On-Call Coverage: Should Hospitals Pay Orthopedic Physicians

By Mark Taylor

An obscure 1986 law continues to vex hospitals as they struggle to provide the on-call coverage for emergency rooms the law requires and elicit the support of physicians struggling with many of the same issues.

The Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the “Patient Anti-Dumping Law,” changed the way hospitals deliver emergency care and their relationships with physician staff.

11 Key Concepts From the Stark Law

By Scott Becker, JD, CPA, Ji Hye Kim, JD, and Jessica Smith, JD

The Stark law prohibits physicians from ordering designated health services for Medicare patients from entities with which the physician, or a family member, has a financial relationship unless an exception applies. This article reviews 11 key concepts under the Stark Law, in the context of changes to the Stark law made by CMS.

1. Agreements between providers and referral sources must be in writing

CMS has set forth numerous exceptions to the Stark law. These exceptions permit certain financial relationships between providers of DHS and physician referral sources, so long as certain conditions are met. These exceptions almost uniformly require that the agreement between a provider of DHS and the physician referral source be in writing. For example, the following exceptions to the
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FEATURES

5 Publisher’s Letter
By Scott Becker, JD, CPA

17 Average Annual Salary for Spine Surgeons by Region

18 Orthopedic, Spine and Pain Management-Driven ASC Conference

22 Secret to Spine Surgery Center Success: The “5 + 3 C’s”
By Jeff Leland

24 Orthopedic Surgery Salary Statistics by Region

25 Trends, Developments and Legal Issues in the Orthopedic and Spine Device Markets
By Scott Becker, JD, CPA, and Nancy A. Temple, JD, CPA

27 5 Challenges Currently Facing Orthopedic and Spine Practices
By Renée Tomcanin

28 Developing Centers of Excellence — Key Concepts, Strategies and Tactics
By Scott Becker, JD, CPA, and Lindsey Dunn

30 Resources

31 Centers of Excellence Achieved by Focus, Sweat and Determination
By Mark Taylor

33 Adding Outpatient Spine to Multi-Specialty ASCs
By Joseph Stapleton, MD
Consolidations Increasing - Buyouts Stagnant; 7 Key Legal Areas for 2009; ASC Communications and the ASC Association June Orthopedic, Spine and Pain Management Driven ASC Conference – June 11-13, Chicago, Westin Michigan Avenue – $200/$100 Discounts on Registrations Available

I. Two overall observations

1. Consolidation of providers and businesses. This year we are seeing more transactions where two providers or several providers are consolidating operations to provide for greater revenues over a single platform. This is as opposed to transactions where a seller is cashing out at a high multiple of EBITDA. The consolidation transactions are being done among ASCs, hospitals (e.g., two hospitals in Rhode Island just announced their merger), group practices and healthcare companies. We are also seeing hospitals increasingly acquiring and/or combining with ASCs and practices.

2. Seven key legal areas and issues for 2009. We see the following seven key legal areas of concern for hospitals, ASCs and practices in 2009.

(i) Data mining. We expect increased enforcement as the government uses government data and data mining more fully to pursue both billing fraud and anti-kickback cases. The cases are being driven by both whistleblowers and by the government’s own investigations. Here, the government is increasingly using data mining to drive enforcement and to detect patterns in billing that differ from norms. We are also seeing qui tam cases and private party complaints leading to more complete investigations.

(ii) Recovery Audit Contractors. There is substantial concern among hospitals that data entry errors and other errors will provide ammunition for RACs. The RAC program is set to recommence this March. There is a great deal of focus on items that can be picked up by the use of computers and data mining — heavy on data use as opposed to relationship-kickback type crime.

(iii) Stark Act concerns. Here, there is little wiggle room for technical violations, and a backlog of Stark cases at CMS. We are seeing more overall activity here than ever before. For a copy of a white paper on “11 Stark Issues,” see below.

(iv) Medicaid enforcement. False claims and similar efforts are being unveiled at state levels to fight fraud and to drive state false claims act recoveries. We have seen states (such as Illinois) take new approaches to kickback and false claim cases and unique positions on fee splitting and kickback cases.

(v) Quality of care. We see more cases being brought against providers by regulators based on substandard quality of care. We have one such investigation that is currently ongoing.

(vi) Anti-kickback cases. These are a variant of Stark Act cases but subject to a different standard of proof of intent and not just applicable to physicians.

(vii) Tax-exempt compensation and community benefits. The IRS recently completed a study that indicates that the average CEO compensation at the 500 hospitals it reviewed was $490,000. It also found compensation on average of $1.4 million at the top 20 hospitals. Finally, it found that approximately 10 percent of all hospitals provided nearly 60 percent of all community benefits as measured by the IRS.

II. White papers available — No charge

We have recently completed three white papers and articles that are available upon request. If you have an interest in obtaining a copy of any of the following, please contact me and we would be happy to provide you a copy of the same.

1. Developing Centers of Excellence — Strategies and Tactics. This is an article regarding developing centers of excellence. It focuses on both developing a strategic vision and the tactics to be used in developing specialty driven centers of excellence. This was drafted from a presentation we gave at a conference in February devoted to developing orthopedic-driven centers of excellence. The talk was well received. If you would like a copy of the paper, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

2. ASC – An Overview and Primer on Key Issues. This paper was drafted as part of a presentation for both the American Health Lawyers Association and for the February issue of Becker’s ASC Review. It discusses pricing of surgery centers as well as the key legal agreements and legal and business issues related to such transactions. Should you desire a copy of this paper or a copy of the February issue of Becker’s ASC Review, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com. Also, please feel free to visit www.BeckersASC.com.

3. 11 Key Concepts from the Stark Act. As we review different Stark issues for clients, we see more different and interesting issues than ever before. These relate to such items as lithotripsy, agreements that are not in writing, per-click arrangements, the impact of the “Stand in the Shoes” rules on hospital relationships with their subsidiaries and several other issues. Should you desire a copy of this paper, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

III. 7th Annual Orthopedic, Spine and Pain Management Driven ASC Conference

This June we are hosting our 7th Annual Orthopedic, Spine and Pain Management Driven ASC Conference. The conference is June 11-13. For this conference, we have 94 speakers, 68 sessions, 30 CEOs and 24 physician leaders speaking. We also have great topics and should have a great turnout. Here are just 27 of the topics covered at the conference:

1. The Evolution of Healthcare and the Impact on ASCs — Uwe Reinhardt, James Madison Professor of Political Economy and Professor of Economics at Princeton University

2. Orthopedics - The Forecast for the Next Five Years — John Cherf, MD, Dept. of Orthopedics, The Neurologic & Orthopedic Hospital of Chicago

3. Using Spine as the Backbone of a Multi-Specialty ASC — James Lynch, MD, Surgery Center of Reno

4. 7 Steps to Maximizing an Orthopedic-Driven ASC’s Returns in a Tough Economy — Brent Lambert, MD, CEO, Ambulatory Surgical Centers of America

5. Case Study – Two Years Later, A Physician-Owned Spine ASC: A Frank and Open Discussion of Financial Performance, Organizational Issues, Challenges and Problems — John Caruso, MD, Parkway Surgery Center, Hagerstown, Maryland

6. A Payor’s View of Orthopedics, Spine and Pain Management — Steven Stern, MD, VP Neurosurgery, Orthopedics and Spine, United Healthcare

7. A Case Study Review of Current Outcomes and Issues — Marcus Williamson, MD, and George Goodwin, SVP and Chief Development Officer, Symphony Healthcare

8. Making Big Cases Profitable in an ASC — Naya Kehayes, CEO, Eveia Healthcare; and Greg Cunniff, CFO, National Surgical Care

9. Using Orthopedics and Spine to Turn Around an ASC — Tom Mallon, CEO, and Jeff Simmons, President Western Division, Regent Surgical Health
10. Capturing Your Partners’ Cases: The Carrot and Stick Approach — Chris Bishop, VP, Ambulatory Surgical Centers of America

11. Key Legal Issues: Safe Harbor Compliance, Out of Network and Other Legal Issues — Scott Becker, JD, CPA, Partner, and Bart Walker, JD, McGuireWoods

12. How Economic Conditions Impact Health Care Strategies for Success — Tom Geier, Senior Advisor, Texas Pacific Group; and Joe Clark, Executive Vice President, Surgical Care Affiliates

13. Uni Knees and Shoulders in the Outpatient Setting: Cost, Staffing and Profitability Issues — Peter Kargavel, MD, and Margarita de Jesus, Administrator, Surgery Center of Long Beach

14. Key Issues Faced by ASCs Today — Thomas Yerden, CEO and Founder, TRY HealthCare Solutions

15. The Pros and Cons of Total Knees in a 23-Hour Setting: Financial and Safety Issues — Eric Monesmith, MD, OrthoIndy; and John Martin, CEO, OrthoIndy

16. Pain Management: 5 Keys to a Superior Pain Management Program Surgery Center — Lance Lehmann, MD, Medical Director, and Lilianna Rodriguez Lehmann, MBA, Hallandale Outpatient Surgical Center


19. Pain Management in ASCs - Current Methods to Increase Profits — Amy Mowles, President & CEO, Mowles Medical Practice Management

20. 5 Tips for Managing Anesthesia in Your ASC — Thomas Yerden, CEO and Founder, TRY HealthCare Solutions

21. How to Recruit Great Surgeons to Work at Your ASC — Robert Carrera, President, Pinnacle III

22. Turnarounds: 2 Case Studies; 5 Key Ideas for Success — Joe Zasa, President, Woodrum/ASD

23. What Does a National Company Want After a Deal? 10 Facts That Will Drive a Buyer Away — Bill Kennedy, SV/P Business Development, NovaMed; Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners; Richard Pence, President and COO, National Surgical Care; George Goodwin, SV/P and Chief Development Officer, Symphony

24. Is Your Center Too Dependent on a Single Specialty? How to Diversify and Make Change Happen — John Seitz, CEO, Ambulatory Surgical Group; Joe Zasa, President, Woodrum/ASD; and Larry Taylor, President and CEO, Practice Partners in Healthcare

25. 5 Core Concepts for Great ASC Joint Ventures With Hospital Partners — Mike Pankey, Administrator, Ambulatory Surgery Center of Spartanburg; and Caryl Serbin, CEO, Serbin Surgery Center Billing


27. 5 Core Strategies to Immediately Improve ASC and Hospital Operations — Doug Johnson, COO, RMC MedStone Capital

Should you have questions about the conference or desire to see a copy of the brochure, please contact me at sbecker@mcguirewoods.com or go to www.BeckersASC.com. In addition, should you desire to register for the conference, please feel free to deduct $100 from the registration price if registering for the main conference. Please deduct $200 if registering for the combined pre-conference and main conference. Please note on the registration, $100 (main conference only) or $200 (for main and pre-conference) discount per Scott Becker.

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Very truly yours,

Scott Becker
814 survey respondents reported problems with their hospitals getting on-call specialty coverage. Forty-six percent said they paid specialists for that coverage, a figure that has risen closer to 70 percent in 2009.

In the past decade the rate of emergency department utilization has rise 7 percent, from 36.9 to 39.6 visits per 100 persons. And nationally 73 percent of emergency departments reported inadequate on-call coverage by specialist physicians, according to a survey published in the Feb. 2008 issue of the New England Journal of Medicine's “NEJM CareerCenter Recruiting Physicians Today Newsletter.”

Because of improved technology, treatments and drugs, many procedures formerly performed exclusively in hospitals have migrated to outpatient settings. Specialists like orthopedic surgeons and spine specialists are among a growing number of specialists demanding to be paid for on-call duty, or refusing it. Many hospitals have acquiesced to the pressure, feeling they have no other choice.

One Southern California system paid $17 million for on-call coverage in four emergency rooms. An Orange County hospital pays $4,000 per shift to neurosurgeons, while a Florida hospital pays $6,000.

Susan Reynolds, MD, president and CEO of the Los Angeles-based Medical Leadership Institute, says on-call coverage drives hospital medical staff chiefs crazy as well. Dr. Reynolds says the most exorbitant fees are found in California, Florida and Texas.

“Our view is many of those on-call fees exceed fair market value,” she says. “The squeaky wheel gets the grease and hospitals are in bidding wars with the hospitals down the street that want your orthopedists and raises the ante. We encourage doctors and hospitals to put data together and crunch numbers before they pay physicians for call duty.”

### Hospitals seeking creative approaches

Pittsburgh healthcare attorney Dan Mulholland of the firm Horty, Springer & Mattern says that the rising level of payment for something hospitals never previously paid for is unsustainable. “Some hospitals are in bad financial shape and can't afford to pay for call coverage,” Mr. Mulholland says. “Nonetheless they still face EMTALA obligations.”

He says nationally hospitals and physicians are collaborating on programs that recognize the limited resources of hospitals as well as the contributions and personal and financial sacrifices of on-call physicians.

One example might be the work of Max Hockenberry, senior partner and co-founder of the Charlotte, N.C.-based MaxWorth Consulting, who has employed an innovative strategy to bring doctors and hospitals together to resolve on-call payment issues. MaxWorth's program, Call Pay Solution, is a deferred compensation plan funded by a financial insurance tool common in banking and other industries, but only recently been applied to on-call coverage. Called a hospital-owned life insurance (HOLI), the hospital purchases life insurance policies on its medical staff as a means to fund on-call coverage.

“Mortality in a group setting is very predictable and quantifiable,” he says. “You know what the numbers will look like. The hospital places insurance on the physicians in the plan and as those people pass away, there is a cost recovery to the hospital. This not only provides long-term stability, but helps the hospital pay for call coverage into the future. We see that as a win-win.”

### Why do doctors choose deferred compensation instead of cash?

“Taxes are as much a problem for them as anyone else,” Mr. Hockenberry says. “They're look-
ing for ways of reducing their personal income tax liability by leveraging the tax exempt status of hospitals. Higher compensation specialists like orthopedic surgeons will gravitate to this model quickly.”

He says hospitals with employed deferred compensation programs to fund call coverage also have used the program in other ways, such as leveraging physician participation in quality programs and as disincentives against staff physicians investing in competing facilities. “A hospital can’t control where physicians refer patients, but can incentivize them not to invest in facilities that compete against the hospital,” he says.

Hospitals also have employed the program to fund medical directorships in an era when it’s increasingly difficult to attract doctors to serve on committees. He says the program encourages older physicians to remain on the call schedule even after they have left or are no longer required to take such duty. Around two dozen hospitals have adopted the programs since MaxWorth began offering them in 2006, including many that had not paid for call coverage before.

Al Pilong, president of 411-bed Winchester (Va.) Medical Center and senior vice president of five-hospital Valley Health, says Winchester committed to funding its call coverage program with 10 percent of its operating margins, with a bottom of $2.5 million and a $4.5 million ceiling. Mr. Pilong says its Attending Faculty Program is operated by a call committee run by physicians and an advisory board of system board members and physicians. He says staff physicians were ranked into five tiers based on the frequency and acuity of their call burden. Based on those tiers, they are accorded a fee for each call shift they perform and that money goes into a deferred compensation fund that Winchester doctors can access after a five-year vesting.

“We want to reward physicians who are committed to us over the long haul,” he says. “When you hit 60, you can be paid out. If you leave before you’re vested, then the money stays with the hospital and reduces the hospital’s expense.”

Mr. Pilong says when he arrived in 2005, there was tremendous pressure on the administration to pay physicians for call duty. “Doctors weren’t willing to do traditional call duty for privileges anymore and rather than just writing a check, the hospital sought a more lasting solution,” he says. “The program works well for the most part and satisfies our (350-physician) staff.”

Mr. Pilong says many of the physicians view the on-call plan as a means for funding their retirement or paying for their children’s education.

He says call duty is not as big of a problem as it was, but remains an ongoing issue.

“It’s a necessary evil in the minds of our medical staff to come out in the middle of the night, but this has definitely softened the physicians’ pain and burden and they know there’s money going into a fund that allows us to do it in a responsible way and gives us some retention and commitment to our ER and community,” says Mr. Pilong.

Attorney Mr. Mulholland, who worked with Winchester, says the on-call compensation program has enjoyed almost universal acceptance from physicians and hospitals.

“Several thousand doctors now have these contracts around the country,” he says, noting that many physicians have found the deferred compensation for call duty a better deal than retirement.

For better or worse, California sets the trend

Los Angeles attorney Mr. Brown says in California the trend has escalated to pay physicians, especially specialists.

“Ortho and spine are critical areas of specialty that they’re paying for,” says Mr. Brown, who specializes in EMTALA law. “There are all kinds of ways to pay. One is to make the doctor whole by covering him for treating patients who are uninsured, typically paying at a Medicare rate plus a percentage over that. The other is to pay some kind of stipend to be available on call, whether or not the doctor actually comes in.”

Mr. Brown says stipends range from $500 per shift to several thousand dollars for hard-to-get specialties.

James Lott, executive vice president of the 170-member Hospital Association of Southern California, said hospital emergency department on-call systems were on the brink of disaster just three years ago, noting then that paying physicians for on-call coverage was becoming the norm. Mr. Lott says Southern California’s uninsured population leveled off in 2007 but grew again last year to 6.5 million, or one in every four patients presenting to emergency rooms.

“If anything, it’s gotten worse since then,” observes Mr. Lott, who says in many states hospitals resolve some of their on-call coverage obligations by employing physicians, such as hospitalists or traumatologists, to relieve some of their on-call burden. But California is one of seven states that ban the employment of physicians by hospitals, except for public hospitals and HMO hospitals like Kaiser.

Mr. Lott says Southern California hospitals pay as little as $250 per shift, but noted the one Orange County hospital paying $4,000 per shift to compensate neurosurgeons. “It’s more commonly $750-$1,000 per shift, plus a guarantee to cover uninsured patients with Medicare plus between 20-50 percent,” he says.

Richard Sheridan, general counsel and senior vice president for San Diego-based Scripps Health, which operates four emergency rooms, says physicians now expect to be paid and hospitals have little choice but to comply.
“If we ask them to serve [call] as a condition for privileges, then they say goodbye,” Mr. Sheridan says. “Some of the toughest specialists to find for on-call don’t do much in hospitals anymore, such as ENTs. But just having them is incredibly important to us for our patients. They don’t need us, we need them. We have an obligation under EMTALA to serve all patients, but physicians have no similar obligation and that has driven this market.

“We started by paying needed certain specialists like neurologists and OB/GYNs for each shift,” he says. “That worked for awhile. But we got ourselves into a lot of trouble because we were paying disparately and whenever anyone learned about the differences, they wanted more and we felt trapped.”

He says Scripps contracted with a third-party medical group established for this purpose and engaged on-call physicians to be paid a service rate (based on a percentage of Medicare) for on-call shifts. “They collect the money and we subsidize the difference,” he says. “We felt good that we weren’t just paying for people to be sitting on-call, but paying for people actually providing services.”

That system-wide payment arrangement, however, has eroded and required replacement.

He says an innovative group of physicians at 180-bed Scripps Memorial Hospital in Encinitas, Calif., agreed to provide on-call duty for the amount the hospital spent last year on on-call duty — and also agreed to drive up quality scores. They set up a two-year agreement to form a special purpose independent practice association set up to only take ER calls.

“Now we’ve offloaded the problem and they’ve agreed to indemnify us if they cause an EMTALA problem or med malpractice incident,” says Mr. Sheridan. “They’ll make a nice margin on this, which seems like a good business model. This is the first of its kind in Southern California, but I’ll bet exclusive call arrangements will become the norm.”

**Orthopedists struggle for solutions**

Adam Bright, MD, an orthopedic surgeon from Sarasota, Fla., remembers the on-call, two-hospital coverage crisis of 2004 in his Gulf Coast city. Dr. Bright says the city’s largest hospital, not-for-profit Sarasota Memorial Hospital, announced plans to double the size of its emergency room. At the time the hospital’s ER already was overflowing with growing numbers of uninsured and 10 orthopedic surgeons were rotating for ER call duty. The other Sarasota facility, Doctors Hospital, which is owned by for-profit HCA, treated fewer uninsured.

Sarasota Memorial’s call policy mandated younger physicians assume call duty, noting that some of the older practicing doctors had not shared the obligation for 20 years. A Young Turks rebellion was in the making.

“It got to the point where we were losing money taking call duty,” Dr. Bright says. “You could go bankrupt treating too many uninsured patients. At the same time we were feeling higher real estate prices and leases, greater documentation requirements and higher medical malpractice insurance.”

He says the call duty required doctors to get up in the middle of the night, sometimes treating patients all night so that the next day they’d have to cancel appointments for their paying patients. “And we did this without pay,” he says. “The disruption to our office practices convinced many doctors to no longer take call. It wasn’t a matter of not enjoying doing it. We could no longer afford to do it.”

Dr. Bright and some of the other young orthopedic surgeons approached the hospital with a proposal: consider contracting with the groups to provide call for ER. Sarasota Memorial began to pay them.

He says Sarasota Memorial pays specialists around $1,000 per night because its uninsured patient load is greater than nearby Doctors Hospital, which pays around $400 per shift.

“Before we took call without pay and took a bath,” he says. “The hospital recognized that and decided to pay a stipend for us to be available and care for the uninsured that night. We were able to work it out. We still don’t have a solution for every problem.”

Orthopedic surgeons are often caught in the middle of the call issue and pay a price. That’s why Joseph Zuckerman, MD, president of the American Academy of Orthopedic Surgeons, says the academy is meeting with the American Hospital Association to find solutions to the on-call coverage problem.

“We want to do things to make this better and need to involve all the stakeholders, not just nationally but locally,” says Dr. Zuckerman, a professor at the New York University School of Medicine and on staff at the New York University Hospital Joint Diseases. “If a hospital has trouble with ER coverage, it must involve the physicians. In many parts of the country hospitals and orthopedic surgeons have worked out systems to provide coverage without disrupting physician practices. You may see a stalemate in one community,” he says. “But five miles away they’ve worked it out. Institutions have become more creative.”

Howard Salmon of the Salt Lake City-based Phase 2 Consulting, says the environment is unlikely to improve unless several things happen nationally. Mr. Salmon says the HHS’ Inspector General needs to investigate and address the legality of skyrocketing on-call fees some specialists are demanding far above fair market value and say they will not tolerate them.

“And hospitals must also find legal ways to counteract the growing market power of some specialists who are exploiting their market advantage,” Mr. Salmon says. “Resolving the high numbers of uninsured patients will go a long way to fixing this. Physicians have to deal with a lot of uncompensated care and that’s driving this as well.”

Mr. Salmon says in a recent seminar with the CEOs of 10 for-profit hospitals, all part of the same chain, that the regional head of that chain told him that on-call coverage for emergency departments is the fastest growing expense line item.

*Contact Mark Taylor at mark@beckersasc.com.*
11 Key Concepts from the Stark Law
(continued from page 1)

Stark law require a written, signed agreement: office space and equipment rental, personal service arrangements, physician recruitment arrangements, group practice arrangements and fair market value compensation arrangements. 42 C.F.R. 411.357.

CMS has indicated that the purpose of requiring a written agreement is “so that [the agreement] can be objectively verified, and meets the terms and conditions of [the exception].” 66 F.R. 949 (Jan. 4, 2001). The inadvertent error of not placing an excepted financial relationship in writing generally means that the arrangement will not meet an exception, even if all other requirements of the given exception were satisfied.

The excepted financial relationship that need not be in writing is for bona fide employment relationships. 42 C.F.R. 411.357(c).

2. Per-click leasing arrangements

As of Oct. 1, physician referral sources and providers of DHS will no longer be permitted to have per-click relationships for office space and equipment leases. Four exceptions currently permit these types of arrangements: the office space exception, the equipment lease exception, the fair market value exception and the indirect compensation arrangement exception. 411 C.F.R. 411.357(a), (b), (l), and (p).

The 2009 Hospital Inpatient Prospective Payment System final rule modified these exceptions to explicitly exclude per-click arrangements for lease of equipment or real estate. 73 F.R. 48343 (Aug. 19, 2008). CMS limited per-click leasing arrangements in large part due to its concern that per-click office space or equipment lease arrangements will go into effect on Oct. 1, 2009. Any existing per-click office space or equipment lease arrangement that relies on one of these exceptions will need to be restructured prior to the Oct. 1, 2009, compliance deadline.

3. Percentage-based arrangements

The revisions to Stark law made by the IPPS do not extend to percentage-based compensation formulae outside of the office space and equipment lease context. Thus, “if a compensation formula for physician compensation for items or services — other than the rental of office space or equipment — was permissible prior to Oct. 1, 2009 … that formula would not be made impermissible by this final rule.” 73 F.R. 48712 (Aug. 19, 2008).

For example, percentage-based management and billing service relationships are still permissible so long as they satisfy certain criteria set forth in the Stark law and anti-kickback statute. CMS has indicated, however, that the prohibition on percentage-based compensation arrangements may be extended outside of the office space and equipment lease context: “although we are not extending, at this time, the prohibition on the use of percentage-based compensation formulae to arrangements for any non-professional service (such as management or billing services), we reiterate our intention to continue to monitor arrangements for nonprofessional services that are based on a percentage of revenue raised, earned, billed, collected or otherwise attributable to a physician’s (or physician organization’s) professional services.” 73 F.R. 48710 (Aug. 19, 2008).

4. Lithotripsy arrangements

As mentioned, the Stark law prohibits physicians from ordering DHS for Medicare patients from entities with which the physician has a financial relationship. Lithotripsy services are not considered DHS. Am. Lithotripsy Soc. v. Thompson, 215 F. Supp. 2d 23 (D.D.C. 2002). The IPPS commentary confirms this analysis, suggesting that lithotripsy services are not DHS regardless of whether the services are billed by the provider or a hospital. 73 F.R. 48730 (Aug. 19, 2008). As a result, the upcoming prohibition on per-click leasing arrangements will not apply to lithotripsy lease arrangements or under-arrangement agreements. CMS draws a very significant distinction between leases of equipment which can generally no longer be per-click and services agreements which include some equipment therein, and can be per-click or per-service. In the case of lithotripsy, the distinction is critical to whether urologists can make other DHS referrals to the hospital.

A urologist who leases a lithotripter to a hospital through a leasing agreement on a per-click basis cannot make other referrals to that hospital (i.e., other referrals outside of lithotripsy). Per-click leasing agreements, in short, will not meet an exception and thus the urologist cannot make other referrals. A per-click lithotripsy agreement, in contrast, that provides overall lithotripsy services (not just equipment) may be structured to fit into the fair market value exception. Thus, the urologist would be able to arguably make other referrals to the hospital.

In the case of a local urologist providing lithotripsy services to a hospital at which he or she generally practices, the key question will come down is the agreement a lease of equipment or a service agreement.

Two key comments from CMS as to this issue are as follows:

• Currently, lithotripsy is not considered a designated health service for purpose of the physician self-referral law. Therefore, if the physician owners of the lithotripsy partnership make referrals to the hospital for lithotripsy services ONLY, the physician self-referral law would not be implicated, and a per-unit or percentage-based compensation formula for the compensation arrangement between the lithotripsy partnership and the hospital would be prohibited, even if the compensation arrangement is considered to be a lease of equipment (and other items or personnel).

• If the physician owners of the lithotripsy partnership refer Medicare patients to the contracting hospital for any DHS, the compensation arrangement between the lithotripsy partnership and the hospital must comply with an applicable exception to the physician self-referral law. Where a compensation arrangement between the hospital and the physician-owned lithotripsy partnership is considered to be a lease of equipment, a per-unit or percentage-based compensation formula would fail to satisfy the requirements of any of the potentially applicable exceptions for the lease of equipment found in §411.357(b), §411.357(l) or §411.357(g).

5. Professional courtesy

CMS recognized the longstanding tradition of extending professional courtesy to physicians and their family members in 2004 by promulgating an exception to the Stark law for professional courtesy arrangements. 69 F.R. 16116 (March 26, 2004). The professional courtesy exception covers free or discount services provided to a physician or his or her immediate family members, so long as certain conditions are satisfied. 42 C.F.R. 411.351.

Specifically, the arrangement must be: (i) extended to all physicians on the medical staff or in the community; (ii) for items and services typically
provided by the entity; (iv) set forth in writing and approved by the provider’s governing body; (v) unavailable to any physician or family member who is a federal health care program beneficiary; and (vi) does not violate the anti-kickback statute or any billing or claims submission laws. 42 C.F.R. 411.357(e).

6. Retention payments
A hospital, federally qualified health center or rural health clinic may make retention payments to physicians in order to induce them to stay in its geographic service area. Retention payments may be made when a physician has a bona fide offer or presents a written certification that he or she has a recruitment opportunity that would require the physician to relocate at least 25 miles outside of the entity’s geographic service area. 42 C.F.R. 411.357(f).

The Stark law recently added more flexibility to the retention payments exception by widening the “geographic service area.” 72 F.R. 51065 (Sept. 5, 2007). The entity’s “geographic service area” not only encompasses a Health Professional Shortage Area but also rural areas and an area with a demonstrated need for the physician, as determined by the Secretary of the Department of Health and Human Services. In addition, the geographic service area may include an area where at least 75 percent of the physician’s patients reside in a medically underserved area or are members of a medically underserved population.

7. Mission support payments
Many DHS entities make mission support payments to their affiliates in order to fulfill their missions of medical research, education and healthcare services to the community.

The Stark law provides a safe harbor for those DHS entities that meet the Academic Medical Centers exception. 42 C.F.R. 411.355(c). The AMC exception is extensive as it is complicated. Each element of the exception must be satisfied when an academic medical center makes mission support payments to a faculty practice or other affiliates. The indirect compensation exception may also be available in those cases where the support arrangement constitutes an indirect compensation as defined by the Stark law. Like the AMC exception, the indirect compensation exception entails a number of elements; each element of the indirect compensation definition and the exception must be satisfied. 42 C.F.R. 411.354(c)(2) and 411.357(p). An indirect compensation relationship may exist when at least one person or entity is interposed between the DHS entity and the referring physician. If the affiliate that is receiving the mission support payment is a physician organization and its physician employee has an ownership or investment interest in the organization, the physician-owner is deemed to stand in the shoes of the organization. As a result, arrangements that were previously treated as indirect would now be direct, and one of the direct compensation exceptions must be satisfied. 42 C.F.R. 411.354(c)(1)(ii).

A DHS entity may avoid the Stark law implications entirely if it has no financial relationship with the physician employees of the affiliate. There is no financial relationship under the Stark law if: (i) a DHS entity provides mission support payments directly to its affiliate; (ii) the affiliate is not owned by any of its physician employees; and (iii) the affiliate’s compensation of its physician employees does not take into account the volume or value of referrals or other business generated by the physician employees to the DHS entity. If these three conditions are met, a DHS entity may make payments to its affiliate to keep it in good financial shape and accomplish its missions without implicating the Stark law.

8. Publicly-traded company exception
The Stark law excludes certain ownership interests in a DHS entity from the definition of the financial relationship, including ownership of investment securities that could be purchased on the open market when the DHS referral was made. These securities must either be listed on the NASDAQ or a similar system, or traded under an automated dealer quotation system by the National Association of Securities Dealers. Further, the securities must be in a corporation that had stock holder equity exceeding $75 million either at the end of the corporation’s most recent fiscal year or on average during the previous three fiscal years. 42 C.F.R. 411.356(a). Here, stock holder equity means the excess of the hospital’s net assets over its total liabilities.

9. Isolated transactions
Physicians may engage in an isolated financial transaction with a DHS entity without violating the Stark law only if the following conditions are met. First, the amount of remuneration must be based on fair market value and not take into account the volume or value of any referrals a physician makes to the DHS entity or any other business generated by the parties. Second, the arrangement must be commercially reasonable even if no referrals are made between the parties. Finally, no additional transactions, except ones specifically excepted from the Stark law, may occur for six months after the isolated transaction. 42 C.F.R. 411.357(f). Installment payments may qualify as payment as part of an isolated transaction if the total aggregate payment is: (i) set before the first payment is made; (ii) does not take into account, directly or indirectly, referrals or other business generated by the referring physician; and (iii) is secured. 72 F.R. 51055 (Sept. 5, 2007).

10. Non-monetary compensation benefits
A physician may receive from a DHS entity non-monetary compensations up to $300 in the aggregate a year (i.e., meals, parking, training, etc.) (This amount is adjusted annually for inflation; the aggregate amount is $355 for 2009). Non-monetary compensation cannot take into account the volume or value of any referrals or other business generated by the physician. Further, the physician must not have solicited such compensation. The compensation must also not violate the anti-kickback statute or any federal or state law. 42 C.F.R. 411.357(k). CMS recommends that hospitals implement compliance systems, such as mechanisms to track and value the provision of gifts, complimentary items and other benefits for physicians, to ensure non-monetary compensation does not exceed the annual spending limit. 72 F.R. 51058 (Sept. 5, 2007).

The Stark law does allow a hospital with a formal medical staff to throw a local staff appreciation event once a year without adhering to the spending cap. Any gifts or gratuities provided
in connection with the event, however, are subject to the spending cap. 42 C.F.R. 411.357(k)(4). Finally, the recent revision to the Stark law now allows an entity to stay below the spending cap when it inadvertently exceeds the cap by no more than 50 percent and the physician repays the excess within that calendar year or 180 consecutive days from receipt of the excess compensation, whichever is earlier. The entity and the physician may rely on the repayment provision no more than once every three years. 42 C.F.R. 411.357(k)(3).

11. Splitting profits from ancillary services within a practice

There are several ways to split profits from DHS within a group practice, so long as the given profit-splitting method is not related to the volume or value of referrals. Two profit-sharing methods that are not prohibited by Stark include certain profit-sharing arrangements between members of a group practice and certain productivity bonuses.

When a physician's group meets the Stark law's definition of a “group practice,” its physicians may receive a share of the overall profits so long as the distribution is reasonable, verifiable and unrelated to the volume or value of referrals. The Stark law deems certain methods of profit sharing as not relating directly to the volume or value of referrals. The profits, for example, may be divided per member of the group. The group may also distribute DHS revenues based on the distribution of the groups revenues attributed to services that are not DHS payable by any federal healthcare program or private payor. Finally, the Stark law allows any method of profit-sharing if DHS revenues constitute less than 5 percent of the group practice's total revenues and no physician's share is more than 5 percent of the physician's total compensation from the group practice. 42 C.F.R. 411.352(j)(1) & (2).

CMS has explicitly stated that “all physicians, whether employees, independent contractors, or academic medical center physicians, can be paid productivity bonuses based on work they personally perform.” 69 F.R. 16067 (March 26, 2004). A physician may be paid a productivity bonus based on work personally performed by that physician, so long as the productivity bonus is not calculated in a way that directly relates to the volume or value of a physician's DHS referrals. One such method of calculating productivity bonuses is to base a physician’s bonus on his or her total patient encounters or relative value units. 42 C.F.R. 411.352(j)(3).

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Louisville. During medical school, he was a member of the “Spinal Chords,” an all-male chorus that performed for patients at local hospitals.

David Abraham, MD — Dr. Abraham is the founder of The Reading Neck and Spine Center in Wyomissing, Pa. He is also a partner at The Reading Surgery Center in Wyomissing and at the Surgical Center of Pottsville (Pa.). Dr. Abraham, whose interests center around ambulatory and minimally-invasive spinal surgery, attended Jefferson Medical College, performing his internship at Thomas Jefferson University Hospital in Philadelphia and his residency at the Rothman Institute in Philadelphia. He completed a fellowship in adult spine surgery at William Beaumont Medical Center in Detroit.

Scott Blumenthal, MD — Dr. Blumenthal is a spine surgeon with the Texas Back Institute and the first surgeon in the United States to devote his practice solely to the research and application of artificial disc replacement. Dr. Blumenthal is a leader in spinal arthroplasty working with a large number of discs currently on the market and in trials. He serves as a clinical assistant professor of orthopedic surgery at the University of Texas Southwestern in Dallas and as an ongoing contributor to the first non-profit created for arthroplasty patients, ADRSupport.org. He also currently serves as a spine consultant for the Dallas Mavericks. Dr. Blumenthal graduated from Northwestern Medical School in Chicago and completed his general surgery internship and orthopedic surgery residency at the University of Texas Health Science Center in Dallas. His fellowships include work at the Rehabilitation Institute of Chicago for physical medicine and rehabilitation and at Midwest Regional Spinal Cord Injury Care System at Northwestern Memorial Hospital in Chicago for spinal trauma surgery. Dr. Blumenthal was recently featured in ON Magazine in the publication’s “ON Personality” section.

Charles Branch, MD — Dr. Branch is a neurosurgeon who specializes in the spine and is currently president of the North American Spine Society. He practices at Wake Forest University Baptist Medical Center in Winston Salem, N.C. Dr. Branch attended medical school at the University of Texas Southwestern Medical School in Dallas. He completed his residency in neurological surgery at Wake Forest University Baptist Medical Center and a fellowship at the University of California, San Francisco. Dr. Branch has been published in numerous medical journals and once served as editor-in-chief for The Spine Journal. He recently was profiled by Spinal News International, where he discusses his family’s involvement in the field. Two of his children are currently enrolled in medical school and his oldest will pursue neurosurgery. His father, Charles Branch, Sr., was awarded the Humanitarian Award from the American Association of Neurological Surgeons in 2004 for his medical mission work in Nigeria.

John R. Caruso, MD — Dr. Caruso is a neurosurgeon with more than 16 years experience. He currently practices with Neurosurgical Specialists in Hagerstown, Md., where he has performed numerous spinal procedures including minimally invasive procedures to complex instrumentation of the cranial, thoracic and lumbar spine. He also serves a chairman of the board and medical director of Parkway Surgery Center in Hagerstown. Dr. Caruso attended Eastern Virginia Medical School in Norfolk, Va., and completed residencies at the Eastern Virginia Graduate School of Medicine in Norfolk and at the University of New Mexico, Albuquerque.

Leonard Cerullo, MD — Dr. Cerullo is a neurosurgeon with more than 30 years experience and the founder and medical director of Chicago Institute of Neurosurgery and Neuroresearch. He helped pioneer the use of lasers in neurosurgery and has published several articles and books on this subject. He also serves as a professor in the Department of Neurosurgery at Rush Medical College in Chicago. Dr. Cerullo attended medical school at Jefferson Medical College in Philadelphia and completed his residency training in neurosurgery at Northwestern University Medical School in Chicago. Dr. Cerullo held fellowships at the Neurological Institute of New York and Columbia-Presbyterian Medical Center, both in New York City, and at Hôpital Foch in Suresnes, France. Dr. Cerullo has been featured repeatedly in Chicago Magazine’s “Top Doctors” issues.

E. Jeffrey Donner, MD — Dr. Donner is an orthopedic surgeon, fellowship-trained in the management of spinal disorders. His specialties include spine surgery and general orthopedics. He is a co-founder of Rocky Mountain Associates in Loveland, Colo., and also works at Loveland Surgery Center, a spine center of excellence for Blue Cross/Blue Shield. Dr. Donner is recognized internationally as an expert in the diagnosis and surgical treatment of chronic cervical whiplash disc injuries. His orthopedic residency included rotations through Shriners Hospital for Children in Philadelphia and St. Christopher’s Hospital for Children in Philadelphia. Dr. Donner’s fellowship in spine surgery was completed at the Hospital of the University of Pennsylvania and Temple University Hospital, both in Philadelphia. Dr. Donner has published articles in several scientific journals and is the past president of the Larimer (Colo.) County Medical Association.

Stephen Doran, MD — Dr. Doran is a neurosurgeon and chairman of the board and medical director of Midwest Surgical Hospital in Omaha, Neb. This facility brought together a preeminent group of neurosurgeons, orthopedic surgeons, ENT and pain medicine physicians and partnered with a large local healthcare system. Dr. Doran is an active lobbyist for physician involvement in healthcare. He is also a clinical assistant professor of surgery at University of Nebraska Medical Center. Dr. Doran’s areas of interest include spinal instrumentation, stereotactic and functional neurosurgery, deep brain stimulation and disorders of the spine. He has received national recognition for his research in gene therapy related to the central nervous system and his research has been published nationally. Dr. Doran received his medical degree from the University of Nebraska Medical Center in Omaha and completed his internship and residency at the University of Nebraska Medical Center.

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of Michigan Medical Center in Ann Arbor. According to Todd Flickema, senior vice president at Surgical Management Professionals, “Dr. Doran is a very articulate, intelligent and caring physician. He has a vision that is beyond his practice and hospital that encompasses his community and healthcare in general with extremely high ethical standards. He is one of the finest people I have ever had the pleasure of working with.”

Wesley H. Faunce, III, MD — Dr. Faunce practices with the Southwest Florida Neurological Associates in Cape Coral, where he focuses on degenerative spine disease of all areas of the spine. He has been involved in a variety of medical research studies and is an accomplished author or coauthor of numerous studies, publications and presentations. Dr. Faunce received his PhD in biochemistry and molecular biology from the University of Florida in Gainesville. He then earned his medical degree at the same university. He also completed an internship at the university’s department of surgery and residency training at its department of neurosurgery. While at the University of Florida, Dr. Faunce served as president of the University of Florida’s AMA Medical Student Section and was awarded the Lyerly Neurosurgery Award.

Thomas Forget, MD — Dr. Forget is a St. Louis-based neurosurgeon focusing on cerebrovascular disease, stroke and general neurosurgery. He is an owner and medical director of The St. Louis Spine Surgery Center, a spine-focused ASC in Creve Couer, Mo. He also leads the Division of Neurosurgery at Neurological Specialists of West County. Dr. Forget has co-authored two books, as well as multiple book chapters, articles and presentations. He attended medical school at Georgetown University School of Medicine in Washington, D.C., and completed his residency at Saint Louis University School of Medicine. He completed a fellowship in neurosurgery at Thomas Jefferson University Hospital, Jefferson Medical College in Philadelphia.

Dr. Faunce practices with the Southwestern Florida Neurological Associates in Cape Coral, where he focuses on degenerative spine disease of all areas of the spine. He has been involved in a variety of medical research studies and is an accomplished author or coauthor of numerous studies, publications and presentations. Dr. Faunce received his PhD in biochemistry and molecular biology from the University of Florida in Gainesville. He then earned his medical degree at the same university. He also completed an internship at the university’s department of surgery and residency training at its department of neurosurgery. While at the University of Florida, Dr. Faunce served as president of the University of Florida’s AMA Medical Student Section and was awarded the Lyerly Neurosurgery Award.

Richard Harrison, MD — Dr. Harrison is a spine surgeon focusing on the comprehensive management of spine conditions, including minimally invasive surgery to spinal reconstruction and fusion procedures. He practices at the Bay Care Clinic in Green Bay, Wis., among other locations in Wisconsin and Illinois. Dr. Harrison attended medical school at Texas Tech University in Lubbock, Texas, and completed his residency at Loyola University Medical Center in Chicago. He completed a fellowship at the National Hospital for Neurology and Neurosurgery in London, England. He has been featured by his local ABC news station, Action 2 News, for his work.

Richard Kube, II, MD — Dr. Kube is a spine surgeon at the Prairie Spine & Pain Institute in Peoria, Ill., which he owns and operates. He regularly performs procedures at the Peoria Day Surgery Center. He previously practiced at St. Anthony’s Memorial Hospital and with the Bonutti Clinic in Effingham, Ill. Dr. Kube attended medical school and post-graduate training in orthopedic surgery at Saint Louis University. He completed a spine fellowship at Spine Surgery PSC in Louisville, Ky. Dr. Kube’s research on motion preservation has been presented on an international level at several different venues. Dr. Kube is a clinical assistant professor of surgery at the University of Illinois College of Medicine at Peoria. According to Bryan Zovin, business manager of Peoria Day Surgery Center, “Since joining Peoria Day’s medical staff, he has been instrumental in assisting staff and management with cost-effective equipment needs along with working with us to provide high-quality spine treatment surgery services for our community. This is a new service line for our center and his knowledge and assistance to the center has been outstanding.”

Michael Janssen, MD — Dr. Janssen is a surgeon at the Center for Spinal Disorders in Thornton, Colo. He founded the Spine Education Research Institute, a non-profit dedicated to clinical research, physician education and youth science and community education. Dr. Janssen also serves as a clinical associate professor at the University of Colorado. He received his medical education at the University of Health Sciences in Kansas City, Mo. His internship and residency were completed at the Medical College of Georgia in Augusta, and he completed a spine fellowship at Lakewood Orthopaedic Clinic in St. Gallen, Switzerland.

Iain H. Kalfas, MD — Dr. Kalfas is a neurosurgeon who works for Cleveland Clinic’s Center for Spine Health. He is also the head of spinal surgery for the clinic’s department of neurosurgery. His specialties include complex spinal surgery and reconstruction including instrumentation and fusion, image-guided spinal navigation, neck and back disorders and minimally-invasive surgery. Dr. Kalfas attended medical school at Northeastern Ohio Universities College of Medicine in Rootstown, Ohio, and completed his internship and residency in neurological surgery at the Cleveland Clinic. He completed fellowships at Barrow Neurological Institute in Phoenix and at Allegheny General Hospital in Pittsburgh, Pa. Dr. Kalfas recently edited the book, Spinal Reconstruction: Clinical Examples of Applied Basic Science, Biomechanics & Engineering, and has written numerous book chapters.

Jordi Kellogg, MD — Dr. Kellogg is a neurosurgeon who has published more than 40 professional articles and abstracts since 1997. He is also a regular speaker at neurosurgery conferences. In private practice in Portland, Ore., since 2001, Dr. Kellogg is an investor-owner in the highly successful East Portland Surgery Center. Dr. Kellogg attended medical school at the University of Southern California in Los Angeles and completed his residency and fellowship at Oregon Health Sciences University in Portland.
James Lynch, MD — Dr. Lynch is a neurological surgeon who specializes in complex spine surgery, as well as minimally-invasive spine surgery. He is director, spine services, for Regent Surgical Health, where he directs Regent’s program to help physicians develop spine-focused ASCs and specialty spine hospitals. He is the founder and CEO of Spine Nevada and chairman and director of spine at the Surgical Center of Reno. He is also on staff at St. Mary’s Hospital and Renown Regional Medical Center, both located in Reno. Dr. Lynch is a frequent lecturer at national meetings on spine topics related to ASCs. He earned his medical degree from Trinity College in Dublin, Ireland, followed by a residency at the Mayo Clinic in Rochester, Minn. Dr. Lynch completed three spine fellowships at the Mayo Clinic, National Hospital for Neurology and Neurosurgery in London, England and the Barrow Neurological Institute in Phoenix. His work has been published in several professional publications including The Journal of Neurosurgery and Neurosurgery and Spine.

James Macon, MD — Dr. Macon is a neurological surgeon with Framingham-Wellesley Neurological Surgery in Framingham, Mass. In addition to being a member of several neurological associations, Dr. Macon is a member of the American Pain Society, International Association of the Study of Pain and American Academy of Pain Medicine. Dr. Macon attended medical school at Harvard Medical School and completed his internship at Stanford University Medical Center. He completed his residency in neurosurgery at Massachusetts General Hospital in Boston. Dr. Macon worked as a clinical associate for the National Institutes of Health’s Institute of Neurological Disorders and Stroke in Bethesda, Md., and received a Fulbright Scholarship to study neuropharmacology in Paris, France. According to Chris Zorn, vice president of Spine Surgical Innovation, “Dr. Macon is compassionate, innovative, reputable and patient-focused professional.”

Paul McCormick, MD — Dr. McCormick is a neurosurgeon at Columbia-Presbyterian Neurosurgery in New York City, specializing in disc disease, spinal stabilization and instrumentation, spinal tumors and spinal cord injury. He attended medical school at Columbia University College of Physicians and Surgeons and completed his residency at the Neurological Institute of New York. He completed a fellowship in spinal surgery at the Medical College of Wisconsin in Milwaukee. He currently serves as a professor of clinical neurosurgery at Columbia’s College of Physicians and Surgeons and has published more than 70 peer-reviewed articles.

Greg McDowell, MD — Dr. McDowell is an orthopedic surgeon specializing in adult and pediatric spine care. He currently practices with Ortho Montana in Billings and is co-director for the Northern Rockies Regional Spine Center. Dr. McDowell completed medical school and his residency at the University of Virginia in Charlottesville.

Kenneth A. Pettine, MD — Dr. Pettine is a co-founder of Loveland, Col.-based Rocky Mountain Associates and a surgeon at Loveland Surgery Center, a spine center of excellence for Blue Cross/Blue Shield. He has an extensive background in spinal surgery, research and rehabilitation. He is co-inventor and co-designer of the Maverick Artificial Disc, a patented disc replacement device for the neck and back, currently the subject of a clinical trial. Dr. Pettine is currently the chief investigator for eight FDA IDE studies involving non-fusion spine technology. He is a distinguished speaker at national and international symposiums and the author of nearly 20 research publications. Dr. Pettine completed his residency and his master’s degree in orthopedic surgery at the Mayo Clinic in Rochester, Minn. His medical degree was awarded from the University of Colorado School of Medicine, and he completed a Spine Fellowship in Minneapolis.

Joan O’Shea, MD — Dr. O’Shea is a dually-trained neurological and orthopedic spine surgeon. She has concentrated her training and dedicated her career to the treatment of spinal disorders. She helped found the Spine Institute of Southern New Jersey and previously practiced neurosurgery at Cooper Medical Center in Camden, N.Y. She received her medical degree at the State University of New York Upstate Health Center in Syracuse. She completed a residency in neurosurgery at Mount Sinai Medical Center in New York, N.Y., and completed an additional orthopedic spine surgery fellowship at the Hospital for Joint Disease and the Spine Institute of Beth Israel Medical Center, both located in New York City. She has been an invited lecturer for the American Association of Neurological Surgeons and the Congress of Neurological Surgeons annually since 1996. Ms. O’Shea has been described by a colleague as “very sharp and entrepreneurial. She is excellent at working with and marketing to workers compensation case nurses.”

Carlton Reckling, MD — Dr. Reckling is a spine surgeon at the newly-formed Spine Center Cheyene (Wyo.). He attended medical school at Creighton University in Omaha, Neb., and completed his internship and residency at the University of Minnesota Hospitals & Clinics in Minneapolis. He completed a fellowship in spinal surgery at Queen’s University Medical Center in Nottingham, England. According to Richard Slater, attorney, friend and patient of Dr. Reckling, “Carlton is the only orthopedic spine surgeon in our community. Like his father and grandfather who were also physicians, Dr. Reckling performs major reconstructive spine surgeries for scoliosis and other deformities. He is also a regional leader in minimally invasive techniques and non fusion technology.”

Mike Russell, II, MD — Dr. Russell is a spine surgeon at Azalea Orthopedics in Tyler, Texas. He holds hospital privileges at the Texas Spine and Joint Hospital, Trinity Mother Frances Hospital and the East Texas Medical Center, all in Tyler. Dr. Russell attended medical school and completed his orthopedic training at the University of Texas Southwestern Medical School in Dallas. He completed a fellowship in spine surgery at the Carolinas Medical Center in Charlotte, N.C.
Larry L. Teuber, MD — Dr. Teuber serves as director of Medical Facilities Corp. and as the physician executive of Black Hills Surgery Center in Rapid City, S.D., which he founded in 1997. Dr. Teuber is also the founder and current managing partner of The Spine Center in Rapid City. He provides consultative services and frequently speaks to physician organizations concerning the development of surgical facilities for neurosurgical and spinal care. Dr. Teuber earned his medical degree from the University of South Dakota in Vermillion. He completed his general surgery internship and neurosurgery residency at the Medical College of Wisconsin in Milwaukee. Dr. Teuber served for 17 years in the active and reserve Army, retiring with the rank of major after serving in Desert Storm.

Daniel Tomes, MD — Dr. Tomes, a neurological and spine surgeon, practices in Lincoln, Neb., where he sits on the Board of Directors of the Madonna Rehabilitation Hospital and serves as medical director of the Gogela Neuroscience Institute. Additionally, he led the development of the Southwest Lincoln Surgery Center, a multi-specialty ASC that includes spine and is slated to open in April 2009. Dr. Tomes attended medical school at the University of Nebraska College of Medicine in Lincoln and completed postgraduate training at the University of Nebraska Medical Center.

Ensor Transfeldt, MD — Dr. Transfeldt is a staff surgeon at Twin Cities Spine Center in Minneapolis, Minn., specializing in deformities and tumors of the spine. He also serves as an associate professor at the University of Minnesota. Dr. Transfeldt attended medical school at the University of Witwatersrand in Johannesburg, South Africa; completed an internship at Baragwanath Hospital in Johannesburg; and completed his residency at the University of Toronto, Canada. He completed a spine fellowship at the University of Toronto and held the John H. Moe Spine Fellowship at the Twin Cities Scoliosis Spine Center in Minnesota.

William Watters, III, MD — Dr. Watters is an orthopedic surgeon who specializes in spinal surgery. He is the current research council director for the North American Spine Society and is the chairman of the American Academy of Orthopaedic Surgeon’s Guideline and Technology Assessment Oversight Committee, which oversees all clinical practice guideline development and technology assessments produced by the AAOS. Dr. Watters attended Harvard Medical School and completed two residencies, one in internal medicine and one in orthopedic surgery at the University of Pennsylvania in Philadelphia.

Jeffrey C. Wang, MD — Dr. Wang is currently chief of the University of California Los Angeles Spine Service and director of the UCLA Spine Surgery Fellowship. In addition to a busy clinical practice, Dr. Wang runs a science laboratory where he develops new methods for treating spinal disorders. Dr. Wang has received numerous research grants and is currently involved in many clinical trials in the treatment of spine problems. Dr. Wang attended medical school at the University of Pittsburgh School of Medicine. He completed a residency in orthopedic surgery at UCLA and a fellowship in spine surgery at Case Western Reserve University in Cleveland.

Richard Wohns, MD, MBA. — Dr. Wohns is a spine surgeon and one of the first physicians involved with the development of ambulatory spine practices. He is the founder of South Sounds Neurosurgery in Puyallup, Wash. He also founded Neospine, a spine ASC development company, currently part of Symbion Healthcare. His areas of expertise in the field of neurosurgery include brain tumor and skull base surgery, numerous complex minimally invasive spinal surgical techniques, teleradiology, computer-based neuronavigation and stereotaxis. He was one of the first neurosurgeons in the United States qualified to perform the revolutionary XLIF technique for minimally invasive lumbar fusions. Dr. Wohns attended medical school at Yale University School of Medicine and completed his neurosurgery residency at the University of
Washington in Seattle. Dr. Wohns also holds an executive MBA from the University of Washington and is currently pursuing a law degree from Seattle University School of Law. Dr. Wohns has advanced the knowledge of outpatient spine surgery and minimally invasive techniques through the Mazama Spine Summit, an educational meeting which has organized for the past six years. According to Hiroshi Nakano, CEO of South Sound Neurosurgery in Puyallup, Wash., “Dr. Wohns has been a pioneer in the development of the ambulatory spine world, stressing clinical excellence and business performance. In addition, he has dedicated a great deal of his time to the improvement of the profession and continues to be a voracious learner.”

**Average Annual Salary for Spine Surgeons by Region**

Here are the average annual salaries for spine surgeons by region, according to the 2008 *Physician Compensation Survey* conducted by the American Medical Group Association.

- **Overall average** — $611,670
- **East** — $507,889
- **West** — $635,675
- **North** — $590,000
- **South** — Not available

*Source: American Medical Group Association 2008 Physician Compensation Survey.*

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THURSDAY, JUNE 11, 2009

8:00 – 8:55 am
A. Orthopedics in ASCs – What Works and What Doesn’t From a
Clinical and Financial Issues
Blaine Farley, M.D., and James McGeehee, RN, Administrator, Cleburne
Surgical Center; and Sarah Martin, RVP of Operations, Meridian Surgical Partners

B. Uni Knees in the Outpatient Setting – Is This the Right Fit for
Your ASC? Clinical and Financial Issues
Blaine Farley, M.D., and James McGeehee, RN, Administrator, Cleburne
Surgical Center; and Sarah Martin, RVP of Operations, Meridian Surgical Partners

C. The Development & Integration of Orthopedics into a
Multi-Specialty ASC
Jeff Leland, Managing Director, Blue Chip Surgical Center Partners

2:30 – 3:20 pm
A. Managed Care Negotiation Strategies for Orthopedic and Spine-
Driven Centers
Naya Kehayes, CEO, Eveia Health Consulting and Management

B. Orthopedics – The Forecast for the Next Five Years
Lisa Shriver, Administrator, Turks Head Surgery Center

C. How to Recruit and Retain Great Administrators and Directors
of Nursing
Greg Zach, Partner, and Kaye Basman

THURSDAY, JUNE 11, 2009

4:15 – 5:00 pm
A. Physician Recruitment in 2009 – Some Key Thoughts and
Challenges on Recruiting Orthopedics Neurosurgeons and Pain
Management Physicians
Kerry Spierer, SVP Development, HealthMark Partners

B. New Trends in Ambulatory Spine Surgery
David Abraham, M.D., Reading Neck and Spine Center

C. Ten Keys to Improving Billing and Collections in a Challenging
Economy
Caryl Serbin, CEO, Serbin Surgical Center Billing

D. Healthcare Valuations – Current Trends and Perspectives in
Majority Interest Valuations
Todd Melin, Principal and Co-Founder, Healthcare Appraisers

E. Physician Owned Hospitals – Key Concepts to Increase Profits
Tom Michaud, CEO, Foundation Surgery Affiliates

5:00 – 7:00 pm – Networking Reception & Exhibits

FRIDAY, JUNE 12, 2009

8:00 – 8:55 am
A. Buying and Selling ASCs – 5 Key Concepts
Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Cost Justifying an EHR, What Is The ROI?
Bill Southwick, President and CEO, HealthMark Partners

C. 5 Tips for Managing Anesthesia in Your ASC
Scott Becker, JD, CPA, Partner, McGuireWoods LLP

D. 2009 Pain Management Coding Update and Pain Industry Business
Trends
Lax Manchikanti, M.D.

E. Turnarounds – 2 Case Studies – 5 Key Ideas for Success
Tom Geiser, Senior Advisor, Texas Pacific Group; and Joe Clark, Executive Vice
President, Practice Partners in Healthcare

5:00 – 7:00 pm – Networking Reception & Exhibits
FRIDAY, JUNE 12, 2009

B. Pain Management in ASCs – Current Methods to Increase Profits
Amy Mauers, President & CEO, Mauers Medical Practice Management

C. 5 Tips for Managing Anesthesia in Your ASC
Thomas Yerden, CEO and Founder, TRP HealthCare Solutions

D. How to Recruit Great Surgeons to Work at Your ASC
Robert Carreton, President, Pinnacle III

E. Turnarounds – 2 Case Studies – 5 Key Ideas for Success
Joe Zaza, President, Woodrumb ASD

2:45 – 3:45 pm – Exhibits Open
3:45 – 4:20 pm
A. How Much is Your ASC Worth? What Terms Can You Expect?
What Does a National Company Want After a Deal? 10 Facts That
Will Drive a Buyer Away
Bill Kennedy, SVP Business Development, NovaMed; Kenneth Hancock, President and Chief
Development Officer, Meridian Surgical Partners; Richard Pence, President and COO,
National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion

B. Is Your Center too Dependent on a Single Specialty? How to
Diversify and Make Change Happen
John Seitz, CEO, Ambulatory Surgical Group; Joe Zaza, CEO, Woodrumb ASD; and
Larry Taylor, President and CEO, Practice Partners in Healthcare

C. 5 Core Concepts for Great ASC Joint Ventures with Hospital Partners
Mike Panek, Administrator, Ambulatory Surgery Center of Spartanburg; and
Carol Serbin, CEO, Serbin Surgery Center Billing

D. Assessing the Profitability of Orthopedics, Spine and Pain in ASCs
Luke Lamber, CEO, Ambulatory Surgery Centers of America

E. 5 Core Strategies to Immediately Improve ASC and Hospital
Operations
Doug Johnson, COO, RMC MedStone Capital

4:20 – 4:55 pm
A. How Much is Your ASC Worth? What Terms Can You Expect?
What Does a National Company Want After a Deal? 10 Facts That
Will Drive a Buyer Away (continued)
Bill Kennedy, SVP Business Development, NovaMed; Kenneth Hancock, President and Chief
Development Officer, Meridian Surgical Partners; Richard Pence, President and COO,
National Surgical Care; George Goodwin, SVP and Chief Development Officer, Symbion

B. Ulnar Collateral Ligament Reconstruction: “The Tommy John Surgery”
Timothy Kermoch, M.D., Medical Director, Cincinnati Reds; Larry Taylor,
President and CEO, Practice Partners in Healthcare

C. The Development & Integration of Orthopedics into a
Multi-Specialty ASC
William Jacobo, M.D., President, West Lakes Surgery Center; Rob McCarville,
Principal, Medical Consulting Group; and John Marasco, Principal
and Owner, Marasco and Associates

D. 2 Key Issues: Working with Implant Brokers and Out-of-
Network Issues
Dan Connelly, Vice President, Pinnacle III

E. Turnarounds – Lessons of the Last Five Years – Expectations of
the Next Five Years
Bill Southwick, President and CEO, HealthMark Partners

4:55 – 5:30 pm
A. Orthopedics in ASCs – What Works and What Doesn’t From a
Business and Clinical Perspective
John Chech, M.D., Dept. of Orthopedics, The Neuropath & Orthopedic Hospital of Chicago

B. Physician Owned Hospitals – What Should You Do Now?
Ajay Mangal, M.D., CEO, Precisus Health; and Brett Guynor, CEO,
Animas Surgical Hospital

C. How to Work Successfully with Generation Y
Lt. Colonel Bruce Bright, Director of Business Development, The Sanders Trust

D. The 5 Best Ways to Improve Billings and Collections and to
Improve Revenue Cycle Management
Lisa Rock, President, National Medical Billing Services; and David Hamilton,
President & CEO, MNET Collections

E. Common Litigation Issues in ASCs – Antitrust, Non Competes and More
Jeff Clark, Partner, and Richard Greenberg, Partner, McGuireWoods LLP
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Secret to Spine Surgery Center Success: The “5 + 3 C’s”

By Jeff Leland

W henever someone asks me what it takes to succeed in the ASC business, I immediately tell them about “the five C’s.” These are the five core concepts or competencies that must be mastered by physician-owners at all types of ASCs, in every region, if they are to prosper.

The five C’s are:
• Case volume and mix
• Contracts
• Case costing
• Compressed schedules
• Cash

I will highlight each of these in more detail later, and describe their importance. However, as spine surgery centers have proven to be feasible businesses (and in some cases absolutely outstanding ones), we’ve recently expanded our thinking and added “three C’s for spine:”

• Surgeon and patient comfort
• Staff confidence
• Collaboration with payors

Collectively, the “5 + 3 C’s” add up to a recipe for success in the unique spine ASC market.

5 universal C’s

Our many years of experience in the industry have shaped our thinking about the requirements for profitable ASC businesses. We apply the five C’s as best practices and foundational elements of the business model for all types of centers, including spine ASCs. And we use them as a means to engage the owners around common goals and shared responsibilities.

Case volume and mix. ASC success is predetermined long before the doors open. We firmly believe that no surgery center should be launched until the right volume and mix of cases is assured. While many ASCs start with the assumption that they’ll grow into sufficient volume over time, ours is a fixed-cost business; hence, a baseline volume is required to support operations. At many underperforming ASCs, optimistic partners start digging a hole on day one and are never able to climb out. An analogy from the travel business: An airline with the most experienced and skilled pilots, the most sophisticated aircraft, and the highest flying gates can lose money if only 50 percent of the seats are filled.

Business plans should be based on fully accurate, highly detailed and rigorously validated case volume projections. In spine, this often requires the addition of pain management cases to augment the lower number of major spine procedures (pain cases are also an effective way to orient patients to the notion of outpatient treatments and to the ASC itself). These projections should be viewed as a “go/no-go” decision in the planning process for new ASCs.

Once facilities are operational, case volume and mix should be monitored and analyzed carefully, by surgeon, with the results communicated to all stakeholders and compared each month to actual projections. That way, issues can be identified proactively and addressed quickly, long before the hole gets too deep.

Contracts. It’s nearly impossible to overestimate the importance of strong contracts to ASC success. In our experience, about 20 percent of the cases generate about 80 percent of the profit. An ASC’s contract portfolio must reflect that ratio. That’s one of the few generalizations that can be made about outpatient spine contracting, however. The in-network vs. out-of-network (OON) question, particular market conditions and constantly changing reimbursement rates, mean each ASC needs to seek contracts tailored to its unique goals, specialties and location. Contracts for supplies, implants and instruments must also be negotiated carefully. Because of the complexity and many details involved, contracting is arguably the area where corporate partners can deliver the most value.

Spine ASCs raise unique contracting issues. Certainly, the revenue potential is terrific, largely because ASCs compete directly with hospitals and usually not other ASCs. OON contracts must be properly managed and understood to realize the high upside. Considerable follow-up work is necessary, too. On the payor side, the opportunity to reduce costs by moving cases from hospitals to ASCs is just as compelling (which we’ll discuss more later). While OON contracting may not provide long-term synergy, the high cost will often bring payors to the table. The lack of Medicare groupers for most spine procedures means many payors do not yet understand how to assess outpatient spine fees and most payors do not understand how to accurately assimilate the costs of spine cases at hospitals.

Another issue is how pain cases can help boost revenue at the ASC, even though, in some cases, they can be more lucrative for physicians who treat such patients in their offices. Based on our experience, we believe that a small spine surgery center with one OR and one procedure room can generate 100 percent annual return on investment with 400 surgeries and 1,500 pain cases. Bigger isn’t necessarily better when it comes to developing new spine surgery centers.

Again, the OON issues are the keys, both strategically and operationally. It’s also important to remember that there is still plenty of work to do when your spine surgery center is OON. Everybody at the ASC — surgeons, RNs and business office staff — must be educated to handle OON issues. First and foremost, claims and billing must be monitored to ensure claims are paid accurately and in line with contracts. Once in-network, payor relationships should be tended carefully, with an emphasis on mutually beneficial arrangements. Re-negotiation strategies should be ready in case of regulatory change or market shifts. It’s important to recognize that optimal contracts are usually moving targets; ASCs willing to do their homework can often improve contracts after they’re signed. In fact, we revisit each contract with changes of some sort at least twice annually.

Case costing. One hallmark of profitable ASCs is knowing how much it costs to perform each type of case, including any variable costs (like supplies and instrumentation), and how much they are reimbursed. Further, surgeons and staff alike understand why those figures are important and how they affect the bottom line. In outpatient spine facilities, with more expensive equipment and implants involved, the value of case costing only increases.

Case costing is closely related to volume projections in that it defines the requirements for profitability and provides insight into contracting needs, physician preferences and practice patterns. Put simply, without accurate case costing data, it’s difficult to tell a profitable contract from a money-losing one. With detailed cost data, surgeon owners will quickly see what drives profitability and where improvements are necessary. Strategically, case costing provides the transparency necessary to build strong partnerships. Operationally, it clarifies the need for supply standardization, comprehensive fee schedules and other effective management practices.
Compressed schedules. Schedule compression is an important — but often undervalued — technique for improving productivity. It can also boost revenue by making time for non-owner surgeons to use the ASC. Clustering cases helps ensure that staffing costs and other overhead are minimized at lower-volume ASCs. We counsel our surgeon-partners that it’s perfectly acceptable to turn off the lights on Thursdays and Fridays if caseloads are too light. Busier centers will want to employ block scheduling, set deadlines for OR reservations and regularly communicate available slots. Turnover times of 10 minutes or less between cases should be the goal for many types of procedures.

In spine ASCs, the scheduling issue may seem less urgent in that fewer cases are necessary to sustain profitable operations. Because spine cases typically last longer, speedy OR turnover may be less important at spine-focused ASCs than at multi-specialty centers. Compressed scheduling and productivity are critical, however, if pain cases are also handled at the spine surgery center. Treating three or more pain cases in an hour is a worthy and feasible goal. At some centers, these procedures are handled in street clothes to keep things moving along. Typically, these challenges are not too difficult, which is one reason why pain often makes an excellent complement to spine-focused ASCs.

Cash. Managing cash is all about managing accounts receivable (A/R) and ensuring contracts are administered properly. Top-performing ASCs manage these tasks more effectively. That’s true for all types of centers, including spine. Conversely, almost all unsuccessful centers struggle with A/R. “Swamped,” “overwhelmed,” “nightmare” — those are the words most often used to describe ASCs with serious A/R issues. The stakes are high, however. OON cases may require that ASC staff collect $20,000 checks from patients.

How to avoid this common problem? Efficient, knowledgeable and detail-oriented staff — whether employed by the ASC or a management partner — is a must. The goal is to process every claim expediently and stay on top of A/R status at all times. That starts by completing insurance forms long before treatment day, securing pre-authorizations and always taking co-payments when patients arrive. It’s particularly important that potential problems are identified early for OON cases, with patients made aware of the process and their responsibilities. These should be the rules, not the exceptions.

Further, post-treatment, operative notes should be based on templates and processed quickly, claims submitted electronically to payors and individual claims followed up aggressively. Yes, it’s a lot of work, but that’s how centers can operate at 38 days or less of receivables. There’s no doubt that the payoff — strong and predictable cash flow — is well worth the effort.

Three additional C’s for spine

The five universal C’s apply to all types of surgery centers. The following are three additional concepts that lay the groundwork for business and clinical success at spine-focused ASCs.

Surgeon and patient comfort. In some regions, outpatient spine has become very popular — up to 10-15 percent of all spine cases. In other areas, surgeons are not yet comfortable with outpatient spine, thanks to local biases and standards, the influence of hospitals and payors and physician misconceptions about risk and patient preferences. This is gradually changing. As more neurosurgeons, orthopedic spine surgeons and other specialists become comfortable in outpatient settings, more and more cases (including more advanced treatments) will migrate to ASCs.

What we’ve found in launching a number of successful spine-focused ASCs is that patient selection is the critical component to surgeon comfort. Not every case is well suited for ASCs. Thus, to minimize the risk of co-morbidities and complications, patients must be evaluated on a case-by-case basis. Obesity, surgical approach or positioning issues, history of respiratory illness and sleep apnea are the main criteria. Well-defined contingency plans are also critical for reaching the appropriate comfort level with outpatient spine. Additionally, only those cases where surgeons have suitable experience should be handled at ASCs. Outpatient surgery centers are not the place to learn new techniques, especially in spine. That’s what our medical director and surgeons tell me.

Patient comfort is important, too. I know spine surgeons who bring all their spine patients to the ASC before surgery, either for initial pain treatments or simply to familiarize them with the facility, staff and the idea of outpatient care. Familiarity breeds comfort and significantly reduces patient anxiety. Patient perceptions are also affected by referring physicians, RNs, PAs and the like. Therefore, all of these people should be educated about the appropriateness and advantages of outpatient treatments.

Confident staff. This “C” is an extension of the previous one. Spine-focused ASCs need to have top-notch staff committed to the highest clinical standards. The entire staff should be strong proponents of outpatient spine.
patient spine and fully trained with specific procedures. Further, they should be active participants and strong team players who understand their roles. In all of our centers, if the staff or anesthesiologists are uncomfortable with a patient or case, they can veto certain cases handled on an outpatient basis.

Staff confidence is also a matter of remaining calm under pressure, helping to devise back-up plans for emergency transfers and trusting in those plans if complications arise, as they inevitably will. The good news is that ASCs often liberate surgeons to choose exactly the team they want to work with. Typically, that means skilled, experienced and confident staff the surgeons trust.

Collaboration with payors. Since outpatient spine is a relatively new phenomenon, payors are uncertain about what it means to their business or how to approach it. Equipment and supply providers have been similarly hesitant. As a result, many payors have dragged their feet on signing on any contracts for fear that they would sign bad ones. Some even preferred to ask their customers (employers) to pay higher rates than admit their confusion.

For entrepreneurial surgeons, the lack of reimbursement standards and Medicare grouper rates represents a great opportunity. Specifically, spine-focused ASCs should work directly with payors to define algorithms for specific treatments and forge a comprehensive payment system for outpatient spine. Collaborating in this way may cost established spine ASCs some of the massive revenue they’re currently generating, but by demonstrating a savings for the payors, they’ll be more likely to capture a steady, long-term profitable revenue stream.

The risk is that this will prove to be a narrow window of opportunity. Even the slowest-moving payors will eventually “crack the code” on outpatient spine. Collaborating with them now on mutually beneficial deals will help ensure outpatient spine remains profitable for ASC owners as it inevitably grows more popular with patients and more comprehensible to payors.

Bottom Line: 5 + 3 C’s lead to success in outpatient spine

Many of the surgeons we’ve worked are motivated to join ASCs because they want to focus on treating patients and delivering the highest quality care. In other words, they have very good reasons for investing in an ASC. And while some surgeons really enjoy the business, most are less interested in the details of claims management, supply standardization or payor negotiations. We developed the “5 C’s (+ 3)” to help surgeon-owners understand the importance of these concepts, their role in adding value to the spine ASC businesses and their impact on surgeons’ return on investment.

We believe such high-level understanding is useful. But the C’s are also valuable in highlighting the many moving parts that must be monitored and synchronized if an ASC is to achieve near- and long-term profitability. In other words, spine-focused ASCs that master the 5+ 3 C’s are well on their way to success.

Mr. Leland (jleland@bluechipsurgical.com) serves as managing partner of Blue Chip Surgical Center Partners, a surgery center development and management company focused on spine and multi-specialty ASCs. Learn more about Blue Chip Surgical Center Partners 

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Orthopedic Surgery Salary Statistics by Region

Here are statistics on the 2008 cash compensation earned by orthopedic surgeons, as compared by region, according to the Integrated Healthcare Strategies 2008 Healthcare Executive Compensation Survey and supplementary IHS statistics.

20-25th percentile
National — $335,000
North — $360,000
South — $282,000
East — $294,000
West — $356,000

50th percentile
National — $437,000
North — $475,000
South — $369,000
East — $383,000
West — $444,000

75-80th percentile
National — $561,000
North — $606,000
South — $562,000
East — $518,000
West — $530,000

90th percentile
National — $706,000
North — $730,000
South — $668,000
East — $669,000
West — $699,000


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This article focuses on current events and risks in the growing orthopedic and spine devicemaker industry. Orthopedic and spine procedures can be very profitable for surgery centers, as confirmed by the increasing number of centers performing these procedures. Reimbursement is solid for orthopedic procedures, and demand for implants is increasing as the Baby Boomer generation is aging. More implant and spine cases are being performed at ambulatory surgery centers than ever before.

This article focuses on current events and risks in the growing orthopedic and spine devicemaker industry. Orthopedic and spine procedures can be very profitable for surgery centers, as confirmed by the increasing number of centers performing these procedures. Reimbursement is solid for orthopedic procedures, and demand for implants is increasing as the Baby Boomer generation is aging. More implant and spine cases are being performed at ambulatory surgery centers than ever before.

Current issues raised by new devices — gender-specific implants, minimally invasive surgery and new spine devices

A significant development in the orthopedic implant industry is the increased number of products available. In particular, gender-specific devices, or devices designed with the female anatomy in mind, are in-vogue since the first such device, a knee implant designed specifically for the female anatomy, was approved by the FDA in 2006. The demand for gender-specific knee implants in particular is high and expected to increase. Over 400,000 knee replacements are performed in the United States each year and two-thirds of knee replacement patients are women. Although knee replacements are the first foray into gender-specific devices, it is expected that orthopedic devices for hips, shoulders and other parts will continue to be developed and marketed.

Devicemakers searching for a market niche have touted gender-specific products. The ability of a manufacturer to market directly to patients, combined with the proliferation of information available via the Internet, has had a big impact on patients’ perspectives. As noted by Laura Quigley, APN, clinical nurse specialist for Rush Hospital’s joint replacement program in Chicago, service providers now have the challenge of helping educate and guide the patient regarding the appropriate use of resources and devices.

The core distinction in gender-specific devices is that the size of the implant is generally slightly different to reflect different sizes in bones between genders. It may also provide for a narrower shape, a thinner shape and an increased groove angle. The hope is this will lead to better function and longer durability. Many orthopedic physicians will tell you that implants already come in different sizes so that the concept of gender-specific is really a marketing term and not a real change.

Additionally, new approaches to joint replacement are publicized as superior because they are minimally invasive. Minimally invasive, in simple terms, means making an incision that is much smaller than those made in traditional joint replacement surgery, usually measured as one-half the traditional size incision or less. While minimally invasive procedures are generally desirable, this marketing claim raises certain issues.

The purported core positives to minimally invasive procedures are that they can lead to better cosmetics, less discomfort and less blood loss. On the negative side, such techniques can impair the surgeon’s visual field, provide for limited implant and device choices and lead to certain other challenges. There are also other longer-term uncertainties that are still being explored.

The growth in the number of different implant products available also has increased costs, as noted by John Barnard, MD, of the Orthopedic Center of Central Virginia. Physicians have to sift through an increased volume of information to determine the optimal approach for their patients, and this learning curve takes time. With the competition among the devicemakers and the anticipated growth in demand for implants, this trend is likely to continue.

Another trend is that patients receiving implants have a wider range in age; younger and older people are undergoing joint replacement surgeries to improve their mobility. Over the last five years in particular, the number of knee replacements is outnumbering the number of hip replacements, and, according to Ms. Quigley, the growth in knee replacements shows no signs of slowing down.

Arthrocare, in an effort to capitalize on the minimally invasive market, has recently been touting its single-use “spine wand.” Approximately 400,000 lumbar micro discectomies are performed each year. The concept of the spine wand is to use this device in connection with smaller incision spine surgery and coblation technology. Instead of a 6mm access point, this is intended to be used with a 2.5mm access point. The spine wand is used with coblation to dissolve soft tissue. Another ongoing discussion involves the debate over whether disc replacement is superior to inter-body infusion approaches. Here, device manufacturers such as Medtronic assert that total disc replacement, using, for example, Medtronic’s Maverick metal on metal prosthesis, is superior to fusion technologies.

Business issues

Devicemakers are capitalizing on the demand for joint replacements through an increased number of initial public offerings. Last year was a record year for IPOs for healthcare providers, devicemakers and technology companies. From January to November 2007, 11 device companies filed plans for IPOs. The rise in volume of initial public offerings has increased costs, as noted by John Barnard, MD, of the Orthopedic Center of Central Virginia. Physicians have to sift through an increased volume of information to determine the optimal approach for their patients, and this learning curve takes time. With the competition among the devicemakers and the anticipated growth in demand for implants, this trend is likely to continue.

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Anti-kickback and related conflict of issues

Several well-publicized legal cases highlight the risks devicemakers face. Although these manufacturers must necessarily market their products to physicians who decide whether to use, the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)(1)(B), constrains the manufacturers’ business practices in trying to promote their products.

One recent example of this legal risk is the indictment of Arkansas neurosurgeon Patrick Chan, MD, for violation of the federal Anti-Kickback Statute. The four-count indictment was filed in the United States District Court for the Eastern District of Arkansas in October 2006. The indictment charged that from January 2004 until June 28, 2006, Dr. Chan demanded that distributors for four medical supply companies pay him 50 percent of their commissions on the sales of any products he used in his neurosurgery practice. The indictment alleges that Dr. Chan received approximately $7,000 to $8,000 per month for two-and-a-half years. On Jan. 3, Dr. Chan pled guilty to one count of violating the Anti-Kickback Statute and is awaiting sentencing. Dr. Chan also faces a civil qui tam
suit brought by the whistleblower who disclosed his kickbacks to the government, and civil medical malpractice claims by patients claiming he prescribed unnecessary procedures in order to sell more products and receive the kickback payments.

Another well-publicized legal problem relates to the ongoing federal and state investigations into devicemakers’ consulting payments and other transfers of value to physicians which may constitute illegal inducement or bribes in violation of federal and state Anti-Kickback statutes. The spinal and cardiac devicemaker Medtronic has recently announced that it is undergoing investigation by the United States Justice Department, the Senate Finance Committee, the United States Attorney in Philadelphia and the Securities and Exchange Commission concerning payments it has made to doctors. The SEC has jurisdiction to investigate payments by publicly held companies to foreign doctors under the Foreign Corrupt Practices Act, which generally prohibits foreign bribes.

Similarly, orthopedic devicemakers Biomet, DePuy, Smith & Nephew, Stryker and Zimmer have recently settled federal investigations into their business practices by agreeing to eighteen months of federal monitoring and paying a combined total fine of $311 million. Stryker, it should be noted, did not have to pay any fine as it voluntarily cooperated with prosecutors before the other devicemakers and executed a non-prosecution agreement with the government. None of these devicemakers admitted to any liability in this settlement.

In the ASC industry in particular, as the number of joint-ventures between hospitals and physicians grows, there is likely to be increased scrutiny on the potential conflict of interest involving the use of specific devices. In particular, a conflict of interest can occur when doctors direct hospitals to buy devices from companies from which the doctors receive royalties. For example, Jay Yadav, MD, is suing the Cleveland Clinic because he was fired regarding a stent he helped develop and for which he receives royalties from the stent-maker. The Cleveland Clinic claims that the doctor failed to disclose the financial relationship, resulting in his dismissal.

In addition to the federal investigations, state regulators are beginning to exercise their oversight authority. In February 2008, the New Jersey Attorney General announced that it is investigating devicemaker Synthes Spine, which manufactures an artificial spine disk called ProDisc. Synthes Spine has touted the ProDisc based on the results of a study that concluded that the disk works better for patients than standard spinal-fusion surgery, but apparently many of the physicians involved in the study had agreements with Synthes Spine under which they would profit if ProDisc became successful. The attorney general is investigating whether Synthes Spine properly disclosed the financial interest of the physicians involved in the study and has subpoenaed documents from the company, as well as the venture capital firm that provided the initial funding to develop the ProDisc. The FDA is also investigating whether the physicians’ investments in ProDisc were properly disclosed.

Additionally, recent reports question the efficacy of the ProDisc device and evidence supporting the marketing claims, indicating that some patients have had difficulties with the device. There is likely to be additional scrutiny of claims that particular devices achieve results in clinical studies. Indeed, the Association for Ethics in Spine Surgery, a recently formed organization of spine surgeons, states that it is dedicated to promote “evidence-based medicine” and to educate the public about “the detrimental and pervasive financial influence of industry on many health care providers and patients.”

Other legal issues

Devicemakers caught a significant break when the United States Supreme Court ruled in favor of manufacturer Medtronic during the closely watched product liability case, Riegel v. Medtronic. Charles Riegel had sued Medtronic over an allegedly faulty catheter which had received approval by the FDA. The court upheld Medtronic’s argument that once the FDA approves a drug or medical device, no patient should be allowed to file a claim in state court alleging that the product has a defect. The industry argued that FDA approval should bar such claims and not simply be part of a defense, as the plaintiff proposed. The plaintiff also contended that FDA review is not as rigorous as the industry claimed. The Supreme Court based its ruling on the interpretation of Congress’s intent in the FDA statute, so Congress now has the power to disagree with that interpretation and enact a new law to clarify its intent. Because the current administration sided with the industry in Riegel, the upcoming election could affect this issue if there is a change in power in Washington.

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1 We appreciate the assistance of professionals who have contributed to this article, including Dr. John Barnard of the Orthopedic Center of Central Virginia in Lynchburg, Va.; Dr. Philip Davidson of the Tampa Bay Orthopaedic Specialists; Rick Ferguson of the Oklahoma Orthopedic Hospital in Tulsa, Ok.; and Laura Quigley, APN, and Margaret Hickey, APN, of the Rush University Medical Center’s Department of Orthopedic Surgery in Chicago.

2 See the AESS website at www.ethicalspinesurgeon.org.

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5 Challenges Currently Facing Orthopedic and Spine Practices

By Renée Tomcanin

The current struggling economy has impacted many industries, including orthopedic and spine practices. As a result, many practices are facing challenges to remain profitable and efficient. Here are five major challenges identified by industry experts that orthopedic and spine practices may face in this economy:

1. Increase in high-deductible healthcare plans, low reimbursement rates and uninsured patients. As the economy continues to struggle, copays and deductibles on many patients’ healthcare plans also continue to rise. Alan Davidson, executive director of the Orthopedic Institute of Pennsylvania in Camp Hill, says that this trend can lead to many patients not paying their copays at the time of their procedures.

Don Love, administrator of an orthopedic practice in Roanoke, Va., mentions several ways in which practices can help collect payments from patients, including pre-screening each patient’s insurance benefits prior to the office visit to determine coverage eligibility and collecting copays at the time service is rendered. “It is important to help patients understand and be aware of what their copays and deductibles will be,” he says.

Mr. Davidson agrees that increased attention to the workings of the revenue cycle will help combat this problem. “Staff must be trained to collect these payments at the time of service,” he says. “Some insurance contracts provide obstacles to timely collection, and these clauses must be negotiated out of payer contracts.”

As the unemployment rate increases, practices will see the number of uninsured patients rise as well. Mr. Love says that his practice saw uncompensated care increase significantly from 2007 to 2008. According to him, it is important for physician practices to evaluate the amount of uncompensated procedures and excessive paperwork.

In addition, Dr. Austin notes that many patients have employers who constantly switch healthcare providers, and oftentimes the patients are not aware of what their requirements are as they change from plan to plan. “Insurers make it as difficult as possible for patients to understand,” he says.

In order to protect their free-enterprise rights, Mr. Davidson encourages orthopedists to become more active in politics and to improve their own lobbying efforts. “Physicians need to reeducate legislators concerning the central role of the physician in healthcare,” he says. “They need to dispel the notions that have been fostered by lobbyists and are imbedded in some politicians that physicians are untrustworthy because they wish to foster competition in healthcare.”

Dr. Austin agrees that there is a trend in politics today for the government to take more control over healthcare. “Some politicians tend to think, ‘we’re the government; we know better,’” he says. “However, that can be the quickest way to create problems.”

3. Demonstrating quality care. As patients become more cautious with their money, they will put a higher stake into finding the best quality of care. Web sites, such as HealthGrades.com, make it easy for patients to find reporting of a physician or hospital’s quality of care. Mr. Love suggests that practices should take a proactive approach to collect their data to demonstrate quality, efficiency and level of patient satisfaction.

4. Retaining staff. A struggling economy may cause orthopedic and spine practices to closely monitor their staffing expenses, which may lead to salary cuts and layoffs. In addition, many practices may be faced with choosing savings over the quality of their staff.

Mr. Love says that “highly motivated and competent staff are one of the keys to a practice’s survival.”

5. Managed care contracting. The state of the economy may make negotiating managed care contracts more difficult for orthopedic and spine practices. According to Mr. Love, health insurance payors who have more than 25-30 percent of a given market will make it increasingly difficult for practitioners and physicians to negotiate those contracts. “Those payors will have a take it or leave it attitude with physicians.”

Mr. Love sees no easy solution to this problem, but it is important for practices to be aware of what this challenge will mean in terms of cost and revenue.

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Developing Centers of Excellence — Key Concepts, Strategies and Tactics

By Scott Becker, JD, CPA, and Lindsey Dunn

The importance of developing outstanding programs, often referred to as “Centers of Excellence,” in specific specialties has taken on new importance in critical specialties such as orthopedics, neurosurgery and spine, cardiology and oncology. This article discusses how developing a grand vision or plan comprised of clear goals can guide the development of a Center of Excellence. This article then examines specific strategies and tactics that can be used to implement such a plan.

Systems that develop dominant service lines can attract more patients, higher margins and more physicians. An outstanding or dominant service line can make a hospital a destination in an area of care and serve as a magnet for a range of opportunities. Thus, many hospitals and systems are constantly considering plans to develop a specialty Center of Excellence in conjunction with a group of physicians within that practice area. Such efforts, if developed well, can also provide physicians who are involved in the effort a competitive advantage in recruiting additional physicians and attracting patients.

Physician-hospital relationships

There are currently a great number of changes evolving in physician-hospital relationships. These include substantial changes in the way in which hospital and physicians interact with each other. The overall landscape as to what types of relationships are being undertaken is moving very fast. These relationships again, in return to a 1990s strategy, include employment of physicians and acquisitions of practices as well as many variations in relationships. The employment efforts may prove to be beneficial or may again lead to serious financial problems for systems.

There are more legal concerns with regard to physician-hospital relationships than ever before. This is likely to complicate the development of Center of Excellence concepts. These concerns arise, for example, under the Stark Act, the Federal Anti-Kickback Statute, the Tax Exempt Rules and Regulations applicable to exempt hospitals, the False Claims Act and state laws. Every week there appears to be a report of a new case or settlement related to hospital-physician relationships or other payment relationships. The employment efforts may prove to be beneficial or may again lead to serious financial problems for systems.

A leader of a hospital or health system driving the development of a specialty-driven program must be able to defend his or her tactics both from a legal and business perspective. To a great degree, the question will ultimately come down to, “Is the system developing and engaging in a grand plan for a specific area of care?” or “Is it simply utilizing tactics to capture referrals?”

Develop an overall vision

A grand, overall vision or plan is critical for a facility or program to become dominant in a specialty area. Specific strategies are then developed in light of this plan. If strategies are not utilized in connection with a grand plan, it is much more likely that the efforts will fall short, from a business perspective. It also increases the chances that the implementation will simply look like payments for referrals as opposed to tactics aligned an overall plan.

Clear and big goals

There are a few critical efforts that need to be made early on at the inception of a plan. First, the hospital or system and its physician leadership must define its overall goal — i.e., what is it trying to accomplish? For example, is the program trying to be the best orthopedic program in the state? Is it trying to be a program that does more procedures of a certain type than any other system? Or, in contrast, is it trying to be a global leader in orthopedics and to develop an international brand in orthopedics or spine? Will the grand plan include a research or teaching function?

The system, in addition to this grand vision, may have other specific goals such as cost savings, improving trauma care, reducing wait times, providing all services or offering pediatric orthopedics. A grand vision with a clear goal is a prerequisite for determining the tactics that will be implemented by the parties to help the specialty program meet that goal. At the end of the day, the more that a system builds a grand vision and a clear plan as to what it wants to be known for, the easier it is to build tactics and strategies around those plans.

Senior leadership must drive the plan

Hospital and physician leadership must not delegate the plan. Rather, the highest level of leadership should be involved in the plan from the very beginning and all the way through implementation and operation. The more that the system sees leadership such as the CEO and top physicians in the specialty involved in every meeting related to the plan, the easier it will be for the hospital and physicians to take action and gain buy-in throughout both systems. Delegating a critical plan and not involving key leadership throughout almost always leads to the ultimate failure of the plan.

Role model hospital or program

As a system begins to form a concept or idea for its grand plan, it is very helpful to seek a role model hospital or center to use as a guide in developing its own plan. For example, can you find two or three hospitals or systems that have the attributes that your system or plan desires? Is there a great example that you could model your plan after? After determining a role model hospital or program and finalizing your own grand plan, one starts to determine tactics and strategies that will support and comprise the plan. Many of these will be similar to those used by the model system.

Tactics and strategies

There are several tactics and alignment options that can be used to implement a plan. The tactics utilized range from full integration tactics to minimal integration efforts to a number of hybrid efforts. All tactics used should be targeted to meeting the big goals.

Full integration

There are at least two core types of full integration models. The less common example of a full integration model is a whole hospital joint venture between a hospital and physicians. One example of this type of venture is the Institute for Orthopaedic Surgery in Lima, Ohio, between St. Rita’s Medical Center and physicians. The Institute, a specialty orthopedic hospital, is majority owned by St. Rita’s. However, physicians also have a financial stake in the facility. The Institute was originally developed by physicians.

Another increasingly common type of full integration model involves a situation where the physicians become employees of the hospital or a related subsidiary. For example, the dominant orthopedic group in Greenville, S.C., was acquired by a local hospital system a few years ago. This has become more common again in critical specialties. A few years ago the idea of large orthopedic groups or neurosurgeons being acquired by hospitals would have been immediately disposed of. Now, employment is often a critical part of developing a dominant service line.
Semi-integrated models
Many parties pursue different types of semi-integrated ventures. These can include joint ventures for surgery centers, joint ventures for equipment and real estate, joint ventures which will provide management services and several other types of joint ventures. Here, one big distinction between true provider joint ventures such as those involving ownership of a whole hospital or a surgery center are that physicians can own an interest in the venture, derive the real profit from the venture and take real risk with the venture. In contrast, with equipment or real estate joint ventures, the payment to the lessor entity must be fixed fair market value and cannot vary based on the volume of business performed at the provider that the lessor leases to. In essence, there will not be any revenue or profit and loss congruence between the leasing entity and the provider that leases the equipment or real estate.

These semi-integrated models may be one dimension of an overall plan to develop a dominant service line.

Compensation relationships
A third type of integration effort revolves around compensation relationships. These include many different types of arrangements. These can include call coverage arrangements, trauma arrangements, medical directorships, gain sharing arrangements, teaching relationships, research relationships, administrative/management relationships and several other types of payment relationships. The more that these are developed in light of a core, overall vision and clear plan for what the system desires to accomplish, the easier it is to reasonably justify having several different types of relationships with your physician specialists which the center of excellence is being built around. Almost all of these arrangements must be in writing and almost universally cannot vary or have payments tied to the volume or value of referrals by the physicians. This can be a critical part of developing leadership in an area of care.

Managed care strategies
A last general model of integration revolves around integrating and coordinating managed care functions. These can involve physician-hospital organizations that serve as managed care entity contracting ventures or bundled price initiatives. For example, a party might work on an alternative pricing model whereby the physicians and hospital jointly sell an entire package related to the top 10-20 most important orthopedic procedures or cardiovascular procedures. This has been experimented with in some circles and was experimented with to a greater level 10-12 years ago. However, with increased consolidation of payors, this approach again offers a way for providers to attempt to band together in the marketplace. As such, we are seeing an increase in this activity.

Four more examples
Four other examples of working together with physicians towards development of a dominant position in a service area are as follows:

Co-marketing and branding. Certain systems have evolved outstanding co-marketing efforts with independent group physicians to jointly demonstrate the strength in the services and build a brand around those services. A great example of this involves the Rush University Medical Center and the orthopedic program at Rush. The joint marketing program which highlights and includes the physician leadership is outstanding and its overall focus on the Rush orthopedic program is excellent.

VIDS approach. Another concept that parties use to jointly align services is something that we have seen called a virtually integrated delivery system. Here, independent parties, such as a hospital and lead group of physicians,
subject to certain anti trust requirements, work closely together to decide how they can approach the market in as aligned a manner as possible. This may include weekly strategic meetings on how they approach the market and several different implementation alternatives. This may or may not include various different financial relationships.

Acquisition of practice. We are again seeing many systems examine acquiring practices (and then employment of the physicians) to provide a beachhead in certain service lines. This again is an example of a full integration model. This may be aimed at having more critical mass in an area than any other competitor or to acquire specific expertise.

Professional services agreement. We see some situations where a hospital will buy a certain amount of professional services to provide them some contingent in a specialty where they are otherwise completely reliant on independent contractors or staff physicians. This may include a professional services agreement whereby a system buys the services of three full-time orthopedic physicians from a group. The group and the individual physicians are generally required to be on the contract pursuant to Stark Act and billing requirements.

Choosing a few key strategies

Given that there are several different, major categories of ways to work with physicians to develop a dominant program and then numerous different tactics within those, we often recommend that a party choose no more than two or three key strategies to really pursue as part of establishing and implementing a plan. This might be the mix of a joint venture strategy together with employment models or a mix of employing some physicians but much more heavily relying on other types of compensation agreements with others to align efforts with the core goals.

This is intended as a summary of some of the planning and strategies involved in developing a specialty-driven area of dominance or a Center of Excellence. Should you have further questions as to these issues, please contact Scott Becker at (312) 750-6016 or at sbecker@mcguirewoods.com.

For more information or an introduction to any of the following companies, e-mail sbecker@mcguirewoods.com, call (800) 417-2035 or fax with the company circled to (866) 678-5755.

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Centers of Excellence Achieved by Focus, Sweat and Determination

By Mark Taylor

Hospital executives leading nationally recognized superior programs offer a variety of tips for achieving those coveted designations, but they all sound like variations on the answer to that old Broadway joke: How do you get to Carnegie Hall? Practice. Practice. Practice.

Executives from four award-winning hospitals took different approaches to achieving distinction. And their advice reflects that. Hire good consultants. Listen to your doctors and patients. Study and improve your processes. Integrate the latest, evidence-based practices and protocols. Design the facilities to focus on the patient. Make it easier for physicians to practice there. Sweat the details.

“It’s not one thing,” points out Kevin Lundon, vice president of operations for 525-bed St. Joseph Hospital in Orange, Calif. “It’s a whole series of commitments.”

Mr. Lundon says his hospital achieved the ranks of U.S. News & World Report’s “Top 50 Hospitals for Orthopedics” in 2007 and 2008 by committing to improvement. Mr. Lundon, who oversees orthopedics for St. Joseph, says the organization decided with its physicians to distinguish themselves as the best in its region. “The goal was linking with our physicians and not just treating orthopedics as another procedure, but to develop it as a topnotch program.”

Mr. Lundon says St. Joseph hired an experienced program coordinator to oversee the entire orthopedics continuity of care, from pre-op to post-op and follow-up, and built dedicated orthopedics, spine and joint specialty teams working exclusively within those areas.

“As they become more expert in orthopedic procedures, it allows for very smooth procedures and helps to make the patient experience the best possible,” he says.

The program hired joint and spine surgical coordinators to work with the dedicated teams and coordinate supplies, equipment and implants, getting the programs off the ground in 2004.

“It takes years for those teams to coalesce and work well together,” he says.

Mr. Lundon says surgeons need three things to be happy and successful: tools, time and teams. The hospital spent more than $500,000 on the most advanced surgical tables, microscopes and a computerized joint system. “We made a commitment to being leading edge. We committed to our surgeons to allow them to be the most efficient practitioners they could be.”

St. Joseph provided the high volume surgeons with PAs to assist them. The most efficient surgeons are allowed to “flip” two of the hospital’s 31 operating rooms and patients are transported post-op to a 30-bed orthopedics unit staffed exclusively by a post-op nursing team. The hospital, which is one of only a few hundred designated a Nursing Magnet Hospital for nursing excellence, also invested in the “SMART OR” program.

The hospital’s efforts weren’t recognized only by awards. Orthopedic volume has increased by 25-40 percent and the program’s contributions to the hospital margin have risen commensurately, particularly in the spine program. Mr. Lundon says St. Joseph logged the third highest volume of orthopedic procedures in California in 2008, performing 28,000 inpatient and outpatient surgeries, among them about 1,200 joint replacements.

“You need phenomenal surgical expertise and we’re blessed to have high quality surgeons and great nurses,” he says.

Integrate health improvements throughout the hospital

Colleen Becker, director of peri-operative services for the Barnes Jewish Hospital Center for Bariatric Surgery, says the St. Louis center for treating obesity dates to the late 1970s. But it expanded its focus to include the entire continuity of care at Barnes Jewish, involving pre-counseling, dietary, social work, mental health and rehabilitation, as well as patient families and even former patients.

“We believe in working together to best manage the patient’s needs,” Ms. Becker says. “We saw this as an opportunity to improve outcomes and wanted to pursue the centers of excellence designation.”

Barnes Jewish was designated a Center of Excellence by the American Society for Bariatric Surgery, which sets standards for care. “They left no stone unturned,” she recalls.

To achieve designation, the organization pulled together a bariatric care committee that involved multiple services from throughout the hospital and involved other departments from surgery to oncology.

“We examined everything, from the kind of slippers we offered to the size of the bed and toilets and chairs in the cafeteria and the IV catheters, from shower curtains to ambulances and helicopters and the stretchers and tables we use,” says Ms. Becker. “We looked at equipment and whether it met our needs. We realized that the bariatric population is throughout the hospital, not just in our center. We don’t separate them out.”

She says the results of those efforts manifested itself in new designs and influenced construction projects throughout the hospital, not just within Barnes Jewish.

“Our entire environment was evaluated for all patients, not just bariatric patients. It expanded our entire focus from the time patients enter as outpatients or in patients. We looked at every facet of how we provide care,” she says. “The changes spanned the organization.”

She says the organization’s gastric bypasses have increased since 2005 and overall hospital patient satisfaction scores have risen as well. Surveyed bariatric surgery patients reported higher quality of life outcome scores.

“The program has helped boost the hospital overall and supports our hospital mission. Bariatric surgery isn’t always profitable, but it’s the right thing to do,” she says.

Treat well patients like healthy patients

Teresa Woodard, administrative director of rehabilitation and sports medicine for 262-bed Bon Secours St. Francis Health System in Greenville, S.C., says that program won distinction in U.S. News & World Report as one of the nation’s best hospitals for orthopedics and joint replacement.

Ms. Woodard says St. Francis began by contracting with a consulting group, TVC, which advocates a very standardized approach to healthcare delivery. She says the hospital organized a multidisciplinary group that still meets monthly to develop care pathways and documentation templates for physicians.

“We’d always had a good program. But we were trying to get over that last hurdle to the next level and that’s when we thought we needed outside help, a model to work from,” she says.

Ms. Woodard explains that all the orthopedic patients except hip patients are well people choosing to have surgery. “And we treat them that way. There’s a lot of emphasis on education, bringing patients in early so they know what to expect. We involved family members. We call the joint replacement program, Joint Camp.”

She says the Joint Camp concept resonated with staff, physicians and patients, who were getting mobile sooner. “We branded everything. There were Joint Camp tent cards and T-shirts and
coaches’ pins and group exercises. We tried to make it fun. There’s a graduation ceremony.”

The results have validated the investments. Joint replacement volume more than doubled from 704 in fiscal 2003 to 1,664 in 2008, the most in South Carolina for the fifth consecutive year. Total inpatient orthopedic volume grew as well, from 1,775 procedures in 2003 to 2,762 last year. The program also achieved the top decile in patient satisfaction at both campuses for orthopedics and earned a 2005 award from Premier for hip and knee replacement. Ms. Woodard says the contribution margin for inpatient orthopedics has increased 50 percent in the past three years and by 25 percent for outpatient orthopedics. HealthGrades has conferred its five-star ranking on St. Francis in hip, knee and total joint replacement through 2009. Regionally HealthGrades ranked St. Francis 7th in the Southeast in joint replacement and 18th in overall orthopedics through 2009.

Community outreach programs connect prospective joint replacement patients with St. Francis doctors and promote the program.

“We help them build their practices,” she says. “The patients love it. Our scores average between 97-99 percent. Our market share has risen from 24 percent to 32 percent and the doctors appreciate what we’ve done for their patients.”

**Starts with ground up and top down**

Jeff Senall, MD, who chairs the department of orthopedics at the Central DuPage Hospital in Winfield, Ill., says its successful orthopedics programs starts from the ground up and goes the top down.

“We strive to be the best and everything we do is based on being in the top decile in country,” Dr. Senall says. “That approach is taken in every hospital department, but certainly in orthopedics.”

But saying it alone didn’t make it happen. Dr. Senall says the orthopedics program worked hard to improve an already solid department.

“Our recent administrations have had a vision of being the best, of being a destination hospital. We were one of the first in the country to do joint replacements and we’ve always had strong clinicians,” he says.

He says Central DuPage reexamined its processes, improving the turnaround time between cases so doctors who wanted to could perform more procedures. The hospital changed the way surgical instruments are processed to track them better and improve efficiency.

Dr. Senall says Central DuPage performed 1,459 joint replacements in 2008 and expects to do 2,000 this year, and the orthopedics department performed 4,400 procedures, accounting for about one-quarter of the hospital’s 17,225 cases. Orthopedics accounted for 10.4 percent of revenue in fiscal 2007, and that figure is expected to rise to 11.3 percent in 2009.

“We are second in the state in the number of joint replacements and for years we’ve had a fellowship program training fellows from Rush University (in nearby Chicago). That was a big move for a community hospital and helped increase our volume in joint replacements. We’re very lucky to be financially sound as a hospital to be able to provide the resources that our patients and doctors want and to make it easy for surgeons to practice here,” he says of the program, which staffs 31 orthopedic surgeons from nine group practices.

Contact Mark Taylor at mark@beckersasc.com.
Adding Outpatient Spine to Multi-Specialty ASCs

By Joseph Stapleton, MD

About one year ago, my partners and I decided to add spine cases to our outpatient surgery center, the East Portland Surgical Center (EPSC). It was a big decision, with important clinical and operational implications, so we thoroughly assessed the risks and opportunities before moving forward. I’m pleased to report that our decision has worked out very well.

Of course, our surgery center was in very solid shape before adding outpatient spine. That may be the most important conclusion to draw from our experience. Yes, spine cases offer great revenue potential and can be profitably added to existing multi-specialty ASCs — but only if surgeon-owners proceed carefully and clearly understand a few critical issues. At a minimum, existing surgery centers that want to add spine should have:

• an efficient operational environment (with excellent scheduling practices);
• good working rapport with the new spine surgeons (whether or not they are investors);
• a strong and highly skilled team; and
• the ability to contract effectively.

In other words, a surgery center with a strong backbone can add spine cases without disrupting clinical operations or taking on unnecessary risk. Conversely, ownership of underutilized centers should very carefully deliberate before adding spine if they view new revenue from spine as a means to save their businesses should. Again, it’s a huge decision.

Starting from strength
As a physician, I’m very proud of our surgery center. We have an outstanding clinical staff committed to the highest standards of care and patient satisfaction. Patients love the environment, which is convenient, comfortable and welcoming and therefore helps lessen the anxiety felt by patients and their families regarding surgical care. My partners at EPSC feel we’re more productive at our center and, better yet, able to focus fully and completely on patients.

As a business, we have enjoyed a healthy run of profitability in the few years since the physicians teamed with Blue Chip Surgical Center Partners to purchase an underperforming business from a large national ASC chain. In establishing new management procedures and clinical processes, we generated outstanding returns — 100 percent ROI in the first year and 200 percent in the second year. Today, we see a large and consistent number of patients, including eye, GI, orthopedic, ENT, general surgery and pain management cases in our three operating rooms and two procedure rooms. We have formed good working relationships with the major payors.

Overall, my partners and I are happy — both clinically and financially — with what we’ve developed at EPSC. It’s gratifying to be a part of an efficient, well-managed operation, where people like coming to work, trust their colleagues and can do great work. So, when it came to adding spine cases, we were confident and had a lot working in our favor.

Addressing the issues
Still, we proceeded deliberately because spine presents unique challenges. We looked carefully at the clinical literature, which made clear that complication rates for appropriate spine cases are no higher in ASCs than in hospitals. On the business side, we knew that spine offered a lot of revenue for a relatively small number of cases but also that the contracting was complicated. Since we would be competing with hospitals on spine cases (as opposed to other ASCs), we were confident that we could offer lower costs. Our goal was to capture some of that savings for our surgery center but have the bulk of the savings accrue to patients and payors.

There were important questions to ask: Did existing agreements keep us from out-of-network reimbursement, which was higher? What about implants and supplies? The regulatory issues can be just as problematic. For example, some states prohibit overnight stays or require minimum post-operative stays. Though these policies can be “dealbreakers,” they weren’t a major obstacle for us but rather a practical detail (one of many) that had to be worked out.

Finding the right surgeons
After working through contracting and regulatory issues, we next addressed an equally important consideration: who will bring the cases and perform the surgeries. It’s possible that existing partners can bring spine cases, but it’s more likely that new relationships with individual spine specialists or neurosurgery practices will be necessary.
In identifying new surgeons to invite to EPSC, there was healthy dialogue among our ownership group. We sought clinically distinguished physicians with excellent reputations but also wanted hard workers and team players. These qualities make for excellent partners in any type of surgery center. But the most important criterion was a high level of caution in patient selection. Not every spine case is appropriate for outpatient facilities. Surgeons must carefully examine patient weight and respiratory history, incision routes and other factors before choosing between an ASC and hospital for specific procedures.

We first engaged with one neurosurgeon we knew and regarded highly and, several months later, invited a few more to bring cases to our surgery center. So far, it's been a very good fit. I think what these physicians like most about operating at EPSC is that their patients are more comfortable and that it's so easy to check on them after procedures are complete. Of course, these benefits apply to all specialties, not just spine.

To smooth the new physicians’ transition, we encouraged our new colleagues to start with the easiest, most straightforward cases (e.g., carpal tunnel, ulnar nerve and laminectomies). Once the surgeons grew comfortable with the people, equipment and procedures at our center, they began transferring anterior cervical discectomy and fusions and other more challenging cases. This gradual transition also gave everybody a chance to get to know each other. It's not necessary that everybody at an ASC become great friends; it is necessary, however, for everyone to get along generally, share similar standards for clinical quality and respect basic business requirements and operating policies.

And there will be occasional issues to address. For instance, one of the new neurosurgeons was welded to a specific set of instruments, which was much more expensive than what we already had. One of surgeon-partners met with him to hear his concerns and discuss the issue of standardization. Once the new surgeon understood the financial impact — our costs would have been several times higher for each patient — and tried our standard equipment, he agreed to switch.

Whether or not the new surgeons ultimately become owners in EPSC remains to be seen. But the “try before you buy” approach has been mutually beneficial; the spine surgeons now operating EPSC have seen our staff in action and what we offer in terms of patient experience; at the same time, our center benefits from more revenue, increased exposure in the community and the opportunity to vet future partners.

**Preparation and training**

Staff preparation, especially in anesthesia protocols and discharge policies, is another critical element in successfully adding spine. Patient care and safety is the absolute number one priority at our center. Thus, we had to ensure we had the formal procedures in place for recovery and discharge, and appropriate staff on hand at all times. We developed detailed plans for patient transfer in the event of complications. In terms of anesthesia, I was comfortable handling many types of spine cases in an outpatient setting but I had to ensure everybody else shared my confidence. In particular, the lower sedation levels dictated by shorter recovery times were an adjustment for some anesthesiologists and nurses. We did a fair amount of education and communication on the clinical side before taking our first spine case.

And it wasn’t just our staff that needed training and education. Because outpatient spine is a relatively new phenomenon, it’s important that everybody patients interact with — referring doctors and primary care physicians and their office staffs and schedulers — believe in it. If one person says, “Usually these procedures are overnight stays,” patient anxiety can go up.

For that reason, my partners and I proactively reached out to the local medical community, sharing outcome data, detailed post-op protocols and other relevant information. We also expressed our confidence in the entire team at EPSC. And, again, we emphasized that referring the simplest cases first was a good idea.

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**Getting practical**

Adding spine cases to our already busy schedule required us to make some adjustments. Some of my partners gave up their preferred slots early in the day to give the new surgeons ample block times. Spine cases need to be done in the morning to ensure there’s ample recovery time. Here again, the partners led the effort to educate staff and other surgeons who use our center of the changes to come and why they made sense. That helped ensure the new stream of cases was quickly and smoothly integrated into operations.

Equipment was another question we addressed. We already had a C-arm but decided to add a second to eliminate potential scheduling conflicts. We also plan to add a second set of neurological instruments. These decisions were not taken lightly. We drew up a clear business case establishing the link between new equipment and increased revenue, negotiated with our supplier and made the purchase in cash. We didn’t want to compromise our new revenue stream with unnecessary capital investments.

**Bottom line: The promise of outpatient spine**

Given the growth rate in case volumes and attractive reimbursement rates, it’s clear that more multi-specialty surgery centers will want to add spine cases in the future. Our experience shows it can be profitably done — provided center management proceeds carefully and understands both clinical and business impacts. We also benefited from having efficient operations, a strong team and trusting partnership group, rock-solid contracts and a thoughtful approach to identifying spine surgeons to invite to our center. In other words, it was our strong business and clinical backbone that allowed us to add lucrative spine cases to our already profitable center.

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