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

Meeting the Current Business Challenges in Ophthalmology

By Stephanie Wasek

Ophthalmology has never been an extremely high-reimbursement specialty, and CMS's new ASC payment system did little to change that. Further, Medicare patients remain the largest patient group for these procedures, so there isn't much in the way of opportunity for compensating for minimal reimbursements. In other words, the challenges in this mature ASC specialty remain the same.

"We've been performing cataract surgery the same way for quite a long time," says Steve Blom, RN, MA, MAHSM, CASC, administrator of the Specialty Surgery Center in San Antonio, Texas. "There have been improvements in phaco machines and lenses but, really, they've been doing phaco for cataracts for over 20 years, and a lens is a lens. If you want to do cataracts, you have to find ways to be efficient and keep supply costs within reason."

Here is the experts' advice for doing just that in order to maintain and enhance profitability in this challenging environment.

1. Focus on volume first

"It's a volume-driven business; on a monthly basis, you probably need at least 200 cases to sustain an ophthalmology program," says Don Cook, founder

continued on page 7

Merging Two Centers — Can it Solve Certain Problems?

By Tom Yerden, MHA, and Scott Becker, JD, CPA

The merger of two centers with each other has not been a traditional strategy for surgery center growth over the past 10 years. Traditionally, merging two centers, absent certain motives such as redeeming certain physicians, has been viewed more as a negative than a positive. Mergers would often expand annual fixed costs and leave more physicians owning interests in two centers with less of a definite connection between the physicians that practice at the specific centers.

For example, a merger might result in 40 physicians who have interests in two different centers instead of 20 physicians at each center who are highly tied to the centers. Notwithstanding this traditional hesitancy to merge centers, we are currently seeing a significant increased interest in the merger of surgical centers.

This article walks through a specific case study of a merger of two centers and explains some of the reasons a merger can be attractive.

The specific situation that this article principally focuses on includes an initial multi-specialty center that

1. had been open for 20 years;
2. was owned 70 percent by physicians;
3. had many physicians which had ownerships in other centers, and
4. was short on capacity.

continued on page 5

Ambulatory Surgery Centers
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INSIDE

See conference brochure on page 30.

Letter from the Editor

Second Quarter 2008

This has been a challenging year in the healthcare business.

In the surgery center business, many of the participants are finding that it is harder to increase growth at existing centers. This is due to two core factors. First, there are fewer independent doctors available to be recruited to centers. Second, centers are experiencing increased pressures on reimbursement.

Hospitals are facing many of the same challenges as surgery centers. Hospitals are experiencing increased downward pressures on reimbursements and a lack of same-store growth (i.e., admissions). Further, hospitals are finding that some of their most profitable product lines (orthopedics, neurosurgery, cardiology and oncology) are becoming less profitable. In addition, hospitals that loaded up on debt for rebuilding and other projects over the last few years are now facing some of the challenges that come with substantially increased debt loads.

Finally, the picture for specialty hospitals remains extremely challenging. This federal legislative session has been very negative for specialty hospitals. Existing specialty hospitals will survive. However, the ability to build new physician-owned hospitals seems regularly to be on the verge of being curtailed.

As the profit margins in many of the healthcare businesses tighten, it becomes more challenging to find the ready momentum to bring buyers and sellers together. Here, the buyer is not willing to stretch on the purchase price and, from the seller's perspective, there is not enough money being offered to accept the purchase price. Hence, there is more interest in simply continuing to try to profit from the continuing operation of the center rather than pursue a sale.

Scott Macon, an investing banking firm in healthcare, reported a large decrease in mergers and acquisitions activity due to tightening credit markets. Here, it reported, "M&A activity as measured by total deals and total deal value fell dramatically as compared to the first quarter of 2007. The value of all United States M&A deals dropped 41 percent from the first quarter of 2007 to $204 billion in the first quarter of 2008. One major reason for the drop off in M&A activity is the decrease in the number of private equity-led deals due to market conditions related to the credit markets. As private equity deal activity continues to slow, there is an increased opportunity for strategic buyers with strong balance sheets to lead the M&A market."

We see that the deals that are most quickly being completed are those in which a company is coming in and buying at a relatively "value" price with the intent of trying to reinvigorate the center and try a new strategy to make it work. For example, it may be switching from a majority management company ownership to minority, third-party ownership. The new strategy may involve renegotiating payor contracts, recruiting new physicians and taking other steps to bring the center to profitability. We continue to see parties pursue these strategies effectively.

1. ASC Communications and the ASC Association — 15th Annual ASC Conference, Oct. 23 to 25. We have completed the plans for our 15th Annual ASC Communications and ASC Association Improving Profitability and Business, Strategic, Clinical and Legal Issues Conference. This conference will take place from Oct. 23 to 25 at the Sheraton Hotel and Towers in Chicago. The hotel has a terrific location right off of Michigan Avenue.

We have outstanding speakers for this conference such as Uwe Reinhart, a renowned national speaker on healthcare economic issues; Kathy Bryant, the President of the ASC Association;

Luke Lambert, the CEO of Ambulatory Surgical Centers of America, Joe Zasa, CEO of Woodrum ASD, and Deanne Manchester, senior vice president at USPI, speaking on physician/hospital joint-ventures; John Cherf, MD, a speaker on orthopedics and the future of orthopedics; and Bill Mobley, MD, and Herb Riemenschneider, MD, speaking on urology in ASCs.

We will also feature such speakers as Stephanie Ellis, RN, CPC, a leader in coding for ASCs; Caryl Serbin, RN, BSN, LHRM, a leader in billing for ASCs; Bill Southwick, CEO of HealthMark Partners; Jeff Leland, CEO of Blue Chip Surgical Partners; Mike Lipomi, CEO of RMC Medstone; Boyd Faust, CFO of Titan Healthcare; Kenny Hancock, President of Meridian Surgical Partners; John Caruso, MD, a spine surgeon; and several other speakers who consistently receive tremendous feedback as speakers.

For a complete brochure, please e-mail me at sbecker@mcguirewoods.com or visit www.BeckersASC.com. A brochure is included on page 30 of this issue. **To register for the conference, please call the ASC Association at (703) 836-5904.**

2. Nominations sought. We are seeking nominations for the following lists:

1. 25 Physician Leaders in Ambulatory Surgery Centers
2. 25 Women Leaders in Ambulatory Surgery Centers
3. 10 Great Administrators Who Lead IT implementation in Ambulatory Surgery Centers

Please e-mail sbecker@mcguirewoods.com with nominations.

3. Compliance committee of major health system. We have had the privilege of recently being added to the compliance committee of one of the most prestigious local systems in the Chicago area. We are delighted to have this opportunity. Recently, we have spent a lot of time with surgery centers and with hospitals working on compliance-driven issues. This has been more important in the last couple years, as there seems to be a weekly announcement of another settlement between the federal government and a health system related to how health systems are paid or how they are compensating physicians. Examples of some of these settlements are set forth at www.BeckersASC.com.

4. ***The Hospital Review.*** ASC Communications has launched an additional magazine called *The Hospital Review — Business and Legal Issues for Hospital Leadership*. Should you be interested in seeing an electronic copy of this magazine or receiving a sample issue, please contact me at (312) 750-6016 or at sbecker@mcguirewoods.com, and we would be happy to provide you the same.

If you have a question or would like to discuss any of these issues noted herein, please e-mail myself at sbecker@mcguirewoods.com or at (312) 750-6016.

We hope you are doing well.

Very truly yours,

Scott Becker

The *ASC Review* is published six times a year and is delivered to 25,000 surgeons, surgery centers, ASC administrators and industry leaders per issue.

See conference brochure on page 30.

Ambulatory Surgery Centers

Improving Profitability and Business and Legal Issues

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Merging Two Centers — Can it Solve Certain Problems? (continued from pg. 1)

This center also enjoyed a relatively long track record of success and distributions.

The second center

1. was a newer, multi-specialty center;
2. included many of the physicians from the first center;
3. worked principally on an out-of-network model; and
4. had, to date, enjoyed limited financial success.

The market was also clouded by a local hospital preparing to open a new joint-venture ASC.

The initial center had many challenges, including

1. a need for additional capacity;
2. concerns about divided loyalty amongst its physicians; and
3. competition with the new hospital joint-venture ASC.

It was also in the process of restructuring its own management company relationship.

The first center evaluated several different options. These included adding an additional operating room, attempting to improve operational efficiency and examining relocating the surgery center entirely. However, it was concerned about expending a great deal on money on expansion or relocation if it did not have a greater sense of loyalty from its physicians and stronger contractual relationships with them. It also examined, as a compliment to expanded capacity, a resyndication to expand physician ownership, efforts to enhance payor contracts, adding additional services and enforcing safe harbor rules.

The center, in addition to facing decisions as to whether to expand and how to handle contractual issues with its physicians, was looking at potentially restructuring its partnership. This would include enhanced management efforts, converting from a partnership to an LLC, creating a new operating agreement that was more up-to-date and removing certain barriers to entry for physicians.

The center decided to focus on the specific option of merging with the other surgery center. This allowed it, as part of the merger, to both add the capacity it needed (and add physicians) and to restructure its operating agreement to include both sets of physicians with stronger contractual requirements. The parties, as part of the merger, had to determine the respective values of each center and determine how ownership would be comprised after the transaction. Further, the parties had to examine how they could cluster their cases and reduce total overall staff time while taking advantage of the improved capacity. Finally, the centers agreed to a management relationship with a national management company that would own part of the center and help steer the venture going forward.

The benefits of this merger include the following:

1. Merger of both centers resulted in a projected reduction in labor costs per case of more than $250/case.
2. Merger added needed capacity to the first center, resulting in capital avoidance associated with expansion of $2 million.
3. Management of both merged centers was now performed by a consolidated management team, further reducing operating costs.
4. The national management company's influence relative to payor contracting has improved reimbursement on several critical payor contracts.
5. Projected savings associated with supply chain management were significant.
6. The merged centers became better positioned to compete with the hospital and its ASC.

This case study really examines a situation where centers were merged to expand capacity and address a few other challenges. The alternative type of merger, which we now see more and more often, is the type of merger where two centers are merged together with the intent of clustering more cases over a single space. In this situation, instead of expanding capacity, the two centers close down the operations at one center and work to decrease fixed cost per case. This can be a very successful strategy where there is significant capacity at one center to handle twice as many cases or at least the cases that would come from the second center.

The financial analysis as to whether such a merger will make sense in these situations starts in the following manner:

1. Center One owns 100 percent of an ASC which currently earns $1.5 million per year.
2. Center Two's shareholders currently make $500,000 per year and own 100 percent of Center Two.
3. After the deal, Center One's shareholders will own, e.g., 75 percent of the combined entity. In short, can there be a reasonable chance that the 75 percent ownership will generate more than $1,500,000 a year?

The shareholders must ask themselves the following questions:

1. What are the risks and challenges to continuing to earn $1,500,000 a year, ($2,000,000 overall)?
2. Are there significant cost savings or other synergies that make it is likely that the combined centers will do better than $2,000,000 in net income?
3. Will the contribution make it easier to recruit physicians or improve managed care contracts?
4. Are there other risks, such as loss of key doctors or reduced reimbursement, that need to be considered?

To answer these questions and move forward with the transactions, here are steps to consider:

1. Examine combined enterprise and develop combined business plan.
2. Assess respective values and negotiate terms of combination.
3. Enter into letter(s) of intent.
4. Provide private placement memorandum or disclosure documents to all holders of shares.
5. Assess consents needed to restructure partnership at a state- and a third-party-contract level.
6. Assess the need to buyout certain partners as part of the combination.
7. Set a closing date

We believe that these types of mergers, particularly the second type where people are trying to cluster more cases over a single set of fixed costs, will become increasingly common over the next few years. ■

Contact Tom Yerden at ***tyerden@aol.com*** *or Scott Becker at* ***sbecker@mcguirewoods.com****.*

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of Pacific Surgical Partners, based in southern California.

To do that, Mr. Cook requires that PSP's ASCs' schedulers have face-to-face meetings with the surgeons' schedulers at least once a month.

"They have great phone relationships, but it's even more important to take the physicians' schedulers to lunch or breakfast or just to see them in their offices in order to develop personal relationships," he says. "It's amazing, but every time the schedulers go out, the number of cases for the surgeons [whose schedulers were visited] increases.

"We also are sure to give visible credit on a daily basis for how many cases are booked, and give kudos when we reach 100 cases hard-booked for the next month. Even without big money incentives it becomes much more exciting when success is visible; it becomes personal for the schedulers to try to achieve these goals."

2. Compress the schedule

"The volume isn't as important as the efficiency" once you're actually performing the cases, says Brent Lambert, MD, FACS, founder and director of business development for Ambulatory Surgery Centers of America (ASCOA) in Hanover, Mass. "If you're only doing two cataract cases an hour, you're not going to make the kinds of profit margins you need. But if you let the surgeon work out of two ORs and have rapid turnover time, you can do six an hour.

"Most of our surgeons are doing at least four an hour. When you are that efficient, you can be profitable."

This kind of practice can let you compress the schedule so that you're doing more cases in fewer days, a practice Mr. Cook recommends.

"If you can do the cases in three or four days a week — even if you can only do that every other week — that's enough to use part-timers or reduce the staff, and that's enough" to significantly cut expenditures, he says. Further, he recommends having a mix of full-time core staff and permanent part-time staff who are flexible based on your ASC's needs.

3. Take case-costing seriously

"Throughout our centers, we case-cost, and we know what the supplies are on every case for every surgeon," says Dr. Lambert.

So, for example, he says, you should know that a surgeon's six-minute procedure time costs you $108 in overhead, that he spends $200 per case on supplies and that, therefore, your out-of-pocket costs are $308 per procedure on his cases.

"At $308, since we're getting reimbursed $960, that's very, very profitable," says Dr. Lambert. "For the average ASC, my most important advice would be to case-cost on every case. This lets you find the most efficient surgeons and share the best practices with the other surgeons."

But you can't know that if you don't track and measure everything you can, says Mr. Cook.

"Doing so lets you set objectives for all parties involved to improve on any of those measures — cutting time, cutting supply costs, setting a target for average cost per case," he says. "I know there are national benchmarks, but each center starts from a slightly different place. You need to be able to look at where you are, and find realistic but challenging goals you want to reach."

In Mr. Cook's centers, there are incentives for staff such as the materials manager, director of nursing and administrator, who have an impact on the process.

"It's not a huge portion of their base salaries, but it's still an incentive," he says. "Depending on the level of their responsibility for cost structure and revenue, the incentive potential goes up."

4. Be open about costs

In terms of keeping supply costs down, it's "unlikely you'll be able to trim fat by just trying to negotiate a better deal on supplies," says Mr. Cook. It is better, he says, to put your tracking efforts to work for you with the surgeons. He cites an example from preference cards of two of his surgeons.

Surgeon A specified six different medications for use at a total cost of $216.20 per procedure. Surgeon B was using a pre-mixed dilating solution that cost $25.02 per case. When Mr. Cook shared the costs with the surgeons (and showed that the pre-mixed solution was a best practice), several agreed to switch to the pre-mixed solution; eventually, everyone changed to the less expensive method.

"It's a dramatic example of the differences that are driven by physician preferences," says Mr. Cook. "You're not going to make progress in the short run by saying, 'Doctor, if you do it this way, you can save us a bunch of money — can you do that?' But if you openly provide data to the medical executive committee, you can talk about ways to get the costs down through practice improvement. Let them provide efficiency ideas and let it be their decision. That's the only way to get implementation efficacy."

In the aforementioned example, the surgeons who changed to the pre-mixed solution "ended up liking it better and feeling collaborative because they got to interact with their fellow doctors in a way they don't usually get to."

Mr. Cook also doesn't automatically say no when a surgeon says he needs a special knife or one viscoelastic versus another. They simply must report their requests directly to him, and he is up front about the costs.

"When a surgeon calls and says he needs a new viscoelastic, I say, 'That will cost $40 a case. In the 600 cases you're going to do here this year, that's $24,000,'" says Mr. Cook. "When you put it like that, virtually all of the time the surgeon will say it's not worth it."

Dr. Lambert recommends sharing not just among surgeons, but among centers — and building an exchange so you can learn as well.

"Don't be afraid to pick up the phone and call the administrator of another center, introduce yourself and say, 'I just want to share my data and would appreciate it if you could share with me your supply costs for your most efficient cataract surgeon,'" he says. "The ASC industry is very collegial; we're trying to improve and make things better for patients, and helping each other is better for the industry." ■

Contact Stephanie Wasek at ***stephanie@beckersasc.com.***

3 Ancillary Procedures to Consider Adding

1. Glaucoma Procedures

The reimbursements for glaucoma procedures are ramping up, and incorporating these cases into your center could prove to be very lucrative, says Brent Lambert, MD, FACS, founder and director of business development for Ambulatory Surgery Centers of America (ASCOA) in Hanover, Mass.

"If you know of surgeons who are doing eight to 10 of those a week, those are the kinds of people you want to bring in," says Dr. Lambert. "As long as the surgeon is efficient with the procedures — he's not taking two hours to do a filtering procedure, burning up assets, staffing costs, OR overhead — by 2011, you're going to want to be doing glaucoma procedures in the ASC."

2. Refractive IOLs

There are now several options for these multi-focal and accommodating IOLs that offer the possibility of seeing well at more than one distance and of replacing glasses or contacts.

"The lenses are getting better — they even have one that corrects astigmatism — the physicians are getting better at the procedure, and patients are becoming more willing to have the procedure done," says Don Cook, founder of Pacific Surgical Partners, based in southern California. "There is enough of a patient base out there that wants to have it done, because they don't want to have to wear glasses or contacts."

One caution: While the government now reimburses for a portion of these procedures, with the Medicare beneficiary paying the rest out-of-pocket, this is still by and large a procedure for patients younger than Medicare age who pay out-of-pocket. As a result, the poor economy may have an impact on the number of people willing to shell out several thousand dollars for the procedure, says Mr. Cook, so you may want to hold off until the economy improves.

3. Ophthalmic plastics

"Ophthalmic plastic procedures have always been there, and they still reimburse reasonably well," says Dr. Lambert. "The equipment requirements are much less [than for other ophthalmology procedures] — all you need is a knife and a needle holder. If someone can do a bilateral upper-lid blepharoplasty in a half-hour, you can do well financially with that."

— Stephanie Wasek

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Expert Guidance to Help You Capitalize on New Urology Opportunities

By Rob Kurtz

The new Medicare payment system and expanded list of procedures brought with them new, profitable opportunities for centers performing urological procedures or considering offering urology in the future.

In fact, while over 80 percent of urology procedures tracked in quarter four of 2007 were performed in hospitals, Millenium Research Group says it fully expects "these numbers will begin to shift to ASCs and office settings … providing additional market potential."

"The reimbursement shift may encourage physician and patient adoption of in-office procedures, expanding the number of facilities performing them," says Nadia Lachowsky, senior Marketrack analyst at MRG.

But to ensure a profitable return on this volume-driven specialty requires good business sense and careful planning and analysis. Follow this advice offered by several urology experts to help your ASC achieve financial success when offering and performing urological procedures.

1. Identify the best surgical location.

Since urology is often a volume-driven business, it is critical for you to determine which procedures you should perform in your surgery center and which should go to an office or hospital setting, says William C. Mobley, MD, FACS, of Spring Park Surgery Center in Davenport, Iowa.

With the fee changes, "some of the more sophisticated procedures pay better, but some of those procedures, even though they pay better, still don't pay enough to justify moving them from a hospital to a surgery center partly because the volume is not there and partly because the fees still haven't really caught up to the technology," Dr. Mobley says.

In some instances, Medicare is now paying less for less-sophisticated procedures, making them better candidates for an office environment where the facility offset for the professional services is not applied.

"It really comes down to a challenge of determining the best place to perform the surgical procedure: in the office, surgery center or hospital, then really clearly establishing each of those niches," he says. "The most valuable thing you can do to make this work is to have a clearly established relationship with the office of urologists that you're working with."

Developing this relationship becomes easier if your ASC is partly owned by a group of urologists who will perform the office-appropriate procedures in their offices. If you do not have such an ownership structure, you will want to hold discussions with a nearby urology office and discuss the business relationship you are looking to build.

Once you have established a relationship with an office, then it's just a matter of working with a local hospital to ensure you can refer patients to that location when performing the procedure is impractical for either the ASC or office.

"It's important to realize that the surgery center business is a boutique business; it needs to establish its niche," says Dr. Mobley. "What is not profitable is trying to be as big and sophisticated as the hospital. There really are limitations to what you ought to be doing in a surgery center from a quality and a profit standpoint.

"You do a number of things really well and you're happy with that. And the hospital does what makes sense. Once you have that little niche agreement, worked out, things go better."

So what are some of the more common urological procedures that should be performed in each setting?

• **ASC.** Some of the procedures that used to be

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performed in the hospital but are now ripe for the surgery center include implantation of penile prostheses and more advanced kidney stone procedures, Dr. Mobley says.

His surgery center also invested in a lithotripsy machine to perform related procedures.

"Medicare, in its most recent revision, has established the fact that a surgery center can directly bill for lithotripsy services and that reimbursement is much more commensurate with what it costs and is more profitable now than it used to be," he says. "A lot of those procedures used to flow through the hospital but now they're done directly by the surgery center."

He has also seen some more sophisticated incontinence procedures that were once performed in a hospital, as an outpatient procedure, now finding their way into ASCs.

• **Office.** "We've moved all of our prostate biopsies to the office over the past few years," Dr. Mobley says. "It used to be that we did most of them in the surgery center, but they don't pay well in the surgery center and some advancements in technology have allowed this (procedure) to be done easier, better, faster, quicker and more profitably in the office, and patients appreciate that efficiency."

Other procedures that Dr. Mobley suggests for the office include almost all plain, diagnostic cystocopies and occasionally the removal of small bladder tumors.

• **Hospital.** Examples of some of the more sophisticated procedures now allowed in ASCs that Spring Park has not moved from the hospital include implantation of radiation seeds and cryosurgical destruction of prostate cancer.

"They really don't have the volume or we have determined that reimbursement is inadequate," Dr. Mobley says.

2. Achieve cost-effectiveness.

Unlike a specialty such as orthopedics in which a single case can bring your ASC a very high profit, you're probably performing several urological cases each surgical day to bring in a strong return. Since many of these cases are likely repeat procedures, it is vital that you ensure maximum cost-effectiveness on these cases so you can turn the most profit each time you perform the procedure.

"Once you start to do things the same way each time in a cost-effective way, you have a well-established boutique business," Dr. Mobley says.

To achieve such cost-effectiveness, you will certainly want to focus on typical areas such as turnover time, payor contracts and efficient scheduling, says Bryan Zowin, administrator for the Peoria (Ill.) Day Surgery Center. Another crucial area you should examine regularly for urology is supply costs, he says.

"Direct costs are huge right now," Mr. Zowin says. "We're looking at that one hard for every case to make sure we're maximizing our profit margin. "(Ask yourself), how much do you have on inventory? How quickly are you turning it? How much are you paying for it? If you do a ton of cystoscopies and manage those costs, it's a good deal."

Peoria Day Surgery Center makes sure to take advantage of the services offered by two group purchasing organizations, which send representatives to the ASC periodically.

"They review our data and look to see where we can maximize what we're purchasing for similar products," Mr. Zowin says. "It really helps with analysis."

But the most important piece of advice Zowin can offer for your ASC to become cost-effective with its urological procedures is to focus on …

3. Effective carve-outs.

"The biggest tip I have for surgery centers is for the procedures that require any type of implant or male/female slings, it's so important on those procedures that, if you're managed care, to get those carved out at invoice plus cost," Mr. Zowin says.

Mr. Zowin offers the following tips to effectively carving out implants with your payors:

• **Meet face-to-face.** "Get in front of them," he says. "If you can eliminate the telephone and e-mails, I've had a lot more success doing the face-to-face meetings. Once you get them face-to-face, I think you're able to get a lot more accomplished than either phone or e-mail allows."

• **Educate your payors.** "Tell them the story of what these things cost. We're not looking to make any real profit on them; we just want to get paid our service plus the invoice cost with a little bit of a handling fee type of deal," Mr. Zowin says. "The biggest thing is just making sure you can have that dialogue with those payers."

• **Show them the data.** Bring any data you can share with your payors to your meetings.

"If you're paying us $1.500 for this case and we've got an implant cost of $1,100, all we're asking for is to pay that plus the invoice cost," says Mr. Zowin. "Be right up front with them. We're not trying to up-charge, and that's the biggest thing. And they will appreciate it. A lot of times, hospitals will mark those up considerably and I'm willing to just take regular invoice cost on them."

• **Reference Medicare.** The new Medicare APC system includes a service-fee portion, which Mr. Zowin says he references and then asks for a little above invoice costs for his implants and devices.

"I tell them my service fee is X times Medicare and you've got some parameter to go off of, whereas in the past you really didn't have that," he says. "It was a grouper model, here's the flat rate. Now they have a service portion for a lot of these implantable devices, I (point out) what Medicare is paying — 200 percent or 250 percent — and then we'll use that and the invoice cost."

• **Solicit your vendors' help.** Your vendors want you to use their products so you will order more from them. But if you can't get good carve-outs for the implants or devices they provide you, your physicians will be forced to move the cases to the hospital. Part of the physician's blame for this inconvenience of moving the procedure may fall on the vendor for providing a product for which payors are unwilling to fairly compensate the ASC.

"So we're even trying to get the vendors to go to the payors and say they should be paying for this in the surgery center," Mr. Zowin says. "The vendors benefit from this as well."

• **Explain benefits.** As your center invests in new technology, you will want to inform your payors of the reason for your investment and its benefits, and show them why you should receive additional compensation for your commitment to quality.

"Tell them, 'We were doing it this way but we're doing it this other way now because the outcomes are better, the retreats are less,'" Mr. Zowin says. "You have to be able to stay on top of that. If your direct costs start to jump as new products come out, which it does in many cases, and then you have to get that message out there" to your payors to receive more reimbursement because of the improved patient outcomes.

4. Add procedures.

With better reimbursement and an expanded list of Medicare-approved procedures, you have a great opportunity to expand the types of cases you perform in your ASC.

"The number of procedures we can now do in a surgery center has increased significantly," says Herbert Riemenschneider, MD, founder of Knightsbridge Surgery Center in Columbus, Ohio. "The question is whether a procedure can be done profitably, and can we do it in a way that benefits our patients beyond what the system provides that exists now?"

Dr. Riemenschneider suggests the following procedures as worthy considerations for addition.

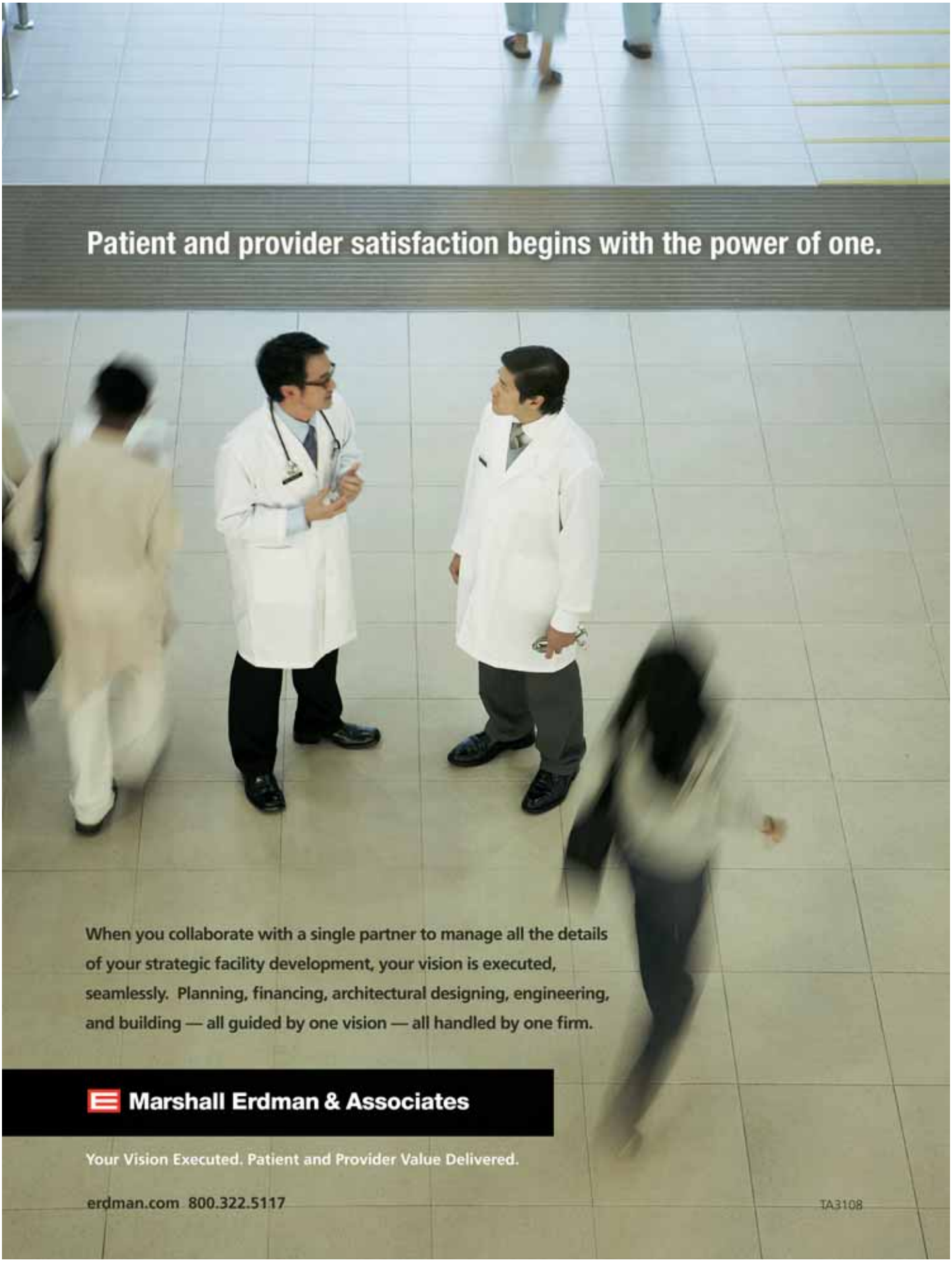
• **Shorter, less-complex procedures.** "Look at smaller procedures that have a known, black bottom-line that's not huge," Dr. Riemenschneider says. "What's the advantage? Most of those are short procedures and if scheduled efficiently, you can do quite a few procedures in a morning or block day and benefit from rapid turnover of cases. It isn't unusual to be able to do eight or more cases in your allotted time."

Here are some procedures to consider.

• Bladder pathology — "Biopsy or resection of small- to medium-sized bladder tumors is quite appropriate for the ASC environment," he says.

• Incontinence treatments — By use of urethral sphincter collagen injections and, in those who have recalcitrant overactive bladders, you can consider Botox injections and even InterStim, Dr. Riemenschneider says.

• Urethral stricture — This includes treatment with balloon dilatation or urethraplasty, and treatment of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• Vasectomies — "There are centers that do a many vasectomies," Dr. Riemenschneider says. Why do them in a surgery center? If a patient has the choice to have sedation or an anesthetic in the secure ASC environment when he has anxiety, he will be pleased with this option in the current reimbursement system."

• Hydrocele repairs
• Hernia repairs
• Orchiectomy
• Varicocele ligation
• Circumcision

• Moderately complex procedures
• Laser treatment of prostate for benign prostatic hypertrophy (BPH) — This may be the GreenLight Laser prostatic vaporization procedure (PVP) or the holmium laser ablation of the prostate (HoLAP) procedure.

"Either is well-suited to the ASC environment," Dr. Riemenschneider says. "For this to be a successful and productive case, the resources used must be monitored and the billing procedures refined. Patients are usually discharged to home after 60 to 90 minutes of recovery time."

• More complex procedures
"These have a higher cost structure but also have a good bottom-line provided you manage the process well," Dr. Riemenschneider says (see "Should You Add These Complex Urology Procedures?" on p. 13 for more).

Consider the following procedures and technologies:

• Stone disease treatment — "With fiber-optics, there are very few places in the urinary tract we can't access. When using flexible ureteroscopy plus laser technology, the upper urinary tract is accessible and treatment is possible and practical."

"A patient can present with a significant problem and pain, be treated and be back at home in his own bed that evening," Dr. Riemenschneider says. "We can respond very quickly to make these things happen. This is also a great marketing technique for your practice and center."

One challenge a surgery center will face is that fiber-optic instrumentation is fragile and it is essential to educate those who handle the instruments. For example, ureterscopes used in the upper urinary tract can cost around $15,000 and probably have a case life of 40 cases, Dr. Riemenschneider says.

"At the same time, the reimbursement is such that if you use them carefully, you can have a nice bottom-line profit," he notes.

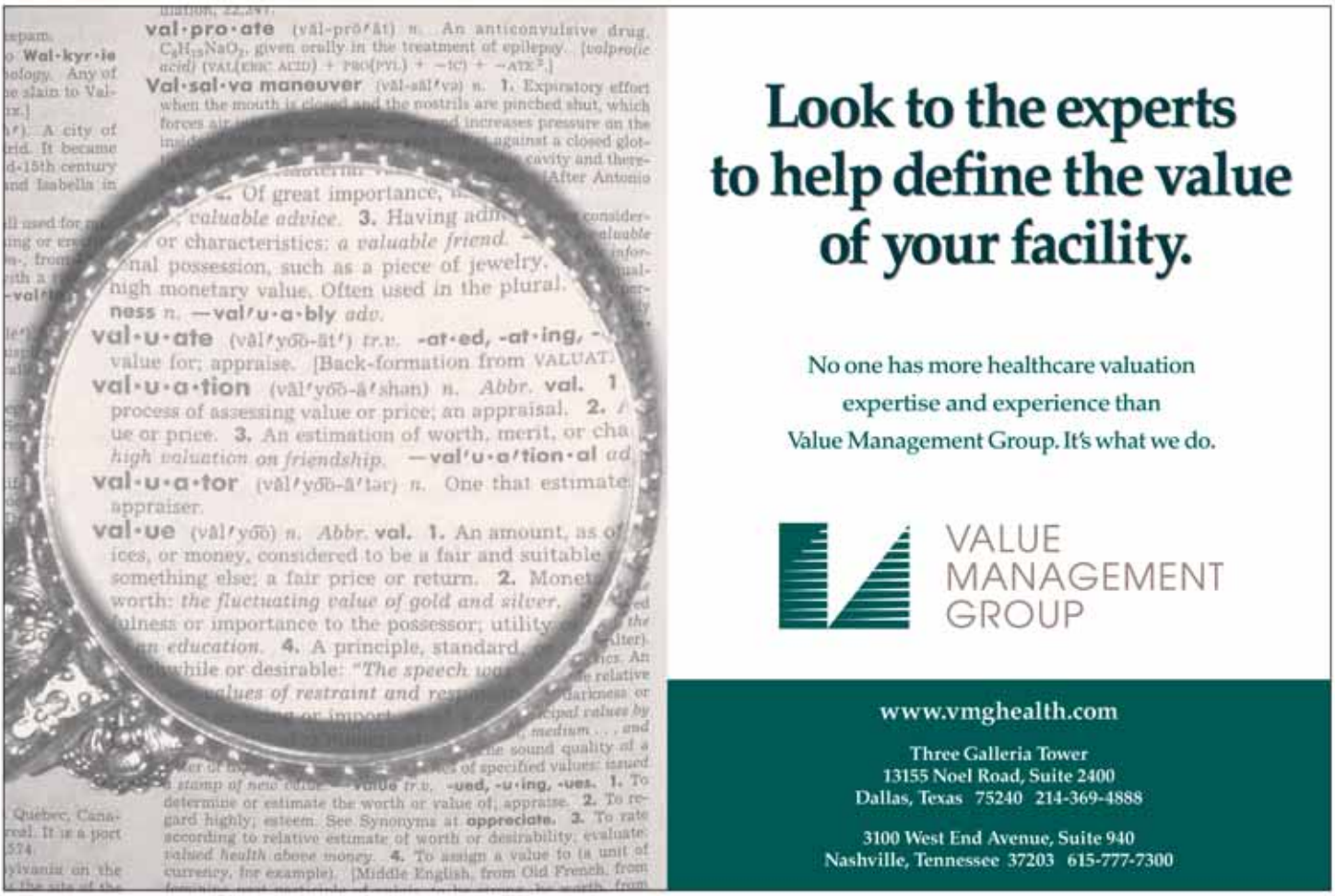
• Extracorporeal shockwave lithotripsy — "While it's not new technology, the Medicare Modernization Act (MMA) opened the door for ASCs to consider investing in this equipment," Dr. Riemenschneider says. This non-invasive technology is based on electrically generated shockwaves that are transmitted percutaneously through the body to treat a stone in the kidney or ureter. It has been in use for years in hospitals.

"It's more available now than it has been in the past. In the commercial environment, you can make a very nice return on the application of lithotripsy in the surgery center," he says. Patients can often pass the stone fragments and go back to work a day or so after this treatment is performed.

While the equipment is expensive, it is not unreasonable for a group of urologists to invest in it.

"There are lithotripsy partnerships involving groups of urologists who have banded together to buy this million-dollar type of equipment and place it in a surgery center," he says. "We have had a lithotriptor at the Knightsbridge center for two and a half years. The technology has become smaller, mobile and more capable. A surgery center is an ideal place for a lithotripter and ureteroscope."

• Artificial urinary sphincter — This can be implanted in the ASC, Dr. Riemenschneider says. "It takes an interested support staff and careful management of costs and reimbursement. The MMA has cleared the way for the Medicare patients and opened the opportunity for commercial patients, however, the carve-outs have to be negotiated."



5. Online scheduling.
The use of an online scheduling resource has helped improve the efficiency of the Knightsbridge Surgery Center, Dr. Riemenschneider says.

"It allows the office schedulers to see what is available in a very timely fashion. However, it still gives the center control over its scheduling process. It makes it possible to do many cases very efficiently on relatively short notice; it makes apparent the OR time that would not otherwise be used such as when cases are unexpectedly cancelled or blocks are not filled. It has made taking care of urgent cases, such as the painful stone case, possible."

Online scheduling has allowed the offices of physicians who use Knightsbridge to see the availability of ORs and resources, such as the C-Arm, even after-hours, so that many patients can be put on the ASC's schedule very quickly.

"It's been very effective in helping Knightsbridge grow, even attracting patients experiencing stone pain from hospital waiting rooms," Dr. Riemenschneider says.

6. Diversify services.
While it may prove to be a difficult venture, Dr. Mobley believes a diversity of services offered is an asset to a surgery center.

"The way fee structures change from specialty to specialty, we would not want to be a surgery center that only practiced urology," he says. "We have expanded and have a group of ophthalmologists that practice here as well."

Spring Park was approached by a group of ophthalmologists who would not be able to secure a certificate of need to build their own center. The urology group welcomed the new investors and it has worked out very well for the ASC.

"They are a very profitable portion of it," Dr. Mobley says.

In fact, the urologists and ophthalmologists have expanded beyond what their existing ORs can handle, so the center is considering physical expansion. The challenge facing the center is that it has determined an addition of one and half ORs is all that is needed to handle the overflow from current ORs. Unfortunately, it is not possible to build half of an OR, so the ownership is looking to recruit some general surgeons to fill the available space.

"If you have to build two ORs, it makes sense to get a group of general surgeons in there to fill that other half. It would be a lot easier to make this (expansion) investment. They won't be as profitable as the ophthalmologists, but given their volume it does offer some additional diversity," Dr. Mobley says. "I think diversification within the group spreads out the risk and we're looking at appropriate areas that are still profitable to get into." ■

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Should You Add These Complex Urology Procedures?

By Stephanie Wasek

In both single-specialty urology and multi-specialty ASCs, longer, more complex procedures can be a good fit and good for profitability. The key for either type of facility is having a dedicated fluoroscopy unit, with a cysto-fluoro table and a C-arm.

"The procedures that require more expensive equipment, that are more invasive and that require full anesthesia, were undervalued in the past," says Ira Klimberg, MD, of the Urology Center of Florida in Ocala, Fla. "These procedures are going to see their reimbursements go up by 60 to 100 percent over the next four years. I think that these more complex, more time-consuming cases are really going to be major drivers of new revenue."

Here's an overview of five such procedures — penile implants, slings for incontinence, kidney stone procedures, laser for benign prostatic hyperplasia and prostate cryotherapy — that your ASC might consider adding.

1. Penile implants

Historically, penile implant cases have been done in very limited numbers in freestanding surgical centers, by a limited number of surgeons, because the procedure code was not even part of the Medicare ASC payment list.

"The sugeons who did it specialized in it, and went out and contracted with payors in their areas to work out a reimbursement schedule," says Dr. Klimberg. "They showed that the procedures are amenable to the ASC, and while it's great that Medicare has added these procedures to the ASC list, the problem is that CMS is bundling payments to the ASC for the procedure and implant cost. This is not sufficient to cover the cost of the implant, so it is not feasible to do the procedure in the ASC for Medicare patients."

As a result, he says, penile implants will "remain limited to patients who are non-Medicare — either self-pay or who have insurance with which you can negotiate a carve-out."

Mike Shea, CEO Treasure Coast Management Group in Vero Beach, Fla., agrees.

"I suspect that Medicare and some of the private payors will refuse to pay except for a very limited diagnosis," he says. "Consequently, I think penile implants are going to go the way of breast implants and be considered non-covered, self-pay cosmetic procedures. Once that happens, the cosmetic surgeons will pick it up well; that group is very adept at marketing."

2. Slings for incontinence

"As we go forward, sling procedures are becoming less invasive, and the reimbursements have gone up in the ASCs," says Mr. Shea. "Because urologic procedures such as these have as many components as orthopedic procedures oftentimes do, these will consequently lend themselves well to the ASC."

The catch is that there are a lot of different types, sizes and materials of these implantable slings, and they can get quite pricey.

"The good news is that manufacturers are advancing rapidly with these, and the prices are dropping," says Mr. Shea. "But you still will want to get a carve-out with private pay to cover the cost — even with that reimbursement added on to that of the procedure, you can offer the insurer a package price that's one-third of what it would cost them in the hospital."

3. Kidney stone procedures

"When you look at the numbers, I think the biggest increase is going to be in procedures for stones," says Dr. Klimberg.

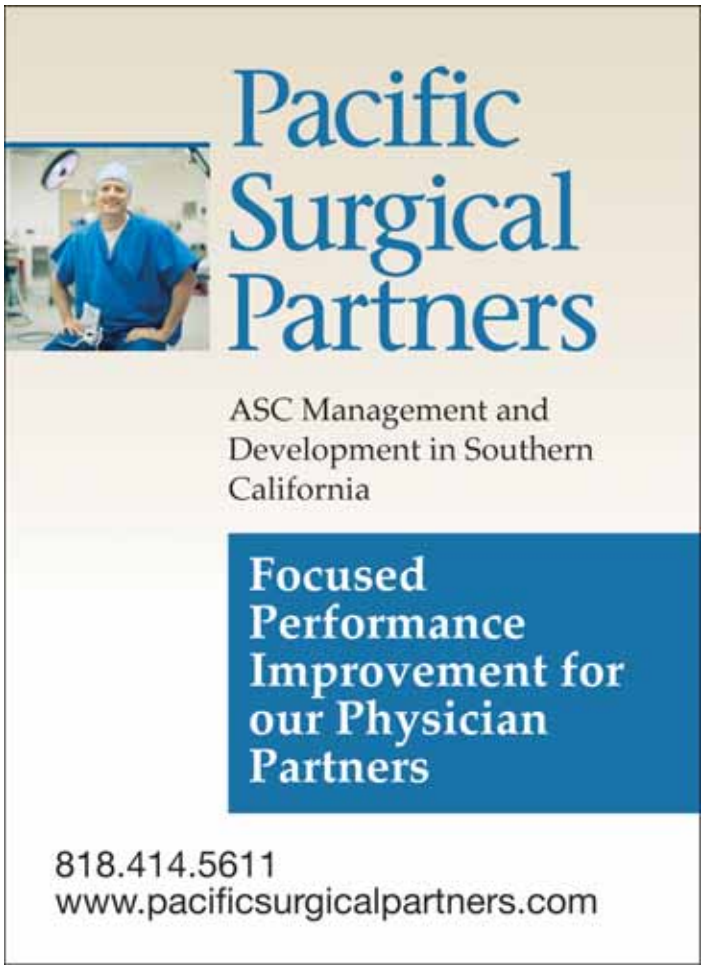
Medicare did not previously compensate ASCs for lithotripsy, notes Jorgen Madsen, president and CEO of United Medical Systems in Westborough, Mass., so its addition to the ASC payment list — at a scheduled reimbursement of $1,782 — is an important step forward for this procedure.

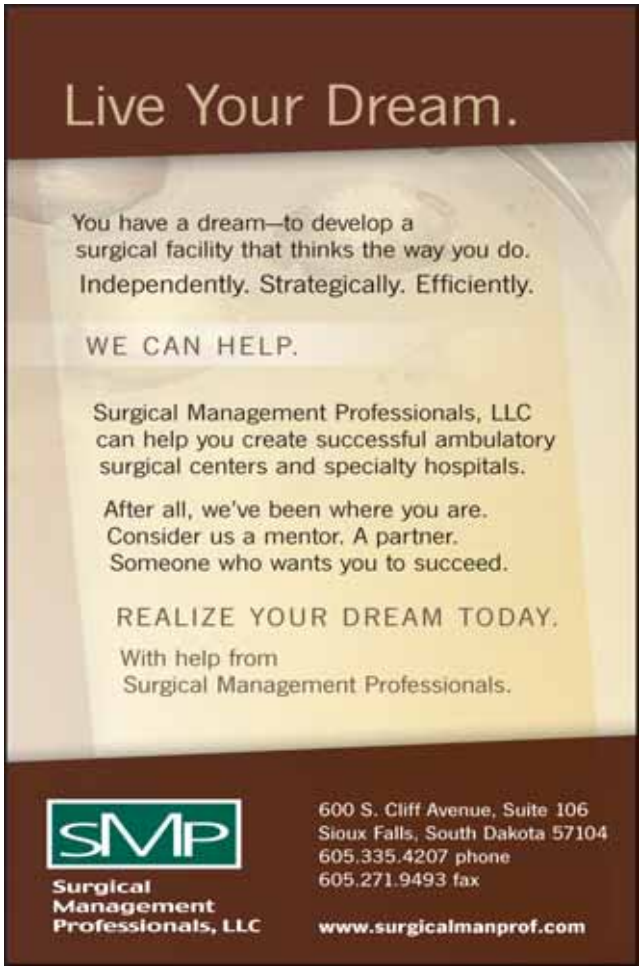
"Medicare's paying for lithotripsy in the surgery center is a big deal," says Mr. Shea.

For Dr. Klimberg's practice, the addition represents a "nice line of business. We have access to the equipment where we either pay a flat fee for the day or a per-case rate, and we can negotiate a lower per-case rate for the Medicare patients, which gets us out of the hospital for those patients," he says. "If you have a couple of private payor patients [scheduled for lithotripsy] at the ASC, you can add a couple of Medicare patients, and both increase the reimbursement to the ASC that day and experience more efficiency as the physician, because you're not splitting your time between the ASC and the hospital."

While extracorporeal shockwave lithotripsy's addition makes the most waves, there are other kidney stone options that are also now more viable for ASCs.

"The ESWL is a half-million dollar machine that's fairly heavy," says Mr. Shea. 'The procedure pays





very well, but it's expensive to perform. Another way to do [stones] is with holmium laser. The reimbursement there is very good, though it depends on the size and placement of the stone and which modality the doctor uses: With the laser, you're chipping away at smaller ones as opposed to smashing them with a sledgehammer."

Mr. Shea also notes that there are some physicians who are doing stone procedures very effectively with high-powered green-light laser. However, you might want to delay incorporating the laser procedures into the case mix, as the "government didn't front-end load the laser reimbursement for ASCs," and the payment will become more viable as the new Medicare system is phased in over the next few years.

Further, says Dr. Klimberg, "reimbursement for ureteroscopic stone procedures have gone up appreciably — from $500 or $640 to $1,046. Facilities that have urologists on board should be thinking about adding fluoroscopic capabilities [necessary for such procedures] if they don't already have that capability."

4. Laser for benign prostatic hyperplasia

Treatment for benign prostatic hyperplasia (BPH) aims to remove some of the tissue from an enlarged prostate. There are two types of lasers used for these hour-long procedures: holmium and green light.

"You can do either of these treatments in a fairly short amount of time, with no bleeding, quick recovery and minimal inconvenience to the patient," says Mr. Madsen. "Clinically, it makes a lot of sense — all aspects of the procedure really fit in the ASC environment very well."

While many men are able to delay treatment by using drugs, "they will have to cross that bridge eventually," says Mr. Madsen. "It's a high-volume procedure, half a million a year, and there are going to be increasingly more candidates. Almost twice as many men need treatment for BPH as there are people who need kidney stone treatment."

The lone problem, as mentioned, is that the reimbursement won't be equal to the task of adding the service line in the ASC right away.

"The laser is roughly a $120,000 piece of equipment, and in order to keep disposable costs low, you have to purchase quite a large volume of laser fibers," says Mr. Shea. "The part that generates the beam itself has a finite life, so you're going to have higher maintenance costs on the service contract. So the true cost does not equal the reimbursement."

Mr. Madsen agrees.

"The reimbursement schedule unfortunately favors the hospital setting at this point in time," he says. "We run an ASC (in addition to offering mobile urologic procedure services), and we don't do them yet to any extent there, because purely from a financial standpoint, it's hard to make it work."

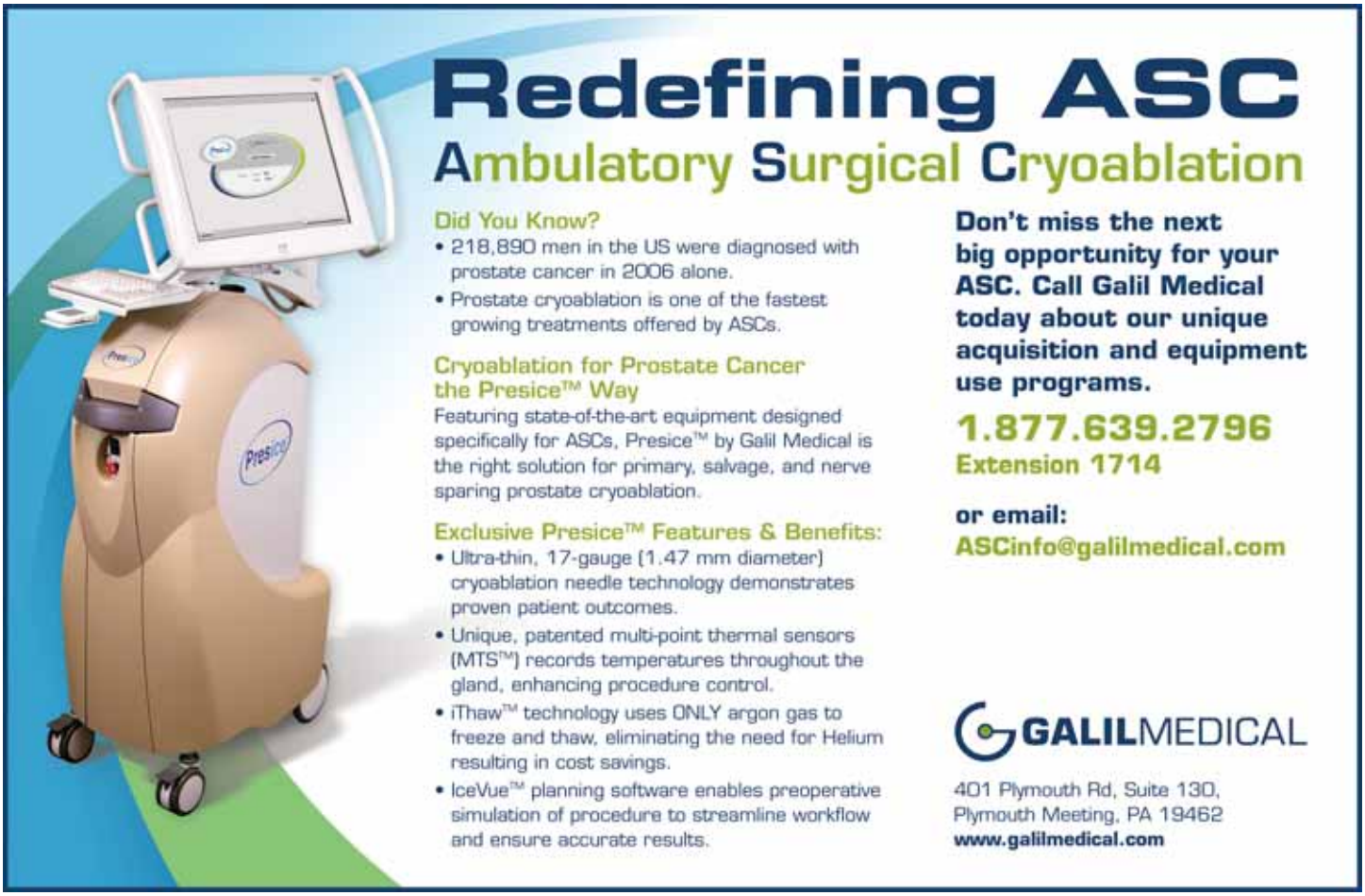
Mr. Shea works with some ASCs who are doing the treatments essentially at cost as a convenience for surgeons and to gain an early foothold in the marketplace. He estimates that BPH laser treatment will start to become profitable in year three of the new payment system's implementation, and that "once it's ramped up, it will be very profitable."

5. Cryoablation therapy

Various cryotherapy techniques have been available and in use since the early 1990s, and in 1999, a CPT code was approved by Medicare for prostate cryoablation. But now, that CPT code — for both primary and salvage prostate cryoablation — is open to ASCs, which could be a boon for your center beginning in 2008. According to data pending publication, results of the minimally invasive therapy are equivalent to or better than surgery at 10 years, says Marie Molnar Hammond of Galil Medical, which makes the Precise Cryoablation System.

"It's a great procedure to add to the ASC," she says. "It's been streamlined — just needle and grid — and can be done in skilled hands in less than an hour and in new hands in an hour-and-a-half. Further, it's going to be the second-highest-paid procedure in the ASC. It's not going to be an incredibly high-volume procedure, maybe one to two a week. But for ASCs already doing urology procedures, or for multi-specialties looking to increase OR utilization, this is a great procedure to add."

Mr. Shea says cryoablation is worth considering, as



"if you have a patient in which the tumor is so aggressive, you didn't get to kill 100 percent of the cancer cells in the gland, you can go in and re-freeze. You can't do another surgery, can't put the patient through another round of radiation."

As a result, he says, it is "becoming the gold standard for failed radiation of the prostate, especially economically. Intensity-modulated radiation therapy, which is the latest and greatest that the oncologists and urologists are doing, can go to $60,000 or $80,000; cryoablation is about $6,500 to $6,800. It's very cost-effective as opposed to robotics."

Ms. Molnar Hammond estimates that costs run about $4,000 per procedure. An external company employed by Galil to determine 2007 ASC benchmarks found that the average income to the bottom line after all expenses is about $232 per procedure; for cryoablation, that figure ranges anywhere from $900 to $1,800.

"It took a big bump and now has a pretty hefty reimbursement. But right now, because of the disposable costs, we don't feel the margins are going to be particularly strong," says Dr. Klimberg.

It's another case of wait-for-full-implementation, says Mr. Shea: "It's going to ramp up more. We have signed out with a number of centers, and with the efficient physicians doing two or three a day, the ASC makes a margin of $2,000 to $3,000 per case at an hour per case. It's only going to get better." ■

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Options for Adding Complex Urology Procedures

There are two business models for adding the procedures requiring a laser or extracorporeal shockwave lithotripter: invest in buying the capital equipment and disposables, and hiring a tech — or contract with a mobile service provider that brings the equipment, disposables and tech to your facility.

Volume is key to being able to afford the former model; if your facility is going to have lower volumes of EWSL, laser kidney stone or laser BPH procedures, however, you might want to go the latter route.

"We service the average facility twice a month, typically doing five cases per visit, though we can do as many as 15 in a day," says Jorgen Madsen, president and CEO of United Medical Systems in Westborough, Mass. "If a center has three or four urologists, you're doing pretty well, and that number will bring 120 EWSL cases a year. You probably need 500 cases a year for buying your own unit to make sense."

The machines themselves cost $150,000 to $500,000, and with disposables running into the several thousands per case, you might not be able to purchase enough to get the best volume price, as a turnkey mobile service provider might. Further, the machines themselves are large, and in a multi-specialty center that doesn't have a dedicated urology room, moving and storing the equipment might be a challenge for an ASC.

"A single surgery center may be hard-pressed to bring all those elements together," says Mike Shea, the president and CEO of Treasure Coast Management Group in Vero Beach, Fla. "Using a mobile service provider makes a $6,800 case rate profitable, because often the reimbursement would have to be twice that for a surgery center to break even."

Mr. Madsen also points out that investing in the equipment can be risky especially if urologists are utilizers but not owners of the center — at any time, theoretically, they could take their cases elsewhere, leaving you with several thousand dollars' worth of equipment and nothing to do with it.

"There are no real out-of-pocket expenses," says Ira Klimberg, MD, of the Urology Center of Florida in Ocala, Fla. "When you lease a technology in this way, you are just leasing the expenses you would otherwise incur."

— Stephanie Wasek

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Prostate Brachytherapy: 2008 ASC Coding Changes

By Denis Rodriguez, CPC, CCS

Anyone associated with ASCs is aware of the sweeping changes CMS has instituted to the facility payment system. Few specialties or procedures have undergone more changes than prostate brachytherapy.

When coding for prostate brachytherapy, think in terms of coding for each "component" of the procedure. There are several steps of the brachytherapy procedure that are separately reportable, and several supplies and implants now have new codes associated with them.

Procedural components

Prostate brachytherapy involves insertion of needles or catheters through the perineum into the prostate. Once these needles are placed into the desired areas of the prostate, radioactive sources known as seeds are then placed via the needles into the prostate. This is done under imaging guidance.

A urologist will often perform the needle placement portion of the procedure, and a radiation oncologist/radiologist will perform the source implantation. In many cases, one physician will perform the entire procedure. Whether one or two physicians perform the procedure, the facility coder will assign the same CPT codes: 55875 for the needle insertion and 77778 for the source implantation. 77778 is for complex source application, which, according to the Sept. 2005 *CPT Assistant*, is for application of more than 10 sources. Prostate brachytherapy normally involves application of between 40 and 150 sources. According to the code descriptor for 55875, it includes a cystoscopy performed at the same session as brachytherapy.

The non-wage adjusted transitional payment for 2008 is $1377.66 for 55875 and $243 for 77778. This includes the procedural component of the code and the imaging component, which we discuss next.

Imaging components

Imaging is normally performed throughout a prostate brachytherapy session. An ultrasound volume study of the prostate (76873) is often performed perioperatively. Ultrasound guidance for placement of the needles and sources into the prostate (76965) is also performed. Fluoroscopic guidance (77002) is often performed in addition to ultrasound guidance.

While the ultrasound volume study of the prostate, code 76873, is a "separate procedure," it bundles into 77778 per CCI edit rules. This code should therefore not be coded separately and is considered included in 77778.

Ultrasound and fluoroscopic guidance do not bundle into the main procedure codes (55875 and 77778) per CCI edits; however, they are assigned payment indicator N1, which means that their payment is "packaged" into or included in the payment for the main code. When looking at the payment for 55875, we can consider the $1377.66 to include payment for ultrasound and fluoroscopic guidance.

We know that bundled codes should not be separately reported on a claim, but what about packaged codes? According to CMS, packaged codes should not be listed separately on a claim. However, the charge for the packaged code should be added to the charge for the main procedure on the same line item.

For example, let's say your facility charges $5,500 for code 55875 and $600 for code 76965-TC. There would be no separate line item for code 76965-TC

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on the claim; however, the charge of $600 would be added to the charge for 55875. Therefore, the 55875 line item charge would be $6,100 instead of $5,500.

Commercial payors have typically not yet incorporated the packaging concept for ASCs, and a separate payment for 76965-TC may be available, as this code is not bundled into any other brachytherapy procedure.

Supply and source components

As stated earlier, brachytherapy involves the use of needles and radioactive sources. This year, ASCs can use HCPCS Level II C codes associated with these materials. These C codes were previously restricted to hospital outpatient departments paid through the outpatient prospective payment system.

Needles used in brachytherapy can be coded using C1715. C1715 is reported per needle, not per procedure. Code C1715 has an N1 payment indicator and its payment is packaged into the main procedure code 55875.

Brachytherapy sources should be coded to the appropriate C code as shown in the table below. Two codes have been developed for sources that do not yet have a HCPCS code assigned: C2698 for stranded sources and C2699 for non-stranded sources. Make sure you only use these codes for sources that are FDA-approved and marketed and that consist of a radioactive isotope consistent with CMS's definition of a brachytherapy source eligible for separate payment, as discussed in the Nov. 24, 2006 final rule (71 FR 68113).

HCPCS Code	Descriptor
C2638	Brachytherapy source, stranded, Iodine-125, per source
C2639	Brachytherapy source, non-stranded, Iodine-125, per source
C2640	Brachytherapy source, stranded, Palladium-103, per source
C2641	Brachytherapy source, non-stranded, Palladium-103, per source
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source

When coding for brachytherapy sources, you should enter the total number of units prescribed and acquired for the beneficiary on the line item for the appropriate HCPCS code. For stranded sources it is important to code per source and not per strand.

But what if most, but not all, of the sources acquired for a patient are implanted into that patient? Medicare will cover the few brachytherapy sources that were not implanted in the following circumstances:

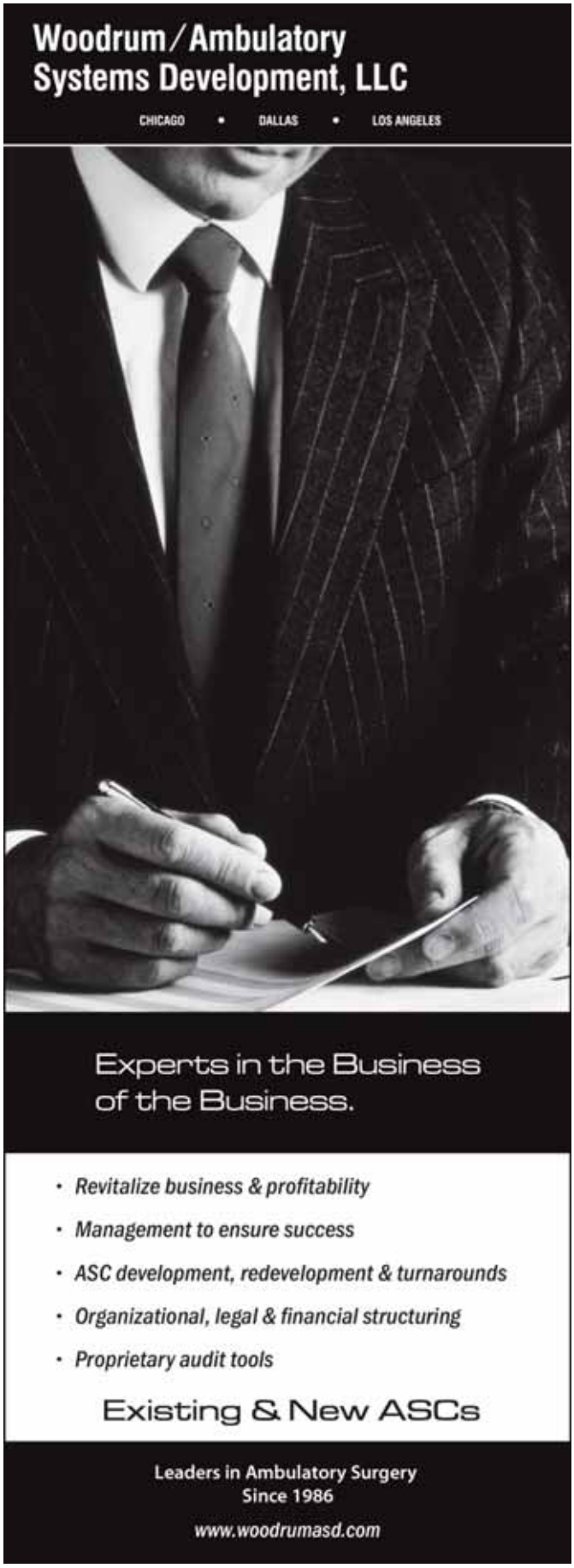
1. The sources were specifically acquired by the ASC for the particular beneficiary according to a physician's prescription that was consistent with standard clinical practice and high-quality brachytherapy treatment.
2. The sources that were not implanted in that beneficiary were not implanted in any other patient.
3. The sources that were not implanted were disposed of in accordance with all appropriate requirements for their handling.
4. The number of sources used in the care of the beneficiary — but not implanted — would be expected to constitute a small fraction of the sources actually implanted in the beneficiary.

If these circumstances are not present, then it would not be appropriate to bill Medicare for the non-implanted sources. Commercial payors may have different guidelines for billing non-implanted sources.

Medicare payment for brachytherapy sources is at contractor-priced rates.

Associated procedures

There are other procedures associated with brachytherapy that you may code in addition to those already described. Computer-generated, three-dimensional reconstruction may be used for brachytherapy. Documentation is required with three-dimensional reconstruction and dose distribution. The scan images used for computer data entry should be based on three-dimensional depictions of the implanted site. The source positions may be digitized directly from these images



or the three-dimensional reconstruction, and the tumor volume and normal tissue image may be merged electronically. Code 77295 can be used to report this at a non-wage adjusted transitional payment of $561.48 for 2008. Please note that simple three-dimensional representations by treatment planning computer programs derived from planar radiographic images are not sufficient justification for the use of this code.

When you perform basic dosimetry calculation during brachytherapy (the determination of dwell times other than those times estimated in the isodose plan), you can report code 77300 (transitional payment of $44.18). You should include the treating physician's prescription, as well as documentation of the calculation, in the patient's chart.

Coding for brachytherapy can be challenging. Breaking the coding down to manageable components will help you to get the most for each procedure while ensuring correct coding and compliance. ■

*Mr. Rodriguez (**denis.rodriguez@email.com**) is a senior ASC coder and compliance auditor for The Coding Network, the country's largest specialty-driven coding and auditing company. For more information, visit **www.codingnetwork.com**.*

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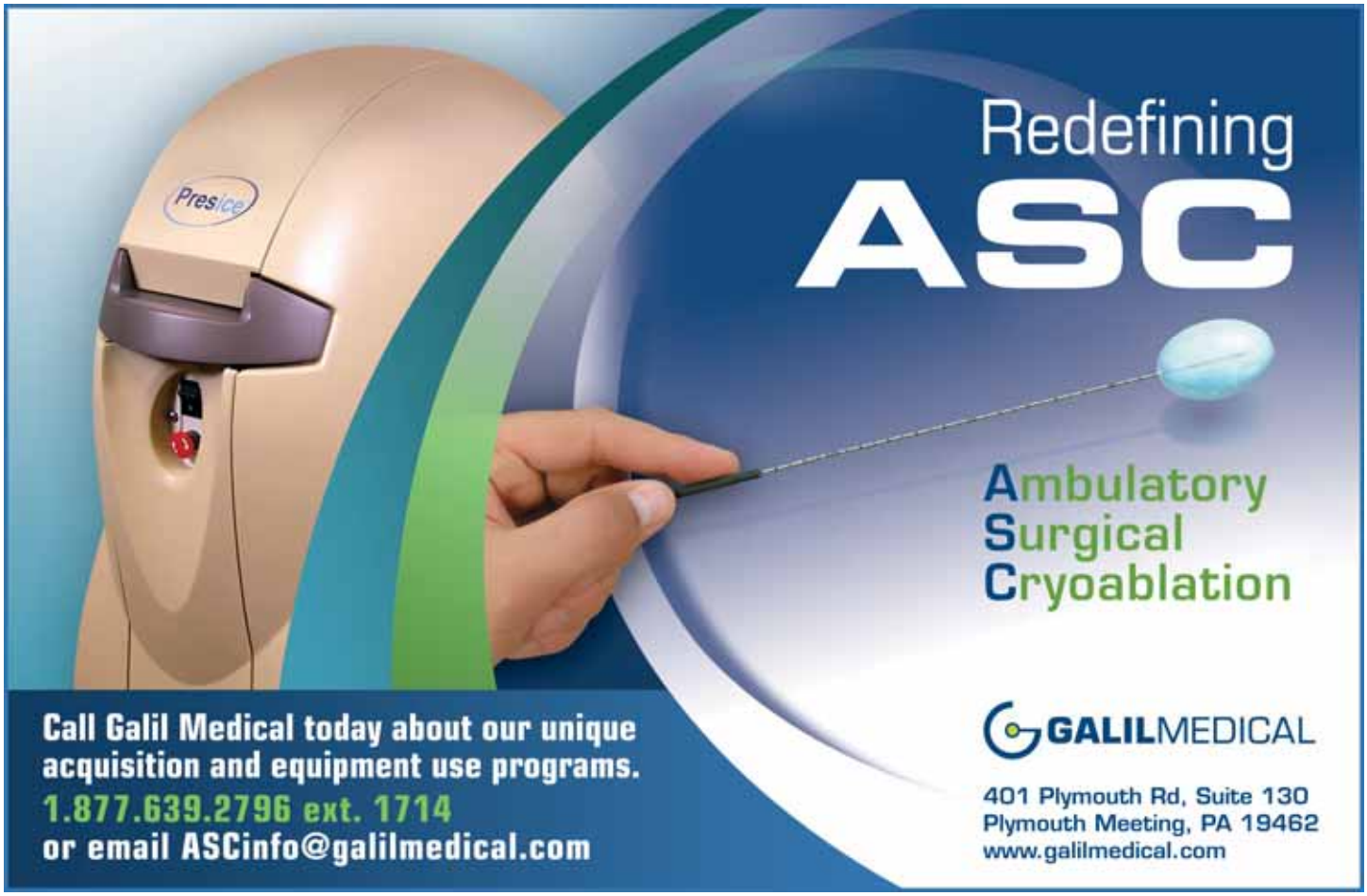

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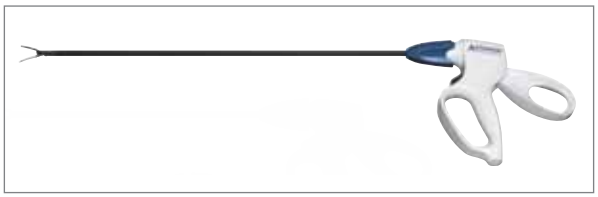

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Four Steps to Profitable Retina in the ASC

By Stephanie Wasek

Unlike cataracts, retina procedures are not ideally suited for the ASC: They can be unpredictable, time-consuming and expensive in terms of supplies and equipment. But the Medicare ASC payment system's increased reimbursement for these cases makes them an intriguing possibility at the very least. Here's what you need to know to add retina as a profit line in your surgery center.

Explore costs

The minimum you can expect to spend on retina equipment is $125,000, according to Scott Baratta of Ascent Health Care Advisors in a presentation at ASCs 2008 in San Antonio in May. He breaks down the capital costs like this:

• $50,000 for the average refurbished posterior segment vitrectomy machine, including light source;
• $25,000 for the necessary microscope modification (for faster turnover, you may want to do this to two microscopes);

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"You can easily be at $240,000 on capital costs [for retina] without blinking an eye," says Steven R. Blom, RN, MAHSM, CASC, administrator of the Specialty Surgery Center in San Antonio, Texas. To test out a retina program, "we're renting some of the equipment for a while. If it doesn't work out, then the cataract surgeons will have a fancy microscope."

Further, says Mr. Blom, supply costs are "terribly high — retina uses more expensive supplies. If you're not careful, you can easily be at supply costs of $750 or $800 and only $1,200 reimbursement.

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When you add in overhead and other costs, it might not be profitable."

Disposable packs containing laser probes, gas and oil will run you at least $320 to $650 per case, says Mr. Baratta.

Look at reimbursements

The reimbursement for five retina codes will increase substantially by 2011, says Don Cook, the founder of Pacific Surgical Partners, based in southern California:

1. 67107 scleral buckling dissection (up 50 percent),
2. 67108 scleral buckling w. vitrectomy (up 24 percent),
3. 67110 injection of air or other gases (previously unlisted),
4. 67112 complex procedure (up 24 percent) and
5. 67113 repair complex retinal detachment (previously unlisted).

"And modifiers will let us get some extra reimbursement, more than covering the cost of doing these procedures," says Mr. Cook. "Most retina procedures are more complicated, yes. But I look at it in terms of reimbursement per surgery center resource. And the gross margin on the cases is comparable to cataract in terms of price per unit of time."

Recruit surgeons

"It's very important to seek active, efficient surgeons," says Brent Lambert, MD, FACS, founder and director of business development for ASCOA. "We don't do retina in most of our eye centers currently, but by 2011, we'll be doing it because the reimbursement will be such that we can make money."

Dr. Lambert recommends asking your eye surgeon partners who the most efficient retina surgeon in the community is.

"Sometimes we get more than one name, but usually there's agreement on two or three extremely efficient surgeons," he says. "We go to them and tell them that our surgeons are saying they are excellent, and ask if they would like to join us to at least try using our ASC for retina for a while. If we ask, 'How long does it take you to perform membrane stripping?' and the surgeon says 30 minutes, we bring them on now. If they say an hour, we tell them we're ramping up, and that we'd love to talk to them again in January."

Put it into practice

Once you've got your efficient surgeons, it's time to actually give it a go in the ASC and see how the retina program would actually work.

"You want to have the same types of cases bunched up in one day or one block, so you're not flipping the room for different types of cases," says Mr. Cook. "The volume looks as if it's out there, so we have high hopes we can do that. Especially because profitability of retina is dependent on efficiency of the cases, you have to push to collect the cases in

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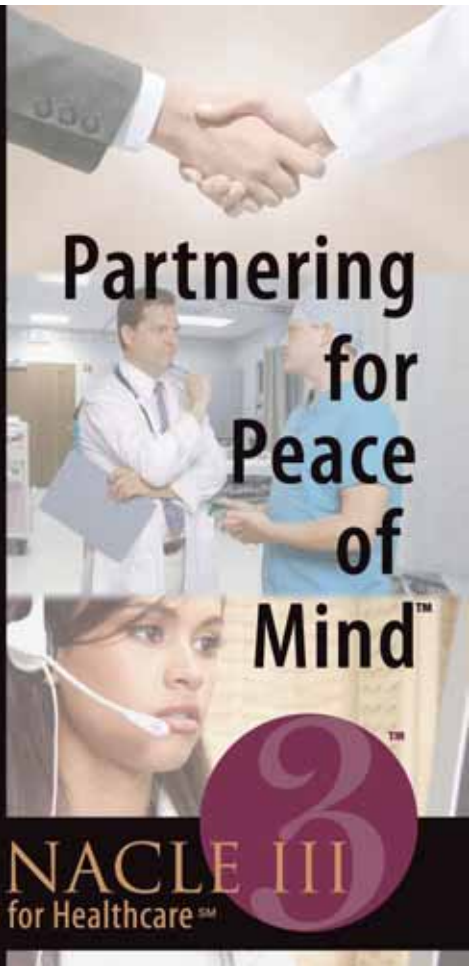

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the most efficient scheduling categories so you can provide the right staff, right instruments and fast turnover."

Because cataracts are the bread and butter of ophthalmology, and it's necessary to keep those going at a rapid-fire pace, you don't want to stop one guy from working two rooms and slow him down in order to bring in a retina case. But that's one of the challenges provided by retina: Cases are often emergent in nature.

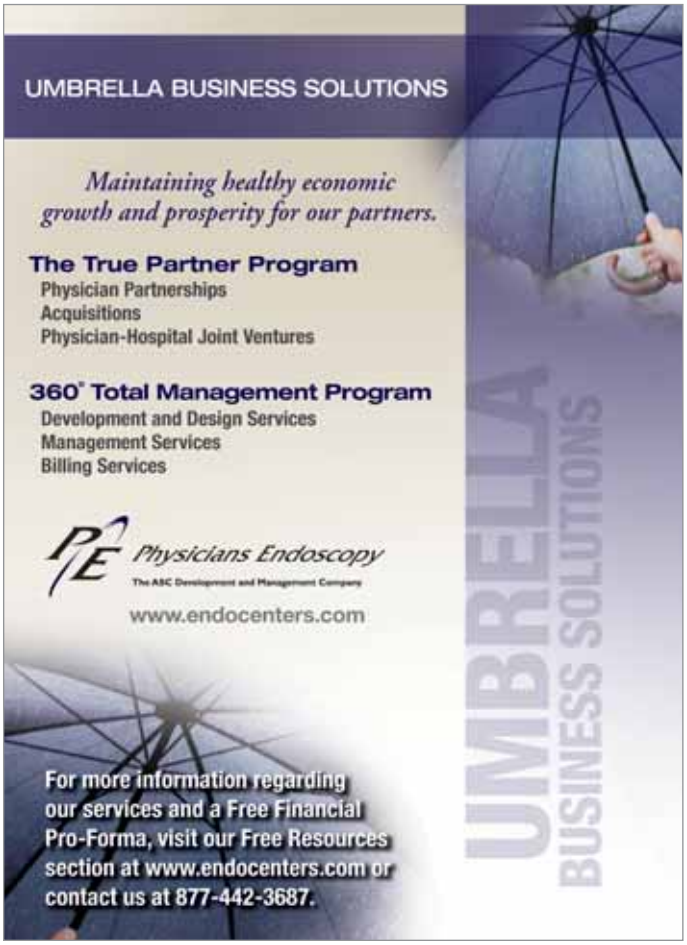
"Typically, the center is busy with ENT cases in the mornings and cataracts in the afternoon," says Mr. Blom. "You have to be careful with longer cases or you could end up sitting there doing retina cases at 6, 7, 8 at night, running staff on OT and losing money."

Mr. Blom's center has five ORs. Four of the five are used daily and are near capacity five days a week; the fifth was running at about 20 percent capacity, so it "made sense to invite four retina surgeons to the ASC Monday through Thursday and let them utilize the available time to test the potential profitability."

However, he was up front with the surgeons about limitations to ensure his center doesn't run into a money-losing situation, such as the one described above.

"There are no on-call teams and the center isn't open on weekends," says Mr. Blom. "If they have a case at 3 p.m. or 4 p.m., we'll tack it on. If they have an 'emergent' situation in the office, we have a loose agreement with the cataract surgeons, who are often their referral sources, to use one of the two ORs they may be working out of. But they can't call me at 8 p.m. and tell me I have to open the center up. There are some retina physicians who aren't willing to work here because of this arrangement. That's fine. But some physicians say they don't really do that much emergency work, so they're happy to bring their non-emergent cases to the ASC." ■

Contact Stephanie Wasek at ***stephanie@beckersasc.com****.*



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Per Click and Ophthalmologist – Vendor Payment Arrangements

By Scott Becker, JD, CPA

This article describes a situation in which an ASC pays a physician such as an ophthalmologist as a supplier on a per-case or per-click basis for disposables, equipment and other items needed for surgery; the ophthalmologist then performs procedures at the ASC. This type of arrangement is fairly uncommon and, further, we believe it raises very significant legal concerns under the Stark Act and the Medicare Medicaid Anti-Kickback Fraud and Abuse Statute (the Anti-Kickback Statute).

I. Per-click arrangements

1. Stark Act commentary on per-click arrangements. The government has articulated substantial concerns with per-click arrangements during the past 12 to 18 months in its commentary to the Stark Act. For example, it stated: "After reconsidering the issue, we are proposing that space and equipment leases may not include unit-of-service-based payments to a physician lessor for services rendered by an entity lessee to patients who are referred by a physician lessor to an entity. We believe that such arrangements are inherently susceptible to abuse because the physician lessor has an incentive to profit from referring a higher volume of patients to the lessee, and we would disallow such per-click payments, using our authority under section 1877(e)(1) of the [Social Security] Act, even if the statute does not expressly forbid per-click payments to a lessor for patient referred to the lessee."[1]

2. No safe harbor for per-click arrangements. Under the Anti-Kickback Statute, there is no safe harbor that permits per-click arrangements. Further, consulting agreements must also be structured to be fixed per arrangement. The Anti-Kickback Statute safe harbor basically states that all rental charges for arrangements, aside from being reasonably necessary and consistent with fair market value, must be set in advance, the lease must be commercially reasonable and it must not be determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. This type of arrangement would not meet these tests and thus, it would not meet a safe harbor. Moreover, it is the type of arrangement that is suspect.

In order to meet the "equipment rental" safe harbor, the arrangement must meet the following six standards:

(c) Equipment rental. As used in [the Social Security Act], "remuneration" does not include any payment made by a lessee of equipment to the lessor of the equipment for the use of the equipment, as long as all of the following six standards are met —

(1) The lease agreement is set out in writing and signed by the parties.

(2) The lease covers all of the equipment leased between the parties for the term of the lease and specifies the equipment covered by the lease.

(3) If the lease is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such interval.

(4) The term of the lease is for not less than one year.

(5) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner

that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or all other Federal health care programs.

(6) The aggregate equipment rental does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

Note that for purposes of paragraph (c) of this section, the term fair market value means that the value of the equipment when obtained from a manufacturer or professional distributor, but shall not be adjusted to reflect the additional value one party (either the prospective lessee or lessor) would attribute to the equipment as a result of its proximity or convenience to sources of referrals or business otherwise generated for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.[2]

In order to meet the "personal services and management contracts" safe harbor, the arrangement must meet the following seven standards:

(d) Personal services and management contracts. As used in [the Social Security Act], "remuneration" does not include any payment made by a principal to an agent as compensation for the services of the agent, as long as all of the following seven standards are met —

(1) The agency agreement is set out in writing and signed by the parties.

(2) The agency agreement covers all of the services the agent provides to the principal for the term of the agreement and specifies the services to be provided by the agent.

(3) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.

(4) The term of the agreement is for not less than one year.

(5) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.

(6) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

(7) The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

For purposes of paragraph (d) of this section, an agent of a principal is any person, other than a bona fide employee of the principal, who has an agreement to perform services for, or on behalf of, the principal.[3]

3. Anti-kickback cases — large and small. There have been several cases over the last few years in which the government has incarcerated individuals or otherwise prosecuted them for what appeared to be relatively small amounts of money, which the government alleged such individuals fraudulently obtained. For example, in *U.S. v. Goss*, a lease case in Ohio, the lessor was being paid on a lease basis for services that were not really necessary in exchange for providing referrals to the lessee. Although the physician only received four hundred dollars under this lease, the physician nonetheless went to prison for a period of time.[4]

Additionally, in *U.S. v. Kats*, an owner of a medical clinic was prosecuted for accepting payments from a medical laboratory.[5] Kats claimed these were payments for drawing blood and preparing the sample for shipment to the laboratory. The prosecutor alleged that this payment was also an inducement to use the laboratory, and, therefore, it was an illegal arrangement. The court rejected Kats' argument, stating that a "'kickback' also includes a payment for granting assistance to one in a position to control a source of income, unless such payment is wholly and not incidentally attributable to the delivery of goods or services." This ruling made it clear that the

prohibited conduct was any payment that encouraged a referral, irrespective of whether the physician receiving the payment provided goods or services in return.[6]

The case law has always held that if any one purpose of a payment is to induce referrals then such a payment is considered illegal under the Anti-Kickback Statute.

There have also been several other recent Federal cases and investigations relating to the payment of money in exchange for referrals. The Federal government has repeatedly indicated that these types of per-click arrangements are susceptible to abuse and are therefore problematic, highly suspect arrangements.

II. Physician/vendor kickback arrangements

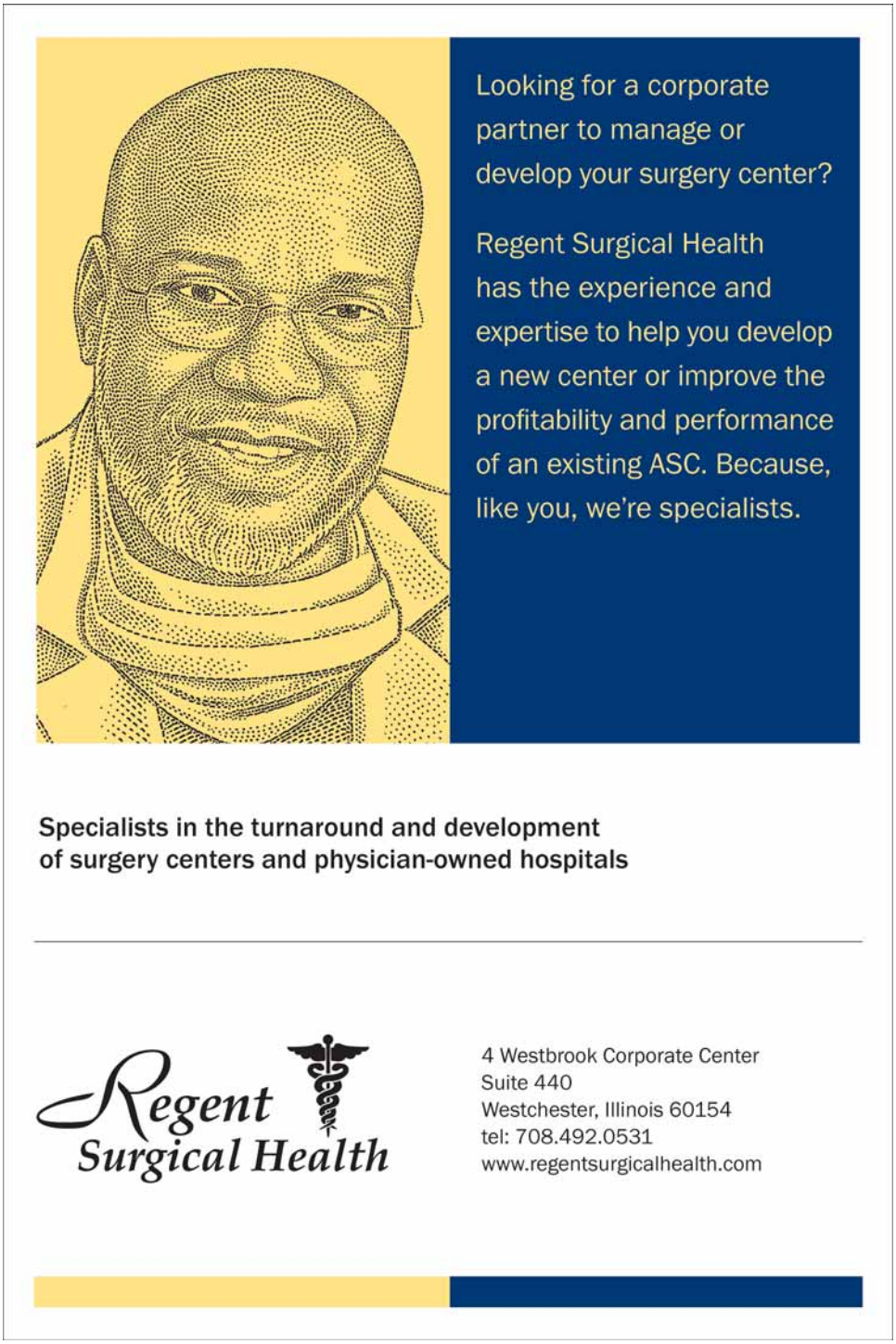
This article also discusses a situation in which a physician performing procedures as an ASC enters into an agreement with a third-party provider of cataract outsourcing services. Per the agreement, the physician receives a fee from the vendor for each case performed in which the vendor's disposables, equipment or other services are used by the ASC. There are situations in which a physician performing procedures at the ASC has an ownership interest in a vendor. These types of arrangements are also uncommon, and create significant legal risk under the Anti-Kickback Statute.

As described above, arrangements in which a physician receives remuneration based upon the volume of referrals in return for purchasing items or services directly, or influencing the purchasing decisions of an organization, for items or services reimbursable by a federal healthcare program are inherently susceptible to abuse. A physician who receives a per-procedure fee from a vendor providing items or services reimbursable by Medicare or Medicaid has a financial incentive to use products or services of such vendor even if they do not represent the most cost-effective option. A physician who has an equity interest in a vendor often has an identical financial incentive. These types of relationships between vendors and physicians are at the core of an existing and lengthy investigation of relationships (and settlements) between orthopedic device companies with orthopedic surgeons.

Furthermore, such referrals do not qualify for protection under the Anti-Kickback Statute safe harbor, and the OIG's guidance suggests that vendors should consider the following factors indicative of a federal Anti-Kickback Statute violation when determining whether to enter into a transaction with physicians: (i) might an incentive to a physician interfere with his or her clinical decision-making; (ii) is there a potential for increased cost to Federal healthcare programs or beneficiaries; (iii) does the arrangement pose a risk of overutilization or inappropriate utilization; and (iv) does the arrangement raise patient safety or quality concerns?[7] The relationships described above raise all four concerns.

It would be unwise for an ASC or its administrator to disregard the potential fraud and abuse risks associated with the above described problematic relationships. To minimize liability to the ASC and its physicians, the ASC should implement a conflict of interest policy in which physicians and other key employees with purchasing and decision-making authority are required to disclose any financial interest or compensation arrangement they have with vendors and other parties doing business with the ASC. ■

[1] 72 Fed. Reg. 38,183 (July 12, 2007).
[2] 42 C.F.R. § 1001.952(c).
[3] 42 C.F.R. § 1001.952(d).
[4] 96 Fed. Appx. 365, 2004 WL 953926.
[5] U.S. v. Kats, 871 F.2d 105 (9th Cir. 1989).
[6] 871 F.2d 105 (9th Cir. 1989).
[7] Compliance Program Guidance for the Durable Medical Equipment, Prosthetics, Orthotics and Supply Industry, 64 Fed. Reg. 36368 (Jul. 6, 1999).



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12 Reasons to Consider Cataract Outsourcing Services as an Option for Providing Cataract Surgery

By Rob Kurtz

As the Medicare patient base continues to grow, so will the number of instances of cataracts affecting these patients. While Medicare reimbursement for cataract procedures saw small increases with the new payment system, cataract cases are still a potentially solid addition for a surgery center looking to increase profits and case volumes.

The cost of the equipment needed to perform this type of surgery is not inexpensive. ASCs considering equipping themselves with the latest in cataract technology can expect to invest anywhere from $100,000 to $150,000 per OR in capital equipment, such as phacoemulsifiers, microscopes, and instrumentation. In addition to the equipment expenditures, thousands more dollars will be spent in related inventory items such as intraocular lenses, balanced salt solution, viscoelastics, equipment tubing, custom eye packs and other surgical supplies.

However, organizations interested in determining whether cataract surgery can become a profitable addition to their centers can consider soliciting the services of a cataract outsourcing company to alleviate the capital investment and inventory hassles.

This turnkey service can provide an ASC with all of the equipment it needs to perform cataract surgery on a case-by-case basis, customized to meet a center's needs and its surgeons' surgical preferences. A representative from the cataract outsourcing company will bring the requested and required equipment and surgical supplies to the ASC for the scheduled cataract surgery day, and may become part of the surgical team by monitoring the equipment, handling inventory needs and assisting with room turnover in between cases. Once surgeries are completed, the representative loads up the equipment and the excess supplies and then leaves the ASC. Cataract outsourcing companies that offer this service may provide other benefits as well.

So might a mobile cataract service be right for your ASC?

Ann Deters, co-founder of Vantage Technology, a cataract outsourcing service based in Effingham, Ill. and serving both urban and rural facilities in 19 states, says that "many of the company's clients are not just new organizations considering whether cataract surgery is a wise addition to their surgery schedule, but rather they are high-volume centers that have been doing cataract procedures for years and are looking to upgrade equipment, lower costs, and/or increase efficiencies. Time and time again, we have proven to these types of clients how cataract outsourcing saves them money, improves their profits and eliminates a lot of their hassles with eye equipment and inventory."

Ms. Deters shared the following 12 benefits — for centers considering cataract surgery and more mature centers performing ophthalmology — of working with a cataract outsourcing company:

1. No capital investment. One of the biggest barriers for centers considering adding any new specialty is the investment of significant capital to obtain the equipment necessary to perform the new cases, assuming such capital is even available. With cataract outsourcing, as long as you have an operating room and an ophthalmologist who can perform cataract surgery, you can perform the procedures without investing a dime in purchasing equipment.

"It's a great way to test the market risk-free," Ms. Deters says. "You don't have the outlay of the equipment upfront, plus you don't have the on-going maintenance contracts, repair costs and replacement expenditures."

2. No inventory. The added investment and work needed to maintain a proper inventory can be another deterrent for ASCs considering adding cataract services. With a mobile cataract services company, this factor becomes a non-issue.

"It's just-in-time inventory with no ordering headaches; you call in with the number of cases you have scheduled, you pay for the product and service as you use it. There's no obsolescence, no inventory storage, there's no last minute shipping and no need to stress about having the right supplies on hand," Ms. Deters says.

If there is any concern about physicians potentially leaving an ASC, using cataract outsourcing can eliminate the stress and expense of having unused inventory and equipment.

3. Physician-preference flexibility. If your ASC employs several ophthalmologists or is considering bringing in several physicians to perform cataract cases, keeping them all happy with the right equipment they desire can certainly prove challenging (and expensive). With cataract outsourcing services, you tell the company what your physicians want and it's delivered, although there still are benefits to standardization even with the service.

"We work with a facility to determine how standardization between doctors can save money; but if the physicians have their own preference, we work with that as

well," Ms. Deters says. "We are able to address the needs of multiple equipment and disposable requirements."

4. Latest technology. A physician may request, and expect, to use new technology for their cases, which can be frustrating for a center that has invested significantly in what the physician now views as outdated equipment. To keep their clients pleased with their services and meet their needs, cataract outsourcing companies will stay abreast of and stock the latest technology.

5. Group purchasing savings. Vantage solicits the services of group purchasing organizations to save money on the bulk equipment and inventory it purchases for its many service locations, enabling case costs to be lower for their clients.

6. "Extra-hand" assistance. Some cataract outsourcing companies train their representatives who deliver the equipment to assist their clients. In Vantage's case, this trained and certified technician performs a number of tasks, including monitoring the equipment for the doctor during procedures, performing IOL management and helping with room turnover.

"Our technicians are fully trained; they are put through extensive training on equipment and OR procedures," Ms. Deters says.

7. Overall savings. All of the benefits described thus far can add up to savings for an organization. In a recent analysis of a prospective client performing 1,500 cataract cases annually, Ms. Deters calculated that Vantage could save the organization money in the following areas (with estimated additional cost for performing in-house in parentheses):

- soft costs, such as software upgrades, repairs and shipping of disposables and IOLs ($25 to $30 per case);
- capital costs, for the use of phacoemulification equipment (around $25 to $30 per case); and
- labor, in terms of room turnover, equipment monitoring, inventory ordering, and IOL management ($10 to $15 per case).

The fees for Vantage's services range from $250 to $700 per case, depending on facility and surgeon needs.

8. Cash-flow bonus. Many of the cataract patients you may or already treat are likely insured by Medicare. Since Medicare requires electronic billing, you would likely bill for services rendered the day of or day after the procedure on the Medicare patient. Medicare reimburses within 14 days of filing the claim. If you contracted for Vantage's services, you gain 15 days of free cash flow, as you would not be required to pay for the service for 30 days.

9. More efficient scheduling. Vantage requires the facility to schedule at least a stated case minimum for the day of surgery. This should not prove difficult for organizations because cataracts are not an emergency procedure and, thus, you can schedule them together and on a day that best suits your organization's and physician's schedule. Grouping procedures significantly improves efficiencies in scheduling and staffing, as well as OR utilization, thus improving profitability for the organization.

10. Attract new investors. If you identify a physician — or group of physicians — who would like to perform cataract surgery in your area, you can offer them the use of your ASC to perform their cases while providing the equipment they desire. If this ophthalmologist starts to perform a significant number of procedures and volume builds up, you will have the opportunity to approach this physician to inquire about interest in becoming a new physician-investor.

"Eyes are profitable for our clients," Ms. Deters says. "For facilities that have never performed eye procedures, we've been very successful in finding ophthalmologists for such facilities." Partnering with a cataract outsourcing service in this situation may be ideal and can lead to increased cases and profits for such ASCs.

"Our facilities often offer ownership to these ophthalmic users, thus, making it a win-win situation for both the facility and the ophthalmologist," Ms. Deters says.

11. Fully compliant. From a regulatory perspective, you would want your cataract outsourcing services to be fully compliant with the anti-kickback statute, as the physicians at the organization should not have ownership in the company or receive remuneration for using the service.

In addition to being anti-kickback compliant, look for your cataract outsourcing company to address any other regulatory concerns. Vantage, for example, maintains all necessary records for its clients, including documentation necessary to meet Medicare and the Joint Commission requirements, and provides paperwork about its technicians and their training and certifications.

12. Only pay when service is used. Quite simply, you pay for the product and service as only when you use it, and if you don't use it, you pay nothing. So if a cataract surgery experiment reveals that the procedures would not make a worthwhile addition to a center, there is little harm done — eliminating the risk and fixed costs associated with owning your own equipment, Ms. Deters says.

Developing cataract surgery in-house

While there are numerous benefits to cataract outsourcing services, not all ASCs are jumping at the opportunity to use such a service, including one organization that has worked to develop efficiency and cost-effective practices.

Springhill Surgery Center in North Little Rock, Ark., uses consignment purchasing to manage its IOL inventory and keep expenses low, says Laura Gusewelle, RN, clinical manager for Springhill.

"We don't pay for them until we use them, and then we immediately turn around and bill for our patients since most of them are Medicare," she says.

The center is profiting by the use of a new technology IOL that's intended to decrease the reformation of a cataract.

"Medicare actually reimburses us an additional $50 over the cost of the lens, so supply and utilization-wise, I couldn't see paying someone to do that business for me when it's really not costing me anything to do it," Ms. Gusewelle says.

The organization has also worked to standardize the practices of its ophthalmologists, which perform approximately 15 cataract procedures per week, Ms. Gusewelle says. The only differences between the physicians are their techniques and preferred instrument technicians. The standardization has allowed the organization to recently purchase a new phacoemulsification machine for $65,000 by knowing in advance that its physicians would both appreciate and use it.

"We did a cost-benefit analysis as to how many cases and what period of time it would take to pay for the purchase of that machine, which we were able to capitalize as equipment on our budget anyway," Ms. Gusewelle says.

She recognizes the fact that not all organizations are in a position to invest in such significant capital, and the cataract outsourcing services would be an appealing option.

"Maybe some places don't have the volume that we have to be able to finance that phacoemulsification machine, but for us it was a good business decision," she says.

Ms. Deters recognizes that, for some centers, the benefits of cataract outsourcing services may not be as evident. But she feels confident that the service can offer great benefits which would make it worthwhile for any organization when considering all costs.

"Even at the higher volume, we can find savings in soft costs and equipment and often still come in lower than what they can do in-house," Ms. Deters says. ■

Contact Rob Kurtz at ***rob@beckersasc.com.***

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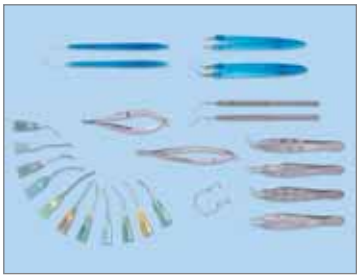

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127 People to Know in the ASC Industry

By Scott Becker, JD, CPA

Sami S. Abbasi. Sami Abbasi leads National Surgical Care as its chairman and CEO. Before National Surgical Care, Mr. Abbasi served as president and CEO of Radiologix, a leading national provider of diagnostic imaging services.

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

Clifford G. Adlerz. Clifford Adlerz has served as president of Symbion since May 2002 and as the COO and a director of Symbion since its inception. Before co-founding Symbion, Mr. Adlerz served as division vice president of HCA (formerly Columbia/HCA Healthcare Corporation) and as a regional vice president for HealthTrust.

David Ayers. David Ayers is the president of the surgical facilities division of Nueterra Healthcare. Mr. Ayers brings 20 years' experience in developing, building and managing ambulatory facilities including surgery, imaging, physical therapy and urgent care centers.

Tim Bogardus. Tim Bogardus is the director of ASCs for Community Health Systems, where he works with the 13 joint-ventured ASCs and oversees the start-up process for new centers and feasibility studies for potential projects. Before joining CHS, he served as group vice president for Nuetera Healthcare, where he was responsible for the operations of seven ASCs and surgical hospitals, and has also served as vice president of operations for a start-up ASC company and as administrator for two de novo ASCs.

David "Buddy" F. Bacon, Jr., CPA. Buddy Bacon is the CEO of Meridian Surgical Partners, an acquirer, developer and manager of physician-owned ASCS. Mr. Bacon previously served in roles as CEO and, before that, CFO for Medifax EDI, a healthcare information technology company based in Nashville, Tenn.

Joseph Banno, MD. Dr. Joseph Banno founded the successful Peoria Day Surgery Center and is the current past-chair of the ASC Association. He is driven, smart and a tireless worker on behalf of the ASC industry.

Curtis H. Bernstein, CPA/ABV, CVA, MBA. Curtis Bernstein is a manager at HealthCare Appraisers. His national practice specializes in valuation, transaction advisory, strategic and operational consulting services. He has extensive experience working closely with ASCs, hospital systems, physician groups and other healthcare providers.

Chris Bishop. Chris Bishop is a vice president of business development for Ambulatory Surgical Centers of America, where he currently leverages his extensive experience with surgeon partnerships to develop new ASCs. Before joining ASCOA, he was responsible for developing Smith & Nephew Endoscopy's surgery center sales team and strategy.

Tom Bombardier, MD. Dr. Tom Bombardier is a board-certified ophthalmologist, Ambulatory Surgical Centers of America's COO and one of its three founding principals. Before founding ASCOA, he established the largest ophthalmic practice in western Massachusetts, two ASCs and a regional referral center.

Regina Boore, RN, BSN, MS. Regina Boore is the principal/CEO of Progressive Surgical Solutions. Ms. Boore has more than 25 years of clinical, administrative, teaching and consulting experience in ambulatory surgery.

Brett Brodnax. Brett Brodnax is executive vice president and chief development officer at United Surgical Partners International and has distinguished himself as one of the ASC industry's leading development executives. Due to his leadership, efforts and integrity, Mr. Brodnax has made USPI one of the fastest-growing ambulatory surgical chains, with a portfolio of nearly 100 surgical centers and several surgical hospitals.

Kathy J. Bryant, JD. Kathy Bryant is the president of the ASC Association and leads the activities of the nation's largest ASC membership association. Ms. Bryant also serves as president of the Ambulatory Surgery Foundation.

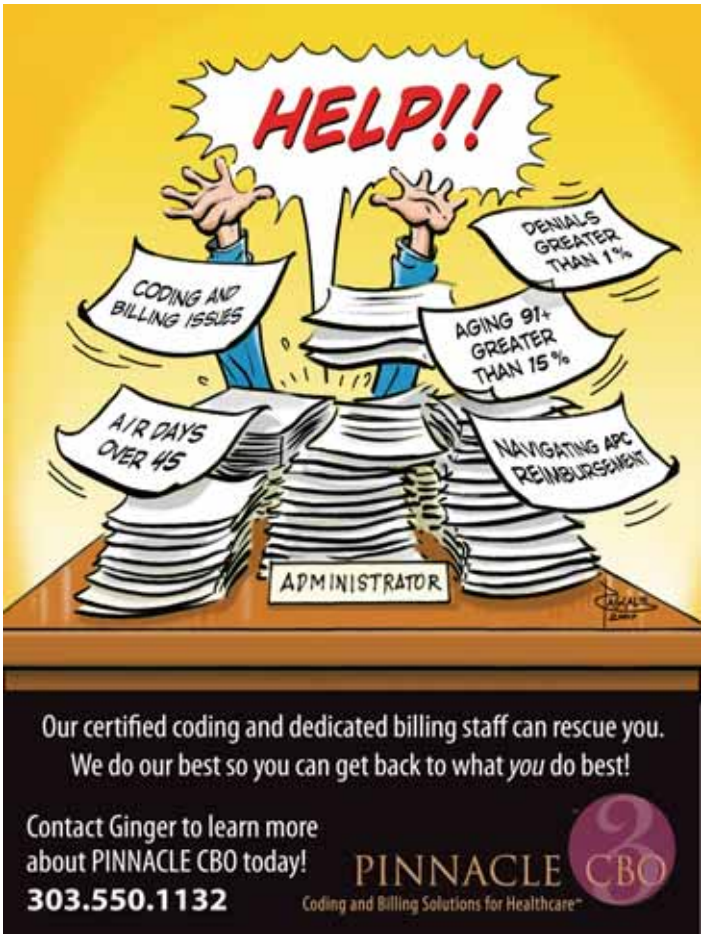
Jason B. Cagle. Jason Cagle is general counsel for United Surgical Partners International. Before joining USPI, Mr. Cagle was in the corporate and securities section at Vinson & Elkins in Dallas.

Robert J. Carrera. Robert Carrera is the president of Pinnacle III. With more than 20 years of healthcare experience, Mr. Carrera has spent the last 15 years developing and managing ASCs, physical/occupational rehabilitation centers, diagnostic imaging facilities, and occupational medicine clinics nationally.

John Caruso, MD. Dr. John Caruso has more than 16 years' neurological surgery experience. Since completing residencies at the Eastern Virginia Graduate School of Medicine and the University of New Mexico, Dr. Caruso has been in private practice with Neurosurgical Specialists in Hagerstown, Md.

Ravi Chopra. Ravi Chopra is the president and CEO of the C/N Group, which is involved in the development of surgery and imaging centers throughout the country. Under his leadership, the C/N Group has completed healthcare-related projects totaling over $80 million in capital expenditures.

Joseph Clark. Joe Clark is the executive vice president and chief development officer of Surgical Care Affiliates. Mr. Clark served as president of HealthSouth's surgery center



division since March 2005. Before joining HealthSouth, he served as president and CEO of HealthMark Partners.

James H. Cobb. James Cobb is the founder, president and CEO of Orion Medical Services. With 37 years in management, Mr. Cobb has primarily focused the last 25 years in the medical field. Mr. Cobb has previously served as CEO for the Pacific Cataract Laser Institute and Pacific Eye Center.

Don Cook. Don Cook is the founder and CEO of Pacific Surgical Partners, an ASC management and development company based in Los Angeles. With more than 20 years' experience in outpatient healthcare management, Mr. Cook has built and operated private and public companies in a number of industries including surgery, cardiology, home infusion therapy and physician practice management.

H. Dodd Crutcher. Dodd Crutcher is the chief investment officer of RMC MedStone Capital. Mr. Crutcher has primary responsibility for sourcing and closing all asset acquisitions and dispositions for the company.

Gregory R. Cunniff. Greg Cunniff is the CFO of National Surgical Care and directs the financial activities of the company, including treasury, budgeting, audit, tax, accounting, information technology, long-range forecasting, risk management and investor relations activities. Mr. Cunniff was previously vice president and treasurer of United Medical Corporation, a privately held for-profit company comprised of hospitals and other healthcare-related properties.

R. Blake Curd, MD. Dr. R. Blake Curd is an upper-extremity and general orthopedics physician with the Orthopedic Institute in Sioux Falls, S.D. Dr. Curd completed his fellowship training at the Indiana Hand Center, the largest freestanding center dedicated to hand and upper-extremity care, research and education in the world.

Philip A. Davidson, MD. Dr. Philip Davidson practices orthopedic surgery in Florida, where he is the founder and CEO of Tampa Bay Specialty Surgery Center. He specializes in cartilage restoration and shoulder surgery, with extensive experience in the area of tissue transplantation, including allografts, xenografts and the use of autologous growth factors.

Richard DeHart. Rick DeHart is the co-founder and CEO of Pinnacle III. He has more than 18 years of experience in the outpatient healthcare industry. Mr. DeHart provides Pinnacle III's clients with expertise in strategic planning, development and management of ASCs, diagnostic imaging and physical rehabilitation services.

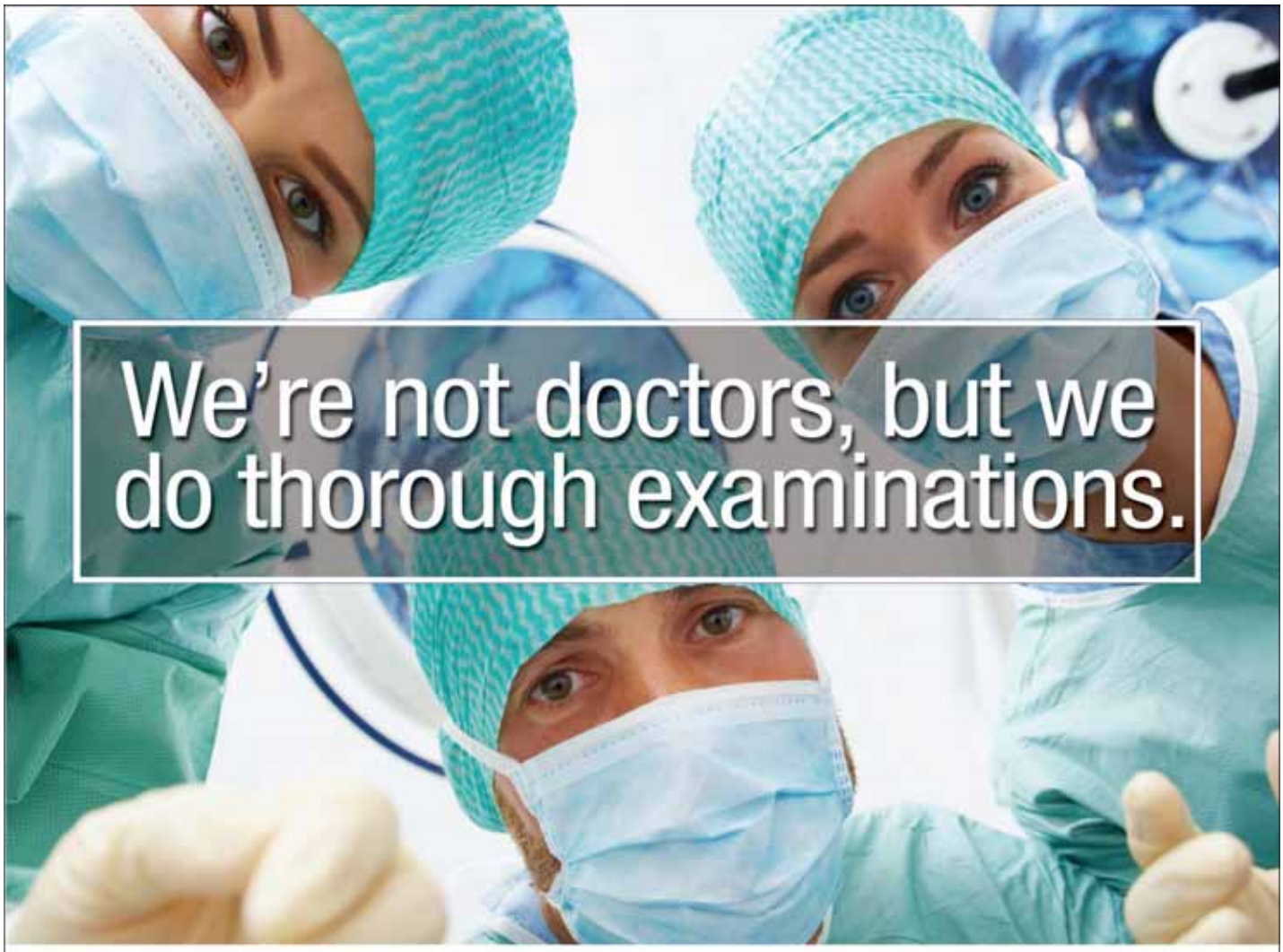
Joyce Deno. Joyce Deno is the COO, eastern region, for Regent Surgical Health. Before joining Regent, she served as the executive director of Loveland Surgery Center in Colorado and worked for HealthSouth as a regional director of quality improvement and as an administrator.

Ann S. Deters, MBA, CPA. Ann Deters is CEO/co-founder of Vantage Technology, providing cataract outsourcing to hospitals and ASCs throughout the lower 48 states for more than 18 years. Ms. Deters has started several healthcare industry ventures (investing or managing ASCs in the Midwest), providing billing services and OpNoter technology to surgery centers.

Steve Dobias. Steve Dobias is a principal with Somerset CPAs. Mr. Dobias's work focuses on providing services for physician groups and hospital systems. Steve initiated the ancillary services group that facilitates the feasibility, organization, funding and set up of operations of ASCs, and medical office buildings.

Stephanie Ellis, RN, CPC. Stephanie Ellis is the president of Ellis Medical Consulting. EMC is a healthcare consulting firm providing chart audits for coding and documentation issues, business office operational assessments, research of coverage issues, litigation support, reimbursement research, ASC and physician coding/billing training, and the development and implementation of billing compliance programs for healthcare providers.

Judith English. Judie English is a senior vice president with Serbin Surgery Center Billing. She has done a tremendous job of helping Caryl Serbin, RN, BSN, LHRM, to grow the company considerably to where it has more than $25 million in collected revenues related to it per year.



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Peter Fatianow. Peter Fatianow is the director of mergers and acquisitions for Health Inventures. He began his career on Wall Street at Credit Suisse First Boston in New York in healthcare investment banking. Mr. Fatianow has worked on dozens of domestic and international transactions worth billions of dollars.

Richard E. Francis, Jr. As president, chairman of the board, CEO and a director of Symbion, Richard Francis has helped transform Symbion into one of the country's leading ASC management and development firms. Under his leadership, Symbion has become a publicly held company and grown to nearly 100 successful ASCs.

Tom N. Galouzis MD, FACS. Dr. Tom Galouzis is president and CEO of the Nikitis Resource Group. Dr Galouzis is a practicing general surgeon in northwest Indiana and previously served as associate staff in the department of surgery as a clinical instructor of surgery at the University of Chicago Pritzker School of Medicine.

Nap Gary. Nap Gary is the president, eastern region for Regent Surgical Health. Mr. Gary has worked in the healthcare industry for 23 years. He previously served as senior vice president and assistant corporate counsel for HealthSouth.

Ann Geier, RN, MS, CNOR, CASC. Ms. Geier has been a perioperative nurse for 30 years. She is currently a vice president of operations for Ambulatory Surgical Centers of America with responsibility for ASCs in New England and Florida. For the last 20 years, her focus has been ambulatory surgery, primarily freestanding ASCs.

David S. George, MD. Dr. David George is an ophthalmologist at the Eye MDs (of George, Strickler and Lazer). He specializes in topical cataract surgery, glaucoma and diabetic eye care. Dr. George is a member of the board of directors for the ASC Association and the Outpatient Ophthalmic Surgery Society.

Brett Gosney. Brett Gosney is a founder and CEO of the first physician-owned hospital in Colorado, the Animas Surgical Hospital. He is the vice president and president-elect of Physician Hospitals of America. He helped lead the efforts to develop the hospital and fought through a wide range of local and state battles and handled a number of efforts to help make the hospital a terrific contributor to healthcare services in the Durango, Colo. community.

George Goodwin. As director and vice president of mergers and acquisitions of Symbion, Mr. Goodwin has stepped into a leadership spot over the last several years. He is extremely bright and has done a terrific job of handling the acquisitions and mergers of so many different providers at Symbion.

Russ Greene, RN. Russ Greene has more than 28 years' experience in surgery, hospital and ASC management, and consulting services, including more than three years as COO of U.S. Orthopedics and one year as vice president of operations for National Surgical Hospitals. He is currently the CEO of Physicians' Surgery Center in Fayetteville, Ark., which performs more complicated spine surgeries, orthopedics, pain management and podiatry; the facility is converting to a specialty hospital.

Michael Guarino. Michael Guarino has been in the surgery center business for more than a decade; an accountant by trade (and former IRS employee), he has been successful in working the day-to-day operations of ASCs, along with long-term planning. Mr. Guarino currently serves as president of Florida Society of Ambulatory Surgical Centers and as a board member of the ASC Association.

James T. Grant. Jim Grant is the COO of National Surgical Hospitals and the past-president of Physician Hospitals of America. In his role as PHA's president, he has overseen a nearly five-year battle to prevent limits and prohibitions on physician ownership of specialty and surgical hospitals.

David Hall. David Hall has a long and successful career as a healthcare innovator and businessman. Currently he is chairman at Titan Health, an ASC management company; director of Radiant Research, a clinical trials company; and director of Cogent Healthcare, a hospitalist staffing company.

Thomas S. Hall. Thomas Hall has served as president and CEO of NovaMed and has been a member of its board of directors for several years. Mr. Hall previously served as president and COO of Matria Healthcare, after having joined Matria in Oct. 2002 as executive vice president and COO.

Kenneth N. Hancock. Kenny Hancock is the president and chief development officer of Meridian Surgical Partners. He has more than 20 years of experience in the healthcare industry developing ASCs and surgical hospitals, and recruiting and building relationships with physicians.

Richard Hanley. Richard Hanley is the CEO and founder of Health Inventures. Mr. Hanley has held leadership positions at Health Inventures for the past 20 years and has been instrumental in creating more than 100 successful outpatient ventures. He is a leading national advocate for ASCs.

Andrew Hayek. Andrew Hayek is the new president and CEO of Surgical Care Affiliates, which operates more than 130 ASCs and surgical hospitals nationwide. Before joining SCA on May 1, Mr. Hayek most recently served as president of VillageHealth, an insurance and care management company owned by DaVita, the nation's leading independent provider of kidney dialysis services.

Allen D. Hecht, MBA. Allen Hecht is president of Health Resources International, which is engaged in developing ambulatory care programs in new and emerging markets. Mr. Hecht formerly served as executive vice president and COO of the ASC Network, a national surgical center company formed as a result of a merger between SunSurgery and Premier Ambulatory Systems of Pasadena, Calif.

Edward P. Hetrick. Edward Hetrick is the president of Facility Development and Management and has more than 20 years' experience in the healthcare industry. Before founding FDM, Mr. Hetrick was vice president in Healthcare Facilities Management, a firm that specializes in reimbursement consulting for physicians and outpatient hospital accounts.

Jeremy Hogue, JD, MBA. Jeremy Hogue is the president and CEO of Sovereign Healthcare, a privately-held company based in Orange County, Calif., that partners with physicians for the ownership and management of ASCs. In that capacity, Mr. Hogue works closely with some of the nation's leading physician specialists. He also works as an investor and consultant to numerous other healthcare-related ventures.

Christopher Holden. Christopher Holden joined AmSurg in Oct. 2007 as its president, CEO and director. Mr. Holden is a healthcare industry veteran of more than 21 years, engaged during most of his career directly in multi-facility and multi-market healthcare management. Before joining AmSurg, Mr. Holden served as senior vice president and a division president of Triad Hospitals.

Marion K. Jenkins, PhD. Dr. Marion Jenkins is the founder and CEO of QSE Technologies. He has held many strategic C-level positions in technology, communications and operations, including COO of NAREX, which provides artificial intelligence-based software for financial service companies; executive vice president and CTO at FirstWorld Communications, a DSL, Internet services, hosting and data center provider; and vice president of sales operations at Qwest Communications.

Douglas V. Johnson, MBA. Doug Johnson is the executive director of Surgical Management Professionals and provides strategic leadership and direction of the Sioux Falls (S.D.) Surgical Center. He is a seasoned professional and administrator with more than 28 years in healthcare.

Sandra J. Jones, BA, MSM, MBA. Sandra Jones is a principal of Ambulatory Strategies and serves on the board of the ASC Association. Ms. Jones has 30 years' experience in healthcare and has overseen or contributed to the successful establishment and development of more than 75 ASCs nationwide.

Mike Karnes. Mike Karnes is the COO of Regent Surgical Health. He recently served as chief administrative officer of GTCR-Golder Rauner, one of the nation's largest and oldest venture capital firms. He also has been CFO for Prime Group Realty Trust and Balcor, a subsidiary of American Express.

Naya Kehayes, MPH. Naya Kehayes is the founder and CEO of Eveia Health Consulting & Management (formerly Millennium Health Consulting). She is a nationally recognized expert in reimbursement and managed care and insurance contract negotiations for ASCs and surgical practices.

R. Matthew Kilton, MBA, MHA. Matthew Kilton is a member and COO of Eveia Health Consulting & Management. Mr. Kilton's expertise is in ASC and surgical practice managed care contract negotiations and reimbursement analysis. He has an extensive background in orthopedic surgery, clinic operations and management.

Beverly Kirchner, RN, BSN, CNOR, CASC. Beverly Kirchner is the owner and CEO of Genesee Associates. She serves on the Association of periOperative Registered Nurses board of directors, has authored many AORN manuals and leads research in collaboration with the organization on violence in the nursing workplace.

Susan Kizirian, BSN, RN, MBA. Susan Kizirian is the COO of Ambulatory Surgical Centers of America. Ms. Kizirian has more than 20 years' experience in all aspects of ASC operations, having served as an executive director and a consultant for ASC management and development.

Marc E. Koch, MD, MBA. Marc Koch is the president and CEO of Somnia, where he focuses on furthering the company's mission of offering high-quality and cost-efficient anesthesia solutions to hospitals, ASCs and office-based facilities nationwide. He co-founded the medical practice Resource Anesthesiology Associates in 1996.

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

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

Michael Kulczycki. Michael Kulczycki is the executive director of Ambulatory Care Accreditation for the Joint Commission. In this role, he has greatly expanded the import of the Joint Commission with respect to ASCs.

Joan Lapham. Joan Lapham is the CEO of Sierra Surgery Hospital, a joint-venture between a physician investor group and a not-for-profit community hospital. Ms. Lapham was responsible for comprehensive oversight of the hospital construction; transition of the organization and staff from a surgery center to a fully operational hospital; negotiation of the joint-venture operating agreement; arranging financing; and many other critical components of the joint-venture.

Brent Lambert, MD. Dr. Brent Lambert has revolutionized approaches to ASC management. He is the chairman of the board and a founder of Ambulatory Surgical Centers of America, and not only has a brilliant strategic mind but also takes a hands-on approach to ASC management.

Luke Lambert. Luke Lambert is the CEO of Ambulatory Surgical Centers of America. Before joining ASCOA as its CFO in 1997, Mr. Lambert worked in equity research for Smith Barney and has management consulting experience with Booz, Allen & Hamilton and Ernst & Young.

Peter Laterza, JD, MBA. Peter Laterza is the chief legal officer for Prexus Health Partners, where he is responsible for general supervision of legal and regulatory affairs. Mr. Laterza has more than 20 years of progressive experience as a lawyer and business executive, which includes extensive experience advising healthcare clients, including five years service as vice president and general counsel for Omnicare.

John W. Lawrence, Jr. John Lawrence is the senior vice president and general counsel for NovaMed, and has served as NovaMed's Corporate Counsel since 1996. Mr. Lawrence is responsible for all legal matters relating to NovaMed and its operations, including structuring and negotiating all development transactions.

Jeff Leland. Jeff Leland is a managing partner with Blue Chip Surgical Center Partners. Before Blue Chip Surgical, Mr. Leland was with Ambulatory Surgical Centers of America, where he was responsible for de novo surgical center development and surgical center management.

Mike Lipomi, MSHA. With more than 30 years' experience in hospital and ambulatory facility management, Mike Lipomi is now the president of RMC Medstone Capital. At RMC Medstone, he and a team of experts cover all aspects of healthcare facility development, conversion and management with RM Crowe's real estate professionals.

James J. Lynch, MD, FACS. Dr. James Lynch is the president, founder and CEO of SpineNevada based in Reno, Nev., and he also serves as the director, spine service, for Regent Surgical Health. Dr. Lynch is a board-certified neurological surgeon who specializes in complex spine surgery, cervical disorders, degenerative spine, spinal deformities, trauma, tumor infection and minimally invasive spine surgery.

Tom Mallon. Tom Mallon founded Regent Surgical Health. Before this, he served as a founding member and remains a general partner with Gryffindor Capital Partners, a Chicago-based venture-capital fund. In 1994, he co-founded Same Day Surgery, which acquired five distressed and underutilized ASCs and a physician management company.

Ajay Mangal, MD, MBA. Dr. Ajay Mangal is the founder, CEO and a board member of Prexus Health Partners. He is also an ENT physician. As a hands-on executive at Prexus, Dr. Mangal has been instrumental in developing surgery centers and assisting existing centers and hospitals to prosper.

Roger Manning. Roger Manning is the founder and president of the Manning Search Group, which serves more than 100 national/international banking/financial institutions, construction industry companies, healthcare/medical services organizations and medical equipment/device manufacturers. Mr. Manning has more than 25 years' healthcare operations and sales management experience.

McGuireWoods Healthcare Lawyers. There are about 15 lawyers at McGuirewoods that work very closely with Scott Becker in the ASC and related areas. These include Scott Downing, Melissa Szabad, Amber Walsh, Krist Werling, Bart Walker, Sarah Abraham, Elissa Moore, Alison Mikula, Gretchen Heinze, Ron Lundeen, Tom Stallings, Paul Fisher, Joel Spitz and Don Ensing. Each is a terrific person. Obviously, the publisher, has a built-in bias!

Todd J. Mello, ASA, AVA, MBA. Todd Mello is a principal and co-founder of HealthCare Appraisers and manages the firm's Colorado office. Mr. Mello has 18 years of healthcare finance and valuation experience, the last eight of which have been spent building HealthCare Appraisers to become one of the nation's preeminent valuation firms focused exclusively on the healthcare industry.

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

Thomas A. Michaud. Thomas Michaud is the CEO and chairman of the board of Foundation Surgery Affiliates. Before founding FSA, Mr. Michaud held the positions of COO and CFO of a regional surgery center management company.

Evie Miller. Evie Miller is the director of acquisitions of United Surgical Partners International. She is one of the architects of the company's strategy to focus on physician- and hospital-driven ventures, and is responsible for the process and strategic direction of USPI's acquisition efforts.

Robert D. Mosher, JD. Robert Mosher is a partner with Nossaman Guthner Knox & Elliott in Los Angeles. He is experienced in healthcare law, mergers and acquisitions, partnerships, securities and business transactions, and his clients include large managed care provider groups and facility-based companies.

Amy Mowles. Amy Mowles owns Mowles Medical Management. She is the nation's premier expert with respect to pain management services provided in practices and provided in surgery centers.

Tom Mulhern, MBA. Tom Mulhern is the executive director of Limestone Medical Center, a large medical office building complex and ASC in Delaware. He has been a leader in the development of ambulatory surgical services and as an advocate for the industry.

Charlie T. Neal. Charlie Neal is the COO of HealthMark Partners. He was CEO of Alliance Surgery before its merger with HealthMark and was formerly with Symbion, where he was president of the multi-specialty group that managed 47 ASCs in 17 states.

Jon O'Sullivan. Jon O'Sullivan is a senior principal and founding member of VMG Health where he provides financial valuation, joint-venture

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development and transaction advisory services exclusively in healthcare. Since the inception of VMG, he has led the company's strategic objective of providing unparalleled financial and transaction advisory services in the healthcare market.

Matthew Parra. Matthew Parra is a vice president of business development for Ambulatory Surgical Centers of America. Before joining ASCOA, Mr. Parra served as a senior business development manager at a Fortune 100 company, focusing on document management and imaging solutions.

Richard Pence. Richard Pence is president of National Surgical Care and leads the development and management of National Surgical Care's ASCs. Before co-founding NSC, he was executive vice president and COO of Magella Healthcare, a national group of perinatal healthcare providers.

Jeffrey E. Péo. Jeffrey Péo is a vice president of business development for Ambulatory Surgical Centers of America. Before joining ASCOA, Mr. Péo ran a knowledge management and information technology consulting division for a Fortune 100 company.

Thomas J. Pliura, MD, JD. Dr. Tom Pliura is a doctor, lawyer and the founder and manager of several ASCs. Additionally, he is the founder of zChart EMR, an electronic medical records related company. In addition to these accomplishments, he is an incredibly inventive and interesting individual.

John Poisson. John Poisson is the executive vice president and strategic partnerships officer of Physicians Endoscopy, the leading company in the development and management of freestanding endoscopic ASCs. He has more than 14 years' experience in healthcare, most of which is focused on medical service outsourcing.

John Rex-Waller. John Rex-Waller is the chairman, president and CEO of National Surgical Hospitals, which partners with physicians to develop freestanding surgical facilities. Mr. Rex-Waller has also served as the CFO of Hawk Medical Supply, a provider of disposable medical supplies to physicians, and previously was the CFO and a co-founder of National Surgery Centers, which was one the largest independent owner and operator of ASCs in the country.

Jay Rom, MBA, CPA. Jay Rom is the president of Blue Chip Surgical Partners, which focuses on developing spine, ENT, sleep, radiosurgery and multi-specialty ASCs. Before joining Blue Chip, Mr. Rom served as CEO of a cardiology group in Cincinnati with 15 physicians and was vice president for physician services of the Franciscan Health System, where he was responsible for a 60-physician multi-specialty group.

Dan Saale. Dan Saale is the executive vice president and CFO of Nueterra Healthcare. Mr. Saale oversees all the financial activities of the company. He directs the financial services within each of Nueterra's physician partnership ventures.

Karen Sablyak. Karen Sablyak is the CFO and executive vice president of management services at Physicians Endoscopy. With 10 years' experience in healthcare finance and operations, Ms. Sablyak's leadership skills and financial acumen have resulted in tremendous results in reporting and management at Physicians Endoscopy.

Donna St. Louis. Donna St. Louis currently serves as a vice president for diagnostics and outpatient services for BayCare Health System and is on the board of the ASC Association. Before joining BayCare, Ms. St. Louis was a group president for Symbion and responsible for more than 45 ASCs.

Molly Sandvig, JD. Molly Sandvig is the executive director for the Physician Hospitals of America. As such, she leads the organization's day-to-day business and operational functions and directs PHA's membership recruitment, public relations and political advocacy efforts.

John Schario, MBA. John Schario is the president of Nueterra Healthcare, an industry leader in developing healthcare facilities. He brings together the extensive resources that let Nueterra develop, operate and nurture ambulatory care facilities including ASCs and surgical hospitals, and any other ambulatory care facilities created through partnerships.

John R. Seitz. In his position as the co-founder, chairman and CEO of Ambulatory Surgical Group,

John Seitz oversees business development, the operational and financial management of all ASCs and central business office services. For more than 25 years, Mr. Seitz has focused in the healthcare industry and is widely recognized in the ASC industry as a developer and manager of de novo ASC projects.

Bob Scheller, CPA, CASC. Bob Scheller is the COO of the Nikitis Resource Group. He was formerly senior vice president at Aspen Healthcare and has been involved in the development and management of more than 50 surgery centers in the past 15 years.

Caryl Serbin, RN, BSN, LHRM. Caryl Serbin is the president and founder of Surgery Consultants of America and Serbin Surgery Center Billing. She provides consulting services for a variety of ASCs and has developed a tremendous team and provides credible and hard working leadership for her company.

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

Sarah Silberstein. Sarah Silberstein is the executive director of the ASC Association, where she manages the activities of the nation's largest ASC membership association. Before joining the ASC Association in 1999, Ms. Silberstein worked in the federal government relations department of the American College of Obstetricians and Gynecologists and the American Public Health Association.

Jeff Simmons. Jeff Simmons is on the board of directors of Regent Surgical Health and is the western region president of Regent. He is a leading developer of ASCs and extremely gifted at trying to keep centers focused on their core goals.

Sheldon S. Sones, RPh, FASCP. Sheldon Sones is president of Sheldon S. Sones and Associates, a pharmacy and accreditation consulting firm based in Newington, Conn. Established in 1985, the group, serving over 100 sites in five states, specializes in safe medication management and pharmacy consulting to freestanding and hospital-based ambulatory surgical, endoscopy and renal dialysis centers, with expertise in accreditation success.

Bill Southwick. Bill Southwick is president and CEO of HealthMark Partners. He is chiefly responsible for ASC turnaround strategies and creative joint-venture structures that have enabled HMP to partner with both physicians and hospitals in developing new or taking over underperforming facilities.

Joe Sowell, JD. Joe Sowell is a partner at Waller Lansden Dortch & Davis and practices in the areas of healthcare law, mergers and acquisitions, joint-ventures, private equity financing, tax law and general corporate law. He co-manages the firm's corporate and commercial transactions practice.

Kenny Spitler. Kenny Spitler serves as senior vice president of development for HealthMark Partners. He is responsible for all aspects of development including acquisitions, de novo projects and physician syndications, and he also serves as head of marketing and partners in the role of vendor relations as well as physician recruiting.

Donald E. Steen. Don Steen founded United Surgical Partners International in February 1998 and served as its CEO until April 2004. Mr. Steen continues to serve as chairman of the board of directors and the executive committee.

Debra Saxton Stinchcomb, RN, BSN, CASC. Debra Saxton Stinchcomb is the director of surgical services for Progressive Surgical Solutions, an ASC consulting company. She has 25 years' healthcare experience, including clinical, administrative, operations and sales, with the last 11 years exclusively on ASCs, with an emphasis on multi-specialty centers.

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

Barry Tanner. Barry Tanner is the president and CEO of Physicians Endoscopy. Before joining Physicians Endoscopy, Mr. Tanner was the co-founder, CFO and COO of Navix Radiology Systems of Miami, Fla., where he helped build the company into a $75 million enterprise.

Dan Tasset, CPA. Dan Tasset leads Nueterra as its chairman and founder. Since 1989, Mr. Tasset has been in the business of working with physicians to develop surgery centers and surgical hospitals.

Larry Taylor. Larry Taylor is the president, CEO, founder and developer of Practice Partners in Healthcare. He has 25 years' experience in healthcare delivery, management and physician relations.

Larry Teuber, MD. Dr. Larry Teuber, a neurosurgeon, is the founder and physician executive of Black Hills Surgery Center, one of the country's most successful small surgical hospitals. Due to his dynamic skills and knowledge, Dr. Teuber transformed the ownership of that hospital so that now it is a publicly held company that is partially owned by the Medical Facilities Corporation, where he now is president.

David Thoene. David Thoene is the vice president of business development for Titan Health. Mr. Thoene has 24 years of experience consulting for and developing ASCs along the West Coast; his background and expertise include the turnkey development of ASCs, hospitals and medical office buildings.

John T. Thomas. John Thomas is the president and chief development officer of Cirrus Health. Under Mr. Thomas's leadership, Cirrus has quickly become one of the country's leading companies in ASC and specialty hospital development.

Jon Vick. Jon Vick is a leading consultant in the ASC industry and is renowned for matching corporate partners with physicians and matching buyers and sellers of ASCs. His career in the industry started with developing an endoscopy chain.

R. Bruce Wallace, III, MD. Dr. Bruce Wallace, III, is the founder and medical director of Wallace Eye Surgery, Laser and Surgery Center in Alexandria, La. He is board-certified by the American Board of Ophthalmology and the American Board of Eye Surgery.

Michael Weaver. Michael Weaver is an executive vice president at Symbion. He is one of the strongest development executives in the ASC industry and has helped Symbion to grow into one of the largest ASC chains.

Robert Welti, MD. Dr. Robert Welti is the corporate medical director and COO, western region, for Regent Surgical Health. Previously the medical director and administrator of the Santa Barbara Surgery Center, Dr. Welti also was affiliated with Santa Barbara Cottage Hospital for 20 years.

Robert Westergard. Robert Westergard is the CFO of Ambulatory Surgery Centers of America. Before joining ASCOA in 2002, he worked as the controller for Truman Capital Advisors, a mortgage banking firm specializing in the securitization of subprime mortgage loan assets.

William H. Wilcox. Bill Wilcox serves as the president and CEO of United Surgical Partners International. Before joining USPI, he served as CEO of United Dental Care, president of the Surgery Group of HCA and president and CEO of the ambulatory surgery division of HCA.

David Woodrum. David Woodrum is a co-founder and partner of Woodrum/Ambulatory Systems Development, an ASC management and development company. He provides clients with consultations in planning, management, finance, loss prevention, marketing, physician group practice management, executive recruitment and JCAHO compliance.

Thomas R. Yerden, MHA. Tom Yerden is president and CEO of TRY Health Care Solutions. He was the founder and CEO of Aspen Healthcare before selling it to National Surgical Care. He has established and planned more then 40 physician/hospital ASC joint-ventures.

Joe Zasa. Joe Zasa is the co-founder and managing partner of Woodrum/Ambulatory Systems Development, a national ASC development and management firm that specializes in developing, managing and operating multi-specialty and single specialty ASCs. Woodrum/ASD currently manages 21 ASCs throughout the United States and is one of the largest privately held surgery center companies.

Robert Zasa. Robert Zasa is a co-founder and partner at Woodrum/Ambulatory Systems Development. He is experienced in all phases of business development in multi-service ambulatory care facilities, group practices, ASCs and hospitals,

including management, development, expansion, acquisition, ownership structuring and marketing.

J.A. Ziskind, JD, MBA, PhD. J.A. Ziskind is the founder and CEO of Global Surgical Partners, which focuses on developing and managing hospital/physician and physician-owned joint-ventured ASCs. He has been actively involved in Florida's healthcare industry over the past 35 years, having served as CEO of Cedars Medical Center and since 1984 as a healthcare lawyer.

Greg Zoch. Greg Zoch has been involved with the marketing of healthcare organizations and services and with the recruitment of healthcare professionals since 1990. His primary focus with Kaye/Bassman is on the strategic growth and staffing initiatives of client companies, who develop, manage, consult with, or own and operate ASCs and specialty hospitals throughout the United States.

Bryan Zowin. Bryan Zowin is the president of Physician Advantage, a healthcare management company based in Peoria, Ill. The company provides management services to a wide range of healthcare specialties including ASCs, anesthesia, orthopedics, urology, ENT, OB/GYN, facial plastic, pain management and primary care. ■

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Benchmarking Statistics

Gross Charges and Net Revenue Per Case for ENT, Ophthalmology and Urology

For ENT, ophthalmology and urology, here are the gross charges per case and net revenue per case:

1. ENT — $5,182 and $1,776;
2. ophthalmology — $4,367 and $1,276; and
3. urology — $3,951 and $1,802.

Note: This information is derived from the VMG Health Intellimarker, published in 2007. For more information, e-mail Greg Koonsman at **gregk@vmghealth.com** or e-mail Jon O'Sullivan at **osullivan@vmghealth.com**.

ASC Distribution Intervals

Q: How often should an ASC make distributions?

A: Jim Cobb, CEO of Orion Medical Services: "We have found that physician-owners prefer that distributions be made on a monthly basis. It eliminates the need for the ASC manager or management company to find an interest-bearing account until the distribution is made, especially if it is made on a quarterly or annual basis. It also helps retain a great nexus between the center's results and its owners.

"In all our centers, we make the distribution before the 15th of the following month. When your center is distributing profits in substantial amounts, it increases the need to distribute those profits sooner than later to avoid the build-up of significant cash balances.

"We have quarterly meetings after a new center is stabilized, which usually takes from one year to 18 months. A new center should have monthly meetings with the regional VP for operations for that region or the management of the center and the physician-owners or executive committee."

Learn more about Orion at **www.orionmedicalservices.com**.

Multi-specialty ASC Hours Per Case

Q: What should a multi-specialty center aim for in terms of hours per case?

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A: "I would generally suggest eight hours for ophthalmology or pain management, 12 hours for a multi-specialty ASC and 14 hours for orthopedics," says Tom Mallon, the CEO of Regent Surgical Health.

These numbers of hours would represent the total worked hours per case by the entire facility, which includes members of the business office, says Joyce Deno, the COO, Eastern region, for Regent Surgical Health.
The benchmarks for a multi-specialty facility will also depend heavily upon the case mix of the organization, says Ms. Deno.

If a center performs ophthalmology, GI and pain procedures, it should target eight hours per case, she suggests. If the specialty mix is orthopedics, gynecology, general surgery and ENT, the benchmark will be closer to 14 hours.

"What will dilute it to the 12 (hours) is if the center has one of the above high-volume specialties," such as GI endoscopy, ophthalmology and pain management, says Ms. Deno.

She also points out that one- or two-room facilities not operating at least 80 percent capacity will exceed benchmarks, particularly if they are orthopedic-driven facilities.

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Five Current Business and Clinical Issues for ENT in ASCs

By Stephanie Wasek

Overall, much like ophthalmology (see "Meeting the Current Business Challenges in Ophthalmology," starting on the cover, for more), the keys to success and profitability in ENT lie in being able to perform a large number of procedures, and to do them as efficiently as possible.

"It's a mature specialty — it was one of the original groups to leave the hospital to start ASCs," says Steve Blom, RN, MAHSM, CASC, administrator at the Specialty Surgery Center in San Antonio, Texas, which performs about 4,000 ENT cases annually. "It's predominantly bread-and-butter procedures: generic sinus, ear tubes, tonsillectomies and adenoidectomy. ENT got a slight increase from CMS, but we still have to run lean. So we have to carry on with the same pressures for reimbursement, the same pressures for supply costs."

However, there are some business and clinical issues specific to ENT and new technology that merit further examination. Here is what experts have to say.

1. Accommodating pediatrics

Because a large portion of procedures are T&As and ear tubes, ENT brings more pediatric patients to the ASC than other specialties do. As a result, accommodating the needs of this specialized patient population is always a challenge.

"Some states require that you have special pediatric isolation recovery rooms and waiting rooms," says John Seitz, the CEO of Ambulatory Surgical Group. "So what we've done in two of our centers is dedicate a morning every week or every other week, depending on volume, for pediatrics. On those days, we bring out the miniature furniture and toys and turn them into pediatric facilities for that half-day."

Not only can this help meet state regulations, it also gives you an opportunity to specialize staff who may have pediatric advanced life support training or who are particularly good with children.

"It's very patient-friendly," says Mr. Seitz. "It's easier for the physicians' schedulers, and the everyone knows when they're coming in that day exactly what to expect."

2. Steps to combat low payments

One of the big challenges that the inherently large pediatric population poses is that it can mean a large portion of Medicaid cases at your center.

"Medicaid reimbursement is very low and will only pay on one procedure. Here, we are doing anywhere from 25 to 32 percent Medicaid a month," says Mr. Blom. "And the fact of the matter is, you won't make money, but you can't consistently lose money."

To that end, he says, it is key that you "case-cost absolutely everything." For example, he says, Medicaid reimbursement for a regular tonsillectomy runs about $500 per case; he knows that overhead on such a case is about $230, plus supplies and salaries.

Further, you must "take a hard line with physicians on supply costs," says Mr. Blom. "You can buy ear tubes for $78 or $14. It's just a piece of plastic; we buy the $14 ear tubes and use them on everyone to maximize reimbursement regardless of payor."

Brian Weeks, MD, an ENT surgeon in San Diego, Calif., says that sharing supply costs with physicians is an effective method for getting them to help keep expenditures down.

"I do 300 to 400 sinus procedures — what if the staff opens a handheld cautery on every one?" he says. "I know that's $100 a case. I don't ever use it, so why would it be part of the pack? I push for that to be removed from the pack; I can't stand to watch people waste."

With per-case margins so small, high volumes are necessary to make them pay off on a larger scale.

"We had a center where we had just one ENT, but it didn't work well for anybody; we moved him to a center with four others, and it was a great fit," says Mr. Seitz. "I'd say you have to have at least three or four for the specialty to start to make sense, so you can hit critical mass on volumes. You need to be able to make a production line of it, have them go rapid-fire in order to make it profitable."

Dr. Weeks notes that your surgeons can help keep turnover times short, too.

"For example, it can be something as simple as giving the anesthesiologist a heads up that I'm 10 to 15 minutes from finishing," he says. "That way, as I'm putting in the packing, the patient's starting to cough. That's ideal, and then I'm on my way to the next case."

Further, by providing a place for your surgeons to efficiently perform these high-turnover cases, you've already won half the battle.

"Fifteen or 20 years ago, physicians used to make 30 percent of their money at the clinic and 70 percent on surgery — now that's reversed, and probably more like 80-20," says Mr. Blom. "Time is absolutely imperative to them. They don't want to break off a clinic day to go to the hospital. If you can start offering more complex cases at your center, you may be rewarded with higher reimbursements and better physician relationships."

Dr. Weeks agrees: "I don't like to jump around; that's inefficient. If an ASC can accommodate me with my bigger cases, I'm more likely to bring all my cases there."

3. Transitioning thyroidectomy to outpatient

A recent study shows that, with careful patient selection and prophylactic calcium supplementation to minimize hospital stay, thyroidectomy can be safely performed in ASCs. "Outpatient Thyroid Surgery is Safe and Desirable," presented at the 2006 Annual Meeting of the American Academy of Otolaryngology — Head and Neck Surgery Foundation, examined 91 patients undergoing thyroidectomy who were segregated into inpatient (39 — 26 for 23-hour stays, 13 admitted) and outpatient (52 — discharged directly from the ambulatory recovery unit) groups.

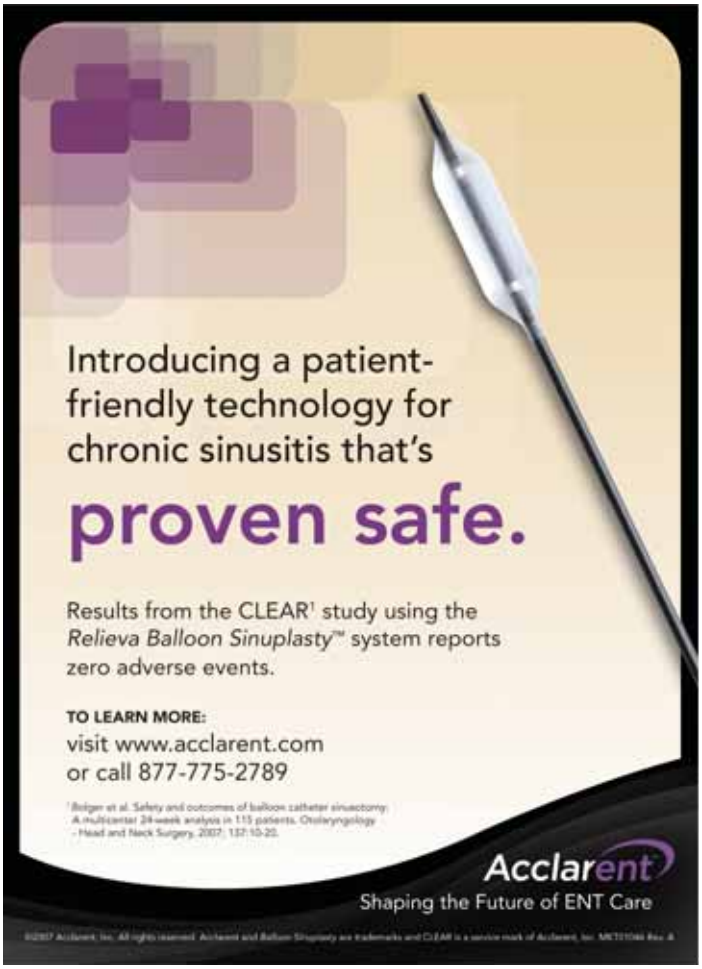
"Despite the trend toward outpatient surgery, surgeons who perform thyroid and parathyroid surgery have been reluctant to adopt this approach primarily out of concern for bleeding and transient hypocalcemia," write the authors. "However, the advent of new ultrasonic technology … has improved the ability to achieve and maintain a bloodless field. This technology has led to a conclusion by many that surgical drains, a soft plastic tube that drains fluid out and sources of infection of the area, offer no benefit to the patient, and if anything, result in a higher rate of infection and bleeding."

Several surgical techniques were used, including a Kocher incision, minimally invasive thyroid surgery with access to the thyroid compartment, and endoscopic thyroidectomy. Laryngeal nerve monitoring was employed as required. Vocal cord mobility was assessed and documented preoperatively and again in the post-anesthesia care unit or on the ward using flexible fiberoptic laryngoscopy. In post-op, outpatients were assessed and discharged once ambulatory, tolerating a diet and managing their pain with oral medications.

"A second major deterrent to performing thyroid (and parathyroid) surgery on an ambulatory basis is the fear of life-threatening hypocalcemia, or low blood calcium level," write the authors. "Ten years ago, researchers described a regimen of oral calcium administration following parathyroidectomy, supporting outpatient status in nearly all cases performed at a major hospital. Researchers for this current study provided oral calcium supplementation in patients undergoing total or completion thyroidectomy to accomplish outpatient thyroid surgery safely. This method has proven uniformly successful with the study subjects, with none displaying any signs of calcium deficiency in the blood."

Finally, and most importantly, the authors found that costs were significantly lower for outpatients ($7,814) than for inpatients ($10,288) and that operative time was lower in the outpatient group (102 versus 144 minutes). This suggests that "for carefully selected patients who prefer convalescence at home, and are not weak due to age and disease, outpatient thyroid surgery is safe and cost-effective, even when a total or completion thyroidectomy has been performed."

Mr. Blom is seeing more thyroidectomies transition out of the hospital and into his center and other ASCs in the region.



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"The only thing really holding this transition back now is the global reimbursement, which means the ASC doesn't get reimbursed for running labs — you have to contract that service out and pay out of your reimbursement," he says. "But as reimbursements go up through 2011, this procedure may become more attractive."

4. Picking a modality for visualization

Aside from the high-volume pediatric cases, functional endoscopic sinus surgery (FESS) is another procedure that makes up a large percentage of ENT case volumes. The minimally invasive surgery is used to remove unwanted tissue in paranasal sinuses in order to facilitate normal respiration, ventilation and outflow for the patient; it has replaced more conservative sinus procedures as it has been shown to improve on their outcomes. In fact, a 2007 study published in the *Journal of Laryngology and Otology* even showed FESS significantly improved all symptoms when used in the management of chronic rhinosinusitis.

But with a new gold standard procedure comes new challenges. The biggest with FESS is accurately targeting tissue to be removed while navigating around anatomical structures in order to avoid injury to vulnerable structures. Computer-aided navigational technology for visualization of sinus surgery has been gaining a foothold for years. However, whether it is the new gold standard is up for debate.

Mr. Blom says that use of computer-assisted navigation in conjunction with FESS has been largely specific to certain regions of the United States, but that it may be increasingly popular, as surgeons feel that the visualization leads to better outcomes and potentially faster operative times (though the literature jury is out on OR time). Unfortunately, the equipment to add this can be expensive. So is it worth it? Here is a summary of two options.

• **Image-guidance.** In the first and older of the two technologies, images created by CT, MRI or fluoroscopic imaging systems are used to build an anatomical "roadmap" that the surgeon can see on a monitor. This technology also maps the progress of the surgeon's tools into the sinuses.

"This lets the ENT surgeon more safely perform procedures in the delicate sinuses without damaging any of the surrounding structures," says Mr. Seitz. "This is something that, up until six months ago, was only being done at the hospital. But now the ASCs are getting increased reimbursement. You still need about five ENT physicians to bring in the volumes to make buying a $150,000 piece of equipment viable, but once we hit that number of referrals, it's a very well-reimbursed procedure that's opening up some avenues previously exclusive to the hospital."

Another advantage, he says, is that image-guidance lets the surgeons perform the more complex sinus procedures, which come with higher reimbursements. Drawbacks include the use of radiation, a learning curve for surgeons and staff and sometimes-expensive disposables.

• **Near-infrared transillumination.** In this method, the surgeon uses a light wire to illuminate the sinus of interest, so that he can better visualize where he is working.

Dr. Weeks enumerates the benefits from his point of view:

- no bulky, space-consuming C-arm;
- no need to wear heavy, radiation-shielding gowns;
- patient positioning is much more simple and straight forward;
- rapid learning curve; and
- faster than image-guidance because the transillumination system is ready to go as soon as it's hooked up.

"I like having the freedom to move around the patient, and there's no radiation on the patient's head or my hands," he says. "The main light wire costs $150 to $175 a case, but that's better than the disposable costs for image-guided, in my experience. And this lets an ASC without the capital budget to purchase a large piece of navigation equipment to open up more complex procedures to ENT surgeons."

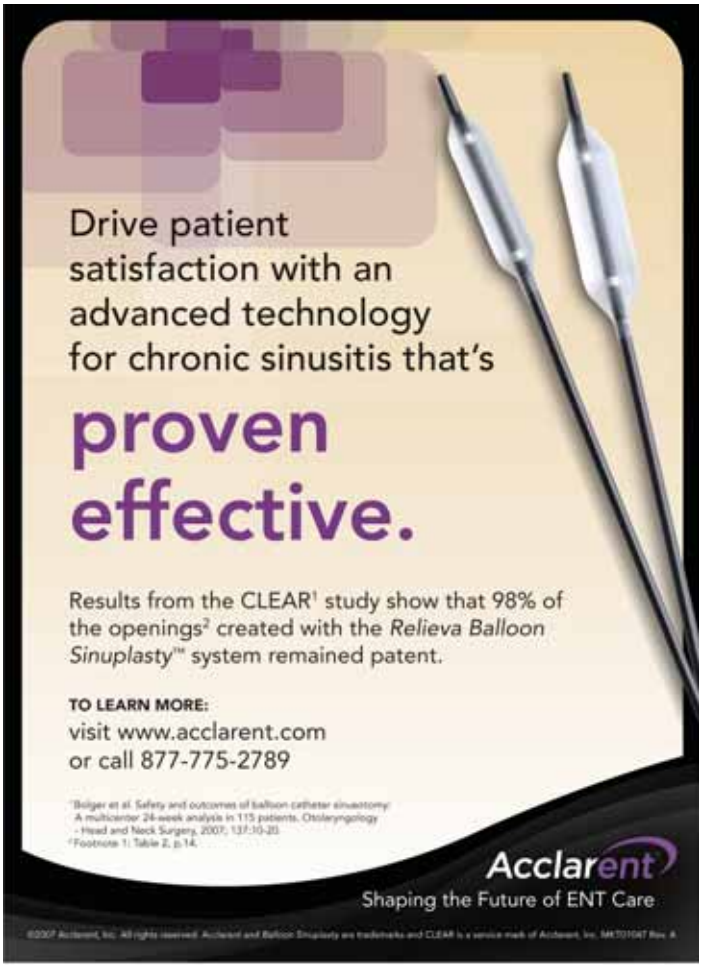
5. Adding balloon sinuplasty

Currently performed mostly in hospitals, Balloon Sinuplasty devices used as a replacement for or adjunct to traditional FESS is a logical fit for ASCs for a variety of reasons. The minimally invasive, minimally disruptive procedure has a 98 percent patency rate at six months, as well as a strong safety profile and patient satisfaction rating, according to the results of recently published data.

"The Balloon Sinuplasty technology opens up FESS to a wider population of patients because it expands the option of an ENT surgeon," says Robert Wood of Acclarent, maker of the Balloon Sinuplasty devices. "What really sets this technology apart from the traditional instruments used in FESS is the ability to navigate around anatomy and open the obstructions of the peripheral sinus ostia with a minimal disruption to healthy tissue. This is particularly important for patients undergoing FESS for the first time. Traditional instrumentation can be used when tissue and anatomy need to be removed, and this flexible instrumentation can be used when they can stay intact. Balloon Sinuplasty technology broadens the surgical options for treating patients who suffer from this complex condition."

Standard FESS procedure times run about 90 minutes to two hours for an average of six sinuses including ethnoids plus septoplasty. Acclarent's data shows that using the Balloon Sinuplasty system for the peripheral sinus in same set of procedures saves an average of 51 minutes of OR time, says Mr. Wood, helping to make up for the roughly $1200 in disposable costs per procedure. CPT codes for tools used in FESS, which Balloon Sinuplasty is billed under, are well-reimbursed. While the CMS reimbursement looks positive for sinus surgery, the overall impact will be small, says Mr. Wood.

"This is because 90 percent of ENT procedures are done under private payers, because chronic sinusitis affects people in their mid-40s, working-age people, for the most part," he says. "These are the same age people who are interested in innovation that will relieve their problem with the least disruption to their anatomy or their lives. These are all positive factors for



ASCs looking to add growth, especially when you consider ENT and sinus surgery are established bread-winners."

Mr. Blom says that, while he finds Balloon Sinuplasty to be interesting, he worries that it would be too difficult to use on patients who need more than just their frontal sinuses operated on.

"If you want to go and do the back sinuses, then you have to use the old technology," he says. "When you have to use two modalities, suddenly your case cost is out of control, because you're only getting reimbursed for one procedure."

As a result, he finds its use too narrow for the ASC, but Dr. Weeks says it's imperative that it be incumbent upon the physician to choose the right patients for the ASC.

"If you do that, using this tool can be very profitable — and it's such an incredible procedure for the practice and patients," he says. "Having the transillumination technology allows us to overcome the cost barrier. If you look at the net costs — not having fluoroscopy of image-guidance, not using shavers and other expensive pieces of equipment inherent in FESS, eliminating excessive packing, speeding operative times — you can increase profitability." ■

Contact Stephanie Wasek at ***stephanie@beckersasc.com****.*

Follow Example Operative Note to Help Code Common ENT Procedure Correctly

By Rob Kurtz

The reimbursement rates for many ASC procedures have benefited and will benefit under the new Medicare payment system. One such procedure seeing a noticeable reimbursement boost is endoscopy with ethmoidectomy (surgical drainage of the ethmoid sinus). Total endoscopy with ethmoidectomy (CPT code 31255) will see its reimbursement increase 31 percent at the 2008 fully implemented rate. If your ASC performs ENT procedures, this is a case that you may see more often because of this reimbursement boost.

To help you code such cases correctly, Susan E. Garrison, CHC, PCS, FCS, CCS-P, CPAR, CPC, CPC-H, the executive vice president of healthcare consulting services for Magnus Confidential, shares an example operative note for this procedure, then analyzed it to guide you through how you should properly code the case.

Note: We have italicized the information you would have wanted to highlight to ensure proper coding.

Sample operative note

Preoperative diagnosis:

1. Chronic hyperplastic rhinosinusitis
2. Allergies
3. Asthma
4. Status post prior polypectomy and sinus surgery

Postoperative diagnosis: Same.

Operative procedure:

Left sinusotomy (three or more sinuses) to include:

- Nasal and sinus endoscopy
- Endoscopic intranasal polypectomy
- Endoscopic total ethmoidectomy
- Endoscopic sphenoidotomy
- Endoscopic nasal antral windows, middle meatus, and inferior meatus
- Endoscopic removal of left maxillary sinus contents

Right sinusotomy (three or more sinuses) to include:

- Nasal and sinus endoscopy
- Endoscopic intranasal polypectomy
- Endoscopic total ethmoidectomy
- Endoscopic sphenoidotomy

- Endoscopic nasal antral windows, middle meatus, and inferior meatus
- Endoscopic removal of right maxillary sinus contents

Anesthesia: General endotracheal.

Estimated Blood Loss: 250 cc.

Fluids Replaced: 1200 cc.

Specimens sent to pathology:
1. Left ethmoid and spheroid contents for routine and fungal cultures
2. Right maxillary contents for routine and fungal cultures
3. Left intranasal ethmoid, spheroid, and maxillary specimens for pathology
4. Right ethmoid, spheroid, maxillary, and right intranasal contents for pathology

Complications: None.

Drains/packs: Bilateral Gelfilm in the middle meati. Bilateral Telfa gauze impregnated with Bacitracin. Bilateral Vaseline gauze between the folds of Telfa.

Findings: Complete nasal obstruction by polyps with obscuring of all of the normal landmarks. The right middle turbinate was found and preserved. The residual bode of the left middle turbinate was found and preserved. There was thickened hyperplastic mucosa throughout the sinuses with some polyps in the sinuses and the majority of the sinus cavities were filled with inspissated glue-like mucopurulent debris. At the end of the case there were no visible polyps, the airway was clear and the debris had been removed.

Procedure: The patient was taken to the operating room, placed in the supine position, and general endotracheal anesthesia adequately obtained. A pharyngeal pack was placed. The nose was infiltrated with xylocaine with epinephrine and cottonoids soaked in 4% cocaine were placed. *The procedure was performed in a similar manner on the left and right sides.* The cottonoids were removed.

The 30-degree wide-angle *sinus telescope* with endoscrub and the Stryker Hummer device were used to *remove the polyps* starting anteriorly and working posteriorly. *This led to visualization* of the middle turbinates.

The *middle meati disease was removed.* The area of the *uncinate process and infundibulum was shaved away and forceps were used to remove portions of bone particle.* Using blunt dissection, *the agger nasi cells, ethmoid and spheroid sinuses were entered and the contents removed with forceps and suction.* The *inferior turbinates were infractured*, a mosquito clamp placed through the lateral nasal wall into the maxillary sinuses through the inferior meatus. That opening was opened with forward and backward biting forceps, *sinus endoscopy was performed, and inspissated mucus and debris cleaned out of the sinuses.*

In a *similar manner the sinuses were opened from the middle meatus and the sinuses cleaned.* In the above manner, *the ethmoid, spheroid, and maxillary sinuses were cleaned of debris and inspissated mucus suctioned from the frontal recesses.*

The patient was then suctioned free of secretions, adequate hemostasis noted. Gelfilm was soaked, rolled, and placed in the middle meati). Telfa gauze was impregnated with Bacitracin, folded and placed in the nose. Vaseline gauze was placed between the folds of Telfa. The pharyngeal pack was removed. He was suctioned free of secretions, adequate hemostasis noted, and the procedure terminated. He tolerated it well and left the operating room in satisfactory condition.

Coding analysis

Since the procedure was bilateral, modifier -50 would apply except to the diagnostic functional endoscopic sinus surgery (FESS). You would not append modifier -50 to the diagnostic FESS because it is inherently bilateral. The diagnostic FESS was performed, which is coded with CPT 31231; however, since additional surgical FESS procedures were performed, you cannot code 31231, says Ms. Garrison. Diagnostic scoped procedures are always bundled into therapeutic scoped procedures when performed during a single session, no exceptions.

Next comes the endoscopic removal of polyps, which would indicate CPT 31237, but since polyp removal was for visualization, you cannot code 31237 either.

Uncinate process and infundibulum were removed in prepping for the ethmoidectomy, so there is no code here (see Jan. 1999 *CPT Assistant* for guidance), says Ms. Garrison.

This leaves us with the FESS with total ethmoidectomy (CPT 31255 with -50 modifier); maxillary antrostomy with removal of tissue (CPT 31267 with -50 modifier); and sphenoid sinusoscopy with removal of tissue (CPT 31288 with -50 modifier).

Therefore, the codes for this case are 31255-50, 31267-50 and 31288-50.

Note: Under the current Medicare ASC payment system, CPT 31255 has a 2008 payment of $772.90; it has a fully implemented payment, at 2008 projected rates, of $940.59.

CPT 31267 and CPT 31288 have 2008 payments of $617.65; they have fully implemented payments, at 2008 projected rates, of $940.59. ■

Contact Rob Kurtz at ***rob@beckersasc.com.***

5 Products for ENT Surgery

Relieva Luma Sinus Illumination System

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FYI: Acclarent's Relieva Luma Sinus Illumination System presents a new option for ENT surgeons trained to treat chronic sinusitis symptoms with balloon catheter dilation. Using trans-sinus illumination technology, Relieva Luma delivers full-strength, targeted fiberoptic light transmission

and agile device handling, to let surgeons confirm sinus access under direct visualization.

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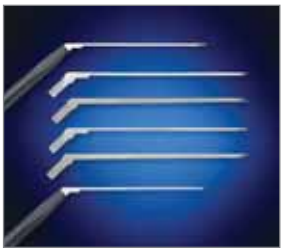

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Recent Attacks on Out-of-Network Practices Highlight the Need for Careful Assessment of Efforts

By Scott Becker, JD, CPA

Two recent actions, one by the Office of the New York State Comptroller, and one a court decision that comes out of a New Jersey case, further highlight the need for ASCs to be very cautious in their actions relating to out-of-network payments.

First, the state of New York released its fifth report on a surgery center operating out-of-network. There, the state investigating agency determined and alleged that the center had billed over $1 million improperly and that the state should be entitled to recoup the money through its insurance plan. The basis of the claim is the concept that the surgery center was improperly waiving or reducing co-payments:

> "We found that South Shore routinely waived Empire Plan members' required out-of-pocket costs for services provided. We calculated that, as a result of this practice, United overpaid claims submitted by South Shore during our six-year audit period of at a cost of $2.7 million to the State. This practice drives up costs for the Empire Plan, since it increases the likelihood that members will use non-participating providers, such as South Shore, which generally receive higher reimbursement rates than participating providers. Furthermore, routinely waiving such costs may constitute insurance fraud."

Here, the court explained the situation as follows:

> "When United processes South Shore claims for services to Empire Plan members, it is with the understanding and belief that members are liable for a portion of the claimed amount representing their out-of-pocket obligation. Our audit found that South Shore is routinely waiving Empire Plan members' out-of-pocket obligation. This negates the intended disincentive from using the more costly non-participating providers and thus drives up the cost of the Empire Plan to taxpayers.
>
> "As South Shore's intention was to waive members' out-of-pocket costs, the amount claimed by Endoscopy should reflect this reduction, and the reimbursement by United should have been calculated on the lower amount. United was presented with and made reimbursement calculations based on inflated claims. We calculated that, as a result, United overpaid claims submitted by South Shore during our audit period at a cost of $1,000,000 to the State."

It further claimed that there might be possibilities of fraud and possible violations of the state insurance act. The state will now turn its investigator report over to both the payor — to encourage it to try to recoup the claims from the center — and to the New York State Department of Civil Service, in an effort to have the state examine whether to bring further actions against the surgery center.

The report also noted:

> "Additionally, under the New York Penal Law, submitting an insurance claim with false information, such as an inflated charge for service, may constitute insurance fraud. In addition, waiving of out-of-pocket costs unjustly enriches the provider because the payment should be based on the provider's

actual charge, which is the amount the provider intends to accept as payment. Finally, the New York State Insurance Department concluded that it may be a violation of the State Insurance Law, and a fraudulent billing practice, when a provider routinely waives out-of-pocket costs and accepts the amount the insurer reimburses as payment in full.

"Officials at the Department of Civil Service and the State Insurance Department are concerned about fraud in the Empire Plan. Officials are concerned that providers who waive Empire Plan members' out-of-pocket costs are doing so intentionally, in order to benefit from the higher reimbursement rates for non-participating providers."

The second case was brought by a plaintiff's surgery center against the payor alleging that it had been underpaid and unpaid for numerous out-of-network claims. Here, the Court held that the surgery center had not committed fraud of any sort.

"Defendant is not only refusing payment of outstanding claims but is also affirmatively seeking disgorgement of facility fee payments previously made to Plaintiff. Defendant is also alleging that Plaintiff's billing practices amount to a violation of the Insurance Fraud Prevention Act.

"Defendant also asserts that Plaintiff has violated the Codey Law against self-referrals. Under the Codey Law, a practitioner is precluded from referring a patient to a facility in which the practitioner has a significant beneficial interest."

However, the court held that the surgery center had been providing services out of compliance with the Codey Law in New Jersey and that, accordingly, the insurer did not have to pay the claims allegedly owed to the surgery center.

"Accordingly, this Court finds that Plaintiff has violated the Codey Law's ban on self-referrals, and Plaintiff is not entitled to payment on the outstanding claims. Summary Judgment is granted in favor of Defendant on this point."

This case helps to underscore the amount of caution one must take in handling out-of-network patients and in bringing a legal action related to collecting out-of-network claims where a party itself may not have a completely defensible position to stand upon.

For out-of-network practices, it is critical that a surgery center fully disclose its practice to payors. This allows the surgery center in part to help argue that it is not operating in any sort of fraudulent manner. Then, the surgery center may still have risk of recoupment actions and, in states that do not permit waiving or discounting of co-payments at all, it may still be in violation of the law.

There are several options by which to approach out-of-network activity. In each option, it is critically important that a center and its board evaluate the risks of each option and select a strategy that is both lawful and with an understanding of potential consequences even if lawful but not completely consistent with the practice of collecting fully all co payments and deductibles. ■

Contact Mr. Becker at sbecker@mcguirewoods.com.

4 Case Studies: How You Can Use Benchmarking to Improve Practice

By Stephanie Wasek

You know you have to track quality and patient satisfaction indicators. Your accreditation agency requires it; increasingly, your third-party insurers may require reporting of data; and, soon, CMS will ask you to track and report selected indicators.

But how much of your benchmarking practice is about analyzing numbers and enacting change, rather than just doing?

"Everyone knows they need to benchmark and track quality data; every January, we get an influx of calls," says Jennifer Green, RHIT, of Surgical Outcomes Information Exchange. "We've seen a shift toward more ASCs understanding the value of benchmarking, but a lot of people are still taking the data, putting it in and not knowing what to do with the results."

It's increasingly important: Accreditation surveyors are now looking not just to see that you have a quality improvement process, but also what the process entails and how you're using it, says Ms. Green. In addition, embracing benchmarking is simply a good business practice.

"People get scared off by the jargon, but benchmarking is simply a matter of knowing the measurement, how it measures up, finding the problems and determining solutions," says Ms. Green. "Time is money; you can cost-justify those things that you want to do but might not otherwise have the evidence for. Maybe you always thought Dr. A was slow, that you weren't processing patients fast enough. When you see numbers outside the range, you can now do a QI process and determine where the system is breaking down.

"Then you can think about solutions: Do you need staff training? Do you need to fire someone? Hire someone? Sit down with a doc and have a discussion?"

Here are four case studies of centers that have been able to make practical and tangible changes thanks to benchmarking.

1. Enhancing efficiency

When Blake Woods Medical Park Surgery Center in Jackson, Mich., started using the services of a national benchmarking service, the staff found that "in a lot of respects, we were doing better than we thought," says Margaret Acker, RN, MSN, Blake Woods' CEO.

That's not to say she didn't find room for improvement. Here are several areas where Ms. Acker has been able to put benchmarking to use at her ASC.

• **Extended downtime.** Blake Woods started as a single-specialty ophthalmology center, and when it looked at downtime between cataract cases, it found it was slow compared with similar centers.

"At the time, we admitted one patient every 10 minutes to three pre-op bays," says Ms. Acker. "The benchmarking tipped us off, so we did a time study, and we found that we needed to pre-op more than three patients at a time to open up more beds."

The result: Blake Woods started using six pre-op beds at a time, admitting three to the right eye room and three for the left eye room every 10 minutes. This method decreased downtime because "we always had a patient ready," says Ms. Acker.

• **Long discharge times.** "When we looked at our discharge times, they were far longer than the industry standard," says Ms. Acker. "We thought our nurses were just being especially nice, taking time to make sure patients were ready. But on our patient satisfaction surveys (which Blake Woods also benchmarks), patients were complaining that they were at the center too long after surgery and that they forgot discharge instructions."

So the center incorporated explanation of discharge instructions into the pre-op process and began discharging patients as soon as they were comfortable.

"We use topical anesthesia for the most part, so if they're stable, anesthesia discharges them in the OR," says Ms. Acker. "We get them a drink, get the IV out and reaffirm that they're stable in the post-op area, then we send them home. Patient satisfaction scores went up immediately after we implemented this change and remain in the 99th percentile."

• **Help with adding specialties.** Blake Woods recently opened a third OR and added orthopedics and general surgery, and Ms. Acker used available benchmarking information — especially with regard to supply costs — to help guide all parts of the process, from planning to setting expectations to purchasing.

"For scheduling purposes, we looked at the time frame we should expect a knee or a shoulder to take," she says. "We looked at cost-comparison benchmarking, so when surgeons said, 'We need this $300 anchor,' we were able to say no. We also looked at case volumes and average reimbursements" to determine the number of cases needed for profitability and to guide negotiations with insurers.

"I think with any project you want to start or any area you want to grow, you really need to look at the data that's out there," says Ms. Acker. "When I want to do something, I pay for the benchmarking report; I've used something from every one I've ever received."

2. Cost-justifying equipment purchases

"We had a facility that was finding its recovery times were five minutes longer than the national average," says Ms. Green. "So we helped them devise a formula to understand how much that five minutes was costing — and how much trimming that excess could save them."

Here is Ms. Green's formula:

Charge per procedure / OR minutes per procedure = OR cost per minute

_____

Procedures per month x OR minutes = Current OR time

Procedures per month x Target OR Minutes = Target OR Time

Current OR Time – Target OR Time = Wasted Minutes

Wasted minutes / Procedures per month = Average time wasted per case

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Average time wasted per case x OR cost per minute = Wasted Dollars

"This let us show not only how much they stood to save by becoming more efficient, but how much income they could add by streamlining and using formerly wasted time to perform procedures," says Ms. Green. "One facility we work with was able to cost-justify purchasing eye stretcher chairs that the patients never leave from pre- to post-op using this formula. The chairs save time because the patients don't have to get out of them, and the saved time meant more procedures."

Because the chairs are a one-time cost, the facility has continued to reap the efficiency benefits long after purchase. Further, they enhance safety by preventing patient falls and protecting the skin integrity of older patients because you eliminate having to move them.

"You can adapt the formula to determine the charge per minute of the entire procedure, through discharge," adds Ms. Green. "Then, when you look at complication rates, you can figure out how much a complication costs you. If patients are staying two to four hours instead of 30 minutes, you can see how that would eat up all your profit on the case; you might even have to do more cases in order to make up for the hit from that one complication."

3. Making patients more comfortable

In addition to tracking various clinical indicators, Digestive Health Specialists—Puyallup keeps close watch on patient satisfaction scores.

"If we see complaints consistently, we take them to the standards of practice committee to develop a plan of action to correct the issue," says Chalene Wilson, RN, the center's director of nursing. An example: "One of the things we ask on our patient satisfaction surveys is whether patients had any swelling, redness or tenderness at their IV sites. A lot were coming back with reports of these symptoms."

To address this, a product rep from the supply company in-serviced the staff on proper technique.

"Our phlebitis rates decreased quickly," says Ms. Wilson. Rarely do we have an IV site problem. The in-service was an easy fix for something that had been a discomfort for patients, but that we might not have spotted otherwise."

4. Meeting best-practice standards

Sometimes, when quality tracking reveals inefficiencies, you may find that you aren't fully utilizing national best practices. Central Bucks Specialists in Doylestown, Pa., for example, 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. When the surgeon 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, Central Bucks started scheduling his procedures for an extra 15 minutes each, and built it into the schedule, eliminating backups for his patients. And the faster physician was able to slow his scope withdrawal to ensure greater consistency and better adhere to identified GI best practices.

Contact Stephanie Wasek at ***stephanie@beckersasc.com****.*

Key Statistics for Cataracts, Colonoscopy and Knee Arthroscopy

Cataract surgery

Here are selected national averages for cataract surgery times and an interesting practice statistic, courtesy of Surgical Outcomes Information Exchange. The numbers represent the average for 27,000 cases submitted to SOIX from 2006 to March 2008.

- OR time — 25 to 30 minutes
- Recovery time — 25 to 30 minutes
- Surgical time — 15 to 20 minutes
- 76 percent of facilities use MAC anesthesia for cataracts.

The 2007 AAAHC Institute report "Cataract Extraction with Lens Insertion" offers data from 70 organizations that perform more than 131,000 cataract surgeries each year. Here are some of the data from the report, the latest of seven conducted since 1999 on cataract and lens operations:

- Intraoperative anesthetic techniques included topical (42 percent), peribulbar block (24 percent), retrobulbar block (26 percent).
- Individuals insured by Medicare were less likely to receive high-tech replacement lenses that also correct presbyopia (15 percent) compared to non-Medicare eligible patients who received the corrective reading lens (28 percent).
- Two weeks after surgery, 95 percent of patients said their vision had changed for the better. Ninety-nine percent said they would recommend the procedure to friends or family members with cataracts.

Colonoscopy

The AAAHC Institute report gathered data from 107 organizations that perform nearly 500,000 colonoscopies each year. Here are some findings from the report, also the seventh in the series of colonoscopy best practices studies conducted by the AAAHC Institute:

- In 94 percent of cases, a time was given for visualization of the cecum.
- In 80 percent (1,871) of the cases, the time from cecum visualization to the end of the procedure was six minutes or more.
- The average time from the visualization of the cecum to the end of the procedure (by organization) ranged from four to 18 minutes, with a median of nine minutes.

Knee arthroscopy with meniscectomy

This AAAHC Institute study gathered data from 31 organizations performing more than 17,800 procedures a year participated. Among the findings:

- Forty-five percent of procedures were performed due to traumatic injury and 55 percent due to degenerative disease.
- Average discharge time ranged from about 94 minutes for patients receiving epidural/spinal anesthesia to 66 minutes with local anesthesia and IV sedation.
- All but 35 patients (5 percent) indicated they had begun walking within seven days of the procedure.

— Stephanie Wasek

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Resources

National trade associations

The ASC Association. The ASC Association is a membership and advocacy organization that provides member benefits and services; combats legislative, regulatory and other challenges at the federal and state levels; assists state ASC associations; enhances ASC representation at the state and federal levels; and established a political action committee. The other arm of the ASC Association, the Ambulatory Surgery Foundation, is an educational and research organization. To learn more, contact Kathy Bryant, president, at (703) 836-8808 or e-mail ASC@association.org.

Physician Hospitals of America. Physician Hospitals of America offers support, advocacy and educational services to the physician-owned hospital industry. PHA envisions a healthcare system focused primarily on patient care, in which physicians are involved in every aspect of delivery. For more information, visit http://physicianhospitals.org or contact Molly Sandvig, JD, executive director at (605) 275-5349 or e-mail info@physicianhospitals.org.

Accreditation

The Accreditation Association for Ambulatory Health Care. The Accreditation Association for Ambulatory Health Care, founded in 1979, has become a leader in ambulatory health care accreditation with more than 3,800 organizations accredited nationwide. For more information, visit www.aaahc.org or call (847) 853-6060.

The Joint Commission: Ambulatory Care Accreditation Program. The Joint Commission has been accrediting ambulatory surgery facilities since 1975, and has more than 1,600 ambulatory organizations accredited nationwide. For more information, visit www.jointcommission.org/ASC or call (630) 792-5286.

Anesthesia staffing and practice management

Anesthesia Healthcare Partners. Anesthesia Healthcare Partners was established in 1997 as an anesthesia staffing and practice management company. To learn more, visit www.ahphealthcare.com or call (800) 945-6133.

Superior Medical Services. Superior Medical Services is a full-service medical recruitment firm specializing in permanent and locum tenens placement of anesthesiologists, CRNAs and pain management physicians nationwide. Visit SMS at www.smsanesthesia.com or call (847) 816-9296.

Back-office management, outsourcing and accounting

Credentialing Corporation of America. Credentialing Corporation of America is a credentials verification organization that provides ongoing credentialing services for ASCs and other healthcare entities. Contact CCA at (866) 222-0034 or visit www.ccacredentialing.com.

MedHQ. MedHQ provides accounting, revenue cycle, human resources and credentialing services to clients in 10 states. Learn more at www.medhq.net or call (708) 492-0519.

Somerset CPAs. Somerset's healthcare team is comprised of more than 20 dedicated professionals serving clients nationwide, including all types of healthcare organizations — ancillary service providers, surgery, imaging, infusion and dialysis centers, therapy facilities, other relevant ancillaries and physician groups. For more information, call (800) 469-7206 or visit Somerset CPAs online at http://healthcare.somersetcpas.com.

Billing, coding and collecting

Affiliated Credit Services. Affiliated Credit Services is a Colorado-based professional account receivables management firm which focuses on increasing businesses cash flow by providing superior collection services. Learn more at www.acscollects.com or call (970) 867-8521.

Key Health. Key Health is a leader in providing unique financial solutions to healthcare facilities, healthcare providers and attorneys, and it funds medical services on a lien/letter of protection basis on behalf of injured patients. Learn more about Key Health at www.keyhealth.net or call (877) 633-5436.

The Coding Network. The Coding Network is committed to provide cost effective state-of-the-industry procedural and diagnostic coding support to medical groups, academic practice plans, hospitals, ambulatory, surgery centers, and billing companies throughout the United States. Learn more at www.codingnetwork.com or call (888) 263-3633.

National Medical Billing Services. National Medical Billing Services specializes in freestanding outpatient surgery center coding and billing, offering a cost-effective service, subject matter experts and integrity in business relationships. To learn more about NMBS, call (636) 273-6711 or visit www.asccoding.com.

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

Cataract outsourcing

Vantage Technology. Vantage Technology is a turnkey service providing eye programs to both rural and metropolitan hospitals in 19 states. Visit www.vantage-technology.com or call (217) 342-4171 to learn more.

Compounding pharmacies

JCB Laboratories. JCB Laboratories is a compounding pharmacy that serves the ASC marketplace. Contact CEO Brian Williamson, PharmD, at (877) 405-8066 or visit www.jcblabs.com for more information.

Construction and architectural firms

AMB Development Group. AMB Development Group specializes exclusively in the development of ambulatory care facilities nationwide, including surgery centers, medical office buildings, clinics, imaging centers and outpatient centers. E-mail Jack Amormino at jamormino@ambdevelopment.com, call him at (800) 779-4420 or visit www.americanmedicalbuildings.com for more information.

BBL Medical Facilities. BBL Medical Facilities is a single-source business unit with plan, design, build and development capabilities, and has been developing attractive, efficient and cost-effective medical facilities for more than 30 years. Learn more at www.bblmedicalfacilities.com or call (888) 450-4225.

Clayco. Clayco, a privately-owned real estate, architecture, engineering, design-build and construction firm, serves the healthcare industry. For more information, contact Rice A. (Sandy) Jacobs at (888) 429-3330 or via e-mail at jacobss@claycorp.com or visit www.claycorp.com.

Irmscher Construction. Irmscher is a 115-year-old national healthcare project development firm specializing in the design and construction of healthcare facilities. For more information, visit www.irmscherinc.com or call (260) 422-5572.

L3 Healthcare Design. L3 Healthcare Design is a surgery center design and research firm, focused on ASCs and clinics. To find out more, visit www.l3healthcaredesign.com or call (866) 929-5353.

Lauth Property Group. Lauth Property Group is a leader in the development, construction, management and ownership of commercial real estate throughout the United States for the past 30 years. Learn more at www.lauth.net or call (317) 848-6500.

Leopardo Construction. Leopardo Construction is a leading construction company offering preconstruction, general contracting, construction management, design-build and development services across several vertical industries. Find more information at www.leopardo.com or call (847) 783-3000.

Marasco & Associates. Marasco & Associates is a national architecture and consulting firm, dedicated to providing quality facility design and development assistance for outpatient medical facilities, private physician groups, hospitals and institutional clients. Contact the Marasco & Associates office at (877) 728-6808 or visit www.marasco-associates.com for more details.

Marshall Erdman & Associates. For more than 50 years, the name Marshall Erdman & Associates has been synonymous with the delivery of innovative healthcare facility solutions. For more information, visit www.erdman.com or call (608) 410-8000.

McShane Medical Properties. McShane Medical Properties is an integrated design/build construction and real estate development firm offering comprehensive services for the healthcare industry. Contact John Daly, vice president, healthcare, at (847) 692-8616 or visit the firm's Web site at www.mcshane.com for more information.

MedBridge Development. MedBridge Development is a medical facility development and management company creating state-of-the-art healthcare delivery environments in partnership with leading physicians. For more information, visit MedBridge online at www.medbridgedevelopment.com or call (805) 679-7560.

Consultation and brokerage of ASCs

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Finance

Bank of America. Whether your need is to expand due to growth, acquisition or merger, or make a strategic investment, Bank of America offers ASCs flexible equipment finance options with competitive rates. For more information, contact BALHealthcarefinance@bankofamerica.com or call (800) 835-8488.

CIT Healthcare. CIT Healthcare offers a full spectrum of financing solutions and related advisory services to companies across the healthcare industry. For more information, please visit www.cithealthcare.com or contact CIT Healthcare at (800) 547-7026.

CitiCapital. Whether you are looking to construct a two-room ASC, diagnostic imaging center, cancer treatment center or build a 20-bed surgical hospital, Citi's dedicated team of outpatient financing specialists can help make your plans a reality. Learn more at www.citicapital.com/medical-outpatient, or contact Ann Heck by e-mail at ann.e.heck@citi.com or call (877) 276-2249.

MarCap. MarCap puts its 30-plus years of healthcare finance experience to good use every day, working with its clients to find ways to improve patient care and increase business. Visit MarCap at www.marcapcorp.com or call (800) 621-1677.

Physicians Capital. This Nashville-based firm provides loans based solely on the future cash flow of a surgery or diagnostic center. Learn more at www.PhysiciansCap.com or call (615) 342-0824.

Physicians Financial Resource. Physicians Financial Resource is a leading advocate for physicians when sourcing capital for commercial investments and providing wealth management. Call (407) 830-7763 or visit www.physiciansfinance.net.

Health information technology providers

Amkai. Amkai is a software company with 20-plus years of experience delivering administrative and clinical solutions to ASCs, surgical hospitals and physician practices. Learn more at www.Amkai.com or call (866) 265-2434.

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Experior Healthcare Systems. Experior Healthcare Systems is a leading software developer specializing in practice management (ExpertPM) and electronic health records (RemedyEHR). Learn more at www.experior.com or call (260) 432-2020.

GHN-Online. GHN-Online is an industry innovator in online enterprise class healthcare transaction processing. Visit www.ghnonline.com or call (214) 696-5717 to learn more.

Laserfiche. Laserfiche offers a suite of products and services that address enterprise-wide challenges from the perspective of executives, records managers, IT staff members and end-users. Find more information at www.laserfiche.com or call (800) 985-8533.

Mednet. Mednet is a software technology company, led by a group of professionals from the ASC market who understand the core of your business practice and its unique requirements. Learn more at www.mednetus.com or call (866) 968-6638.

Medtek.net. Medtek.net is a leading provider of medical transcription solutions for healthcare providers and healthcare organizations, with clients including hospitals, ASCs, clinics and

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ScheduleSurgery.com. ScheduleSurgery.com offers SCOR, a multi-purpose communication and case scheduling tool that leverages the Internet to improve ASC case scheduling efficiency, customer service and ability to market services. Learn more at http://schedulesurgery.com or call (888) 463-9058.

SourceMedical Solutions. SourceMedical is a leading provider of outpatient information solutions and services, collectively serving ASCs, rehabilitation clinics and diagnostic imaging centers. For more information, visit www.sourcemed.net or call (800) 719-1904.

Surgical Notes. A preeminent nationwide provider of medical transcription, coding and other related value-added information technology services for the ASC market, Surgical Notes provides transcription, coding and practice management solutions to more than 420 surgery centers and 6,300 physicians in more than 40 states. To learn more, visit Surgical Notes online at www.surgicalnotes.com or call (214) 821-3850.

VersaSuite. VersaSuite is a comprehensive integrated software management system which consists of a number of modules, both healthcare- and business-related. Find more information at www.versasuite.com or call (512) 250-8774.

zChart EMR. zChart EMR, a first-rate, intelligent, 21st-century surgical chart, was developed by dozens of healthcare professionals — administrators, office staff, nurses and physicians — at multi-specialty outpatient surgery centers. For more information, contact Kent Barber at (866) 924-2787 or visit www.zchart.com.

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Medical Protective. Medical Protective is a national leader in primary medical professional liability coverage and risk solutions to healthcare providers. To learn more, call (800) 463-3776 or visit www.medpro.com.

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

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

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Foundation Surgery Affiliates. Foundation Surgery Affiliates is a healthcare management organization specializing in project development, innovative facility design, partner recruitment and facility operations for ASCs, medical office buildings, surgical hospitals and bariatric hospitals and healthplexes. More information about FSA can be found at www.foundationsurgery.com or call (405) 608-1700.

HealthMark Partners. HealthMark Partners owns and operates single and multi-specialty ASCs throughout the United States by creating joint-ventures with physicians or physicians and hospitals. Please visit the company Web site at www.healthmarkpartners.com, e-mail Senior Vice President — Development Kenny Spitler at kspitler@healthmarkpartners.com or call him at (615) 341-0701 to learn more.

Health Inventures. A management and consulting services firm, Health Inventures has been developing and expanding ambulatory surgery care and other outpatient services since 1976. Learn more at www.healthinventures.com or call (720) 304-8940.

Instantia. Instantia is a company founded by Jack Amormino and Lisa Freeman to provide development services to surgical centers. For more information, visit Instantia online at www.instantiahealth.com or call (303) 554-0046.

Medical Facilities Corporation. Medical Facilities Corporation is a publicly traded company and a leading acquirer of majority interests in high-quality specialty hospitals and ASCs. Visit MFC's Web site at www.medicalfacilitiescorp.com or contact Steven Hartley at (866) 766-3590 ext. 105.

Medstone Capital. RMC MedStone Capital combines the strength of several industry standards like Mike Lipomi, Tim Noakes and the Stanislaus Surgical Hospital of Modesto, Calif., with one of the leading real estate companies in Dallas, RM Crowe, to form a very strong team. You can see more information on MedStone at www.MedstoneCapital.com or call Mr. Lipomi directly at (209) 602-3298.

Meridian Surgical Partners. Meridian Surgical Partners aligns with physicians in the acquisition, development and management of multi-specialty ambulatory surgery centers and surgical facilities. E-mail Kenny Hancock, president and chief development officer of Meridian, at khancock@meridiansurg.com or call him at (615) 301-8142 for more information.

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

Nikitis Resource Group. Nikitis Resource Group is a new ASC development, management and consulting firm with a team that encompasses more than 100 combined years of ASC development and management experience, HOPD and hospital consultation experience and licensure and accreditation assistance to centers. To learn more, contact Dawn Q. McLane, chief development officer, at DAQuay@aol.com or call (720) 320-6577.

NovaMed. NovaMed acquires, develops and operates ASCs in partnership with physicians. For more information, visit NovaMed at www.novamed.com or call (312) 664-4100.

Nueterra Healthcare. Nueterra Healthcare partners with physicians and hospitals to develop and manage community hospitals, surgical hospitals, ASCs and physical therapy centers including new development, joint-ventures, acquisitions and turnarounds. For more information e-mail Denise Mayhew at dmayhew@nueterra.com, call her at (888) 887-2619 or visit Nueterra's Web site at www.nueterra.com.

Orion Medical Services. Orion Medical Services offers a turnkey approach to ASC development and management by covering all aspects of a project from financial feasibility analysis to site and operational development. For more information, visit Orion Medical online at www.orionmedicalservices.com or call (541) 431-0665.

Pacific Surgical Partners. Pacific Surgical Partners was created to own and operate outpatient surgery centers exclusively in southern California, primarily in conjunction with physician partners. For more information, visit www.pacificsurgicalpartners.com or call (818) 881-1106.

Physicians Endoscopy. Physicians Endoscopy develops and manages endoscopic ASCs in partnership with practicing GI physicians and hospitals. Visit the company on the Web at www.endocenters.com, e-mail John Poisson at jpoisson@endocenters.com or call him at (215) 589-9003.

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Prexus Health. Prexus Health is a 100 percent physician-owned company that specializes in the development and management of multi-specialty, physician-owned ASCs and small hospitals. For more information, call (513) 454-1414, e-mail Prexus at info@phcps.com or visit the Web site at www.prexushealth.com.

Regent Surgical Health. As buyers, developers and managers of outpatient surgery centers and physician-owned hospitals around the country, Regent Surgical Health is an experienced developer and specialist in turnaround situations. You can learn more by visiting Regent Surgical Health online at www.regentsurgicalhealth.com or call (708) 492-0531.

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Surgical Management Professionals. With a seasoned team of healthcare professionals, SMP specializes in the management and development of ASCs and surgical specialty hospitals. For more information, visit SMP's Web site at www.surgicalmanprof.com or call (605) 335-4207.

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In the Spotlight: Michael Kulczycki, Executive Director of the Joint Commission's Ambulatory Care Accreditation Program

By Rob Kurtz

1. What do you see as the top safety challenges facing ASCs today?

Michael Kulczycki: First, infection prevention, despite the fact that ASCs, historically, have had a very low infection rate. I think the last -report from the ASC Association's benchmarking has infection rates well under 1 percent. I think occurrences recently in Nevada and New York are raising a lot of visibility on that, and ASCs are going to see, potentially, some increased regulatory pressure about some very specific practices including guidelines around the use of multi-dose medications.

Longer-term, I think you're looking at the use of best practices regarding surgical infections — things like no hair-clipping, antibiotic use before surgery and then suspension of antibiotic medications are also going to get a lot more attention. It's likely CMS will adopt some of those best practices as part of its future requirements for reimbursement. A recent preliminary study showed that more than half of the organizations were already doing it but the industry will have to come a lot farther, a lot faster.

Also, the case in Florida just reminds people of the need to stay on top of malignant hyperthermia. The Malignant Hyperthermia Association of the United States is rich in resources about basic reminders of what you need to have on hand and just a reminder that this can affect everybody.

2. What makes/continues to make these challenges so difficult?

MK: The one advantage of an ASC over a hospital is if they recognize a change in practice, they can much more quickly implement it. The downside of that is, as opposed to a hospital where they can more simply mandate it for the surgeons, changing surgeon behavior and practice is more difficult in an ASC setting, particularly when some of the surgeons might be the principal owners of the overall organization. It's the nature of behavior.

I'll use an example of our current Universal Protocol. That protocol has been around since 2003, it's been endorsed by many of the physician specialty societies, and we here, at the Joint Commission, continue to see rates of 20 to 25 percent non-compliance. Behavior is hard to change.

3. Can you offer some quick tips for what ASCs should be doing (that perhaps they aren't already) to keep these challenges from becoming problems in their centers?

MK: In terms of infection prevention, CDC recently updated some very specific resources about infection prevention (**www.cdc.gov/ncidod/dhqp/gl_isolation.html**), particularly with needle use, and I think ASCs should obtain that resource and make sure everybody's well-versed in it. My other suggestion is to take advantage of the Association for Professionals in Infection Control and Epidemiology, the society for prevention of infection, and use it as a resource. The Association of periOperative Registered Nurses is another good resource. Finally, the ASC Association is also engaged with states like Nevada and others to help encourage improvements.
I also encourage ASCs to stay very tuned to the regulatory agencies in their states. In Nevada, they've already talked about some state-specific things; they're talking about it in New York as well. ASCs in other states should pay attention to what is happening in these states. As it is with wrong-site surgery, it's the issue of practices, such as those dealing with multi-dose vials or using multi-dose medications that are really designed for single-dose. I think that practice is much more widespread than people realize and, again, it's a matter of changing behavior.

4. What does the Joint Commission see as major future challenges for ASCs in the next year, five years and 10 years?

MK: One area I would suggest ASCs look closely at is sleep apnea. In 2008, the Joint Commission looked very hard at recommending a National Patient Safety Goal in this area. We're likely to re-look at it for 2010. The issue here is there is so much undiagnosed sleep apnea and it has so much impact on unintended and unanticipated outcomes from use of certain anesthetic agents that it's very hard to predict, so this is an area that I think organizations will need to pay more attention to.

Another area for ASCs is patient falls. The Joint Commission does not currently make applicable to the ambulatory setting a current patient safety goal as it has for some institutional settings on patient falls. As I watched the field, I've seen a lot more attention in the ASC environment to that issue. I'm aware of a lot more organizations that have implemented some steps, so that's another area that we likely may look at: making the current goal in terms of falls, adapting it to the ambulatory environment and then making it potentially applicable in the future.

A third challenge is for ASCs to continue to improve their compliance with Universal Protocol for prevention of wrong-site surgery. The Joint Commission just released revisions to this protocol for 2009 (**www.jointcommission.org/PatientSafety/UniversalProtocol**), including suggestions from the surgery field as captured during the Wrong-Site Summit in 2007.

The final thing in this area is, as part of the Joint Commission's own improvement efforts, we're just now starting to launch what we are calling a robust process improvement. We're going to take a look across the quality spectrum and start to train some staff internally and take advantage of some quality mechanisms that are much more widely used in the commercial environment, and in a limited fashion in the healthcare environment. These tools include such approaches as Lean, Six Sigma and accelerated-change processes. We're going to train Joint Commission staff and to generate changes to our own internal processes so we can better serve our current customers and, more importantly, we're going to use those same processes and focus on how can we help healthcare organizations become what is known as high-reliability organizations, much like airlines, nuclear submarines and nuclear reactors.

To do that, we're going to be launching, in 2009, a new center that's going to focus on trying to pilot test these quality mechanisms with some healthcare organizations, initially at the hospital level but ultimately cascading those practices down as appropriate to other settings including ambulatory.

5. What are some effective means you have seen ASCs use to publicize their high level of quality and commitment to safety to patients, physicians and even payors?

MK: More and more organizations are promoting their accreditation status, and the Joint Commission's "gold seal of approval" is well-recognized.

I was recently at a surgery center in West Des Moines (Iowa). It was using a number of resources available on our Web site under our Speak Up initiatives program (**www.jointcommission.org/PatientSafety/SpeakUp**), including how to prevent surgical mistakes, how to prevent infection and how to prevent medication mistakes. Organizations can use these free resources in a downloadable brochure format and distribute those to their patients.

Increasingly, you see ASCs participate in national time-out day, a joint program between AORN and the Joint Commission.

I've also seen organizations take things like wrong-site surgery and elements of our Universal Protocol and create internal staff games, contests and fairs to have staff become fully aware of it, and I've seen some these even spill over to the patient environment.

Note: Learn more about The Joint Commission's Ambulatory Care Accreditation Program at **www.jointcommission.org/AccreditationPrograms/AmbulatoryCare/**. ■

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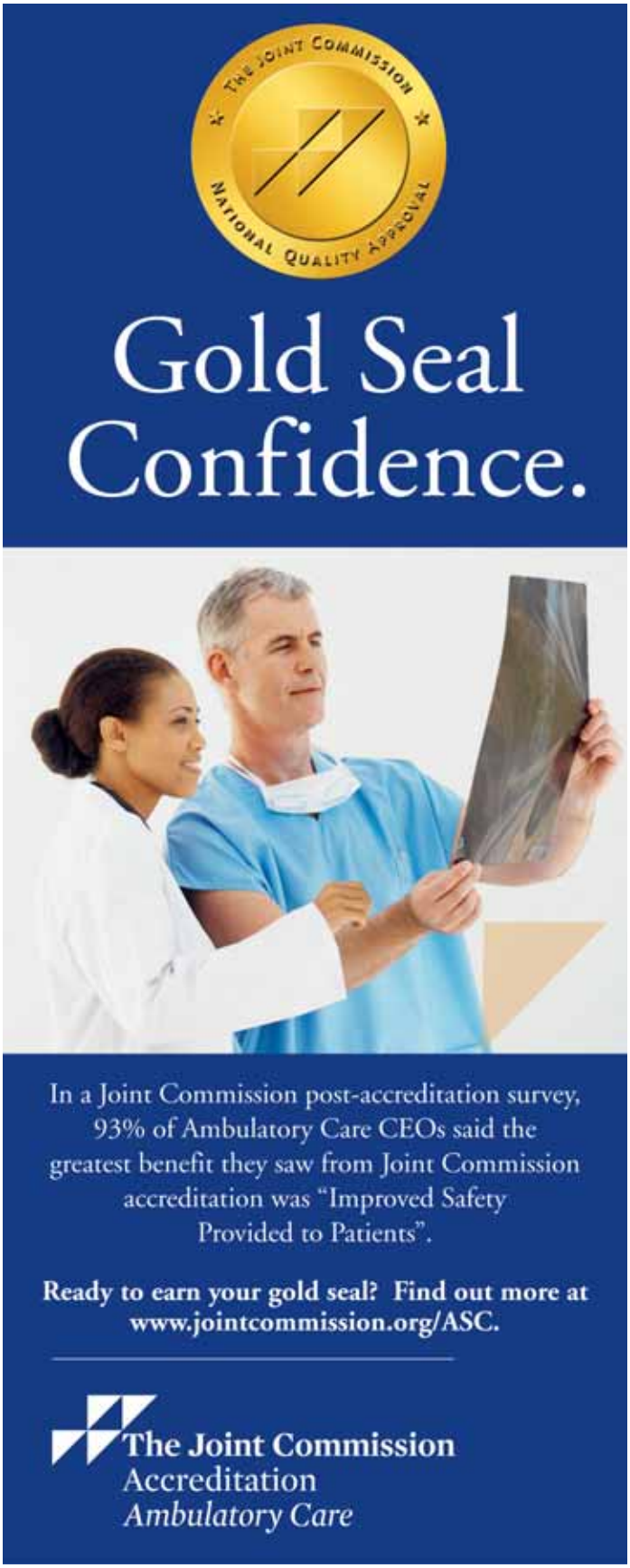

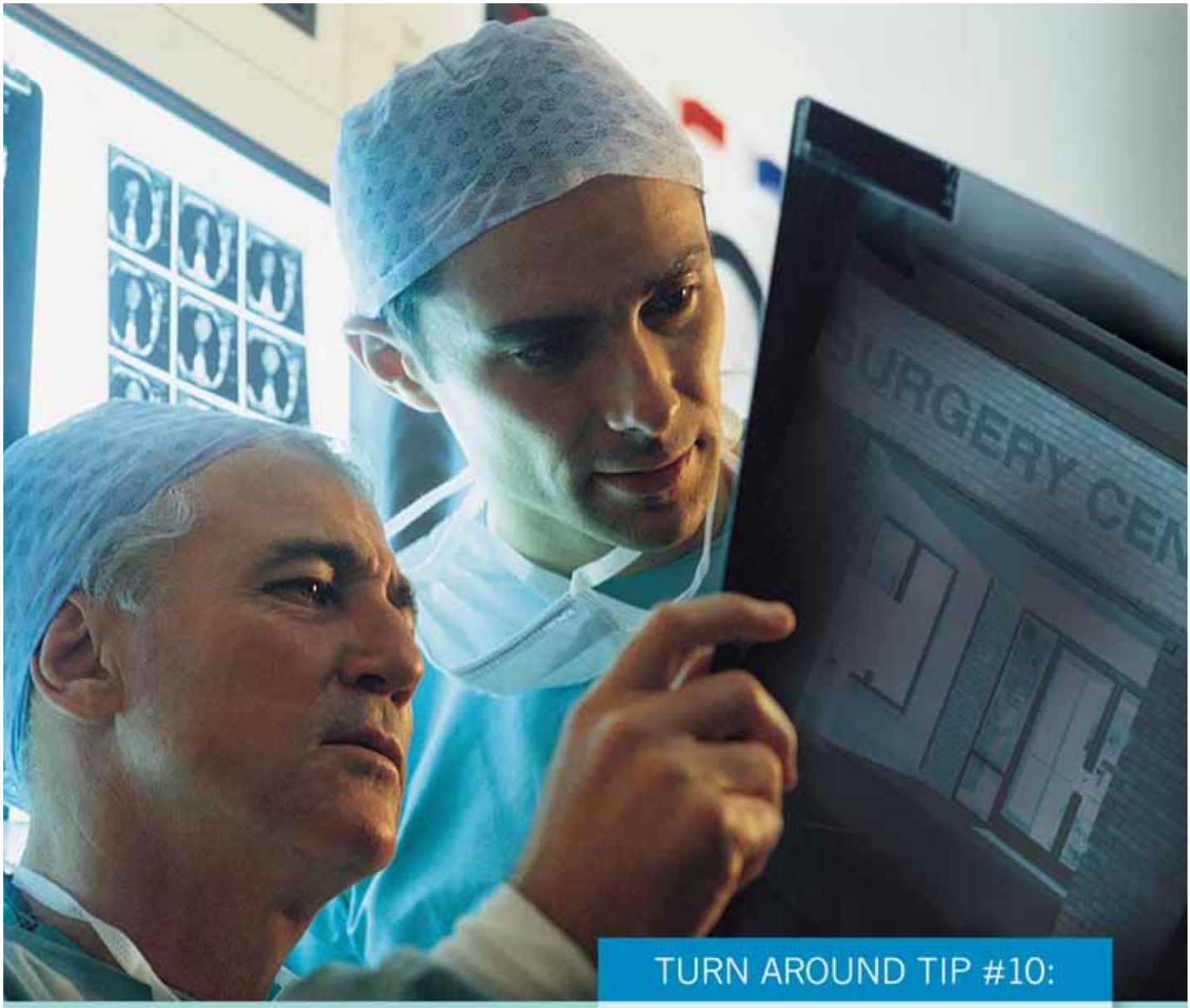

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