

ASCRReview

PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

Hospital-Physician Joint-Ventures: Current Tips for Success

By Stephanie Wasek

Physicians and hospitals, it would seem, can complement each other in many ways that would benefit both parties. For example, for physicians, running an ASC is more difficult than ever: Competition is stiff, regulatory and legal issues are more complicated than ever, and the reimbursement climate is difficult, to say the least. At the same time, hospitals are looking to expand market share and revenue streams, and their administrations have expertise in managing facilities and navigating bureaucracy. So what hampers such projects?

"All start out with varying levels of misunderstanding and even some acrimony," says Todd Flickema, senior vice president of development and operations at Surgical Management Professionals.

But as the healthcare market becomes increasingly difficult to survive in, "We're going to see more three-way partnerships with hospital systems, physicians and management companies," says Kenny Hancock, the chief development officer at Meridian Surgical Partners. "It's part of an evolution of thought, as it relates to the administration of healthcare systems; you absolutely have to have a motivated healthcare system that recognizes the need to partner with physicians, and vice versa. Otherwise, you waste a lot of time."

So how can tensions be eased and true partnerships formed so that physician-hospital joint-ventured

continued on page 13

Four Tips for Profitable Endoscopy in ASCs

By Stephanie Wasek

By all accounts, GI as a specialty — and especially single-specialty GI ASCs — will be hit the hardest by CMS's restructuring of the ASC payment system. But despite a 4.3 percent average cut for GI procedures, the situation is not as dire as it may seem at first glance, nor is it impossible to increase profitability in the new market.

"We performed a site-by-site analysis to determine the impact at each facility," says John Poisson, the executive vice president at Physicians Endoscopy, which works exclusively with GI-focused facilities. "You really need to look at all your payers and not just Medicare in determining what will be the real impact on your center."

And according to Physicians Endoscopy's calculations, "not taking into account payment increases from non-governmental payers over the next couple years, we're seeing an impact of only about 1 percent per year average reimbursement per procedure," says Mr. Poisson. For a center that does 11,000 procedures annually (34 percent of them being Medicare and commercial Medicare patients), the bottom-line impact is only \$60,000 total (see "Breaking Down GI Cases").

"That's only three endoscopes in the grand scheme of things," he notes.

Based on Physicians Endoscopy's analysis, Mr. Poisson lists four key steps you can take to compensate for the Medicare cuts' estimated hit, and to help increase the profitability of GI in your ASC.

1. Stay on top of third-party payors.

Looking first for ways to enhance your reimbursement is a far more efficient route for boosting the bottom line than trimming "fat" from operations or supply costs, for example, could be. As a result, examining your contract with third-party insurers is a good place to start.

"In terms of managed care contracting, we haven't seen any negative from Medicare interpretation from the private payors, so that has been encouraging to date," says Rodney H. Lunn, the CEO of

Surgical Health Group in Brentwood, Tenn. "If you're concerned about [private payors' rates] going down, I think looking at contracts for three years is a wise decision. I think especially when you're looking at cuts from Medicare, it probably would be smart to because I think ultimately there will be cost pressure or payment pressure."

He notes that it's best to deal with contracts as they expire, however.

"We haven't had too much success between contract periods," says Mr. Lunn.

Mr. Poisson recommends renegotiating with non-governmental payers every 18 to 24 months.

"The vast majority will provide rate increases," he says. "It may be 3 to 5 percent, though in some cases up to 10 percent, but any rate increases will help offset increases in expenses and decreases in governmental reimbursement."

Any increase will help — just \$15 more per procedure equates to \$105,000 pure profit in a center that

continued on page 5

INSIDE

2 Letter from the Editor

18 ORTHOPEDIC & SPINE MEDICAL
DEVICE MARKET LETTER

18 Trends, Developments and
Legal Issues in the Orthopedic
and Spine Device Markets

21 SPECIAL PULLOUT SECTION:
Establishing an Ambulatory Surgery
Center — A Primer from A to Z

37 Four Cornerstones to Strategic
Planning for Ambulatory
Surgery Centers

42 Spotlight On: A Better Way
to Collect Fees

46 3 Best Practices for Better
Outpatient Anesthesia

48 The Empire Strikes Back:
N.Y. Probes Underpayments
by Insurers to Out-of-Network
Providers, Patients

50 GI Catches a Break: Aetna Delays
Controversial Sedation Policy

**Save the dates for this year's
conferences from
ASC Communications!**

**The 6th Annual Orthopedics, Pain
Management and Spine Driven
ASC Conference: Improving Profits,
Business and Legal Issues**
June 19 to 21, 2008

**ASC Association and
ASC Communications:
Improving Profitability and Business
and Legal Issues for ASCs**
Oct. 23 to 25, 2008

See conference
brochure
on page 33.

Letter from the Editor

Only one-fourth of Medicare beneficiaries receive recommended screenings for colorectal cancer since Medicare initiated coverage for screening colonoscopies, according to an American Cancer Society study printed in the association's journal *CANCER* in January. The study looked at a sample group of more than 150,000 Medicare beneficiaries.

While it's not particularly good news that millions of older Americans are missing out on potentially life-saving colonoscopies — and, it's likely, so are working-age people who have commercial insurance coverage — it does show that there's a large, untapped market for GI ASCs' services.

"Not everybody's compliant with getting their colonoscopies when they reach the appropriate age," says Rodney H. Lunn, the CEO of Surgical Health Group in Brentwood, Tenn., "As a result, I think there are a whole lot of people out there who need and could be having procedures done, but who aren't."

Community outreach is one key to finding those patients and bringing them into your center, says Mr. Lunn. The president of the ACG believes improved reimbursement for these tests and payments to ASCs can help strengthen access to screenings. (For tips on casting a wider net, increasing reimbursement and more, see "Four Tips for Profitable Endoscopy in ASCs," which starts on the front page.)

"The good news is that colorectal cancer deaths are down, but marked differences in the experience of colorectal cancer, its impact on quality of life, and death rates are seen between whites and blacks, and between the uninsured, and even those with health coverage under Medicare and Medicaid," says Amy E. Foxx-Orenstein, DO, FACP, the president of the American College of Gastroenterology. "The [ACG] is committed to national policy changes to improve access to colorectal screening and increased use of these proven prevention strategies, including reversing Medicare's massive cuts to reimbursement for these tests since the benefit was first introduced, as well as to payments in ambulatory surgery centers where many screening tests are performed."

GI as a whole, especially single-specialty GI ASCs, has been the hardest hit by CMS's restructuring of the ASC payment system, suffering a 4.3 percent average cut per procedure. While it might seem counter-intuitive to bring in more Medicare cases, adding even one of these underserved patients per day can help make up for the cuts, according to calculations from John Poisson, the executive vice president at Physicians Endoscopy. See how it all breaks down — it's not as bad as has been billed — on page 8.

In another spot of good news, Aetna has announced that it will delay indefinitely its plans to institute a new policy under which it would cover monitored anesthesia care only for high-risk patients. Critics of the policy change, which was announced in December and had been slated to take effect April 1, said it would taken patient-care decision-making out of the hands of physicians and restricted use of propofol, which they said would deter patients from undergoing screening colonoscopies. Outcry from providers and specialty societies prompted Aetna to wait until patient-friendly alternatives that do not require the added expense of an anesthesiologist become available, the insurer said on its Web site. For the full story, see "GI Catches a Break: Aetna Delays Controversial Sedation Policy," on page 50.



Stephanie Wasek

stephanie@beckersasc.com or (484) 866-1292

Need a Great Administrator? Hire a Great Search Firm!

Executive Search & Recruitment Since 1981

- Administrators
- Directors of Nursing
- ASC Corporate Executives
- Mergers & Acquisition Consulting

Call Greg Zoch, ASC Specialist

Thinking of Selling Your ASC?

Greg provides Merger & Acquisition
Consulting with

NO-COST
to Physician Owners

Call Greg Zoch
972-931-5242 (ext. 5290)
gregz@kbic.com

KBIC
KAYE/BASSMAN

- Ranked Top Ten U.S. Search Firm
- Ranked #1 "Largest Retained Executive Search Firm" by Dallas Business Journal
- Recognized as an industry expert by Becker's ASC Review, The Wall Street Journal, Fortune, Business Week, USA Today, Fox, CNN, Bloomberg and others

Letter from the Editor

This is an interesting and challenging time in the surgery center industry. There are a variety of trends that overall can affect surgery centers in a negative way. There are also several steps that an operator can take to help strengthen a surgery center. This letter briefly lays out certain of the challenges facing the surgery center industry. Then, it provides a few thoughts as to how one ought to approach the challenges we are facing.

1. The surgery center industry remains a tremendous industry. There are still situations in which the correctly planned centers, operated incredibly well, can still provide margins that are outstanding and returns on investment that are terrific. Surgery centers also continue to provide physicians great efficiency and enhanced productivity, while providing patients with a better and safer alternative to most large mega hospitals. The surgery center remains an outstanding type of healthcare facility and also remains a potential profit center for physicians and others.

2. Negative Trends. There are several negative trends affecting the surgery center industry. These include: (1) increased payor consolidation, which is now leading to payors taking unilateral actions to reduce reimbursement rates in some markets; (2) increased payor pressure on out-of-network reimbursement and out-of-network practices, which weakens a center's hand in several ways, including the ability to negotiate fair contracts with payors; (3) state investigations of out-of-network practices; (4) increased employment of individual physicians by hospitals and the lessening of the pool of overall specialists available to be brought in to surgery centers; (5) economic pressure on the government to reduce the increase in healthcare spending; and (6) continued pressure on physician ownership and specialty hospitals due in part to the negative leadership of Sen. Charles Grassley (D-Iowa), Sen. Max Baucus (D-Mont.) and Rep. Pete Stark (D-Calif.), and pres-

sure on physician ownership of ASCs in certain states such as New Jersey.

3. Success tips. Surgery centers, despite these negative trends, can take several different actions to assure that they remain viable and strong in the face of such situations. Certain of the actions a center should examine include the following:

- Move toward higher-acuity cases and higher-reimbursement procedures to help offset some of the losses in reimbursement in lower-acuity procedures.
- Make sure that, operationally, a center is operated on a higher-efficiency basis, with an emphasis on management of supplies, expenses and implant costs (managing costs well is one of the best ways to protect oneself from reimbursement reductions).
- Examine recruitment of additional physicians or, in some cases, the merger of two centers into one. Surgery centers remain a high-fixed-costs business. Thus, we are seeing several mergers of surgery centers where two centers are looking to combine their caseloads over one set of overall costs.
- Make management by objective and benchmarking a constantly relentless effort at a surgery center to help ensure that cost, reimbursement and other indicators are brought into line with desired results.
- Take actions to diversify payor mix, physician mix, procedure mix and suppliers. For example, we are seeing parties double their efforts to bring in patients from afar, even from outside the United States, and efforts to enter into contracts with new networks.
- If an ASC has specific strengths such as great relationships with a group of physicians, consider other services you can provide with the group, such as additional procedures, expanding into a small hospital or other means to take advantage of your current strengths. If you have an outstanding director of nursing or administrator, try

to get her or him more involved in your recruiting efforts and other efforts.

• If you are building a surgery center or adding a specialty or room, don't do so unless there is a significant margin of safety to ensure that, if results don't hit exactly as you want them to, you will still do fine with the addition and the change.

4. Upcoming conferences. We have three upcoming events that may also prove helpful for people trying to understand how to better operate in challenging times. These include a teleconference on March 19, "Handling Complex Orthopedic Spine Procedures in ASCs," that offers CME credit; a conference focused on orthopedic-driven ASCs from June 19 to 21 at the Westin Michigan Avenue in Chicago; and a conference hosted with the ASC Association, "Improving Profitability and Business and Legal Issues Related to Surgery Centers," from Oct. 23 to 25 at the Sheraton Hotel in Chicago. We are expecting terrific turnouts for each of these events.

5. Scott Becker annual conflict of interest disclosure. Scott Becker exclusively provides legal and counseling services through McGuireWoods. He is not separately available for hire. Mr. Becker over the years has provided counsel to hundreds of physician-owned ASCs, served on the boards of directors of a few companies in the ASC business, served as general counsel to several management and development companies, and has invested directly in a small number of ASCs, owning very small interests therein — usually 0.25 to 2 percent (on the very high side). When Mr. Becker has invested in an ASC, he pays for any units in cash (he cannot trade interests for advice or services of any sort), he discloses it fully to the partners, and the partners are advised to have independent counsel review and negotiate the agreements. Mr. Becker does not seek investment opportunities, nor does he own interests in any management and development companies with the exception of one (in which he owns a very small amount) with a very limited focus that is generally not competitive with any other management company Mr. Becker works with on a regular basis.

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

Very truly yours,



Scott Becker

The *ASC Review* is published six times a year and is delivered to 20,000 to 25,000 people per issue.

Two Great Opportunities from *Becker's ASC Review*

Check out the May/June issue focusing on:

- An ASC's Guide to Orthopedics and Spine – Business, Clinical and Legal Issues
- An ASC Administrator's Guide to Anesthesia in ASC's – A Focus on Business, Clinical and Product Issues



Featuring ten orthopedic products and ten anesthesia products every ASC Administrator and Medical Director should be aware of.

Don't miss the 6th Annual Orthopedics, Pain Management and Spine Driven Conference!

June 19 – 21, 2008 • Chicago, Illinois

Sponsorship Opportunities and Exhibiting Opportunities are over half gone!

Reserve today!



For more info: www.beckersasc.com
(800) 417-2035

BECKER'S
ASCReview
PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

McKesson ScanManagerSM

McKesson's Automated Bar Code Inventory Management System



Manage your surgery center supply purchases more efficiently with ScanManager



McKesson Medical-Surgical is proud to provide the McKesson ScanManagerSM ordering and supply management system to our ASC customers.

ScanManager's bar code-based technology helps eliminate the burdensome chore of manually ordering and managing supplies, while helping to save time and reduce errors.

The ScanManager system also provides reports detailing total dollars spent by G/L code and automates the physical inventory process.

To learn more about McKesson Medical-Surgical and our ScanManager inventory system, please contact us at 888.234.7717, ext. 8776, or visit us online at www.mckesson.com.

McKESSON
Empowering Healthcare

Four Tips for Profitable Endoscopy in ASCs (continued from page 1)

performs 7,000 procedures annually — but there's absolutely no reason to accept a decrease.

"We're negotiating contracts and we are emphatic about not allowing Medicare cuts to be transferred over to third parties," says Bergein "Gene" Overholt, MD, FACP, MACG, of Gastrointestinal Associates in Knoxville, Tenn., and a past-president of the American Society for Gastrointestinal Endoscopy and the American Society of Outpatient Surgeons. "They are trying and they are testing the water, and we are just flat rejecting that approach. We won't discuss that. We'll walk."

2. Bring in the cases. "If you can increase your volume, that will go a long way to offset any bottom-line discomfort," says Mr. Lunn. There are several areas to mine in order to ensure you're getting a maximum number of cases referred to your center.

"Not everybody's compliant with getting their colonoscopies when they reach the appropriate age. As a result, I think there are a whole lot of people out there who need and could be having procedures done, but who aren't. You need to make sure your physicians are doing everything they can to recruit new physicians or bring more volume into the center. In-servicing your primary care physicians to make them aware and community awareness programs are both important."

For example, he says, "a lot of women go almost exclusively to their GYNs. Are these physicians fully aware that maybe their patients need to have

screening colonoscopy done? That might be an area that is neglected in terms of education from a colon cancer standpoint."

The schedulers in the physicians' practices are possibly the biggest factor in bringing in cases to your ASC, so it's important to network with them and make their lives as easy as possible, especially if the physicians are utilizers but not owners.

"Provide schedulers with a script that lists what to say and where to say it. The schedulers truly want to do a good job, but it's very easy to fall back into scheduling patients at the hospital because it's less work and less challenging," says Mr. Poisson. "We encourage the physicians to monitor the scheduler's interactions with patients frequently in the first few months — you need to trust they are doing what they've been asked to do, however, verification by management is critical."

Further, it's key that you communicate with schedulers (and their physicians) the importance of early notice of vacations or other planned time off that might leave blocks open in the future. Physicians Endoscopy has found that the success rate of filling a block with at least 30 days' advance notice is greater than 85 percent in its partnered centers; it's less than 15 percent for less than 48 hours' heads up. Estimating average reimbursement of \$500 per case, leaving one room open for just one day costs an ASC \$7,500; one open block weekly for a year costs \$390,000 in revenue, says Mr. Poisson. He advises using a three-step open-slot process that highly

involves the schedulers at the physicians' offices to help fill every patient block within each daily physician block.

- Patients evaluated in office are scheduled normally for a procedure in the ASC and asked if they wish to be placed on a priority list if availability in the physician's schedule arises within the next three weeks.
- Patients who are evaluated by phone are also both scheduled normally and asked about priority list placement.
- If a patient slot opens up in any physician block at the ASC within four business days, patients on the priority list are contacted until one fills the gap.

Adding just one incremental case to each room daily works out to more than 750 annually for the typical three-room ASC — about \$375,000 in revenue annually. This is a way the schedulers can contribute to one of the biggest contributors to profitability — utilization — and much can be done on the ASC side as well.

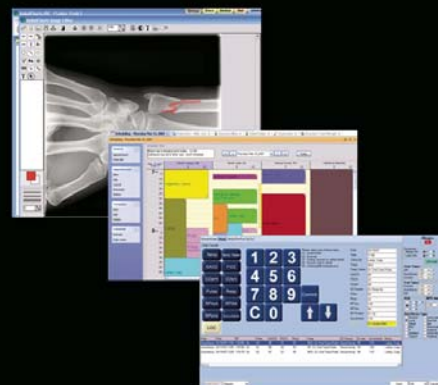
3. Assess room utilization. This is a very important decision the board needs to make regarding what it will and won't require of utilizing physicians and physician-owners alike.

"[To keep up with the Medicare cuts], we are planning to enhance business as usual," says Dr. Overholt. "That means being sure that our volumes

Increase Your Bottom Line with AmkaiEnterprise™

"Amkai's support is immediate..."

"Amkai understands our business..."



The only comprehensive administrative and clinical software solution for ASCs, Surgical Hospitals, and affiliated practices developed by one company.



866.265.2434
www.amkai.com

are high, scheduling properly to fill block times and being sure people start on time. We don't tolerate tardiness and we want people on task."

The difficulty is that, in GI, physicians by and large want morning blocks — but you're paying for the room, whether it's full or sits empty, all day.

"We tend to see very high utilization rates in rooms in the morning, typically greater than 95 percent," says Mr. Poisson. "But in the afternoon it often plummets to the mid-70s. Yes, it's hard to ask a patient on NPO to come in at 3:30; however, it's very important to examine whether you're running rooms at lower utilization for physicians' convenience or because you don't have the cases."

When approaching utilization issues in your center, honestly determine whether you are already high-utilization or have room for improvement, based on these criteria:

- performing 3,000 to 3,500 procedures a year per room;
- performing 12 to 16 procedures per room per day between 7:30 a.m. and 3 p.m.;
- meeting a utilization rate of 95 percent in the morning; and
- meeting a utilization rate of 80 percent in the afternoon.

For those centers in which all rooms are being utilized to a large degree each day — in other words, the minority of centers — you're not a victim of your own success.

"If you happen to be well-utilized, you have the ability to make the decision to not bring certain payors into the mix," says Mr. Poisson. "Have physicians take the less-profitable cases to the hospital or another venue. For example, the Medicare codes for screening, which took the biggest hit, that's the first thing I pull out of our fully utilized centers. If you know a particular patient is just a simple screening, and you have the option of filling that slot with a payor that's more profitable, you should do that."

The second kind of center, those with potential for greater utilization, are those running under the 90 or 95 percent mark, and that's where most fall. The good news: You likely have opportunities for improvement.

"It's just a matter of coming up with what works for your center, or even physician by physician," says Mr. Poisson.

On the center level, one example of a fix is slightly overbooking the schedule.

"You can usually count on one or two patients either canceling or not showing, so knowing that, you can double-book and add one or two patients beyond the slots available," he says. By doing so, "nine times out of 10, if you've got 15 patient slots for a given room that day, you end up with 15 actually showing up. When all 17 do show up, in my experience, it doesn't cause a bump; staff and physicians step up to that challenge and meet it."

Don't be afraid to customize physicians' blocks if they work at different speeds — especially if it means enhancing utilization.

"Most centers book each physician a 30-minute patient block, but there are just some physicians who are faster at the same level of quality," says Mr. Poisson. "There's nothing to say that, for certain faster physicians, you couldn't book 20-minute blocks. The ability to add one procedure per room per day adds up to tremendous additional profits by the end of the year."

You must ensure that relative staffing levels in admitting and recovery permit these moves, of course; "the No. 1 objective always has to be patient safety," he says. "I'm a big believer that patient safety and quality medicine can be mutually inclusive with profitability."

4. Undertake quality initiatives. "High quality just improves the product of endoscopy," says Dr. Overholt. "Not just how you perform it, but it also improves patient satisfaction scores and physician satisfaction scores."

Further, when you track quality indicators, you can put the performance data to use as a bargaining chip with insurers.

"Some centers, with certain payors, have arrangements where, for example, on a quarterly basis, they will provide quality reporting to the insurer and get a reimbursement increase for meeting specific

They say it's lonely at the top.



Let's meet at
the ASC Conference!
June 19-21 in Chicago

Schedule a Meeting – 3 Easy Ways:

1. Call - Kenny Hancock at 615-301-8142
2. Email - khancock@meridiansurg.com
3. Visit us online at www.meridiansurg.com

Not when you have the right partner.

Meridian Surgical Partners can help you plan, develop and manage your own surgery center. We also acquire partnership interests for those seeking a return on investment. We have the expertise and capital to get you there. We realize not every journey to the top is the same. That's why we tailor each facility based on the partnership's definition of success. It's how we help physicians reach the top – the meridian – of a joint venture. Call us at 615-301-8140 when you're ready to begin your journey.


MERIDIAN
SURGICAL PARTNERS

Performance, Efficiency, Achievement, Knowledge

targets," says Mr. Poisson. "An extra 5 percent in reimbursement, that translates to a lot of dollars."

Within your center, you can use quality tracking to detect inefficiencies and devise methods for improvement that will produce savings that go directly to the bottom line, says Sean Benson, the vice president of consulting and co-founder of Provation Medical, which makes procedure documentation software. As an example, he cites Central Bucks Specialists in Doylestown, Pa., was suffering from inconsistent room turnover that caused scheduling problems and resultant frustration on all sides.

"When we tried to get to the bottom of the problem we got myriad answers," says Zvi Weinman, MBA, the administrator of Central Bucks, which performs 8,000 GI procedures annually. "The staff thought it was caused by the physicians, the physicians thought it was caused by the staff, and occasionally, everyone thought it was caused by the anesthesiologists."

Mr. Weinman was able to have hard data in hand that allowed him to analyze the problem objectively by tracking quality indicators: arrival to patient in room; patient in room to time-out; time-out to scope-in; scope-in to scope-out; scope-out to recovery start; recovery start to discharge; and polypectomy rate. Two areas stood out.

• **Time-out to scope-in time.** Five of six practicing physicians, were averaging within minutes of one

another; the sixth was averaging close to 20 minutes longer than the others per procedure. The discrepancy was due to his conscious sedation practice: "Rather than giving a big bolus up front, he was doing a little at a time, and onset of the anesthetic took markedly longer as a result," says Mr. Benson. "When he was able to see the difference his conscious sedation practices were having on his procedure times, and that what his peers were doing wasn't affecting outcomes adversely, he changed practice."

• **Scope-in time to scope-out time.** Four of six doctors averaged within minutes of one another for scope time. One took markedly longer, and another was significantly shorter. It was not a matter of quality, but rather a matter of practice preference. For the physician who took longer, "they just scheduled his procedures for an extra 15 minutes each, and built it into the schedule," says Mr. Benson. "That way, the staff could anticipate, and backups for his patients were eliminated."

The faster physician opted to slow his scope withdrawal to ensure greater consistency and better adhere to identified GI best practices.

Some good news is that "GI is clearly out in front of every other specialty with regards to quality improvement," says Mr. Benson. "There are a lot of things going on in the world of GI QI, thanks to the ASGE and ACG getting together to create a QI pilot study that captures 80 data points for each

colonoscopy (download it: <http://www.asge.org/WorkArea/downloadasset.aspx?id=3386>). For day-to-day practice, this needs to be distilled down to a handful, but it's helpful that efforts in this area are so thorough."

(For more on GI and QI, see "Are You Ahead of the GI QI Curve?" on page 10.)

Stick to basics

"The best ways to enhance profitability are by looking at fundamentals; there's nothing really new here," says Mr. Poisson. "It's just a reminder that, to run a GI ASC, you really need to be an efficiency expert."

Further, the four-year phase-in will help offset declining Medicare reimbursements, especially in GI.

"Reimbursement is clearly going down," says Mr. Poisson. "But you can't look at it in a vacuum; if you do, the situation is horrible. The average center's cases are two-thirds non-governmental payors. If you integrate Medicare payments with the rest of your payer mix, the situation is not nearly as Draconian as has been broadcasted." ■

Contact Stephanie Wasek at stephanie@beckersasc.com. Rob Kurtz (rob@beckersasc.com) contributed to this report.

UMBRELLA BUSINESS SOLUTIONS

Maintaining healthy economic growth and prosperity for our partners.

The True Partner Program

Comprehensive business solutions and thought leadership ensuring your financial and personal bottom line are well taken care of.

Physician Partnerships

Acquisitions

Physician-Hospital Joint Ventures

360° Total Management Program

Professional, ongoing and personal "hands-on" business solutions letting you and your team focus on what matters most – the care of your patients.

Design and Development Service

Management Services

Billing Services

For more information regarding our services and a Free Financial Pro-Forma, visit our Free Resources section at www.endocenters.com or contact us at 877-442-3687.

PE *Physicians Endoscopy*
The ASC Development and Management Company

www.endocenters.com



The right partnership means everything.

- Acquisition Services
- Financial Expertise
- Payor Contracting
- Physician Recruitment
- Operational Expertise
- Risk Management
- Marketing
- Human Resources
- Business Plan Preparation
- Regulatory Compliance
- Supply Chain Management



NSC owns and operates a network of surgery centers in partnership with physicians. An industry leader with a solid reputation and years of ASC experience, NSC is a premier management company specializing in acquisitions. If you are considering selling a part of your surgery center, contact us.

For an evaluation of your center, phone
Alan Hale, Vice President of Development
(866) 866-2116
 or visit
www.natsurgcare.com

3 More Ways to Enhance Profits

• **New lines of service.** “For those centers that are underutilized, there is the ability to add pain or lumps and bumps or things like that,” says John Poisson, the executive vice president at Physicians Endoscopy. “If you have the capabilities, you can use procedure rooms for these.”

You might also look into adding ancillary services, says Bergein “Gene” Overholt, MD, FACP, MACG, of Gastrointestinal Associates in Knoxville, Tenn.

“We are investigating the possibility of implementing new revenue streams,” he says. “Pathology is the big one, but there are also imaging centers and labs — a new [service line] is the possibility of adding a pharmacy dispensing GI medications.”

• **Cut repair costs.** “Is there any way to cut your repair costs, which can add \$4 or \$5 to a procedure just on scope maintenance and repair?” asks Rodney Lunn, the CEO of Surgical Health Group. If you find that maintenance costs eat up a large portion of the budget for equipment that is fairly new, you should look at how staff are handling the instruments and determine whether they are employing proper handling and reprocessing techniques.

“Are scopes tested for leaks before they are submerged, for example,” says Mr. Lunn. “There are procedures that people can go through to determine whether you have a leak, so you can have it repaired before it damages the scope. A lot of people will buy used scopes and find that their maintenance costs are higher and you’re better off just buying newer equipment because your maintenance costs are down. You spend a little bit more on the front end but you’re able to save and have better material to work with.”

• **Examine supply costs.** Dr. Overholt cites his facility’s membership with a GPO as a key factor in saving on supplies, but also notes that there are steps you can take within the facility to save.

“We are controlling supply costs, within reason,” says Dr. Overholt. “Standardization of items such as gowns, gloves, and masks, and those types of supplies where physician preference often differs but quality doesn’t, lets you control your costs more effectively. We make our physicians aware that supply costs are a critical element; we just point out that everybody’s little variations that they like, even though they like them and it would be nice to do for everybody, drives costs up. They get involved in this aspect, and peer pressure to standardize helps bring costs down.”

Breaking Down GI Payments

According to Physicians Endoscopy’s calculations, which don’t take into account any cost-of-living increases that may later be built into payments, there’s only a \$7 per-procedure average difference.

- 2007: \$446 is the average per-procedure reimbursement across GI procedures
- 2008: \$441
- 2009: \$439
- 2010: \$437
- 2011: \$439

“That’s why case-costing is so important,” says John Poisson, the executive vice president at Physicians Endoscopy. “Say the center is doing 30 procedures a day, you’re down \$170. If you’re able to schedule just one more patient in that day over your typical utilization, you’re up.”

“The profit-drivers in ASCs are always volume and utilization, those are always the biggest bang for you buck. No. 2 is the payer rates, third tier is expenses. Get the right staff, don’t overstaff. Then you can focus on things like extending scope life, better purchasing power with a GPO, things of that nature.”

Facility Profile: Overcoming Adversity to Build Case Volumes

Heading into 2006, the Michigan Endoscopy Center in Farmington Hills, Mich., was coming off a year in which it had performed 16,300 cases, a 70/30 mix of lower and upper GI, respectively, in its three procedure rooms and three ORs. In the middle of 2006, one of the original physician members, who had contributed more than 1,000 procedures annually, moved his practice out of state mid-year. Michigan Endoscopy Center managed to still perform 16,100 cases, but needed ways to fill the gap in '07. Then, it got even tougher: The equivalent of one full-time physician was lost for nearly half the year due to maternity leave and back surgery.

Despite being down a physician-and-a-half for 2007, Michigan Endoscopy Center managed to not simply hold steady, but to top the previous two years' volumes and perform a record 16,500 procedures. And the 5-year-old facility is on track to do 17,000 in 2008.

How did Michigan Endoscopy Center do it?

For one thing, demand is higher than ever for GI procedures, and Michigan Endoscopy Center looked to its coalition of 17 physicians from five off-site practices to fill the space.

"We were proactive in repackaging available block time to the physicians," says Brien Fausone, MA, MBA, the administrator of Michigan Endoscopy Center. "One of our busy physicians who was on medical leave assigned his patients to one of the junior physicians, which helped preserve some of the volume fallout. Several of the physicians picked up additional days during the five months of open block time."

In smaller practices, adding another physician might be an option. According to Physicians Endoscopy's data, credentialing just one additional qualified physician with the ability to perform 500 procedures annually in an existing, profitable GI endoscopy ASC can generate \$250,000 in collections a year at a very high profit margin.

That would easily cover the losses incurred by CMS's restructuring of the ASC payment system. Increasing the ability to perform procedures is one of the major steps Mr. Fausone started preparing last year in an effort to take the sting out of the Medicare GI cuts.

"As a result of the success of offering additional block time and in anticipation of the Medicare reimbursement cuts, the board of managers decided to make the capital investment in opening an additional procedure room late in Q4 of 2007," he says. "We opened the additional procedure room to give those physicians who had maximized their current

block time additional opportunities to scope at MEC. This additional procedure room provides an additional 50 potential cases a week, bumping our daily capacity to 90 cases per day."

On a more macro scale, Mr. Fausone credits an "all-star team of employees, both clinical and non-clinical," as the driver that allows the physicians to chalk up the large volumes.

"Most of our clinical staff were personally recruited by our physicians when we opened five years ago, and we make a conscious effort to recruit nurses and techs who will fit our busy ASC," he says. "Most of our clinical staff have many years of experience in GI or surgery and have worked side-by-side with our physicians over many years. This allows our staff to anticipate the needs of the physicians and provide individualized attention based on each physician's surgical preferences."

To reward staff for their efforts, "We also provide quarterly bonuses to our staff for various quarterly benchmarks, including quality, patient satisfaction and billing error rates," says Mr. Fausone. "This is a confirmation from the physician-owners as to the importance of the team in the overall success of MEC."

— Stephanie Wasek

The case was completed **in less than 75 minutes—**
Why wait 90 days to get paid?



Receive your facility fee—**now** with CareCredit® Patient Payment Plans

■ Reduce Accounts Receivable and collection costs

■ Receive payment in 2 business days with no responsibility if the patient delays payment to CareCredit or defaults

■ Offer patients 3, 6, 12 & 18 month No Interest and 24, 36, 48 & 60 month Low Interest Extended Payment Plans

Get paid now and increase your cash flow with CareCredit.
Call **800-300-3046** ext. 4519 **today**.

CareCredit®
Patient Payment Plans
carecredit.com

Are You Ahead of the GI QI Curve?

Nearly nine in ten (88 percent) gastroenterologists either currently capture quality indicator data or plan to do so in the next two years, according to a January 2008 independent, national survey of gastroenterologists commissioned by ProVation Medical and Caris Diagnostics. Of those surveyed who collect QI data, majorities cited scope withdrawal time (62 percent) and rate of adenomatous polyp detection (52 percent) as indicators they capture most frequently.

"Scope withdrawal time and adenoma detection are the two biggest indicators, but there's a little bit of subtlety when looking at those data," says Sean Benson, the vice president of consulting and co-founder of ProVation Medical. "Scope withdrawal is a poor proxy for what physicians really want, which is adenoma detection rate, but you kind of have to look at them together to really get a good understanding. Rate of reaching the cecum, patients' ASA classifications, and quality of prep for colonoscopy, are also discussed as important factors to track."

Here are a few more key points from the QI study on what gets tracked, where, by whom, and how the data is used by gastroenterology facilities:

- More than eight in 10 of the gastroenterologists surveyed capture intraprocedure and post-

procedure QI data (84 percent and 83 percent, respectively), compared to 61 percent who capture pre-procedure data.

- While 64 percent of these gastroenterologists use QI data for comparison purposes, only 4 percent provide QI data to their patients.

- Eighty percent of those who use QI data for comparison purposes are comparing their practice to national benchmarks, and 64 percent use the data to compare physicians within the facility.

- Of those who currently capture QI data, other uses include research (24 percent), marketing (14 percent), negotiation of payor contracts (12 percent), pay-for-performance reimbursement (9 percent), and sharing with referring physicians (9 percent).

- The typical gastroenterologist surveyed is most likely to work in a group practice (49 percent); use a combination of hospitals and physician-owned ASCs/endoscopy centers to perform procedures; make use of hospital-based pathology labs (69 percent) and offer open-access endoscopy (63 percent), in which patients are scheduled without prior consultation.

- On average, gastroenterologists in this study perform 45 percent of their procedures in a hospital, 34 percent in a physician-owned or partially physician-owned ASC or endoscopy center, and 8 percent in an office setting.

- Though 43 percent of gastroenterologists who collect QI data use procedure-based software to do so,

82 percent overall consider it the preferred method to capture the data.

"To give you an idea of how important QI is becoming, CMS issued the PQRI — about 75 different data elements across all specialties — in July, offering to increase reimbursement by 1.5 percent in return for facilities that capture, report and meet quality benchmarks," notes Mr. Benson. "A lot of those data are focused on general practitioners, but there has been a lot of talk in the ASC space about CMS's coming out with new data elements to report on for an extra 2 percent in reimbursement. It could happen as soon as 2009, but even if it's delayed, this is what the future holds."

ProVation Medical provides procedure documentation software that tracks QI and supports several medical facilities currently participating in a national QI tracking study currently led by two major gastroenterological societies. Caris Diagnostics is a national, GI sub-specialized anatomic pathology laboratory that has developed the capability to capture and report discrete pathology diagnoses, such as the number of adenomatous polyps, with procedure documentation systems like ProVation MD. The two organizations combined their competencies to support this research effort. The survey was conducted by Renaissance Research from Jan. 8 to 16; it was completed by 182 gastroenterologists.

— Stephanie Wasek

The Solution to Your ASC's Liability Insurance Needs

As the leading provider of professional liability insurance protection to healthcare practitioners, Affinity Healthcare provides coverage for over 1,000,000 healthcare clients with over 30 years of expertise protecting physicians, dentists, nurses, and allied professionals. As a part of Aon, the #1 insurance broker in the world, we are proud to bring our experience, market knowledge and unparalleled client service abilities to ambulatory healthcare.

Call Affinity Healthcare for a fast, free, no-obligation quote.

For more information,
call 877-738-3714, or visit www.aisbrokerage.com

AON Affinity Insurance Services, Inc.
HEALTHCARE FACILITIES PROGRAM

Affinity Healthcare is a division of Affinity Insurance Services, Inc.; in NY and NH, AIS Affinity Insurance Agency; in MN and OK, AIS Affinity Insurance Agency, Inc.; and in CA, AIS Affinity Insurance Agency, Inc. dba Aon Direct Insurance Administrators License #0795465.

© 2008 Affinity Insurance Services, Inc.

ASC0308



THE FREEDOM YOU WANT.
THE SUPPORT YOU NEED.
THE QUALITY YOU DEMAND.

If you're looking for a partner with unparalleled experience developing and operating physician joint ventured short-stay surgical facilities, look no further. Find out how we can put our experience to work for you.

For more information, call (615) 234-5926
or visit www.symbion.com.

SYMBION
HEALTHCARE

THE VISION TO SEE. THE EXPERIENCE TO SUCCEED.

8 New GI Products to Know



Radial Jaw 4 Biopsy Forceps

Boston Scientific
(888) 272-1001

www.bostonscientific.com

FYI: The Radial Jaw 4 Biopsy Forceps' new jaw design and micro-mesh tooth configuration provide larger and more consistent samples without the need to use large-channel therapeutic endoscopes. These single-use forceps are also engineered for precise sample identification and enhanced passability through tortuous anatomy and are ideally suited for surveillance biopsies of Barrett's esophagus or inflammatory bowel diseases due to the increased jaw size and the ability to fit down a 3.2mm working channel.



CRE Fixed Wire & Wireguided Balloon Dilators

Boston Scientific
(888) 272-1001

www.bostonscientific.com

FYI: The CRE Fixed Wire Balloon Dilator's rounded shoulders facilitate visualization while dilating, and give physicians the ability to dilate to three distinct diameters with only one pass of the catheter. The balloon produces high pressures at each diameter and deflates rapidly. Incorporating features from the Fixed Wire Balloon, the Wireguided also includes a preloaded guidewire that facilitates placement within tight strictures and tortuous anatomy. In addition, it may reduce procedure time.



Environ-mate DM6000 Series

MD Technologies
(800) 201-3060

www.mdtechnologies.com

FYI: The Environ-mate DM6000-2 Series Suction-Drain system's compact, wall-mounted unit collects fluids directly from the suction field

and disposes directly to the sanitary sewer, providing fluid waste management for endoscopy and preventing exposure to suctioned fluids and reduces expensive disposable supplies. The unit has two independent suction inputs for EGD, ERCP and bronchoscopy procedures, or offers back-up suction in single-field procedures, such as colonoscopies. An optional fluid totalizer records fluid volume aspirated.



Endo Capsule

Olympus America
(800) 645-8160

www.enteropro.com

FYI: The Endo Capsule offers high-resolution, a wider field of view and an enhanced depth of view, automatic brightness control, advanced color reproduction and structure enhancement when imaging the small bowel. A portable, lightweight real-time viewer conveniently lets physicians verify the device is fully functional before ingestion, and the capsule can easily be activated or deactivated to conserve battery power. The hands-free, comfortable harness lets patients conduct normal activities while the capsule records images.



EPK-i Digital Image Processor

Pentax Medical
(800) 431-5800

www.pentaxmedical.com

FYI: The EPK-i features high-resolution, progressive-scan still imagery and video. Since it is built on computing technology, the digital EPK-i images can be filtered (at the touch of a button for surface, contrast and tone enhancements), giving doctors varying views of vascularity and surface irregularities that may increase rates of problematic tissue detection. The EPK-i can record and report procedure timestamps that can be analyzed and benchmarked for improving unit efficiencies and lab flow management.



90 i-Flex Endoscopes

Pentax Medical
(800) 431-5800

www.pentaxmedical.com

FYI: The ergonomically engineered 90 i-FLEX endoscopes, give physicians increased capabilities for problematic tissue detection and increased maneuverability and intraoperative patient comfort. The 90i i-FLEX boasts 1 megapixel diction power for still and image video capture, the highest resolution on the market. All i-FLEX models are built on the revolutionary, three-phase PENTAX "Cecum Finder" variable graduated stiffness scope platform, resulting in up to nearly 25 percent faster times to the cecum. With significantly improved engineering in illumination, accessory and air/water channels (including a powerful forward water jet) — without increasing the tip diameter, the 90 i-FLEX scopes provide unparalleled productivity and patient care.

Endo-Ease Discovery

Spirus Medical
(781) 297-7220

www.spirusmed.com

FYI: The single-use Endo-Ease Discovery SB has a 115cm working length to aid advancement through the small bowel with gentle rotation. The spiral naturally follows the lumen of the small bowel as it is rotated with gentle forward pressure and offers the option to stabilize the small bowel at any point the physician chooses while the scope is independently advanced. The Discovery lightly connects to an existing pedi-colonoscopy and rotates independently to preserve visual perspective.



SDC Ultra

Stryker Endoscopy
(800) 624-4422

www.stryker.com

FYI: The SDC Ultra is the first HD Capture Device for minimally invasive surgery with the ability to capture video in native HD format. The unit features an intuitive user interface, two channels of video inputs, patient scheduling and DVD and USB burning formats. The SDC Ultra can support a broad spectrum of surgeons using HD recording and Dual Channel Video input support, while offering simple, effective image and video capture for archiving purposes.

**To advertise in or subscribe to
the ASC Review, please call
(800) 417-2035.**

Hospital-Physician Joint-Ventures: Current Tips for Success (continued from page 1)

ASCs can flourish? Here are four tips from the experts on making this model succeed.

1. Understand the parties' commitment.

"There must be a common goal for success," says Tom Mallon, the CEO and founder of Regent Surgical Health. "The worst thing that can happen is having a hospital in the project under duress and doing everything it can to kill the project from the beginning. You must assess the hospital's motivation and willingness to join a project."

Bill Southwick, the president and CEO of Healthmark Partners, agrees.

"On the physician side, you need to understand if the hospital is undertaking the project as part of an offensive or defensive strategy," he says. "If it's offensive, they're likely looking forward to it and solidly committed from day one. If it's defense only, there's sometimes not a commitment on the front end, which can strain the very same physician relationships they may be trying to preserve."

It's not that a deal can't get done if the strategy is defensive, just that it usually will take more work on the front end to get both parties on the same page.

"Find compatible partners — those on physician side who can do a good job representing the physicians' interests in a constructive, non-combative way, and those from the hospital that are also well-respected by the medical staff and have a good deal

of experience with physician relationships — and have them be the lead players and be dedicated to driving the process forward," advises Mr. Southwick. "It's important to get the baggage (i.e. the must haves and the can't-live-withs within the deal), so to speak, on the table quickly, and without unpleasant meetings or hard feelings that delay and can cause further division."

Adds David Hall, the chairman of Titan Health Corporation: "If you don't have a relationship, you don't get a deal structured. I've been in a lot of situations where the relationship with the hospital and surgeons has the potential of becoming increasingly contentious and our involvement as a third party expert provides the bridge needed to craft a successful venture. There's a lot of money at stake, and both doctors and the hospital have their reputations at stake with those who refer to them and in the community at large. It's a big decision, no doubt. That's why you must establish trust."

2. Acknowledge each others' strengths and needs.

One good way to do that is to understand what each party brings to the table, and what each needs to get out of the deal.

Hospitals first and foremost need to understand the types of cases that are in the pro forma, so they can budget for their surgical departments.

"It will be somewhat cannibalistic to their business,

and they need to think about staffing, how to deal with the change in volumes, those kind of backside repercussions," says Mr. Southwick. "It's reasonable that the physicians should understand the financial repercussions to the hospital of any decision before moving forward."

At the same time, the hospital should not begrudge physicians for wanting to establish a center or be too quick to perceive cherry-picking by physicians in the cases they will bring to the center.

"Yes, it happens to some extent, but the ASC will still take all comers," says Mr. Southwick. "The practice patterns of some physicians may need to change, flexibility in surgical scheduling is an important early issue to address so as to avoid challenges later and ensure a successful partnership."

Physicians need to have input into the design process of the facility, and in the capital and governance structures, says Mr. Southwick.

"They need to not be outsiders coming in, but rather insiders from the get-go," he notes.

"A lot of physicians say they just need efficiency, so they can make it through all of the requirements of their surgical day," says Mr. Flickema. "Others just want to have dinner with their families and catch the last inning of the T-ball game. It's a lifestyle choice."

In either case, control is often at the fore for surgeons.



Unlock Capital Based on ASC Cash Flow ONLY

- ▶ "Buy-in" financing to get new physicians into a partnership
- ▶ Cash-in-hand for physician partners with no loss of ownership
- ▶ Working capital for new projects
- ▶ Turn-key project financing

Physicians Capital loans are based **ONLY** on the cash flow of the ASC. Traditional lenders usually require a pledge of other assets and/or other guarantees.

Call us today at 615.342.0824 or learn more at:

www.physicianscap.com

2525 WEST END AVENUE, SUITE 725 • NASHVILLE, TN 37203



"While some physicians would like to augment their incomes, they want even more, to get control of their time," he says. "Because that's their most precious resource — their issue is, how can they get control of their schedule, and do two cases or more in one hour at the ASC versus two in five hours at the hospital? From my perspective, it is rarely an economic issue for physicians in and of itself."

Because hospitals are focused on the whole realm of healthcare activities in a different type of regulatory environment, they may tend to view outpatient focused surgeons as a small — albeit significant — part of their overall business strategy, says Mr. Hall. A hospital needs to understand that the advantages of a partnership with surgeons extends beyond the outpatient surgery center and can serve broader strategic objectives such as expanding a hospital's market footprint in both geography and service.

"Hospitals have historically had a hard time with manpower reports — that they're going to need X orthopedic surgeons, X general surgeons — and physicians have been reluctant to recruit others because they may feel they're helping cut up the pie and diminishing income," says Mr. Flickema. "The ASC can help convince physicians that a surgeon they recruit will be somebody who works at the center and brings in cases, and they become more engaged with those manpower recruiting reports." Further, a good relationship between a hospital and physicians is a powerful recruiting tool for the community.

"Especially in a metropolitan community, aligning in a joint-venture ASC project with independent physicians and in some cases even employed physicians has the ability to sway physicians to feel like, 'This hospital is my partner, and I'm going to help them,'" says Mr. Flickema. "[The partner hospital] is where higher-acuity-level outpatients and inpatients are going to go, and whose specialists are going to get referrals.

"The hospital will win almost every race it runs with its competitors for physician loyalty because of the positive relationships created."

A strong partnership in which physicians, now running their own center and seeing the impact of capital equipment on the bottom line, can also help end the game hospitals and physicians play when it comes to such purchases: Physicians ask for far more than they need, knowing they're probably not going to get it; hospitals assume physicians are asking for too much and trim the list. In the end, physicians generally get what they do need, but this chicken-and-egg situation — did outlandish requests or assumptions of excess come first? — is not collaborative and doesn't contribute to a positive relationship.

"Once in a joint-venture ASC, however, when they sit down to buy equipment, they prioritize and come to reasonable conclusions pretty quickly without the gamesmanship," says Mr. Flickema. "It can be a wonderful catalyst for other equipment and supply issues at the hospital as well. For example, there might be an implant the hospital is currently

buying from three companies and can't negotiate very good prices on; eight surgeons from the joint-venture ASC will say, 'You're right, let's start looking and see if we can't shrink to two or one and get some bargaining power for controlling costs.' It makes some of those other things physicians might not have contemplated before come to the forefront."

The big question surgeons have, says Mr. Hall, is, "What does the hospital bring to the table?"

Plenty, say the experts.

"One-third of our projects have hospital partners, and these are some of the most successful," says Mr. Mallon. "The hospital gives a sense of stability and validation to the project. These are often on the campus, which is more convenient [for physicians]. Hospitals want to build bridges to their medical staffs in any way they can to enlist their help in controlling costs and increasing efficiency."

Mr. Flickema lists several fronts on which the hospital can be a boon from the physician perspective:

- If there's a contract negotiation problem, the hospital might "get involved and say, 'This is an extension of our business,' even if it doesn't do the negotiating itself."
- The hospital and ASC can coordinate on supplies to leverage buying power for both entities.
- The hospital's presence can help politically within the community. "While there is sometimes a



Let us acquire your surgery center building. So you can maximize your investment profits.

At The Sanders Trust, our primary focus is the acquisition of outpatient surgery center buildings. If you are a physician partner in an ambulatory surgery center, you may have substantial equity tied up in that property. You can free that trapped capital by selling your building to The Sanders Trust. You eliminate debt and personal liabilities, end uncomfortable conflicts with non-owning physicians, and enable the operator/tenant to maintain control of the building's management. So you're free to focus on your patients and enjoy the gain on your investment.

THE SANDERS TRUST
Strategic Healthcare Properties NationwideSM

1000 Urban Center Suite 675 Birmingham, Alabama 35242 **800.565.2585**

www.sanderstrust.com

misunderstanding regarding the for profit status of a surgical center,” he says, “when the hospital is a partner, that aspect seems to be better understood. The hospital can bring legitimacy to the venture that may be characterized differently if a partnership doesn’t exist. If the hospital is aligned, it’s easier to understand by some that this is what’s best for the community.”

- The hospital’s resources and presence can facilitate the process in states that require obtaining a certificate of need.
- Competitiveness with the hospital that might otherwise be counterproductive can be eased. “They don’t have to think, ‘Who’s watching my back?’” says Mr. Flickema. “Most physicians I know went into medicine for a love of science and a compassion for human beings, and they got swept up in politics and business. Diminishing competitiveness between hospital and physicians because of a good working center is very attractive.”

There will likely always be, on some level, the feeling that the two sides have disparate interests, but “as we talk about the future of the center, the gap shrinks,” says Mr. Flickema. “They are surprised for a minute, then it just makes sense to them that they should have many of the same goals and priorities. The tension diminishes even more once the center opens, and they see it works and that everyone is pulling in the same direction.”

With healthcare dollars increasingly limited, it’s easy to look at a for-profit entity like an ASC and paint it as pure greed. It’s also easy for the parties involved to view it as a money-maker, an investment like a stock or bond. On both sides, that’s the one mistake you can’t afford to make.

“One of our mantras is that, if you’re only going to do this to make money, you’re probably going to fail,” says Mr. Flickema. “If you work to elevate the science, increase efficiencies, enhance quality and improve lifestyle, you and the hospital partner will be successful.”

3. Establish a plan everyone can stick to.

There are several major components to this.

- **Define a timeframe.** “The initial coming together to form a partnership creates a lot of excitement on the physician side,” says Mr. Southwick. “But hospitals are larger, and there are bureaucratic processes required before an ASC project can really get rolling. That’s understandable to us as third-party managers, but it’s harder for physicians to understand, so we try to set realistic expectations of how long each step is going to take — and make sure things stay on track. Delays can be an irritant to physicians, or they might suspect that the hospital doesn’t want to do it; that’s usually not the case, so the timeframe must be laid out up front.”
- **Agree on location.** There are several considerations, and both on-campus and off-campus ASCs offer their own benefits and drawbacks.

An off-campus location might “pose the opportunity for other physicians in the marketplace who may not be owners in the ASC to own the real estate, which can unite the complicated politics of a medical community, especially in smaller towns where the need for physician participation is greater,” says Mr. Southwick. Further, “many hospitals have been at the same location for a long time, which may not be where a new growth corridor is. An off-campus location can serve both physician and patient convenience by being closer to where people work and live for added convenience, or can help the hospital expand into new markets and capture new physicians who may not be part of the core medical staff.”

However, one major consideration is that, “unless the ASC is within 200 yards of the hospital campus, the ASC and hospital can’t share a contracting relationship,” reminds Mr. Hall.

“And, in some communities, surgeon offices are mostly located on the hospital campus, and they want to be within walking distance to the ASC,” says Mr. Southwick. “Convenience for physicians will dictate volumes and, therefore, success associated with the center. If the core group of physicians you’re counting on for volume is on campus, then that might be the best choice.”

A third, lesser-used (for cost and logistics reasons) option is also out there.

Woodrum / Ambulatory Systems Development, LLC

CHICAGO • DALLAS • LOS ANGELES



Experts in the Business
of the Business.

- *Revitalize business & profitability*
- *Management to ensure success*
- *ASC development, redevelopment & turnarounds*
- *Organizational, legal & financial structuring*
- *Proprietary audit tools*

Existing & New ASCs

Leaders in Ambulatory Surgery
Since 1986

www.woodrumasd.com

At the Request of Our ASC Staff Physicians

**Serbin Surgery Center Billing
is now offering billing services
to physician practices**

**Get the same expert service
that our ASC clients enjoy**

CALL US TODAY!

866-889-7722

Serbin
Surgery
Center
Billing, LLC

© 2007 SSCB

Serbin Surgery Center Billing™
12670 Creekside Lane, #401
Fort Myers, FL 33919
www.ascbilling.com



Caryl A. Serbin,
President - Founder

"If you collaborate on your plan up front, you may find there's an opportunity for two different centers, the mothership on campus and a satellite surgery center that may attract physicians who aren't members of the hospital staff," says Mr. Southwick. "It's all market-driven, so it's important to look at and understand what the market needs in a new ASC, in addition to what the physicians and hospital want."

- Differentiate between ownership and control. "Perhaps the biggest issue is control," says Mr. Hall. "You find hospitals want 51 percent of the ownership, and the rationale is they must have control for various issues, especially with non profits as it relates to their charitable mission."

However, control and majority ownership are different things, and you can accommodate ownership, charitable mission alignment (as defined by regulatory bodies) and control with the right operating agreement.

"It really comes down to how much of the ownership lies in surgeon's hands, how much in the hospital's, how much in a company's, and what each entity does that brings value," says Mr. Hall. "The hospital and management company might have 51 percent, but the board is 50-50, or decisions require a super-majority, so the physicians feel like they have a strong voice in decision-making and feel as if they're getting the most out of the 49 percent available for physician investment."

Mr. Southwick notes that Healthmark Partners generally facilitates similar agreements.

"In our arrangements, the hospitals end up being a non-controlling partner," he says. "That way, they aren't perceived as taking advantage of the minority shareholders (a common physician fear), but also can maintain their charitable intent."

4. Engage a mediator.

Given that some level of hostility likely underlies physician-hospital relations, even at the best of times, it's probably a good idea to bring in a third-party management company to guide the process, moderate meetings and mediate relations as issues inevitably pop up.

"Sometimes you need someone who's not going to take things personally, who can act with maturity and at a high confidence level," says Bob Zasa, MSHHA, FACMPE, one of the founders of Woodrum/Ambulatory Surgery Development. "A corporate partner can make the tough calls while helping to keep the lines of communication open."

And communication is the key to maintaining relationships between both sides of a joint-venture, so the project can move forward without a hitch.

"It generally falls on us when there is some friction to communicate what each side is thinking and why, so there's no beating one's chest," says Mr. Southwick. "Needs and wants coming indirectly from a third party manager allows for a softer sell on difficult issues and often is better received by both sides. You've got to be able to bring the psychology

together, because no one can really afford a failure — anytime you put a foot in that water, you want it to be a success. There's a lot of lose-lose potential if the venture isn't established correctly."

It's the corporate partner's job to make sure interests stay aligned so the venture is done right.

"The hospital often views us as an ASC company that will side with the doctors, but we're there to be an arbiter and an advocate for the best interests of the project," says Mr. Zasa. "We're hired to make money and make the ASC successful, and not get involved in previous baggage. The physicians and the hospital want the same thing, really: someone who's not anti-them or pro-the other side, somebody who's going to work with them and appreciate what they're all bringing to the table. A corporate partner can bring that stability."

The experts recommend working with a corporate partner that is experienced, has worked with a project like yours (whether de novo or an existing ASC where one party or the other buys in), and that can provide plenty of references — both hospitals and physicians.

"In a successful project, occasionally, the hospital or the physicians may be upset about something and we as a management company tend to take the heat — it goes with the territory," says Mr. Flickema. "At the end of the day, however, we work to make sure the hospital and physicians aren't divided, and that's what's most important. It's a community effort, and we work for the center's best long-term interests. There's no sense getting involved in something this complicated if it's going to be short-lived."

Trending up

A joint-venture is not simply a transaction; it's an extension of practice. Done right, it should be a sustainable entity that both pays dividends to the physicians during their careers and is still going strong 20 years down the line, perhaps with different physician-partners. In short, it can be a win-win for both sides, which makes it an appealing prospect that will be an increasingly popular model in the future, predict the experts.

"Hospitals are smarter competitors than they used to be with ASCs," says Mr. Southwick. "There are too many positive attributes of ASCs in terms of quality, cost and efficiency, and ASCs aren't going away. Hospitals recognize that they can either continue to fight, or they can be part of it, and in the

process solidify physician relations and increase market share.

"With declining reimbursement and a more challenging regulatory and legal environment, physicians are seeing the opportunity have a partner with a lot of that expertise while being able to decide when they work more and when they see family more, lifestyle issues remain important."

It's not that either side is failing in the ways they're currently operating, just that it's possible they could do better together.

"I really do believe that hospitals do the best job they can with the efficiency of their surgical departments," says Mr. Flickema. "It's hard to stay at the same high level as an ASC when the surgical team is going from a knee scope to a trauma that the helicopter just brought in. There are huge swings in time and efficiency when you do a trauma, an outpatient case, an inpatient, a trauma, and three outpatients in the same OR."

"There's starting to be a realization that there is a better model, one that's better for physicians, staff, patients and even the hospital. Joint-ventures aren't easy to structure and manage, but we truly believe they are a good choice for many communities and a wise investment for the progressive hospital/system and its surgical staff." ■

Contact Stephanie Wasek at stephanie@beckersasc.com.



Your Partner in the Next Generation of Healthcare

The horizon is full of opportunities for surgical care. Nueterra provides our physician and hospital partners with the control you desire but we provide the strategic guidance you need to keep the risk small and the rewards large.

Specializing in the development and management of:

- ASCs
- Surgical Hospitals
- Community Hospitals
- Hospital Joint Ventures
- Physical Therapy
- Real Estate

For more information, contact Nueterra at 1.888.887.2619 or visit www.nueterra.com.

BECKER'S

ORTHOPEDIC & SPINE**MEDICAL DEVICE MARKET LETTER**

Providing Business and Guidance on Orthopedic and Spine Medical Devices to Orthopedic Surgeons and Spine Surgeons and to Medical Device Companies

Trends, Developments and Legal Issues in the Orthopedic and Spine Device Markets

By Scott Becker, JD, CPA, and Nancy A. Temple, JD, CPA

This article focuses on current events and risks in the growing orthopedic and spine devicemaker industry.¹ Orthopedic and spine procedures can be very profitable for surgery centers, as confirmed by the increasing number of centers performing these procedures. Reimbursement is solid for orthopedic procedures, and demand for implants is increasing as the Baby Boomer generation is aging. More implant and spine cases are being performed at ambulatory surgery centers than ever before.

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

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

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

The core distinction in gender-specific devices is that the size of the implant is generally slightly different to reflect different sizes in bones between genders. It may also provide for a narrower shape, a thinner shape and an increased groove angle. The hope is this will lead to better function and longer

durability. Many orthopedic physicians will tell you that implants already come in different sizes so that the concept of gender-specific is really a marketing term and not a real change.

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

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

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

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

Arthrocare, in an effort to capitalize on the minimally invasive market, has recently been touting its single use "spine wand." Approximately 400,000 lumbar micro discectomies are performed each year. The concept of the spine wand is to use this device in connection with smaller incision spine surgery and coblation technology. Instead of a 6mm access

point, this is intended to be used with a 2.5mm access point. The spine wand is used with coblation to dissolve soft tissue. Another ongoing discussion involves the debate over whether disc replacement is superior to inter-body infusion approaches. Here, device manufacturers such as Medtronic assert that total disc replacement, using, for example, Medtronic's Maverick metal on metal prosthesis, is superior to fusion technologies.

Business issues

Devicemakers are capitalizing on the demand for joint replacements through an increased number of initial public offerings. Last year was a record year for IPOs for healthcare providers, devicemakers and technology companies. From January to November 2007, eleven device companies filed plans for IPOs. MedAssets was the latest example in December 2007.

Anti-kickback and related conflict of issues

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

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

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

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

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

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

Additionally, recent reports question the efficacy of the ProDisc device and evidence supporting the marketing claims, indicating that some patients have had difficulties with the device. There is likely to be additional scrutiny of claims that particular devices achieve results in clinical studies. Indeed, the Association for Ethics in Spine Surgery, a recently formed organization of spine surgeons, states that it is dedicated to promote "evidence-based medicine" and to educate the public about "the detrimental and pervasive financial influence of industry on many health care providers and patients."²

Other legal issues

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

Contact Scott Becker at sbecker@mcguirewoods.com; contact Nancy Temple at nancytemple@sbcglobal.net.

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

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

NEWS IN BRIEF

Study: Surgery for Spinal Stenosis Provides More Long-Term Relief Than Non-Surgical Options

Surgical patients for spinal stenosis saw improvement more rapidly and reported better physical function and less pain than did the non-surgical patients, according to a multi-center, multi-state trial led by Dartmouth clinician researchers in the Spine Patient Outcomes Research Trial, or SPORT. The study also reveals that patients who choose not to have surgery are likely to improve over time as well, though they report only moderate improvement two years after their diagnosis.

The paper, published in the Feb. 21 edition of the *New England Journal of Medicine*, is the third in a series of study results; earlier papers reported that, for herniated disk with sciatica, surgical patients did slightly better than non-surgical patients, and that, for spondyloisthesis, surgical patients did markedly better than

Strategies and Solutions for Healthcare™

ASC Development, Management & Revitalizations

- Equity and Non-Equity Models
- Development • Management
- Joint Ventures • Physician Owned

PINNACLE CBO

Coding and Billing Solutions for Healthcare

- Maximizing Reimbursement
- Minimizing A/R days • Certified Coders

303.550.1132
www.pinnacleiii.com

PINNACLE III
Strategies and Solutions for Healthcare™





Gold Seal Confidence.



In a Joint Commission post-accreditation survey, 93% of Ambulatory Care CEOs said the greatest benefit they saw from Joint Commission accreditation was “Improved Safety Provided to Patients”.

Ready to earn your gold seal? Find out more at www.jointcommission.org/ASC.



The Joint Commission
Accreditation
Ambulatory Care

**See conference
brochure on page 33.**

non-surgical patients. Future studies from the SPORT trial will examine cost-effectiveness and other measures.

“Spinal stenosis is the most common reason for lumbar spine surgery in patients over 65,” says lead researcher James N. Weinstein, MD. “For the first time, we have an evidence base on which to advise our patients.”

The new study followed 803 patients, 398 of whom underwent surgery. After two years, 63 percent of those who had had surgery reported major improvement in their conditions, compared with 29 percent of non-surgical patients. Both groups reported improved pain and physical function, though surgical patients self-reported in the 60-point range and non-surgical patients (who underwent treatments such as physical therapy) in the low 40s.

Lumbar laminectomy is the most common surgical treatment for spinal stenosis, but there is another option that may be even more advantageous: The X-Stop, a titanium implant made by Kyphon, decompresses the spine to alleviate leg and lower back pain.

“What’s interesting about it is that it’s a 15-minute outpatient procedure, compared with laminectomy, where the gold standard is about 35 to 45 minutes,” says David Abraham, MD, an orthopedic surgeon with Reading Neck and Spine Center in Wyomissing, Pa. “During laminectomy, the surgeon must identify the compressed nerve and remove parts of bones and joints. But when you use the X-Stop to separate the neuroforamen, you don’t see nerves, you decompress the nerve indirectly. While laminectomy is safe and efficacious, this is a smaller operation.”

X-Stop implants cost about \$4,400 each. Depending on the state, Medicare reimburses the procedure from about \$300 per level to about \$1,800 per level, plus a facility fee, plus a separate carveout that covers the majority of the implant cost (Dr. Abraham notes that he uses two implants about 50 percent of the time). This compares with roughly \$800 reimbursement for laminectomy.

— Stephanie Wasek

Supreme Court Ruling Gives Medical Device Manufacturers Greater Liability Protection

The U.S. Supreme Court issued an 8-1 ruling on Wednesday in a decision that will protect medical-device manufacturers from patients who sue them for harm caused by a device with pre-market approval from the FDA, according to published reports.

The case, *Riegel v. Medtronic, Inc.*, involved a New York man injured in 1996 when his doctor inflated a balloon catheter during an artery-cleaning procedure. The decision serves to reaffirm that the FDA approval process appropriately preempts state tort lawsuits because the process balances patient benefits and risks, according to a statement from Medtronic. The company claims the doctor failed to follow the labeling directions for the catheter, which Medtronic no longer manufactures; and that the device was used in a patient for whom it was not recommended.

“This is a very important decision, which ensures that patients continue to have appropriate access to innovative, life-saving medical devices,” says Bill Hawkins, Medtronic’s president and CEO, in the statement. “The decision recognizes the rights and interests of the vast majority of patients who benefit from a medical device.”

— Rob Kurtz

Establishing an Ambulatory Surgery Center — A Primer from A to Z

By Scott Becker, JD, CPA, and Bart Walker, JD

This article summarizes several critical issues related to establishing an ambulatory surgery center. The article focuses on business and planning issues. An article in an issue later this year will discuss key operating agreement and legal and regulatory issues for an ASCs.

I. Financial planning issues

1. Financial feasibility; a comprehensive feasibility study. A group of physicians (or physicians and management company or hospital) must first examine their outpatient case numbers to determine whether an ASC will be financially feasible. ASC revenue is equal to the number of procedures the group can perform at its own ASC multiplied by the expected reimbursement for these expected procedures. As a general rule, in a reasonable reimbursement market, a center focusing on higher reimbursement procedures can be profitable with as little as 2,000 procedures per year. With lower

reimbursement cases, this number can jump to 3,000 to 3,500 procedures. Further, in low reimbursement markets, a center may struggle to become profitable in some specialties at almost any case level. Financial prudence dictates that one should only begin a project with a case level that is substantially higher than the threshold or break-even amount.

A first step to take prior to establishing an ASC is to prepare a pro forma income statement as part of performing a feasibility study.

A pro forma analysis and feasibility study should rely on sound physician data regarding projected case volumes, case mix, scheduling preferences and their expected reimbursement rates. Physician involvement will not only ensure sound data but accomplishes two other important tasks. First, it provides a chance to inform potential partners about the expectations, risks and profits. Second, it gives you a real opportunity to assess each physician's commitment to the project.

The case volume and reimbursement rate data collected are the key assumptions upon which the revenue part of pro formas are built. The greater the accuracy and certainty of these two types of information, the greater the accuracy and reliability of the final pro forma projections. In one center we helped to develop, the viability of the project itself was threatened when one or two of the key assumptions changed, thus resulting in the prospective loss of several hundred cases per year. A corollary to the statement that case volume projections should be reliable and accurate is the concept that the physician partners involved in the project should be fully committed to the project from the outset. There are few changes that will negatively impact the financial outlook for a new center as much as the departure of a core physician during the later stages of development. While a project can recover from a minor setback or challenge during the early planning stages, it is more difficult to correct severe problems that occur later in development.

Practice **Partners**[™]
IN HEALTHCARE, INC.

The right team. The right project. The right partner.
On time. On budget. Every time.

We fit your center like a glove.

Practice Partners in Healthcare, Inc. is focused on the planning, start-up, management and partnership of your ASC. Practice Partners in Healthcare, Inc. develops, manages and partners with physicians and hospitals creating value and operational efficiencies. We bring experienced team members to the drawing board and the board room. We are focused on the detail, allowing you to practice medicine while team members execute the plan — a plan that is physician centric and customer based. Let us take your initial concepts or mature center to the next level.

“Practice Partners... Partners for the life of your practice.”

205.824.6250
www.PracticePartners.org

2 Chase Corporate Drive, Suite 15
Birmingham, Alabama 35244



Sample summary pro forma from VMG Health Intellimarker

Dollars in Thousands	Mean
Patient Revenues	
Gross Charges (procedures multiplied by revenues per procedure)	\$20,233
Adjustments	(13,914)
Net Revenue	6,768
Operating Expenses	
Employee Salary & Wages	1,491
Employee Taxes & Benefits	320
Occupancy Costs	429
Medical & Surgical Supplies	1,338
Other Medical Costs	335
Insurance	70
Depreciation & Amortization	305
General & Administrative Bad Debt	133
Management Fees	282
Other G&A	593
Total G&A	881
Total Operating Expenses	4,903
Operating Income	1,812
Other Expenses (Income)	100
Net Interest Expense	73
Earning Before Taxes	1,734
EBIDTA	\$2,117

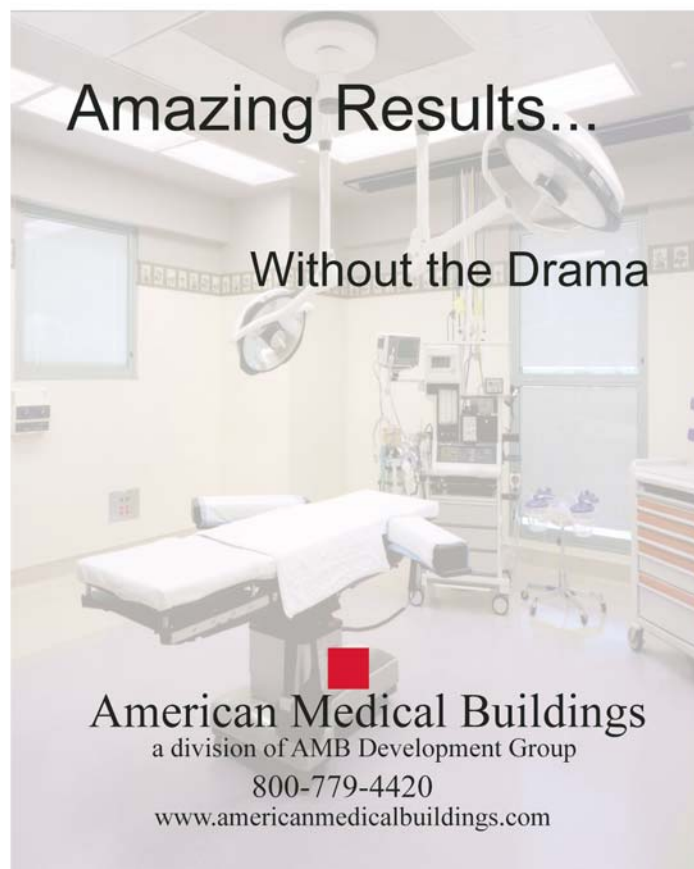
In one example where the pro forma results were very different than actual results, "The pro formas that supported the decision of the lead physician to develop a three OR surgery center were not close to reality," says Tom Yerden, CEO of TRY Healthcare Solutions. "The revenues per case were overstated by 35 percent, volumes based on phone conversations with potential physician utilizers were too high, construction costs \$155 per square foot were below real costs. Then, when operational, the results were far different than the pro forma."

Counting cases is a crucial component of the development process. "Regardless of which specialties you develop the center around, it's critical to understand the surgical case volume represented by each," says Catherine Kowalski, executive vice president and chief operating officer of Meridian Surgical Partners. "Determine the universe of surgical case by physician and always calculate the net case transfer to the ASC, factoring in issues that discount volume including: insurance contracts, regulatory, politics, convenience, scheduling, surgeon behavior, etc. A good rule of thumb is about 50 percent of the surgical case universe for a conservative analysis."

Attendance at meetings to discuss development of your new facility is another good indicator of the likelihood of the project's success. "If after two meetings to investigate and develop a project your key physician members' attendance remains strong, then it is time to get excited," says William Southwick, CEO of Healthmark Partners. "Every surgeon likes the concept of developing a center; it is the core group that remains after two initial meetings that tells you whether the excitement is real or not."

2. Reimbursement by market differs significantly; CMS reimbursement system; out-of-network concerns. Throughout the country, centers have had difficulty contracting with certain insurance companies. Thus, in assessing case volumes, one should discount the number of cases to a certain extent to reflect the possibility that certain insurance plans may not contract with the ASC. Moreover, certain insurance plans (and geographic regions) reimburse at levels below national standards. Hence, the center may find it financially impractical to provide services to these patients covered by such plans or in such regions. For example, a mediocre ASC located in an area with strong third-party reimbursement may do better than a great ASC in a bad reimbursement market. There is almost no way to fix a center that is built in a market with poor reimbursement from third-party payors.

In the planning stage, the center should attempt to



Amazing Results...

Without the Drama

American Medical Buildings
a division of AMB Development Group
800-779-4420
www.americanmedicalbuildings.com



discuss contracting with payors and obtain a real sense of whether contracts will be available and at what price. Payors have increasing power in many markets and are becoming harder to work with on an out-of-network basis. Payors and state regulatory agencies are increasingly scrutinizing out-of-network reimbursement strategies. In recent months we have seen more insurers attempting to recoup amounts they have paid on an out-of-network basis. Similarly, state agencies have been more aggressively policing this area. For example, in one recent case in New York, state auditors alleged that several surgery centers improperly waived patients' out-of-pocket payments in connection with the care they received at the centers. In all, the state alleged that about \$8,000,000 was overpaid by the state employee insurance plan, the Empire Plan, and United HealthCare, the state's insurance administrator.

Deutsche Bank, in its 2008 annual report on ASCs (dated Feb. 4, 2008), report that, for ASCs, "out of network situations typically result in greater overall costs to the system because both the patient and the third party payer have higher outlays" and "over the long term we believe that any ASC that builds its business model around unsustainable out-of-network reimbursement levels is bound to fail."

One benefit a hospital partner may add to surgery center development is the ability to jointly negotiate reimbursement rates or to include the center on the

hospital's own payor agreements. However, the ability to jointly negotiate reimbursement rates in this context is often legally restricted in that it is subject to certain antitrust rules and regulations that require the hospital to have a sufficient amount of control over the venture on whose behalf it is negotiating. In many situations, the hospital will be unable to force the payors to negotiate with them on a joint basis. To further complicate matters, some hospitals fear that by seeking to negotiate the ASC's rates with a particular payor, they will expose themselves to renegotiation of their current hospital outpatient department rates for that payor.

Another alternative to consider is hiring a third-party contracting consultant who can provide insight and advice with respect to the planning stages of reimbursement contracts. In addition, the center can ultimately use these consultants to negotiate the contracts on behalf of the center. Some management company partners employ their own in-house contract negotiators, while others outsource this function.

The new Medicare rates for surgery centers are generally more negative than positive. They essentially set reimbursement at an amount equal to 65 percent of the price paid for the same surgical procedures at hospital outpatient departments. Under the rates, of the top 20 procedures performed in surgery centers, approximately 17 will

suffer a decrease in reimbursement. For many procedures, the decreases will be significant. For example, reimbursement for many gastroenterology and pain management procedures will decrease nearly 20 percent to 30 percent. Many ophthalmology procedures will experience a 5 percent to 10 percent reduction in reimbursement. Ultimately, many high-volume procedures are becoming less profitable to perform. In contrast, many higher acuity procedures, such as orthopedic procedures, will receive improved reimbursement under the new rates.

Commercial payors often follow the Medicare reimbursement trends. Some payors define their rates in terms of a percentage of the Medicare rate. The recent reimbursement changes remind us that, overall, one way to limit the risk associated with rate cuts is to operate a multi-specialty center so that cuts to any one single specialty will not be fatal to the center as a whole. While diversification of specialties can limit losses, it can also be less efficient to operate and equip, and can limit the upside potential if one specialty enjoys especially high rates.

3. Capital requirements. The typical development of a stand-alone ASC, with tenant improvement, requires a cost of approximately \$220 to \$250 or more per square foot to become operational. Additionally, money is also needed for equipment. Of the total budget amount, a substantial portion of the money can be provided through debt financing



Building Alliances in Healthcare

- Maximize OR Capacity
- Increase Profitability and Cash Flow
- Enhance Device Access
- Preserve Physician Preference
- Decrease Reimbursement Risk
- Reduce Implant Expenditures

**Increase Implant Cases
Decrease Reimbursement Risk**

**Proven
Dependable
Partner**

The Nation's Leading Provider of Implantable
Device Solutions For Over a Decade

877.985.4850 www.accessmediquip.com

without guarantees. However, a certain portion of the debt may require personal guarantees (such as tenant improvements and working capital). Moreover, a cash capital contribution of a substantial amount must also usually be contributed to an ASC venture. Typically, anywhere from \$500,000 (on the low side) to \$1,500,000 is required as an equity cash contribution in total by the owners.

An ASC will typically initially issue one hundred ownership units. These units will be issued to members based on the amount of capital that each member contributes to the ASC. For example, if each unit costs \$10,000 and a member will own 15 units, he or she will contribute \$150,000. The amount of capital required depends upon the size of the project, whether the ASC will be a "tenant" or own and develop the real estate, and the amount of debt to be secured. The equity plus the debt borrowed from lenders equals the total amount of money needed to develop the project. Where a single-specialty ASC, such as an endoscopy ASC, will lease the space in which it operates, total initial equity capital contributions are often in the area of \$400,000 to \$800,000; however, the members may be able to contribute less money up front if a more substantial working capital line of credit is obtained. For a multi-specialty ASC that leases space rather than owns the building, initial equity capital contributions are often in the range of \$700,000 to \$1,200,000. One option, even where all of the investors want to invest in both the surgery center

and the real estate, is to have the ownership of the real estate and the ownership of the surgery center held in separate entities. This allows for additional investors to own a portion of the real estate holding company, thus making it less expensive for the investors in the surgery center entity. By separating the real estate from the operating entity that will run the ASC, investors can choose whether they would like to invest in the surgery center, the real estate or both. There are, however, significant benefits to fully congruent ownership.

The operating agreement will set forth the dates on which the capital must be contributed. Typically, all or a significant portion is contributed at the signing of the operating agreement. In some situations, part of the capital will be due at a later date, such as upon receipt of a certificate of need or perhaps six months after the initial signing. Additional capital contributions may be required of the members upon the vote of the board of managers and often a vote of the holders of a certain percentage of the units. The group will need to assess the total equity to be contributed.

Working with experienced lenders will facilitate the financing of an ASC. It can be tempting to work with a friend or a local bank, but this could be a mistake. Often with ASCs, time is of the essence and problems occur which are normally much better handled by an experienced lender than by a friend. For the best result, look for a lender with specific ASC financing experience.

There are some general costs you can use to help estimate the approximate investment necessary to build a facility.

"Although it varies based on location, the cost to develop a new ASC is approximately \$1 million dollars per operating room," says Kenny Hancock, president and chief development officer of Meridian Surgical Partners. "This figure captures the costs associated with tenant improvements, equipment and working capital. A small center with two surgical suites will range from \$2 to \$3 million and a larger multi-specialty ASC \$4 to \$6 million. Typically, the majority of the investment, including the construction cost and surgical equipment, is leveraged with debt financing. The members should plan on raising a minimum of 20 percent of the capital needed in cash to invest in the partnership. The investment typically ranges from \$10,000 to \$15,000 for a 1 percent ownership interest plus pro-rata guarantees of debt. The typical timeline is 18 to 24 months from initial discussion to opening of the center."

4. Expense management. Surgery centers tend to have a level of fixed costs that generally require at least \$3 to \$5 million in revenue to become significantly profitable and still cover the necessary expenses.¹ Centers with \$5 million to \$10 million in annual revenues can, on average, expect to have an EBITDA of around 30 percent, or earn about a 30 percent operating margin before deducting interest, taxes and depreciation.² The three biggest costs for



Control your practice. Control your life.

You want a more satisfying practice, and life. By taking care of financial, legal and ongoing management, Blue Chip lets you focus on patient care in a surgical center you control. That's what makes us, and the relationship we form with you, blue chip.



www.bluechipsurgical.com 513-561-8900

an ASC typically include staffing costs (about 20 percent to 30 percent of revenue), supply costs (about 20 percent of revenue) and facility costs (about 10 percent of revenue).³ With staffing costs making up the majority of an ASC's expenses, it is critical to benchmark the hours per case to those at other similar centers to ensure your staff is working efficiently. Generally, multi-specialty cases will entail between 13 to 15 hours per case and single-specialty cases will entail six to eight hours per case. This number is often translated in simple terms to approximately five full-time equivalents per 1,000 patients. To control staffing costs, it is imperative to use staff efficiently by cross-training where appropriate, being open only as many hours as cases require and, if possible, by sending staff home when they are not needed.

Supply costs, to a degree, may be reduced by use of a group purchasing organization or, in some cases, a hospital or management company partner that is able to aggregate expenses over a number of facilities and, as a result, benefit from volume pricing with vendors. Another common way to reduce supply costs is to implement standardization of certain common surgical supplies and reduce the use of non-essential supplies. These are both areas where a seasoned management company can help a surgery center to achieve greater operational efficiency. While staffing and supply costs can be modified over time, facility costs, once a lease has been signed or construction has commenced, are much more difficult to change. It is very

important to obtain expert advice relative to these three cost items early and often.

Equity ownership, physician partner issues, and hospitals and management companies as partners

1. Management and equity ownership. A group must determine whether or not it will have a management company as an equity partner. An experienced manager can help with myriad aspects of the project, such as financing, financial planning and analysis, Medicare certification, equipment planning, construction planning and physician recruitment. A good management company can significantly reduce the likelihood of problems in completing the project, operating the center, financing the project and ultimately prospering from the project.

The key downside to having a management company as a long-term equity partner relates to the disparate quality of companies that provide services to ASCs, and the profits that are shared when bringing in a management company. As a general rule, physician ownership alone, under the right circumstances, can be very attractive. However, having an experienced management team substantially lowers the risks, and, in the overwhelming majority of situations, can provide substantial benefits and actually improve profitability. Further, an equity owner/advisor often will have a much greater level of concern regarding the project's success, even when it owns only 15 percent to 30 percent of the center.

Deutsche Bank, in its 2008 ASC Report, reports that the 25 largest management companies own interests in aggregate in about 1,000 of the country's 4,700 Medicare-certified ASCs. (Contact Darren Lehigh at 212-250-2629 for more information).

Key items to negotiate with the management company include the percent of ownership, the management fee, the services provided, the personnel employed or provided, the length of the management contract, the board rights and the reserve or veto rights of the management company. A group should interview three to five management companies and talk extensively to other centers managed by the companies.

In addition to a management fee, the leading management companies are increasingly requiring equity in the surgery center. Before rejecting such an arrangement, evaluate how that management company compares to other management companies.

A solid management company partner can also substantially improve the financing prospects of a center. Some finance companies will not finance an entity without an experienced management company being involved.

John Marasco, CEO of Marasco Associates, notes that understanding recent partnership trends can help you gauge the direction other ASCs are choosing for their development.

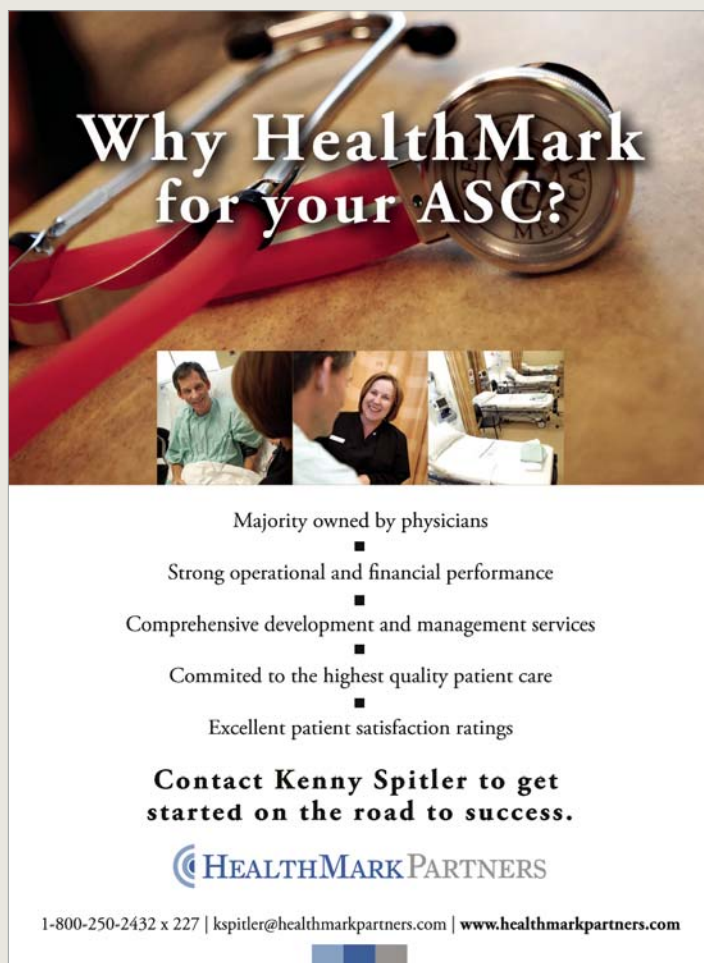


Manning Search Group

- ▷ Skilled at precision-accurate search
- ▷ Focused on your needs
- ▷ ASC industry expertise

MSG
Manning Search Group LLC

ASC executive search & recruitment services
800-203-3106
www.manningsearchgroup.com



Why HealthMark for your ASC?

- Majority owned by physicians
- Strong operational and financial performance
- Comprehensive development and management services
- Committed to the highest quality patient care
- Excellent patient satisfaction ratings

Contact Kenny Spitler to get started on the road to success.

HEALTHMARK PARTNERS

1-800-250-2432 x 227 | kspitler@healthmarkpartners.com | www.healthmarkpartners.com

"In the last few years our business has seen an increase in joint venture ASC's and physician-hospital ASCs, as compared to individually developed projects," says Mr. Marasco, "They range from physician/hospital to physician/management company to physician/hospital/management company joint ventures. We have helped develop an almost equal number of single-specialty/single-group joint ventures as we have multi-specialty/multi-group joint ventures, which is also a shift in direction. It appears that groups are shifting towards going it alone, surgically speaking, but having a partner to share in the risk as well as bring expertise and insurance contract stabilization to the table. We haven't seen a huge rise in the overall number of operating or procedure rooms in our average ASC — just a shift in who owns them and who they serve."

2. An ASC can have too many physician investors. You can have too many physician partners. With too many physician investors, there is often a dilution of individual physician responsibility and ownership interests. With too little ownership, physician investors often lose their commitment to the ASC and look for other alternatives. Further, a great deal of resentment can develop between productive and less productive parties. Of course, with too few physician investors, the price of buying in will be greater, there will be more risk of case volume losses, and the overall case volume of the center can suffer. The number of investors is a delicate balance that requires significant forethought and planning. The average number of physician-owners in an ASC is approximately 15:1 according to Deutsche Bank's 2008 ASC report.

3. Single- or multi-specialty center. Single-specialty centers can be more efficiently staffed and built than multi-specialty centers. Moreover, a single-specialty center avoids the turf wars and the level of concern regarding sharing profits and revenues with other

specialties that are often present with multi-specialty centers. However, changes in reimbursement can affect single-specialty centers more dramatically than multi-specialty centers. For example, Medicare has instituted significant cuts in ASC reimbursement for gastroenterology, pain management and, to an extent, ophthalmologic procedures. These cuts can disproportionately impact a single-specialty GI or pain management ASC's overall revenue and financial health.

On the other hand, a multi-specialty center can help reduce reimbursement reduction risk through a diversification of reimbursement sources and a mix of physicians. In addition, a multi-specialty center can provide for greater staff and physical plant economics of scale, which may be needed if single-specialty volumes are insufficient. In many cases, the operating margins in single-specialty ASCs are much higher than multi-specialty ASCs.

Specialty net revenues per case, according to the VMG Health 2007 Intellimarker, can be seen for several specialties in the following chart:

Specialty	Net Revenue
ENT	\$1,776
GI/Endoscopy	\$825
General Surgery	\$1,572
OB/GYN	\$1,864
Ophthalmology	\$1,276
Oral Surgery	\$1,056
Orthopedics	\$2,435
Pain Management	\$915
Plastic Surgery	\$1,548
Podiatry	\$2,664
Urology	\$1,802

The number can be heavily influenced by sample size, and several factors such as out-of-network considerations.

4. Hospitals as partners. Approximately 25 percent of the surgery centers in the country have a hospital partner. In many situations, a hospital can add value through either helping with managed care contracting, making it easier to recruit physicians or otherwise reducing physician concerns regarding being excluded from privileges or having other types of retaliatory action taken against them by the hospital. On the other hand, it is critical in surgery centers that physicians own a significant amount of the equity and that they remain interested and excited about the venture. We have seen hospital partners own from 10 percent to 30 percent of the venture on the low end to 60 percent to 70 percent on the high end. There are a number of lawyers representing hospitals who believe that they must own 51 percent or more. In contrast, many lawyers believe that hospitals can own a smaller interest and either agree to treat the income as taxable income or otherwise have separate special powers to help assure that the venture serves exempt purposes. From a business perspective, having a hospital partner in many circumstances can prove helpful. However, it is not a panacea for surgery centers and there are a great number of surgery centers that have hospital partners that still underperform.

"Some hospital-physician joint ventures never survive the transition from a 'spirit of negotiation' to a 'spirit of partnership,'" says Mr. Yerden. "Regardless of the strength of the projections (business plan), those joint ventures that I have seen fail (do so) due to lack of trust among the parties."

5. Ophthalmology procedures can still be profitable. Do not make a blanket decision to exclude ophthalmology as a specialty. ASCs can still profit from ophthalmology procedures if the ASC has significant volumes and effective internal cost control; in other words, the ASC must run very efficiently.

Here is what Luke Lambert, the CEO of Ambulatory Surgical Centers of America says about the specialty: "Most mature eye practices are already participating in surgery centers. When ophthalmologists start working in an ASC they never want to go back to the hospital, because the fast nature of eye cases plays to ASC strengths."

6. Pain management and anesthesiologists. Pain management services are often provided in an office setting. Centers are increasingly concerned that physician investors will perform their pain management procedures in their own offices rather than in the ASC. Medicare's site-of-service differentials, which often pay more for in-office procedures, along with other incentives, may very well encourage physician investors to perform these procedures in their own offices. ASCs should plan accordingly and diversify services to accommodate a potential loss of pain management revenue. CMS has also implemented relatively large reductions in pain management

Orthopedic, Pain Management and Spine Driven ASC Conference

IMPROVING PROFITS AND BUSINESS AND LEGAL ISSUES

June 19th – 21st, 2008

Westin Hotel • Chicago, IL

Contact us toll-free at
1-800-417-2035

Visit www.beckersasc.com

Email for more information:

Scott Becker sbecker@mcguirewoods.com

Jessica Cole jessica@beckersasc.com

Emily Noyes emily@beckersasc.com

Dan Bragaw dan@beckersasc.com

AN ASC COMMUNICATIONS CONFERENCE



reimbursement for ASCs. In order to control the flight of pain cases from the surgery center to physician offices, it is necessary to engage in a frank conversation with pain physicians fairly early in the planning process to clarify which procedures will likely be performed in their offices versus those that will likely be performed in the surgery center. For financial planning, it is critical that both parties fully understand the expectations for these types of cases.

Notwithstanding these concerns, "Efficient pain specialists can be a pillar of strength in a successful ASC," says Mr. Lambert. However, "ASCOA recommends against inviting anesthesiologists to be owners in ASCs. We feel it is better to be the consumer and contractor of anesthesia services than to be partnered with them."

7. Gastroenterology can still be profitable. In a 2006 study, gastroenterology was the largest surgical specialty, representing 25 percent of all surgical cases performed at ASCs.⁴ Medicare has implemented decreased reimbursement for gastroenterology procedures performed in an ASC. This can hurt an ASC because gastroenterology-endoscopy centers typically rely on Medicare for about 20 percent to 40 percent of their cases. Fortunately, because these centers still generate from 60 percent to 80 percent of their gastroenterology business from outside Medicare, the specialty can still be profitable if they have significant volumes and the non-Medicare business continues to grow.

"This is a specialty characterized by high volumes," says Mr. Lambert. "ASCs are important to enhancing productivity. Profits per case are low and declining but given sufficient volume it can be attractive."

Gastroenterologists will increasingly have to minor in anesthesiology. Increasingly, payors will not pay physicians separately for anesthesia procedures provided in connection with gastroenterology procedures. Thus, increasingly gastroenterologists must be competent at offering all types of anesthesia procedures.

8. Plastics. In multi-specialty surgery centers, plastics, particularly cosmetic procedures, often are very challenging. Here, the physician often bills globally, and the ASC and the physician are adverse to each other in that the ASC must negotiate its rates with the surgeon as opposed to charging a third-party payor.

"Cosmetic plastic surgery is not of benefit to most surgery centers as the facility fees paid tend to be too low for these lengthy cases," says Mr. Lambert.

9. Bariatrics is booming, but don't count on it as a long-term profit center. Bariatric procedures are growing rapidly and increasingly being

performed in ASCs. Initially, ASCs will earn outsized profits from these procedures. However, as the number of bariatric providers increases and price competition evolves, the prices on these procedures will eventually normalize and become less profitable. For this reason, and because substantial concerns remain regarding the safety and risks related to bariatric programs, ASCs should use caution and proceed conservatively when developing bariatric programs.

10. Lasik. Lasik surgery, for reasons akin to why plastic surgery is problematic, is often best left to physician practices.

11. Neurosurgery and orthopedics remain strong specialties. Orthopedic procedures remain great procedures for ASCs.

"How well you do with orthopedics depends a great deal on how successful you are in negotiating payer contracts," says Mr. Lambert. "Medicare's new fee schedule phase-in is making it possible to cover costs and setting a reference point that is helpful when negotiating with other payors."

Spine procedures are also increasingly performed at ASCs as well; they remain popular and are growing in importance. Orthopedics profits from the new CMS surgery center rates. Spine procedures can be increasingly performed in ASCs and are likely to remain good specialties for ASCs for a substantial period of time to come. In the best situation, the center has a base of cases from both specialties.

Despite the promise it offers, before you invest in spine services, it is important to consider the costs involved.

"Spine service costs up to \$360,000 to set up; \$80,000 for microscope, \$80,000 for trays, \$120,000 for c-arm and perhaps a Jackson table for \$80,000," says Tom Mallon, CEO of Regent Surgical Health. "This should not be taken on frivolously. However, if the surgeon uses loops instead of a microscope and if you have a c-arm, the entry cost is much less: \$160,000. Spine often cannot be performed on contracted patients. So in order for

you to begin even a small program (five cases per month) you need at least some out-of-network patients. However, the surgeon will love the efficiency and the patients will love the facility. This will grow over time and as payors recognize the benefits, we will be able to negotiate reasonable reimbursements."

12. ENT continues to be strong. Ear, nose and throat procedures continue to be a strong specialty for surgery centers. This specialty continues to be reimbursed reasonably well in many markets.

As a result, says Mr. Lambert, "We see ENT as an attractive specialty if the cases in your area are not overly dependent on Medicaid. Special considerations for this specialty include requiring skilled pediatric anesthesia and having a private recovery area for children."

13. Urology. Urology can increasingly also be a real plus for ASCs.

"Many procedures are short and can pay well on a time of utilization basis, of those that are longer some reimburse well," says Herb Riemenschneider, MD, founder of Knightsbridge Surgical Center. He notes that the longer procedures for urinary tract stone disease (such as extracorporeal shock wave lithotripsy and ureteroscopy stone work with laser), urinary prosthetics



**YOU'RE A HEALTHCARE SPECIALIST.
WE'RE SPECIALISTS IN HEALTHCARE ARCHITECTURE**

- NATIONAL HEALTHCARE ARCHITECTURE DESIGN-CONSULTING FIRM
- 30+ YEARS EXPERIENCE
- OVER 1,500 HEALTHCARE PROJECTS, INCLUDING 300+ ASC'S & 15+ SPECIALTY HOSPITALS
- SERVICES: ARCHITECTURE
- FEASIBILITY STUDIES
- FACILITY ANALYSIS
- DEVELOPMENT SERVICES
- MASTER PLANNING
- INTERIOR DESIGN



MARASCO & ASSOCIATES, INC.
HEALTHCARE ARCHITECTS AND CONSULTANTS
1660 WYNKOOP, STE 925, DENVER, CO 80202 TOLL FREE: 877-728-6808
WWW.MARASCO-ASSOCIATES.COM

(penile prostheses and artificial urinary sphincter), prosthetic slings for treatment of female incontinence, and the most recent addition of cryoablation for treatment of prostate cancer, have "big potential if done correctly."

"Urology can be profitable when it involves lithotripsy and female incontinence surgery," says Mr. Mallon. "Both are predominantly commercial populations. Serving Medicare men with prostate cancer can often be break-even at best."

Some ASCs are finding benefits of building a center around urology.

"The surgery center has allowed our urologists to remain more efficient doing outpatient surgery than they could be by performing the same procedures in an outpatient hospital setting," says Bill Monnig, the president of a large urology group. "The single-specialty designation allows us to gain maximum benefit of the special endoscopic equipment that urologic surgery requires and, therefore, may be more financially advantageous than a multi-specialty center where this equipment may not be used as much. Our surgery center also gives us an opportunity to dovetail other ancillary services such as CT scanning, urodynamics, pathology lab, clinical lab, research programs, office-based minimally-

invasive prostate surgery and clinical research programs into adjacent facilities. The number of and type of procedures that we can perform in the surgery center continues to grow each year."

II. Building issues

1. Do not overspend on real estate. Physicians planning centers should purchase property that is cost-appropriate. Normally, a second or third tier commercial property that is level, safe, accessible to your physicians and patients and has easy parking will often be sufficient. Make sure that the less expensive land will not ultimately cost you more due to unknown variables. If a property has a lack of utilities, set-backs or zoning restrictions, it may ultimately cost more. A site should be evaluated by an experienced ASC architect to ensure that it can meet the ASC's requirements. This includes performing a thorough analysis of state and municipal codes and regulations in regards to health and zoning issues prior to purchasing the land. Do not assume, for example, that a space used for an ASC in the past is automatically qualified to fit your needs. In many cases, existing structures may not meet standard coding requirements and a change in ownership or management of the facility will trigger a need to update it to current specifications.

A visible, expensive parcel is often an unnecessary cost. It is not important that the ASC be visible in order to attract drive-by or foot traffic. This is significant because premier commercial lots can cost considerably more than otherwise equally appropriate, yet less visible, lots.

2. Do not overbuild. A building should meet the group's volume and specialty needs, as well as the financial parameters. The space plan should be integrated with your staffing and equipment plans. Knowing your case numbers, how many technicians, nurses, schedulers, business office and administrative staff and other staff you will need, as well as your equipment requirements, should drive your space needs.

3. Lease or build from the ground-up; lease or own the real estate. A center does not need more than one operating room per 1,000 to 1,500 cases. A typical two-room ASC can be built in 7,000 to 8,000 square feet. An average size ASC is approximately 13,000 square feet.⁵ VMG Health's Intellimarker also indicates that the median ASC includes four ORs and two procedure rooms. Centers can be leased from a third party or built from the ground up. Often, it is quicker and less expensive to lease space and operate as a tenant. On average, rental rates are approximately \$27 per square foot each year.⁶



56 Medical Projects, 107 OR's, 28 ASC's and counting!

As an ASC Design/Builder, **Irmscher Construction** is **large enough to know** the intricate details of designing and building a beautiful and efficient Ambulatory Surgery Center, but we're **not too big to care**. We will give your project our personal attention and a guaranteed contract price so you can concentrate on what you do best, delivering great health care.

Irmscher Construction has been a trusted commercial builder since 1892. Call or email Tom Irmscher (tirmscher@irmscherinc.com) or Leo Kuntz (lkuntz@irmscherinc.com) for more information. We're excited about getting you started on a facility that we'll both be proud of.

Design/Build

Leaseback or Own

IRMSCHER
Since 1892 *Construction*

1030 Osage Street
Fort Wayne, IN 46808

Phone: (260) 422-5572
Fax: (260) 424-1487

www.irmscherinc.com
build@irmscherinc.com

"We prefer to lease our ASCs' real estate because we lease without personal guarantees and avoid having to put cash/equity into real estate," says Mr. Lambert. "Surgery centers, if conceived and managed properly, can offer returns that are superior to that of the typical ASC real estate investment."

The disadvantage to this approach is that one does not ultimately own the real property nor completely control the project. At the same time, the long-term capital costs can be substantially lower.

Tom Irmscher, President of Irmscher Construction, makes two interesting observations on this subject. First, he says, the larger public companies typically do not want to own their real estate. In contrast, the private small group will often choose to own their real estate. Second, in the private projects, the group will typically form a separate entity to own the real estate.

4. Equipment budget and planning. When developing a center, you have to decide whether or not to use an equipment planner. The argument for using equipment planning is that it costs approximately \$200,000 to \$500,000 per OR to set up the OR. This will be one of the largest expenses you have at a surgery center. Thus, the argument is that you use an expert to help you do it, help save costs and plan more efficiently and coordinate better through design, development and construction. The counter argument is that either a center can do it itself or it could use a management or development company to do it as well. In fact, many people resent the concept of using a management or development company and then, on top of that, having to use an equipment planner. Further, there are situations where the equipment planning firm may have such close ties with industry (equipment manufacturers) that using an equipment planner might not get you some of the benefits that you expected to get from the process.

5. Other building issues. Early in the design process, an ASC should examine how information technology systems, fluid management systems and anesthesia systems will be incorporated into design. For example, as to fluid waste management, Bill Merkle of MD Technologies notes:

"ASC design should consider fluid waste management since disposal systems require plumbing, drains and medical gas piping most easily installed during construction or remodeling. Procedure room layout should address fluid management to assure that utilities and piping are conveniently located near the patient bed as well as near medical equipment (such as an endoscopy cart with light source). System size and floor space requirements should be assessed, particularly if suctioned fluid must be transported to disposal sites.

Today, most (about 80 percent) fluid management costs is for canisters, with remaining cost for waste disposal. Tremendous cost savings can be realized if both costs are eliminated. Advance planning can improve room efficiency, reduce turnaround time and minimize fluid management costs."

III. Miscellaneous.

1. Accreditation and state licensure. Many surgery centers are state-licensed, Medicare-certified and accredited. For example, in 2005, over 4,500 ASCs were Medicare-certified.⁷ There are currently approximately 5,500 to 6,000 ASCs. Many states require ASCs to be licensed. In addition, ASCs should attempt to become accredited by the Joint Commission, the Accreditation Association for Ambulatory Healthcare or another reputable accrediting agency such as the American Association for Accreditation of Ambulatory Surgery Facilities. Accreditation often lets ASCs be deemed Medicare-certified, to serve certain payors and to measure their services and performance against national recognized standards, thereby helping them to improve the quality of their care.

Speak with your state health department early on in your development process to learn your state's ASC licensing requirements as each state is different. In all cases, you will want to speak with them very early in the process to access state requirements and processes, and to help avoid unexpected delays in licensure requirements.

2. Hire strong leadership; cost; timing. High-quality management is critical to an ASC's success. Many management companies offer superior services. However, many are of little value. All management companies are not equal. For this reason, it is important to work with an experienced management company that has a proven track record of successes. Working with a low-quality, inexperienced company will do more harm than good. You will need to start by hiring an administrator and director of nursing.

It is far better to overpay the employee a bit to hire outstanding help as a great staff is crucial to an efficient and profitable ASC. You need not necessarily employ your staff full-time. However, you are best off paying your staff well and attempting to obtain the highest quality staff—even if highly paid on an hourly basis. It is also critical that you treat the staff extremely well so that you are able to recruit and retain the best possible staff. Finding and retaining an experienced and competent staff can prove challenging.

Registered nurses can make superior administrators. Experienced RNs often make great ASC administrators. The RN must study and be interested in the business side of ASCs. Generally,

RNs are trained to be disciplined and dedicated workers; a work ethic that carries over to the administrator position. As such, RNs are often vibrant and willing to contribute in many ways to improve the surgery center. An administrator should typically be hired four to six months before a center intends to become operational.

Here are some insights from Roger Manning, founder of the Manning Search Group, on the costs and timing of hiring certain leadership:

- Base salaries can, of course, vary depending on the geographic locations with California and certain areas of the Northeast (such as Boston) being the most highly paid.

- On average, an owner can expect to pay an ASC Administrator from \$70,000 per year to \$110,000 for more experience. "We occasionally will find an administrator who is paid far higher than this, but I think it is because of close long-term relationships with the physicians and/or the physicians made a strong deal to get them to help open up their ASC," says Mr. Manning. "Multi-site management positions will start paying in the \$110,000 range to \$125,000 as their low range and can go up to a high average of \$150,000 to \$175,000. Most of my [multi-site]-type positions are paying in the higher end due to the competitive pressures to gain experience."

- The opening of an ASC by a surgery center management company is usually done with the assistance of a key development manager until 30 days within the opening date. Between 30 to 60 days, "I am usually given a call to find the new administrator," says Mr. Manning. "If a private group of physician investors is opening the center without the assistance of a national management company, they should consider hiring an administrator who has had prior ASC development experience that will stay on as the administrator. In this case, the hire should be done at the conception of the deal."

- Again, base salaries can vary depending on the geographic areas of the United States. "I have seen directors of clinical services (director of nursing) salaries vary from \$55,000 in small ASCs or single-specialty ASCs to \$100,000 per year," he says. "I would say that owners should expect to pay on the average \$75,000 to \$88,000. Recruiting a doctor with experience from a national competitor will probably cost you \$90,000-plus because of the highly competitive nature of the ASC industry coupled with the nursing shortage (especially in California)."

3. Typical problems for surgery centers. The No. 1 problem for most ASCs is the inability to effectively recruit the right number of physicians and cases or the inability to obtain appropriate commitments from their physician partners. The

Implantable Devices Impacted by Payor Industry Changes

By Jay Ethridge, CEO, Implantable Provider Group

With expanding indications and increased utilization of procedures involving high-cost implantable devices, the level of scrutiny applied to related claims has forced payors to look for solutions.

Although the overall volume of implants at any given facility is high, it usually spans a wide range of therapeutic areas. This magnifies the risk factors for ASCs, especially for procedures that are low volume but include equipment or device costs in the tens of thousands of dollars.



One small mistake in the claims process can wipe out profits on many other successful procedures

Reimbursement for these devices has never been simple, but Medicare changes in the last year as well as the continued trend for commercial payors to insist upon procedure case rates including those associated with high-cost implantables has shifted significant financial risk to the ASC. It is imperative for the ASC to have analytical capability within its organization to understand how these new reimbursement methodologies can affect the procedures they provide. If you don't have this capability, there is a high probability you are losing significant money on these procedures as well as tying up precious capital. Additionally, for many elective procedures, commercial payors are requiring more rigorous documentation to substantiate the medical necessity of the procedure. Often the ASC relies on the physician's surgical authorization to substantiate that the payor requirements are being

met. This may be an assumption that can cost the ASC dearly.

When coupled with the focus by the commercial payor industry to rein in costs and better understand utilization, making money on the equipment side of implants is quite often a risk that isn't worth taking.

Not unlike the specialty pharmacy arena, companies have emerged whose only focus is working with high-cost implantable devices. Atlanta-based Implantable Provider Group (IPG) is one such company whose sole focus is high-cost implantables in the neurological, cardiovascular and orthopedic industries.

IPG provides ASCs and hospitals a full range of services that can dramatically decrease the resources required to handle procedures that include an implantable device. Because IPG works directly with the commercial payor market, they are able to provide meaningful Implantable Device Management (IDM) solutions that eliminate the unwanted risks, but allow you to continue to provide billable core facility services.

IPG works directly with manufacturers to supply the device or equipment for the procedure. They also assume all of the responsibilities of administrative functions associated with the device, including:

- Preauthorization
- Predetermination
- Billing and Collection
- Payor Contract Analysis

As payor focus turns to the implant world, now is the time to transfer the burden of Implantable Device Management to IPG. Visit ipgsurgical.com today to find out how to protect your facility's profits by partnering with IPG.



Working with IPG

IPG has created a culture of excellence internally, which translates into an extremely high level of service for their customers. We talked with a client in Florida to get feedback on their experience working with IPG and here is what we learned:

Why did your practice start using IPG?

Our practice started working with IPG because it made case processing and approvals faster and easier. The outpatient facility we use no longer has to worry about pending payments or outstanding balances. Our partnership with IPG is very effective for our practice.

How would you rate the service you receive from IPG?

I would rate the service from IPG at the highest possible standard. I've never had an issue with approvals, and if I need a task completed in a hurry, it always comes through quickly and without problems. I can't say enough about how much the IPG staff helps me and my practice.

How easy is it to initiate cases through IPG?

I find it extremely easy to initiate cases through IPG. All I have to do is send in my notes, a patient information sheet and the signed release. After that, it's smooth sailing. IPG's steady communication assures me that the process is staying on track.

Jennifer Hoyt

Dr. Roberto Duran's office
Jupiter, Florida

www.ipgsurgical.com

most successful centers are increasingly built around a core group of physicians. This approach lessens certain risks related to the center and clarifies the level of physician commitment. Over time, an evolving risk in many markets relates to the actual number of independent physicians available for recruitment.

A second set of core risks includes overstaffing an ASC and building a facility that is too big. The desire of partners to have the latest and greatest technology and equipment can quickly kill a budget. It is often useful to have third-party input in these decisions to help inject some rational, efficiency-minded thought into the process.

Despite their growth throughout the country (nearly 5,500 to 6,000 ASCs), a substantial number of ASCs still fail. The failures occur mostly due to bad management, low-volume of cases, poor reimbursement or overbuilding. Knowing the risks involved in developing an ASC can help to ensure that your ASC will prosper and not fail. Working with experienced managers in developing a center can also help prevent failures.

Many centers also face significant risks related to reimbursement, managed care exclusion, poor billing and collection practices and failing to contain supply and equipment costs. In essence, because the reimbursement for procedures is becoming less predictable, there is an extensive need to assure that the project is well-managed and well-thought out. A failure to do either of these can lead to significant financial problems for the entity.

Turning around struggling ASCs requires many changes.

"You must change the thinking of the partners and staff," says Mr. Mallon. "They need to be open to doing things differently. True insanity is doing the same thing over and over and expecting different results. We must understand how we make money and how we lose it. Every center has losing cases, but they must be performed judiciously. Do a losing case in a lineup of profitable cases — that is OK. Do losing cases that have small supply costs and no implant — that is OK. Avoid high-cost implants and surgeons who only bring losing cases based on fully loaded cost analysis."

4. Advisors, management, architects, builders and lawyers. Given that more than 5,500 ASCs now exist, we strongly advise that ASCs utilize experienced advisors. Should you need recommendations, please contact Scott Becker at (312) 750-6016 or at sbecker@mcguirewoods.com.

5. Establish MIS and billing systems early. An ASC should establish its management

information system and other operational systems, such as billing, materials management and marketing. You should set up your MIS as early as three months prior to your ASC's opening. The MIS is a critical part of an ASC's organizational backbone and can support the effective management of the ASC. If established early and populated with appropriate information, upon opening, your clinicians, front office and management will have immediate efficiencies scheduling surgeries, billing, performing collections, case-costing and taking inventory, among many other tasks.

Caryl Serbin, CEO of Serbin Surgery Center Billing, implores those planning ASCs to decide early whether to outsource billing or handle billing internally — an ASC should decide at least four to six months prior to becoming operational. Further, she says, an ASC should also set up its billing office early so that it can start billing

(and collecting) reimbursements from day one. Another option is to outsource billing and collections services. If you choose to use an outside provider, it is advisable to also get them involved early in the development stage in order to expedite implementation of their systems. ■

Contact Scott Becker at sbecker@mcguirewoods.com and Bart Walker at bwalker@mcguirewoods.com.

¹ Intellimarker, Ambulatory Surgical Centers Financial & Operational Benchmarking Study (2d Ed. May 2007) ("2007 ASC Study") at p. 30.

² Id.

³ 2007 ASC Study at p. 15

⁴ 2007 ASC Study at p. 7

⁵ 2007 ASC Study at p. 35

⁶ Id.

⁷ 2007 ASC Study at p. 7

For information about conference registration, subscription information, advertising or exhibiting, please call (800) 417-2035.

ASC BECKER'S Review

PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

☐ **Yes! I want to subscribe to Becker's ASC Review, 6 issues annually for ONLY \$199**

☐ **Yes! I would like a two-year subscription for ONLY \$299**

ORDER BY FAX OR MAIL: Return this form by fax or mail.

Mail: 315 Vernon Avenue, Glencoe, IL 60022

Fax: (866) 678-5755

CALL (800) 417-2035 to subscribe by phone.

SHIP TO:

Name: _____

Title: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

PAYMENT:

☐ **Bill Me. PO#:** _____

☐ **Check Enclosed (by mail or fax only)**

☐ **Credit Card (by mail or fax only)**

Card #: _____ Exp: _____



Signature: _____

Make checks payable to **ASC Communications, Inc.**


ORDER TOTAL: _____

For additional information visit www.beckersasc.com



Patient and provider satisfaction begins with the power of one.

When you collaborate with a single partner to manage all the details of your strategic facility development, your vision is executed, seamlessly. Planning, financing, architectural designing, engineering, and building — all guided by one vision — all handled by one firm.

 **Marshall Erdman & Associates**

Your Vision Executed. Patient and Provider Value Delivered.

erdman.com 800.322.5117

TA3108

ASC Communications, Inc. Proudly Presents

THE 6TH ANNUAL ORTHOPEDICS, PAIN MANAGEMENT AND SPINE DRIVEN ASC CONFERENCE: IMPROVING PROFITS, BUSINESS AND LEGAL ISSUES

June 19–21, 2008

THE WESTIN MICHIGAN AVENUE – CHICAGO, ILLINOIS

Visit www.beckersasc.com

The 6th Annual Orthopedics, Pain Management and Spine Driven ASC Conference provides guidance on improving the profitability of and on operating and establishing orthopedic, pain management and spine-driven ambulatory surgery centers.

This event focuses on ASC business and legal issues. For example, presentations and case studies will discuss successful turnarounds; start-ups and physician hospital joint ventures; regulatory and legal issues; implant purchasing; recruiting surgeons; revitalizing an ASC; and a wide variety of other issues. The conference also provides insight on new procedures being handled in ASCs, including total joints to spine procedures and to various types of pain management procedures.

The conference combines high-level views from national speakers such as Tucker Carlson, leading political commentator and media personality, to Brian Cole, MD, a leading national expert on cartilage restoration and advances in orthopedics; to practical guidance from leading national experts and operators of ASCs.

More than 70 speakers will address topics such as selling an ASC, joint-venturing an ASC, out-of-network issues, physician-hospital joint-ventures, Medicare payment changes, managed care contracting and recruiting physicians. The event will also include numerous case studies.

The conference will include an outstanding opportunity to share insights, learn from and network with other orthopedic surgeons, pain management physicians and spine surgeons.

The conference is designed for surgeons, ASC owners and administrators, hospital leadership and companies that work with surgery centers and hospital out-patient departments, with a focus in the musculoskeletal area.

KEYNOTE SPEAKER: Tucker Carlson



Tucker Carlson

Hear Tucker Carlson Speak Friday, June 20, 2008:

The Political Landscape, Healthcare and ASCs

Keynote speaker Tucker Carlson is the host of MSNBC's *Tucker*, a fast paced, no-holds-barred conversation about the day's developments in news, politics, world issues and pop culture. A longtime magazine and newspaper journalist, Carlson offers insights on "The Political Landscape, Healthcare and ASCs."



Thank you to our Senior Level Sponsor: **VMG Health**
Visit: www.vmghealth.com Email: osullivan@vmghealth.com
Phone: 214-369-4888

Visit www.beckersasc.com or call (800) 417-2035

PRELIMINARY CONFERENCE AND EXHIBIT SHOW AGENDA

Thursday, June 19, 2008

Noon-4:30 pm	Exhibit Set-Up
2:00-5:00 pm	Pre-Conference Concurrent Sessions
5:00-7:30 pm	Networking Reception and Exhibits

Friday, June 20, 2008

7:00-8:00 am	Registration, Exhibits and Continental Breakfast
8:00-10:30 am	General Session
10:35-11:20 am	Networking Break and Exhibits
11:20 am-12:30 pm	Concurrent Sessions
12:15 -1:30 pm	Networking Lunch and Exhibits
1:30-2:45 pm	Concurrent Sessions
2:45-3:45 pm	Networking Break and Exhibits
3:45-5:30 pm	Concurrent Sessions
5:30 -7:00 pm	Networking Reception and Exhibits

Saturday, June 21, 2008

7:30 -8:30 am	Registration, Exhibits and Continental Breakfast
8:30-10:25 am	General Session
10:30 am-12:55 pm	Concurrent Sessions
1:00 pm	Meeting Adjourns

ACCREDITATION

CME Accreditation: This CME activity has been planned and implemented in accordance with the Essential Areas and Politics of the Accreditation Council for Continuing Medical Education (ACCME) through the Joint Sponsorship of Institute for Medical Studies (IMS) and ASC Communications, Inc. IMS is accredited by the ACCME to provide continuing medical education for physicians. IMS designates this educational activity for a maximum of 13.5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CASC Accreditation: This program is approved for 13.5 hours of AEU credit by BASC Provider #3672.

BRN Accreditation: Nurses may claim credit for activities approved for AMA PRA Category 1 Credits in most states, for up to 50 percent of the nursing requirement for recertification. This activity is designated for up to 13.5 AMA PRA Category 1 Credits™.

For information on Exhibits or Sponsorships, please call (800) 417-2035.

CONFERENCE PROGRAM

THURSDAY, JUNE 19, 2008

Track A - Establishing Orthopedic-Driven ASCs, Pain Management and Physician Hospital Driven ASCs

Track B - Turning Around ASCs; Establishing a Spine Driven ASC; CMS Reimbursement Issues for Orthopedics

Track C - The Intersection of Health Care and Wall Street; An Analysis for the Next Five Years for ASCs; 3 Quick Methods to Add Profits to an ASC

Track D - Reducing Operating Room Costs, Medical Devices and Implants, The X Stop Procedure

2:00 – 2:55 pm

A. A Case Study Approach to Building an ASC Around Orthopedics: What Works and What Does Not

Brent Lambert, MD, FACS, Principal, Ambulatory Surgical Centers of America

B. Successful Strategies and Methods to Use Orthopedics, Spine and Pain Management to Pump New Life Into a Multispecialty ASC

Tom Mallon, CEO/Founder, Regent Surgical Health

C. The Intersection of Health Care and Wall Street: How the Capital Markets View ASCs and Health Care

John C. Riddle, Managing Director, Dresner Partners

D. Handling Spine Procedures in ASCs

Russ Greene, RN, CEO, Physicians' Surgery Center and John Caruso, MD, Neurosurgeon and President of Parkway Spine Surgery Center

3:00 – 3:30 pm

A. Pain Management in ASCs: A Clinical and Business View

Scott Glaser, MD, DABIP, FIPP, Pain Specialists of Greater Chicago

3:00 – 3:55 pm

B. Building a Spine Driven ASC – The Chesterfield Surgery Center

George Goodwin, Chief Development Officer, Symbion, Inc., and

Brett A. Taylor, MD, The Orthopedic Center of St. Louis

C. 3 Different Methods to Improve Profits Quickly in an ASC – A Panel Discussion

Brent Ashby, Administrator, Audubon Surgery Center; Steve Burton, Ion Healthcare; and Bob Wood, Acclarent Inc.; moderated by Tom Yerden, TRY Healthcare

D. The X Stop Procedure: A New Outpatient Treatment of Spinal Stenosis

David J. Abraham, MD, The Reading Head, Neck and Spine Center

3:30 – 4:00 pm

A. Developing a Consistent Model for Success: Why What Works in One Market Often Works in Other Markets

Ajay Mangal, MD, MBA, President/CEO, and Don Jansen, Vice President Marketing and Development, Prexus Health Partners

4:00 – 5:00 pm

A. Developing and Managing a Physician Hospital Joint-Venture

Joe Zasa, CEO, Woodrum ASD

B. The Impact of the New CMS Payment System on Orthopedics and Pain Management

Greg Cuniff, CFO, National Surgical Care

C. A Strategic Analysis for ASCs and Physician Owned Hospitals: What Works, and What Does Not

Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

D. Developing a Spine-Driven ASC

Jeff Leland, CEO/Founder, and Richard Roski, MD, MBA, Neurosurgeon, Chief Medical Officer, Blue Chip Surgical Partners

5:00 – 7:30 pm – Networking Reception & Exhibits

FRIDAY, JUNE 20, 2008

7:00 – 8:00 am – Registration & Continental Breakfast

General Session

8:00 am

Introductions

Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

FRIDAY, JUNE 20, 2008

8:00 – 8:55 am

The Political Landscape, Healthcare and ASCs

Tucker Carlson, Noted Political Columnist and TV Commentator

9:00 – 9:40 am

Using Orthopedics, Spine and Pain Management to Turn Around and Drive an ASC's Success – 3 Key Tips: Great Recruiting, Outstanding Operations and Intelligent Case Management

Brent Lambert, MD, FACS, Principal, Ambulatory Surgical Centers of America

9:45 – 10:35 am

Key Clinical Developments That Will Transform Orthopedic Surgery

Brian Cole, MD, MBA, Professor, Departments of Orthopedics and Anatomy and Cell Biology, Section of Sports Medicine; Section Head, Cartilage Restoration Center at Rush University Medical Center

10:35 – 11:20 am – Exhibits Open

11:20 – 11:55 am

Spine Surgery as a Core Driver in Multispecialty ASC

Jim Lynch, MD, Chairman, Director of SpineNevada and Surgery Center of Reno; Director of Spine Services, Regent Surgical Health

11:55 am – 12:30 pm

Managed Care Contracting for Orthopedic, Pain Management and Spine Driven ASCs

Naya Kehayes, MPH, CEO, Eveia Health Consulting and Management

12:15 – 1:30 pm – Networking Lunch & Exhibits

1:30 – 2:05 pm – Concurrent Sessions

A. Why On Site Leadership is Critical to an ASC's Success: How to Hire Great Administrators and Empower the Same

Thomas Michaud, Chairman/CEO, Foundation Surgery Affiliates

1:30 – 2:45 pm

B. Billing, Coding, Collecting and Contracting for Ortho, Spine and Pain Management Driven ASCs – A 75-Minute Workshop

Caryl Serbin, RN, BSN, LHRM, President/Founder, Surgery Consultants of America, Serbin Surgery Center Billing

1:30 – 2:05 pm

C. Maintaining Successful Physician Investor Relationships Over a Long Period

Jack Jensen, MD, Athletic Orthopedics and Knee Center

D. Building a Private Orthopedic Practice in the Context of an Academic Medical Center

Dennis Viellieu, Midwest Orthopedics at Rush

E. Five Creative Strategies to Overlay Orthopedic Service Lines in a Struggling ASC

Darin Jay Hill, MBA, Chief Development Officer, Titan Health Corporation

2:10 – 2:45 pm

A. Keeping the Team Together – A Case Study on Keeping an Orthopedic and Pain Driven ASC Profitable and Managing Conflicts

Tom Yerden, CEO/Founder, TRY Health Care Solutions

C. Contracting for Spine Cases: Get Excellent Reimbursement and Do Not Pay Too Much for Implants

John Caruso, MD, Neurosurgeon and President of Parkway Spine Surgery Center, Beth Johnson, Vice President Clinical Systems and Elizabeth Smallwood, Vice President of Contracting and Reimbursement, Blue Chip Surgical Partners

D. Pain Management in ASCs – Yes, Pain Management Can Still be a Key Leader for ASCs

Amy Gail Mowles, CEO/Administrator, Mowles Medical Practice Management, LLC

E. Using Financial Benchmarking to Measure and Enhance the Value of an ASC

Jon O'Sullivan, Senior Principal, VMG Health

2:45 – 3:45 pm – Exhibits Open

CONFERENCE PROGRAM

FRIDAY, JUNE 20, 2008

3:45 – 4:20 pm

A. Revitalizing ASCs – A Case Study

Bill Southwick, President/CEO, HealthMark Partners

B. 5 Tips to an Outstanding and Cost Effective Staff: Staffing Strategies for ASCs

Ann Geier, RN, MS, CNOR, CASC, Vice President of Operations, Ambulatory Surgery Centers of America

C. Should You Sell Your ASC – Assessing Your Value and the Pros and Cons

Kenneth Hancock, President/Chief Development Officer, Meridian Surgical Partners

D. How An ASC Can Thrive with Physicians, a Hospital and Management Company: Tips for Success and How to Avoid Problems

Monica Cintado, Senior VP, USPI

E. Ownership and Financing of Your Medical Real Estate – Finding the Optimal Solutions

Jack Amormino, President/CEO, American Medical Buildings, and John Daly, Vice President, Healthcare Services, McShane Construction Corporation

4:20 – 4:55 pm

A. How a Hospital Partner Can Add Stability and Help an Orthopedic Driven Center Excel

Tom Lorish, MD and Miriam Odermann, CEO/Administrator, Ambulatory Services Division, Providence Health System – Oregon

B. Successful Approaches to Investment and Portfolio Management

Robert S. Burnstine, Portfolio Manager, Harris Associates, LP

C. Post Acquisition Success with a Corporate Partner

Richard D. Pence, President/Chief Operating Officer, National Surgical Care

D. Acquiring an ASC or Interests in an ASC – Due Diligence and Trouble Shooting

Darlene Johnson and Jeff Peo, Vice Presidents, Ambulatory Surgery Centers of America

4:20 – 5:30 pm

E. Legal Issues for ASCs – A 70-Minute Discussion – Regulatory Issues and Common Litigation Issues

Scott Becker and Jeff Clark, McGuireWoods, LLP

4:55 – 5:30 pm

A. How to Improve My Center Monday Morning: Leadership Tips from Industry Experts

Joe Zasa, CEO Woodrum ASD; Bill Southwick, CEO HealthMark; Kenneth Hancock, President, Chief Development Officer, Meridian Surgical Partners; Moderated by Tom Yerden, CEO/Founder, TRY Healthcare

B. Payor Contracting with Carve Outs for Orthopedic and Pain

Robyn Finnegan, Vice President/Managed Care, Prexus Health Partners

C. Recruiting New Physicians to ASCs

Chris Bishop, Vice President Business Development, Ambulatory Surgical Centers of America; Kristian Werling, McGuireWoods, LLC; and Ronald E. Lundeen Jr., Associate, McGuireWoods, LLP

D. Core Tips and Strategies to Succeed with Orthopedics and Neurosurgery

Mike Lipomi, CEO/Founder, RMC Medstone

5:30 – 7:00 pm – Networking Reception & Exhibits

SATURDAY, JUNE 21, 2008

7:30 – 8:30 am – Continental Breakfast

8:30 – 9:10 am

How to Implement Macro Industry Trends and How to Assess and Implement Them on a Center By Center Level

Cliff Adlerz, President/COO, Symbion, Inc.

9:10 – 9:50 am

Current Opportunities and Challenges in the ASC Industry

Mike Snow, CEO, Surgical Care Affiliates, LLC

SATURDAY, JUNE 21, 2008

9:50 – 10:25 am

Building an ASC Around Orthopedics, Spine and Pain Management

Tom Mallon, CEO/Founder, Regent Surgical Health

10:30 – 11:00 am – Concurrent Sessions

A. Utilizing Customer and Patient Surveys to Enhance Operations

Larry Teuber, MD, Physician Executive, Black Hills Surgery Center, President, Medical Facilities Corporation

B. Financing and Recapitalizations for ASCs and Specialty Hospitals

Ken Seip, Vice President, CitiCapital; Anthony Mai, Vice President, CIT Healthcare; William M. Karnes, Chief Financial Officer, Regent Surgical Health; Don Ensing and Bart Walker, McGuireWoods, LLP

C. Advanced Case Costing: Using Case Costing to Implement Strategy and plans for Orthopedics, Spine and Pain Management

Susan Kizirian, Vice President, Ambulatory Surgical Centers of America

D. Develop and Operate a Successful Spine Center of Excellence in Any Setting

Marcy Rogers, CEO, SpineMark Corporation

11:05 – 11:35 am

A. 6 Keys to Making a Physician Hospital Orthopedic Joint Venture Successful Plus Handling Total Joints in ASCs

James Caillouette, MD, Orange County Orthopedic Surgery

B. Overview of the Medical Malpractice Insurance Market: The Use of Captives and Other Strategies for Orthopedic and Neuro Groups and Related Facilities

Pat Sedlak, Director, and Frank Dodaro, Chairman, AON

C. 10 Ways to Maximize the Use of Your ASC's IT System

Scott Palmer, Source Medical, and Melody Mena, Administrative Director, Surgery Center at Mount Zion

D. Healthcare Real Estate Decisions

Bruce Bright, Director of Business Development, The Sanders Trust

11:35 – 12:10 pm

A. Physician-owned Hospitals: The Benefits and the Business Case

John Rex-Waller, CEO, National Surgical Hospitals

B. Out of Network – Can Your Business Still Utilize Out of Network as an Option – How Insurers are Fighting with ASCs and Imaging Facilities

Tom Pliura, MD, JD

C. The New Jersey Codey Case and Other Attacks on Physician Ownership of ASCs and Hospitals – A Panel Discussion

Scott Becker, Amber Walsh and Gretchen Heinze, McGuireWoods, LLP

D. Using Healthcare Information Technology and Implementing Strategies to Improve the Revenue (i.e., cash) Cycle for ASCs – Revenue Cycle Management and Automation

Azadeh Farahmand, CEO, GHN-Online

12:15 – 12:55 pm

A. Physician-owned Hospitals at the Crossroads: How to Stop the Government from Killing Innovation

Molly Sandvig, Executive Director, Physician Hospitals of America

B. Physician Owned Community Hospitals – How to Design and Complete a Hospital

Michael S. McCoy, Senior Vice President Operations, Neuterra Healthcare

C. Sales and Syndications of ASCs: Tips for Success

Steven Rosenbaum, CPA, The Bloom Organization

D. ASC Real Estate: Understanding Your Options – What to Consider When Developing an Orthopedic Driven ASC or Specialty Hospital or Orthopedic Driven MOB

Todd E. Larson, AIA, Principal, Marasco and Associates, and Christopher M. Bowen, Chief Development Officer, Marshall Erdmann and Associates

1:00 pm – Meeting Adjourns

ASC COMMUNICATIONS, INC. PRESENTS
The 6th Annual Orthopedics, Pain Management and Spine Driven ASC Conference
 June 19-21, 2008
 The Westin Michigan Avenue – Chicago IL

REGISTRATION INFORMATION

First and Last Name: _____
 Degree (as it should appear on your badge): _____
 Title: _____
 Facility/Company: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Email: _____
 Web site: _____

REGISTRATION FEES

ANNUAL CONFERENCE & EXHIBITS

Receive multiple registrant discounts. The more people you send, the greater discount you receive. The prices listed below are per person. Your registration includes all conference sessions, materials and the meal functions.

MAIN CONFERENCE ONLY

	FEES (Before 5/1/08)	FEES (After 5/1/08)	AMOUNT
First Attendee	\$650	\$750	\$ _____
Additional Attendee (from same facility)	\$600	\$700	\$ _____

MAIN CONFERENCE AND PRE-CONFERENCE SESSIONS




	FEES (Before 5/1/08)	FEES (After 5/1/08)	AMOUNT
First Attendee	\$875	\$975	\$ _____
Additional Attendee (from same facility)	\$825	\$875	\$ _____

OPTIONAL

Becker's ASC Review	Special Introductory Offer	\$99	\$ _____
TOTAL AMOUNT			\$ _____

PAYMENT INFORMATION

☐ Enclosed is a check payable to **ASC Communications, Inc.** Check #: _____

☐ I authorize **ASC Communications, Inc.** to charge my: ☐  ☐  ☐ 

Credit Card Number: _____ Expiration Date: _____

Printed Cardholder Name: _____

Signature: _____ CW/3-digit #: _____

FOUR EASY WAYS TO REGISTER COMPLETE THIS REGISTRATION FORM AND:

- 1 MAIL:** Make checks payable to **ASC Communications, Inc.** and mail to:
 ASC Communications
 c/o a5 Inc.
 1 North LaSalle Street, 47th Floor
 Chicago, IL 60602
- 2 FAX:** Fax registration form with credit card information to (312) 706-2526. Please show ASC Communications c/o a5 Inc. in the subject line.
- 3 CALL:** Phone (312) 546-6042 to register over the phone.
- 4 ONLINE:** Go to www.beckersasc.com

Cancellation Policy: Written cancellation requests must be received by May 11, 2008. Refunds are subject to a \$100 processing fee. Refunds will not be made after this date.

GENERAL INFORMATION

HOTEL RESERVATIONS

The Westin Michigan Avenue has set aside special group rates for conference attendees. ***Be sure to mention you are attending the ASC Conference in order to receive the discounted group rate.***

THE WESTIN MICHIGAN AVENUE
 908 N. Michigan Avenue
 Chicago, IL 60611

To make a reservation, go to
www.starwoodmeeting.com/Book/ASC2008

Group Name: **ASC Conference**
 Group Rate: **\$269 (Single/double)**

Phone: (888) 627-8385 or (312) 943-7200

SUBSCRIBE TO BECKER'S ASC REVIEW

Becker's ASC Review is published six times a year. If you would like to subscribe, please submit your \$99 payment with your conference registration fees.

EXHIBITS OR SPONSORSHIPS

For information, please call (800) 417-2035.

CONFERENCE QUESTIONS

For additional information or questions regarding the conference, please contact us.

For Conference Questions Contact:

Sara Rechten
 Phone: (312) 706-2525
 Fax: (312) 706-2526
 Email: srechten@a5inc.com

For ASC Communications, Becker's ASC Review and Exhibitor or Sponsorship questions, call (800) 417-2035.

Jessica Cole: jessica@beckersasc.com
Emily Noyes: emily@beckersasc.com
Dan Bragaw: dan@beckersasc.com

ADA REQUEST

If you require special ADA accommodations, please contact us at (312) 706-2525.

**Visit www.beckersasc.com
 or call (800) 417-2035**

Four Cornerstones to Strategic Planning for Ambulatory Surgery Centers

By Scott Becker, JD, CPA, and Nancy Temple, JD, CPA

This article provides insight into four different concepts to strategically attack and manage operations in a surgery center.¹ The four cornerstones are derived from a *Harvard Business Review* article, "The Four Principles of Enduring Success." The author, Christian Stadler, studied successful European corporations to determine why they have consistently performed well as compared to peers in their industry. His study identified four characteristics of the best companies:

- Exploit your existing strengths and assets before you explore new business lines,
- diversify your assets,
- remember your mistakes, and
- make big changes slowly and conservatively.

Mr. Stadler notes that "[t]he outstanding companies in our sample survived and prevailed during the Great Depression, two world wars, and two energy crises, not to mention the advent of the telephone, the television, and the computer." This article examines those four principles as they apply to the surgery center industry.

1. Exploit before you explore. A surgery center

or other business should first endeavor to understand its own strengths in its business and build on those strengths. Exploring or seeking out new assets or service lines can be expensive and can be a risky process. Great companies are good at growing by enhancing or taking advantage of their existing strengths. As Mr. Stadler found:

Though they did not neglect exploration, as a strategy the gold medalists consistently chose to pursue exploitation efforts over exploration initiatives. ... In other words, great companies don't innovate their way to growth — they grow by efficiently exploiting the fullest potential of existing innovations.

ASCs can readily apply this principle. For example, before building a second facility, it might make much greater efforts to maximize the volumes at its existing facility. Further, management might ask: Does the center have great staff or is it particularly strong in certain types of procedures? If a center has advantages in providing certain types of procedures, before

seeking to add new service lines or types of procedures, it should ascertain whether it is fully profiting and fully exploiting success in those particular areas. Are there more procedures that could be done by the same physicians at the center? Can you cut costs on the cases that you are performing at the center? Are there additional physicians in the same specialties that are available for recruitment? In essence, before you conduct research and development to seek out the next new business idea or the next type of procedure, a surgery center should first explore how to further profit from its existing physicians and the types of procedures it is currently performing.

Successful surgery centers have exploited their existing assets before expending resources to explore for new innovations. According to Michael Weaver, vice president of acquisitions and development for Symbion, a national outpatient surgery center and hospital-physician joint-venture company based in Nashville, Tenn., this principle was successfully applied

ACCOUNTING | BILLING & COLLECTING | HUMAN RESOURCES | CREDENTIALING



Spending too much time and effort managing your business office?

Call MedHQ. The experts in back office operations for health care.

- Reduce Risk
- Reduce Cost
- Enhance Revenue

Experts in accounting, billing and collecting, human resources and credentialing for healthcare facilities.

4 Westbrook Corporate Center, Suite 440
Westchester, Illinois 60154
708.492.0519 | www.medhq.net

MedHQ

when Symbion acquired a surgery center in the St. Louis area several years ago. Relying on the same core base of physicians, Symbion closed that particular center and relocated it to a preferable site to maximize profits. Symbion also noted that the physicians at the center had strong, positive relationships with other physicians in the area, so Symbion capitalized on those relationships by developing a new spine center using the services of the original physicians' friends and colleagues.

Larry D. Taylor, president, CEO, founder and developer of Practice Partners, a privately held business based in Alabama providing management and operational services to surgery centers across the country, notes that the industry's resyndication process of the physician partnership groups is an example of surgery centers building off of their existing physician assets instead of exploring for new ones. Mr. Taylor further emphasizes that the ability of his company to manage and process quickly all of the details required for syndications regulatory licensing and accreditation has saved substantial sums and time for its clients, an example of Practice Partners maximizing its assets to process that information and provide prompt profit enhancing services for centers.

Similarly, Woodrum/Ambulatory Surgery Development identifies its core assets as managing and operating surgery centers. When the

surgery center market changed in the mid-1990s and shifted to hospital-physician joint ventures, the principals of Woodrum ASD sold their prior surgery center business in which they were the primary owners and started a new national surgery center management business in which they were minority owners. As Joseph Zasa, JD, a partner and the CEO of Woodrum/ASD explains, Woodrum/ASD did not start from scratch; it hired many qualified people from the partners' prior business experience and used the prior knowledge about operating surgery centers and refined those systems, focusing on the same market but improving upon those systems based upon past industry experience.

Perhaps the epitome of the exploitation of existing assets is Surgical Care Affiliates, which was created as a stand-alone business when HealthSouth's Surgery Division was acquired in 2007. As SCA's CEO and President Mike Snow explains, SCA's entire investment model was built around using an existing portfolio and applying management expertise in an effort to improve results. In essence, before entering into new businesses, its core goal was to improve and enhance its existing portfolio of ASCs.

2. Diversify. Successful companies diversify their business portfolio. While these companies focus on their core strengths and are not conglomerates, they diversify their exposure to

economic downturns by branching into related businesses and by spreading their business geographically. Historically, companies that focus on a single business tend to be relatively short-lived because once the cycle for that particular business has matured, it typically must merge or be sold to avoid closure. Good companies avoid this risk by evolving their core strengths into a diversified portfolio.

Moreover, successful companies diversify risk by maintaining a broad range of vendors and customers to avoid dependence on any single relationship. Diversification is therefore relevant to both the revenue and supply sides of the surgery center business. Mr. Taylor notes that Practice Partners' use of new and refurbished equipment adds value and reduces costs. Mr. Zasa preaches diversification, or different "pipelines" so as not to put all of Woodrum/ASD's eggs in one basket, operating approximately twenty-five centers across the country. Similarly, Mr. Snow reports that they "look at the portfolio like a pipe" and try to continually fill the pipe. Mr. Weaver notes that the recent CMS changes in reimbursement are an example of an economic change that the diversified Symbion was well equipped to handle, and even positively impacted Symbion, due to its diversified centers across multiple specialties.

As you look at your portfolio of business, consider

Looking for ASC Consulting?

- ▶ Seeking to maximize your ASC's success?
- ▶ Perhaps you're considering the development of a new surgery center?
or
- ▶ Trying to solve problems among partners?



Proven solutions for complex challenges.



Corporate Office: TRY Health Care Solutions, LLC

Tom Yerden MHA, Principle

P.O. Box 98 • North Fork, Idaho 83466

tyerden@aol.com • O: 208-865-2400 • C: 208-303-0173

whether there is the ability to develop adjacent lines of business or alternative suppliers. As an example, if a center is heavily dependent upon two physicians, in addition to striving to develop a strong relationship with those physicians and their business, a center likely should try and recruit additional physicians to reduce its reliance upon just two physicians. Further, if all of a surgery center's business is in one specialty, it makes sense not only to exploit further that line of business but also to identify additional lines of business for that center.

The same principle applies for a surgery center's supply side. It is important to support existing employees who are indispensable by recruiting more employees to have some redundancy and strength. Additionally, if a center spends a significant amount on one type of medical device or on one type of implant or product, it makes sense to nurture multiple supply sources, particularly if there are any challenges in accessing the product.

3. Remember your mistakes. The best operators in almost any business have an uncanny ability not to repeat the same mistake twice. It is often said that making a mistake is fine — indeed, in order to grow and learn, companies need to make mistakes. However, making the same mistake over and over again can doom a business, and the best companies learn from and exploit their mistakes. Mr. Stadler notes in his study that the great companies had a practice of telling and retelling stories about their mistakes as a teaching technique and not to forget their mistakes so as to learn their lesson.

Indeed, Mr. Zasa claims that the “best thing that ever happened to us [Woodrum/ASD]” could be characterized as a “mistake.” When Woodrum/ASD lost the renewal of a contract, it realized that was not demonstrating to the physicians the value that Woodrum/ASD put into each of its centers. Once they worked more closely with the center staff and formalized the systems to show the value added, Woodrum/ASD went from good to great results, expanding its centers by threefold.

Here, this concept is notable in the overall surgery center industry. Initially, years ago, surgery centers were often developed without incorporating “noncompete covenants.” After the initial excitement of recruiting a number of physicians to invest in a surgery center, as the business evolved and the surgery center became successful, the most successful physicians often left the center to develop their own surgery center. Now surgery center developers recognize that they need to incorporate covenants not to compete in all surgery center transactions.

Second, center developers often make the mistake of being committed to a particular physician based on that physician's statistical credentials, without considering the physician's reputation or ability to work with patients, center owners and

others. When surgery centers enter into transactions with such difficult professionals, performance often is poor. This can be because he or she has an unprofessional attitude towards others or because he or she can choose not to bring cases to the surgery center. The mistake is not to fall in love with a physician simply based on paper statistics. The physician must be qualified in all aspects, including the ability to work with others, and should not be just a high-volume producer of cases.

There are many types of mistakes that can be made in operating a surgery center, as in operating any business. The goal is to remember such

mistakes so that they are not made again. In essence, one of the terrific executives we work with, Tom Mallon, the CEO of Regent Surgical Health, often says to his colleagues, “Please make new mistakes — don't make the same old mistakes.” Mr. Weaver chimes in that, “if you are not trying hard, you would not be making a few mistakes.”

4. Don't make big changes quickly.

This cornerstone dictates that companies should approach change conservatively. Change is important and necessary to grow but how great companies manage change is critical to their level of success. Mr. Stadler's study found that “[g]reat



Looking for a corporate partner to manage or develop your surgery center?

Regent Surgical Health has the experience and expertise to help you develop a new center or improve the profitability and performance of an existing ASC. Because, like you, we're specialists.

Specialists in the turnaround and development of surgery centers and physician-owned hospitals



4 Westbrook Corporate Center
Suite 440
Westchester, Illinois 60154
tel: 708.492.0531
www.regentsurgicalhealth.com

companies ... go through radical change only at very selective moments in their history ... They use their core values and principles as guidelines and approach change in a culturally sensitive manner that requires patience to work through."

In many surgery centers and similar service providers, situations have occurred where the leadership of the center or business has great clarity as to where they want to lead the organization. However, some leaders fail to take into account their entire constituency and attempt to move the organization through change far too rapidly or abruptly for many of their colleagues to follow. One particular example typically arises in the amendment of operating agreements of shareholder groups. In attempting to impose stricter or

more precise rules, e.g., adopting clearer and imposing higher hurdles for redemption events or redemption pricing or adopting stricter noncompete covenants, leaders may attempt to push the remainder of the shareholder group very quickly to accept such changes. Physician shareholders, rather than understanding the potential overall benefit to the center and thus to themselves, may perceive any such proposed change as an event that causes them to "punch out of" or exit the venture entirely. They react prematurely to the proposed change, which may be perceived as being too drastic, and seek to leave the venture and be redeemed. Rather than announcing and demanding immediate acceptance to such changes to an operating agreement, in many

situations it may make more sense to conduct individual discussions with the physicians to explain the purpose of the proposed changes and to gauge the reaction to such changes. In essence, leaders may want to approach such changes slowly.

Mr. Taylor echoes this approach as the leader of Practice Partners by emphasizing that change should be "thoughtful" and all of the consequences of a proposed change should be well thought out, including the impact to a clinical outcome and physician acceptance. For example, Mr. Taylor notes that a change in a vendor, equipment or process will be ineffective if it does not improve the clinical outcome and if physicians do not accept and implement the change.

The same concept of making changes conservatively often applies to large expansions of businesses or acquisitions. A typical surgery center may work extremely well with ten to fifteen committed investors, but when merged with another center that results in a shareholder base of twenty to thirty investors. This may diffuse responsibility and will often substantially increase overhead. These immediate impacts can be devastating to a surgery center if those changes are not managed appropriately. In short, while it is critical not to be stagnant, simultaneously, it is critical not to make big changes without proper efforts to assure that the business is secure and that the key people that will be involved in the changes have fully bought into the concept.

Mr. Snow comments, however, that SCA distinguishes between strategic changes and tactical changes, such as outsourcing non-core business functions, improving the financial close process and focusing on supply chain initiatives to improve results. SCA strives to implement aggressively the tactical changes to achieve prompt results.

Conclusion

Overall, Mr. Stadler "observed that companies have to work very, very hard to adhere to the four principles in the face of the constant temptation to diverge from them." ("The Four Principles of Enduring Success," page 2.) In short, these four cornerstones, strategically applied consistently to surgery centers, can help centers go from good to great results. ■

Contact Scott Becker at sbecker@mcguirewoods.com and Nancy Temple at nancytemple@sbcglobal.net.

¹ This article also relied on insights provided by the following industry leaders: Joe Zasa, the CEO of Woodrum/ASD; Larry Taylor, the president and CEO of Practice Partners; Mike Weaver, senior vice president at Symbion; Mike Snow, CEO of SCA; and Tom Mallon, CEO of Regent Surgical Health.

EMPOWERING PHYSICIANS



to focus on the future of healthcare

Experts in physician owned, multi-specialty surgical facilities

- Development of new surgical hospitals and new surgery centers
- Conversion of ASCs to surgical hospitals
- Revitalize established, under performing centers
- Help centers repurchase equity from passive investors
- Development of Imaging Centers and other Ancillary Businesses
- Minimal management fees provided at cost
- Surgical hospital proficiency
- Experienced, full service management team

Compare our Prices ...

ASC & Imaging Centers	Members*	Non Members
• Accounting	Included	\$1.5K/mo
• Billing**	2%	3.5%
• Coding	\$3	\$5
• Dictation (55cpl)	\$.05	\$.07
• Management**	\$5K + 1%	NA
Hospitals	Members*	Non Members
• Accounting	Included	\$2.5K/mo
• Billing**	2%	3.5%
• Coding**	0.35%	0.5%
• Dictation (55cpl)	\$.05	\$.07
• Management**	\$5K + 1%	NA

* Please call for more information.

** % of net revenue



PREXUS HEALTH
3145 Hamilton-Mason Road, Suite 100
Hamilton, Ohio 45011
(513) 454-1414
www.prexushealth.com
info@phcps.com

For information about conference registration, subscription information, advertising or exhibiting, please call (800) 417-2035.



Paper



Electronic

VMR Express

Eliminate hard cost and reduce employee hours
for as little as \$16 per day.

VMR Express Benefits

- Print forms directly from your office PC's with ACCURATE patient information on each form
- Customize forms for each physician procedure
- Customize forms for your particular practice
- Automatically print barcode information identifying every form
- Scan forms back into your PC for safe storage
- Pull data directly from your Practice Management Software schedule
- Eliminate the need for manual chart preparation

VMR Express Cost-Saving Advantages

- Eliminate wasted employee hours performing manual processes
- Eliminate the cost of pre-printed forms and sticky labels
- Eliminate human error on ADT Information
- Eliminate wasted chart expense from "no show" patients and inaccurate data
- Reduce medical record storage and retrieval fees



Tomorrow's Solution Today

6688 N. Central Expy, Suite 1140

Dallas TX 75206 • 214.821.3850

www.surgicalnotes.com

Spotlight On: A Better Way to Collect Fees

An interview with Rob Morris

Stephanie Wasek: Can you summarize briefly what CareCredit offers both practices and patients?

Rob Morris: CareCredit lets patients pay their current bills in full immediately with the use of interest-free and low-interest extended monthly payment plans. ASCs get paid in two business days with no responsibility if the patient delays or defaults.

SW: So when patients want to have truly elective procedures, such as cosmetic surgery or LASIK, these plans can help. How much of a problem is this for patients with commercial insurance carriers?

RM: They're requiring patients to shoulder more of the load now. When a patient shows up at the front door of an ASC, he might be faced with large deductible, co-pay or self-pay fee that he didn't realize he was responsible for. Deductibles are going up, too: The patient might have to come up with \$2,000, \$5,000, even \$10,000 and

facility fees can, of course, range from a few hundred to thousands, depending on the procedure.

While the office may have tried to get in touch with the patient and let him know he's got a \$1,200 deductible for the facility fee, that can be tough to do. On the day of the procedure, he's informed he owes \$1,200. Or your office reaches the patient and, when he finds out he's going to have to pay that money, doesn't show up the day of surgery.

SW: Let's say he does show up. What does an ASC typically do?

RM: Most ASCs can accept cash, check, Visa, MasterCard — that sort of thing. The problem there is that, statistically, most people are maxed out on their credit cards. The average American has about \$300 available credit on consumer cards and can't comfortably write a check for more than \$500 out of their monthly cash flow. So a patient likely can't write a check for \$1,200, either.

SW: Why can't the ASC just set up a monthly payment plan directly with the patient? That way, you don't have to send him away, create a hole in the surgery schedule, upset the surgeon.

RM: Well, many do, but what generally ends up happening is that, whether you give the patient 30 days or three months, you don't get paid, because you already performed the service.

On average, ASCs receive 79 cents on every dollar of A/R, and you lose 1 percent of value on your outstanding cash every month. In these cases it typically takes about 76 days to be paid in full from date of treatment. Beyond 90 days, your chances of recouping your money fall to 20 percent. Beyond 100 days, that money is generally uncollectible.

Then you factor in the time and money you spend to devote staff to following up on the accounts. No one — staff or patients — enjoys being on either end of a collection call. Is



Our affinity for cleanliness goes way back.

That's why at JCB we specialize in Sterile Product Compounding.

JCB is your pharmacy source for sterile compounded products.

Quality is our priority and we stake our reputation on it. Our clean room is state of the art and meets or exceeds USP<797> requirements. With these high standards, service and our fast turnaround JCB is matched by none.

- Betamethasone NaPhos/Acetate PF
- Betamethasone Sodium Phosphate PF
- Dexamethasone NaPhos/Lidocaine HCl
- Triamcinolone Acetonide PF
- Intrathecal Syringes
- Baclofen PF
- Ophthalmic Dilating Drops





THE FUTURE OF STERILE COMPOUNDING

1.877.405.8066  www.jcblabs.com

that really what you want to have your staff doing anyhow?

The fact is, you've already extended service, and on average, people have 42 bills a month to pay. Healthcare is going to come last on that list, so it's key that you be paid at the time of service, as happens in any other business.

CareCredit gives the patient another payment option, a new line of credit strictly for healthcare that's low-interest or interest-free. It's owned by GE, and patients are going to receive a statement just like for a credit card; they'll pay it because they know it's going to affect their credit scores.

SW: What are the advantages, then, of partnering with CareCredit for this difficult area of the ASC business?

RM: It reduces risk and costs of carrying accounts receivable, increases cash flow, and eliminates outsourcing and resultant fees to outside billing and collection agencies. We give the ASC its fee in two business days via electronic transfer.

When you consider that, for example, we charge 5 percent to the practice when it offers the 90 days, no-interest option, that's a lot more money coming in for the ASC. Say you want to offer patients more time — it's 6.9 percent of what's charged for six months interest-free. That's 95 or 93.1 cents on the dollar guaranteed in two days, compared with 79 cents recouped two-and-a-half months out.

The other thing we have found is that ASCs who offer CareCredit decrease A/R by about 38 percent overall. That's a huge increase in cash flow; the ASC gets its full fee up front, and is charged a merchant fee at the end of the next statement period. (Most accountants like to see the full fee remitted to the ASC for accounting purposes, so that's how we designed it, rather than taking the fee out up front.)

SW: So when a facility offers CareCredit, how does it work in practice?

RM: Well, the facility enrolls and gets trained in CareCredit, and decides what kinds of plans it's

willing to offer. There are interest-free plans for three, six, 12 and 18 months, and low-interest plans for two to five years.

So when a patient comes in, is responsible for a large fee and decides CareCredit is his best option, he fills out a quick, quarter-page form. One of the facility staff inputs the information and amount requested to CareCredit online and gets a decision in 10 seconds. We typically approve 55 to 57 percent of applicants for some amount of money. Only about 27 percent of applicants are approved for new credit cards. So it's likely patients will be approved for this line of healthcare credit, and the facility will be able to do the procedure and keep the day running smoothly while ensuring it gets paid and increases cash flow. ■

Mr. Morris is the vice president of marketing at CareCredit, a GE Money Company. CareCredit is the nation's leading patient financing program.


Calculate your Future with
EVEIA HEALTH
 Consulting & Management

**Reimbursement Management
and Contracting Experts**

- Payor Due Diligence
- Revenue Assessment
- Reimbursement Modeling
- Cost Analysis
- Managed Care & Payor Contract Evaluation
- Negotiation
- Fee Schedule Analysis
- Reimbursement Training
- Contract Compliance

Eveia understands your revenue requirements and we know how to achieve success. We have a proven track record with over 100 clients in 25 states.

For more information, call
 (425) 657-0494
www.eveia.com



EVEIA HEALTH
 Consulting & Management



MEDSTONE



At RMC MedStone Capital, we provide an extraordinary approach to your healthcare management needs. Our qualified team of experts is focused on:

- + Acquisition of ambulatory surgery centers and hospitals
- + Leading the conversion process for mature ambulatory surgery centers that are ready to provide hospital services
- + A comprehensive program of operations, compliance, financial and clinical support services

**"Only the
Exceptional is
Acceptable."**

Michael J. Lipomi,
President, MedStone Capital

For more information, please visit us at
www.medstonecapital.com or call 209-602-3298.



We're not doctors, but we do thorough examinations.

At HealthCare Appraisers, we know the complexities of the healthcare industry inside and out. Our valuation professionals are experts in healthcare regulation, finance, operations and reimbursement – making us the recognized leader in providing Fair Market Value analysis exclusively to the Healthcare community.

Our trusted, independent services include:

- **Business Valuation** (ASCs, Specialty Hospitals, Physician Practices, and Other Diagnostic and Treatment Facilities)
- **Fair Market Value Opinions for Compensation & Service Arrangements**
- **Consulting & Advisory Services**
- **Litigation Support**

Put your valuation needs in the hands of a specialist. Contact HealthCare Appraisers today.

HealthCare Appraisers
INCORPORATED

The recognized leader in Fair Market Value analysis.

Florida – Corporate Office | **Colorado**
ph: 561.330.3488 | ph: 303.688.0700
www.HealthCareAppraisers.com



**Look to the experts
to shine some light on
your valuation.**

No one has more expertise and experience valuing surgery centers than VMG Health. It's what we do.

 **VMG HEALTH**
WE VALUE HEALTHCARE

www.vmghealth.com

Three Galleria Tower
13155 Noel Road, Suite 2400
Dallas, Texas 75240 214-369-4888

3100 West End Avenue, Suite 940
Nashville, Tennessee 37203 615-777-7300

ORION

Nationwide ASC Development
Multi-specialty – NeuroSpine – Ophthalmology

ORION Medical Services offers a turnkey approach to your ASC development and management by providing a team of experts with proven experience.

Development Services

- Financial Feasibility Analysis
- Assistance with Financing
- Site Analysis & Selection
- Design & Architecture
- Construction Management
- Equipment Acquisition
- Operational Development
- Site Management

Management Services

- Accreditation and Certification
- Medical Staff Organization
- Human Resources
- Payroll
- Accounts Payable & Receivable
- License Compliance
- Insurance Contracting
- HIPAA Compliance
- Healthcare Law Compliance
- Billing, Coding & Collections
- Marketing
- Information System Network Mgt
- Expansion & Development



Our results speak for themselves. ORION has worked with numerous ASC's across the country resulting in profitability, high quality, and improved efficiency every time.

Physicians get...

- ✓ Total control over your surgical practice
- ✓ Significantly higher income
- ✓ More efficient use of your time, less bureaucracy
- ✓ Control your working hours, create your own schedule
- ✓ Select your equipment and supplies
- ✓ Help design the facility so its tailored to your specialty
- ✓ Select your staff, work only with who you want to

Our track record speaks for itself...

- ✓ Every ASC we've done has been profitable
- ✓ Expert negotiations with reimbursement contracts
- ✓ Nationwide reach with ASC's all over the country
- ✓ Orion is among the first in the country to develop a successful NeuroSpine ASC

877-391-5390 | www.orionmedicalsolutions.com |

"Orion is a pioneer in NeuroSpine ASC Development"

McSHANE

HEALTHCARE



**REAL ESTATE
DEVELOPMENT AND
CONSTRUCTION SERVICES
FOR THE HEALTHCARE INDUSTRY**

Invest. Own. Profit.



847.292.4300
www.mcshane.com

Chicago ■ Atlanta ■ Austin ■ Dallas ■ Houston ■ Los Angeles ■ Phoenix

3 Best Practices for Better Outpatient Anesthesia

By Rob Kurtz

Since the administering of safe and effective anesthesia is such an essential component of the procedures performed in your ASC, you should approach the decision of who will provide anesthesia to your patients with due diligence. Here are three best practices offered by Robert Welti, MD, medical director and administrator of the Santa Barbara (Calif.) Surgery Center, to help you identify and attract the right anesthesia provider to your ASC.

1. Make your ASC an appealing setting for anesthesiologists. Your ASC will likely compete with hospitals for the service of anesthesia groups. If these groups use a salary system based on anesthesia unit production, they may look for reasons to stay with "big unit" cases such as cardiac procedures or neurosurgery performed in the hospital even if they find working at your facility more enjoyable. You must make sure your ASC remains an attractive setting for anesthesia providers or risk overpaying for services.

"If your cases are scheduled back to back with little down time and volume is consistent, your ASC will be a very attractive location," Welti says. "Conversely, lots of down time between cases, slow

days, and a shortage of anesthesia practitioners in the area could render the center subject to demands for anesthesia stipends."

2. Find anesthesia care fit for your ASC. Despite the advances in anesthesia pharmacology, the skills and attitudes of successful hospital-based anesthesiologists may not always transfer to the ASC setting, Welti says. If practitioners cannot adapt their services to your setting, do not hesitate to find an option that better suits the efficiency of your ASC.

"Whereas the number one priority in both hospital and ASC setting is patient safety, the ASC anesthesia practitioner must provide this safety in a highly efficient setting where turnover time, cost effectiveness, and a more personalized service to both patient and surgeon play a much larger role," he says.

3. Don't overlook the service provided by your anesthesiologists. As ASCs perform new and more complex procedures, ASC anesthesia providers must also adapt and tackle this new challenge. It is important to recognize their efforts in maintaining the high quality of care offered by your center.

"As ASC administrators, we must not lose sight of the incredible job that our anesthesia practitioners do

with respect to handling the increasingly aging and physically challenged patient population that we now accept into our facilities," Welti says.

Although you may struggle to secure an optimum small, core group of anesthesia practitioners who limit themselves to the ambulatory setting and understand the priorities of ASCs, you can make small or large gestures to keep your ASC as an attractive source of business for anesthesiologists.

"In the ideal world, the ASC would ... provide to the practitioners some sort of incentive to 'sign-on' to the mission of the center and align their common interests," Welti says. "Such incentive could range from the very simple, such as the all too often missing expression of appreciation for the services provided, to the more complicated, such as ownership positions when permitted by state or federal law." ■

Contact Rob at rob@beckersasc.com.

Note: This article shares some of the thoughts and insights from a larger article discussing clinical and business issues in ambulatory anesthesia that will appear in the May/June issue of the *Becker's ASC Review*.



An experienced financial partner where your practice and patients are your primary focus.

Medical Facilities Corporation ("MFC"), a leading group of specialty hospitals, is interested in acquiring partnership interests in established specialty hospitals, ambulatory surgery centers, and imaging facilities. As a publicly traded company, MFC offers physician owners the opportunity to:

- Gain immediate liquidity
- Retain local operational control
- Maintain existing management
- Participate in the broader healthcare market

For information contact Steven Hartley, Managing Director, Alluence Capital Advisors, advisors to MFC, 866- 766-3590 ext. 105. Or visit our website www.medicalfacilitiescorp.com





Today I learned...

regional anesthesia
could save my facility
\$1.2 million a year.¹



*Stimplex® HNS 12
Nerve Stimulator
facilitates nerve blockade*

Start saving now with B. Braun.

Peripheral nerve blocks save time and money compared to general anesthesia.¹

- Fewer pain and PONV symptoms requiring medication
- Less labor-intensive PACU monitoring due to higher bypass or fast track rate
- Reduced anesthesia-controlled OR time
- Reduced nursing labor costs
- Reduced unplanned hospital admissions

B. Braun is the recognized leader in regional anesthesia.

From epidural needles and nerve stimulators to customized trays and training programs, B. Braun provides products and services that can help your facility perform PNBs safely and easily.

Find out how easy PNBs can be.

Call **1-877-949-9529** today to learn more about PNB procedures, our CME-accredited workshops and product training at Aesculap Academy or your facility.

B. Efficient.

B | BRAUN
SHARING EXPERTISE

www.bbraunusa.com

See us at
Booth #373 on
May 14 at ASCA.

Rx Only. ©2008 B. Braun Medical Inc., Bethlehem, PA. All Rights Reserved.

861A ASCB 2/08 KFD

¹ Williams BA, Motolenich P, Kentor ML. Hospital Facilities and Resource Management: Economic Impact of a High-Volume Regional Anesthesia Program for Outpatients. *Int Anesthesiol Clin*. 2005 Summer; 43(3):43-51

The Empire Strikes Back: N.Y. Probes Underpayments by Insurers to Out-of-Network Providers, Patients

By Stephanie Wasek

After several years of insurance companies aggressively setting limiting rates as to what they will pay out-of-network providers, New York has launched an investigation into whether insurance companies are unfairly setting those rates and causing patients to pay disproportionately high amounts of provider bills. Health insurers are being probed as part of a healthcare industry-wide investigation to determine whether they have schemed to “defraud consumers by manipulating reimbursement rates,” according to the N.Y. Attorney General’s Office.

A six-month investigation found that Ingenix, the nation’s largest provider of healthcare billing information, “operates a defective and manipulated database that most major health insurance companies use to set reimbursement rates for out-of-network medical expenses.” Further, the investigation found that two subsidiaries of United “dramatically under-reimbursed their members for out-of-network medical expenses by using data provided by Ingenix,” according to a release.

As a result, state Attorney General Andrew M. Cuomo has issued 16 subpoenas to the largest insurers in the country, including Aetna, Cigna, and

Empire BlueCross BlueShield; he has announced that he intends to file suit against Ingenix, its parent UnitedHealth Group and three additional subsidiaries.

In one example cited by the attorney general’s office, United insurers knew most simple doctor visits cost \$200, but claimed to members that the typical rate was only \$77 — a rate manipulated to be “remarkably lower than the actual cost of typical medical expenses,” despite the fact the Ingenix database was supposed to be used to calculate a “reasonable and customary” rate. The insurers then applied the contractual reimbursement rate of 80 percent, covering only \$62 for a \$200 bill, and leaving the patient to cover the \$138 balance.

Further, “When members complained their medical costs were unfairly high, the United insurers hid their connection to Ingenix by claiming the rate was the product of ‘independent research,’” says the attorney general’s office. This created “concern that the company’s ownership of Ingenix created a clear conflict of interest because their relationship gave Ingenix an incentive to set rates that benefited United and its subsidiaries.”

Interestingly enough, New York is the same state that is aggressively attacking centers that may be waiving or reducing out-of-network payments. On the positive side, this is one of the few situations we’re aware of where a state is actually taking issue with insurance company underpayments. ■

Contact Stephanie at stephanie@beckersasc.com.

ON THE WEB

- Press release from N.Y. Attorney General’s Office
http://www.oag.state.ny.us/press/2008/feb/feb13a_08.html
- Notice of proposed litigation
<http://www.oag.state.ny.us/press/2008/feb/UnitedHealthcare.pdf>
- Audio of Mr. Cuomo’s announcement of the investigation results and subpoenas
<http://www.oag.state.ny.us/press/audio/2-13-08.mp3>

New & Refurbished Medical Equipment

- One-Stop shopping for your OR, Pre- and Post-Op areas
- National contract pricing with leading manufacturers
- Refurbishing performed by factory trained and certified technicians
- Savings from 30%-50% on refurbished equipment

Anesthesia Systems

Patient Monitors

Surgical Lights & Tables

Warming Cabinets

Pain Tables

Microscopes

Sterilizers

And more

The Alpine Surgical Equipment team is well known throughout the ASC Industry and has worked on well over 1,000 surgery centers nationally. We know your business and will provide you with the products that you need, at the price you want, and the quality you deserve.

Call us toll-free for your free catalog.

Alpine
SURGICAL EQUIPMENT

800.394.6911
www.alpinesurgical.com



This announcement appears as a matter of record only.

ASCs Inc.

Is pleased to announce the closing of acquisition transactions for the

Coral Springs Surgical Center (FL) & Laguna Hills Surgery Center (CA)

ASCs Inc. advised the sellers.

ASCs Inc. advises owners of surgery centers, endoscopy centers, and surgical hospitals on realizing maximum value from the sale of their facilities and real estate to leading companies.

For information contact:

Jon Vick, President

ASCs Inc.

760-751-0250 (CA)

www.ascs-inc.com

Reality Check.

If short term profitability and long term viability are the things that keep you awake at night, you should probably consider partnering with the solutions company used by more facilities than all other competitors combined. Only SourceMedical has the experience of 2,200 ASC customers, almost 30 years of real world application, and the largest range of solutions and enhancements to make optimal performance a reality. Don't settle for anything less. Contact Scott Palmer and his team today and we'll demonstrate the performance advantage only SourceMedical can deliver.

 **SOURCEMEDICAL**
Leading Source for Outpatient Solutions.

Call 866.675.3546
www.sourcemed.net

GI Catches a Break: Aetna Delays Controversial Sedation Policy

By Rob Kurtz and Stephanie Wasek

Aetna has announced that it will delay its plans to institute a new policy under which the insurer would cover monitored anesthesia care only for high-risk patients, according to the company's web site.

Aetna came under scrutiny from GI groups when it announced this policy in December; critics said the insurer was prioritizing profits over patient safety and that the policy would negatively impact colorectal screening rates. Further, they said the new policy would take patient-care decision-making out of the hands of physicians. Finally, critics said that Aetna's policy, which would have restricted when the insurer covered the use of the anesthesia drug propofol, would have forced organizations performing colonoscopies to limit when patients could receive the drug.

"Not all patients can be sedated with moderate sedation," noted Nicholas LaRusso, MD, the president of the American Gastroenterological Association Institute, in a letter to Aetna dated Jan. 25. "Anesthesiologists are necessary for patients who need deep sedation with propofol, but whose gastroenterologists aren't trained to administer deep sedation."

The inability of providers to offer the powerful sedation drug, would discourage patients from undergoing colonoscopy, he posited. As a result of the AGA letter and outcry from providers, the policy — which had an implementation date of April 1 — will now be delayed until patient-friendly

alternatives that do not require the added expense of an anesthesiologist become available.

"We have determined that in those few markets where monitored anesthesia care has become the routine approach to sedation, implementation of our policy on April 1 would inconvenience our members in those markets and potentially depress cancer screening rates in the short term," says Troyen A. Brennan, MD, Aetna's chief medical officer, in a statement.

Aetna stressed in its announcement that it has always covered moderate sedation for routine colonoscopies and endoscopies, and that the new policy would not have eliminated coverage for sedation, but rather monitored anesthesia care in "routine" cases. The company says that its member data "confirms there is no relationship between improved screening rates and the use of monitored anesthesia care."

The policy delay was lauded by GI professional groups.

"We believe that physicians and patients should determine the best place, method or procedure to be used in a particular situation," says the American College of Gastroenterology in a statement. "Aetna's decision not to interfere with physician/patient decision-making regarding appropriate sedation practices for colonoscopy is important for our members and their patients because it preserves the ability of physicians and their patients to make an assessment of the proper method of delivering patient care on a case-by-case

basis without interference by the insurance company. We applaud all parties who voiced their concerns about Aetna's decision and applaud Aetna's recognition of the need to withdraw this misguided policy."

The AGA echoed those sentiments.

"Aetna has engaged in an exchange of information and viewpoints with our society regarding the possible public health impact of this policy," says Joel V. Brill, MD, AGAF, chair of the AGA Institute practice management and economic committee. "We are dedicated to working with all stakeholders involved to provide clear recommendations to physicians, patients, purchasers and payers regarding the appropriate use of sedation for endoscopic procedures." ■

Contact Rob at rob@beckersasc.com.

ON THE WEB

- Aetna announcement
<http://www.aetna.com/news/2008/0227.htm>
- American Gastroenterological Association statement
<http://www.gastro.org/wmspage.cfm?parm1=4981>
- AGA letter to Aetna
<http://www.gastro.org/wmspage.cfm?parm1=4831>



zCHART™

The paper chase ends here.

zCHART EMR means the end of busy work. No more chart assembly. No more filing or re-filing. No more copying. Put an end to paper handling. Paper charts create an endless confusion of forms and procedures. Confusion leads to inefficiencies and mistakes. Put an end to your paper chase with zCHART EMR.

**Electronic Medical Record for Ambulatory Surgery Centers
Fits in. Stands out.**

(866) 924-2787 • www.zchart.com

IT'S TIME POTENTIAL BECAME A LINE ON A BALANCE SHEET.

Healthcare finance and M&A Advisory Services are about more than just numbers on a balance sheet. That's why at CIT Healthcare, we look beyond the data and focus on your ideas, people and possibilities. As part of CIT, a company with over \$80 billion in assets, we understand the challenges facing today's ambulatory surgery centers, such as referral patterns, regulatory issues and competitive pressures. As a result, we can offer our clients a wide range of customized solutions. **To find out more, visit cithealthcare.com or call us at 1.800.547.7026.**



ASSET-BASED LENDING CASH FLOW FINANCE M&A ADVISORY SERVICES REAL ESTATE SENIOR AND EQUITY FINANCING LARGE & SMALL LEASES/LOANS

© 2008 CIT Group Inc. CIT, the CIT logo and Capital Redefined are registered service marks of CIT Group Inc.

Index of Advertisers

Access MediQuip	23
Affinity Insurance Services	10
Alpine Surgical	48
American Medical Buildings	22
Amkai	5
ASCOA	52
ASCs Inc.	49
B. Braun	47
Blue Chip Surgical Partners	24
CareCredit	9
CIT Healthcare	51
Eveia	43
HealthCare Appraisers	44
HealthMark Partners	25
Implantable Provider Group	30
Irmscher Construction	28
JCB Labs	42
Joint Commission	20
Kaye/Bassman	2
Manning Search Group	25
Marasco and Associates	27
Marshall Erdman	32
McKesson Medical-Surgical	4

McShane	45
MedHQ	37
Medical Facilities Corporation	46
Meridian Surgical Partners	6
National Surgical Care	8
Nueterra Healthcare	17
Orion Medical Services	45
Physicians Capital	13
Physicians Endoscopy	7
Pinnacle III	19
Practice Partners in Healthcare	21
Prexus Health Partners	40
Regent Surgical Health	39
RMC Medstone	43
Source Medical Solutions	49
Surgery Consultants of America/Surgery Center Billing	16
Surgical Notes	41
Symbion Healthcare	11
The Sanders Trust	14
TRY HealthCare Solutions	38
VMG Health	44
Woodrum ASD	15
zChart	50

ASC Communications, Inc.
77 West Wacker, Ste. 4100
Chicago, Illinois 60601
sbecker@mcguirewoods.com
312-750-6016

PRSRT STD
US Postage
PAID
Merrill WI
54452
Permit No 24

**YOU FIX PATIENTS.
WE FIX SURGERY CENTERS.**



Turn Around Tip #3

Schedule Compression and Block Time Release
Will Decrease Staffing Costs While Boosting Profits



* ASCOA has founded or turned around over 40 surgery centers nationwide. Surgeon-founded and managed. Superior patient care with outstanding margins. To learn what makes ASCOA different, contact us today.



866-98ASCOA • (866-982-7262)
www.ascoa.com

© 2008 Ambulatory Surgical Centers of America. All rights reserved.