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BECKER'S
ORTHOPEDIC & SPINE
REVIEW

Business and Legal Issues for Orthopedic and Spine Practices

20 Shoulder Specialists to Know

Vivek Agrawal, MD — Dr. Agrawal is director of The Shoulder Center in Zionsville, Ind., which specializes in providing advanced care for shoulder problems. As a college student, he injured his shoulder playing competitive tennis, and the lack of available, adequate treatment piqued his interest in shoulder care.

Dr. Agrawal received a bachelor of science in biochemistry from the University of Illinois at Urbana-Champaign and his medical degree from the Indiana University School of Medicine. He completed his surgery residency at Indiana University and a shoulder and knee fellowship with Dr. Eugene Wolf in San Francisco. He is a member of the Arthroscopy Association of North America, the American Academy of Orthopaedic Surgery and the American Board of Orthopaedic Surgery.

David W. Altchek, MD — Dr. Altchek is an attending orthopedic surgeon and co-chief of sports medicine and shoulder service at Hospital for Specialty Service in New York, N.Y., and

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Improving and Maintaining Profitability in Orthopedic and Spine Practices: 12 Areas of Focus

By Renée Tomcanin

Recent reports in the media show that many healthcare practices are losing money in this struggling economy. However, many orthopedic and spine practices have managed to implement initiatives that have helped them to maintain profits. Others have reexamined their practices and found simple ways to improve current procedures. A few more have investigated new business opportunities that have helped increase profits.

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10 Large Orthopedic Practices to Know

By Lindsey Dunn

Proliance Surgeons (Seattle). Proliance Surgeons is one of the largest surgical practices in the country, with 160 physicians specializing in orthopedics, ENT and general surgery. The surgery practice features 100 orthopedic surgeons who treat patients at a number of hospitals and 13 outpatient surgery centers owned by Proliance surgeons. All of Proliance's orthopedic surgeons have training in general orthopedics with additional specialized training in sports medicine, joint reconstruction, arthroscopic surgery, spine surgery, hand surgery, foot surgery, fracture care and major orthopedic trauma. Proliance surgeons see patients in 30 office locations in four counties and received approximately 600,000 office visits last year, two-thirds of which were orthopedic cases.

David Fitzgerald, CEO of the practice, says that the practice's success comes from its ability to

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Publisher's Letter

Healthcare Reform; Hospitals and Health Systems: Improving Profitability of Orthopedic and Spine Programs - Growing Volumes, Assessing Financial Relationships, and Business and Legal Issues – October 7th; 16th Annual Improving the Profitability of ASCs Conference (Oct. 8-10, Chicago) - Special Discounts Available; Free White Papers Available

The first six months of 2009 have been an extraordinary time in the healthcare sector. First, this letter first discusses certain observations regarding healthcare reform. Second, this letter notes new white papers available and provides information on two upcoming conferences.

1. Healthcare reform. The healthcare industry, including both payors and providers, is starting to consolidate its positions against significant healthcare reform. Healthcare reform can briefly be categorized into two distinct parts. First, covering the uninsured. Most parties are wholly for some method of assuring that all people have coverage. With coverage, the core concerns seem to be will coverage lead to reduced reimbursement or to extraordinary national debt. Second, providing an alternative option, a "public option" for insurance, to traditional managed care plans and companies. It is the second part of healthcare reform that has parties greatly concerned.

From a payor perspective, a public option is viewed as government-sponsored competition against them. Further, they have concern that a government-sponsored model will be less expensive, that the government will have to deal with less problems (e.g., can unilaterally set rates and it will be immune from lawsuits) and that it will significantly and negatively impact the number of parties that are covered by the traditional large insurance companies.

From a provider perspective, a public option is concerning because providers get paid, on average, substantially less by governmental plans than they do by commercial plans. For example, hospitals are paid approximately 70 percent by government plans compared with what they get paid by commercial plans. Surgery centers and physicians are generally paid between 70-80 percent on average by governmental plans as compared to commercial plans. Thus, the migration of patients from commercial plans to public plans is viewed by providers as likely to cause a substantial negative direct hit to their revenues. This revenue loss would, in most places, be a direct negative reduction to the bottom line.

Over the last few months and next several months, as the President increases efforts to implement substantial healthcare reform, it will be interesting to see the extent of efforts by parties such as the American Medical Association, the American Hospital Association and the Association of Health Insurance Plans to respond to the President's efforts. At first, these parties tended to give positive lip service to the concepts of healthcare reform. Now that they see that the administration seems quite serious about healthcare reform, the gloves are beginning to come off.

2. White Papers. If you are interested in any of the following white papers, please feel free to e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com and we will be happy to provide them to you.

1) 10 Best Practices for Increasing Hospital Profitability, by Lindsey Dunn.

2) Improving and Maintaining the Profitability of Orthopedic and Spine Practices – 12 Areas of Focus, by Renée Tomcanin.

3) HIPAA Settlements Between Health Care Providers and the Government, by Anna Timmerman.

4) What Hospitals Needs to Know About ARRA and the HIPAA Updates, by Anna Timmerman.

3. E-weekly: Becker's ASC Review and Becker's Hospital Review. If you would like to be added to the *Becker's ASC Review* E-weekly, please go to www.BeckersASC.com or e-mail sbecker@mcguirewoods.com. If you would like us to add you to the Becker's *Hospital Review* E-weekly, please e-mail me at sbecker@mcguirewoods.com or go to www.BeckersHospitalReview.com.

4. 16th Annual ASC Conference: Improving Profitability, and Business and Legal Issues. ASC Communications with the ASC Association has two large conferences planned for the fall. First, we have our 16th Annual ASCs Improving Profitability, and Business and Legal Conference on Oct. 8-10 at the Westin Hotel in Chicago. This year we have nearly 97 speakers and nearly 70 sessions. We have great speakers from the surgery center industry as well as outstanding outside speakers such as Bill Lane, long-term speech writer for Jack Welch; Norm Ornstein, a political commentator of American Enterprise Institute; Craig Frances, MD, a leader in healthcare investing from Summit Partners, and several others. To register for the event, please contact the ASC Association at (703) 836-5904. The brochure for the event is also online at www.BeckersASC.com. If you register for the event, and provide a copy of this letter (or reference this letter) with your registration, and register by Aug. 15, please feel free to deduct an extra $100 from the conference registration.

5. Hospitals and Health Systems: Improving the Profitability of Orthopedic and Spine Programs. We have a second conference planned for Oct. 7. This conference is titled Hospitals and Health Systems: Improving the Profitability of Orthopedic and Spine Programs – Growing Volumes, Assessing Financial Relationships, and Business and Legal Issues. Should you have an interest in this program, please contact (800) 417-2035 or e-mail Scott Becker at sbecker@mcguirewoods.com.

Should you have questions about any of the issues raised in this letter, please feel free to contact me at (312) 750-6016 or at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

20 Shoulder Specialists to Know
(continued from page 1)

has special expertise in arthroscopic surgery of the shoulder. He is medical director for the New York Mets and a medical consultant for the National Basketball Association. Dr. Altchek received his medical degree from Weill Cornell Medical College, where he currently serves as a professor of surgery in clinical orthopedics. He is the author of more than 100 articles and book chapters on problems of the shoulder, elbow and knee. He was also a recipient of American Shoulder and Elbow Surgeons' Charles S. Neer Award.

Joseph Burkhardt, DO — Dr. Burkhardt is an orthopedic surgeon at Brookside Surgery Center in Battle Creek, Mich. He received his medical degree from the Kansas City University of Medicine. He performed his internship at Garden City (Mich.) Hospital, completed his residency at Michigan State University and his fellowship at the University of Southern Florida and The Florida Knee and Orthopedic Center. He is board certified by the American Osteopathic Board of Orthopedic Surgeons.

Stephen S. Burkhart, MD — Dr. Burkhart is an orthopedic surgeon at the San Antonio Orthopaedic Group and a clinical assistant professor in the department of orthopedic surgery at the University of Texas Health Science Center at San Antonio. He specializes in arthroscopic surgery and reconstructive procedures of the shoulder and total joint replacement, and has pioneered a number of arthroscopic shoulder procedures. Dr. Burkhart is a frequent speaker at national and international medical symposia on these procedures.

Dr. Burkhart received his medical degree from the University of Texas Medical Branch at Galveston, completed his orthopedic surgery residency at the Mayo Clinic in Rochester, Minn., and his sports medicine fellowship at the University of Oregon and Orthopaedic and Fracture Clinic in Eugene, Ore. Over the past 20 years, he has invented or patented more than 20 surgical devices and developed new surgical procedures for repairing shoulder injuries. Dr. Burkhart has also helped many professional athletes, including pitcher Curt Schilling.

Dr. Burkhart is a past president and current member of the board of directors and trustees of the Arthroscopy Association of North America, and he is a frequent contributor to *Arthroscopy: the Journal of Arthroscopy and Related Surgery*

William Carlson, MD — Dr. Carlson is an orthopedic surgeon at Treasure Coast Center for Surgery and South Florida Orthopaedics & Sports Medicine, both located in Stuart, Fla. He is board certified by the American Board of Orthopedic Surgery. Dr. Carlson received his medical degree from St. Louis University School of Medicine and completed his orthopedic surgery residency at Wayne State University in Detroit, Mich., where he later served as chief resident. He is president of the medical staff for Martin Memorial Health Systems, also located in Stuart. He served as the chief of the department of surgery at Martin Memorial Hospital and was secretary/treasurer of the executive committee. Currently, he is the team orthopedic physician for Martin County High School.

Claiborne "Chip" Christian, MD — Dr. Christian is the medical director at Baptist DeSoto Ambulatory Surgery Center in Southaven, Miss., and is on staff at Baptist Memorial Hospital-DeSoto, also located in Southaven. He received his medical degree from the Medical College of Virginia at Virginia Commonwealth University in Richmond and he completed his residency in orthopedic surgery at the Campbell Clinic in Germantown, Tenn. He completed his fellowship in sports medicine from the University of Florida in Gainesville, Fla. Dr. Christian is board certified and is a member of the American Medical Association, the American Academy of Orthopedic Surgeons, the Mississippi Medical Association, the American Orthopedic Society for Sports Medicine and the American Academy of Independent Medical Examiners. He has been published in numerous journals including *Clinical Orthopedics and Related Research* and the *Journal of Parenertal and Enteral Nutrition*. Dr. Christian previously served as chief of surgery at the Baptist Memorial Hospital-Huntington (Tenn.) from 2003-2006.

Ralph "Bud" Curtis, MD — Dr. Curtis is a physician with the Sports Medicine Associates of San Antonio, Texas. H received his medical training at the University of Texas Medical School in San Antonio, where he also completed a residency program in orthopedic surgery. He completed a fellowship in shoulder surgery at the UT Health Science Center at San Antonio and has been a clinical faculty member since 1986. He has authored six text book chapters in orthopedics and sports medicine. Dr. Curtis is board certified by the American Board of Orthopaedic Surgery and a member of the American Academy of Orthopaedic Surgeons. He serves as a team physician for many San Antonio area high schools and the University of the Incarnate Word in San Antonio. He is the shoulder consultant for many professional sports teams including the San Antonio Spurs, the San Antonio Silver Stars, the San Antonio Missions AA Baseball Club and USA Swimming. Dr. Curtis is a past president of the Texas Society of Sports Medicine and is an active member of the American Orthopaedic Society for Sports Medicine and the American Shoulder and Elbow Surgeons.

James P. Emanuel, MD — Dr. Emanuel is a physician with ParkCrest Orthopedics in St. Louis, Mo. He specializes in the care of the upper extremity, and has extensive experience in arthroscopic shoulder reconstruction and total shoulder replacements. Dr. Emanuel received his medical degree from the Washington University School of Medicine in St. Louis and completed his orthopedic residency at the university. He is a member of the American Academy of Orthopedic Surgeons, the National Orthopedic Education Society and the Arthroscopy Association of North America. Dr. Emanuel is board certified by the American Board of Orthopedic Surgeons.

Blaine Farless, MD — Dr. Farless is an orthopedic surgeon at Cleburne (Texas) Surgical Center and a physician at Cleburne Orthopedic and Sports Medicine Center. He is an active staff member at Walls Regional Hospital in Cleburne and Glen Rose (Texas) Medical Center. Dr. Farless received his medical degree from the University of Texas Health Science Center at San Antonio, completed his orthopedic surgery internship at Cook County Hospital in Chicago and completed his residency at Loyola University Medical Center in Maywood, Ill. He completed a sports medicine and arthroscopic surgery fellowship at Associated Orthopedics and Sports Medicine in Plano, Texas. He has served as the chairmen of the department of surgery at Wells Regional. Dr. Farless is a member of the American Academy of Orthopedic Surgeons, the Texas Medical Association, the Texas Orthopedic Association, the Texas Sports Medicine Association and the Tarrant County Medical Society.

James McGehee, administrator of the Cleburne Surgical Center, says, "Dr. Farless has seen shoulder surgery progress light years during his practice. He always stays up to date on all the latest techniques and takes great pride in his shoulder repairs."

Evan L. Flatow, MD — Dr. Flatow is a professor and chair of the orthopedics department at Mount Sinai School of Medicine in New York, N.Y., and is the president of the American Shoulder and Elbow Surgeons. At Mount Sinai, he has established an internationally renowned shoulder service, with particular interest in minimally-invasive fracture repair, arthroscopic repair, arthroscopic rotator cuff surgery and shoulder replacement. He has pioneered, in collaboration with the department of anesthesiology, the use of regional blocks so that that shoulder operations may be performed without general anesthesia, and helped to develop a comprehensive shoulder replacement system, which is widely used by shoulder surgeons around the world.

Dr. Flatow received his medical degree from Columbia University College of Physicians and Surgeons and completed residencies at St. Luke's Roosevelt Hospital Center and Columbia's Presbyterian Medical Center, located in New York, N.Y. Dr. Flatow completed a shoulder and elbow fellowship at Columbia's Presbyterian Medical Center. He has received the American Shoulder and Elbow Surgeons' Charles S. Neer Award four times.

Brad Harman, MD — Dr. Harman is a surgeon at Cleburne (Texas) Surgical Center and Cleburne Orthopedic and Sports Medicine Center. He received his medical degree from the University of Texas Medical School at Houston and completed his orthopedic surgery residency at Scott & White Memorial Hospital and Texas A&M Health Science Center. He completed his sports medicine fellowship at The Foundation for Orthopaedic, Athletic and Reconstructive Research at the University of Texas Medical School at Houston.

Dr. Harman is on the medical staff for the U.S. Water Ski Team and has served on medical staff for various professional and collegiate teams, including the Houston Texans and Rice University. He is the member of a number of professional organizations including the American Medical Association, the Texas Medical Association, the Texas Orthopedic Association, the American Orthopaedic Society for Sports Medicine, the Arthroscopy Association of North America, the Texas Society of Sports Medicine and the Johnson County Medical Society.

On his Web site, Dr. Harman says, "I work to develop a partnership with my patients. This dialogue allows the patient to understand the diagnostic process and participate in the treatment choices."

Mr. McGehee says, "Dr. Harman is a shoulder specialist, who goes out of his way to make the patient and her family feel comfortable during their surgical care. He has taken care of multiple sports figures and is the team physician for the award-winning U.S. Water Ski Team."

S. Wendell Holmes, Jr., MD — Dr. Holmes is director of The Sports Medicine Center of the Moore Orthopaedic Clinic, and is medical director of the Providence Orthopaedic & Neuro Spine Institute, both located in Columbia, S.C. He is board certified by the American Board of Orthopaedic Surgery. He received his medical degree from the University of South Carolina School of Medicine and completed his residency at Palmetto Richland Memorial Hospital, both located in Columbia.

Dr. Holmes training and love for sports medicine began with his own participation in soccer, basketball and football. He has continued his service to the community in sports medicine as the medical director of sports medicine at Providence Hospital's Orthopaedic and Neurospine Institute in Columbia, chairman of the South Carolina Medical Association's Medical Aspects of Sports Committee and team physician for 15 high schools, middle schools and colleges in South Carolina. Dr. Holmes has made countless surgery-specific presentations, written for numerous publications and holds five patents.

"Dr. Holmes is an incredible surgeon and patient advocate. He works tirelessly to assure the finest care for his patients and their families, often donating his time for athletes unable to obtain care," says Sean McNally, CEO of the Moore Clinic.

Spero G. Karas, MD — Dr. Karas is assistant professor and director of the sports medicine fellowship program at Emory Orthopaedic & Spine Center in Atlanta, Ga. He currently serves as a consulting team physician for Georgia Tech University, Emory University Athletics and Mount Vernon Presbyterian High School. He received his medical degree from Indiana University School of Medicine and completed his residency at Duke University Medical Center in Durham, N.C., and a sports medicine and shoulder fellowship at the Steadman-Hawkins Clinic in Vail, Colo.

Dr. Karas is certified by the American Board of Orthopaedic Surgery and has held leadership positions in numerous societies including the American Orthopaedic Association, the American Academy of Orthopaedic Surgery, the Arthroscopy Association of North America and the American Orthopaedic Society for Sports Medicine. Dr. Karas has been selected as one of America's "Top Sports Medicine Specialists" in *Men's Health* magazine and has been named one of the "Top Doctors for Women" by *Women's Health* magazine, "Best Orthopaedic Surgeons in America" by Castle Connolly and "the most trusted sports specialist in Atlanta" by *Atlanta Magazine*. He has been inducted into the society, American Shoulder and Elbow Surgeons. In his free time, Dr. Karas enjoys sports such as golf, skiing, snowboarding and fitness training. He also enjoys computers and digital photography.

Edward G. McFarland, MD — Dr. McFarland is director of the division of adult orthopedics and Wayne H. Lewis Professor of Orthopedics and Shoulder Surgery at Johns Hopkins University in Baltimore. He is also team physician for Johns Hopkins University department of athletics and serves as a team physician for the Baltimore Orioles. He received his medical degree from the University of Louisville School of Medicine and completed his residency at Mayo Graduate School of Medicine in Rochester, Minn., and a sports medicine fellowship at the Kerlan-Jobe Orthopaedic Group in Inglewood, Calif.

Dr. McFarland serves on the editorial board for various publications including the *American Journal of Sports Medicine*, *Physician and Sports Medicine*, *Your Patient and Fitness* and *Orthopaedics and Traumatology* (international edition). He is a member of numerous professional organizations including the Southern Medical Association, the National Athletic Trainers Association, the American Orthopaedic Society for Sports Medicine, the American Society for Bone & Mineral Research, the Society for American Baseball Research, the American Academy of Orthopaedic Surgeons, the Baltimore County Medical Association, the Maryland Medical Association, the Maryland Orthopaedic Society, the Society for Tennis Medicine & Science, the American Orthopaedic Association and the American College of Sports Medicine.

Gregory P. Nicholson, MD — Dr. Nicholson is a surgeon with Midwest Orthopedics at Rush University in Chicago, where he is associate professor of orthopedic surgery. He specializes in shoulder and elbow surgery and sports medicine. Dr. Nicholson is a team physician for the Chicago White Sox and the Chicago Bulls. He received his medical degree from the Indiana University School of Medicine in Indianapolis, completed his internship and residency at University Hospital of Cleveland and served a fellowship in shoulder surgery at the New York Orthopaedic Hospital at Columbia-Presbyterian Medical Center in New York, N.Y.

Dr. Nicholson recently was named to *Chicago Magazine's* 2009 Top Doctors. He is board-certified in orthopedic surgery.

Dr. Nicholson says his favorite aspect about working as a shoulder surgeon is "that it allows me to help people and watch them return to function and return to the things they do for work, recreation and sport." Dr. Nicholson says his approach to surgery is to "be honest and treat patients the way you would like your family to be treated."

Anthony A. Romeo, MD — Dr. Romeo is a surgeon with Midwest Orthopedics at Rush University in Chicago, and is an associate professor and director of the section of shoulder and elbow at the university. His surgical specialties include shoulder surgery, elbow surgery and sports medicine. Dr. Romeo received his medical degree from St. Louis (Mo.) University. He completed his internship and residency at The Cleveland Clinic Foundation. He completed a shoulder and elbow fellowship at the University of Washington in Seattle.

According to his Web site, lifelong interests in science and sports contributed to Dr. Romeo's pursuit of the most advanced methods to treat and restore the function of injured or arthritic shoulders and elbows.

Dr. Romeo was named one of the top physicians in Chicago by *Chicago Magazine*. He is a member of the American Shoulder and Elbow Surgeons Society, the American Orthopaedic Society for Sports Medicine, the Arthroscopy Association of North America, the Mid-America Orthopaedic Society and the American Academy of Orthopaedic Surgery.

Joshua Siegel, MD — Dr. Siegel is a founding member of Northeast Surgical Care, an ASC in Newington, N.H., and the sports medicine director at Access Sports Medicine & Orthopaedics in Exeter, N.H. He has treated professional, national and division I collegiate athletes. He is a team physician for the U.S. Ski and Snowboarding Team. He has brought innovative new treatment and diagnostic options to Seacoast area patients including platelet-rich plasma therapy, musculoskeletal ultrasound and the latest in minimally invasive arthroscopic shoulder surgeries. Dr. Siegel helped pioneer various procedures, such as a new resurfacing prosthesis and biologic rotator cuff repairs.

For five consecutive years, Dr. Siegel has been selected by his peers as one of the "Top Doctors" by *New Hampshire Magazine*.

Dr. Siegel received his medical degree from the State University of New York at Buffalo. He completed a fellowship in sports medicine at the American Sports Medicine Institute in Birmingham, Ala. He is a fellow of the American Board of Orthopaedic Surgeons and a member of the American Orthopedic Society for Sports Medicine, the Arthroscopy Association of North America and the Sports Medicine Fellowship Society.

Mark Veenstra, MD — Dr. Veenstra is a surgeon at the Surgery Center of Kalamazoo and a physician at K Valley Orthopedics in Kalamazoo, Mich. He specializes in sports medicine and shoulder and knee surgery, especially utilizing arthroscopic techniques. Dr. Veenstra received his medical degree from Wayne State School of Medicine in Detroit, Mich., and completed his orthopedic surgery residency at Henry Ford Hospital in Detroit.

In addition to his practice work, Dr. Veenstra has been involved in missionary medical work for the past 15 years, annually taking medical groups to Honduras on medical brigades. He is a member of Westwood Christian Reformed Church in Kalamazoo and has served on church council for many years. In his spare time, he enjoys sports including golf, basketball and softball. He is also a private pilot.

Gerald R. Williams, Jr., MD — Dr. Williams is director of the Shoulder and Elbow Center at Rothman Institute in Philadelphia, where he is also a shoulder surgeon. His areas of surgical expertise include shoulder replacement, shoulder arthroscopy, rotator cuff repair and shoulder dislocations, among others. He is also president-elect of the American Shoulder and Elbow Surgeons. Dr. Williams received his medical degree from Temple University in Philadelphia and completed a fellowship in shoulder reconstruction at the University of Texas in San Antonio.

He is an active participant in many major orthopedic societies and has held leadership positions on the Academy of Orthopaedic Surgeons Board of Directors and the Philadelphia Orthopaedic Society. Dr. Williams has been published in numerous publications and has served or currently serves on the editorial boards for the *Journal of Bone & Joint Surgery*, the *American Journal of Sports Medicine*, *Clinical Orthopedics and Related Research*, *Seminars in Arthroplasty*, *Operative Techniques in Orthopedic Surgery*, the *Journal of Shoulder and Elbow Surgery* and *Techniques in Shoulder and Elbow Surgery*.

George White, MD — Dr. White is president of the Orlando (Fla.) Hand Surgery Associates and a surgeon at the Altamonte Surgery Center in Altamonte Springs, Fla. He is also an attending physician at Florida Hospital in Orlando, Orlando Regional Medical Center and Winter Park Memorial Hospital. Dr. White specializes in surgery of the shoulder, elbow and wrist.

Dr. White received his medical degree from Johns Hopkins University School of Medicine in Baltimore and completed his residency and fellowship at Johns Hopkins. He is a member of numerous professional societies including the American Medical Association, the Florida Medical Association, the Orange County Medical Society and the Academy of Orthopaedic Surgeons. He has published many articles on orthopedic surgery. ■

Improving and Maintaining Profitability in Orthopedic and Spine Practices: 10 Areas of Focus
(continued from page 1)

Here are 12 areas that orthopedic and spine practices can focus on to maintain and increase profitability in the face of a tough market.

1. Focus on the revenue cycle. Keeping an eye on collections and payments is important for practices, especially in a struggling economy. Michael H. Cox, PhD, CEO of Central Maine Orthopedics in Auburn, Maine, says that many patients many are not aware of what plans they qualify for, such as Medicaid, so practices should take the time to work with patients to help them figure that out.

With rising copays and deductibles, many patients may find it difficult to make these payments. Don Love, administrator of an orthopedic practice in Roanoke, Va., advises practices to prescreen their patients and to speak with them prior to arriving at the office so that patients are aware of what cost their insurance will cover and what they will be expected to pay.

"It's important to provide a patient with a complete financial picture," Mr. Love says. By taking these steps, patients and physicians can work together to arrange a payment schedule, and the chances of patients paying their copays upfront increase.

Curt Mayse, a principal with LarsonAllen, suggests that practices should work better with their front-desk staff members to help them understand all aspects of the billing cycle and collections process. "Many practices are too focused on their payor reimbursement and Medicare to notice that the patient portion of healthcare payments is growing," he says.

Mr. Mayse says that practices should figure out how they can stay on top of this information and help patients gain a clear understanding of their payment responsibilities, as Mr. Love suggests. Mr. Mayse suggests gathering the following information for patients regarding their responsibilities:

- Co-payments
- Deductibles
- How many patient visits to the office or physical therapist will be covered

Mr. Love suggests that practices should closely watch their bad debts and other outstanding debt in A/R.

Mr. Mayse agrees and notes that practices should focus on getting their collections out of the door immediately following a patient visit. "These should be sent within minutes or hours, not days, of a visit," he says. "This way, the practice will get their reimbursements or denials back quicker from insurance companies."

When practices receive a denial, Mr. Mayse says that they should not sit on this information. "The business office should pass the reasons for the denial on to the front-end to communicate to them why the claim was denied." By improving the communication between these two parts of the practice, offices can cut down on repeat mistakes and improve their overall collections and billing.

One way to improve the revenue cycle is to focus on efficiency within a practice. Total quality management, or process improvement, can help a practice to develop more efficient processes. Mr. Love sees now as a good time to implement changes within a practice. "It's not something that you'll be able to do in three or six months," he says. "It really is a culture change within the practice."

Mr. Love suggests taking the time to teach process improvement techniques to the practice's management team and staff. In addition, he says that it is important to reinforce its use so that the new techniques become part of the operation of the practice.

2. Work on managed care contracting. Poorly negotiated contracts with payors can mean lost reimbursements for many practices. "Many practices tend to neglect to actively manage their contracts or fail to see how they can get better reimbursement rates because they had heard of relatively little success in this area," Mr. Mayse says.

Mr. Mayse says that now is a good time for practices to examine their contracts with payors and see where they currently stand. "Even if you don't improve your rates, discussing your contracts with payors can help you understand the methodology of your reimbursements," he says. Practices can see if they have budget neutrality adjustment factors, determine what pay rates they are receiving based on the 2008 or 2009 relative value unit methodology and understand their contracts on a better level, according to Mr. Mayse.

Another benefit this evaluation can have is that practices can look into what items they aren't receiving reimbursement for and work to get these items or services covered.

Furthermore, practices can decide if they want to stay in-network or go out of network with certain payors, as most practices initially try to join with as many insurance companies as they can. "It is important to understand a payor's payments and look for inaccuracies," Mr. Mayse says.

"A recent study found that a large national payer paid 73 percent of their claims lines correctly. This still means that 27 percent were paid incorrectly, and it is important to understand why," he says.

Evaluating these contracts gives physicians and billing staff members the chance to look over their coding, especially the coding of modifiers and in-office procedures, according to Mr. Mayse.

3. Change the culture and then processes can be improved. "Someone once said that 'culture eats process for lunch,'" says Dr. Cox, who believes that culture plays the largest role in a successful business. If a center has a weak management and has not developed an employee culture of "ownership," attempting to make changes to any operational processes can be difficult and often frustrating no matter how well the processes are designed.

When Dr. Cox took over management at CMO a year and a half ago, the business was struggling. "The employees had no sense of direction and had little involvement in developing the business or daily operations," he says. "Consequently the business was fragmented, and not patient oriented. In addition, our surgeons began functioning as individual practitioners and not owners of the Corporation. I believe this was a survival instinct and not grounded in good business acumen."

According to Dr. Cox, by giving staff more ownership of the daily processes CMO has been able to change the culture. Now, employees are asked to join work groups when CMO undergoes any major projects or initiatives and their input is valued. One of these work groups developed standards of perfor-

mance and behavior, which dictates how employees should behave as part of the business. The document was approved by all employees, and now all new hires are required to sign off on this document before they come on staff.

"People improve and guide processes," Dr. Cox says.

4. Efficient use of ancillary services. Many orthopedic and spine practices have ancillary services, such as physical therapy and MRI imaging. According to Mr. Love, it is important to make sure that these aspects of the practice are running smoothly.

In addition, many practices have found opportunities by distributing durable medical equipment. However, Mr. Love warns that this may look like an attractive option — and it has been successful for many practices — but practices must conduct thorough due diligence to ensure their return on investment.

"Our practice just recently added durable medical equipment as a business, and it is profitable," Mr. Davidson says. "Pro formas to add more imaging services also look good." He mentions one caveat for practices interesting in adding these services. "Medicare changes in imaging center certifications are possible in the near future, so a practice should be mindful of this."

There are other ways in which orthopedic and spine practices can add new services and staff in this economy, according to Alan Davidson, executive director of the Orthopedic Institute of Pennsylvania in Camp Hill. For example, the addition of a non-operative musculoskeletal service, such as physiatry, can lead to the addition of pain management services.

Many surgeons use or are investors in ASCs. Partnering with a good center can be valuable even in this economy. Ken Austin, MD, an orthopedic surgeon in Airmont, N.Y., notes that it is important for surgeons to become involved in the management and oversight of the center they choose to use. He also notes that it is important to find a "beneficial and cost-effective" way to work with the ASC in this economy so that both the surgery center and physicians see positive results.

Mr. Davidson agrees that efforts to improve production in ASCs in which an orthopedic or spine physician is a partner can offer another opportunity, such as adding extended hours in the ASC.

Mr. Mayse notes that practices should also evaluate their durable medical equipment services to determine if what they are offering is still profitable and still state-of-the-art. He also suggests evaluating what the practice could offer in terms of these services.

Additional ancillary services can also be profitable. According to Mr. Davidson, short-stay hospital development presents another business opportunity for physicians at orthopedics and spine practices, but at a high risk.

Joint ventures with hospitals are another area Mr. Davidson says orthopedic and spine practices should consider. "Gainsharing and co-management may be good strategies with hospitals," he says. "Exit strategies in joint-venture businesses with hospitals may be good precautions should the federal legislators put orthopedists out of business. Hospitals that see opportunities to build market share in a down market are good partners. Orthopedists must use leverage in negotiations."

5. Selective marketing. One way orthopedic and spine practices can boost their profits is by selective marketing, which is increasing marketing efforts to a target audience and those people most likely to have need for a practice's services. According to Mr. Davidson, "Selective marketing efforts pay off." He suggests that practices should improve their phone response to patients and processing of patients at all levels of service (reception, clinic visit, etc.) in the practice. Adding an online service or electronic medical records can help with scheduling and registration by allowing patients to take care of this information before they come into the office.

"Efforts to make it easier for referring practices to communicate with an orthopedic practice are essential," says Mr. Davidson. "Aging baby boomers and young sports participants are obvious markets. The middle-aged market with candidates for preventative and life-improving services such as joint resurfacing is likely to be a good population for targeted marketing."

As an example, Mr. Davidson's organization is resuming a once defunct DEXA scanning service in an osteoporosis service, not in expectation of profits but rather in fulfillment of a community need for the identification and treatment of osteoporosis.

Dr. Austin agrees that selective marketing can be beneficial for practices. "It's important to remain involved in the community," he says, and by using marketing techniques, a practice can do just that.

By making efficient use of the practice's Web site, these services can reach a broader audience and offer more information to potential patients than what they can find on online directory sites, according to Mr. Mayse.

6. Consider focusing on niche markets. Large practices with a wide variety of sub-specialties may consider expanding into niche clinics and/or centers of excellence in a poor economy. Dr. Cox says this approach has been very successful for CMO.

"Focusing on specific facets of the industry and marketing clinics around them can help promote that aspect of your practice, improve patient care and eventually clinical outcomes" Dr. Cox says. Currently, CMO has developed specialty centers for hand surgery, sports medicine and joint replacement.

By concentrating sub-specialty areas it may be easier for practices to find efficient and better defined ways to inform their target markets about their services.

7. Evaluate labor utilization. Staffing costs often account for the largest expense for orthopedic and spine practices. According to Mr. Love, they can be more than half of a practice's total expense. However, automatically cutting staff may not the best solution when trying to reduce costs. Mr. Love advises practices to figure out how to maximize efficiency with the existing staff and increase the volume of patients that can be seen during a clinic session. He says that adjustments in staffing should be made without affecting the quality of care.

"We are trying to protect jobs," he says. A key way to maximize the efficiency of your staff, according to Mr. Love, is to keep an open line of communication between staff and management. By paying attention to the needs of the staff, practices can increase efficiency, create higher job satisfaction and potentially boost patient satisfaction.

Nicola Hawkinson, CEO of SpineSearch, a recruitment and educational company with a focus on spinal practices, agrees that physicians need to keep their current staff satisfied. "I consider it a form of preventive practice medicine,"

she says, noting that many problems regarding job performance or employee satisfaction can be handled before they become bigger issues.

Ms. Hawkinson suggests that physicians provide incentives for their staff that are not limited to bonus plans. "An incentive doesn't have to be financial," she says. Dress-down or half-day Fridays can do a lot for staff morale. "A mother of three may prefer a half-day on Friday over $200 or $300 because she may be paying that much in day care."

Mr. Mayse says that many practices, especially orthopedics practices, often have difficulty determining their proper staffing requirements. "It is important to have the right resources available at the right place and the right time," he says.

This includes clinical staff, administrative staff, physical therapists and athletic trainers. "You don't want to have too many people on staff so that they are sitting around," Mr. Mayse says. "At the same time, you want to have enough people so that you don't lose money in having too much overtime."

He also notes that by providing effective leadership in all areas of the practice, many of these issues can be effectively handled.

Physical therapists can be of particular benefit and hassle to a practices, according to Mr. Mayse. In some cases, state law will not allow practices to offer these services. If a state does permit an orthopedic practice to have physical therapists, Mr. Mayse says that having the proper level of management and providers is key.

"Also athletic trainers can be used both internally and externally to promote a practice," Mr. Mayse says. "If they offer services to local high schools and attend their sporting events, they can find a need in the community and act as a perfect marketing tool for the practice."

8. An educated staff is an effective staff. According to Ms. Hawkinson, an uneducated staff often leads to dissatisfaction. "If the staff doesn't have the knowledge they need to perform their duties, they will become easily frustrated and unproductive," she says.

Ms. Hawkinson suggests hosting regular staff meetings so that physicians can be aware of the educational needs of their staff.

Attending continuing medical education courses provide great opportunities for staff to gain information that physicians cannot get in the office or operating room, Ms. Hawkinson notes. "Having staff attend these courses as a group shows that they are an important part of the practice and a part of a team," she says. "If there is a coding course in Las Vegas, send the staff and let them have a good time and gain some valuable information for the practice."

Ms. Hawkinson notes that sending staff to these meetings can be tax deductible, but practices should consult their accountant for proper knowledge of accounting rules.

9. Improve hiring practices to reduce staff turnover. High turnover rates can decrease a practice's profitability because of the time spent on training the new staff member rather than on treating and recruiting new patients. It is not good enough for physicians to just find staff member who can fill the position; the new hire must be a good fit for the practice.

One area where many physicians run into hiring problems is by not having or creating insufficient job descriptions. Ms. Hawkinson, who is a nurse practitioner, says that she had been hired by a physician who was unsure what her job description was. Due to a lack of an accurate job description, the job that needed to be done wasn't being accomplished, and the lack of a defined position became frustrating to Ms. Hawkinson.

"The problem could have been easily remedied with an accurate job description," Ms. Hawkinson says. "With an accurate job description all

three parties involved win. The doctor has a highly efficient staff, the employee knows exactly what is expected of them, and the patient receives optimal care." Ms. Hawkinson has found that through her experience in the field by helping practices define job roles and create optimal staffing methods, profit margins can be increased.

"Before hiring, a physician should identify gaps in the workplace and assess what is needed in the daily workload," Ms. Hawkinson says. "Determine what needs to be done or needs to be done more efficiently."

By taking the time to determine exactly what position needs to be filled can save practices money. "This way, you won't end up hiring an office manager for $75,000 when you can hire a clerk for $35,000," she says.

Dr. Cox notes that in 2007 CMO was experiencing a turnover rate of 50 percent when he joined the Practice. "To address the turnover rate, I took a page from Al Stubblefield's 'Journey to Excellence' and put hiring decisions into the hands of the employees. Subsequently, CMO has reduced the turnover rate to nearly zero. This changed because employees have a vested interest in the success of the new employee, and the interview process is focused on behavior and character rather than skill," he says.

According to Dr. Cox, human resources and the related department manager at CMO create a short list of candidates for a position, which may include some phone or in-person interviews. The short listed candidates are then scheduled for interviews with an employee interview team without managers present. The employee group makes the recommendation on the hiring and Human Resources do the follow-up. Dr. Cox notes that CMO employees who do the interviewing have been trained on the legalities and processes of interviewing.

"Employees have ownership of the process and are selecting a colleague who has the right character and integrity for the center," he says. "Because the employees understand the method and are sincere about the approach the chances of picking the right candidate is improved considerably"

10. Establish a presence in the community. One way practices can maintain and improve the number of patients who come into their offices is by establishing a presence in their local communities.

Dr. Cox suggests that practices engage in community outreach and become involved in their local chamber of commerce and other community groups. CMO also performs outreach to the local university.

CMO has improved its reputation and presence in its community by working with patients through this difficult economic time. One employee is dedicated to working with patients on managing the costs of the healthcare and providing financial counseling.

"Our market reach is wide and we encompass a large rural area in Maine, and we have many patients who are less fortunate and in need," Dr. Cox says. "We provide discounted rates and work with payors, and if we need to, we provide charity care." Through these extra efforts, good word-of-mouth recommendations for CMO have spread to the community, and Dr. Cox says that the center's revenues are up for the second consecutive quarter and compare favorably to the same period last year.

Working with primary care physicians and emergency departments in the area are other ways in which practices can reach out to patients in their communities. "We developed a more formal relationship with the local emergency rooms and developed a telephone ER triage system," Dr. Cox says. "We can now more efficiently handle referral cases and everyone is satisfied."

11. Become active in politics, especially issues related to practices. One area that could greatly impact the overall revenues of orthopedic and spine practices is new legislation that could eliminate business for practices, such as laws that put limits on physician ownership or referrals. Additionally, there are a growing compliance issues which could subject practices to Medicare audits and enormous costs. For these reasons it is critical for orthopedic and spine surgeons to take an interest and involvement in politics that could affect their livelihood, Mr. Davidson says.

"Orthopedists must dive into politics and improve lobbying efforts," he says. "There are many forces that are damaging the public trust of physicians, and work needs to be done to restore the image. Hospitals and payors market and display kindly physicians delivering healthcare on their billboards. As the president of a health plan once told me, 'Insurers are basically marketing organizations.' Physicians must promote their good images though politics and marketing."

12. Make effective use of office space. The building in which a practice is located can affect profitability almost as much as the operations that go on inside of it. According to Mr. Mayse, many orthopedic and spine physicians love big buildings, thinking that a bigger space is a better space. At the same token, many physicians choose to remain at a cramped space when it may be wise for them to expand their practices. Both of these missteps can cause problems for a practice's profitability.

"Physicians need to consider the scope and the layout of a facility that can effectively manage the caseload they have," Mr. Mayse says. This means that office space must be large enough to comfortably accommodate the patients a practice will see in a day but not too much that there is wasted space.

By paying too much on rent or limiting the number of patients a practice can see because of lack of space, the costs can add up over time, according to Mr. Mayse. ■

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10 Large Orthopedic Practices to Know (continued from page 1)

provide outstanding resources for patient care at a local level. "We find the best doctors and provide a large organizational structure to support them, while letting them practice at a local level," he says. "Our office locations are located near primary care providers, and our surgeons are affiliated with every hospital in Puget Sound."

Resurgens Orthopaedics (Atlanta). Resurgens Orthopaedics is a leading orthopedic practice based in Atlanta and is Georgia's largest orthopedic practice. Resurgens is home to 85 physicians who practice at one or more of the practice's 18 offices and six surgery center locations. Resurgens provides patients with a full range of orthopedic, diagnostic and rehabilitation services and features specialty centers for hand and spine treatment as well as total joint replacement. In 2008, physicians at the practice performed more than 426,000 patient visits and more than 44,000 surgery cases.

Resurgens participates in a variety of ongoing clinical research projects including drug studies and implant studies. The physicians and rehabilitation staff at Resurgens host community outreach programs on injury prevention, osteoporosis, ergonomics and sports medicine with local YMCAs and area athletic clubs as well as seminars with CEU credit for attorneys and insurance adjusters. In addition, Resurgens formed a charitable foundation in 2001 with the commitment to support the local community. The foundation is currently funding its 8th all-abilities playground and has contributed more than $500,000 to entities in and around metro-Atlanta since its conception, according to Kay Kirkpatrick, MD, co-president of the practice.

According to Steve Wertheim, MD, the other co-president of the practice, Resurgens' size and outstanding patient care has allowed it to stand out. "Resurgens Orthopaedics is Georgia's largest orthopedic practice offering comprehensive care from diagnosis, imaging and outpatient surgery to rehabilitation, says Dr. Wertheim. "Our size gives patients the flexibility to seek treatment at 20 sites throughout the metropolitan Atlanta area."

Illinois Bone & Joint Institute (Morton Grove, Ill.). Illinois Bone and Joint Institute is home to more than 90 orthopedic surgeons with advanced training in more than 25 specialized clinical areas. IBJI has more than 20 locations to serve its patients and provides complete orthopedic surgical care and on-site radiology and physical therapy. The Institute is actively involved in rheumatology research and is currently participating in 13 different clinical trials. IBJI also offers a physician and physician assistant residency program in orthopedics.

OrthoCarolina (Charlotte, N.C.). OrthoCarolina is one of the largest orthopedic practices in the United States. Its capabilities include both surgical and non-surgical treatment of injuries and disorders of bones, joints, muscles, ligaments, nerves, tendons and other soft tissues of the body. The physician staff of OrthoCarolina is comprised of orthopedic surgeons, physiatrists and physician assistants experienced in all areas of orthopedics, many with fellowship training in areas such as foot and ankle, hand, hip and knee and pediatric orthopedics.

OrthoCarolina is home to 70 highly trained physicians and was created in 2005 by the merger of Miller Orthopaedic Clinic and Charlotte Orthopedic Specialists. The practice has 13 locations in North Carolina and offers a number of educational programs for both clinical staff including athletic trainers, physical therapists and other healthcare professionals, as well as to members of the local community.

OrthoCarolina is also home to the OrthoCarolina Research Institute, an independent, autonomous, not-for-profit research organization with a mission to promote and support scientific research and education as it relates to orthopedic care. The Research Institute currently manages 14 FDA-regulated clinical trials, research grants and more than 50 scientific studies and annually monitors approximately 6,000 study patients. The results of these research studies are shared with other healthcare professionals through peer-reviewed medical journals, medical textbooks and presentations at medical conferences.

OrthoIndy (Indianapolis). OrthoIndy is one of the largest private orthopedic practices in the Midwest and provides complete bone, joint, spine and muscle care. Last year, the practice had more than 170,000 patient visits, according to John Martin, CEO of OrthoIndy. OrthoIndy's 65 medical professionals treat patients in 11 office locations, and OrthoIndy physicians own and operate the well-regarded Indiana Orthopaedic Hospital in Indianapolis. The practice's specialties include bone tumor and soft tissue oncology, cartilage restoration, foot and ankle, general orthopedics, hand and upper extremity, hip and knee, pediatric orthopedics, physiatry and pain management, shoulder, sports medicine, spine, total joint replacement and trauma.

Physicians from OrthoIndy are active in research and clinical trials. The Orthopaedic Research Foundation, founded in 1986, currently has more than 25 nationally and internationally recognized physicians participating in more than 30 investigational studies, resulting in the publication of more than 15 peer review scientific manuscripts annually, according to Jenna Sallee, executive director of the Orthopaedic Research Foundation.

OrthoIndy is also involved in its local community, sponsoring a number of organizations and hosting classes for patients considering joint replacement surgery. The classes provide participants information about orthopedic surgery, the hospital experience, discharge planning, physical therapy, adaptive equipment needs and home safety, according to Deb Robinson, OrthoIndy's total joint replacement manager.

Upcoming plans for the organization include expanding services on the south side of Indianapolis through the development of a new facility, which is scheduled to open in 2010. "In 2009, we announced the plans to build another hospital outpatient department that will serve the residents of the south side of Indianapolis. Spanning over 75,000 square feet, the facility will house a surgery center and clinic and will feature 42 exam rooms, 4 operating rooms, physical therapy and MRI," says Mr. Martin. "We are looking forward to expanding our current presence in the community to provide Southside residents with complete bone, joint, spine and muscle care from an orthopedic practice with 47 years of service."

Midwest Orthopaedics at Rush (Westchester, Ill.). Midwest Orthopaedics at Rush is nationally recognized as a leader in comprehensive orthopedic services ranging from sports medicine, joint, hand, feet, spine, cartilage restoration, pediatrics, trauma, orthopedic oncology and shoulder care. MOR has five locations throughout the Chicago metro area and is staffed by nearly 35 board-certified and fellowship-trained physicians, 31 of which are orthopedic surgeons. Physicians at MOR work closely with Rush University Medical Center to research advances in the evaluation and treatment of orthopedic conditions and have helped to develop several minimally invasive surgical techniques, including the world's first minimally invasive hip surgery. MOR's orthopedic surgeons have also pioneered many advances in hip, knee and spine implants and are recognized for their advancements in the development of cementless implants for hip replacement and innovative approaches to cartilage restoration and treating chronic arthritis.

MOR offers fellowship programs in spine, sports medicine and joint replacement and is a training site for residents and medical students at Rush University Medical Center. In addition, MOR physicians serve as team physicians for the Chicago Bulls, Chicago White Sox and for the highly regarded Hubbard Street Dance Company.

Dennis Viellieu, CEO of MOR, says that the practice is unique due to its structure. "Our structure of combining a private practice model of provid-

ing patient care with an academic program for research and educational purposes … provides for the most effective and efficient development of new techniques and approaches to improve the delivery of care to the general population," he says.

MOR will soon have a new facility. "We are in the process of completing the building of a comprehensive orthopedic facility on the RUMC campus that will bring together all the patient care, education and teaching elements of our program under one roof, which will hopefully enable us to not only continue to make the steps forward in orthopedic care and research but will also help to accelerate these advances," says Mr. Viellieu. "This kind of collaboration between physician group and medical center is critical to the continuation of progress in the orthopedic field."

Steadman-Hawkins Clinic (Vail, Colo.). The Steadman-Hawkins Clinic is a leading sports medicine and orthopedic practice, treating patients at four locations throughout Colorado and at one location in Spartanburg, S.C. Steadman-Hawkins' more than 20 physicians provide a variety of services including ligament and joint reconstruction, sports medicine, arthroscopic surgery, treatment for athletic injuries, knee and hand surgery, anterior cruciate ligament repair and treatment for spinal disorders and injuries.

The practice was established in 1990 and is particularly recognized for its treatment orthopedic problems related to the knee. Steadman-Hawkins has treated a number of professional athletes from all sports, in particular European soccer stars, for severe knee injuries.

The practice works closely with the Steadman Hawkins Research Foundation, one of the largest non-profit research institutes dedicated to the prevention and treatment of orthopedic disorders. The Steadman Hawkins Research Foundation was established in 1988 by J. Richard Steadman, MD. Dr. Richard Hawkins, a renowned shoulder surgeon, joined the Foundation in 1990. The Foundation's most recent research has examined the effects of various treatments on the ACL deficient knee.

The Hughston Clinic (Columbus, Ga.). The Hughston Clinic has eight locations throughout southern Georgia and western Alabama, and the clinic's 19 physicians treat patients with a variety of orthopedic and sports injuries. Hughston' physicians provide comprehensive services including total joint replacement; shoulder, knee, hip and ankle surgery, and spine services. The Hughston Clinic was founded by Jack Hughston, MD, in 1949 and has been credited with elevating sports medicine as a medical specialty.

The Hughston Clinic's research and educational arm, the non-profit Hughston Foundation, provides national and international leadership in orthopedic and sports medicine research and education, and works to develop innovative concepts that help to advance the practice of orthopedic surgery. The foundation provides educations events for both healthcare providers and the local community about the treatment and prevention of sports injuries and is involved in a number of clinical trials.

Kerlan-Jobe Orthopaedic Clinic (Los Angeles). The Kerlan-Jobe Orthopaedic Clinic is a leading orthopedic practice specializing in orthopedic and sports medicine. It has four locations in Los Angeles and surrounding areas. The Kerlan-Jobe clinic was founded in 1965 by Robert Kerlan, MD, and Frank Jobe, MD. Today, the practice is home to a staff of 18 physicians who treat approximately 8,000-10,000 patients annually. Surgeons at the practice perform a number of orthopedic procedures including tendon

repair, total joint replacement, ligament reconstructions, arthroscopic surgery and spine and neck surgery, the majority of which take place at the Kerlan-Jobe Surgicenter.

Kerlan-Jobe Orthopaedic Clinic has been responsible for developing a number of advanced surgical methods and procedures in orthopedics. Physicians at the practice are currently pursuing advances in rotator cuff repair and augmentation, shoulder and elbow instability and articular cartilage repair. The clinic is also dedicated to medical education. The Kerlan-Jobe Foundation supports a fellowship program, which is currently the oldest and largest program for sports medicine in the United States, according to Ralph Gambardella, MD, an orthopedic surgeon and president of the clinic.

Kerlan-Jobe is notable because its physicians' expertise span all areas of sports medicine and orthopedics, says Dr. Gambardella,. "What makes us unique is that we all have sub-specialty areas of expertise, and we work together as a group to provide the best, most accurate and comprehensive diagnoses and treatment options for our patients using the most-advanced and proven technology available," he says.

Kerlan-Jobe physicians and fellowship program alumni also take care of more professional and collegiate sports teams than any program in the United States, says Dr. Gambardella. These physicians serve as team physicians and consultants to sports teams including the Los Angeles Lakers, Los Angeles Dodgers, Los Angeles Kings, Anaheim Mighty Ducks and Los Angeles Galaxy.

Florida Sports Medicine Institute (St. Augustine, Fla.). Florida Sports Medicine Institute specializes in sports injuries, fractures, arthritis, joint replacement and workers' compensation injuries and is considered among the strongest single-physician orthopedic practices in the country. Founded in 1997, FSMI's Tod Northrup, DO, a board-certified physician who has completed fellowship training in sports medicine and arthroscopy, treats recreational and elite athletes in two practice locations and performed more than 750 surgeries last year.

Dr. Northrup supports continuing research and educational activities in the field of sports medicine. His research in knee ligament reconstruction earned him the DonJoy Award for scientific research in sports medicine. In addition to conducting research and contributing to academic publications, Dr. Northrup currently serves as the team physician for seven high schools and two universities, including the University of North Florida in Jacksonville. FSMI provides more than 350 free physicals to local high school athletes each year and holds Saturday injury clinics for during football season, allowing athletes to receive information about their injury and recovery time before the clinic reopens on Monday.

Dr. Northrup says that his practice is unique because, as a solo practitioner, he has the ability to base all decisions he makes for the practice as they relate to quality of care. "I think the most important thing we provide is high-quality, cost-effective care, and we do that very efficiently," he says. "In other practices with many physicians, you have leaders and followers. Here, I have the ability to lead not only the care of my patients but the management of the clinic as well, and I am able to make all decisions based on quality of care." ■

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5 Steps for Building a Successful Clinical Spine Practice From Dr. Bruce McCormack

By Mark Taylor

Bruce McCormack, MD, a neurosurgeon and spine specialist who practices in San Francisco, suggests the following five steps to build a successful spine surgery practice.

1. Follow the industry. Dr. McCormack says most of the intellectual advances and innovations in spine surgery were emanating from the private sector. "So to me, it didn't make as much sense to remain in a university-based practice at University of California at San Francisco," where he used to serve on the faculty and practice before leaving just over a decade ago. "I decided to leave and was thinking of returning to New York to private practice. But I decided to stay in San Francisco. I'd heard people saying single practice is over, but I didn't believe that. If you work hard you can make it happen. Going on your own will help you to learn your practice from ground up and if you decide you don't like it, you can always join a group."

2. Practice where you want to live. "I'd enjoyed living in San Francisco, but many people warned me there were too many doctors here to support another spine surgeon," Dr. McCormack says. "That wasn't true. I just needed to market throughout the Bay Area to a broader audience," he says.

3. Be creative in marketing yourself. Since Dr. McCormack was the new guy on the market and relatively unknown, he needed to market himself in different ways to attract physicians who would refer patients to him.

"I began sending out flyers and giving continuing medical education talks at hospitals around the Bay Area — I've been to every hospital in Northern California," he says. "Sometimes nothing comes of them, but if you get just one referring doctor out of the audience, that's great. I actively marketed my practice outside of the city, but as time went by I received more referrals from within the city."

He says the first three or four years after he left the university there weren't many referrals. But as his name recognition and reputation have grown, those efforts produced referral streams. "That was key to building a successful practice," he says.

4. Recognize that not every back surgery outcome will be favorable and respond appropriately to poor outcomes. Dr. McCormack advises investigating any negative outcomes to learn the root causes to avoid recurrences. "A few disgruntled patients can ruin a practice by word of mouth alone," he says.

He recalls some years ago when spine surgeons in the Bay Area were using discography as the sole basis for determining whether certain spine surgeries were necessary. "I wasn't seeing good results from that and quickly dropped that practice. Payors were impressed, but that's not why I did it," he says. "It's not worth it and you can't build a successful practice on something like that. Rejecting it gave me credibility. At the end of the day you want to have a happy patient."

5. Diversify your practice. "Make sure your practice is diversified and not totally dependent on income derived from surgery," he recommends.

Dr. McCormack says he hedged his bets years ago and broadened his practice by performing medical legal evaluations for workers' compensation and other cases.

"Every time you operate there is a risk of a bad result or a medical malpractice lawsuit," he says. "If you write a report analyzing a treatment, there is no downside risk and it is very lucrative. So, as opposed to trying to do more and more surgery, which some doctors do try to keep numbers up, I found another way to support my practice. It was a conscious business decision. I might be better off financially if I perform more surgeries, but performing utilization reviews and analyzing the nature of injuries in auto accidents has helped me avoid the kinds of reduced volume a lot of physicians are seeing. Even as elective surgeries are down considerably, my medical legal work is going through the roof. I'll make as much this year as I did last year." ■

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24 Statistics About Orthopedics in Surgery Centers and Orthopedic Surgeons

1. Orthopedics was fourth among identified specialties represented at single-specialty centers, tied with pain management, and was represented in 5 percent of all single-specialty ASCs.

2. Orthopedics was the fourth most-represented surgical specialty and was represented in 36 percent of all (single- and multi-specialty) centers in 2007, behind plastic surgery, ophthalmology and gastroenterology.

3. Orthopedics represented 8 percent of the total case volume at surgery centers, ranking it fourth behind gastroenterology, ophthalmology and pain management.

4. The average net revenue for an orthopedic procedure was $2,192 in 2008.

5. Here is the average net revenue for orthopedic procedures by region:
- West: $2,265
- Southwest: $2,312
- Midwest: $2,182
- Southeast: $1,865
- Northeast: $1,813

6. Here is the average net revenue for orthopedic procedures by an ASC's number of operating rooms:
- 1-2 ORs: $1,935
- 3-4 ORs: $2,155
- More than 4 ORs: $2,261

7. Here is the average net revenue for orthopedic procedures by an ASC's total number of cases:
- Less than 3,000: $2,136
- 3,000-5,999: $2,313
- More than 5,999: $2,031

8. Here is the average net revenue for orthopedic procedures by an ASC's total net revenue:
- Less than $4.5 million: $1,645
- $4.5-$7 million: $2,179
- More than $7 million: $2,512

9. In surgery centers with more than 50 percent of cases in orthopedics, the average net revenue for an orthopedic procedure was $2,328.

10. Here is the 2008 cash compensation earned by orthopedic surgeons by percentile and region:

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

Medicare charges and payments

Here is the average 2007 Medicare sub charge (submitted charges divided by allowed services), average allow charge (Medicare-allowed charges divided by allowed services, including co-pays and deductibles paid by patient), and average payment (Medicare payments divided by allowed services, not including co-pays and deductibles paid by patient) for 14 orthopedic procedures commonly performed in ASCs.

11. Obtaining small amount of bone for graft (CPT 20900):
- average sub charge: $2,060
- average allow charge: $294
- average payment: $231

12. Open surgical partial removal of collar bone (CPT 23120):
- average sub charge: $3,793
- average allow charge: $477
- average payment: $376

13. Partial repair or removal of shoulder bone (CPT 23130):
- average sub charge: $4,027
- average allow charge: $478
- average payment: $377

14. Open repair of rotator cuff, recent (CPT 23410):
- average sub charge: $4,947
- average allow charge: $671
- average payment: $530

15. Open repair of rotator cuff, old (CPT 23412):
- average sub charge: $5,556
- average allow charge: $984
- average payment: $777

16. Reconstruction rotator cuff, old (CPT 23420):
- average sub charge: $5,653
- average allow charge: $984
- average payment: $777

17. Open repair elbow fracture involving ulnar bone (CPT 24685):
- average sub charge: $3,965
- average allow charge: $502
- average payment: $396

18. Wrist fracture pinning through skin (CPT 25606):
- average sub charge: $2,886
- average allow charge: $487
- average payment: $386

19. Open surgical treatment wrist fracture (radius) (CPT 25607):
- average sub charge: $4,240
- average allow charge: $706
- average payment: $560

20. Shoulder scope, repair cartilage tear (CPT 29807):
- average sub charge: $4,426
- average allow charge: $309
- average payment: $241

21. Shoulder scope, partial removal collar bone (CPT 29824):
- average sub charge: $4,605
- average allow charge: $562
- average payment: $442

22. Shoulder scope, bone shaving (CPT 29826):
- average sub charge: $4,680
- average allow charge: $409
- average payment: $244

23. Shoulder scope, rotator cuff repair (CPT 29827):
- average sub charge: $5,272
- average allow charge: $693
- average payment: $547

24. Injection of lower back joint (HCPCS G02060):
- average sub charge: $1,290
- average allow charge: $281
- average payment: $222 ■

Note: CPT codes are copyrighted by the AMA.

Sources:
Items 1-3: SDI's *2008 Outpatient Surgery Center Market Report.* Learn more at www.sdihealth.com.
Items 4-9: VMG Health *2008 Intellimarker.* Learn more at www.vmghealth.com.
Item 10: Integrated Healthcare Strategies *2008 Healthcare Executive Compensation Survey* and supplementary IHS statistics. Learn more at www.ihstrategies.com.
Items 11-24: CMS.

5 Best Practices to Help Address Increasing Patient Out-of-Pocket Expenses

By Lindsey Dunn

The number of Americans enrolled in health plans with high deductibles is on the rise and is expected to continue as employers look for ways to cut costs in this tough economy. This trend creates challenges for practices as they begin to see more and more patients who are responsible for significant out-of-pocket expenses for treatment.

More than 17 percent of Americans 65 and under with private health insurance are enrolled in a high deductible health plans (defined as a private health plan with a deductible of $1,100 or more for self-only coverage or $2,200 or more for family coverage), according to the NCHS. Additionally, 95 percent of insured individuals face significant cost-sharing expenses, even after their deductibles have been met, for inpatient and outpatient procedures.

The prevalence of HDHPs will continue to grow; 37 percent of employers in a survey by the Kaiser Family Foundation indicated that they would likely increase their deductibles in the next year.

So what can you do to ensure that this trend does not affect your ability to receive payment for services?

Here are five best practices to help you address the increase in patient out-of-pocket expenses.

1. Verify any and all insurance coverage. Experts agree that thorough insurance verification is the first step in ensuring that patients are able to pay out-of-pocket expenses required for a procedure.

According to Lisa Rock, president and CEO of National Medical Billing Services, it is imperative that healthcare providers properly verifying patient insurance coverage.

"ASCs collectively aren't doing their due diligence on insurance verification," she says. "When things get busy, and they get behind, maybe they skip over this step. When the economy was strong, centers were okay if they let this slide. Now, however, ASCs must make sure they are following the verification procedures they have put into place."

Donna Smith, an administrator at The Surgery Center in Oxford, Ala., agrees that insurance verification is extremely important in today's economy. She estimates that one-third of the patients that present to her facility have HDHPs. Her facility, which averages 16 days in accounts receivable, follows strict verification and patient education procedures to help ensure that payment is received for services provided.

"I've found that some surgery facilities only verify primary insurance," says Jennifer Bailey, business office manager at the Oxford facility. "Our center verifies all insurance coverage. Having this information helps us better inform our patients of their responsibilities," she says.

Experts also recommend that insurance verification should be done by qualified staff with knowledge about accounts receivable and experience working with insurance providers.

The Surgery Center in Oxford employs two staff members who are able to verify patient insurance. "It is crucial that your verification staff is knowledgeable and has an extensive background in insurance," says Ms. Bailey.

Ms. Rock agrees. "At some facilities, you may find a nurse making these verification calls. That nurse may get the information, but it may not make sense to her. Having staff that understands the information and can translate it for patients is becoming more and more important," she says.

2. Educate patients about their coverage and financial obligations. Patients who are educated about their financial obligations before a procedure are more likely to fulfill those obligations, sources say.

"Patients may not realize what their estimated responsibility may be for their procedure, so we contact them before the date of service to prepare them for these costs. It seems to be really appreciated," says Ms. Bailey.

Lindsay McQueeney, director of product management for SourceMedical, adds that healthcare providers should begin this process as soon as possible. "It is fundamental that centers work with both the insurance company and the patient as far in advance as possible so that the patient really has a chance to understand his or her coverage and so that the patient is prepared to meet his or her portion of the obligation," she says.

3. Move collections to the front end. The best way to ensure that patients pay their out-of-pocket expenses for a procedure is to require payment before the procedure.

Ms. Smith says, "It is standard practice at our facility to ask that our patients pay in full, on the date of service, for any out-of-pocket costs. That said, we are still always willing to work with patients who may need payment arrangements or financial assistance."

Ms. Rock agrees with the merits of this policy. "Upfront collections are definitely preferable. However, we must have professional courtesy with front-end collections," she says. "We have to remember why it is we're doing these procedures."

Everyone interviewed for this article agreed that patient care should never be compromised due to financial circumstances or a patient's ability to pay.

If patients have a large deductible that they cannot pay upfront, Ms. Smith says that her facility will require them to pay half upfront or work with them to set up payment plans before the procedure.

Occasionally, a patient may be charged more on the day of service than what the patient actually owes due to lag-time in billing clearance. If there are accounts with overestimated patient responsibilities, Ms. Smith recommends that facilities refund any overpayments made by the patient immediately. "Our patients are willing to pay if they can be assured their money will be refunded quickly and without a hassle. We strive to get the money refunded to these patients before most even realize that they are owed a refund," she says.

4. Take a retail approach toward payment. Facilities should start to see billing and payment as retail transactions rather than just the transfer of funds between a facility and a private or public payor.

Earl Winter, CEO and founder of nTelagent, a company that provides self-pay management systems to healthcare providers, says that providers have to take a retail approach toward their billing and collections in order to be successful.

"Healthcare providers have systematically approached billing as an issue between the healthcare facility and some type of public or private payor," he says. "All computer systems that the facilities use for billing were built to bill private and public insurers, not actual people. Now that has switched. More and more responsibility for payment lies with the individual patient, and many facilities haven't yet figured out how to think like a retailer in their payment options."

Thinking like a retailer means that healthcare providers should evaluate each patient individually and offer different payment options based on that evaluation. For example, a facility may offer a discount to encourage a patient to pay upfront for services; however, a facility would probably not want to offer that discount to a patient who would be willing to pay the full price upfront.

"Solutions are out there to help providers determine a patients' ability to pay. This information can help business managers offer payment options that are most appropriate for each patient," says Ms. McQueeney.

Mr. Winter, whose company offers one of these solutions, says that providers need to be careful in how they determine ability to pay. "When determining patients' ability to pay, providers should be most concerned about predicting the likelihood that they'll pay healthcare bills, which can be tricky," he says. "Some facilities use credit scoring, which alone can be legally problematic. Plus, credit scores only show how patients have paid in the past. You have to use other predictors, such as demographics, to figure out the likelihood that they'll pay in the future."

Ms. McQueeney recommends that facilities develop business rules for offering discounts, credits or payment plans to patients after they have determined their ability to pay. Facilities may also benefit from offering payment plans regardless of the patient's ability to pay. "Centers may increase patient satisfaction by offering automated monthly withdrawals from the patient's bank account or a recurring charge to their credit card. These types of payment plans offer flexibility while ensuring that the facility receives the entire payment," she says.

Mr. Winter, however, warns that some facilities may not have enough information to develop sound business rules or lack the technology to offer certain payment options, such as automatic reoccurring billing from a patient's credit or debit account.

"I see a lot of facilities that either have trouble figuring out where it makes financial sense to provide discounts or have trouble offering the ones they've implemented," he says. "You might have an employee with a bunch of post-its on her computer screen trying to figure out what to offer to which patients. Or you have a front-office employee who has to call a business manager to approve every discount. Neither of these processes is efficient."

5. Do everything you can to keep unpaid bills from going to collections. While sending bills to collections is an option, sources say that facilities should do everything possible to avoid this last resort.

"I've seen statistics that say that less than 15 cents on the dollar is recovered during back-end collections," says Mr. Winter.

Ms. Smith concurs. "Once a patient leaves a facility, the chances of receiving any payments from them decreases drastically," she says.

According to Mr. Winter, healthcare providers need to do everything they can to keep even relatively small bills from going to a collection agency.

"Most people think that outliers with huge bills cause the biggest problems for facilities, and that just isn't true," he says. "The average bill in collections is usually around $700-$1,100 dollars, depending on the services offered by the facility"

Providing other payment options are also a good alternative to help ensure that money is collected upfront, sources say. Ms. Bailey says her facility occasionally allows patients to post-date checks if necessary. The facility also offers patients financial assistance through CareCredit, which extends some loans with no interest for 12-18 months, according to Ms. Smith.

"This assistance allows us to collect on the date of service, and the financial provider works with patients directly on any defaults," she says.

Practices must anticipate the increasing prominence of patient out-of-pocket expenses. By moving collections to the front-end and using sound business principles to offer payment options to patients that will keep bills out of collections, facilities can prepare themselves for the business challenges caused by this trend. ■

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10 Statistics About Surgery Centers With More Than 50% Orthopedics

Here are 10 interesting statistics about surgery centers with greater than 50 percent of their case volume in orthopedics, from the VMG Health *2008 Intellimarker.*

1. The average net revenue for facilities with more than 50 percent orthopedics is $5.5 million. The median net revenue is $4.3 million.

2. The average total operating expenses for centers with more than 50 percent orthopedics is $4.1 million. The average EBIDTA is $1.6 million.

3. The average center with more than 50 percent orthopedics performed an average of 2,800 cases annually, which averages to 11.2 cases daily.

4. The average center with more than 50 percent orthopedics has 11,547 square-feet, 3.24 operating rooms and two procedure rooms.

5. The average net revenue per orthopedics case for centers with more than 50 percent orthopedics was $2,328.

6. The operating expenses per case in centers with more than 50 percent orthopedics is $1,621 on average. The average operating expenses per OR is $1.2 million.

7. Centers with more than 50 percent orthopedics spend an average of $1.1 million on employee salary and wages.

8. The average number of full-time equivalent employees at surgery centers with more than 50 percent orthopedics is 20.1 — 10.4 nurse FTEs, 4.5 technical FTEs, 6.4 administrative FTEs and 1.1 administrator FTEs.

9. Here are the average hourly salary and wages and administrator's salary for surgery centers with more than 50 percent orthopedics:

- Nursing staff — $30.46
- Technical staff — $19.36
- Administrative staff — $19.16
- Administrator — $82,020

10. Here are the average staff hours per case for surgery centers with more than 50 percent orthopedics:

- Nursing staff — 7.8
- Technical staff — 4.1
- Administrative staff — 5.5
- Administrator — 1.2 ■

Source: VMG Health 2008 *Intellimarker. Visit www.vmghealth.com.*

5 Critical Steps to Build a Successful Sports Medicine Practice From Surgeon Keith Pitchford

By Mark Taylor

Keith Pitchford, DO, 48, an orthopedic surgeon specializing in sports medicine, is the president and CEO of Great Lakes Orthopedics & Sports Medicine in St. John, Ind., and is the medical director for the Sports Medicine Institute in Crown Point, Ind., a joint venture athletic training, treatment and rehabilitation center with St. Anthony Medical Center in Crown Point. Dr. Pitchford, a gregarious practitioner who engages his patients and is popular with local athletes and their coaches, says in building his practice he took to heart the "Three As" taught in medical school.

"I accepted that affability, availability and ability would help make me a better and more successful doctor," Dr. Pitchford says. "It's pretty basic stuff, but it's true. If you can be affable with your patients, they'll open up to you. You have to be available when they need you and able once they test you and you measure up to the demands. But that's just the jumping off point."

He says it's crucial to have a well-defined mission and to hire and train an office staff that understands the mission that the practice must be patient centered.

"Patients come to our office hurt and frightened. They don't know if they'll play sports or work again," he says. "We have to shepherd them and try not to corral them to a recording when they call and try not to make them wait except for emergencies."

And in building his practice he wasn't afraid to refer patients to other specialists.

"You can't have the hubris to think you can do everything," he cautions. "If you can't help a patient, send him to someone who can. Some doctors think if they refer patients to other specialists, that they'll never come back. That's wrong. If you can't help patients in need at all, then they're lost to you forever. But if you help them, they'll see you as at the go-to guy. Not having an ego in that process is very helpful."

Dr. Pitchford says some physicians create problems down the road by failing to explain the proposed course of treatment in plain English.

"I think people appreciate that I try to explain things well. While it's true patients possess different levels of education and understanding, I believe the more that patients know, the better they'll do," he says. "Almost everyone is capable of understanding the segment of information important to them. And they're motivated to learn it. The fear of the unknown is always the worst thing. Reality is never as bad as what's anticipated. If you can help patients to understand what's going, it diminishes fear and establishes a relationship of trust."

Here are five critical steps he took that helped grow his orthopedic practice.

1. Trust your judgment. "When I completed my fellowship in sports medicine in 1995, I joined a big orthopedics group," he remembers. "But they didn't have a business sense and ran the practice like it was the 1950s. It was very top-heavy and our overhead was impressively high. The first decision I made was to structure my compensation as performance-related. Rather than taking a big upfront guaranteed salary, I chose to incentivize it through bonuses. My compensation was determined by how hard I worked. I went from the brand new guy to the number two guy in nine months.

"They were so overwhelmed by the size of my bonus that they couldn't pay me at once and had to pro-rate the payments," Dr. Pitchford says. "The following year it became even more of an issue. I had this huge pile of money they owed me. Some time earlier I decided this group wasn't working for me. I thought I had a better idea for a more efficient office. So when I left they paid me monthly installments for more than one year. I used that as seed money to start my own practice and because it was paid to me in monthly installments, it was like I'd been saving it all along. It boiled down to control and once I left I finally had the input to make those things happen."

2. If you can, live in the community in which you work. "The best decision I made was to move back to Northwest Indiana. I could relate to the people better. I've seen many doctors who live in Chicago and commute to work here. It's like they're not invested in the communities they serve, like they don't want to belong here," he says. "But if you live here, you see people, you become part of the church and the PTA and a member of the community and people see you. It reinforces the brand and heightens your visibility. And living in the community also encourages you to do a good job ... People see you at the grocery store and it keeps you on top of your game every day. If don't live locally, you may have a level of anonymity and it may give you a shield, but you're viewed differently."

3. Reinvest in the practice. Instead of taking it all out, Dr. Pitchford says he socked his profits back into the practice, eventually building a new facility, adding therapies that better served patients and investing in a talented staff.

"We've all been to doctors' offices that look like grandpa's back storage room," he says. "Crowded waiting rooms. Inaccessible doors. It looks bad, like the doctor doesn't care. But if you invest back into your practice, patients see that you care and take pride in the physical plant and by extension, your practice."

4. It's better to build a bridge than to burn one. Dr. Pitchford has chosen to collaborate with nearby St. Anthony Medical Center on the Sports Medicine Institute because he says it's important for a physician to ally with larger entities. "St. Anthony's has been consistently reasonable as hospital systems go and it's better having them inside my tent working with me than outside working against me," he says. "My decision was to work with the hospital. In the scheme of things it's vital to have good relations with the big players in your market."

5. Practice your profession well or somebody else will. He advises orthopedic surgeons to stay current with the latest procedures, not just to successfully compete with others in the marketplace, but for survival.

"Like Warren Buffet said, don't be the first to buy the stock or the last to sell it," he says. "You need to be willing and able to perform new, tested procedures, or have a good reason not to if you won't. It pays to explore them and read the journals and take the classes. I've made it a point to go to courses to learn new procedures. They're not cheap and they take me away from my family and practice. But you need to become an expert on new procedures as they hit the horizon and stay abreast with trends in your specialty. You can't just be competent. You must become proficient at those procedures." ■

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7 Best Practices From Surgeon Aleksandar Curcin to Build and Maintain a Successful Spine Practice

By Mark Taylor

Aleksandar Curcin, MD, was born in Novi Sad in the former Yugoslavia and eventually made his way to the East Coast where he studied medicine at the University of Maryland. He performed his orthopedic residency at Brown University in Providence, R.I., and spine training at the University of Maryland, where he remained on the faculty for seven years at the University Maryland Shock and Trauma Institute.

"That education has been priceless to me over the years," Dr. Curcin says. "My background and education has allowed me to engage the management in whatever practice I'm engaged in."

After working for a group practice in Baltimore, Dr. Curcin moved to Coos Bay, Ore., three years ago. There he joined South Coast Orthopaedic Associates, a group practice that includes six orthopedists and a pain management specialist. They practice at their own ASC, South Coast Surgery Center, and Bay Area Hospital, an 80-bed facility that is the largest coastal hospital between San Francisco and Seattle.

Here he offers seven best practices that have helped him build his successful spine practice.

1. Take care of your patients. "The dynamics of success are wildly different in an academic setting than in the real world," Dr. Curcin says. "But the common denominator in both settings is taking good care of patients. My success stems from the fact that the vast majority of patients I treat or operate on have good clinical results and tell their friends and family."

2. Don't neglect your referral sources. Dr. Curcin says learning that developing and maintaining good relationships with the physicians who refer their patients to you, primarily internists and other primary care, was vital to his practice's growth and success. "Spine surgeons and all specialists must become good networkers," he advises.

3. Be available. "Sometimes in this profession we get numb to that whole concept of what it's like to be a patient waiting for a doctor in an office or waiting months for an appointment," he says. "It's not that difficult to schedule appointments appropriately so patients don't have to wait."

His eyes opened to the patient experience when he was in an attorney's office for a legal proceeding and waited nearly an hour, feeling the frustration of patients stuck in an office indefinitely.

"I thought: what the hell is this?" he says. "It was a valuable experience for me."

He says it's also important to be available to physicians referring patients. "They need to know you're responsive to them and to their patients."

4. Explain things to patients. "I can't tell you how many times a primary care doctor has called to tell me that I was the first specialist to sit down their patients and explain their condition and my recommendation for what should be done," he says. "Taking the time to explain pays off in so many ways, particularly in this day and age when 80-year-old patients are telling me they researched things on the Internet."

5. Ask the right questions before joining a group practice. Dr. Curcin says young physicians completing their fellowship training need to decide which practice to join. He says the most critical business question is to learn how the group makes business decisions.

"I've had both personal experience and also when I was the fellowship director at the University of Maryland and I've heard similar tales of woe," he recalls. "In my case, I went to the practice and saw a nice office and great group of guys. But once I got there to work I realized that the decisions they made were not equitable."

He says the practice had decided to branch out into physical therapy, MRI and a satellite office within one year.

"The problem is I was a first-year partner in a group of 16," Dr. Curcin says. "We had physicians at both ends of the spectrum. A guy doing this for 30 years doesn't have cash flow problems. But for the young guys cash flow was a problem. There was bitter fighting and emergency weekend meetings. We'd come to an agreement and the next day we'd be back to square one. These factors pointed to a group that was dysfunctional when it came to making business decisions. I couldn't see myself here long term."

He says it is considered acceptable in the later stages of negotiating to ask for financials. "But seeing last year's books isn't enough," he advises. "They need to know how financials are reported to doctors on a month-to-month basis. I was told I couldn't see the books, that I was just an employee. Young physicians need to ask how conflicts are resolved within the group."

6. Don't ignore the business side of your practice. "My advice for young and old physicians is not to fear looking into the business side of your practice," Dr. Curcin says. "Don't have this aloof mentality that this is something you shouldn't be concerned with. Roll your sleeves up and examine how well your practice is running. Be engaged with your management team. In transitional medical training we don't get exposed to the business side"

7. Bigger isn't always better. Dr. Curcin says group size is a significant issue. He says specialists leaving their fellowship training to seek out group practices to join should consider the size of the group. He says his former group in Baltimore had 16 doctors and ballooned to more than 20.

"The decision-making processes in groups that big are dramatically different than the group I'm in now," Dr. Curcin says. "We make decisions much faster and more efficiently to implement ancillary revenue services. In a big group there is so much debating and discussing that slows the process and causes rancor." ■

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The Outpatient Evolution in Spine Surgery: 7 Critical Focus Areas for a Smooth Transition

By Richard A. Roski, MD, FACS, MBA

Many neurosurgeons I know are interested in handling spine surgeries at outpatient facilities, but have questions about managing risk as they make the transition from inpatient. That's just as it should be. In developing ASCs with Blue Chip Surgical Center Partners, I've worked with many surgeons who've successfully made the transition, and together we've outlined a few critical steps to take.

Managing transition risk

Successfully making the transition to the outpatient environment involves the careful consideration of many questions. Here are seven key areas of focus that represent something of a checklist for surgeons to consider, especially in terms of risk management. It's not a comprehensive list but it is helpful to frame the key issues and lay the foundation for a smooth transition. They apply both for surgeons seeking to establish new, spine-focused ASCs, and for surgeons planning to add spine to existing ASCs.

1. Patient selection. Not every case is ideal for ASCs. Therefore, risk management for outpatient environments starts with careful assessment and evaluation of the patient. Obviously, the younger and the healthier the patient, the more likely he or she will be a good candidate for outpatient surgery. Probably the biggest concern is with complex treatments like anterior neck or spine procedures, which have a higher risk of hematoma. Obese patients and those with a history of respiratory problems often don't make sense for outpatient spine surgeries.

2. Managing patient perceptions. A good way to build patient comfort and confidence in outpatient spine surgeries is to handle epidural steroid injections (ESI) at an ASC. The treatment usually takes no more than 20 minutes and patients don't have to change out of their street clothes. They can relax for an hour or two afterwards and go home. If they must come back to the ASC later for a surgical procedure, patients and their families will have a better feel for the staff, routine and tempo of treatment at an ASC.

3. Building surgeon confidence. Patient perceptions are largely determined by medical personnel. If you, as a surgeon, are confident handling spine surgeries on an outpatient basis, your patients will also be confident. Referring physicians and support staff should also make it clear that ASCs are perfectly suitable for these procedures, and indeed preferable to hospitals. To build their own comfort level with outpatient spine surgeries, some of our colleagues start handling surgeries on an outpatient basis at hospitals. That's especially true for surgeons who are waiting for new ASCs to be built.

4. Postoperative care. Outpatient environments can give surgeons more control over postoperative care. Specifically, they, or their staff, can provide better and more personalized oversight and care instructions at the time of discharge. They can share detailed instructions about when and how to take medicines, how to deal with pain and what to do if anything goes wrong. Again, the reduced trauma of minimally invasive techniques and better drugs give surgeons a lot to work with. Compare that to typical hospital environments, where surgeons have little or no influence over the discharge process.

5. Responding to complications. Surgeons who remain skeptical about outpatient spine surgery seem most worried about managing the complications, which can sometime arise. As for hematomas, the incidence is low, and all of us had to deal with them. In outpatient cases, you must be certain you can get to the ER in time to re-explore, if necessary. In some ways, preparing for complications in outpatient environments is the same as in traditional inpatient settings; that is, it's primarily a matter of planning and foresight.

6. Staffing. Physicians control the staff at ASCs — that's a big advantage of operating at an ASC. Surgeons love working with staff they trust and feel comfortable with, which is also a big plus for ensuring quality outcomes. It's easier to hire who you want, and train a small, focused staff in an ASC, than trying to manage large hospital staffs. With outpatient surgeries, you'll want staff — including OR nurses and anesthesiologists — who are skilled and experienced with specific treatments. You have more say in evaluating the performance of everyone in the OR and you can more directly interact with your anesthesiologist to plan ahead and solve problems. There are more anesthesiologists who have grown comfortable working in outpatient environments. That's good news.

7. Technology. With so much new technology (and more being released all the time), it's easy to overestimate the importance of tools and instruments. In many ways, technology is a red herring when it comes to transitioning spine treatments from inpatient to outpatient. I know surgeons who prefer to use older (but still highly useful) tools in their outpatient ORs.

The point is, you don't need the latest, most expensive instruments to succeed with outpatient spine surgery. In my experience, it's the more humane parts of medicine — patient assessment, building the right OR team, and self-confidence — that enable smooth transitions to outpatient environments. ■

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15 Medicare/Medicaid Anti-Kickback and Fraud and Abuse Statute Cases Making Headlines in 2009

This is a short summary of 15 anti-kickback and fraud cases and investigations that have made headlines in 2009. The situations involve a range of participants including hospitals, device companies, physicians, payors and other suppliers.

1. Medtronic whistle-blower suit. A lawsuit filed by two former Medtronic employees of the company's Memphis-based spine business accused 120 leading spine surgeons across the country and 18 medical device distributors of promoting "off-label" use of the Medtronic product Infuse, which is used in spine surgery to promote bone growth between vertebrae. The product is approved by the FDA for use in the lower back but was allegedly being used in neck surgeries by a number of spine surgeons. Although off-label use of the product is not illegal, the plaintiffs claimed that the defendants took a total of $8 million in consulting fees for promoting the product in 2006. A Massachusetts federal judge dropped the suit in March, ruling that the case did not constitute a whistle-blower suit and blocked an amended complaint by the defendant. However, a civil suit is still active in federal court.

2. Orthopedic device maker antitrust/anti-kickback suit. A lawsuit against Zimmer, Stryker and three other orthopedic device manufacturers accused the device makers of driving the McCulloughs, a family of commissioned salespeople for a competitor of the defendants, out of business. The McCulloughs claimed the defendants provided kickbacks to orthopedic surgeons for using their products over competitors. A federal judge dismissed the antitrust case against the Zimmer and Stryker in March, stating that the plaintiffs lacked standing to bring an antitrust action and lacked insufficient evidence for racketeering charges, which the suit also alleged. The three other device manufactures named in the suit, DePuy, Smith & Nephew and Biomet, previously settled with the McCulloughs.

3. Federal oversight of orthopedic device makers ends. The U.S. Attorney's office ended 18 months of federal oversight of orthopedic device manufacturers Zimmer, Depuy, Biomet, Stryker and Smith & Nephew in March. The federal oversight resulted from charges by the U.S. Attorney's office in 2007 that the device makers violated anti-kickback statutes by paying tens of thousands of dollars to surgeons as incentives to use their products. The companies avoided prosecution by agreeing to new corporate compliance procedures and federal monitoring. Zimmer, DePuy, Biomet and Smith & Nephew remain subject to the terms of separate agreements entered into with the OIG until 2012.

4. NeuroMetrix kickback allegations. In February, medical device maker NeuroMetrix agreed to pay $3.7 million as part of a deferred prosecution agreement for federal allegations from the U.S. Attorney's office that

it gave kickbacks to physicians. The allegations accused NeuroMetrix of paying physicians in the form of free boxes of disposable biosensors for use with the company's NC-stat System to encourage the physicians to recommend the device to colleagues. NeuroMetrix also allegedly asked physicians to seek reimbursement using a higher valued CPT code under certain circumstances when physicians performed a nerve conduction study using the NC-stat System. Of the $3.7 million, NeuroMetrix agreed to pay $1.2 million as a criminal penalty after admitting that it provided the free biosensors; the remaining $2.5 million in civil damages will settle the kickback and fraudulent up-coding allegations. Under the deferred prosecution agreement, NeuroMetrix will not be prosecuted in connection with the illegal kickbacks if the company complies with the obligations of the agreement for a term of 36 months.

5. Illinois radiology centers kickback suit. Fourteen radiology centers in Illinois that allegedly paid illegal kickbacks to doctors in exchange for referrals agreed to pay a total of $1.2 million to settle a lawsuit filed by the Illinois Attorney General in January. The case, which was filed in 2007, alleged that the radiology centers entered into sham "lease" agreements with doctors under which the doctors paid a reduced rate for MRI and CT scans, charged the patient's insurance carriers a higher rate and then pocketed the difference. The lawsuit asserted that the defendants' actions violated the Consumer Fraud and Deceptive Business Practices Act, as well as Illinois' anti-kickback law, the Insurance Claims Fraud Prevention Act.

6. UnitedHealth Group class action suit. UnitedHealth Group, the nation's second largest health insurer, agreed to pay $350 million to resolve a class action lawsuit with the American Medical Association and the Medical Society, the State of New York and the Missouri State Medical Association in January. The suit alleged that UnitedHealth's wholly-owned subsidiary, Ingenix, rigged the databases that health insurers rely upon to set the "reasonable and customary" rates they charge for out-of-network physician fees so that providers and health plan member were underpaid for these services. The company also settled a separate investigation into these practices by the New York Attorney General for $50 million in January. UnitedHealth admitted no wrongdoing in conjunction with either investigation.

7. Medicaid fraud suits against New York hospitals. Seven hospitals in New York were accused in January of fraudulently billing Medicaid for more than $50 million for alcohol and substance abuse treatment even though the hospitals lacked a state license to provide this treatment. The lawsuits, brought by the New York State Attorney General and U.S. Attorney Benton Campbell, also claim that four hospitals — Columbia Memorial Physicians Hospital Organization in Hudson; Long Beach Medical Center; New York Downtown Hospital; and St. Joseph's Medical Center in Yonkers — allegedly paid kickbacks to Missouri-based SpecialCare Hospital Management Corp. to get more patients into drug treatment programs. The suit also accused Queens' Parkway Hospital, which closed in 2008, of trying to bribe homeless patients to participate in a detox program. The other defendants are the former Our Lady of Mercy in the Bronx and Benedictine Hospital in Kingston. The state settled for $4.5 million with Our Lady of Mercy, now run by Montefiore Medical Center, which denied all wrongdoing.

8. Florida HIV clinic Medicare fraud scheme. The owners and operators of two Miami medical clinics named Medcore Group and M&P Group of South Florida, and a phlebotomist at one of the clinics, were charged and plead guilty in January of conspiring with others to submit approximately $5.3 million in fraudulent claims to Medicare. The defendants admitted that they entered into kickback arrangements with Medicare beneficiaries whereby the beneficiaries were paid every week in exchange for their Medicare billing information, thus allowing the clinics, which claimed to specialize in the treatment of HIV-positive patients, to submit fraudulent bills. The defendants also admitted that none of the Medicare beneficiaries needed the injection and infusion treatments administered and billed to Medicare by the clinics. Four additional co-defendants in the case did not plead guilty and stood trial in March. All four co-defendants, which included two physicians, were found guilty.

9. Texas medical supply companies' Medicare fraud scheme. Rhonda Fleming, who owned several Houston-based medical supply companies and a Medicare billing firm, and her two business associates were convicted by a federal jury in April of healthcare fraud, conspiracy to defraud Medicare and wire fraud. The three were found to have participated in a $36 million Medicare fraud scheme and face sentences of up to 20 years in prison for each count.

10. Biomet spinal product sales investigated. The U.S. attorney's offices in Massachusetts and West Virginia began investigating Biomet, a leading orthopedic device manufacturer, for improper sales, promotion and billing by its spinal device unit, EBI, in January. The company allegedly promoted the off-label use of its spine stimulation devices, which resulted in fraudulent Medicare and Medicaid billing. The federal probe in West Virginia stemmed from a whistle-blower lawsuit alleging that a West Virginia surgeon implanted the devices in clinical research without asking for the consent of the patients. The complaint also alleges that on 15 occasions, a representative of the EBI unit was in the operating room while the spinal products were used for off-label proposes. The Massachusetts investigation may have stemmed from another whistle-blower suit from March 2005 which claimed Biomet was improperly billing bone-growth stimulators as devices that must be purchased rather than rented. Biomet denies both allegations.

11. Yale-New Haven Hospital settles Medicare fraud allegations. Yale-New Haven (Conn.) Hospital agreed to pay $3.77 million in March to settle an investigation by the U.S. Attorney's Office, District of Connecticut, in response to allegations by CMS that it billed Medicare for inflated charges related to infusion therapy, chemotherapy and blood transfusion services. Authorities claimed that the organization billed Medicare for multiple units of these services when the program only allows payments for a single unit of infusion therapy and chemotherapy administration per patient, and one unit of blood transfusion per day. The hospital also disclosed, under the OIG's Provider Self-Disclosure Proto-

col, that it had inadequately documented claims pertaining to services provided in its oncology infusion services in patients' medical records, including dispensing medication and conducting laboratory studies without written orders signed by a physician; the protocol encourages such voluntary disclosure. Under the settlement, Yale-New Haven Hospital did not admit liability.

12. Illinois physician pleads guilty to fraud. James Durham, MD, of Benton, Ill., pleaded guilty in April to charges that he overcharged Medicare and Medicaid for services while president of Franklin (Ill.) Rural Health Care Clinic. Dr. Durham was accused of instructing employees to bill Medicare and Medicaid for services not covered by the payors. In total, Dr. Durham improperly charged Medicare for $42,503 and Medicaid for $145,388 between Jan. 1, 2003, and May 31, 2006. Dr. Durham faces possible prison time and a $100,000 fine and will be sentenced in July.

13. WellCare settles Medicaid fraud allegations. WellCare, a Tampa, Fla.-based health insurer, agreed to pay $80 million in May to settle allegations that it defrauded Florida's Medicaid program. The U.S. Attorney's Office in Tampa accused WellCare of submitting fraudulent charges to Medicaid and Florida Healthy Kids Corp., which cost the programs around $40 million. Under the agreement, WellCare agreed to a civil forfeiture of $40 million and an additional $40 million in restitution to Medicaid and Healthy Kids. In addition, WellCare agreed to implement new reporting policies, institute corporate financing governance programs and retain and pay an independent monitor to ensure compliance.

14. Houston's Methodist Hospital settles Medicare fraud charges. The Methodist Hospital in Houston agreed to pay $9.9 million in March to settle allegations that it improperly increased charges to Medicare patients. The allegations brought by the Dept. of Justice against the hospital claimed that Methodist inflated charges for inpatient and outpatient care to receive outlier payments — supplemental reimbursement to hospitals to pay for care when it is unusually high — that it should not have received. The hospital denied the allegations.

15. Synthes settles kickback inquiry. Synthes, maker of the ProDisc artificial spinal disk, settled an inquiry in May by the New Jersey Attorney General, which accused the device maker of failing to disclose financial conflicts of interest for doctors researching its products. The Attorney General accused Synthes of compensating physicians who were testing the ProDisc for recommending its use to patients with company stock. Synthes agreed to disclose any future payments or investments held by doctors involved in researching its products through its Web site and will pay $236,000 to reimburse the Attorney General's office for its investigation. ■

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Serbin Surgery Center Billing. Serbin Surgery Center Billing (SCB) was founded in 2001 to provide solutions for ASCs' billing and collection needs. For more information, contact SCB at (866) 889-7722 or visit www.ascbilling.com.

Specialty Billing Solutions. Specialty Billing Solutions offers a cost-effective alternative to your typical in-office billing department while helping to positively impact your bottom line. For more information about Specialty Billing Solutions, call Dan Connolly, vice president of development and payor contracting, at (877) 710-3047 or visit www.pinnacleiii.com/services/cbo/cbo_services.htm.

Construction and architectural firms

Raymond Fox & Associates. Raymond Fox & Associates is a full-service medical architectural firm, has completed over 4,000 projects ranging from small, single-specialty offices to large, multi-specialty medical office buildings and has been involved in over 400 surgical centers. Learn more at www.raymondfox.com, call (619) 296-4595 or e-mail Raymond Fox at ray@raymondfox.com.

Management, development and equity firms

Ambulatory Surgery Centers of America. ASCOA is a leader in the surgery center industry, achieving exceptional quality of care and outstanding financial results. For more information, visit ASCOA online at www.ascoa.com or call (866) 982-7262.

Blue Chip Surgical Center Partners. Blue Chip Surgical holds an equity stake in its projects and also serves as a managing partner, with several highly profitable, physician-led centers in operation around the country and a number of projects in the works. For more information, visit Blue Chip online at www.bluechipsurgical.com or call (513) 561-8900.

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National Surgical Care. National Surgical Care is a nationwide owner and operator of ASCs, focuses on addressing the needs and problems confronting surgery centers across the country. Contact Rick Pence at (866) 866-2116 or at rpence@natsurgcare.com, or visit www.natsurgcare.com.

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Online Scheduling System Can Help Improve Efficiency in Orthopedic Practices

By Renée Tomcanin

Orthopedic practices are often very busy places, and keeping schedules orderly can present a challenge. Further complicating issues is the fact that many orthopedic surgeons receive patient referrals from local emergency rooms who must be added into their schedules, often at short notice

The Center for Orthopedics in Sheffield Village, Ohio, ran into this challenge. The multi-specialty orthopedic practice manages the schedules of five physicians at three locations and needed to find a way to manage follow-up visits from the ER.

As a result, the center developed an online scheduling system called "Fast Track" for just these kinds of patients, which has allowed the physicians to maintain the referrals from ER as well as see their regular patients in a timely manner.

Too many patients at once

According to Daniel Zanotti, MD, a physician at The Center for Orthopedics, the physicians at the center are consultants at six different ERs in their area. As a result, they receive many referrals from the ER of patients who have broken bones.

The center also has an "open cast room" policy, which means that any one of these referral patients can come to the clinic the next day for a consultation by an orthopedist, rather than a physician assistant or other staff member, without an appointment.

"It gives us great access to patients," Dr. Zanotti says. "Plus, we enjoy the patient interaction."

However, oftentimes on a Monday, dozens of patients who had been seen in the ERs over the weekend would be at the clinic waiting to be seen. This would require staff to get the charts and additional paperwork of each patient and often required patients to wait a significant amount of time before they could be seen by an orthopedist.

As many physicians in the area don't offer the same open cast room policy as The Center for Orthopedics, the facility wanted to find a way to make this service more efficient and accessible for patients and staff to ensure that the service was viewed positively.

Dr. Zanotti says that the center had worked with ERs in the past to develop a solution for this problem; however, none were effective. Then, the center decided to look to the Internet and an online scheduling option.

"Because patients were so familiar with it, the Internet was the most effective, much more than programs with the hospital," he says.

Developing an online system

In order to expedite the waiting room process for open cast patients, the center wanted to create a system that would let patients select a time for their appointment that was convenient and would allow enough time for the patients to complete their paperwork before arriving at the facility.

The current system enables patients to do just that. After their visit to the ER, they can log on to The Center for Orthopedics Web site, click on Fast Track scheduling and select a 15-minute interval that works best for them. The site allows patients to see what times are already taken and choose a time up to five days in the future.

After patients select a time, they can then enter their medical histories into the system, which is received by the facility's staff. The history is then waiting for the orthopedist when the patient comes in for a consultation.

Dr. Zanotti says that the center hired a Web site consultant and designer to help create the system. It took multiple trials to get the system working the way the facility wanted it to, and the process took the center more than a year to complete.

"It takes a lot longer than one would think because there are a lot of nuances in the system," Dr. Zanotti says. "However, if you have a good developer, it can make the process easier."

Seeing progress

After The Center for Orthopedics started using its Fast Track scheduling, it began to receive positive feedback from the patients.

One area that patients especially liked was the ability to do their paperwork online before arriving at the center rather than completing multiple forms at the time of the appointment, according to Dr. Zanotti. "Paperwork is tedious, and the patient doesn't want to deal with it when he's injured," he says. "Our system allows patients to complete it in the comfort of their own home, and once the information is in the database, we can access it at both ends."

Providing electronic medical records was one area that had been tested prior to the final launch of the Fast Track system. According to Dr. Zanotti, the option had been given for patients to download paper files or to input the information directly into a secure Web site. Patients preferred the electronic version.

As an added bonus, the new patient data is integrated into the center's existing EMR system and the information is on-hand for follow-up appointments or future visits.

Patients have experienced increased convenience because they have been able to choose the 15-minute block and avoid the lengthy wait they had seen in the past, according to Dr. Zanotti.

Time and investment worth the benefits

Dr. Zanotti says that The Center for Orthopedics has seen many positives since implementing the Fast Track online scheduling system.

Aside from increasing the number of patients the center can continue to see after they receive treatment in the ER, the physicians have seen other benefits. "It eliminates the need for follow-up phone calls or delays in treatment," he says.

Most of all, by enabling patients to determine what times work best for them, online scheduling has increased patient access to physicians and overall patient satisfaction.

For any practice considering developing an online scheduling system, Dr. Zanotti says that it is important to remember that it will take some time because it is necessary to test the system multiple times.

He also notes that it takes the support of the staff and the physician partners in a practice to take this kind of initiative and be successful. "Everyone has to be on board," he says.

Currently, the Fast Track scheduling is only available for the Sheffield Village open cast room, but The Center for Orthopedics has considered expanding the service beyond the open cast room for use in day-to-day scheduling at its two other centers. One consideration in this process that Dr. Zanotti notes is that it may be difficult to integrate the schedules of multiple physicians into a single online program. ■

To learn more about The Center for Orthopedics and to see the Fast Track open cast room scheduling system, visit www.center4orthopedics.com/fast-track.

Top Five Hiring Pitfalls

By Nicola V. Hawkinson, MA, NP

Employers make many mistakes, for a multitude of reasons, when hiring employees. These consequences can hit hard on the bottom line of the business as well as effect moral and or patient perception of the practice. Heed these top five hiring pitfalls listed below and you will save on time, money, energy and reputational risk.

1. Don't hire too quickly and out of desperation
2. Have a clear job description
3. Prepare for the interview
4. Include valued members of your team in the process
5. Utilize references and confirm credentials

Pitfall 1: Don't hire too quickly and out of desperation

Do you feel like you need that nurse, office manager, assistant now? Do you feel if you do not hire someone now your office will collapse? Adopting the mindset of "finding the appropriate individual" for the job will help you avoid pitfall number 1. Hiring a "Head Hunter" is a short-term band-aid for hiring. The solution is your practice either takes the time for a careful search or alternatively engages a medical specialist firm for the complete search and the perfect fit.

When hiring, we are often in a rush to fill the position. However if you just think about how quickly hiring the "wrong" person will affect your business' bottom line, you may take a step back and look at the big picture. Consider the cost of hiring and training an employee only to learn after a short time that he/she lacks the skills needed for the job. Not only will you find yourself back to square one but you will also have the arduous task of firing, and rehiring, another employee. This will quickly lead to frustration, loss of resources and negative office morale. Don't rush an interview or candidate. If more than one interview is needed to determine the best fit for the position, bring the candidate back again for another interview.

If you find yourself in a pinch, hire a temporary employee (very cost effective). You can accomplish this through word of mouth (from respected professionals) or by utilizing a full service recruitment firm. A temporary employee will help maintain balance in the practice while you take careful time and consideration in searching for a permanent employee to join your team. Adopting these procedures will aid in your ability to find the right fit for your organization.

Pitfall 2: Have a clear job description

Are you creating a new position? Has someone left your office and you are replacing an existing position? Have you written a job description? Is it clear and concise? Does it meet all of your needs?

A job description is a map for the employer as well as the employee and is crucial in the hiring process. Without a job description the employer cannot appropriately represent the job he/she needs filled. In addition, a job description gives the employee an understanding of their role in the office. Without this clarity a successful hire is left to chance, and the possibility of confusion, lack of productivity and dissatisfaction is greatly increased. In writing and presenting a full job description, the employer may only uncover a specific skill set or expertise that may be vital to help maximize efficiency and profitability for the office. Take the time to create or revise a job description prior to a new hire. This will ensure the responsibilities of the employee are clear and concise. In addition, it will give the employer the opportunity to confirm those duties needed to run the office are being performed. It also gives a yardstick that is useful in judging if a new employee is completing all expected aspects of the position — both for the employer and employee. *No guessing!*

Pitfall 3: Prepare for the interview

Are you, the employer prepared for the interview? Have you reviewed the resume prior to the candidate's arrival in the office? Did you leave enough time in your schedule for the interview?

No matter what your position — surgeon, physician or office manager — you have taken many years to train and prepare for your specialty. On a daily basis you prepare for meetings, presentations and patient consultations. So don't fly by the seat of your pants when you interview someone to join your team. They are a representation of you and the quality you expect and deliver. Review their resume prior to the interview so that you can appear educated and interested about their background. If you don't appear interested in the candidate, why would they want to work for you? Take heed of yearly job changes on a resume and be prepared to question this if necessary. Identify gaps in work periods and inquire. As an employer, taking the time to be educated for an interview shows the employee your interest in your practice and your employees.

Of course, you want to give the interviewee an opportunity to be prepared as well. This can be achieved by presenting him/her with some information prior to the interview, such as your Web site. Then, during the interview learn what the interviewee did with that information

Throughout the interview you can have carefully planned questions to uncover the candidate's use of the information. This will give you a better idea of how the employee will utilize the tools given to him/her in their daily job. Allow the candidate the opportunity to speak as this will help you learn a lot about the individual. Remember, you want to leave the interview with a good picture of how this candidate will fit in the position and within the organization.

To simplify the process and make it as methodical as possible, I recommend making a SOP (Standard Operating Procedure) much like a physician has a standard diagnostic procedure when treating a client. It creates an efficient, easy environment for the interviewer to conduct his interview.

Pitfall 4: Include valued members of your team in the process

Do you do all the hiring by yourself? Do you have good, effective and efficient people in your organization now? If you answered "yes" to both questions, try and utilize your current staff in deciding which candidate is the best fit to join the team.

When working in an organization there is no "me." An individuals' personality, work ethic, behaviors and attitudes will affect all the employees and clients he/she has contact with. It is important the candidate is a fit not just with skill set, but with the office environment as a whole. Before the interview, share with the staff that there will be an interview and invite some to engage in conversation with the candidate. Provide the applicant a tour of the office given to them by a trusted employee. This frees up physician time and allows the physician to get feedback from the person providing the tour (second opinions are invaluable). Candidates are usually less guarded when they move away from the interviewer. Don't hesitate to do a second interview and include or have it conducted by another trusted staff member. You can also invite the candidate to attend a meeting and share in staff discussion.

Pitfall 5: Utilize references

Have you hired someone without a reference check? If so, an inadequate reference check could set you up for disaster. A medical office with unconfirmed credentials could be exposed to litigation.

Anyone can misrepresent themselves on a resume. Some can even eloquently tell untruths and conjure up great misrepresentations of the facts. Utilize those references you required from the candidate. Make sure *you* make the phone call to the preceding employer. You can gain a wealth of information from the managers' tone of voice on the phone and the manager's description of the candidates' performance.

With the candidates authorization you can also perform a background check to guard from unfortunate mishaps.

Hiring the right person is the biggest benefit you can give to yourself, your staff and your practice. Ask yourself if you are guilty of any of these hiring pitfalls. If so, make a commitment to change your current hiring practices. The strategies mentioned can help avoid hiring pitfalls, and help you find the right track and the right fit for your practice. ■

Note: This article previously appeared on the SpineSearch Web site at www.spine-search.com.

Ms. Hawkinson is the CEO and founder of SpineSearch, a recruitment and educational firm that specializes in services for spine professionals. Learn more about SpineSearch at www.spine-search.com.

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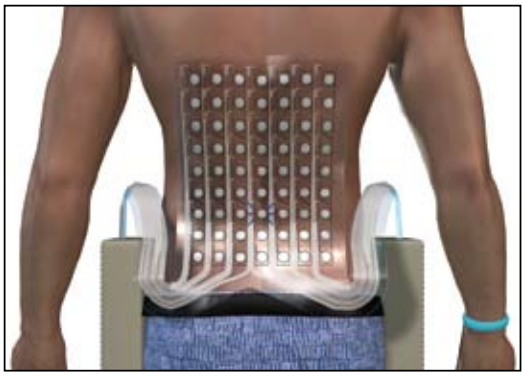

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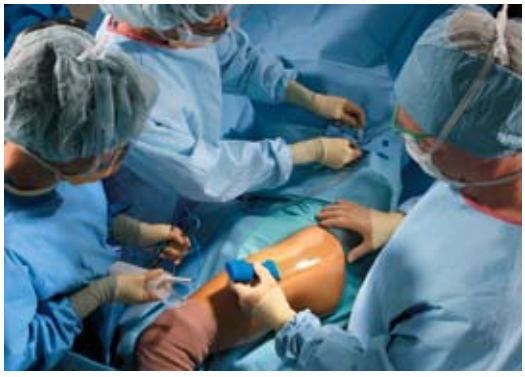

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