Inside: 17th Annual Improving Profitability, and Business and Legal Issues for ASCs Conference Brochure (p. 35)

BECKER'S ASC REVIEW

Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

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INSIDE

INDEX

5 Financial Implications Healthcare Reform Will Have on ASCs

By Leigh Page

Andrew Hayek, president and CEO of Surgical Care Affiliates and chairman of the ASC Advocacy Committee, discusses five key ways the healthcare reform law will affect ASCs.

1. New payment adjustment results in flat reimbursement. CMS will begin applying a new mechanism, called the "productivity adjustment" that will reduce annual payment updates for most healthcare providers. This mechanism goes into effect for ASCs in 2011, and

continued on page 9

6 Key Issues and Trends Impacting Outpatient Services and Physician-Owned Facilities

By Scott Becker, JD, CPA, and Barbara Kirchheimer

This article briefly addresses six key issues impacting outpatient services and physician-owned facilities.

1. Covering more people will lead to the reallocation of limited healthcare dollars. With the goal of bringing insurance coverage to an estimated 30 million people, the healthcare reform law will necessarily reallocate some of the dollars spent within the healthcare system.

continued on page 10

CMS Releases 2011 ASC Proposed Rule: 7 Important Issues

By Marian Lowe, Executive Director, ASCAC

The Centers for Medicare & Medicaid Services released the CY 2011 proposed payment rule for hospital outpatient departments and ambulatory surgery centers. 2011 marks the end of the transition to the revised ASC payment system: This will be the first year in which payments to ASCs will be based solely on the basis of the outpatient prospective payment system (OPPS) relative weights. After taking into account the scheduled increase in the update factor and decrease resulting from the productivity adjustment, the result will be a zero percent increase in ASC payments next year.

The rule, CMS-1504-P, is posted at the *Federal Register* at www.ofr.gov/page2.aspx#spec_C, and the rule and accompanying files will be posted on the CMS website at www.cms.gov/ASCPayment/ASCRN/list.asp

continued on page 12

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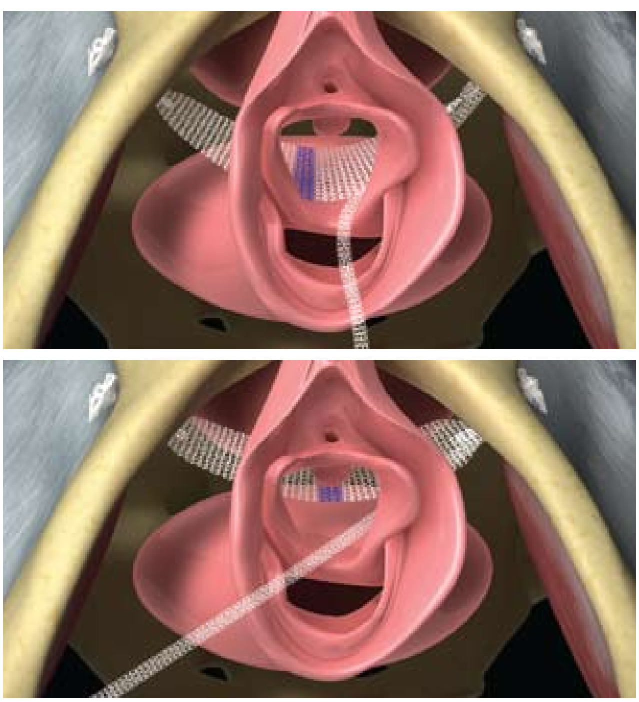

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FEATURES

Publisher's Letter

17th Annual ASC Conference: The Best Business Speakers in the ASC Business – Registration Discounts End September 1

We have put together an agenda that includes the best business speakers and the best topics in the ASC industry for our 17th Annual ASC Communications and ASC Association Conference. The conference is scheduled for Oct. 21-23 in Chicago on North Michigan Avenue.

The conference will include topics on co-management, joint ventures, increased OIG investigations, healthcare reform, accountable care organizations, benchmarking, improving revenues, managed care contracting and a broad range of issues relative to improving the business and profitability of ASCs. We will also include keynote speakers such as Coach Bob Knight and political commentator Tucker Carlson. We believe it will be a tremendous conference.

To receive the early registration discount, please register by Sept. 1. You can register in the following ways: Contact the Ambulatory Surgery Foundation at (703) 836-5904 or fax (703) 836-2090 or via e-mail at registration@ascassociation.org or online at https://www.ascassociation.org/chicagoOct2010.cfm.

To reserve your hotel room at Swissotel on North Michigan Avenue, please call (888) 737-9477 or online at https://resweb.passkey.com/go/asccommunications. We encourage you to stay at the Swissotel on North Michigan Avenue.

Should you have any questions, please contact me.

Very truly yours,

Scott Becker

P.S. For a copy of the conference brochure, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com or go to www.BeckersASC.com.

5 Financial Implications Healthcare Reform Will Have on ASCs
(continued from page 1)

it will reduce future annual updates by an estimate of labor productivity improvement in the general economy, generally one to two percent. For 2011, ASCs would have received a 1.6 percent update (based on the consumer price index), but the productivity adjustment is also 1.6 percent, resulting in no update. This new mechanism, which applies to many categories of healthcare providers, will keep Medicare reimbursement roughly flat for ASCs each year into the future.

2. Colonoscopy coinsurance waiver drives preventive care but removes patient incentive for low-cost care. Medicare patients will no longer pay co-insurance for screening colonoscopies, a step meant to encourage more preventive care. While this is positive overall for ASCs and the patients they serve, the waiver also applies to hospital outpatient departments. This will effectively eliminate the patient's incentive to seek lower-cost care in the ASC setting.

3. Payment will eventually be tied to quality measures. HHS has been directed to create a plan by the end of 2011 to implement "value-based purchasing" (pay for performance) for ASCs. The ASC Advocacy Committee and the ASC Quality Collaboration (ASCQC) will work with Medicare in designing this new system. Medicare's first value-based purchasing program will come online for end-stage renal disease providers next year, and the reform law pushes the agency to develop similar systems for other providers. There are 1,200 ASCs across the country that have already begun voluntary reporting of quality measures through the ASCQC, which has developed six quality measures that have received endorsement from the National Quality Forum, an independent organization widely recognized as an authority for establishing quality measures in health care. The ASCQC is working on additional measures that could also be the basis for payment incentives for ASCs performing at high levels. The results are published quarterly at www.ascquality.org. Generally, the expectation is that Medicare will use ASCQC's work as a starting point for its value-based purchasing plan.

4. ACOs may benefit surgery centers. Most of the structure and processes for accountable care organizations (ACOs) is still being created, but the central premise of ACOs is clear: to improve quality and reduce cost for their assigned population. Because ASCs are paid 42 percent less than the HOPD rate (the difference rises to 44 percent next year), ACOs have an incentive to shift surgical volume from the HOPD setting to ASCs in order to create cost savings and trigger incentive payments to the ACOs.

5. New Independent Payment Advisory Board could favor ASCs. The new Independent Payment Advisory Board (IPAB) will have broad authority over Medicare payment and policy, and its mandate is to dramatically reduce the rate of growth of Medicare cost. The implementation of the IPAB in the next several years will create significantly more downward pressure on reimbursement generally throughout the healthcare system. In this context, the ASC industry will have the opportunity to demonstrate that it provides outstanding clinical quality at a lower cost, and, therefore, the best payment policy is to encourage more migration of outpatient surgical cases from the HOPD setting to the ASC setting. ■

Contact Leigh Page at leigh@beckersasc.com.

6 Key Issues and Trends Impacting Outpatient Services and Physician-Owned Facilities (continued from page 1)

The individuals who will gain insurance coverage under the new law are likely to be low-paying, which means the system will have to absorb a great number of additional covered lives with very little additional aggregate reimbursement. Most new patients will be covered at amounts close to Medicaid reimbursement rates.

Over the next three to five years, the new law does very little to take dollars out of the overall system. However, in the longer term, the reallocation of dollars from this influx of newly covered individuals is likely to increase the pressure to cut costs. The likely scenario five years out is a very different distribution of healthcare dollars and potentially significant tax increases.

2. Erosion of independent medical practice. Against this backdrop, the independent practice model is losing its appeal for many physicians. While aligning with a hospital does not directly reduce physicians' overall outpatient workload, it does affect the entrepreneurial side of their outpatient business.

Available statistics vary on the percentage of physician practices currently owned by hospitals, but it is clear that the number of physicians seeking hospital employment is on the rise.

Physician search firm Merritt Hawkins indicates the percentage of physician search assignments it conducted involving hospital employment rose to 45 percent in 2009 from 23 percent in 2005. Tommy Bohannon, Merritt Hawkins' vice president of hospital-based recruiting, says he expects that figure to jump to more than 50 percent on the firm's next annual survey.

In certain sectors, such as cardiology, the trend is even more pronounced. In his blog, *The Lewin Report*, American College of Cardiology Chief Executive Officer Jack Lewin, MD, took an informal poll asking whether cardiologists had integrated their practices with a hospital in 2009. Some 12 percent responded that they had, while another 21 percent said they had concrete plans to integrate and another 50 percent said their practice was thinking about doing so within the next two years.

"A cardiologist that's part of a hospital system, the revenues they can produce for that system can be very, very good because of the use of ancillary services," says David Gans, MSHA, FACMPE, vice president of innovation and research for the Medical Group Management Association. "Consequently the hospital can support the physician well."

These shifts are likely to affect the prospects for physicians' entrepreneurial business endeavors. Independent practitioners have generally been the lifeblood of ASCs, physician-owned hospitals and other types of freestanding healthcare entrepreneurial ventures. Even slight changes in the total number of independent physicians can have a huge impact on the economies of scale of surgery centers and physician-owned hospitals. These businesses, like any type of business, work with a fairly fixed set of costs. A large portion of their profit accrues after a base number of cases are brought in to cover basic fixed costs. Thus, incremental cases drive their profitability. If the incremental cases are taken somewhere else through employment arrangements with hospitals and other systems, the physician-owned facility is left in a much tougher position.

Several factors are driving this trend in physician employment. The top four are:

- Money: Hospitals can afford to pay physicians well due to the technical fees the physicians generate for hospitals. "The hospital can legitimately preclude its competition and bring those doctors in as admitters and users of ancillary services, so these are the same practices that are better revenue-generators for the hospital," MGMA's Mr. Gans says.

- Money: Physicians are very concerned about the uncertainty of future reimbursements.

- Money: Many physicians took a significant hit in the stock market and real estate crash and are seeking a perceived lower-risk practice environment.

- Work-life balance: Many physicians who graduated over the past decade seem more focused on work-life balance and more predictable hours than a business owner would have.

Scott Gottlieb, MD, a practicing internist, former CMS official and current fellow at the American Enterprise Institute noted this trend in a recent opinion piece in the *Wall Street Journal*. "Doctors, meanwhile, are selling their practices to local hospitals," Gottlieb wrote May 18 in the *WSJ*. "In 2005, doctors owned more than two-thirds of all medical practices. By next year, more than 60 percent of physicians will be salaried employees. About a third of those will be working for hospitals, according to the American Medical Association."

Dr. Gottlieb goes on to mention that a hospital with which he is affiliated recently formed a new subsidiary to purchase local medical practices. "Nearby physicians are lining up to sell — and not just primary-care doctors, but highly paid specialists like orthopedic surgeons and neurologists. Similar developments are unfolding nationwide."

According to Dr. Gottlieb's analysis, salaried physicians and further consolidation of medical practices will leave patients with fewer options and longer waiting times.

3. There are roughly 5,200 Medicare-certified ASCs. While the number of Medicare-certified ASCs increased by over 50 percent from 2001-2008, the rate of growth has slowed significantly. According to MedPAC's June 2009 Data Book, there were 5,174 Medicare-certified ASCs in 2008, up only 3.7 percent from 4,991 in 2007. By contrast, in 2007, the number grew 6.2 percent, in 2006 it grew 5.8 percent, and in 2005 it grew 7.3 percent

An industry expert and founder of a leading ASC company recently hypothesized 2010 might be the first year in which there is a net loss in the total number of ASCs across the country. Of the nation's Medicare-certified surgery centers, 20 percent to 35 percent have a hospital partner, and another 20 percent to 30 percent are rumored to be losing money at any given time.

4. Revenues for outpatient services will be under tremendous pressure. As discussed above, the erosion of the independent medical practice will likely lead to either a deceleration in or actual reduced case numbers, which will contribute to the pressure on revenue for outpatient services. In addition, reimbursements for services from commercial payors and Medicare will face significant downward pressure.

The hospital industry and the pharmaceutical industry are among the projected winners in the healthcare reform legislation. Each have secured a substantial portion of the healthcare budget for the foreseeable future and are somewhat protected from significant reimbursement risk. Here, the Federation of American Hospitals and PHRMA made big bets that healthcare reform would pass, paid big dollars to hire Chip Kahn and Billy Tauzin to negotiate their positions with the White House and Congress, and by all accounts seem to have succeeded in their efforts. That leaves other healthcare sectors more vulnerable to reductions as these big areas remain somewhat protected.

Insurance companies will also be exercising more authority over physicians. As Dr. Gottlieb notes in his *Wall Street Journal* opinion piece, the pending standardization of minimum insurance benefits in 2014 and mandates on insurers to fully cover certain primary care services will make it harder for them to control their expenses.

"One of the few remaining ways to manage expenses is to reduce the actual cost of the products," Dr. Gottlieb writes in the *WSJ*. "In healthcare, this means pushing providers to accept lower fees and reduce their use of costly services like radiology or other diagnostic testing."

5. Co-management arrangements on the rise. These alternatives to traditional hospital-physician joint ventures seem to be gaining momentum as a way for hospitals to align themselves with independent physicians. Under these arrangements, hospitals either hire physicians or groups to manage service lines or they actually buy a business line from physicians and then have the physicians manage the area. For example, a hospital may buy up an ASC from physician-owners (or develop one) and convert it to a hospital outpatient department. The HOPD then commands higher reimbursement rates. Physicians give up equity but take on less financial risk.

It is not clear how long these co-management arrangements will continue to be the new hot thing. It is likely they will remain important for some time to come.

Co-management arrangements also carry with them some legal concerns. Those that are structured with "aggressive" payment arrangements may well need to be rethought and possibly restructured if the federal government intervenes and raises objections.

6. Great management. It is likely that well-managed firms will continue to thrive even in a much tougher economy for surgery centers, free-standing imaging facilities and other physician-driven businesses. Several leaders have show that it is possible to thrive in a tough business line. One of the largest imaging companies, for example, continued to thrive at a time when most other imaging companies struggled to survive. At this time, it is more important than ever to hire great leadership and bring in top level management team. ■

CMS Releases 2011 ASC Proposed Rule: 7 Important Issues
(continued from page 1)

CMS has used the Consumer Price Index for all Urban Consumers (CPI-U) to update ASC payments since the payment system was originally implemented. Although MedPAC took a significant step forward this year in declaring the CPI-U an inaccurate index for updating ASC payments, we are disappointed that CMS did not propose to replace the CPI-U with the hospital Market Basket for purposes of updating ASC payments, a change which would provide a positive update for ASC payments consistent with MedPAC's recommendation. We have made significant strides in urging the agency to move in that direction and will continue to do so this summer by advancing the issue in the Senate with the help of Senators Wyden and Crapo.

There are several important issues in the rule that we will be evaluating as we review the proposal in detail. In the interim, below is a brief recap of a few key issues.

1. Inflation Update: CMS estimates the CPI-U for 2011 will be 1.6 percent. The hospital market basket is projected to be 2.4 percent, but the reform bill requires it to be reduced by 0.25 percent, leaving the HOPD update at 2.15 percent.

2. Productivity Adjustment: As required by the health reform bill, ASC rates will be reduced by a measure of economy-wide productivity gains (a 10-year rolling average calculated the Bureau of Labor Statistics). CMS estimates this adjustment will be 1.6 percent in 2011, meaning the ASC update will effectively be zero percent. This is inconsistent with MedPAC's recommended update of 0.6 percent and an outcome we will vigorously protest.

3. Conversion Factor: After taking into account the update and productivity adjustments, CMS further adjusts the conversion factor to account for budget neutrality in the recalibration of the wage index. This recalibration is slightly positive, so the ASC conversion factor for 2011 will rise from the CY 2010 ASC conversion factor of $41.873 to $41.898 for CY 2011.

4. Scaling of ASC Relative Weights: Each year, CMS applies a 'secondary' budget neutrality calculation to the ASC relative weights to ensure that changes to the APC relative weights under the OPPS do not result in an aggregate increase or decrease in payments. CMS estimates the scaling factor for 2011 to be 0.9090 (the final CY 2010 scaler was 0.9567). The significantly higher scaler is partly due to the fact that these are the fully transitioned weights and partly due to increases in the OPPS relative weights for ASC procedures.

5. Wage Index: CMS continues to use the pre-floor, pre-reclassified wage index to adjust ASC payments for geographic differences in the relative cost of labor. The differences in some markets starting in 2011 will be particularly pronounced because of a policy in the health reform bill that sets the hospital wage index for inpatient and outpatient services in so-called "frontier states" at 1.0. The states affected by the frontier wage index policy include Montana, Wyoming, North Dakota, South Dakota, and Nevada.

6. Quality Reporting: CMS has had authority since 2008 to implement a quality reporting system for ASCs and reduce payments to providers who do not report quality data to the agency. The industry has developed quality measures that have been endorsed by the National Quality Forum. We have also urged the agency to create an infrastructure for ASCs to report quality data and demonstrate their superior performance on these metrics. Once again, the agency has declined to establish such as system. CMS will, however, be developing a report to the Congress as directed by the reform bill articulating a path toward implementing value-based purchasing in ASCs. We expect the agency to provide more detail on their plans for quality reporting in this document.

7. Waiver of Beneficiary Cost-sharing for Certain Services: The health reform bill waives the deductible and coinsurance for certain preventive services that are paid under the ASC payment system and have been recommended by the United States Preventive Services Task Force with a grade of A or B for any indication or population. This will affect several HCPCS codes for colonoscopies. A complete list of affected codes listed in the physician fee schedule below.

HCPCS	Descriptor	Coins./Deductible	Proposed 2011 Payment Indicator
G0104	Colorectal cancer screening; flexible sigmoidoscopy	Waived	P3
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	Waived	A2
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	Waived	A2

CMS published the information on the folloing page in table 58 of their proposed rule to show the estimated impact on ASC payments for the most common procedures. As you can see, many high-volume procedure rates will go down while payments for other services will increase significantly.

HCPCS Code*	Short Descriptor	Estimated CY 2010 Allowed Charges (in mil)	Estimated CY 2011 Percent change (fully implemented and payment)
66984	Cataract surg w/iol, 1 stage	1,091	-2%
43239	Upper GI endoscopy, biopsy	162	-8%
45380	Colonsocpy and biopsy	129	-7%
45378	Diagnostic colonoscopy	109	-7%
45385	Lesion removal colonoscopy	88	-7%
66982	Cataract surgery, complex	73	-2%
62311	Inject spine l/s (cd)	66	-1%
66821	After cataract laser surgery	63	-9%
64483	Inj foramen epidural l/s	61	-1%
15823	Revision of upper eye lid	40	-5%
64493	Inj paravert f jnt l/s 1 lev	36	2%
G0105	Colorectal scrn; hi risk ind	32	-10%
63650	Implant neuroelectrodes	30	3%
29881	Knee arthroscopy/surgery	28	10%
45384	Lesion remove colonscopy	28	-7%
G0121	Colon ca scrn not hi rsk ind	27	-10%
64721	Carpal tunnel surgery	26	10%
29826	Shoulder arthroscopy/surgery	24	16%
43235	Uppr gi endoscopy, diagnosis	24	-1%
29880	Knee arthroscopy/surgery	23	10%
52000	Cystoscopy	21	-7%
63685	Insrt/redo spine n generator	20	5%
29827	Arthroscop rotator cuff repr	20	12%
64622	Destr paravertebrl nerve l/s	17	6%
28285	Repair of hammertoe	17	11%
62310	Inject spine c/t	15	-1%
26055	Incise finger tendon sheath	14	7%
67904	Repair eyelid defect	13	9%
64623	Destr paravertebral n add-on	13	-1%
50590	Fragmenting of kidney stone	13	-4%

Learn more about ASCAC at www.advancingsurgicalcare.com.

12 Ways to Maximize Profits at Your ASC

By Leigh Page

Chris Bishop, senior vice president for acquisitions and business development at Blue Chip Surgical Center Partners in Cincinnati, provides 12 ways to maximize profits at your ASC.

1. Recruit more physicians. An ASC should always be on the lookout for more physicians. ASCs are rarely at full capacity, and even if they were, hours could be extended to increase capacity. Finding more physicians is a matter of networking, reaching out to the physician-owners' partners, competing groups and even surgeons in the doctors' lounge at the hospital. Are they playing solitaire as they wait for their scheduled slot in the hospital OR to be ready?

2. Increase volume of existing physicians. In many cases, surgeon co-owners are only bringing half of their eligible outpatient cases to the surgery center. Identify these surgeons and ask them why. Frequently is has to do with something that could be changed, such as buying a piece of equipment or using a different anesthetic.

3. Go to the practice. If you really want to find out why patients are going to the hospital rather than the ASC, go to the surgeon's practice. Sit down with the scheduler. Are all eligible patients being given the ASC as an option to the hospital? Ask the surgeons what they are telling patients. Ultimately, each patient's choice of surgical venue has to do with what the surgeon is telling them.

4. Extend hours to increase capacity. A very busy center should not be limited by the usual hours of operation. Physician-owners may be reluctant to extend hours but they will appreciate how it can improve finances. It does not have to be very onerous – maybe two Saturdays or a few evenings a month. Such time slots would be a great draw to patients who have a hard time getting time off from work. Younger surgeons who are just starting their practices would be interested in off-hours to build up volume.

5. Calculate what each case costs. Case-costing, calculating how much a center makes or loses on a case, is an effective way to convince surgeon-owners to avoid high-cost items. When surgeons are told they use three shaver blades, and they are shown the specific impact on the cost of the surgery, they have the opportunity to consider whether one shaver blade might have been sufficient. The information is at their fingertips.

6. Calculate down-time. Use the same methods to calculate how much it costs the OR to function per minute, based on clinical staff and other costs. For example, if the cost is $18 per minute, you can calculate how much is being lost per month by a surgeon who is chronically 10 minutes late for each operation. You can also see how much is lost by an unused slot.

7. Compress the schedule. Most surgery centers, even when schedules are fully blocked out, are not at full capacity. The paid clinical staff is waiting for the next case because a surgeon is not using all his block time. If this is happening routinely, the surgeon should be asked to give up the unused block time to another surgeon who will use it. Either part of the block each day or the whole block on a certain day could be handed over.

8. Close the ASC for a day. If volume is well below capacity, consider closing the center for a day and compressing all appointments into the remaining days. The business staff and scheduler still need to come in, but you lose the high expense of hiring clinical staff for a day. Clinical staff initially aren't happy with this and one or two might even quit, but usually most of them accommodate to this change, either by getting part-time work or getting comfortable with a four-day week.

9. Release block time. Five business days before surgery, the scheduler should release unused block time for other surgeons to use. Send an e-mail to other partners or call each practice early in the morning to se if they can fill the slots.

10. Add a higher-paying specialty. Spine and bariatric surgery are two higher-paying specialties that present golden opportunities because they are just beginning to move out of the hospital. Retina is also moving out of the hospital, but it is still borderline in terms of profitability. Retina surgeons have to be fast or it will lose money for an ASC.

11. Regularly review payor contracts. Managed care contracts should be analyzed every quarter, paying close attention to opportunities to raise rates. Contracts may have been signed at below-Medicare rates or your costs may have risen. Have all figures on higher costs for each procedure assembled so you can effectively present your case for a higher reimbursement.

12. Be a tough negotiator. Since payors can dig in their heels in negotiations, be ready to walk away and go out-of-network for as long as 18 months so that the payor can understand how much more expensive hospital-based procedures are. A particularly savvy administrator can effectively negotiate contracts, but in many cases this work should be given to an outside consultant or management partner. ■

Learn more about Blue Chip Surgical Center Partners at www.bluechipsurgical.com.

Spine and Sports Medicine Surgeons Top List of Highest Paid Orthopedic Specialties

By Rachel Fields

Here are seven statistics on orthopedic surgeon compensation by specialty from 2009 data, according to the MGMA *Physician Compensation and Production Survey: 2010 Report.*

1. The median salary for orthopedic surgeons specializing in spine surgery was $613,709

2. The median salary for orthopedic surgeons specializing in sports medicine was $599,759

3. The median salary for orthopedic surgeons specializing in hip and joint surgery was $564,139

4. The median salary for orthopedic surgeons specializing in trauma surgery was $526,501

5. The median salary for orthopedic surgeons specializing in hand surgery was $486,717

6. The median salary for orthopedic surgeons specializing in pediatric surgery was $485,283

7. The median salary for orthopedic surgeons specializing in foot and ankle surgery was $453,543. ■

Growing Your ASC, the Path of Least Resistance: Top 4 Easiest Specialties to Transition Into an ASC

By Tyler Merrill, Vice President of Business Development, ASCOA

When looking to grow the number of cases in your ASC and enhance revenue, the size of a physician's practice along with the skill and efficiency of the surgeon are important factors to consider. However, if we look at a group of physicians from a variety of disciplines and assume they all busy, cost effective and talented, certain specialties will lend themselves better to life in the ASC. This is not big news, but what is interesting is the examination of the conversion rate from the hospital into the outpatient setting for the different specialties. If you are running an efficient ASC it is easy to illustrate the benefits of your center to a potential recruit. Faster turnaround times, lower complication rates, higher patient satisfaction and lower infection rates are just a few of the advantages that exist when compared to the hospital. Why then do certain specialties seem more reluctant to embrace life in the ASC?

This article will illustrate some of the obstacles and highlight those physicians who have proven to be the most enthusiastic adaptors. If your goal is to dramatically ramp up your case volume, the following specialties and subspecialties are the ones to target first.

When adding a new physician to your ASC, it is important to mitigate the risk to the existing partnership. This should be a business transaction with the end goal of creating a more stable, robust and profitable center. A trial period for a new recruit protects both the partnership and the new physician. It allows both parties to synchronize clinically as well as to analyze the financial ramifications. The ideal scenario involves recruiting a surgeon in a specialty already represented in your center. Not only do you already have the equipment to accommodate him/her, but your staff is familiar with the procedures being performed. However, when adding a new specialty, purchasing new equipment can be expensive. When shopping for more expensive pieces of equipment, it is always best to investigate renting or leasing first. In many instances, reps will be willing to let your center "trial" a piece of equipment for a number of weeks while you decide what makes the most clinical and financial sense.

Once your center is properly equipped and staffed, a deeper examination of the specialties represented in outpatient surgery centers reveals that some are easier to recruit than others. They can be broken down into one of three categories: Big Money Makers, Nice Additions and Easy Adaptors.

Big money makers

The first category (Big Money Makers) is comprised of orthopedic, spine and bariatric surgeons. The case mix generally consists of higher acuity procedures and, especially in an out-of-network environment, the reimbursements can be quite substantial. Case mix and high reimbursements are the two main reasons that their bonds with the hospital are not easily broken. The perceived political ramifications, along with the number of cases that must remain in the hospital for clinical reasons makes it impossible for them to divorce themselves completely from this relationship. In fact, any one of these surgeons with great intentions of bringing all of his/her outpatient cases to the center has a tendency to fall short of their commitment. The convenience of slipping simple cases in between larger inpatient cases to cut down on travel, fear of losing block-time, and the use of expensive implants are common excuses for continued hospital use for outpatient cases.

Nice additions

The middle category consists of physicians who do a fair amount of outpatient surgery but neither their volume nor their average reimbursements make them highly coveted. It's for these very reasons that this group of "Nice Additions" often plays second fiddle in the hospital. Consequently, it is not uncommon for these podiatrists, urologists, and GYN surgeons to embrace your ASC simply for the purpose of obtaining better OR times. They can be quite grateful when the red carpet is finally rolled out for them. From an operational standpoint, the capital outlay for their equipment is relatively small when compared to some of the other specialties and there can be quite a bit of overlap if you are already doing general surgery or orthopedic cases. The biggest area of caution with this group however, potentially contributing to lower case volume, is the number of procedures that can be performed in an office setting. Even though Medicare approves a certain procedure to be done in the ASC, if the physician's office is properly equipped, the site-of-service differential combined with the convenience will often be enough to keep that patient in the office.

Easy adaptors

The final category is Easy Adaptors, and not coincidentally, this group of four specialties yields the highest number of patients. While relative reimbursements tend to be lower, the revenue they generate is made up by sheer volume. For this reason your staff must be at the top of their game and be able to turn over a room in less than 10 minutes. Being able to take three days of surgery and compress it into two is an extremely valuable incentive for your center to offer a member of this category of Easy Adaptors.

ENT

In ascending order, the #4 specialty for easy adaptation is ENT. A majority of their cases can be done in an outpatient setting, and especially when treating children, the ASC can be much less intimidating than the atmosphere in the hospital. Along these lines, it is important to be flexible and accommodating with an ENT physician. Make sure you are not losing to the hospital any cases that must be seen promptly because the patient can't wait until the doctors next free block at the center. The ability to be agile and creative is a major advantage of the ASC. Be sure to leverage it.

Pain management

#3 is pain management. Similar to Urology, it is important to make sure that a majority of cases will come to the center and not stay in the office. However, the volume of an average physiatrist or pain specialist, combined with the low supply costs, makes him/her an excellent candidate. Recruiting pain management into a center that already does orthopedics or spine can also create a symbiotic relationship that benefits both practices.

GI and ophthalmology

The top spot for the smoothest transition into an ASC can be debated between two groups. Gastroenterologists perform the highest annual number of procedures in multi-specialty ASCs and ophthalmology is represented at the greatest number of centers (according to SDI's *2008 Outpatient Surgery Center Market Report*). The determination for smoothest transition may also depend on the physical make-up of your ASC and the current physician groups working there. GI can be done in a smaller space, but it's easier to clean and flip an OR being used for cataract surgery. Ultimately, the ease of recruitment, and the speed the surgeons have proven they can ramp up their cases in a new ASC, reveals the winner. When evaluated through this lens … the ophthalmologists are the easiest to convert. They simply relay to their scheduler where they now wish to perform their surgery, walk out of the hospital, never looking back. It is a perfect marriage and their commitment to the center is in-

10 Best Practices for Recruiting New Partners to Your ASC

By Leigh Page

Larry Taylor, president and CEO of Practice Partners in Healthcare, offers 10 best practices on recruiting new physician-partners to an ASC.

1. Get buy-in from existing partners. The decision to add new partners should start with a meeting of the existing partners. "They need to be eager participants," Mr. Taylor says. Enthusiastic, committed partners who understand the value of adding new partners will be effective recruiters and be more likely to accommodate new physicians when they arrive.

2. Understand legal issues. Reapportioning shares in the ASC can create new legal issues. An attorney will be needed for such matters as evaluation of safe harbors and the need to offer shares to each partner equally.

3. Let them take a test run. For potential recruits in an existing specialty at the surgery center, invite them to use the facility and see if they are comfortable with it. This could be for a protracted period of time.

4. Ask about ASC experiences. Potential partners from a new specialty won't be able to test out the ASC, but you can ask if they have prior experience in the ASC environment. Do they have a high volume of ASC-appropriate cases?

5. Look for compatibility. Would the newcomers get along with existing partners? Bad interpersonal dynamics can cripple a surgery center.

6. Survey equipment needs. Would the new surgeon want items requiring a new vendor? Physicians in new specialties involve the biggest changes, but there are ways to make it work, Mr. Taylor says. Find out how much their equipment and supplies would cost. If they are expensive, there are ways to keep costs low, such as lease per click and use of financing.

7. Redraft the OR schedule. Existing partners should be wiling to share highly sought-after block times with newcomers. "Partners need to be flexible with block times," Mr. Taylor says. "This is one reason why their commitment was so important on the front end."

8. Schedule group members together. When surgeons in the same group practice are scheduled together in one block of time, there is less possibility of friction if a difficulty arises, such as a surgeon going over his allotted time. Surgeons are more accommodating to a familiar colleague than to a stranger, Mr. Taylor says.

9. Prepare staff for new surgeons. Prepare staff for the new surgeon. Staff should be given a chance to review the new surgeon's preference cards and specific pre-op and discharge instructions.

10. Throw down the red carpet. "You should always be positive to the new kids on the block," Mr. Taylor says. "Don't have them wind up with the crummiest OR. Don't give them staff who won't be compatible." ■

Learn more about Practice Partners in Healthcare at www.practicepartners.org.

Access to Physicians: 3 Major Challenges Facing ASCs

By Rob Kurtz

The survival and success of ASCs relies on recruiting physicians who can bring patients to the table, and having enough physicians and cases to keep ASCs profitable. But many ASCs are finding that recruiting new physicians to help the facility grow or replace exiting physicians is becoming more of a challenge. Here are three major issues identified by Rajiv Chopra, principal and CFO, for The C/N Group, impacting access to the physicians.

1. Shortage of specialists. On the macro level, there are simply not enough physicians, especially in key specialties, to meet the needs of the current patient base, let alone the additional 32 million people that will become insured under the new health reform law, Mr. Chopra says.

"If you're an ASC and you've got five orthopedic surgeons and they're all 60 years or older, access to physicians is going to be a challenge simply because you're going to have an unprecedented retirement of the boomer level specialists and it's not clear that a sufficient number of young physicians are stepping in to fill those shoes," he says.

2. Employment of physicians by hospitals. Mr. Chopra is seeing an increase in the number of hospital-employed physicians.

"That pendulum is again swinging back towards direct employment models," he says. "If you're an independent ASC relying on the 'free agents' — the orthopedic surgeon, ENT or ophthalmologist that might be part of a practice that's 1-3 individuals — you may face a challenge.

"If those physicians are getting snapped up by hospitals or retiring and their replacements are hospital-employed groups, if you're not aligned with that hospital then it's going to difficult for the ASC if that hospital tries to bring those folks to their campus or they develop or already have a competing ASC," he says.

3. Consolidation of groups. Mr. Chopra says there is a shift away from smaller physician groups and a surge in larger practices, which can create new challenges for ASCs.

"The days of the solo practitioner are going away in certain markets," he says. "You're seeing it very prevalent in areas such as orthopedics — large orthopedic practices where you have 10, 15, 20, even 50 orthopods."

Mr. Chopra says these larger practices will often create 'one-stop shops' where they have a center of excellence approach with physician offices, rehab/physical therapy, imaging and then surgery as well, which may not only remove some physicians from the market but may also challenge existing ASCs for surgical cases.

In light of these challenges, ASCs must continue focusing on fundamentals for the delivery of care to recruit and retain physicians. Physicians remain attracted to a patient-centric mindset, flexible scheduling, excellent equipment and physical plant, and high quality clinical support staff. By excelling in these areas, ASCs can counteract some of these evolving market threats. ■

Learn more about The C/N Group at www.thecng.com.

5 Ways ASCs Lose Money

By Rob Kurtz

Half of all ASCs in the country are either losing money or just breaking even, according to Brent Lambert, MD, president and owner of Ambulatory Surgical Centers of America. Here are five ways he and Luke Lambert, CEO of ASCOA, have seen ASCs go from the black to the red or fail to ever achieve any profits.

1. Physicians receiving management fees. In some ASCs, physicians will be appointed as management experts and draw a fee for the extra work associated with running the ASC. But in many of these cases, the physicians in these management roles might think they are managing the center well but in reality they are just making money off of general oversight of the ASC, which does not contribute significantly to the bottom line, says Dr. Brent Lambert. When tens of thousands of dollars each month are going to physicians for these unnecessary positions, distributions take a hit.

"They apply a little common sense, but a little more sophistication than that is required to have a high performance center," he says. "They are not experts; it's just a way to take money out of the center. The only thing they are doing is getting a fee and they don't like to hear it, but if you get all the doctors present, they're going to ask, 'Why, if you're such great managers, are we not making any money?'"

2. Real estate entity profits, operating entity suffers. In most ASCs owned by physicians, there's a real estate entity and an operating entity. It's ideal if the same people own both but that usually isn't the case — some physician-partners own the real estate, others do not. When the lease expires, it is not uncommon to see the real estate owner-partners raise the rate for the new lease. The increase may not be too onerous, but when you factor in increases in costs for supply and staff, together with declining reimbursement and other financial challenges, the increase saps away more potential profits for the physician-investors.

"Maybe it's another $150,000 a year on a lease rate and the physicians are able to deal with that for awhile, but with all of these other things verging, suddenly they're scratching their heads wondering where the money went and they forgot about the lease that enriches at least some of the partners in one entity but doesn't maybe enrich all of the partners who came into the ASC late and weren't part of the real estate partnership," says Dr. Brent Lambert. "Maybe initially it was a market rate but over the years with the escalators, it becomes no longer market rate but is maybe twice market rate."

High leasing costs can also serve as a deterrent for recruitment of future physicians who are asked to join the ASC and pay the lease but cannot own part of the real estate.

"If you are asking them to lease space well above market rate, they'll go to the ASC down the road and lease at market rate," Dr. Brent Lambert says.

3. Passive planning for profitability. An ASC that doesn't see itself profiting soon after opening may not ever profit, says Luke Lambert. "Some facilities see themselves on the three-year development plan and just because they're losing money the first 2.5 years, if that's according to their plan, they feel like they're doing okay," he says. "If you spend that amount of time losing money, chances are you're at serious risk of never turning the corner."

While a new ASC will need some time to achieve profitability, a few years is likely too long.

"In our world, where we're doing de novo centers, we expect return on the physician-investment in the first year," says Dr. Brent Lambert. "If they haven't gotten any money back in a year, we've failed. So that's an expectation that I think can be met in most cases."

4. Retired physicians. During the life of a surgery center, physicians are likely to retire. Since these retiring physicians are often close friends with the physicians who are still working at the ASC, the retired physicians' ownership stake in the ASC is not bought out and they still receive distributions even though they are no longer bringing cases to the center. With this arrangement, an ASC will have less money to pay working physician-investors, and it becomes a greater challenge to bring in physician-investors to replace the profitable procedures once brought by the now retired physicians.

"No one wants to buy in to a center and bring their cases if they're going to just enrich some guy playing 18 holes a day in Florida," says Dr. Brent Lambert. "You have to get rid of the deadwood."

5. Insurmountable debt. Borrowing money is often critical to achieve a profitable ASC. But knowing the right amount to borrow and when to do so is equally critical, and failure to know when to stop borrowing can cripple an ASC.

"Sometimes physicians keep borrowing, sometimes to enrich themselves in one way or another, and then they get to the point where they have six or seven million dollars worth of debt and they can't meet their debt service obligations," Dr. Brent Lambert says. "Now you can't get someone to come in and buy in to a center and obligate themselves even on a pro rata basis with so much debt. Even if you were going to give them the shares, they wouldn't take them because they'd have a huge contingent liability hanging over their head." ■

Learn more about ASCOA at www.ascoa.com.

5 Observations on the Future of ASCs From Dr. Neal Lintecum of Kansas' Lawrence Surgery Center

By Leigh Page

Neal Lintecum, MD, an orthopedic hand surgeon, is chairman of the board of Lawrence (Kan.) Surgery Center. It has four ORs, about 18 physician-partners and hosts surgery in orthopedics, ENT, plastic surgery, ophthalmology, podiatry and urology. Dr. Lintecum makes the following observations about the future of ASCs.

1. Recession may help ASCs. No one would wish this sort of recession on anyone, but there is one positive outcome for ASCs. More and more people have to pay for care out of their own pockets. As household budgets tighten, "they are realizing that surgery in ASCs costs a lot less than in the hospital," Dr. Lintecum says.

2. Reform doesn't favor ASCs. "The premise behind healthcare reform is 'bigger is better,' " Dr. Lintecum says. He says this is based on the misconception that larger systems can produce savings, but ASCs have proven the opposite. Smaller, more agile entities are what produce savings.

3. Costs are out of hand. "I worry that nothing has been done to bend the cost curve," Dr. Lintecum says. "It is a laudable goal to provide insurance to people who don't have it, but what about the rest of the people in the country who are seeing their premiums skyrocket?"

4. Lack of tort reform. HHS Secretary Kathleen Sibelius previously was Kansas' governor and insurance commissioner. Her last job before leaving the private sector was with the trial lawyers. As HHS starts tort reform pilot projects, Ms. Sibelius will probably side with the trial attorneys and be "the fox in the chicken coop."

5. Uncertain future of Medicare. It is not clear how Medicare can survive without cutting payments. The Medicare trust fund is running out of money and the government is running a deficit. ■

Contact Leigh Page at leigh@beckersasc.com.

7 Observations on ASC-Based EMR

By Leigh Page

ASC-based electronic medical records are very different from EMR in the physician's office or hospital, but the goal is to make all EMR systems, regardless of venue, interoperable with each other, so that records can be sent seamlessly.

Joe Macies, CEO of AmkaiSolutions, maker of an ASC-based EMR system, describes how this approach fits into the nationwide EMR trend. In addition to selling its ASC-based EMR system to more than 100 ASCs, AmkaiSolutions also produces EMR systems for physician practices and hospitals.

1. ASC-based EMR is unique. EMR in a surgery center is very different from EMR in a physician's office. Since there are only a limited number of operations performed, the system doesn't have to be as comprehensive. Steps like diagnosis and treatment, which are necessary for EMRs to track in physicians' offices, are not needed in an ASC-based EMR. An ASC-based EMR follows the process from pre-op through surgery and post-op, making sure safety and compliance requirements are met.

2. No EMR funding for ASCs. Practices that install EMRs are eligible for as much as $44,000 in federal funding per physician, or as much as $67,000 if they have sufficient Medicaid and Medicare volume, and hospitals can get millions of dollars for installing EMRs, depending on their size. But ASCs are not eligible for funds, removing a valuable incentive for installing EMR systems. However, as more hospitals install EMR, ASCs will need to have EMRs to maintain a competitive advantage. EMR systems make ASCs more efficient.

3. True EMR systems still rare in ASCs. Only about 5-10 percent of ASCs have EMRs. Another 5-10 percent have paperless systems that may be mistaken for EMR but do not have the ability to process information. These non-EMR systems display patient information in a PDF-style page.

4. Little interoperability yet. It is still difficult to send information electronically from one EMR system to another, whether the system is in a hospital, physician's office or ASC. Even when both sender and receiver have an EMR, information often must be faxed. For example, the physicians office faxes the patient's history and physical to the ASC. The document might be scanned into the ASC-based EMR and displayed as a PDF-style page, but the information on the page cannot be integrated into the EMR system. The ASC-based EMR can, however, indicate where this information is located and whether it has been processed yet.

5. Interoperability in the future. Some EMR systems, including AmkaiSolutions systems, are beginning to establish interoperability with other systems. HHS' new "meaningful use" standards are pushing EMR systems toward compete interoperability by requiring use of common data sets and other features. The federal funding for EMR available to hospitals and physicians' offices is contingent upon meeting those standards.

6. Progress on meaningful use standards. HHS recently released final "meaningful use" standards for next year. HHS scaled back its original set of proposed requirements, issued in January, which practices and hospitals felt were too stringent. The new requirements will apply to EMR systems in 2011 and 2012 and it is expected that requirements removed from the final rule would be applied to EMRs in 2013 to 2015.

7. Many vendors won't meet requirements. Since the proposed regulations were released in January, vendors have been working hard to update their systems. AmkaiSolutions and many other vendors will offer an updated product to all existing customers free of charge. While AmkaiSolutions expects to meet the requirements, many software systems will probably not be able meet them. ■

Learn more about AmkaiSolutions at www.amkai.com.

Using Inventory Management and Technology to Increase Profits

By Renee Tomcanin

Kimberly Tude Thout is the administrator of Yakima (Wash.) Ambulatory Surgical Center, a physician-owned, multi-specialty ASC.

Q: Last year presented a significant economic challenge for many ASCs. Could you describe one or two successful ways that your ASC was able to reduce costs?

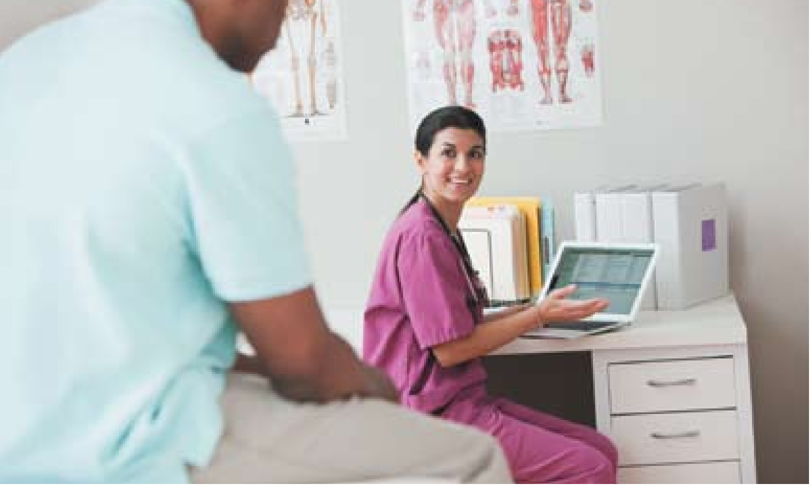
Kimberly Tude Thout: We moved some of our inventory to consignment. We also made sure we were completing inventory checks monthly to really see what our costs were and reached out to our vendors to ask for more cost reduction.

Q: What was one or two ways your ASC was able to improve profits (in addition to cost-reductions) and how were you able to achieve this?

KTT: We added new technology initiatives [including electronic health records], which will result in an increase in profits for 2010. We have moved our billing back in-house and will see a substantial savings even after the cost of the certified coder and technology.

Q: What is a major operational objective for your ASCs for 2010 and how do you plan to approach and accomplish this objective?

KTT: We are adding new OR technology, which will add cases we were not able to do in the past. The addition of technology in late 2009 and early 2010 will decrease our long-term costs and increase our profits. ■



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Reducing ASC Chronic Technology Pain: 3 Rules to Contain IT Costs

By Marion K. Jenkins, PhD, FHIMSS, Founder and CEO, QSE Technologies

Information technology is key to the operations of a surgery center. From front desk check-in and scheduling to medical imaging and materials management, and everything in between, IT does not represent a nice-to-have feature; it is a vital component of both business and clinical operations. At the same time, there is no shortage of new bells and whistles, and there are many vendors who tout the latest and greatest in technology, and so you could end up literally breaking the bank by chasing the next new Big Thing in healthcare IT.

How does an ASC handle IT the right way without breaking the bank? Below we give three guiding principles to save costs and increase uptime and long-term survivability:

Rule #1: Do IT right the first time. Whether you are building a new center, upgrading an existing center, or making a major change like upgrading your software, you need to look at IT as a *system*, taking into consideration the entire needs of the facility, both clinical and business office. In new construction or a remodel, you should do everything possible to "future-proof" the facility, and particularly in patient and clinical areas. For example, on opening day you may not plan to put patient monitoring equipment in preop or PACU, or provide a ceiling-mount monitor or anesthesia workstation in the OR. But if you add those later, what would have cost a few hundred dollars during construction can be tens of thousands of dollars after the center is up and running. And if you add in the lost revenue of an OR being down for several days, combined with re-working the entire sterile corridor, it can easily represent a six-figure cost.

Careful and thoughtful planning up-front can allow you to add new technologies later without tearing out walls or ceilings or performing other "forklift upgrades." It has the same fundamentals as building the surgery center. If you properly design and build the foundation, the walls, the HVAC system, then you can always add more people, more furniture, more artwork on the walls, etc.

Rule #2: Focus on the core fundamentals of IT (and avoid the "bleeding edge"). There are all kinds of new technology gadgets out there, advertised as "plug and play" (knowledgeable IT people refer to them more accurately: "plug and *pray*.") But you need to understand a couple of things: (1) most brand new IT devices have bugs or other issues that aren't completely worked out, so the first users are literally almost like beta testers; and (2) most devices you see advertised are for consumers, not for businesses, so the functionality you may see on TV only works for individual devices, not for multiple devices working on a corporate network. And they also show bandwidth and throughput speeds that are unrealistic (You know those ads that have a disclaimer that says, "Shown larger than actual size?" Some IT gadget ads should say, "Shown with an internet connection with unlimited speed.")

To make all these cool user devices work in an office typically requires robust back-end systems and infrastructure, which costs a significant amount of money to properly engineer and configure. For example, all those Starbucks WiFi hot spots work because they are backed up by a robust broadband network and all kinds of devices hidden in the ceilings and walls, all of which had to be designed with proper power, ventilation and network access. If you focus on making sure you have the proper core infrastructure of server architecture, networking, data security, backup systems and proper power and cooling, you can always add new user devices later, without having to re-do your core systems.

Rule #3: Do IT professionally. It sounds counterintuitive, but if you spend too little on IT, it may end up costing you money. Between systems that have a short lifespan to experiencing significant downtime, trying to save money on IT can actually cost you in the long term. In fact, if you don't spend a certain amount to achieve a sufficiently stable and functional platform, you should probably stick with paper records, a clipboard and a big file room (and possibly roller skates).

Between hardware/software and professional services, how do you determine your needs and get the appropriate solutions?

Have you ever shopped for a server? You can see them advertised from $1,500 to $45,000. You probably think instinctively that your ASC probably doesn't need the $45k behemoth, but can you get by with the $1,500 cheapie? You can buy IT hardware from just about anywhere: a big box store, the internet, an appliance store, even from your local MegaMart. The cheap ones may appear to have the same specifications and horsepower as more expensive systems. How do you sort that out?

It's really very simple. Just like you don't buy a camp cot for an exam table, or a card table for your front check-in desk, you don't want to buy cheap, end-of-life IT systems for your ASC. Look at one of the doors in your ASC, and compare it with a door in your house. They may have the same size, and generally have the same functionality, but inside they are fundamentally different. The same thing is true for IT systems. Business-class IT systems have more substantial components inside and are "beefier," therefore they last longer and have less downtime, which means they provide more efficiency.

On the service side, there are many IT "guys" who advertise very low rates and work out of their basement. On the other end of the spectrum are the big national consultancies, where a $500,000 IT project is considered too small. How can you tell the difference, and how do you determine what you need?

In medicine, there are specialties (ortho, OB, cardio, etc.) and certifications/degrees (MD, DO, RN, MA, lab tech) that clearly designate and communicate a person's training and skill set. Unfortunately in IT, the initials and certifications aren't so easy. What's the difference between a DBA and a CNE? If someone can make my e-mail work and fix my superbills, does that mean he can re-do my server room?

Again, it is fairly simple but you must work at not getting intimidated by the jargon, and stick to the basics. Ask your IT vendors about experience that specifically matches your needs. Just like you wouldn't have a home handyman build you a house, you don't want a desktop support guy designing the IT systems for your new ASC. If you have a LAN/WAN issue, the best Java or database analyst in the world can't help you. Don't be intimidated. Just explain your problem and then ask them to describe how they solved your same problem for someone else (or several someones … you don't really want this to be their first rodeo.)

Managing IT costs in an ASC takes the same effort and follows the same process as in all other operational areas: do your homework, become educated enough to separate fact from fiction, get references from similar projects and use the same common sense that have proven valuable in other areas. ■

Marion K. Jenkins, PhD, FHIMSS, is founder and CEO of QSE Technologies, which provides IT consulting and implementation services for ASCs and other medical facilities nationwide. Learn more about QSE Technologies at www.qsetech.com.

8 Tips for Managing Medical Equipment Software Updates and Upgrades

By James Jernigan, Regional Director, TriMedx

Demystifying software updates and upgrades

How would you define a medical equipment software update? How about a software upgrade? Answering these questions isn't so simple – it's difficult to define software updates versus upgrades because the answer varies based on the industry source, the type of device and the subjective description of the changes involved with each. But it's incredibly important that we understand these terms, because the difference between an update and upgrade could mean many thousands of dollars spent — or saved — for your organization.

8 tips for managing medical equipment software updates and upgrades

1. Negotiate up front. Before an equipment purchase, be very clear with vendors about what updates and upgrades are included. If possible, negotiate for all updates, software keys and codes to be included over the life of your equipment.

2. Only buy what you need. It often does not make financial sense to purchase software upgrades in advance, and therefore you should not include them as part of a service contract. When you purchase upgrade options in service contracts, you are purchasing software that does not yet exist, and may never exist (sometimes called "vaporware".) It's often best to wait for the upgrade to be created, and then evaluate its specific worth to your organization. Specialty devices are sometimes the exception to this rule, those that have well- documented past schedules of frequent valuable upgrades, which would result in a greater cost to purchase each upgrade individually as opposed to the contract coverage option.

3. Research before purchase. Upgrades can be large purchases, often many thousands of dollars each. Prior to upgrading, be sure it's right for your organization and situation. Consider the age of your current equipment, the cost of the upgrade, your upgrade history, as well as the contract options. If a contract option is to be considered, it's important to get the upgrade schedule in writing from the manufacturer before the purchase.

4. Work closely with your IT/IS department. Anti-virus program issues are one of the biggest challenges Clinical Engineering departments face today on computer-based medical devices. Running an after-market anti-virus program on a medical device could potentially alter the function of the device and needs to be researched with the original equipment manufacturer (OEM) before installation. This is one of the areas Clinical Engineering and Information Technology departments must work together. Many times one department doesn't fully understand the intentions or impact of the other, so open communication is necessary. A close partnership with IT will help you remain proactive in managing critical equipment, stay in compliance, and improve Environment of Care standards in your specific clinical environment.

5. Keep detailed records (including downtime). Track information in your CMMS to analyze the service history, and leverage it for future purchase and upgrade discounts. Be sure to track system downtime (one Indiana-based healthcare company successfully negotiated a reimbursement from their manufacturer based on downtime), as well as the time in-house technicians invested in troubleshooting equipment issues; you may be able to use this data in future negotiations.

6. Follow back-up procedures. It is highly recommended that you back up your current system before an update or upgrade is installed. That way, if the system fails you can re-install from the backup which includes configuration information (as well as prior updates and upgrades) that would be missing from an original installation disc re-build, minimizing downtime. Many computer backup options exist, and this is another key area in which to partner with your IT/IS department for additional savings. However, it is imperative that the original software installation disks, as well as the disks needed to install prior updates and upgrades are all retained on-site. Replacement disks will often cost as much as the original purchase.

7. Remain compliant. Though OEMs should let your facility know about alerts, hazards and recalls that may necessitate an update, it's good to be proactive in seeking out this information to help ensure patient safety. MedSun Medical Product Safety Network on the FDA website (www.fda.gov/MedicalDevices/Safety/MedSunMedicalProductSafetyNetwork/default.htm) is a great resource to use as well as the ECRI Institute.

8. Partner with an independent consultant. When making equipment purchases that may include future updates and/or upgrades, make sure you have the right people at the decision-making table. Inviting an independent consultant to be part of your capital equipment project ensures that no one particular party moves too quickly without a proper review of the purchase and that everyone's interests and needs are taken into account prior to the final decision. ■

James Jernigan is a regional director for TriMedx (www.trimedx.com), an Indianapolis-based medical equipment services provider and consultant.

107 Great Women Leaders in the ASC Industry

Margaret Acker, RN, MSN, CASC. Ms. Acker is the CEO of the Blake Woods Medical Park Surgical Center in Jackson, Mich., a multi-specialty, physician-owned surgery center. Previously, she served as nursing supervisor/house manager at Foolinte Hospital and clinical nurse manager for Foote Health System (now Allegiance Health) in Jackson.

Amy Allard. Ms. Allard is administrator of Ramapo Valley Surgery Center in Ramsey, N.J. The center opened in the fall of 2005, and surgeons at RVSC perform around 4,500 cases annually. The multi-specialty ASC focuses on orthopedics, general surgery, ENT, podiatry, pain management, ophthalmology, gynecology and dentistry. Ms. Allard has been with RVSC since early in its construction phase.

Lisa A. Austin, RN, CASC. Ms. Austin serves as vice president of ASC operations for Pinnacle III. She currently is a board member of the Colorado Ambulatory Surgery Center Association and serves on the surgery center advisory board of MedAssets.

Sandy Berreth, RN, MS, CASC. Ms. Berreth is the administrator of Brainerd Lakes Surgery Center in Baxter, Minn., a multi-specialty ASC that performs approximately 4500 cases a year. She has been in the ambulatory surgery management arena for 12 years and has been with the center in Baxtor since 2004. Recently she completed her AAHC surveyor training and has obtained her privileges from AAAHC as a participating surveyor.

Cristina Bentin, CCS-P, CPC-H, CMA. Ms. Bentin is a principal and the founder of Coding Compliance Management, a consulting company specializing in coding support, reimbursement and training for ASCs and specialty hospitals. She is nationally recognized as a leading freestanding ASC coding educator, speaker and writer with more than 19 years of hands-on experience in ASC multi-specialty surgical coding as well as physician office coding.

Lee Anne Blackwell, RN, BSN, EMBA, CNOR. Ms. Blackwell is a director of clinical services, quality and safety for Surgical Care Affiliates. In this position, she is responsible for developing and coordinating clinical-quality strategies, best practice programs, and patient safety initiatives for over 60 facilities including surgery centers and surgical hospitals. Ms. Blackwell's accomplishments include patient care and surgical services in the hospital and surgery center arenas and development of several formal and self-paced nursing clinical education programs,

T. Taylor Burnett. Ms. Burnett is CEO of Plastic and Hand Surgery Associates, a large plastic surgery practice that is the parent company of The Plastic Surgical Center of Mississippi, a physician-owned multi-specialty licensed surgery center in Flowood, Miss. Ms. Burnett is the administrator for The Plastic Surgical Center and lead the turn key operation that opened in August 2003. She is the current president of the Mississippi Ambulatory Surgery Center Association and occasionally consults for other ASCs and their particular concerns.

Regina Boore, RN, BSN, MS. Ms. Boore is the principal and CEO of Progressive Surgical Solutions. She has more than 25 years of clinical, administrative, teaching and consulting experience in ambulatory surgery. Prior to coming to Progressive Surgical Solutions, Ms. Boore worked as a perioperative nurse, OR supervisor and ASC director.

Bonnie Brady, RN. Ms. Brady is the administrator of Specialty Surgical Center, a multi-specialty, two-OR ASC in Sparta, N.J. Ms. Brady has served as administrator of SSC since May 2008. Ms. Brady is a board member of the New Jersey Association of Ambulatory Surgical Centers and has written articles for Becker's ASC Review and Source Medical webinars. Her ASC was recently featured in a New Jersey physician magazine as a notable surgery center.

Mary Beth Brust, CASC. Ms. Brust, vice president of operations for Health Inventures, joined the company in 2000 and was promoted to her current position in 2003. She has over 18 years of progressive experience in healthcare administrative positions and has been involved in outpatient service delivery for 12 years. She began her career as a medical lab technologist and has since advanced through a series of hospital and administrative positions.

Kathy J. Bryant, JD. Ms. Bryant is the president of the ASC Association and leads the activities of the nation's largest ASC membership association. She also serves as president of the Ambulatory Surgery Foundation. She recently announced she will leave the association this fall.

Sue Dill Calloway, RN, MSN, JD. Ms. Calloway is a nurse attorney and president of Patient Safety and Healthcare Consulting. She was the past vice president of legal services at a community hospital in addition to being the privacy officer and the compliance officer. She worked for over 8 years as the director of risk management and health policy for the Ohio Hospital Association. She was also the immediate past director of hospital patient safety and risk management for The Doctors Insurance Company in Columbus area for five years. She does frequent lectures on legal and risk management issues and writes numerous publications.

Susan Charkin. Ms. Charkin is president of Healthcents, an ASC and physician-specialty hospital contracting and consulting group. She has 15 years of experience in senior contracting positions with Health Net, Blue Shield of California, Blue Cross Blue Shield of Washington, D.C., Aetna and MaxiCare. Ms. Charkin is also an author and national speaker on managed care contracting issues and has been published in several journals.

Monica Cintado-Scokin. Ms. Cintado-Scokin is the senior vice president of development for United Surgical Partners International, and she has been with USPI since 1998. Prior to joining USPI, Ms. Cintado-Scokin provided development and operations support in the international group at HCA.

Kelli Collins, RN. Ms. Collins is regional vice president for Surgical Care Affiliates, which manages more than 125 ambulatory surgical facilities and surgical hospitals. With 30 years of experience in the medical field and an operating room nurse by trade, Ms. Collins currently oversees the development, operations and management of a network of surgery centers in North and South Carolina. She has extensive experience in creating and nurturing physician partnerships and developing joint ventures with health systems such as the Wake Med Health System in Raleigh, N.C.

Mary Ann Cooney, RN. Ms. Cooney is the administrator of Riverside Outpatient Surgery Center in Columbus, Ohio, a multi-specialty facility with six ORs and one minor procedure room. Currently, ROSC is a joint venture between OhioHealth and a physician group and is managed by Health Inventures. Ms. Cooney began her career in nursing and gained valuable experience in the hospital setting prior to joining the surgery center in 1981 as the administrator.

Rebecca Craig, RN, CASC. Ms. Craig is CEO of Harmony Surgery Center, a multi-specialty ASC in Fort Collins, Colo. Ms. Craig has been with the center since it opened nearly 10 years ago. She began her career as a registered nurse, working at a rural hospital in the OR, PACU, gastroenterology and pain management areas. She held several management roles in perioperative services before moving into outpatient and ambulatory surgery.

Deborah Lee Crook. Ms. Crook is the administrator of Valley Ambulatory Surgery Center in St. Charles, Ill., a seven-OR, multi-specialty surgery center. Ms. Crook has been with Valley ASC since 1993 as a pre-op nurse. She served as director of nursing at Valley's post-surgical recovery care center before becoming administrator of both facilities in 2006. Ms. Crook began her career as a staff nurse with experience in cardiac and ICU nursing.

Vicki Dekker. Ms Dekker is the director of business development at Blue Chip Surgical Center Partners. Prior to joining Blue Chip, she was responsible for the business office supporting the ENT, Neurosurgery and Neurology Departments at the University of Minnesota. Ms. Dekker also managed an ENT Group in Atlanta, where she developed and managed a single-specialty ENT surgery center that included facial plastic surgeries.

Ann S. Deters, MBA, CPA. Ms. Deters is CEO and co-founder of Vantage Outsourcing (formerly Vantage Technology), which provides complete cataract outsourcing services to hospitals and ASCs throughout the midwest, south, southeast and west into Colorado. She also serves as founder of 7D, a consulting and management service company for ASCs across the United States.

Renee Duff. Ms. Duff has more than 14 years experience managing physician practices owned by a large integrated health system. During that tenure, she was responsible for the general office functions (including coding, billing, and collections) for a number of primary care physicians and surgical specialists. Ms. Duff oversees MCG Billing Services, a Medical Consulting Group affiliate that provides billing and collection services to ASC clients.

Vicki Edelman, RN. Ms. Edelman is the administrator of Blue Bell (Pa.) Surgery Center, a four-room, multi-specialty ASC that opened in Sept. 2008. Ms. Edelman has been with Blue Bell since May 2008, during the center's construction phase. She has been a nurse for 32 years and began her career in medical surgical nursing and high-risk obstetrics.

Rose Eickelberger. Ms. Eickelberger is the director of surgical services at Summit Surgical Center and Beacon West Surgical Center, both part of Beacon Orthopaedics in Sharonville, Ohio. Ms. Eickelberger began at Beacon in May 2006. Previously, she was the director of nursing at the Cincinnati Eye Institute for eight years, after having served as its assistant director for six years.

Stephanie Ellis, RN, CPC. Ms. Ellis is the president of Ellis Medical Consulting and has worked with most surgical specialties, assisting ASCs, physician practices, hospitals and outpatient clinics around the country in her consulting work. Prior to starting the company, she worked as a fraud investigator for the Medicaid program in Tennessee and served as a case manager and utilization review nurse.

Judith English. Ms. English is the vice president of business operations and a partner with Serbin Surgery Center Billing and Surgery Consultants of America. She has more than 35 years of experience in the healthcare industry and has assisted in the development and management of multiple ASCs.

Carolyn Evec, RN, CNOR. Ms. Evec is the administrator at The Surgery Center at Beaufort (S.C.) for eight years. Prior to coming to the center, Ms. Evec opened a surgery center in Missouri and served as the nurse manager at that location. She has 30 years of nursing experience and primarily worked in the OR.

Alisa Fischer, RN, MHSA, CASC. Ms. Fischer has several years in health care with administrative management experiences in a variety of settings including corporate, free-standing centers, and inpatient and outpatient areas. Ms. Fischer is currently the administrator of St. Augustine (Fla.) Surgery Center. Prior to St. Augustine, she served as an administrator at HCA and BayCare Health System. She also ran the operating room schedule at a 16-suite OR in Lexington, Ky.

Ann Geier, RN, MS, CNOR, CASC. Ms. Geier is senior vice president of operations with ASCOA and has been involved in the ambulatory surgery industry in management roles since 1985. She has worked in all areas of freestanding ASCs and HOPDs, including pre-assessment, pre-op, OR, and PACU. She has been a CNOR since 1992 and obtained her CASC certification in ASC administration. Ms. Geier speaks frequently at national meetings on topics relating to case costing, financial topics for ASCs, human resources and staffing, and clinical issues.

Mary Ann Gellenbeck, RN, CASC, CNOR. Ms. Gellenbeck is the COO of Prexus Health and is responsible for operations and quality of care for the company. She holds degrees in surgical technology, nursing and healthcare administration and has more than 28 years of experience in the surgical arena. Ms. Gellenbeck is a member of several associations including the ASC Association and AORN and is an advisory board member for Cincinnati State College.

Judy Graham. Ms. Graham is administrator of Cypress Surgery Center, a free-standing, multi-specialty ASC that opened in Dec. 2000. Ms. Graham has been with Cypress for more than nine years, since construction began. She has a strong clinical background in the operating room and ambulatory surgery and previously served as an OR manager and a clinical director in ASCs before becoming an administrator. Ms. Graham has over 35 years of clinical, managerial and administrative experience in the ASC industry and was named "operating room director of the year" in 1997 while employed by HCA.

Julie Greene, MBA. Ms. Greene is the executive director of the Grand Valley Surgical Center and Grand Valley Health Management in Grand Rapids, Mich. In her diverse roles, Ms. Greene oversees operations of one of the largest ambulatory surgery centers in western Michigan, and also consults with other centers and physician groups who are either exploring the development of a surgery center or require assistance in operations, regulatory compliance and business planning. In addition to her daily responsibilities, Ms. `Greene is an outspoken legislative advocate of surgical centers at both the federal and state level.

Amanda Gunthel. Ms. Gunthel is the administrator of Wilton (Conn.) Surgery Center, a two-OR, two-procedure room ASC that specializes in ophthalmology and pain management. Ms. Gunthel has been with Wilton since its inception, and before taking on the role of administrator, she worked for four years as director of practice management and development for the healthcare management firm that first opened the center.

Barbara Ann Harmer, RN, BSN, MHA. Ms. Harmer is a senior consultant for Healthcare Consultants International, the for-profit subsidiary of the Accreditation Association for Ambulatory Healthcare. She is responsible for providing national and international consulting services for organizations seeking or maintaining compliance with national accreditation standards and other services such as office-based surgery development, assistance with policy and procedure formation, licensure and Medicare certification preparation. Before joining Healthcare Consultants International, she was a director of surgical services for Florida Hospital in Orlando and East Pasco Medical Center in Zephyrhills, Fla., and executive director of Surgical Services for Kennedy Health System in Cherry Hill, N.J.

Dare Hartsell, RN, MSN. Ms. Hartsell serves as vice president of clinical services for Practice Partners in Healthcare. She has over 15 years of healthcare experience including direct patient care experience in CVICU, PACU and PRE-OP. She has experience in capital equipment planning, accreditation support, state licensure, clinical policy and procedure development and staff education, physician credentialing, infection control, risk management, compliance and development in the ASC industry, which enables her to offer a broad scope of services to meet the clinical and regulatory support needs of ASCs.

Colleen Heeter. Ms. Heeter is senior vice president of operations design for Nueterra Healthcare. In her current position, Ms. Heeter oversees the financial, business and clinical components of operations design. She previously served as a group vice president for Nueterra and has more than 10 years of clinical experience coupled with an additional seven years of managing surgical services within the healthcare industry. Prior to joining Nueterra, Ms. Heeter served as administrator of Shawnee Mission Surgery Center, where she was responsible for financial administration, operations and human resource allocation.

Laurie Hendrix, RN, BSN, CASC. Ms. Hendrix is a senior vice president of Ambulatory Surgical Centers of America with over 20 years experience in all aspects of the ASC setting, including administrator, clinical coordinator and OR nurse. Ms. Hendrix was administrator of The Surgery Center in Columbus (Ga.) from 2000-2004. She has an associate degree in nursing from Highline Community College and a BSN from Columbus State University.

Carolyn R. Hollowood, RN, CASC. Ms. Hollowood is the administrator of City Place Surgery Center in Creve Coeur, Mo., which is located in West County of St. Louis. The center is housed in a medical office building and has four operating rooms. The physician-owned, multi-specialty facility focuses on orthopedics and pain management. City Place opened in Dec. 2000 and moved to its current location in April 2006. Ms. Hollowood has been a part of the center for 10 years, since it was at its original location. Prior to coming to City Place, she was a RN first assistant at an acute care center. She has 20 years of nursing experience.

Tracey Hood, RN. Ms. Hood is the administrator of Ohio Valley ASC and Mid Ohio Valley Medical Center in Belpre, Ohio. She previously worked as an ASC charge nurse, OR circulating registered nurse, PACU nurse, certified emergency RN, cardiac catheterization lab nurse and a critical care nurse.

Georganna Howell, RNFA, CNOR, CEN, LNC. Ms. Howell is administrator of Greenspring Surgery Center in Baltimore, part of OrthoMaryland, which opened in 2006. Ms. Howell joined Greenspring in June 2009.

Anita Hunter, RN, CASC. Ms. Hunter has been with Austin (Texas) Gastroenterology since 2000 as the administrator and chief nursing officer. She has more than 30 years of nursing experience and spent most of her time in the emergency and trauma department in varying positions. Ms. Hunter maintains membership in ASGE, SGNA, ENA, ASC, ASPAN and APIC. She has been actively involved in gastrointestinal nursing and looks forward to a long career in GI nursing. Ms. Hunter's management experience includes the director of trauma at Desert Regional Medical Center for several years and director of ER, GI, day surgery, employee health and post anesthesia recovery at the Heart Hospital of Austin as part of their opening management team.

Lauren Jensen, RN. Ms. Jensen is the nursing director of endoscopy centers for Digestive Health Management, which manages the Digestive Health Associates of Texas. The centers were developed over the last seven to eight years, and include Endoscopy at Redbird Square, Old Town Endoscopy Center, Central Park Endoscopy Center, Park Ventura Endoscopy Center and North Richland Hills Endoscopy Center. In addition to helping develop new centers, Ms. Jensen serves as a CPR instructor for her employers and for staff at the physician offices.

Beth Ann Johnson, RN. Ms. Johnson joined Blue Chip Surgical from LCA Vision where she was vice president of operations responsible for the growth of the ophthalmic surgery center business. Previously, Ms. Johnson was with Aetna as director of provider relations, recruitment and contracting for the tri-state region. She has extensive experience in the development and ongoing management of hospital-owned, minimally invasive surgery centers. She also supervised 13 operating rooms and the post-anesthesia care unit in Cincinnati's Good Samaritan Hospital, a major tertiary care medical center.

Ellen Johnson. Ms. Johnson is vice president and COO of Facility Development and Management and has more than 20 years experience within the healthcare arena. She has held management positions within a physician management firm and in various departments of a 370-bed suburban regional medical center. She also served as nursing director for a home care agency and a staff nurse in a medical surgical unit and newborn nursery of a community hospital. Prior to joining FDM, Ms. Johnson was director of clinical services and executive director of an emerging group purchasing organization for a physician management company.

Jen Johnson. Ms. Johnson is the managing director of professional service agreements with VMG Health. Her expertise is related to the in-depth knowledge required to understand fair market value challenges, market data and regulatory guidelines associated with valuing professional service arrangements associated with healthcare systems and life sciences companies. She previously worked with KPMG in their forensic and litigation services department and at University of North Texas as a finance professor. She earned her MBA in finance and her CFA designation while working for several companies as a consultant.

Milla Jones. Ms. Jones serves as vice president of communications and government relations for United Surgical Partners International. Ms. Jones has 35 years of healthcare experience, most recently with Baylor Health Care System in Dallas. Her responsibilities include coordinating and managing state and federal advocacy efforts for USPI and its partners and the development of a communication plan that will tell the "USPI story" to the community and USPI employees.

Sandra J. Jones, BA, MSM, MBA. Ms. Jones is executive vice president of ASD Management, a board member of the ASC Association and Ambulatory Surgery Foundation, and member of the ASC Advocacy Committee. She also owns Ambulatory Strategies. She has 30 years of experience in healthcare and has overseen or contributed to the successful establishment and development of more than 80 ASCs nationwide.

Kelly Kapp, RN. Ms. Kapp is the administrator of Specialty Surgery Center in Westlake Village, Calif. Ms. Kapp began her nursing career as an OR nurse at L.A. County Hospital. She then was an assistant at Southern California Orthopedic Institute and served as orthopedic coordinator at St. John's Regional Medical Center in Oxnard, Calif., for 13 years before accepting a director of nursing position at SSC.

I. Naya Kehayes, MPH. Ms. Kehayes is the founder, managing member and CEO of Eveia Health Consulting & Management. She is a nationally recognized expert in reimbursement, managed care and insurance contract negotiations for ASCs and surgical practices. Ms. Kehayes is a former president of the Washington Ambulatory Surgery Center Association.

Cindy King. Ms. King serves as director of quality services for Health Inventures. She has worked in professional nursing and management for over 32 years, including nearly 26 years in ASCs. She was instrumental in the development, launch and governance of several freestanding ASCs, including an Ohio center currently ranked among the nation's busiest. She was also an assistant director of nursing in a major long-term care facility. As director of quality services, Ms. King monitors quality management activities and assures that centers are in compliance with state, federal regulations and corresponding accreditation standards.

Beverly Kirchner, RN, BSN, CNOR, CASC. Ms. Kirchner is the owner and CEO of Genesee Associates. She has served on the Association of Perioperative Registered Nurses board of directors, has authored many AORN manuals and leads research in collaboration with the organization on violence in the nursing workplace. Ms. Kirchner also sat on the Joint Commission Task Force that assisted in developing the 2009 standards format and content, as well as a task force to revise the National Patient Safety goal on medication reconciliation. She has been a member of the ASC Quality Collaboration group since it was founded.

Susan Kizirian, BSN, RN, MBA. Ms. Kizirian is the COO of ASCOA and has more than 23 years of experience in all aspects of ASC operations. Ms. Kizirian has served as an administrative executive and a consultant for ASC management and development, physician practice management, and clinical site research. She is one of the founders and lifetime president emeritus of the Florida Society of Ambulatory Surgical Centers, past president of the Ambulatory Surgery Management Society of the Medical Group Management Association and past treasurer of the American Association of Ambulatory Surgery Centers.

Catherine W. Kowalski, RN. Ms. Kowalski is the executive vice president and COO for Meridian Surgical Partners. She has more than 20 years of experience in the healthcare industry and is the former executive vice president of operations and co-founder of Surgical Alliance Corp., a specialty surgical hospital company. Ms. Kowalski is also a registered nurse.

Beth LaBouyer, RN, BSN, CNOR. Ms. LaBouyer is the executive director of the California Ambulatory Surgery Association and has been a board member of CASA since 2000. Ms. LaBouyer previously served as director of Feather River Surgery Center in Yuba City, Calif., and as a surgical nurse and manager at Rideout Hospital in Marysville, Calif.

Anita Lambert-Gale. Ms. Lambert-Gale serves as vice president of clinical operations of HealthMark Partners. In addition to having operational accountability for Ambulatory Surgery Centers, she is responsible for managing the development of new facilities. Before coming to HealthMark Partners in 2002, Ms. Lambert-Gale served as director of quality standards for HealthSouth for six years. Ms. Lambert-Gale brings more than 25 years experience in healthcare and a decade in ambulatory care to HMP. She has extensive knowledge in licensure, certification and accreditation in addition to the operations experience.

Mary Beth Lang. Ms. Lang is senior vice president of business intelligence for Amerinet and president of Diagnostix, an Amerinet subsidiary. In her position, she oversees a team that analyzes data to help Amerinet members recognize and sustain significant savings. Prior to joining Amerinet, Ms. Lang directed pharmacy distribution and process improvement efforts at the University of Pittsburgh Medical Center.

Linda LeBlanc. Ms. LeBlanc is the chief administrative officer for AH Holdings, a new entity created to provide shared services to TriMedx and its sister organizations — Axess Ultrasound, eProtex and TriMedx Foundation. Each AH Holdings organization provides medical equipment expertise in a different capacity. AH Holdings is a wholly-owned subsidiary of Ascension Health, one of the nation's largest nonprofit health networks. Ms. LeBlanc was previously vice president of human resources at TriMedx. Prior to joining TriMedx in 2006, she worked as a human resources executive for ATA, Hillenbrand and Brown-Forman. Ms. LeBlanc has 30 years of experience in human resources.

Rebecca Lynn. As director of payor relations for Health Inventures, Ms. Lynn directs projects for multiple ASC clients and assists clients in all phases of third-party payor relations, financial forecasting and identifying opportunities to increase revenue. She has extensive experience in managed care and helps clients with new policy and procedure development as well as HIPAA regulations.

Marian Lowe. Ms. Lowe serves as a partner at Strategic Health Care in Washington, D.C., where she advises clients on Medicare policy and strategy. Through her work at SHC, she has represented the ASC industry in various capacities, including as a consultant to the AAASC and the ASC Association. She currently serves as executive director of the ASC Advocacy Committee, where she directs political, policy and public relations work on behalf of the industry. She has worked to improve Medicare payments to ASCs, expand the list of Medicare-covered services and maintain equitable policies for participation in Medicare. Prior to joining SHC, Ms. Lowe worked in a number of capacities at MedPAC, most recently as special assistant to the executive director.

Debbie Mack, RN, MSN, CNOR, CASC. Ms. Mack is vice president of operations for National Surgical Hospitals and president of the California Ambulatory Surgery Association. She has more than 25 years of experience in the healthcare industry and worked as an OR nurse, with experience in all surgical specialties. During the course of her career, she has been responsible for many operating room duties including serving as director of surgical services and staff development coordinator in an acute care hospital. Ms. Mack has also served on the CASA board of directors since 2003.

Sara McCallum. Ms. McCallum has worked and has actively been involved in the ambulatory surgery center industry for many years. She had worked all phases of peri-operative nursing prior to obtaining her MBA from Nova Southeastern University in Ft. Lauderdale, Florida. She has opened seven surgery centers from construction to operation and has served as an administrator at five of those centers. She is a licensed healthcare risk manager and obtained her certification as and many professional organizations. Three years ago she moved to Fond Florida Society of Ambulatory Surgery Centers in 1991 and served on the board of directors as president, treasurer and has maintained a board member emeritus status since 2001.

Dawn Q. McLane, RN, MSA, CASC, CNOR. Ms. McLane serves as CDO for Nikitis Resource Group, a firm that specializes in development, management, accreditation preparation and consultative work in the ambulatory surgery industry. She has developed and managed more than 20 surgery centers with Aspen Healthcare, NSC, Nikitis Resource Group and independently. Ms. McLane has worked in the hospital setting as director of surgical services and as a staff nurse in surgery, ER and OB.

Suzanna D. Majewski, CASC. Ms. Majewski possesses over twenty years of leadership experience in healthcare management. In 1994, she was employed by the Bedford Ambulatory Surgical Center, where she currently serves as COO. Her expertise includes overall management of facility and staff operations, oversight of compliance with state and federal regulations and development and implementation of marketing and strategic planning ventures. Additionally, her primary responsibilities include payor relations, including negotiation/maintenance of contractual agreements and oversight of all aspects of the accounts receivable process. Ms. Majewski currently serves at the ASC executive member on the board of directors of the New Hampshire Health Care Quality Assurance Commission, and is vice president of the New Hampshire Ambulatory Surgical Association.

Becky Mann. Ms. Mann is the director of Houston Orthopedic Surgery Center in Warner Robins, Ga. Ms. Mann came to Houston Orthopedic in May 2007 and was involved in the development of the center. Houston Orthopedic Surgery Center was featured in the September/October issue of FOCUS as a notable surgery center. Ms. Mann has been working in the medical industry for 37 years and in surgery or in post-surgical care for her entire career.

Marianne Maravich. Ms. Maravich is an account executive-clinical specialist at Kimberly Clark. With more than 30 years in the medical sales industry, Ms. Maravich is responsible for the launch and development of new pain management technologies for Kimberly Clark. She works with neurosurgeons, orthopedic and pain management physicians to sell new devices for spine pain relief. Prior to her career in pain management, she worked in sales and market development for several product and procedure lines for Ballard Medical and Kimberly Clark. The lines included a patented brand of suction catheters, which prevent hospital acquired infections in ventilator-dependent patients and a low-profile feeding tube for children.

Sarah Martin, MBA, RN, CASC. Ms. Martin is a regional vice president of operations for Meridian Surgical Partners. She has over 30 years of healthcare experience, focusing in the ambulatory surgery area for the past decade. Prior to joining Meridian, Ms. Martin was the regional director of ASCs for Universal Health Services and a regional vice president with Symbion Healthcare, where she managed both ASCs and specialty hospitals. She presently serves on the board of the ASC Association.

Chris McMenemy. Ms. McMenemy has been with Ortmann Healthcare Consultants since 2004 as vice president for administration. Before joining Ortmann Healthcare Consultants, Chris worked with IT consulting and software training at a large hospital system in Columbia, SC. With this background, Chris specializes in IT consulting for the centers OHC develop and with other pre-development activities, such as financial feasibility studies, ASC financing, ASC insurance, and HR benefits.

Melody Mena, RN, CNOR. Ms. Mena is director of surgical services for Southern Regional Health System in south metro Atlanta, and Spivey Station Surgery Center in Jonesboro, Ga. She began her career as an x-ray technician and then as an OR nurse. In 2006, Ms. Mena became director of surgical services for the former Surgery Center at Mt. Zion (now Spivey Station). She has also served director of surgical services for the entire Southern Regional Health System in 2008.

Evelyn S. Miller, CPA. Ms. Miller is the vice president of development for United Surgical Partners International and is responsible for the strategic direction of USPI's mergers and acquisitions efforts. Before joining USPI, she was executive vice president of Medway Health Systems, overseeing the financial operations of its medical clinics.

Krystal Mims. Ms. Mims is president of Texas Health Partners. She previously served as CFO for Physician's Medical Center, a specialty hospital in Plano, Texas; Southlake (Texas) Specialty Hospital; and Presbyterian Hospital of Rockwall (Texas). Her background in healthcare began in physician practice management. She was CFO for Texas Back Institute for three years, CFO of Practice Performance and administrator of Steadman Hawkins' Denver clinic.

Melodee Moncrief, RN, BSN, CASC. Ms. Moncrief is the administrator for the Big Creek Surgery Center in Middleburg Heights, Ohio. She has been with the center since Oct. 2005 and helped with the development, initial staff hiring and start-up of the center. She has more than 15 years of experience in the ASC industry after previously serving as a nurse's aid and an ICU nurse at a hospital. Ms. Moncrief served as an administrator of another center for 3.5 years before coming to Big Creek.

Amy Mowles. Ms. Mowles is president and CEO of Mowles Medical Management. As a fee based regulatory consultant, she not only provides rare and valuable expertise, but also educates, prepares and assists her clients with putting into practice all policies and procedures, provisions and standards; resulting in a facility that meets the highest standards for regulatory conformance and third part accreditation, without need to surrender exclusive ownership in an effort to secure outsourced management. She has successfully guided hundreds of single and multi specialty centers in 20 states across the USA.

continued on page 41

Improving the Profitability of Your ASC – Thrive Now and in the Future

This exclusive conference brings together surgeons, administrators and ASC business and clinical leaders to discuss how to improve your ASC and its bottom line in these challenging but opportunity-filled times.

The best minds in the ASC field will discuss opportunities for ASCs plus provide practical and immediately useful guidance on how to bring in more cases; improve reimbursement; manage, reduce and benchmark costs; introduce new specialties; engineer a turnaround; work on joint-ventures with hospitals and much, much more.

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

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

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

PROGRAM SCHEDULE

Pre Conference – Thursday October 21, 2010

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

Main Conference – Friday October 22, 2010

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

Conference – Saturday October 23, 2010

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

Thursday, October 21, 2010

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

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

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

2:30 – 3:05 pm
10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them - Brian Brown, Regional Vice President, Operations, Meridian Surgical Partners, and Reed Simmons, Administrator, Treasure Coast Center for Surgery

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

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

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

Session B – Spine, Orthopedics, Pain and General Surgery

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

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

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

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

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

Session C – GI, Ophthalmology and Management

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

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

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

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

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

Session D – General Management and Accreditation

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

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

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

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

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

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

Session E – Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Opportunities and What it Takes to Expand Services via a Collaborative Effort with the Payor - I. Naya Kehayes, MPH, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management, and Anna Gimble, VP Ancillary Services-West, United Healthcare Services, Inc.

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

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

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

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

Session F – Valuation and Transaction Issues

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

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

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

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

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

5:30 pm
Cocktail Reception, Cash Raffles and Exhibits

Friday, October 22, 2010

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

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

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

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

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

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

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

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

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

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

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

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

Session A – Ideas to Improve Profits

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

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

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

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

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

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

Session B – Orthopedic and Spine ASC Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Session E – Managed Care, Revenue Cycles and Reimbursement Issues

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

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

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

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

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

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

Session F – Leadership, Competition and Legal Issues

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

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

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

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

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

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

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

Saturday, October 23, 2010

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

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

Concurrent Sessions A, B, C, D, E

Session A

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

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

Session B

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

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

Session C

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

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

Session D

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

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

Session E

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

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

General Session

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

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107 Great Women Leaders in the ASC Industry
(continued from page 34)

Cindy Moyer. Ms. Moyer is the administrator of the Surgery Center of Pottsville (Pa.), a multi-specialty, two-OR center. Ms. Moyer has been with the center since it opened in 2006. She previously ran an ENT and allergy practice for 21 years and prior to that worked with an internal medicine group.

Theresa Palicki, MHA, MBA, CASC. Ms. Palicki is the administrator of Eastside Surgery Center, a multi-specialty surgery center in Columbus, Ohio. The center is a joint venture between physicians and OhioHealth and is managed by Health Inventures. Ms. Palicki joined Eastside in Nov. 2005, but she has held positions in healthcare administration since starting her career. She served as administrative director for Consolidated Health Services and was practice administrator for University Orthopaedic Physicians prior to coming to Eastside.

Elaine Peterson, RN, CNOR. Ms. Peterson has 22 years of experience working in a surgical environment as a nurse and consultant, managing a wide range of operational functions for orthopedic, neurological, pain management, ENT, GYN, plastic, and general surgeons. Prior to joining Medical Consulting Group, she served as the director of surgical services for a large orthopedic ASC that also offers pain management services. Ms. Peterson assists MCG clients with licensure, staff training, implementation of policies and procedures, equipment procurement, customization of supply packs, scheduling, accreditation preparedness, and clinical management for operating centers.

Linda Peterson, MBA. Ms. Peterson is CEO of Executive Solutions for Healthcare and has more than 30 years of experience in development and operational management of healthcare organizations. Her previous experience includes executive director for ambulatory care at The Joint Commission, corporate director of development/registered representative for HealthSouth, senior vice president of development for a startup ASC development company and ASC development consultant for a national ASC management and consulting firm. Ms. Peterson areas of expertise include the design, development and operational management of new business and product lines, mergers and acquisitions in the ambulatory service sectors for independent practices, groups, hospitals and integrated delivery systems.

Lori Ramirez. Ms. Ramirez founded Elite Surgical Affiliates in 2008, and now leads as its president and chief executive officer. In 2009, Lori helped launch Elite Orthopedics and Spine – which manages the day-to-day operations of physician practices. Elite Orthopedics and Spine provide the full continuum of services to their doctors. Before founding Elite Surgical Affiliates, Ms. Ramirez was a senior vice president at United Surgical Partners International. She was directly responsible for developing the second-largest network of surgical facilities for USPI in Houston and supervised more than 600 employees. Ms. Ramirez oversaw more than 20 surgical facilities, including two surgical hospitals.

Anne Roberts, RN. Ms. Roberts is the administrator at the Surgery Center at Reno (Nev.). She came to the Surgery Center at Reno in Feb. 2006 when it opened and became administrator in Oct. 2006. She began her career as a nurse in the emergency department, spending 16 years as a staff nurse and 10 years as the manager of a busy ED seeing 55,000 patients annually.

Lisa Rock. Ms. Rock serves as president of National Medical Billing Services, one of the largest ASC billing companies in the country. Ms. Rock is a seasoned healthcare management veteran with over 25 years experience in the industry. Her wide ranging background consists of director of training and education for Mid-Atlantic Medical Services and vice president of business office operations for an ASC development and management company. She has also managed private practices in the specialties of orthopedics, retina surgery, cardiology and anesthesia.

Suzanne Rogers. As vice president of human resources for Health Inventures, Ms. Rogers is responsible for all facets of human resources services provided to Health Inventures' ASCs. She has been employed by Health Inventures since 2000 in a variety of human resources roles and currently has operational responsibility for Employment Management Solutions, an employee staff leasing company owned by Health Inventures. She previously worked for CH2M Hill Companies and The Washington Group.

Mary Ryan, RN, CASC, MBA. Ms. Ryan is the administrator of Tri-State Surgery Center in Dubuque, Iowa, a multi-specialty facility with three operating rooms and two procedure rooms that is currently managed by Health Inventures. Ms. Ryan has over 20 years of experience in the OR. She joined TSSC in 1998 as director of nursing and then became the administrator of the center in 2001. Ms. Ryan has served as regional director during her tenure with Health Inventures and continues to provide clinical consultation. Ms. Ryan is also a past AORN chapter president and a founding member of the Iowa Ambulatory Surgery Center Association, where she is currently serving her second term as president.

Karen Sablyak. Ms. Sablyak is the CFO at Physicians Endoscopy. She has more than 20 years of experience in healthcare finance, billing and business operations. Prior to joining PE, Ms. Sablyak worked as a vice president of practice management for Allegheny University Hospitals in Philadelphia, PA. In her role at PE, Ms. Sablyak has directed a transition to a paperless AR billing system and strives to enhance performance through PE's payer contracting services, group purchasing discounts and performance benchmarking.

Donna St. Louis. Ms. St. Louis currently serves as a vice president for ambulatory services at BayCare Health System. Before joining BayCare, she was a group president for Symbion and responsible for more than 45 ASCs.

Molly Sandvig. Ms. Sandvig was named the executive director for the Physician Hospitals of America, then the American Surgical Hospital Association in November 2005. As such, Ms. Sandvig leads the organization's day-to-day business and operational functions and directs PHA's membership recruitment, public relations and political advocacy efforts. In addition, Ms. Sandvig serves as the president of the South Dakota Association of Specialty Care Providers, representing specialty hospitals and ambulatory surgery centers in South Dakota. She is currently serving a third term as a governor appointee to the South Dakota Healthcare Commission.

Marcy Sasso. Ms. Sasso has been the director of operations at the Ambulatory Surgical Center of Union County in Union, N.J., since May 2004. Previously she served in many roles at other surgery centers and at Saint Barnabas Hospital. She was also the financial and legal administrator for a multi-physician practice and office manager for an outpatient physical therapy center. In 2000, Ms. Sasso and a fellow administrator started, and now co-chair, a surgery center coalition. The SCC now has over 75 other New Jersey centers as its members. She is also a very active volunteer and recently organized the shipment of medical supplies to Haiti following the earthquake.

Tona Savoie, RN. Ms. Savoie is administrative director of Bayou Region Surgical Center in Thibodaux, La. The ASC operates as a 50-50 partnership between physician investors and a subsidiary of the local community hospital, Thibodaux Regional Medical Center. It is managed by ASD Management. Ms. Savoie has been with Bayou Region since its start-up in 2007. Prior to becoming an administrator, Ms. Savoie worked as a circulator for three and a half years at a large hospital and three years as a OR coordinator at an ASC, which was converted to a hospital.

Caryl Serbin, RN, BSN, LHRM. Ms. Serbin is the president and founder of Surgery Consultants of America and Serbin Surgery Center Billing. She has more than 25 years of experience in the healthcare industry, with the last 18 years spent in ambulatory surgery administration and consulting.

Lynda Dowman Simon. Ms. Simon is the administrator at St. John's Clinic: Head & Neck Surgery in Springfield, Mo, the only ASC in Missouri dedicated solely to ENT procedures. The center performed its 30,000th case this July and has a patient satisfaction rating of 98.17 percent. Ms. Simon has been at her center since 1994. Prior to coming to St. John's, she worked for 13 years at a local hospital in the open heart center and urology. Ms. Simon is proud to say her coworkers stay at the center once hired, and she has not hired a new staff member in over three years.

Donna Slosburg. As executive director of the ASC Quality Collaboration, Donna Slosburg, RN, helps ASCs improve healthcare quality and safety by developing standardized quality measures, publically reporting quality data and assembling tools for infection prevention. Ms. Slosburg has worked in the healthcare industry for over 30 years and joined the ASC industry in 1987. As a leader in the ASC industry, she has served as a nurse manager, administrator and regional operations coordinator, as well as a senior vice president of surgery operations and national surgery specialist for HealthSouth, one of the nation's largest healthcare services providers.

Christina Smith, RN, MSN. As vice president, Ms. Smith leads the Amerinet Clinical Advantage consulting team on developing and implementing a process driven, evidence-based program which delivers improved margins and reduced supply costs for physician preference products. Ms. Smith joined Amerinet in 1998 with more than 18 years of progressive clinical leadership experience in perioperative services including staff member, nurse manager and administrative director of surgical services. Her varied healthcare background includes knowledge of both large urban teaching hospitals and small community-based facilities.

Cassandra T. Speier, RN. Ms. Speier has served as senior vice president of operations since November of 2007. She has senior clinical responsibility for NovaMed's surgery center operations and manages NovaMed's multi-specialty surgery centers. Prior to joining NovaMed, Ms. Speier was a vice president for Symbion Healthcare, a surgery center company from 2001 until she joined NovaMed. She managed a significant portion of Symbion's multi-specialty surgery centers, handled development of selected surgery centers and hospital joint ventures. From 1994 to 2001, she was senior vice president and chief compliance officer for Vision America. She also served in senior management positions for Medcath, Medivision and Medical International.

Christy Stafford. As director of information technology at Borland-Groover Clinic, Ms. Stafford is responsible for ensuring IT drives a diverse organization toward aggressive goals. She facilitates the successful direction, implementation, support and maintenance of software, hardware and telecommunications for a 15-node, 400 end user base throughout the state of Florida. She has 17 years of healthcare experience, 15 of which have been spent focusing on and directing IT for a multi-specialty private clinic in Florida. She is currently undertaking a BAS in information technology management from Florida State College of Jacksonville.

Debra Saxton Stinchcomb, RN, BSN, CASC. Ms. Stinchcomb a consultant at Progressive Surgical Solutions and has more than 30 years of experience in the healthcare industry, including positions in administration, operations, sales and clinical areas. She previously served as director of operations preparation and transition management for Health Inventures. She has also held positions as an ASC administrator, assistant regional vice president and regional vice president.

Stephanie Stinson, RN, BSN, CASC. Ms. Stinson is the administrative director of Strictly Pediatrics Surgery Center in Austin, Texas. Ms. Stinson has been administrative director for six years and has been at Strictly Pediatrics since its inception in 2006. She has been a nurse for 17 years and has served as a staff nurse in neuro-surgical ICU, surgery and the recovery room.

Alsie Sydness-Fitzgerald, RN, CASC. Ms. Sydness-Fitzgerald is the chair of the ASC Association and participated in the development of the Certified Administrator Surgery Center credential. She has been involved in the ASC industry since 1976 and has built up outstanding experience in the clinical, business and management aspects of the ASC industry as the director of clinical operations for HCA's ambulatory surgery division.

Stephanie Tarry. Ms. Tarry is senior vice president, business development for Nueterra Healthcare. Since joining Nueterra in 2000, she has successfully recruited physician partners and syndicated 22 ASCs and real estate private placement offerings, of which six have been joint ventures with hospitals. Ms. Tarry is a licensed securities representative knowledgeable in Reg "D" offerings. Her extensive background in finance and accounting allows her to thoroughly understand and explain the financial structure of the partnerships. She began her career with 12 years of banking experience. Before joining Nueterra, she served as the director of treasury for a major Midwestern integrated health system and, before that, as the treasurer for the largest school district in Missouri.

Joyce (Deno) Thomas. Ms. Thomas is senior vice president for Regent Surgical Health. Before joining Regent, she served as the executive director of Loveland (Colo.) Surgery Center and worked for HealthSouth as a regional director of quality improvement and as an administrator. Ms. Thomas recently opened a new facility in Mount Dora, Fla., coordinated the quality, risk and values program for Regent and was involved in the development of two new facilities.

Anne Hargrave-Thomas. Ms. Hargrave-Thomas is CEO of Lakes Surgery Center in West Bloomfield, Mich. The ASC has continued to grow despite a local struggling economy and was recently named to Becker's Hospital Review and Becker's ASC Review list of the "100 Best Places to Work in Healthcare." She is a member of the Michigan Ambulatory Surgical Association and has more than 30 years of experience in healthcare and nursing.

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Dianne Wallace, RN, BSM, MBA. Ms. Wallace is executive director and CEO of the Menomonee Falls Ambulatory Surgery Center near Milwaukee, Wis. She has been with MFASC for over 11 years and has helped lead the organization through three successful AAAHC accreditation surveys. Most recently Ms. Wallace worked with several other ASC colleagues on development of an MGMA benchmarking tool for use by ASC managers and administrators. This tool allows a facility to enter their center's data into a Data Gateway tool which automatically compares their implant and staffing costs with other participants in that organization's most recent financial performance survey.

Michelle Warren, RN, BBA. Ms. Warren is the executive director of Powder River Surgery Center in Gillette, Wyo. She began her career in healthcare as a surgical tech and soon pursed her nursing license and a bachelor's in business administration. She spent many years as an operating room traveling nurse, working mostly in trauma, orthopedic, spine and open heart specialties.

Michelle J. Weidner-Jordan, RN, BSN. Ms. Weidner-Jordan serves as the administrator for Lewis & Clark Specialty Hospital. She has worked as a registered nurse in Norfolk, Nebraska before joining the nursing staff of Lewis & Clark when the facility opened in 2002. Since then, Ms. Weidner-Jordan has been promoted to the position of director of nursing in 2003, and most recently was promoted to the position of administrator in 2006. She oversees the daily operation and management of the hospital, while promoting the values of the hospital's mission and vision statements.

Suzanne Wienbarg, RN. Ms. Wienbarg is a senior vice president of operations at Ambulatory Surgical Centers of America with over 25 years of experience in healthcare management and operations. Prior to joining ASCOA, Ms. Wienbarg was a vice president of operations for the ambulatory surgery division of HealthSouth Corporation. During her career with HealthSouth, she worked extensively in development, operations and physician recruitment. She has been active as a member and officer in healthcare professional organizations.

Kathleen Whitlow, RN, BS, CASC. Ms. Whitlow is the COO for Blue Chip Surgical Center Partners. She has more than 25 years of experience in the medical/healthcare industry and has worked as an ASC administrator and consultant with expertise in development, marketing, operations and strategic planning in support of facilities across the country. As director of surgical services for a large national hospital system, she developed and directed the outpatient and ambulatory surgery programs, clinics, case management and endoscopy department. She has served as an advisor/consultant to a group of attorneys representing physicians.

Stephanie York. Ms. York is the director of business operations for Health Inventures, where she oversees business office operations of 30 ASCs across the country. She performs business office and reimbursement audits for both Health Inventures' clients and the ASC population in general. She has over 25 years experience in medical coding, billing, reimbursement, business office personnel and physician training and has worked with hospitals, physician groups and healthcare organizations.

Cindy Young, RN, CASC. Ms. Young is the administrator of the Surgery Center of Farmington (Mo.), where she started as a staff nurse and moving into the administrator position in 2002. Prior to coming to the center, she was a nurse at a rural hospital for five years and served for two years in the OR at the hospital.

Peggy Zampetti, RN. Ms. Zampetti is senior vice president of facility development and clinical operations for Titan Health. Ms. Zampetti joined Titan in 1999 from HealthSouth where she served as administrator and regional coordinator for Joint Commission accreditation. Previous positions include administrator and director of nursing for ASC Network. With more than 20 years of experience in ambulatory surgery development and operations, Ms. Zampetti has extensive experience in ASC design and construction to ensure compliance with regulatory requirements. She has personally developed 30 centers nationwide from design and construction to first case and has intimate knowledge of ASC licensure, accreditation and Medicare certification.

Becky Ziegler-Otis, RHIA, CPHQ, CHC. Ms. Ziegler-Otis is the administrator of the Ambulatory Surgical Center of Stevens Point (Wis.), a position she has held since Jan. 2008. For two years before coming to the center she worked in an orthopedic/neurology physician practice where she was responsible for implementation of their electronic health record. Prior to this she spent ten years at Bay Area Medical Center in Marinette, Wisconsin where she held a variety of positions including administrative director of process effectiveness, compliance officer, director of performance improvement and interim director of health information management. ■

New Jersey Regulators Approve Penalties for PIP Patients Using OON Centers

By Lindsey Dunn

The New Jersey Department of Banking and Insurance recently approved measures that will allow insurers to assess a penalty of up to 30 percent of eligible charges for Personal Injury Protection plan patients that use out-of-network ASCs.

The DOBI will also now allow insurers to waive co-payments and deductibles when PIP patients seek treatment at an in-network provider, referred to as an "organized delivery system" by the DOBI.

Additionally, the DOBI states that plan members must be notified when submitting a claim about the penalty fee and the waiving of co-payments and deductibles if their plan includes such provisions.

ASCs in the state, many of which operate on an OON basis, see the regulation as yet another challenge to their livelihood. Jeffrey Shanton, director of business management at Journal Square Surgical Center in Jersey City, N.J., further argues that there is no obvious need for the regulation and essentially "forces" ASCs in the state to join networks.

Scott Becker, JD, CPA, notes this is another indication of the reduced ability of ASCs to rely on out-of-network status for revenues and the increased collegiality between insurers and the departments of insurance and their ability to steer patients to in network providers. ■

Contact Lindsey Dunn at lindsey@beckersasc.com.

ICD-10 Implementation for ASCs: What You Must Do Now

By Cristina Bentin, CCS-P, CPC-H, CMA, Principal, Coding Compliance Management

If you think you can wait until 2013 to evaluate your system processes and work protocols for the ICD-10 implementation, think again! The ICD-10 implementation doesn't mean you simply need to purchase a new coding manual. It involves changes and considerations that should be initiated this year. Just for starters, did you know electronic transaction version 4010 will change to version 5010 beginning with internal testing in 2010 and external testing as early as Jan. 1, 2011? If you've just experienced a "deer in the headlights" reaction, fear not. This column will bring you up to speed.

HIPAA requires the HHS to develop standards regarding the electronic submission of health care transactions by covered entities (healthcare providers, health plans and healthcare clearinghouses).

According to CMS, approximately 99 percent of Medicare Part A claims and 96 percent of Medicare Part B claims transactions are received electronically. The current version of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for healthcare transactions) lack the infrastructure required by the healthcare industry, particularly for implementation of ICD-10.

The ICD-10 codes are seven digit alphanumeric codes which are currently not supported by the current electronic transaction standard 4010. Therefore, the format by which your claims are currently sent change to accommodate the new code set. 5010 (Version 005010 of the Accredited Standards Committee (ASC) X12 Technical Reports Type 3 -TR3s) is the next version of the HIPAA electronic transaction standards.

Despite the 2013 implementation date for ICD-10, it is imperative that providers prepare now (internal testing Level 1 began Jan. 1 and external testing Level II begins Jan. 1, 2011) for the new standards version 5010 in order to continue submitting claims electronically and to avoid delays in claim payments. Keep in mind, after Jan. 1, 2012, all electronic claims must use version 5010.

For HIPAA covered entities who electronically file claims, check patient eligibility status, or electronically receive remittance advice data, either directly to a health insurance payer or through a clearinghouse, the formats currently used must be upgraded from X12 Version 4010/4010A1 to electronic claims Version 5010. For Medicare, these HIPAA-mandated formats include the following:

- Claims (837-1, 837-P, 837-1 COB, 837-P COB, and NCPDP)
- Remittance advice (835)
- Claim status inquiry/response (276/277)
- Eligibility inquiry/response (270/271)

Version 5010 is crucial to the adoption of the ICD-10 codes and includes, for example, the following infrastructure changes from the previous Version 4010 in preparation for the ICD-10 codes:

- Increase in field size for ICD codes from five digit to seven digit alphanumeric code
- Addition of a one-digit version indicator to the ICD code to indicate Version 9 versus Version 10
- Increase in the number of diagnosis codes allowed on a claim (eight to 24 codes)

Start now or pay later

Providers should begin to prepare now for the change to assure a smooth transition to the 5010 transaction standard in order to minimize delays in processing and payment of claims.

Contact your software vendor

All providers should verify the following with their software vendors regarding transition preparations:

- Does my current system accommodate the data collection and transaction conduction for 5010?
- Will there be an additional fee for an upgrade from my current system?
- When will my system upgrade be completed and available? *Note:* Upgrades should be available by end of 2010 for external testing to begin in a timely manner in 2011.

Contact your clearinghouse, payors and other billing vendors

Your software vendors may be a great resource to provide you with details about what you need to do to comply with Version 5010 standards and ICD-10. Initiate communications with payors, clearinghouses or billing services and ask the follow questions:

- Will you be upgrading your systems to accommodate the 5010 transactions (ICD-10 code format)?
- When will your upgrades be completed?
- When can a test transmission be sent?
- Will you (i.e., payor) increase fees for the 5010 transactions? (Be prepared to re-negotiate electronic data interchange (EDI) contracts.)

Identify potential changes to existing work protocol

The ICD-10 codes provide a greater level of specificity and as such will require equivalent clinical reporting. Begin now to identify the following areas impacted by Version 5010 and the eventual ICD-10 implementation and plan accordingly:

- Software systems
- Electronic health records
- Forms and/or super bills
- Clinical documentation
- Quality reporting

Establish a budget

The implementation costs for Version 5010 and ICD-10 will overlap somewhat. Keep in mind there may be additional costs. Here are a few areas you may need to invest in:

- Internal system changes and testing
- Staff training
- Resource materials
- Other unforeseen costs

Identify staff training needs

When developing training for all staff members working with diagnosis coding in any form, your ASC should consider the following:

- Key players (physicians, business office support-coders, billers, collections/denials)
- Extent of training
- Method of training
- Continuing education

ICD-10 and Version 5010 Compliance Timelines

HIPAA covered entities affected by the transition to Versions 5010 and ICD-10 transitions include health care providers, such as physicians, alternate site providers, rehabilitation clinics, hospitals, Health plans/carriers, clearinghouses, and business associates that use the affected transactions, such as billing/service agents and/or vendors. Here is an overview of ICD-10 compliance steps and deadline dates, according to CMS. Italicized text under the compliance are additional comments on what ASCs should be doing to meet these deadlines.

Date	Compliance Step
January 1, 2010	Payers and providers should begin internal testing of Version 5010 standards for electronic claims *Discussions between provider and system vendors should be on-going during 2010.*
December 31, 2010	Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance *Providers should be able to demonstrably create and receive compliant transactions by Dec. 31. Providers should complete their internal testing, and are now ready to test with external payers and partners beginning in Jan. 2011.*
January 1, 2011	• Payers and providers should begin external testing of Version 5010 for electronic claims. *Providers are ready to transmit in the new format, but will insurance carriers be ready to receive them?* • CMS begins accepting Version 5010 claims • Version 4010 claims continue to be accepted *Communications with clearinghouses or billing services should be initiated if not already ongoing.*
December 31, 2011	External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance *Completion of end-to-end testing with all partners/carriers.*
January 1, 2012	• All electronic claims must use Version 5010 • Version 4010 claims are no longer accepted
October 1, 2013	• Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and in-patient procedures • CPT codes will continue to be used for outpatient services ■

Resources:

- A web page dedicated to providing all the latest information for ICD10 is available at www.cms.gov/ICD10/.

- *New Health Care Electronic Transactions Standards Versions 5010, D.0, and 3.0* A web page dedicated to providing all the latest versions 5010 and D.0 news for all HIPPA covered entities is available at www.cms.hhs.gov/Versions5010andD0/01_overview.asp on the CMS website.

- For more information on Electronic Billing and Electronic Data Interchange (EDI) transactions, visit the EDI web page at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp* on the CMS website.

- American Health Information Management Association also has good information at www.ahima.org.

Cristina Bentin can be reached at cristina@ccmpro.com. Learn more about Coding Compliance Management at www.ccmpro.net.

10 Steps for ASCs to Collect Full Payment After the Procedure is Performed

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

When analyzing the many components included in the reimbursement cycle, you recognize that there are two major divisions: *prior* to and *after* the procedure is performed. The first part of this article, "6 Areas of Focus for Collecting Full Payment: Critical Steps to Take Prior to Billing," appeared in the July/August issue of Becker's ASC Review and discussed essential steps to perform before the services are rendered to ensure timely and accurate reimbursement.

In part one, we left off with the dictation and transcription of the operative note and its importance in filing an accurate claim. Part two deals with the steps needed to file and collect the full amount due. It is very important to follow all the steps carefully to avoid denials and incorrect payments whenever possible.

#1: Coding the procedure – Determining what is owed

Coding is a crucial step in determining the ASC's financial success or failure. The person coding the operative note is deciding the amount to be charged. It is vital this individual is well-versed in interpreting the operative note accurately and assigning all appropriate codes for the procedure(s) and billable implants and supplies. They must also be aware of all OIG billing compliance regulations and managed care companies' specific requirements. Code optimization while remaining compliant should only be assigned to a well trained and experienced certified coder.

#2: Claim submissions – Getting clean claims out the door

Whether this step is done by the coder or by a separate person, don't underestimate the time required to perform this task accurately. Electronic claim submission is just as complex as submitting paper claims. All required information must be inserted accurately and must meet payor requirements. Remember, different states, different payors and different Medicare carriers may all have different requirements.

In order to submit a "clean claim" and avoid delays, use your software's "scrubbing" program to points out errors. Clearinghouses also have "scrubbing" software that checks for errors and returns for correction. Once corrections are made, the clearinghouse should advise you that the claim has been sent to the payor.

#3. Verification of receipt by payor - Putting the ball in the payor's court

Most clearinghouses have the ability to advise when the payor received the claim. Some of the larger payors also have their own clearinghouse or website which may allow you to verify the claim is being processed (accepted with no errors). Some even have information on the status of the claim and the amount approved for payment. It's important to take this extra step so you are sure the claim is there and being processed. This helps avoid getting an annoying CNOF (Claim Not on File) message when you check the status in a few days.

#4. Follow-up – When will the claim be paid?

In most cases electronic claim filing should be followed up 1-2 weeks after accepted by the payor. Many electronic claims are now being paid within two weeks. If your payors have online claim status information such as amount billed, amount to be paid, date check will be issued, etc., often a phone call is unnecessary. Some payors allow you to question the accuracy of the claim online without having to wait for payment to be received. However, a phone call is often necessary in order to get definite answers. Always document fully the answers you receive.

#5. Posting payment – Is it the correct amount?

Allowing for deductibles, co-pays, co-insurance, contract allowances, etc., is the amount that you received the amount you were expecting to be paid? If so, post the payment and reassign the balance to the appropriate guarantor, either patient or secondary insurance company.

If the amount paid does not reflect what was expected, determine the specific reason(s) for the difference, i.e., deductible, co-insurance percentage, procedure codes disallowed, allowed amount differs from contract, etc. and ask for coding review or call payor to question payment discrepancy. Some erroneous payments can be corrected over the phone without having to file an appeal.

#6. Filing a denial – When the phone call doesn't work

After checking to ensure the payment deficiency was not because of a coding or billing error, review the payor requirements to file a denial. Information can be found in the payor's contract or their website. Use requested special forms and include all attachments, i.e., EOB, operative note, invoice, etc. Send to appropriate address. If necessary, take to the highest level of adjudication available.

#7. Collections – Third-party payors: The check is in the mail, CNOF, etc.

The best advice is to be firm and persistent. Enforce state prompt payment regulations. Immediately send any additional information they request and follow-up again within a few days. Document everything, dates, names, promises, etc.

Follow A/R accounts every 30 days minimum. If claim status information is available online, use this method as it is faster. However, questions that are not answered online require a direct phone call. When working your A/R, recommend grouping accounts by payor so you can make one call to the payor and cover all outstanding accounts. Follow up on larger balances first.

#8. Secondary insurance claim submissions – Chasing the balance

When a correct payment is received from the primary payor, move the balance to the secondary payor, in this case another insurance company. If the primary payor did not automatically send the claim to the secondary, send a copy of the original claim and the EOB to the secondary payor immediately.

#9. Patient statements – Asking the primary guarantor for payment

The patient is always the responsible party – this should have been explained to them prior to the procedure and included in your center brochure/handout. After correct insurance payments are received, send a statement requesting payment of the balance in full to the patient right away. If needed and approved by management, utilize the same payment options as provided during financial counseling. Send statements monthly

These nine steps for ensuring payment in full are common sense. However, in most cases, uncollected balances usually indicate taking short-cuts and not following these steps fully. That is why I recommend step #10:

#10. Internal audits – Guaranteeing the process is running appropriately

Audits are not just about A/R numbers and deposits balancing. They should include checkpoints on the accuracy and efficiency of each area of the reimbursement cycle:

a) Coding — accuracy, timeliness

b) Claims processing — accuracy, timeliness

c) Payment posting — accuracy, timeliness, error follow-up

d) Collections – timeliness, effectiveness, denials

Getting paid in full for services rendered requires a lot of time and effort. Experienced and dedicated employees and management involvement in the process are the keys to your reimbursement success. ■

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

3 Successful Managed Care Contract Negotiation Tactics (and One to Avoid)

By Rob Kurtz

Kevin Dowdy, director of managed care for Meridian Surgical Partners, shares three tactics to improve your chances at successful managed care contract negotiations, and one you should avoid.

1. Know what you want before you begin discussions. The easy part of negotiation is the decision to renegotiate and the subsequent initial contact of the payor. It is best to temper this enthusiasm by first performing the appropriate analysis and setting your goals. Once you know what you want and/or what you will take, then the negotiations can happen more efficiently and effectively.

2. Have all of your tools ready. Similar to "knowing what you want," having your tools ready is key to being prepared. Doing your homework and making sure that you are prepared to answer any question will make the negotiations generate a better outcome. Some of these key tools are things such as case costing, market knowledge, payor's needs, payor's leverage points and any alternatives (i.e., out-of-network or termination). This may sounds simple, but the pushing back from the negotiation table to "look into it" or "better analyze" can result in lost momentum.

3. The absolute best tactic that generates optimal outcomes is to negotiate in person. This may not be cost-effective or practical for all negotiations, but try to make this a priority for the larger payors. Being able to have face-to-face discussions allows for improved discussions and dialogue with the payor representative.

The only tactic to avoid is the "Termination Letter introduction." This always puts the payor on the defensive and can be construed as aggressive. Depending on the payor, this tactic can work for short-terms gains, but most negotiations, similar to investments, should be taken with a long-term benefit focus. ■

Learn more about Meridian Surgical Partners at www.meridiansurgicalpartners.com.

3 Critical Mistakes Made When Reporting Modifier -59

By Rob Kurtz

Here are three common but critical mistakes made by ASC coders when using modifier -59, according to Cristina Bentin, principal of Coding Compliance Management.

1. Incorrect utilization of -59 by ASCs to replace or mimic the -51 used by physicians. Physician practices apply the -51 modifier to multiple procedures after the primary procedure. While the -51 modifier is not an acceptable modifier for ASC use, some ASC carrier contracts/billing policies require it. Unless a facility is required to report the -51 modifier per written directive by its carrier, it should not be appending it to multiple procedures under normal circumstances. Furthermore, to automatically report the -59 modifier for all multiple procedures performed after the primary procedure in place of the -51 modifier is not only incorrect, but it is a red flag for future OIG and Medicare audits.

2. Under-utilization of -59: It's not taboo. When the Medicare edits (NCCI) correct coding modifier indicator (i.e., 1) allows a modifier to indicate a "separate" and "distinct" procedure, users may be able to capture the additional procedure provided operative documentation supports a "separate" and "distinct" procedure. Users must understand the meaning of the Medicare edits correct coding modifier indicators (0, 1 and 9) and when separate reporting is allowed.

3. Over-utilization of -59. Do not use -59 to bypass the edits when a procedure is truly integral to the main procedure. Remember, simply because the Medicare edits may allow for a modifier doesn't mean the procedure can always be reported with a -59 modifier just to bypass the edits. The procedure must clearly be "separate" and "distinct" from the more extensive procedure being performed during the same session. ■

Cristina Bentin can be reached at cristina@ccmpro.com. Learn more about Coding Compliance Management at www.ccmpro.net.

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

3 Surprising Factors That Impact an ASC's Value

By Kevin McDonough, Senior Manager, VMG Health

Participants in the ASC industry are generally keenly aware of the common factors that can impact ASC valuation. Amongst others, these can include the number and age of physician owners, competition in the market, availability of new recruits, reimbursement pressure, facility and equipment needs and specialty mix. There are, however, a number of lesser known dynamics that can ultimately impact ASC value.

1. Historical marketability of the ASC's ownership units. An important, however often overlooked, component of risk, the center's historical ability to market it shares and recruit new doctors provides a telltale sign of the availability of physicians in the market as well as management's skill in recruiting new doctors. It has been well documented that there is an increasing shortage of available physician investors in many markets. Despite this trend, an ASC that has demonstrated the ability to consistently recruit new physicians will be more likely than its competitors to garner new physician investment in the future. As such, when determining value it is just as important to look at the frequency of past transactions as it is to forecast future trends.

2. Reliance upon out-of-network reimbursement is not an absolute black-eye for an ASC's value. After performing valuations in countless markets across the nation, one certainty is that not all OON reimbursement is created equal. The effect of OON reimbursement on valuation should focus on the impact of this strategy on the sustainability of revenue and cash flow. For certain centers, OON reimbursement does not result in significantly above-average rates and commercial payors in the market are not overly aggressive in their tactics to combat this strategy. For such centers, it is reasonable to assume that reliance on OON reimbursement is not an immediate threat to financial performance. Is it a risk factor? Absolutely, but it would be inappropriate to group this ASC with another center that is receiving significantly above average reimbursement and located in a market in which payors are extremely aggressive in eliminating or reducing OON strategies.

3. Level of recruitment activity within the physician-owner's private practices. As the availability of new physician recruits in many markets becomes increasingly scarce, ASCs rely more than ever upon the recruitment efforts of existing physician-owners within their private practices. In recent years, sophisticated buyers in the ASC market have turned their focus to identifying ASCs that are affiliated with self-sustaining group practices (i.e., those that are active in backfilling retiring physicians and pursuing growth with new recruits). Recruiting independent physicians or physician groups to an ASC can be an extremely time-consuming, expensive and often fruitless endeavor. As such, there is a desire by buyers and management companies to align themselves with physician groups that already pursue such activities. ■

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

Is the Independent Practice of Medicine Going the Way of the Dinosaur?

By Tom Mallon, CEO, Regent Surgical Health

There is nothing new under the sun. Back in 1995, former surgery center executives were flying high buying physician practices for Phycor, MedPartners and other public and private companies. The White House was leading the governmental effort to "reform" the industry. Hospitals were bidding for physician practices to control their patient flow. The physician industry was seen as the next "roll up" opportunity, following the same path as waste dumps, funeral homes, and other fragmented industries.

But something went terribly wrong. The models were flawed. Public companies paying out huge purchase prices to physicians saw physician productivity drop. The promise that the corporate partner could replace the income that the physician gave up in the partial sale of their practice was never fulfilled. They could not add income through better contracting nor lower expenses through better management.

After the public companies failed, the hospitals saw their bottom lines crushed by HMOs. Each doctor practice "lost" $70,000. Consequently, the hospitals pushed the physicians out the door. Physicians bought back their practices and resumed running them as independent businesses with little consolidation until now.

How is 2010 different from 1995? The real question is: How is it the same? First, commercial insurance carriers have learned to act like HMOs and compress physician pay. This has caused the physicians to see their standard of living erode. This time, Congress succeeded where the previous Administration failed. They passed a reform law. However, the country is so upset with their leadership that the likelihood of sending Democrats packing in November is high. If President Obama is not reelected in 2012, the reforms will be reworked in a major way. Some of the provisions will survive, but many will be reversed.

Physicians are seeking security and hospitals want to control their patient flow. Many are flocking to the hospital employment model that did not work in 1995. Have physicians suddenly become model employees? Are they compliant and team oriented? I don't think these are the characteristics that enabled physicians to achieve their academic and professional accolades.

But what is different than 1995? CMS is much more aggressive in its desire to control costs. They have the power to roll out those demonstration projects without Congressional approval. One with the most upside is the bundled payments – paying hospitals one payment for an episode of care and allowing them to divide among the various providers. This will bring an alignment of interests and foster competition between health systems. However, in many markets, there is only one hospital. In others, there is a dominant, high quality provider that patients will go to even if it costs more.

CMS has to control costs. Medicare is the single largest unfunded liability in America. It was estimated at $109 trillion shortfall over the life of the current enrollees. The present value is $39 trillion before the healthcare reform bill passed. Social security, which gets all the press, is a mere $9 trillion unfunded liability. Our entire economy produces $15 trillion per year in gross domestic product. This is an unsustainable social program. Will the government crush medical providers to pay for the program? Will they inflate away the problem by printing money? Will they back off on Medicare benefits?

Uncertainty is a productivity killer. The economy is frozen with uncertainty about tax policy, regulatory threats, and economic stagnation. The greatest challenge in times like these is to keep one's perspective. Trees don't grow to the sky. Things are never as bad as they seem. We will see adjustments in the reform bill. It will not be as bad as we think. As small businesses, we enjoy the flexibility of adjusting.

This time feels very much like 1986 when I was in the commercial real estate business. Tax law changed, laying the groundwork for nearly every savings and loan in America to go out of business. This train wreck took 10 years. The best news is it took 10 years! My firm became the repo specialist for downtown Chicago. We had some of our best years during this disaster. We believe there will be opportunities in healthcare in these times. We just need to keep our heads, take the temperature of the industry at each step of the way, and adjust to the winds that blow over us. ■

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

5 Most Attractive ASC Specialties

By Rob Kurtz

Here are the five most attractive ASC specialties and some of the attributes that make them appealing platforms, according to the Astor Group's "Investment in the Healthcare Industry" white paper. For a copy of the full report, visit www.theastorgroup.com/healthcare.

Orthopedics

- Highest per treatment revenue of all ASC specialties
- Overall profitability is strong and reimbursement rates are attractive
- Demand rising and procedures not likely to move into the office setting

ENT

- Moderate volume of procedures
- Procedures generate solid revenue
- Low implant and supply costs contribute to high margins
- Expected to experience moderate but steady growth in the near-term

Gastroenterology

- Highest volume of procedures performed
- Single-specialty gastroenterology centers with limited number of active physicians is best formula for success

Spine

- Technology improvements encouraging growth in number of ASC procedures
- Payors can save significantly by shifting procedures away from the hospital to ASCs
- High revenue procedures

Ophthalmology

- One of the top three volume specialties
- Significant volume is required but obtainable ■

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Using New Processes and Technologies to Maximize ASC Patient Collections

By Barbara Kirchheimer

Many surgery centers attempt to collect the patient portion of a payment for services performed at a surgery center after the patient has left the ASC. This is clearly a recipe for bad debt, says Lindsay Miller, vice president of internal auditing at National Medical Billing Services.

"Our experience has shown that expected collections declines dramatically once a patient leaves the ASC," she says. "In fact, if a patient doesn't pay within 28 days, your likelihood of getting paid at all reduces to below 10 percent."

Further exacerbating the problem, "many of the surgery centers around the nation are taking virtually any case they can get and are rarely checking benefits or determining whether the patient can pay their co-pay, co-insurance or deductible," says Ms. Miller, whose company provides billing, coding and collections for ASCs in over 25 states across the country. "Many of these facilities are hurting for cases, but taking on some of these cases without doing the necessary homework in advance can negatively affect self-pay accounts receivable as well as cash per case if the facility is seeing a lot of patients with poor in- or out-of-network coverage."

Be diligent about collecting up front

Ms. Miller says the most effective way to minimize the amount that needs to be collected from ASC patients is to have the front desk staff collect and verify insurance card and demographic information, perform pre-certifications without assuming that the procedures are covered and collect the co-pay and co-insurance at the time of service. It is also critical, she says, to have knowledgeable, professional and highly diligent financial counselors who are willing and able to call patients in advance and let them know their financial responsibility before they even enter the ASC for their procedure.

"While we fully acknowledge that it can be challenging to do this in all situations, we are staunch advocates of having centers put such policies and procedures in place and do their best to follow them," Ms. Miller says.

New technologies can also be used to significantly improve the likelihood of success in the patient pay arena, such as automating the calculation of patient responsibility so the front desk staff has access to that information when requesting payment, she says. National Medical incorporates online insurance verification, for example, and advises clients to offer various options for payment, ranging from patient payment portals that provide electronic statements and the ability to pay online or over the phone with checks, credit cards or debit cards. "There are also wonderful financing programs that can be quite attractive to patients," Ms. Miller says.

Patient financing plans provide alternative

One organization that provides such a financing program is GE Capital, through its CareCredit product. Rob Morris, vice president of marketing and new business development for CareCredit – GE Capital, says CareCredit allows patients to pay their facility fee over time in monthly installments, while the ASC receives its payment in two business days.

Having a patient financing program in place can remove the awkwardness an ASC faces when billing the patient following treatment. ASCs are sometimes thrust into a difficult position with their physicians if a patient comes in the day of a scheduled surgery and has not brought the necessary payment, Mr. Morris says. If an ASC refuses to provide services to such a patient, it risks angering the surgeon, who will have shown up for nothing and may consider moving to another center. "ASCs cannot afford to alienate their surgeons," he says.

Capturing the otherwise uncollectible

Mr. Morris says he has encountered ASCs that have accumulated hundreds of thousands of dollars in patient A/R they are unlikely to ever collect. A financing program can eliminate this A/R, increase cash flow and save money that would have been spent on staff and materials for collection efforts, he says.

In the case of CareCredit, regardless of whether the patient eventually pays, the ASC receives its payment. There are a variety of no- and low-interest payment plans. The ASC pays a processing fee on the type of payment plan chosen.

Offering extended payment plans through third-party programs can also enhance patient relationships, Mr. Morris says, because they allow the ASC to avoid potentially contentious situations with patients.

With healthcare reform likely to result in more patients entering the healthcare system, and with the burden of payment increasingly shifting toward the patients, it is critical for ASCs to have a well thought-out plan in place to handle patient payments. With patient pay increasing toward 20 percent of the total A/R for many ASCs around the nation, this will become one of the most critical items in determining the level of profitability for surgery centers in the coming years, Ms. Miller says. ■

Learn more about CareCredit at www.carecredit.com. Learn more about National Medical Billing Services at www.nationalascbilling.com.

Anesthesia Models Under Attack

By Scott Becker, McGuireWoods, and Paul DeMuro, Latham & Watkins

Increasingly, surgery centers and practices related to surgery centers attempt to profit from the providing of anesthesia services. In the last couple of years, the American Society for Anesthesia has attacked various models as improper kickback relationships and has argued to the Office of Inspector General that the real intent of these relationships is to provide profits to surgeons who refer business to the ambulatory surgery center through the ability to profit from anesthesia services. More recently, the Maryland Association of Nurse Anesthetists has filed for a declaratory judgment with the Maryland of Department of Health and Mental Hygiene which regulates physicians. Here, the anesthetists argued that a model whereby a physician practice or Ambulatory Surgery Center (ASC) pays the Certified Registered Nurse Anesthetists (CRNAs) a flat fee per day and CRNAs assign all theirs fees to the practice or ASC was illegal. The key background facts as set forth in the anesthetists request for declaratory judgment were stated as follows:

1) Petitioner has received numerous inquiries from its members regarding the propriety and legality of certain contractual arrangements between physician group practices and its members.

2) Historically CRNAs and Anesthesiologists have provided anesthesia services for ASCs on a fee for services basis whether working individually or through an anesthesia group practice. Under this type of relationships the CRNA or anesthesiologist practices as an independent contractor and billed independently for their anesthesia services.[1]

3) Recently however, at least four non-anesthesia physician group practices utilizing ASCs have required anesthesia providers, including CRNAS, to enter into contractual relationships with the physician group practices. Under the Agreement the CRNA is required to relinquish all rights to independently bill and are required to assign all billing rights and rights to compensation to the non-anesthesia physician group practice.

4) Under this new business model, the non-anesthesia group practice is able to dramatically increase profit margins by collecting the fee for service normally collected by the anesthesia provider and in turn, compensating the anesthesia provider, including CRNAs, a flat daily fee. These non-anesthesia physician groups have also increased the rates for the anesthesia procedures care to further maximize their profit.[2] Until this recent development, the non-anesthesia group practices did not bill for the anesthesia services.

5) The non-anesthesia physician group practices in question presented contracts to the CRNAs and informed the CRNAs that they would accept the contract or the non-anesthesia group physician practice would find other anesthesia providers. The CRNAs had no bargaining power and were essentially forced into a contract of adhesion.

6) The new business model adopted by the non-anesthesia physician groups raises serious patient safety concerns. it is feared that the referring physicians may classify a patient's risks factors incorrectly in order to utilize ASCs instead of a hospital setting because of profit motive. Until the implementation of this new business model, the physician's choice of surgery site, hospital or ASC, had no effect on the physician's reimbursement for anesthesia services. Now referring physicians and group physician practices have a financial incentive for performing higher risk procedures in an ASC.

7) Simply put, this new business model results in the redirection of anesthesia fees, earned by the CRNA or Anesthesiologists, to the referring non-anesthesia physician group practice; raises serious concerns about patient safety; and violates Maryland law.

The state Department of Health and Mental Hygiene in a response dated February 2010 indicated that it would be willing to issue a declaratory judgment but in order to do so the CRNAs had to set forth the names and entities that were involved. The physicians have been given until June 17, 2010 to respond.

The practice in question is under increasing scrutiny. An ASC should be able to hire anesthesiology providers to practice in the ASC, if applicable state law does not prohibit same, as a valid means to assure that a center has adequate anesthetist coverage. However, where there is no direct employment relationship, and the ASC merely seeks to extract a profit in exchange for the business generated for the anesthesiology providers, there are serious regulatory concerns.

The Maryland situation is a case that will be watched closely because it has multiple implications on both the state and federal level. To be sure, similar compensation models are proliferating across the country raising a host of questions regarding their legality under state and federal anti-kickback and self-referral laws.

Anti-Kickback Laws

The federal Anti-kickback Statute (AKS) and similar state anti-kickback statutes make it unlawful for any person to offer or pay, or to solicit or receive, any remuneration in order to induce or reward business reimbursable under federal or state health care programs. Under the federal law, violation of the statute is punishable criminally by up to five years imprisonment, a fine of $25,000, or both, and by exclusion from participation in the Medicare and Medicaid programs, as well as other potential administrative and civil penalties.

Applied to compensation arrangements between facilities (physician group practices, surgery centers, ASCs, etc.) and anesthesia providers, the OIG has recognized that the dynamic is unique.[3] This is because rather than the common situation where physicians make referrals to the facility, here, the facility is in a position to generate business for the anesthesia provider. As such, any remuneration received or solicited by the facility in exchange for access to the facility's referral stream potentially violates the AKS. With respect to anesthesia services, specific examples of illegal kickbacks would include situations where a facility compensates anesthesia providers less than fair market value for the services they provide, or a facility requiring anesthesia providers to pay more than fair market value for services provided by the facility to the anesthesia group. In both cases, the OIG's concern under the AKS is that the anesthesia provider's willingness to either accept less for its services, or pay more for the facility's services is actually disguised remuneration paid in return for referrals. The OIG has stated that kickback schemes can often lead to "overutilization of services, increased costs for Federal health care programs, corruption of professional judgment, and unfair competition."[4]

For example, a popular model that is facing increased scrutiny under the AKS is the "company model." Under this model, owners of an ASC form a separate entity under the same ownership to administer anesthesia services. The anesthesia providers are generally paid a flat-fee or a salary, and the owners of the newly-formed entity bill for the professional anesthesia services as well as the facility fees. The company model, similar to the Maryland model referenced above, allows ASC owners to profit from the administration of anesthesia services.

In a 2003 Advisory Opinion, the OIG warned against arrangements where an existing supplier gives a referral source the opportunity to generate a profit.[5] The basis for the warning was the concern that the profit opportunity provided by supplier (in this case, the anesthesia provider) was actually a form of remuneration paid in exchange for continued business from its referral source (in this case, a physician group practice or ASC). Applied specifically to the company model, the concern is that anesthesia providers are signing over all or a portion of their professional fees and/or accepting smaller flat salaries in order to secure the steady business provided by the facility. As such, there is a risk that the OIG may find that the facility is receiving anesthesia services at below-market rates in exchange for providing access to its federal or state health care program business in violation of the AKS.

Other types of compensation arrangements drawing attention under the AKS are those where anesthesia providers lease and/or purchase space, equipment, supplies, or services from the physician group practice or ASC. Often, these payments are at above-market rates or are for items or services that are already provided for as part of the practice's facility fees. Examples of these practices include requiring anesthesia providers to pay full-time rates when their employees work part-time, or forcing them to pay for the costs of pharmaceuticals or to rent space when those costs should be covered by the physician group practice or ASC. These characteristics raise serious red-flags and may also be considered illegal kickbacks provided in exchange for federal or state health care program business.

Self-Referral Statutes

Business models between anesthesia providers and physician group practices or ASCs may also violate state self-referral statutes. As a general matter, these statutes prohibit referrals when the referring health care practitioners stand to benefit financially from the referral.

For example, the declaratory judgment referenced above bases its claims on the Maryland Self Referral Statute which states that "referrals are generally prohibited if the physician refers the patient to a health care entity in which the physician has a beneficial interest or compensation arrangement with the health care entity.[6] The Maryland Association of Nurse Anesthetists argues that under their business model, the physician group practice is both referring the patient to an ASC and to a CRNA for anesthesia health care services. In addition, the physician group practice and the CRNA have a compensation arrangement in which the physician group practice is receiving remuneration from the CRNA for each patient treated via the assignment of their billing rights. They claim this constitutes an illegal referral relationship under Maryland law.

While the outcome of the Maryland matter will ultimately depend on how the Maryland Department and perhaps later, the courts rule on the application of a number of definition and exception questions, it is clear that compensation models between physician group practices and anesthesia providers pose risk under self-referral statutes and as such, arrangements should be structured around the specific state requirements.

Fee-Splitting Laws

State fee-splitting laws may also be implicated by certain types of compensation arrangements between physician group practices or ASCs and anesthesia providers. Designed primarily to prevent the offering of kickbacks for referrals, fee-splitting statutes are increasingly being used to challenge the legitimacy of these business models. For example, in a recent decision, the Tennessee Court of Appeals voided an agreement between a hospital and an anesthesia group because it violated the state's fee-splitting prohibition.[7] In that case, the court found that the assignment of the anesthesia group's collections (less a 20% administrative fee for collection expenses) in return for a fixed monthly payment from the hospital was unenforceable because it constituted illegal fee-splitting.

The petitioners in the Maryland declaratory ruling request also allege fee-splitting violations. Under the Maryland Fee Splitting statute, a physician may be disciplined if the physician "[p]ays or agrees to pay any sum to any person for bringing or referring a patient or accepts or agrees to accept any sum from any person for bringing or referring a patient."[9] Unlike a direct employment model where the two parties (ideally) negotiate a salary in exchange for the anesthesia provider's services and professional fees, the concern with the Maryland model and the company model is that physician group practice is using its leverage to extract the billing rights of the anesthesia group members (as independent contractors) in exchange for a smaller flat-fee and access to the referral stream of the physician group practice. Opponents of such models claim that this practice, in effect, constitutes an illegal splitting of physician fees.[8]

The fee-splitting arguments are particularly significant because unlike most anti-kickback or self-referral laws, they generally cover all patients and thus have the potential to implicate models that do not involve federal or state health care program business.

Conclusion

As physician group practices and ASC owners continue to adopt new models that allow their businesses to profit from anesthesia services, serious questions remain regarding whether these models comply with the requirements of state and federal laws. While proponents argue that these compensation arrangements are legal ways to secure consistent, high-level anesthesia services, others have argued that these compensation arrangements constitute improper and illegal kickbacks in violation of anti-kickback and self-referral laws and violate certain state fee-splitting laws. Opponents further argue that the growth of these business models will lead to the overutilization of anesthesia services and the corruption of professional judgment now that physician-owners stand to profit from the administration of more and/or higher levels of anesthesia services than may be medically necessary. In light of these competing considerations and the undeniable popularity of risky compensation arrangements like the company model, the decision rendered in Maryland will have a significant impact on the manner in which ASCs and physician group practices structure their compensation models with anesthesia providers. ■

References

1. CRNAs have independent billing rights and work in collaboration with a physician to provide anesthesia services.
2. The identify of the group practices and the CRNAs have been withheld because the CRNAs involved are concerned about retribution from the physician group practices in question.
3. OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858 (Jan. 31, 2005).
4. OIG Advisory Opinion No. 03-13, June 16, 2003.
5. Id.
6. Md. Code Ann. Health Occ. Sec. 1-302(a).
7. *Cookesville Reg'l Med. Ctr. Auth. V. Cardiac Anesthesia Servs. PLLC,* No.2007-02561-COA-R3-CV (Tenn. App. Ct. Nov. 24, 2009).
8. For the complete reading of the statute, see Tenn. Code Ann. § 63-6-225.
9. Md. Code Ann. Health Occ. § 14-404(a)(15)

5 Observations on Anesthesia in ASCs From Syed Ishaq of Somnia Anesthesia

By Leigh Page

Syed Ishaq, vice president for business development at Somnia Anesthesia Services in New Rochelle, N.Y., offers five observations on anesthesia in ASCs.

1. Why anesthesiologists are in shortage. The number of new anesthesiologists has not grown. At the same time, due to advances in anaesthesiology and technology, more and more procedures requiring anesthesia are moving out of hospitals and into surgery centers and physicians' offices. This is impacting supply and demand—demand for procedures isn't going down at hospitals and other facilities, while the existing supply of anesthesiologists now has to be spread across more sites.

2. For certain clinicians, working at an ASC is preferable to working at a hospital. Where clinicians prefer to work depends on their personal priorities. If they want more regular, corporate-type hours (no call or weekends), they probably want to work for an ASC. However, if they also want to meet a certain salary level, then they need to be sure the facility has the case volume to fill the days, a situation that which can make recruiting for ASCs more difficult. Although working at a hospital means longer hours (call and weekends) it also offers a wider variety of complex cases for clinicians who are interested in honing certain skill sets.

3. Case guarantees becoming more common. This situation really points to anesthesia providers being able to meet their salary needs which in turn ties to volume. It also relates to the surgeons in that some may prefer to work only in the mornings, leaving afternoons free and no cases for the anesthesia provider. It's a balancing act. So in order for it to be attractive to the anesthesia provider, the ASC may be asked to guarantee a certain number of cases that will ensure the provider meets his/her salary target.

4. Working with large anesthesia groups can get complicated. Typically, large groups are at hospitals and also will contract with nearby ASCs. That can spread providers thinly. For example, when people from the group are on vacation or in emergency surgery, they are unavailable to be scheduled at the ASC. At the same time, surgeons at the ASC may be used to seeing certain faces from the group who are not available so the anesthesia providers need to fill in with someone new, who may not be familiar with the ASC's facility and staff. On occasion, this has the potential to affect the ASC's efficiency and, possibly, its quality.

5. Small groups also pose challenges. A group of two or three anesthesiologists dedicated to a single facility can present coverage issues. For instance, it may be difficult to find a fill-in when one of them goes on vacation and this may cause disruption. Also, small groups are typically unable to provide a quality assurance program, because they lack the infrastructure to support one, which is ever more important as reimbursements become outcome-based. ■

Learn more about Somnia Anesthesia Services at www.somniaanesthesiaservices.com.

4 Ways ASCs Can Improve Relationships Between Surgeons and Anesthesiologists

By Leigh Page

Compared with hospitals, relationships between anesthesiologists and surgeons at ASCs are excellent, but there is also an elevated level of expectation at ASCs, says Thomas Wherry, MD, medical director of Health Inventures and principal for Total Anesthesia Solutions, a company dedicated to finding strategic solutions for issues relating to anesthesia care.

"The surgeon expects a low same-day cancellation rate in an ASC," he says. "Additionally, unlike the hospital, they expect the ASC to be a well-oiled machine. The cases should start on time, turnaround should be efficient and the patient should recover easily from the anesthesia." The anesthesiologist also expects the patients to be well-prepared, relatively healthy and to have the required medications and equipment to safely provide care.

Here are four ways Dr. Wherry suggests surgeons and ASCs can improve relations with anesthesiologists.

1. Approve appropriate patients for surgery. Surgeons should not decide to operate on patients inappropriate for anesthesia in an ASC, such as extremely obese patients with severe obstructive sleep apnea. "Anesthesiologists will feel resentful if surgeons are pushing them to do cases they don't feel comfortable with." There needs to be an agreed-upon methodology on choosing and screening patients.

2. Get to the OR on time. Anesthesiologists must arrive early to get the patient ready for the case, but they may end up waiting for a late surgeon. "This is a big problem with certain ASCs and is a big dissatisfier for the patient, nurses and anesthesia," Dr. Wherry says. ASCs must be more proactive in dealing with the chronically late surgeon.

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," Dr. Wherry says. 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. Consult on decisions. Consult with anesthesiologists on important decisions such as opening an additional operating room or introducing a new service line. "It's a mistake not to include the anesthesiologists because you're counting on them to make the new plans a success," Dr. Wherry says. He also suggests inviting anesthesiologists to medical executive or board meetings. By including them in the process, you will more likely to get their buy-in. An anesthesiologist who is included will be more engaged and be more likely to go the extra mile for the ASC. ■

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

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Impact of the Propofol Shortage on Anesthesiologists: Q&A With ASA President Alexander Hannenberg

By Leigh Page

Alexander A. Hannenberg, MD, president of American Society of Anesthesiologists discusses the current propofol shortage and other challenges facing anesthesiologists.

Q: Has the propofol shortage affected the way you and other anesthesiologists practice?

Dr. Alexander Hannenberg: Over the past several months, we've occasionally needed to find alternatives to propofol infusion for long procedures in order to protect our limited supply. This has only occasionally been necessary. The propofol shortage is made considerably more challenging by the simultaneous shortages of other anesthesia induction agents such as thiopental, etomidate or ketamine and we are still monitoring the impact of the recent announcement from Teva that they will no longer be producing propofol.

Q: How have you and other anesthesiologists been able to continue to provide propofol to patients given the restricted supply?

AH: We've relied on the supply of imported propofol that was made available on ASA's request to the Food and Drug Administration. However, individual situations vary from facility to facility and the shortage may be more acute for some.

The steps needed to produce a reliable supply of propofol and other important drugs are complex and will require cooperation of the specialty, federal agencies and manufacturers. This will not be easy but as the demands on anesthesia providers increase, we cannot be compromised by sudden disruptions in the availability of key pharmaceuticals. ASA is poised to be a leader in this effort.

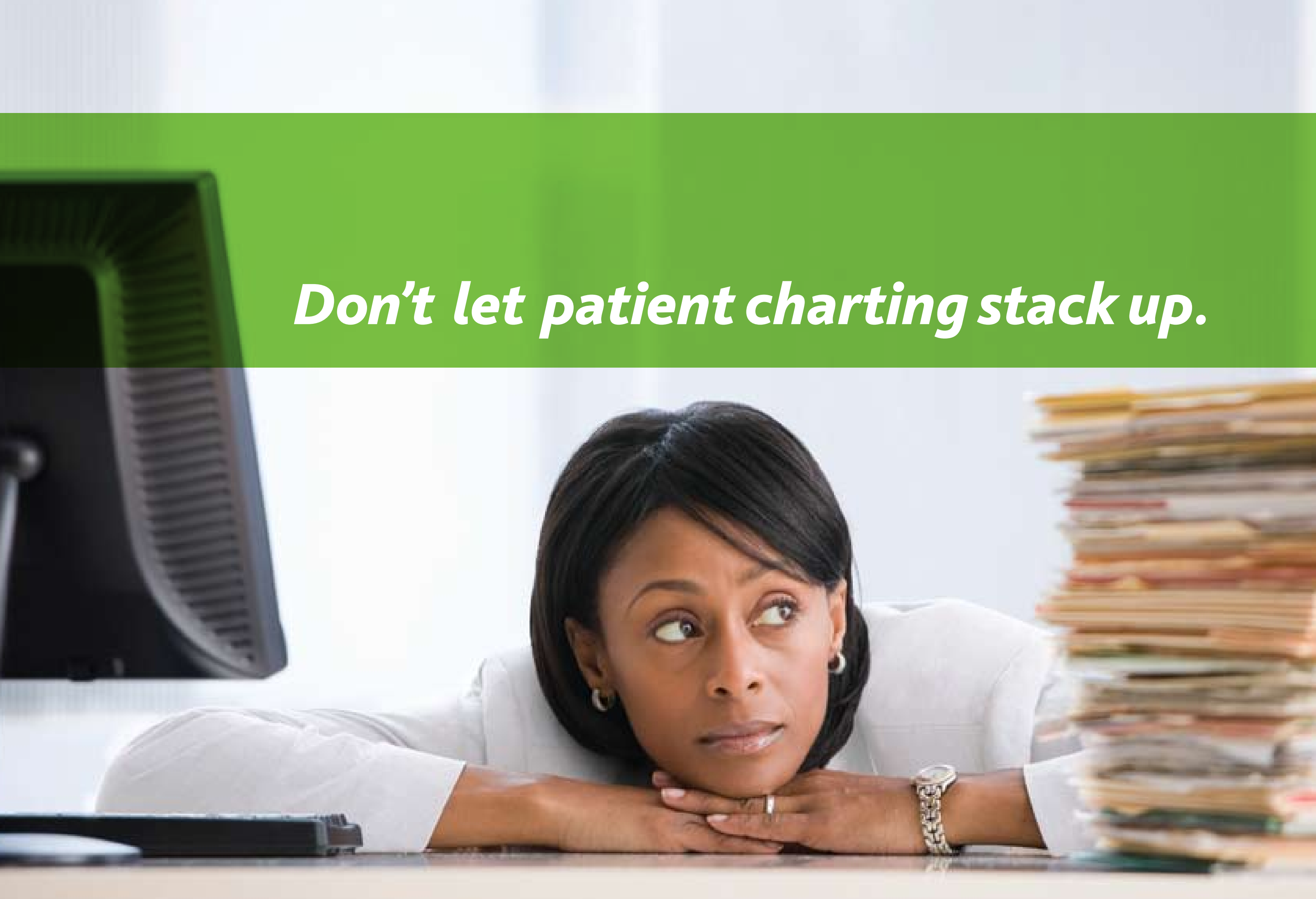
Q: While the propofol shortage is a current major challenge for the specialty, what other challenges are impacting how you practice?

AH: We need to raise the profile of perioperative electronic health records and achieve support for deployment of such systems. We need to ensure that we develop a new generation of anesthesiology researchers and maintain the phenomenal pace of discovery and practice improvement that I've seen over my career. Like other specialties, it's critical that anesthesiologists are thoroughly engaged in the implementation of healthcare reform so that it can be made to strengthen the practice of our specialty and improve the care we deliver to our patients.

Q: What are the biggest opportunities you see for the specialty at this time?

AH: We believe that the specialty's investment in clinical data collection through the Anesthesia Quality Institute has enormous potential to define best practices and provide performance benchmarking data to anesthesiologists for personal practice improvement. The clinical database will fuel a great variety of clinical outcomes research. ■

Learn more about the ASA by visiting www.asahq.org.



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8 Ways GI Centers Can Prosper in the Next Five Years

By Leigh Page

Falling reimbursements and the specter of healthcare reform create an uncertain future for gastroenterology ASCs, says John Poisson, executive vice president & strategic partnerships officer at Physicians Endoscopy in Doylestown, Pa., which operates 20 GI centers across the country. Mr. Poison offers eight tips on how GI centers can prosper on the next five years.

1. Help physicians market new colonoscopy coverage. On Jan. 1, 2011, Medicare begins paying the full cost of screening colonoscopies rather than paying just 80 percent. This is a significant opportunity for ASCs providing this service. About half of the U.S. population has not been screened. ASCs should start helping affiliated physicians plan significant marketing activities to promote screenings in the first quarter of 2011.

2. Joint venture with a strong hospital. Having close bonds with a strong hospital will be essential when accountable care organizations are launched. As the ACO looks for savings, it will turn to member surgery centers as the low-cost alternative to the hospital OR. Also, physicians in the ACO will be a ready-made referral network for ASCs. A surgery center within the ACO would have a leg up on outside centers, which would require carve-out payments.

3. Now is a good time to find more physician partners. Gastroenterologists who have not become partners in ASCs represent a substantial opportunity to increase ASC volume. As their reimbursements continue to decline, these physicians' incentive to share in the ASC facility fee becomes all the more important. This is a good time to reach out to these potential partners and make the case for investing in your ASC.

4. Work more closely with physicians' offices. Closer cooperation with affiliated physicians' offices can boost ASC volume. Front office staff at the ASC should be in daily communication with the front office of each practice of participating physicians. The ASC should track appointment schedules three or four days in advance, so that it can verify insurance and make other preparations for the patient. If there are no-shows at the ASC, the ASC schedule can be moved up and the practice can direct patients to come in earlier.

5. Make staffing as flexible as possible. Since staffing is the ASC's largest single expense item, it is important to have exactly the right staffing size. So in addition to core full-time staff and permanent part-time staff, assemble per-diem staff who can be bought in when volume is unexpectedly high. Per diems should be recruited into separate pools, such as nurses and surgical technicians, and need upfront training in specific policies and procedures of the ASC.

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6. Have quality metrics in place for new payment systems. In the long run, CMS is likely to move from a fee-for-service system to performance-based reimbursements. To prepare for this, ASCs should implement relevant quality metrics now.

7. Make sure staff is patient-friendly. Patients' perceptions of the ASC are expected to become more important, and 80 percent of ASC patients' comments on surveys are about staff. Staff members have to have the right attitude or they should be replaced.

8. Continue to focus on the business fundamentals. Make sure your ASC is operating efficiently and is collecting on claims, because reimbursements are expected to decline. As more people are covered under Medicaid and Medicare, the average payment per patient is likely to fall because CMS tends to have a zero-based approach – as volume rises, it won't allow overall spending to go up. ■

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

5 Statistics About Gastroenterologist Compensation by Years of Experience

By Rachel Fields

Here are five statistics on gastroenterologist compensation based on years of experience in the specialty from 2009 data, according to the MGMA *Physician Compensation and Production Survey: 2010 Report.*

1. The median compensation for gastroenterologists was $465,509 in 2009.

2. The median compensation for gastroenterologists with 1 to 2 years in the specialty was $319,092.

3. The median compensation for gastroenterologists with 3 to 7 years in the specialty was $455,662.

4. The median compensation for gastroenterologists with 8 to 17 years in the specialty was $500,250.

5. The median compensation for gastroenterologists with more than 17 years in the specialty was $447,477. ■

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4 Tips for Preventing Infection in Your ASC

By Rachel Fields

Susan Bakewell, RN, AORN's director of perioperative education, and Bonnie Denholm, RN, MS, CNOR, perioperative nursing specialist, are passionate advocates of infection control in surgery centers. AORN recently launched a four-module quality infection control program, which covers hand hygiene practices, sterilization, high-level disinfection, environmental infection prevention and safe practices for point-of-care devices.

Ms. Bakewell and Ms. Denholm discuss four techniques to promote infection control and lower infection rates in your surgery center.

1. Educate your whole staff, not just your physicians. Ms. Denholm says ASCs should include every staff member in infection control training. "Often the direct caregivers are knowledgeable, but other staff members need a refresher course," she says.

2. Monitor your staff's infection control practices. You won't know if your infection control training worked unless you witness your staff in action. Many ASCs choose to use a back office staff member as a "secret observer" to monitor the rest of the staff for their hand washing techniques and sterilization methods. "Observe your staff at different points in time," Ms. Bakewell says. "Having this observation makes people more alert, involves them in the process and gives them an investment in your success."

3. Use creative techniques to teach infection prevention. The AORN infection prevention course recognizes that staff members will learn information more easily if it's presented in a fun and memorable way. Ms. Denholm says ASCs can help staff members identify infection risks by posting a "what's wrong with this picture?" cartoon in the facility. If staff members can quickly identify safety risks in a picture of a surgery clinic, they'll be more likely to pick up on hazards in their own work environment. The AORN course involves games, periodic quizzes and links to outside sources to keep staff members and physicians engaged in the learning process.

4. Hammer home the financial benefits of infection control. ASC administrators, staff members and physicians shouldn't just take infection prevention seriously because of patient safety, Ms. Denholm says. There are also clear financial benefits to maintaining a safe facility. "If there's evidence that a patient contracted a facility-acquired infection, you're not going to get reimbursed," she says. She also points out that infections can hurt your center's reputation by creating a perception that you provide unsafe care. Your facility will benefit financially from infection prevention through full reimbursements and patient recommendations.

"We always say the cost of prevention is less than the cost of one infection," says Ms. Bakewell. "And everybody wants to be known for providing quality, safe patient care." ■

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Meeting AAAHC Standards for Reprocessing Single-Use Devices and Equipment

By Rob Kurtz

Jack Egnatinsky, MD, medical director of the AAAHC and a retired anesthesiologist, discusses what ASCs must do to meet AAAHC standards if they reprocess single-use devices and equipment.

Dr. Jack Egnatinsky: With many ASCs looking to save money, more and more are reprocessing single-use devices and equipment. Although the most common items sent for reprocessing are arthroscopic shavers and laparoscopic probes and forceps, many organizations are reprocessing other devices and equipment such as saw blades, drill bits, endoscopic scissors and others.

AAAHC Standards 7-I,M (Infection Control) and 10-I,P (Surgical Services) state, "Reprocessing of single-use devices must comply with FDA guidelines, and the devices must have been cleared under the FDA 510(k) process. Policies must clearly dictate the cleaning and handling of these devices in-house before sending them out for reprocessing. A written log must be maintained on all reprocessed devices." The FDA website can be overwhelming, but the best website to search for products you are considering for reprocessing is here.

If you decide to reprocess in-house or through an affiliated hospital, you still must meet all requirements of the AAAHC standard and the FDA standards. If you send your products out to an FDA-recognized reprocessing company, you should clearly understand if you will be getting your own devices back after reprocessing. You should ask them how many times a device can be reprocessed and how they track this. If after cleaning and inspection they determine that a device can not be properly reprocessed, do they discard it or return it to you to discard? The latter process assures you that they have not diverted your equipment and/or devices to another customer.

Reprocessing of single use equipment can be cost efficient, but if not done correctly can lead to much greater costs in the long run for your patients and increase your liability. ■

Learn more about AAAHC at www.aaahc.org.

Air Change Requirements in Ambulatory Surgical Facility Operating Rooms

By William E. Lindeman, AIA, NCARB, WEL Designs

Where air quality standards are applied to surgery facilities, they are based on requirements of the applicable State Health Department — almost always in relation to licensed healthcare facilities. CMS itself does not reference any air quality standard for facilities that are only Medicare certified as ASCs. As a consequence, ASCs developed in States that do not mandate licensure prior to Medicare certification are not specifically subject to minimum air quality standards.

A majority of states that license ASCs use for their physical environment standard a document titled "GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES," written and maintained by the Facilities Guidelines Institute with assistance from the U.S. Department of Health and Human Services. And when you look at requirements for states that license ASCs without reference to the GUIDELINES, you find very similar if not identical standards to those contained in it.

The past many versions of the GUIDELINES (a new one has been released every three to five years), culminating with the 2006 edition, contained a minimum air change requirement in all ASC operating rooms of 15 room air changes per hour. The 2010 edition of the GUIDELINES increases that minimum value to 20 room air changes in Class B and Class C operating rooms (operating rooms where sedation/anesthesia greater than local or topical is administered). Procedure rooms (Class A operating rooms limited to local or topical anesthesia) continue to require 15 room air changes per hour. The updated standards apply to new facilities, additions to existing facilities, and modifications to existing ventilation systems.

The 2010 GUIDELINES ventilation standards are also known as "ANSI/ASHRAE/ASHE Standard 170-2008, Ventilation of Health Care Facilities." ■

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