open New ASC. Newton-Wellesley Hospital in Newtonville, Mass., announced plans to open a new ASC, according to a report by *The Wellesley Townsman*. The ASC will have four operating rooms and will focus on outpatient orthopedic procedures such as hand surgery and arthroscopic surgery. The hospital plans to have the new facility opened in the fall of 2012, according to the report.

17. Texas City Changes Zoning to Allow ASC Development in Cedar Park. Cedar Park, Texas, has changed its zoning to allow for the building of a new ASC, according to a *Community Impact* report. The new ASC, Cypress Creek Medical Plaza, is expected to cost $3 million and be built before year's end. The 34,000-square-foot surgery center will feature

five ORs, an imaging center, pharmacy and office for Austin Pain Associates.

18. Minnesota's MeritCare Detroit Lakes Clinic Breaks Ground on New Surgery Center. MeritCare Detroit Lakes (Minn.) Clinic has announced the groundbreaking of a new surgery center, and the expansion and remodeling of the facility's existing space. The ASC will have two surgical suites, one endoscopy suite and the room to add a third surgical and second endoscopy suite. The $15 million expansion and renovation project, announced in Nov. 2009, will feature a 33,800-square-foot addition and the remodeling of 25,800-square-feet focused on a number of areas, including expansion imaging and lab services.

19. Olean General Hospital in New York Receives Funding for New ASC. Olean (N.Y.) General Hospital will receive $23 million to build an ASC and refinance debt, according to *Olean Times Herald* report. The financing was approved by Cattaraugus County lawmakers. The 22,000-square-foot ASC will include four ORs and three endoscopic suites, according to a news release from Olean General about the ASC, issued in June. The news release indicated the project would break ground in late September.

20. Construction Begins on New Wisconsin Surgery Center in Wausau. Groundbreaking for Pine Ridge Surgery Center in Wausau, Wis., took place May 27, according to the *Wausau Daily Herald*. The 9,500-square-foot, $3.1 million facility, a partnership between Surgical Associates, Urology Specialists and Aspirus, is expected to be completed in winter. The ASC is expected to perform an estimated 2,000 procedures annually.

21. Florida's Tallahassee Memorial Hospital Begins Construction on New Surgery Center in Partnership With Local Physicians. Construction has begun on Red Hills Surgical Center, a joint venture between Tallahassee (Fla.) Memorial Hospital and 35 local physicians, according to a report by the *Tallahassee Democrat*. The 17,000-square-foot center features five ORs and will offer services in orthopedic surgery, general surgery, OB/GYN and ENT. The facility also includes an educational observation room that will allow students to observe operations at the center.

22. Surgery Center Planned by Idaho's St. Luke's Magic Valley Medical Center. St. Luke's Magic Valley Medical Center in Twin Falls, Idaho, is planning to build a new ASC in its hometown, according to the *Times-News*. The $4.5 million, 16,000-square-foot surgery center is expected to break ground in July with plans to open the facility in April 2011. The ASC will initially cater to orthopedic, plastic, and ear, nose and throat patients.

23. Missouri's Freeman Surgical Center Opens in Joplin. Freeman Surgical Center, an ASC developed in Joplin, Mo., by Freeman Health System, Nueterra Healthcare and local physicians, opened in June, according to *The Joplin Globe*. The $5 million, 17,735 square-foot surgery center, announced last October, features four operating rooms to be used by specialists in areas including ENT, gynecology, hand surgery, orthopedics, pain management and general surgery. Freeman and Nueterra will lease the center, and the investing physicians will own the building.

24. Global Surgical Partners Opens Surgery Center in Sarasota, Fla. Global Surgical Partners has announced the opening of their eighth ASC in Sarasota, Fla. Sarasota Physicians Surgical Center opened in the fourth quarter of 2009 with 15 physician investors. The ASC features three operating rooms and one procedure room for pain management. Specialties at the ASC include ophthalmology, orthopedics, general surgery, ENT, ocular plastics, foot and ankle surgery and pain management.

25. California's St. Helena Hospital Opens Surgery Center. St. Helena (Calif.) Hospital has opened the Trinchero Surgery Center, according to a report by the *Lake County News*. The 12,500-square-foot ASC features two surgical suites, two procedure rooms and 10 pre- and post- surgery beds. The center is named in honor of Louis and Evalyn Trinchero, according to the report. ■

Reports compiled by Robert Kurtz. Learn about other new ASCs by visiting www.beckersasc.com.

10 Ways to Improve Anesthesia in Your ASC

By Rachel Fields

Here are 10 tips on using your ASC's anesthesiologists to help save money, promote efficiency and build a great relationship among your staff.

Saving money and promoting efficiency

1. Invest in the right equipment. Certain pieces of equipment make it easier for anesthesiologists to do their job and thus improve ASC efficiency, while other equipment is not as essential, says Doug Yunker, MD, an anesthesiologist and medical director at Upper Arlington Surgery Center in Columbus, Ohio. Here are some examples:

- Ultrasound. Use an ultrasound for regional blocks. The ultrasound system costs $40,000 but it provides a more accurate reading.
- Intubating device. The Gliderscope, which costs about $9,000-$10,000, helps the anesthesiologist intubate patients. Without this device, intubation can take a while for some patients, frequent attempts can make them hypoxic, and in some cases intubation is not possible and surgery must be called off.
- BIS monitor. On the other hand, a BIS monitor for brain waves may not be needed. "We've used it at the hospital and not found it to be helpful on a routine basis," Dr. Yunker says.

2. Partner with exceptional anesthesiologists for your ASC. One of the keys to efficiency in an ASC is the pre-op and post-op process, says Raviv Chopra, principal and CFO for The C/N Group. When you look at some of the more acute surgical specialties — orthopedics is one where this is critical, Mr. Chopra says — you need to maintain an efficiency mindset without compromising patient safety and comfort.

"Your anesthesia can make a difference," he says. "Once the surgery is done, how quickly are patients recovering so they can leave the facility? A lot of this ties back into anesthesia, and if you don't have an anesthesiologist with that skilled component, it can create challenges for you just from a recovery time perspective. Again, you want to maintain safety and quality without having patients clogging up your post-op recovery room.

3. Implement standardized pre-op assessment criteria across all anesthesia providers in the anesthesia group. To maximize ease and convenience of patient preoperative evaluation, with a goal of eliminating same-day cancellations and the elimination or reduction of redundant preoperative laboratory requirements, specific pre-op guidelines are set and disseminated to surgeons and facility staff, says Susan Kizirian, COO for ASCOA. "When all anesthesia providers follow these same protocols, everyone is on the same page, eliminating confusion and case cancellations," Ms. Kizirian says. "Any variance to the protocol allows immediate evaluation for patient appropriateness and subsequent testing and evaluation as necessary."

4. Don't hire; contract out. Rather than hire anesthesiologists, Roanoke's physician-investors preferred to contract with a large independent anesthesiology group because it provided more flexibility. "An employee is on a fixed schedule," T.K. Miller, MD, president and medical director of Roanoke (Va.) Orthopaedic Center, says. "When there is no more work, you still have to pay him for the rest of the day." In contrast, when an anesthesiologist from the group is done at the ASC, he or she can go back to the hospital and do add-on cases there.

5. Discuss expectations about equipment purchase when you are selecting an anesthesia group. Sometimes an anesthesia group will request an expensive piece of equipment your surgery center can't afford. "If you have an anesthesia group that comes in and wants a certain kind of scope for difficult intubations, then the next group comes in and wants something different," that gets expensive, says Vicki Edelman, administrator of Blue Bell (Pa.) Surgery Center. "Discuss equipment before you sign anything."

She says equipment purchasing is one reason to invest in a great anesthesia group and make the effort to keep them in your center. If you keep the same group over a number of years, you will probably have to change your equipment less often, and your center will suffer less transitional stress. "Maintaining the stability of a group within your center is optimal," she says. "It's not good for the ASC to have two, three or four different groups within four years, because then the community and [other providers] see that you're not easy to work for and with."

Building good relationships with anesthesiologists

1. Align anesthesiologists with your ASC's interests by giving them a financial investment in the center. Sandy Berreth, administrator of Brainerd Lakes Surgery Center in Baxter, Minn., says the challenge of aligning anesthesiologists with the financial interests of an ASC can be overcome by giving the anesthesiologists a financial investment in the center.

Her advice: Get your anesthesiologists financially involved by making them a part of the governing body of the center. This could mean making

an anesthesiologist a medical director or a board member and letting them vote on process changes. "The ability to vote on the decisions that matter to them can make your anesthesiologists more engaged in the processes at your center," she says.

For Ms. Berreth, whose physicians and staff are financially motivated by part-ownership and bonuses, respectively, the anesthesia group often seems oddly distant from the center's goals and interests. "Your surgery center is only as good as the people and processes you have in the surgery center," she says. "You want your anesthesiologists financially invested [by purchasing shares or sitting on the board] instead of feeling like outsiders."

2. Appoint a strong medical director. If your medical director is a respected presence, you can guarantee a strong ally. Theresa Palicki, administrator of Eastside Surgery Center in Columbus, Ohio, says ASCs can make the mistake of appointing a "low man on the totem pole" who is brand new to the group as director. Instead, you want a medical director who has been an integral part of the group for a few years and has clinical experience that other anesthesiologists respect. "If things need to be changed in the anesthesia group and you have to send someone inexperienced to talk to the anesthesiologists, they won't listen," she says. Eastside Surgery Center's current medical director is president of the entire anesthesia group. Because he has a lot of sway and connections to the community, he fights for the ASC by reaching out to surgeons and convincing them to joint the center.

3. Be truthful about scheduling. When a surgeon says a case should last two hours, it shouldn't then take four hours. "There needs to be truth in scheduling," says Thomas Wherry, MD, medical director of Health Inventures and principal of total Anesthesia Solutions. The chronically late or under-posted surgeon will have a significant impact on morale. Anesthesia groups tend to run tight schedules and will often travel to several locations. Running past the posted time for preventable reasons will certainly minimize their ability to cover other locations.

4. Recruit a nursing staff that will keep your anesthesiologists happy. Ms. Palicki says anesthesiologist satisfaction often depends on the working relationship between the anesthesiologists and the nursing staff. "You don't want nurses that are too pedantic," she says. "You want nurses that follow the rules, but you also want them to look more at what's best for the patient than at the minute details of the policy."

5. Involve anesthesiologists in ASC operations. Anesthesiologists have the primary responsibility of providing appropriate, excellent anesthesia that allows for a quick turnover, but a good group will not shy away from assisting with other aspects of the ASC's operations.

"They have to be team players," says Ms. Edelman. "They have to realize that if we need them to push a stretcher, give us a hand at moving a patient — we're all in this together. If they function like a team with us, it just makes everybody feel like we're all here for the same reasons and the right reasons." ■

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Impact of November Elections on ASCs: Q&A With Andrew Hayek of the Ambulatory Surgery Center Advocacy Committee

Andrew Hayek is chair of the Ambulatory Surgery Center Advocacy Committee and president and CEO of Surgical Care Affiliates.

Q: What do you predict as the outcome of the November elections?

Andrew Hayek: It appears that there is a lot of momentum for the Republicans to potentially take control of the House. It is significantly less likely that they will take control of the Senate.

Q: What would this outcome mean for the healthcare reform bill?

AH: The notion of repealing the healthcare reform bill is extremely unlikely. It would have to be done over a Presidential veto, and with the Republicans most likely not controlling the Senate, getting to a 60-vote veto override will be very unlikely. There is a nuclear option — since the spending bills originate in the House, the House could say we don't want to fund any of the healthcare reform bill, but I think that is highly unlikely.

I do think Congress will have a robust discussion around the bill and its major components, and there will likely be a lot of discussing and investigation in the House, presuming that the Republicans take control of the House. As to what actually gets modified in the bill is an entirely different question that is very difficult to address. On the whole, I think the bill stays intact at least until the presidential election in two years.

Q: Under the scenario where you have a Republican-controlled House and Democratic-controlled Senate and White House, what does that mean for ASCs?

AH: We have a lot of ground to cover on both sides of the aisle in educating people about ASCs and the value we provide. With the ongoing discussions in Congress about addressing the rapidly increasing Federal deficit and rising health care costs, ASCs provide real cost-savings for patients, providers and the entire health care system, along with outstanding patient care and convenience. This is the message we want to share with Congress and the Administration regardless of which party holds the majority.

Q: If the Republicans do not capture the House, what might that scenario mean for the surgery center industry?

AH: Regardless if Republicans or Democrats have control of the House following the mid-term elections, we as an industry still have a lot of work to do to educate our Congressional leaders about ASCs and the value we provide to the health care system. Our main concern with the healthcare reform bill is that the "productivity adjustment" mechanism, which deducts an estimate for general labor productivity improvement in the general economy from annual updates for most healthcare providers (including hospitals and ASCs), results in approximately zero rate growth for ASCs in the future. This will impact ASCs ability to continue providing patient-centered care to millions, given that costs are growing each year but reimbursement won't.

Also, the House-passed version of reform would have required ASC cost reporting, a provision that would be very burdensome to the industry, especially independent ASCs, which is one reason why CMS is against cost reporting for ASCs. While the bill ultimately did not include cost reporting, the issue could re-emerge in the future.

Additionally, because the healthcare reform bill will likely cost much more than originally estimated (which has been the pattern of almost every major healthcare initiative) and because the Federal deficit will remain a significant long-term problem for our government, I remain concerned about future rate cuts for all healthcare providers, including ASCs and physicians. We have a significant financial problem as a country, given the size of our debt and deficit, and the healthcare reform bill added an enormous additional financial burden on our government — a burden that will almost certainly be bigger than originally estimated. This is concerning as a member of the ASC community and as a tax payer.

Q: If the elections are not likely to significantly impact ASCs, what are the next steps for the industry?

AH: Regardless of who controls the House or the Senate or the presidency, we, as a country, still face a massive fiscal deficit and as an industry, ASCs will continue to feel the pressure from inequities in the Medicare payment system. Regardless of which party is in control of Congress, there's still going to be significant cost pressure on hospitals, on pharmaceutical companies, managed care plans, and on all providers of care.

Most of what we do doesn't change based on which political party is in control in the House. Our message continues to be that if you want to improve healthcare and if you want to lower costs in the system, then you need to shift more cases into the high-quality, low-cost setting that surgery centers provide. That's going to be an important theme that plays out in the government over the next several decades. When you look at the fiscal pressures of the health care system and the need to control cost growth, ASCs are a terrific part of the solution.

We're still going to need to be more active than ever on Capitol Hill — explaining our story and sharing data. We need more facilities to participation in the ASC Association and its activities, and we need to build our political fundraising. Right now our political fundraising as an industry is very small compared to other segments of healthcare providers. We need to build our network of grassroots champions who get to know members of Congress and, we need to continue to work collectively with our local ASCs, and the state and national associations to advance this national effort.

I was just at California's association meeting and it was terrific. The 250 ASC leaders in the room were energized and excited. They have done a great job engaging their Federal lawmakers this year, and they are eager to do more to leverage their relationships. I have had similar experiences in many other states, and this is what we are trying to build across the country.

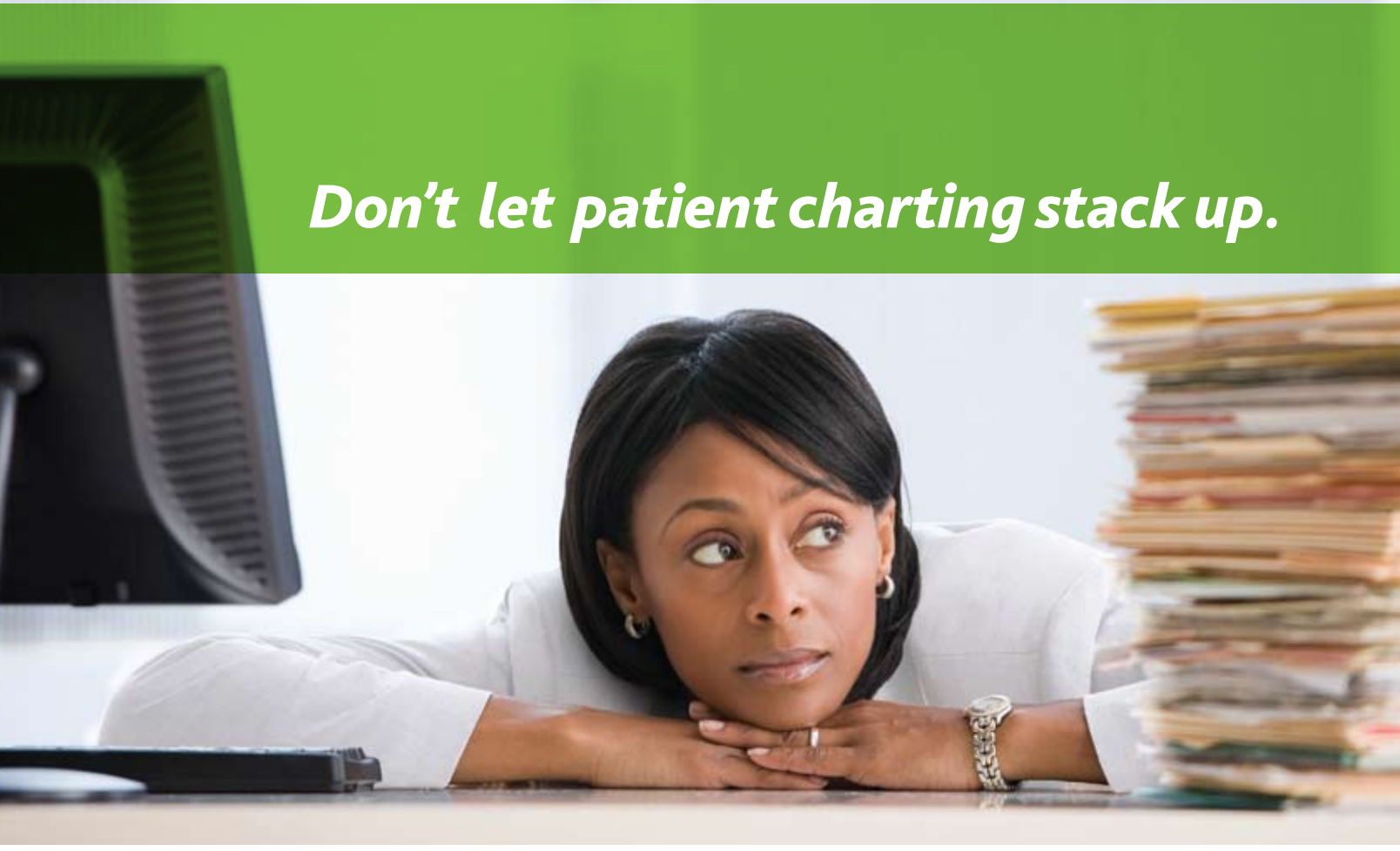
Q: What other issues should the industry focus on to play up the benefits of ASCs?

AH: We need to continue to showcase the benefits of physician ownership in areas like clinical quality and efficiency. When physicians lead surgery facilities, they can play a vital role in ensuring outstanding patient care and in making decisions that improve cost efficiency, like choosing the most cost effective supplies and helping to create efficient schedules..

The healthcare reform bill emphasizes physicians collaborating with hospitals, and we believe that surgery centers exemplify the best elements of physician collaboration We need to, in a very positive way; point out this is a terrific example of where we want to take healthcare, which is tying physicians to the cost and efficiency of their facility just as they're trying to do in hospital setting.

We have enormous talent and possibility as an industry, and we are providing an outstanding service to the healthcare industry — the highest quality of patient care delivered in a lower-cost setting. Our power lies in building our grassroots network across every state and being targeted and consistent in our messaging. I think as we can more fully realize how to effectively coordinate our efforts, we will vastly improve how we communicate our important message on Capitol Hill and we will help ensure a strong future for ASCs on behalf of our patients, our physicians, and the entire healthcare system. ■

Visit the ASCAC website to learn more about the Ambulatory Surgery Center Advocacy Committee (www.advancingsurgicalcare.com)and how you can get involved or contact Andrew Hayek directly at andrew.hayek@scasurgery.com.



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6 Ways Healthcare Reform and ARRA Will Impact Gastroenterology

By Jaimie Oh

The realm of healthcare has changed dramatically in recent years with the signing of the new healthcare reform law and American Recovery and Reinvestment Act of 2009, and more drastic changes are forecasted to change the nature of healthcare. Brian Jacobson, MD, MPH, FASGE, who is a GI physician at Boston (Mass.) Medical Center, associate professor of medicine at Boston (Mass.) University's School of Medicine, and chair of the American Society for Gastrointestinal Endoscopy's Health and Public Policy Committee, shares six ways recent and forthcoming changes to healthcare will impact gastroenterology.

1. Increased number of patients and screening colonoscopies. GI specialists can expect to see a tremendous increase in the number of patients visiting their offices as a result of the new healthcare reform, which will expand healthcare coverage to millions to Americans, and the passage of a provision under the Affordable Care Act that became effective in September which expands coverage of screening colonoscopies for colorectal cancer.

"Healthcare reform is going to be providing health coverage for more individuals, so I think all practicing physicians will have potential for larger number of patients and the reform law also eliminates most cost sharing for preventive services, such as screening colonoscopy. As a result, we'll see greater compliance with screening guidelines," Dr. Jacobson says.

2. Increased use of health information technology. Under the ARRA, healthcare providers are able to qualify for incentive payments upon adopting and demonstrating meaningful use of healthcare information technology, particularly electronic health records. Dr. Jacobson says although the concept of the EHR has been around for some time, the market for EHR products is just now booming as a result of ARRA, which leads to more opportunities for GI specialists to implement health IT in their ASCs.

"There's an obvious push for improved health information technology through the use of EHRs, but there's going to be a lot of growing pains that we're all going to experience with this new push for expanded health IT," he says. "Once these systems are more universal and the glitches are worked out, healthcare providers will find care coordination to be easier because it takes the guesswork out of caring for patients. Health IT eventually will help us take better care of patients by avoiding duplicative testing, or surveillance procedures at inappropriate intervals."

3. Reduced salaries for GI specialists. Dr. Jacobson says the healthcare industry as whole, including GI specialists, will see salary reductions, which aren't tied directly to the reform law but speak to the spirit of healthcare reform as federal regulators and governing bodies attempt to rein in and reduce healthcare costs.

"We've already seen a loss of consultation codes for the GI specialty and payments associated with that, and we're starting to see other private insurers in different locations following suit and dropping consultation codes, too," he says. "We used to get additional reimbursement for the time spent with consultation, which involved going through patients' prior records, preparing final reports back to referring physician and so forth. What I think we all have to acknowledge is that this is the government's desperate attempt to change a healthcare system we're used to, which is unsustainable."

4. Entities with new centralized powers. Secretary of Health & Human Services Kathleen Sebelius has the power to revalue any medical service, including endoscopy services provided by GI physicians; the new Independent Payment Advisory Board will have the ability to do so in 2015. Dr. Jacobson says the two entities have the power to decide that a particular procedure might be overvalued and revalue that procedure. As a result, reimbursement can be devalued simply because either entity thinks it's overvalued, he says.

"IPAB is tasked with looking for ways to save money in the Medicare system, and essentially their recommendations will become policy," he says. "The best we can hope for is that they maintain the current value for GI procedures and provide positive yearly updates for reimbursement to account for increased operating costs. They could very easily decide that if physicians are providing more of a service over time, it suggests there may be either waste or abuse. In the future, there may be more colonoscopies because of an aging population and more people accepting colonoscopies as colorectal cancer prevention. This could trigger a closer look at the value of a colonoscopy, and the IPAB may decide that they're reimbursing too much for the procedure."

5. Increased emphasis on value-based purchasing. Healthcare reform will also push for value-based purchasing, which will require GI physicians to report measures of quality as well costs incurred. With this, physicians will be receiving report cards essentially showing their resource utilization for patient care and how compliant they are with quality measures. These reports to the federal government will then made available to insurance companies who decide if a physician seems to be spending too much for patients without necessarily improving quality.

"Ultimately, patients and private insurers will be able to look up this quality information on individual physicians," Dr. Jacobson says. "The concern is how do you accurately and reliable attribute care to any one physician since patients see multiple physicians for multiple reasons. Furthermore, the quality measures they're using may or may not be valid. It is still very much a big unknown, and we should be monitoring this very closely to protect against unintended consequences for the physicians, such as risk of being misrepresented."

6. New novel payment systems. New payment models, such as bundled payments and accountable care organizations, will impact the practice of GI physicians in the ASC setting, but it is yet to be seen whether this impact will be a positive or negative one. Dr. Jacobson says these payment structures — where physicians will most likely work with a hospital and receive capitated payments to provide care for a large census of patients — can have outcomes on polar ends of a spectrum.

"We don't know yet with these new payment models if there will be cost-savings or if they will ensure the best care for our patients," he says. "For instance, we don't know if this will mean more office visits for GI specialists as primary care physicians rely on us more for quality care or if it's going to mean less work for GI specialists because the primary care physicians don't want to incur more expenses in caring for their patients." ■

ASC GI $100,000 Question: Are You Billing for Second Maneuvers?

By Rob Kurtz

A significant number of ASCs are overlooking a potential billing opportunity that may be leaving hundreds of thousands of dollars on the table, says John Poisson, executive vice president and strategic partnerships officer at Physicians Endoscopy.

"In the ASC environment, when you perform multiple, separate maneuvers, if both are properly documented, those are two billable events," he says.

For example, if, during a colonoscopy, in one part of the colon you perform a *polypectomy* and then in another part of the colon, that is separate and distinct, you do a biopsy, these are two separately billable maneuvers. Medicare, and many of the payors who emulate the Medicare rules, will reimburse this second maneuver at 50 percent of the first one.

"I can't tell you how many times I've had pushback over the years from doctors saying 'you can't bill for that second one or we never do that,'" he says. "There is so much money left on the table. We're not talking about cheating the system or doing anything wrong; we're talking about coding correctly per the Medicare rules."

(View section 40.5 on payment for multiple procedures in the "Medicare Claims Processing Manual" by visiting www.beckersasc.com/pdfs/CMS%20multiple%20procedures.pdf)

ASCs losing thousands of dollars

Failing to bill for this maneuver can add up to significant lost reimbursement very fast. If you're in the average U.S. market where you're getting $425 for a colonoscopy, then that secondary maneuver is reimbursed at $212.50. "Do that a thousand times a year, and that's real money," Mr. Poisson says.

Physicians, he says, typically understand they can bill for a second procedure at 50 percent when they do a flip, such as an upper endoscopy and a colonoscopy in the same day. But when it comes to billing for a second maneuver, this concept is more foreign to them.

The reason, Mr. Poisson says, it might be foreign is billing for the second maneuver works very differently on the professional fee side. "Generally for that secondary maneuver all they get is a delta between the reimbursement of those two CPT codes. Let's say they get paid $220 for one CPT, they get $200 for the other. They end up getting $20 [for the second maneuver]."

Getting paid is simple

So how should ASCs not billing for this second maneuver capture the reimbursement they are losing? "The key is it has to properly documented," he says. "They have to be separate and distinct maneuvers. It's not like you can do a biopsy over here and a biopsy over there; those are similar maneuvers even if they are in different parts of the colon."

If the second maneuver is document properly, Mr. Poisson says clinical report writing software typically have internal coding engines which are very good at making sure that documented maneuver receives a secondary CPT code for billing purposes. ■

Learn more about Physicians Endoscopy at www.endocenters.com.

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

7 Ways to Ensure Payment Without Damaging Patient Relationships

In the current economy, patients are finding it more and more difficult to pay their bills — so much so that they often put off non-elective procedures because their high-deductible insurance plans require a hefty financial contribution. Three ASC collections experts discuss why patients are struggling to pay their bills and seven ways ASCs can still collect what is owed to them from patients without damaging these relationships.

Why patients are struggling to pay

While some experts predict an economic rebound over the next year, most states are still suffering from high unemployment rates and financial hardship. Nevada, Michigan and California reported the highest unemployment rates in the country in August, at 14.4 percent, 13.1 percent and 12.4 percent, respectively, and 27 states reported unemployment increases from the previous month. As the recession makes it harder for patients to keep up with rent, utilities and car payments, healthcare services often take a hit because they fall lower on a patient's priority list, says Rob Morris, vice president of marketing and new business development for GE Capital's CareCredit.

Rhonda Fort, director of business operations at Practice Partners, offers another explanation for patients' inability to pay medical bills: an increase in high-deductible insurance plans. "Most of the problems I have seen deal with a change in insurance, whether the premium cost has shifted to the patient or the patient is [responsible for] a much higher deductible," she says. "Patients want to pay, but they may not be familiar with the increase in their deductible, and if they have not had a procedure for two or three years, the payment may have jumped from $100 to $500."

The inability to pay generally affects non-elective procedures, Ms. Fort says, because patients who opt for elective procedures have usually saved money in preparation for the expense or will wait until they can afford the procedure before proceeding.

How to effectively and appropriately address the problem

1. Institute a strict financial policy and stick with it. In an economy where consumers are struggling to pay their bills, healthcare facilities often suffer because payment isn't required at the time of service. If a service is rendered and the patient leaves without paying, Mr. Morris says ASCs often struggle to collect the payment or even get in touch with the patient after the procedure. He says in order to make sure payment is made in full, ASCs should institute a firm financial policy that requires patients to make payment prior to receiving a service and lay out several payment options: cash or check, major credit cards or a third-party payment plan.

"Billing should not be [an option in the policy]," he says. "I talk to a bunch of ASCs, and they have huge accounts receivable because they don't collect at the time of service. Once people receive the service, they just don't pay, and healthcare providers end up at the bottom of the list of monthly [financial obligations]." He says once an A/R account goes over 90 to 120

days, the chances of being paid are significantly lowered. Even if the ASC hands the patient over to a collections agency, the facilty will receive very little money relative to the actual payment.

2. Explain a patient's financial obligations three days before service. By the time your facility calls the patient to explain the payment, the administrative staff should already have insurance and contact information from the physician. This information will tell your facility how much the patient will owe for the facility fee. Because it can be a challenge to reach patients at home, Mr. Morris recommends ASCs call three days before the procedure to explain the patient's financial responsibility. "They're going to need to say, 'Make sure you don't drink any fluids, you need to be an hour early, don't bring any jewelry or your watch, and we just checked over your insurance and you have an obligation of $600 towards the facility fee. How would you like to pay for that?"' The financial obligation should be a prerequisite for service just like the physical requirements.

Cathy Meredith, vice president of finance for ASCOA, agrees there should be no discussions of what the patient owes at the front desk. "The only reason you should bill after the surgery is if there are changes because of [complications during surgery]," she says. "I say again and again to our surgery centers that your best chance of collecting money is on the day of service. Once the patient is better and leaves the center, your chance of collecting decreases exponentially."

Mr. Morris says explaining financial obligations prior to surgery will reduce instances where the patient arrives at the center without knowing about the required payment. "Try and get the patient to commit," he says. "If you can, take the credit card number over the phone."

3. Help the patient understand how his or her insurance coverage works. Ms. Fort says payment misunderstandings are often caused by a patient's lack of knowledge about his or her insurance. "Most misunderstandings deal with a change in insurance, and we spend a lot of time educating the patients about what their insurance covers," she says. She recommends spending some time asking patients basic questions about their insurance coverage to determine how much they understand. If patients are unaware of a co-pay or recently changed deductible, the bill will come as more of a surprise, which will decrease the likelihood of collecting in full.

Ms. Meredith recommends connecting patients with their insurance company if the ASC doesn't have time to educate each patient. "If a patient is having a difficult time understanding their coverage and really believes they do not owe the amount [you're billing them for], you can encourage the patient to call the insurance company and ask questions," she says. "In [rare circumstances], you can set up a conference call, and get on the line with the patient and the insurance company so the patient can hear the same information [from two sources]."

4. Explain that financial obligations may change during surgery. Ms. Meredith says ASCs must make it clear to patients that their financial obligations may change during the course of a procedure. "You have to make them aware of the fact that the cost is an estimate," she says. "ASCs submit bills based on CPT codes, and often, when the physician does the surgery, depending on how he dictates the operative note about what he's doing, the intended codes could change slightly." If the codes change, the contracted amount with the payor might also change, meaning the patient might owe more money, Ms. Meredith says. Before surgery, let the patient know that while you try to accurately estimate the final billed amount, changes may occur. "A lot of relationships get damaged when patients think the estimate is absolutely all they're going to have to pay," Ms. Meredith says.

5. Work with physicians to determine patient financial history. Depending your state laws and personal practices, your ASC may want to offer a discount on surgery for patients who are having financial difficulty. In this case, it's essential to know whether patients really need financial assistance or they just don't want to pay. Ms. Fort recommends working with your physicians to look at the patient's financial history. If the patient has a history of financial difficulty, ASCs can offer a prompt-pay discount that encourages patients to pay up-front by offering a price reduction. "The physician's offices knows the patient's history, and they can tell you if it's just a story the patient has called with, or if they have really been on a payment arrangement with the physician for years," Ms. Fort says.

6. Use a third-party payment plan for patients who can't pay up front. Not every patient will be able to pay for an expensive procedure up front, and your facility shouldn't have to turn away those patients. In that case, you can use a third-party payment plan through companies like Chase or GE's CareCredit that will approve or deny patients based on their credit rating. If a patient is approved by the payment plan, he or she can make regular payments for the procedure, and any failure to pay is generally absorbed by the payment plan.

These payment plans generally function like dedicated healthcare credit cards that can only be used for healthcare charges. A patient can apply at the center by entering several pieces of personal information, and the payment plan company automatically approves or declines the patient based on how likely or able they are to pay. The third-party payment plan means a third-party company assesses a patient's ability to pay and absorbs the loss, creating less financial hassle for your center.

Mr. Morris says an ASC should only resort to its last option — billing the patient after the procedure — if the patient arrives on the day of surgery and cannot pay and a day-of-service cancellation would create animosity between the surgeon and the center. In that case, ASCs should research how to receive the highest possible payment from post-discharge collections.

7. Follow up by phone about money owed. While your center should try to collect payment up-front instead of billing the patient, you will always have patients that require post-operative billing. If your center notices a patient has not paid the required amount, Ms. Meredith recommends calling the patient to inquire about the bill. "A lot of people are scared to call the patient," she says. "They would rather keep sending a bill, but that isn't going to tell you anything if the patient isn't paying. You may have the wrong address, and whoever lives there now is throwing the bill away. Communication is the most important part of this." ■

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Truth Behind A/R Days: Why It's the Most Important ASC Business Statistic and Why Most ASCs Have it Wrong

By Rob Kurtz

Accounts receivable is easily the most misquoted ASC statistic, says Joe Zasa, co-founder and managing partner of ASD Management, and this is very bad news for ASCs as A/R days is also the most important business statistic.

A/R days, Mr. Zasa says, will tell you if your ASC is collecting properly, billing properly, coding properly, collecting co-pays and deductibles in a timely manner, billing in a timely manner and working collections on the back-end properly and doing effective follow-ups on insurance denials.

"The reason this statistic is so important is because it is the barometer for the business office," he says. "It is the best scorecard and measuring stick for your business office, bar none. All of the processes in the business office point back to this number," which is why it is critical that ASCs accurately determine this figure.

Here are several reasons why ASCs are challenged with doing just that:

1. It requires very good financial information to calculate, Mr. Zasa says. "Specifically, it requires accrual accounting," he says. "In order to get a good A/R number, that's a function of loading the contracts of the facility into the MIS, creating a reserve for out-of-network and creating a reasonable bad debt expense based on historical [figures]."

2. The figure is sometimes misquoted because administrators don't understand what the number is or they're coming up with unreasonable write-offs to pad the number and make it look lower, Mr. Zasa says. "The statistic can be manipulated," he says. "An administrator can do so by writing everything off after 90 days or writing off denials. You don't want to write-off anything after 90 days. You want to create a reasonable reserve broken out by aging of the A/R. This can be tested against historical averages to obtain a good estimate. For example, the actual amounts collected over 90 days may be 30 percent; thus, a reserve account should be set up to account for this."

3. ASCs must manually calculate this figure as MIS systems typically do not do so correctly, he says.

A consistent A/R formula

Calculating the correct A/R days figure requires a consistent formula, Mr. Zasa says. Here is one such formula Mr. Zasa suggests:

The formula is a fraction. The numerator is net A/R. The denominator is average daily net revenue. Average daily net revenue is calculated by taking the net revenue for the last two months and dividing by the number of days in those two months.

For example, an ASC's A/R for September is $300,000, Aug. revenue is $200,000 and Sept. revenue is $200,000. The formula would be:

$300,000 / ($200,000 + $200,000)/61 = ~45.8 A/R days

What should A/R be?

Mr. Zasa believes most ASC A/R days are 56 or higher, and not the typically quoted average of 45 days. His centers average approximately 38 days but 45 days in A/R is what a typical center should target, he says. If an ASC sees primarily Medicare patients, A/R should be far lower than that; the same rule applies if it's a cosmetic/plastic surgery facility where most of the patients are self-pay, he says. If it's an ASC that handles a lot of worker's compensation claims with complicated denials to work through and if the ASC handles "letter of protection cases," it's probably going to be slightly higher than that but should still not be in excess of 50 days, Mr. Zasa says.

Four steps to determine your true A/R days

Mr. Zasa says ASCs should take these four steps to determine their actual A/R days.

1. Load your contracts.

2. Establish a bad debt reserve that's reasonable and based on historical figures.

3. Calculate A/R on your financial statements every month. Even if you're on a cash accounting, you can go to a modified cash basis and have A/R on your balance sheet, he says.

4. Once you have two months of data, plug the figures into the formula provided earlier. ■

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

What to Audit When You Audit Your ASC's Billing Process

By Rob Kurtz

Caryl Serbin, president and founder of Serbin Surgery Center Billing, recommends ASCs focus on the following areas when auditing different components of their billing process.

When auditing coding:

- Accuracy of CPTs
- Need for additional CPTs
- Accuracy of diagnosis codes
- Need for additional/different diagnosis codes
- Accuracy of modifiers
- Need for additional/different modifiers

When auditing charge posting:

- Charges posted correctly
- Diagnosis codes posted correctly
- Modifiers posted correctly
- Up-front adjustments done correctly (automatic/manual)
- Number of days taken to generate claim after received from coder

When auditing payment posting:

- Payment posted correctly
- Adjustment made correctly
- Balance transferred correctly
- Notes posted as appropriate
- Credit balance processed correctly and timely
- Under/over payments handled correctly and timely

When auditing collections:

- First follow-up within 15-30 days
- Additional follow up every 30 days
- Detailed follow-up notes
- Appeal done properly
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8 Ways ACOs Could Impact Surgery Centers With Healthcare Futurist Joe Flower

By Leigh Page

At first glance, surgery centers might appear to be an obvious fit for accountable care organizations. ASCs are the low-cost, high-quality provider, which is exactly what ACOs are looking for. But Joe Flower, a healthcare futurist based in Sausalito, Calif., doesn't think it will be that easy for ASCs to adapt to the ACO approach. Keeping in mind that much is still unknown about how ACOs will work, he makes eight points on how ACOs might affect ASCs.

1. New mindset required. "A surgery center is pretty much the opposite of an ACO," Mr. Flower observes. While the ACO is concerned about the entire continuum of care, the ASC is used to focusing on one niche. "A surgery center does certain kinds of procedures efficiently and well," he says. "But in an ACO, providers are incentivized to have a longer-term relationship with the patient." Providers need to spend time tracking patients and staying involved with them over a long period of time, which is the opposite of how ASCs and most specialists are used to working. "The surgeon thinks, the longer the relationship with the patient drags on, the more it costs and thus the less advantageous it is," he says.

2. Lower surgical volume. ACOs will foster a new cost-saving attitude among providers that could tamp down surgical volume. In the 1990s, HMOs tried to save money by using primary care "gatekeepers," directing patients away from costly treatments like surgery, but ACOs will be less draconian. Mr. Flower observes that in some cases, the medical literature shows viable medical alternatives to surgery. He cited his own experience in a closed-panel HMO as an example. When his knee bothered him and a knee replacement seemed a possible option, his physician did not rule out surgery but suggested other strategies, such as cortisone shots, change in diet, occasional use of ibuprofen and stretching exercises. In comparison, surgery would take a long recovery and he couldn't continue high-impact sports like racquetball. Mr. Flower chose the non-surgical approach.

3. ASCs can't afford to ignore ACOs. Mr. Flower thinks surgery centers cannot afford to ignore ACOs. "In the next five to 10 years, ACOs of one kind or another will come to dominate the business of healthcare," he says. In populated areas, ACOs will compete with each other on the basis of cost-effectiveness.

4. Other trends mirror effects of ACOs. Even if ASCs avoid working with ACOs, Mr. Flower believes other healthcare trends will slow down utilization of surgery.

First, patients are assuming more financial risk, through the growth of health savings accounts and high-deductible plans. Thus patients are highly incentivized to look for less costly alternatives, such as a less complex operation or, even if the medical literature calls for surgery, no operation at all. "The patient may choose just to endure the pain, to just to live with it," he says.

Second, insurers are becoming more aggressive in not paying for surgery they deem unnecessary. If the peer-reviewed literature shows a non-surgical intervention or less complex surgery is just as effective, insurer will be more likely not to pay, he says. However, when there is no real medical alternative to surgery and patients cannot forego surgery, he thinks ASCs will flourish, he says.

5. Benefits of joining ACOs. Surgery centers that join ACOs or contract with them could benefit from referral volume diverted from centers that do not cooperate or are rejected by ACOs due to perceived low quality or inability to meet standards such as IT requirements. ASCs that are members of ACOs might also have more influence over the organization's policies on choice of surgery. And if they become involved in patients' decision-making, they might have more influence over the choices patients make.

6. Need to work closely with primary care. Surgery centers and their specialists will be under increasing pressure to work more closely with primary care physicians. In some areas of the country, PCPs and specialists are already forming "physician integration councils" in which they discuss referral policies. In some cases, these physicians make written agreements on referrals, with violators running the risk of losing referrals.

7. Hospitals face conflicts of interest. When hospitals lead ACOs, they will have to deal with inherent conflicts of interest that affect the way they deal with independent ASCs. Under the current business model, the hospital tries to direct patients to its own ORs, which are usually more expensive than ASCs. But if hospitals followed that policy as leaders of ACOs, the ACO would be unsuccessful. Hospitals that truly want their ACOs to flourish would have to farm out operations to independent surgery centers or something like them. "The hospital will have to offer multiple lines of business, some of which compete with each other," Mr. Flower says. Hospitals will need to tolerate ambiguity, but he says they already do this with their hospital-employed physicians, in that the employed physician may not necessarily refer to the hospital.

8. Hospitals will buy more ASCs. One solution for the hospital is to buy up independent ASCs and integrate them into their operations. We're going to see a lot of hospitals offering to buy ASCs or joint-venture with them. ■

Joe Flower is a frequent speaker on the future of healthcare. Learn more about Joe Flower at www.imaginewhatif.com.

5 Strategies for Saving Your ASC Money by Streamlining Equipment Costs

By Jaimie Oh

Mike Kintner, service contracts manager at TriMedx, shares five strategies ASCs should adopt to achieve significant, sustainable equipment savings.

1. Consolidate equipment purchases. An ASC should strive to make bigger purchases, as opposed to buying equipment and supplies as the need spontaneously arises, by strategizing what the facility needs over a longer period of time. In doing so, an ASC gains an advantage in negotiating prices on the initial acquisition cost and other related expenses.

"Instead of purchasing equipment here and there, it's much better for ASCs to plan a more strategic approach to what the needs are over a long period of time," says Mr. Kintner. "For example, instead of buying three pieces of equipment over six months, the facility should look at possibly buying three pieces of the equipment at once. This way, it can position itself for negotiating discounts on capital and also costs related to services, training, warranty terms, software, manuals and so on."

2. Work to negotiate a warranty tailored to your advantage. Mr. Kintner suggests ASCs take advantage of equipment warranties by tailoring them to specific facility needs. He says most medical equipment warranties last for 12 months, which means companies will provide labor services and extra parts free of cost for that period of time. If your ASC already has a technician who is trained in the clinical and technical support of a newly purchased piece of equipment, he suggests negotiating the labor portion of a warranty and extending the portion of the warranty that guarantees covered costs for additional parts.

"If I'm buying 20 anesthesia machines and they come with a 12-month parts and labor warranty and I already have a trained technician who can support it and do repairs, what I might want to do is negotiate 90 days of labor warranty and two years of coverage of parts instead," Mr. Kintner says. "A warranty is usually already baked into the acquisition price, so what you're doing is just reallocating the value of the warranty."

He says ASCS should also take advantage of warranties by having their clinical engineering teams or other staff technicians work with the original equipment manufacturers during labor services as a form of free training. Additionally, ASCs should use the warranty to evaluate the long-term service needs of that piece of equipment.

3. Standardize equipment. Facilities should standardize equipment make and models by ordering equipment from as few companies as possible. This will save ASCs time and money over ordering different pieces of the same equipment from a wide variety of companies.

"Let's say your facility needed to replace 10 defibrillators. Instead of replacing them each time with different makes and models, an ASC is better off standardizing so that in case a new staff member is hired to work in the facility; [this way] you only need to train and provide support for one make and one model of defibrillators," Mr. Kintner says. "Also, ASCs need consumables like ECG leads in support of the defibrillators, which are gel pads for defibrillators. So standardizing by make and model saves money by avoiding the need to order different kinds of gel pads."

4. Manage the total life cycle of equipment. Mr. Kintner says the costs related to supporting a piece of equipment over its entire life cycle, from the point of acquisition to disposal, may actually equal or exceed what it cost to just purchase it. To minimize life cycle service costs as much as possible, he suggests ASCs strategically analyze whether a piece of equipment requires lifetime support that is cost-effective.

"What organizations don't look at is how much it costs over a piece of equipment's life span to support it, and they usually only look at the capital acquisition," he says. "They have to actively manage service costs to understand that maybe an investment in equipment with higher capital would be better because its service costs over its life span will be lower than cheaper equipment."

5. Create and involve a clinical engineering team. If your ASC doesn't already have a clinical engineering team charged with support of the facility's equipment, Mr. Kintner strongly suggests ASCs create that resource because those staff members understand both technical and clinical aspects of the equipment needed to provide high quality care.

"CETs are a great resource to assist in the operational and financial analysis of equipment purchases because they understand the technical perspective and also have a clinical understanding," he says. "ASCs can bring them into the process of analyzing acquisitions, total life cycle management, warranty options, discount negotiations and all the other things that were mentioned previously." ■

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8 Ways to Save More Money on ASC Supplies

By Rachel Fields

Supplies are one of the biggest costs to an ASC, and according to experts, many centers lose money unnecessarily by failing to negotiate good prices, letting supplies expire and making impulsive purchases. Nine ASC administrators and experts discuss the hallmarks of saving money on the supply chain.

Purchasing

1. Pit supply vendors against each other. There are always several companies that offer the equivalent to a certain type of equipment, so Steve Corl, administrator at Mackinaw Surgery Center in Saginaw, Mich., recommends doing a product comparison. His biggest supply needs for orthopedics are anchors and screws, which act as implants. His ASC looks at each company's product and involves its physicians in the process, which he says "is key because it's not always about prices. Even though one product might be cheaper, you might want the more expensive equivalent because it'll add more value to the facility."

Once his center has compared the products, he lets the companies know that Mackinaw Surgery Center is comparing their prices to other companies. "Then it becomes a bidding war over prices between the three or four companies," he says. "We go to them and say, 'We know the quality is equal in all of your products across the board. We need your best price and we're going to go with the best one out of the rest.'"

2. Consider building a relationship with a hospital. A partnership with a hospital can give an ASC access to supplies and purchasing power to negotiate lower supply costs. "Our relationship with the hospital means they have the same supplies," says Lynda Simon, administrator of St. John's Clinic: Head and Neck Surgery in Springfield, Mo. "If they're low on something, we can share, and if we're low on something, they can share." She adds, "Because all the purchasing goes through the system, that gives you a little bit of extra push because the hospital is working on your behalf to get costs down as low as they can."

3. Reduce purchasing mistakes by giving common items a trial period. An ASC will frequently see a commonly-used item from another manufacturer at a reduced cost, such as a hand cleanser or non-sterile gloves, and immediately switch without a mini-trial, says Susan Kizirian, chief operating officer for ASCOA. The trial doesn't have to be a big deal, she says. Just get the item for trial and gather feedback, and then switch to the new item, giving staff and physicians who use the item time to try the new item, compare it to what's currently used and give feedback. Upfront buy-in saves the dollars that overcoming resistance to change generates.

4. Never buy impulsively. When ordering supplies, an ASC must stay tough and focused on what may be the best deal for the surgery center as a whole and not just for individual physicians. Georganna Howell, administrator of Baltimore-based Greenspring Surgery Center, compares prices between several companies before settling on a final purchase.

"There was a company that offered $18 per unit for a Bovi pen after I was offered $25 per unit [by a previous company]," she says. "But I could get [the deal] if I buy a minimum of 1,000 units. I went with a third company because there was no minimum or maximum purchase required, and I actually ended up with a better price than either company. You never want to lock yourself into a minimum or maximum purchase requirement. Everything we purchase has a thought behind it. I want top-of-the-line supplies and won't settle for less, so I'm going to shop around."

Managing

1. Measure cost, frequency of use and reimbursement. Becky Johnson, clinical director of Lincoln (Neb.) Endoscopy Center, focuses on the cost of any new equipment as well as how often the equipment will be used and the amount of money that will be reimbursed from payors when using the equipment.

"We've talked about [purchasing] equipment for monitoring pH in the esophagus and hemorrhoidal banding, but based on how frequently physicians would even use those, how much it cost and lack of reimbursement from insurance companies, the research didn't support it," she says.

2. Hire an inventory manager. The key to inventory control is an inventory manager who has complete responsibility for tracking your inventory, according to Sandy Berreth, administrator of Brainerd Lakes Surgery Center in Baxter, Minn. "You don't have to hire a medical person, though it doesn't hurt to have an experienced OR nurse because they just know what you need and what you're using," she says. "The key is to have a single person who's completely engaged in the process of inventory control."

If you leave inventory duties up to your administrator or other staff members, they may neglect inventory tasks when your ASC is busy and they have other things on their plate. An inventory manager will let you know which supplies you aren't using, which you could be saving money on and which cases cost you the most in terms of supplies — information you may overlook if you're handling the responsibility on top of everything else.

3. Keep supplies in short stock. If you want to cut costs and prevent waste, look at your supply shelf and make sure you don't have unnecessary supplies sitting around. "We have a very small owned inventory, and everything is in very, very short stock," says Tammy Burnett, administrator of The Plastic Surgical Center in Flowood, Miss. "We order quickly and we don't use supplies when they're not needed."

She says her staff members are vigilant about preventing waste: Before they start a procedure, they look at every supply involved to make sure it's necessary. "If they're looking at a suture, our staff are involved enough to say, 'No, we need this link because it's longer and we'll pay less for it than we would for several shorter ones'," she says.

David Kelly, administrator of Samaritan North Surgery Center in Dayton, Ohio, says most centers have supplies that are rarely used. "Get rid of the things that don't add any value," he says.

4. Review supplies per case every month. Supplies are a significant line item expense ASCs can control. Brian Brown, regional vice president of operations for Meridian Surgical Partners, notes it is essential for ASCs to budget for supplies based on its case mix. Some important supply items to look at are implants, IOLs and pharmaceutical expenses.

Implants should be monitored particularly closely, and ASCs should make sure expensive devices are covered by payors. "ASCs need to break out implants and make sure payments have been received. Back-office employees should make sure patients have the proper authorizations when submitting claims, because margins can be affected if implants are not paid for," Mr. Brown says. ■

6 Best Practices for Implementing an Effective Infection Control Program

By Jaimie Oh

Infection control is gaining widespread attention in all healthcare settings, including ASCs. Incorporating an infection control program is essential to minimizing the incidence of infection and patient revisits. Here are six best practices for ASCs looking to implement an effective infection control program at their facilities.

1. Monitor physicians and staff members. Denise Kesler, director of Athens (Ga.) Orthopedic Ambulatory Surgery Center, says the facility established a monitoring policy where staff members in each department, such as the OR, are selected to secretly monitor their coworkers compliance to hand hygiene protocols.

"It's done anonymously, so no one knows they're being watched," she says. "The monitor tallies up hand washing incidences on a monthly and quarterly basis, and that data is then delivered at a staff meeting. It makes the staff more aware, and compliance has improved greatly since we implemented this."

2. Regularly wipe equipment down. In addition to placing policies and procedures that reinforce compliance to hand hygiene, it is equally as important to make cleaning and wiping down of equipment a priority. After each patient visit, staff members at Athens are responsible for wiping down wheelchairs, blood pressure cuffs and anything else that patient may have come into contact with.

"We always re-emphasize that everything needs to get wiped down," Ms. Kesler says. "At our surgery center, it's usually the nurse attending to the patient that will go into the room this patient was in to make sure everything is wiped clean. But it's a team effort, because if that nurse is walking the patient out, somebody else will follow behind to clean up the room for the attending nurse."

3. Place hand sanitizers throughout the facility. Installing hand sanitizers throughout an ASC gives the facility an added reinforcement to fighting off infection. Athens installed hand sanitizer pumps and motion-sensor hand sanitizers on the walls of the surgery center. More recently, in the midst of ongoing construction, Athens has installed a motion-sensor hand sanitizer at the reception desk for patients and their family members to use as well.

"We've strategically placed hand sanitizers in multiple areas, so no one has the excuse of not having ready access to washing their hands," Ms. Kesler says. "Also, it's not only accessible to the staff and physicians but also the patients and their families. This way, patients are able to sanitize their hands in the patient area prior to surgery."

4. Install a washer sterilizer. ASCs have the option of installing a washer sterilizer, which is a piece of equipment most supply companies offer that can help in sterilizing surgical instruments. Although buying and installing a washer sterilizer is a significant investment, Ms. Kesler says the investment is worth it in the long run.

"For decontaminating instruments, our staff used to do all that by hand, but we just purchased a washer sterilizer that we'll be using pretty soon," she says. "It's like a huge dishwasher that we'll be putting in a sterile work room, and what you would do is place your instrument trays and run it through the machine, which dispenses enzymatic cleaner, detergent and lubricant."

5. Train and test for competency in infection control. Janine Hathaway, administrator at Ashtabula (Ohio) Surgery Center, says an essential part of the center's infection control program is training and regularly testing staff members on various issues, including infection control. The surgery center commits to doing competency meetings twice a year to cover infection control issues by bringing in subject matter experts from various organizations, including the Occupational Safety and Health Administration, to re-train staff.

"We follow each competency day with a test so ensure each staff member is able to physically demonstrate competency, and actually we're really focusing on hand-washing hygiene because that's a huge issue across surgery center," Ms. Hathaway says. "After each staff member takes their test for infection control, we keep those tests in their personnel files."

6. Incorporate infection-fighting materials. Dave Sands, architect at Baskervill in Richmond, Va., says ASCs can also use building materials that are proven to help fight off infection. Materials such as silver and copper are naturally able to kill bacteria, so working those materials into hand rails or using paint with those metals can help ASCs stave off infection.

"There are materials, like silver and copper, that are readily available today to make surfaces of a facility a fighter of bacteria," Mr. Sands says. "Copper does one of the best jobs and is actually something that is getting to be popular in emergency facilities and can go right along with ambulatory care." ■

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