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BECKER'S ASC Review

PRACTICAL BUSINESS, LEGAL AND CLINICAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

40 Companies to Watch for 2008

By Scott Becker, JD, CPA

This article briefly highlights 40 companies that are active in the ASC industry. This list is not an endorsement of any company. This list also has an added six companies that are not directly managers or developers of ASCs.

1. Acumen Healthcare. Acumen works with both physician-owned centers and physician-hospital joint-venture centers. It provides development, operation, accounting and often other services on a non-equity basis. Its leadership includes Tom Pritchett, Andy King, Mark Dunlap and Tina Kern. For more information visit www.acumen-healthcare.com.

2. Alliance Surgery. Alliance Surgery, headquartered in Atlanta, owns and operates ambulatory surgery centers in partnership with physicians and hospitals throughout the United States. Its typical model includes a minority ownership interest plus a development and management agreement. Charlie Neal serves as the CEO of Alliance. For more information, visit www.alliancesurgery.com.

3. Ambulatory Surgical Centers of America. ASCOA was formed by Brent Lambert, MD, FACS, Tom Bombardier, MD, FACS, and George Violin, MD. Its senior leadership team now also includes CEO Luke Lambert, CFA, and CFO Robert Westergard, CPA. The company has grown to be one of the best privately held ASC chains in the country. It currently manages and owns approximately 30 surgical centers in many different

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Components of a Successful Weight-Loss Surgery Program in the ASC

By Stephanie Wasek

With obesity on the rise across the board in the United States, the need for bariatric surgery and related care is not going away anytime soon.

"It's absolutely no secret what's happening in the country with regard to obesity," says Tom Michaud, the board chairman and CEO of Foundation Surgery Affiliates. "It's a pandemic."

For example, he says, more than 30 percent of the population of Mississippi is now obese. Overall, two-thirds of the country is overweight, and one-third of that population is obese; about 7 or 8 percent of that portion is morbidly obese, says Mr. Michaud.

"That opens up a huge market opportunity, the ability for us to help the country in this disease, and it is a disease," he says. "Until about three years ago, it was a condition, but CMS reclassified, which, over time, will allow more insurance coverage when there is a medical necessity for weight-loss surgery."

The confluence of these two major factors — recognized medical need for a condition, increasingly accepted reimbursement — is bolstered by the availability of technology that allows a surgical cure on an outpatient basis. The result is a ripe market opportunity that poses unique issues and concerns of its own. For a discussion of those issues and concerns relating to profitability and a program set up for long-term success, read on.

Embracing the ASC

For ASCs, the surgical opportunity lies in providing laparoscopic banding procedures, a reversible reduction in stomach size that's less risky and requires a shorter stay than Roux-en Y gastric bypass.

"Lap banding isn't as significant in terms of weight loss quickly and long term," says Mr. Michaud, "but that doesn't mean that you don't have to be careful that you're not viewing it as isolated surgical intervention. It still has to be part of a program that includes a psychiatrist, a nutritionist, the surgeon, a physical therapist — it's not just surgery, it's a behavioral change issue."

And that's why the ASC is such a great venue, say the experts: Such a procedure requires a facility that sets patients up for success. (For more on handling patients, see "6 Keys to Caring for Obese Patients in Your Facility" on p. 13.)

"Patient satisfaction is higher when the surgery is done in an ASC," says Kent Sasse, MD, the founder and medical director of the Western Bariatric Institute, a nationally recognized surgical weight loss center and ASBS Center of Excellence, and author of several books. "People prefer the comfort and atmosphere of the ASC environment over the hospital environment. There's often greater privacy protection for patients and a greater feeling of comfort, warmth and welcoming in a surgery center."

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Letter from the Editor

This issue of the *Becker's ASC Review* focuses on the business and clinical issues of bariatrics, management and development companies to know, and key issues for orthopedics and spine.

The following list highlights the top 10 events for 2007 impacting ambulatory surgery centers. This list is, of course, subject to debate.

1. Change in payment system and rates. The event that may have the largest impact on ASCs is the change in the payment system for surgery centers. ASCs, after a long battle, have received the opportunity to bill on a comparable system as hospitals. However, comparable is in the eyes of the beholder. Rather than billing at the same rates as hospital outpatient departments, surgery centers can bill at approximately 65 percent of what hospitals bill at. The system will phase in over four years. Under the system, there are clear winners and losers. Surgery centers that do higher-acuity cases tend to win. Surgery centers that handle lower-acuity cases tend to lose. In any event, the impact of the change in the system will be felt for a long time.

2. Going private. The year witnessed three important transactions that involved large, publicly traded surgery center chains going private. These included the sale of the surgery center division by HealthSouth to SCA, and the going-private transactions of United Surgical Partners and Symbion.

3. The divide between the haves and have-nots in the ASC sector. There seems to be a clearer and clearer breakdown within the surgery center business between haves and have-nots. This includes individual centers that do not have enough cases to operate effectively, and centers that do tremendously well. More and more, it seems that there is a clearer delineation between those centers that are successful and those that are not.

4. New (old) strategies for hospitals. Increasingly, hospitals have returned to an old strategy. This is the strategy of employing physicians and is often not focused on specialties. This has left many surgery centers without enough available partners to succeed and without enough independent physicians to recruit. This has changed the environment for ASCs significantly in many communities already.

5. Physician-owned hospital politics. The physician-owned hospital industry remains under siege. Due to a few Republican leaders who do not quite grasp the concept of free enterprise and capitalism's driving innovation, and the work of some regulatory-driven Democrat leaders, there continue to be aggressive efforts to stop the growth of physician-owned hospitals. Rather than viewing this as one of the great innovations in healthcare (higher and focused quality and a potential for lower cost), it is being viewed as a competitive issue that should be stalled before it impacts the existing hospital bureaucracy. There is an absolutely tremendous quote and discussion of the original hearings on Capitol Hill related to this issue in a book by Regina Hertzlinger titled Who Killed Healthcare. Here, Ms. Hertzlinger tells the following story on pages four and five of her book:

The real issue here is power: the less you and I know about the facts, the greater the power of those in the know–the hospitals, the insurers, and the health policy researchers.

This hearing in 2006 convinced me that some members of the American Congress were not interested in protecting the uninsured by compelling transparency. This got me really worried.

The second experience was also a congressional event, and it proved to be my personal tipping point. It was here that I saw that the U.S. Congress was even willing to suppress competition in order to protect the powerful, entrenched status quo healthcare institutions.

This epiphany occurred at a meeting set up to inform congressional legislative assistants about a new kind of hospital, a small one that specializes only in certain complex, high-tech procedures, like those for treatment of heart disease. These hospitals were partially owned and managed by doctors. It has long been my view that such specialty hospitals generally provide better, cheaper health care than the everything-for-everybody general hospital. These specialized hospitals can become really expert at the focused services they offer because they are run by knowledgeable and experienced doctors–which is often not the case with non-medical administrators in the huge general hospitals most of us frequent.

The hospital sector sorely needs innovation. Hospitals account for most of the costs and cost increases in health care, yet they provide such wildly erratic quality that hundreds of thousands of patients die yearly from medical errors that occur in hospitals. Although this innovation of small specialized hospitals was only a gnat relative to the size of the trillion-dollar general hospital sector, it potentially posed a major threat to them, and they knew it. To protect their position, the hospitals did what they always do: they ran to the legislators and tried to kill this potential competitor through politics, urging the Congress to pass the laws that would legislate this form of hospital out of existence.

The key witness at this event was the CEO of a chain of 24 non-profit hospitals who claimed that the impudent, venal 55-bed specialty hospital in his hospital chain's region would limit the ability of his billion-dollar nonprofit hospital chain to give free care to the poor and subsidize the very sick. He argued that the interloper hospital was hurting his own hospital's ability to help the uninsured because it was siphoning away his best-paying patients, hobbling his ability to help the uninsured as much as he wanted to.

Those in attendance nodded in agreement. They believed him. Most of the legislative assistants were in their 20s — too young to be dubious. How could one argue with the charitable intents of hospitals called "St. Elizabeth's," "Swedish Lutheran," or, in this case, "Sioux Valley Hospitals & Health System" (since renamed Sanford Health)? After all, they've been cornerstones of our communities for as long as anyone can remember. The other attendees in the room knew better, but they were in their 50s, veterans of Capitol Hill, long pickled and emasculated by Beltway cynicism.

Unfortunately, the U.S. Congress bought the hospital executive's argument, too. In a virtually unprecedented move, it shut down his competition with a moratorium on the expansion of specialty hospitals.

Let's peek beneath the veil of the purity and altruism in which this chain of nonprofit hospitals cloaked its argument and look at its financial results. The facts provide staggering repudiation of its expressed point of view. In 2003, while the hospital was supposedly locked in a death struggle with the entrepreneurial specialty hospital, it still managed to earn $26 million in profits after all expenses were paid, and it held another $50 million in cash and liquid investments. This is the money left

over after all charitable activities have been completed. These are huge amounts of money for a supposed non-profit. Then, in 2004, after Congress hamstrung the competitor, profits and liquid assets grew by 15 percent, a rate of growth most Fortune 500 companies would envy. Indeed, the hospital was fat enough to donate millions to activities like its local high school football league, which received nearly $200,000.

6. FASA-AAASC merger. This year marks the merger of the two largest trade associations for surgery centers. The remarkably well-led and -directed FASA merged with the viable and improved AAASC to create a much greater institution representing surgery centers. This could not have come at a better time. The surgery center association has done an outstanding job of protecting the interests of surgery centers throughout the country. To join FASA (to be named the Ambulatory Surgery Center Association — the ASCA or the ASC Association — as of Jan. 1) call (703) 836-8808.

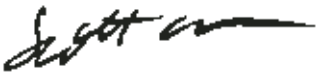
7. Spine and bariatrics. These two specialties have evolved to comprise very important procedures for surgery centers. While many administrators are still struggling to figure out how exactly to make spine and bariatrics work in their centers, increasingly, these are core parts and drivers of ASCs in many places. We expect to continue to see growth of these procedures at ASCs over the next few years.

8. Out-of-network crackdown. We are seeing, in New Jersey, New York and several other states, legal actions aimed at slowing down and stopping the use of out-of-network strategies. Given the small number of payors and the clout they have, this again provides incredible leverage to the payors as to price and reimbursement negotiations.

9. Codey case. Recently, a New Jersey case decided that a statute in New Jersey long held to allow physician-ownership of ASCs doesn't in fact allow physician-ownership. Since New Jersey has a great number of the country's surgery centers, this is a finding that, even though not binding, will potentially have a significant impact on surgery centers in New Jersey and throughout the country.

10. New ASC conditions for coverage. CMS, on the heels of issuing a new payment rate for surgery centers, also issued new conditions for coverage for surgery centers. Certain of these will cause significant confusion in surgery centers, including new discussions of 23-hour requirements and what kind of cases surgery centers can handle.

Very truly yours,



Scott Becker

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

Letter from the Editor

To-Do List Addition: Double-Check Your Data Security

If you're not sure about your data protocols, HIPAA Security needs to be at or near the top of your ASC's list of resolutions/priorities/things you'd generally like to get around to dealing with and/or checking on in 2008. I know, I know: first issue of the new year, and here I am, telling you how to proceed for the next 12 months. But it's estimated that 80 percent of ASCs are non-compliant with HIPAA's data security protocols, and in the first week of January alone, there were two major moves in this area you should know about (and take seriously):

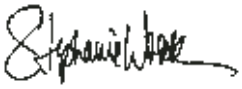
- **California's data-breach law now covers medical information.** If the integrity of patient data or health insurance information is exposed, facilities must notify patients who have been potentially affected. California's first-in-the-nation data-breach law formerly covered only financial information, but AB1298 expands it to include unencrypted medical histories, information on mental or physical conditions, medical treatments and diagnoses, unencrypted insurance policy or subscriber numbers, any applications for insurance, claims histories and appeals, according to the *San Francisco Chronicle*. Furthermore, notification is required even if the exposed information doesn't include Social Security numbers — a name is enough. California is considered a bellwether for legal and regulatory trends, so this won't be the last time you hear of such legislation.

- **CMS hired PricewaterhouseCoopers to perform HIPAA reviews.** After cataloguing more than 200 complaints about possible violations since HIPAA Security went into effect in April of 2005, CMS has hired PricewaterhouseCoopers to review facilities' compliance with the standards. The consulting firm is expected to be assigned 10 to 20 organizations against which security complaints have been filed, and those audits will be performed in addition to stepped-up efforts to review randomly on a non-complaint-driven basis, according to reports.

If these are any indication of the year ahead — and they seem to be — the security of patient data is going to be an increasingly hot topic for all of healthcare, especially ASCs, says Marion Jenkins, PhD, in "17 Red Flags of HIPAA Security in ASCs."

"Just look at the negative publicity generated when a mistake is made in an ASC or physician-owned facility versus a hospital … You may recall a recent news story where a hospital in Rhode Island was fined a mere $50,000 for performing brain surgery on the wrong side of a patient's head — for the third time in a year," writes Dr. Jenkins. "Can you imagine what would have happened had that episode occurred in an ASC? The same holds true for HIPAA Security Rule violations. Any ASC that faces a HIPAA Security-related incident is going to find itself on the front page of the newspaper."

For more guidance on the issue — just in case you're thinking HIPAA Security for '08 — check out page 28.



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Components of a Successful Weight-Loss Surgery Program in the ASC (continued from page 1)

Further, says Dr. Sasse, as with other specialties and procedures, ASCs aren't good for patients only.

"From the surgeon's perspective, having very effective outpatient surgery treatments for obesity really increases the attractiveness to a lot of potential patients who might not be interested in an inpatient, more invasive procedure," he says. "It's easier for me, more convenient. The turnover times are faster, the environment for the practicing surgeon is also friendlier and feels less like a larger institutional bureaucracy. It's a nice atmosphere for any surgeon to practice."

Partner with the right physicians

Given that the general surgeon who specializes in bariatrics will be the one responsible for bringing cases to the center, it's important that there be a true partnership between him and the ASC.

"You need a highly experienced surgeon who commits to a program," says Bret Petkus of Day One Health. "There's a significant effort that needs to take place at the practice level as well as the facility level." (For more, see "One Facility's Advice for Bariatric Success" on p. 12.)

Jeff Simmons, president, Western region, at Regent Surgical Health, agrees.

"The No. 1 key to success is that the surgeons in the program are the best in town," he says. "This is not the kind of procedure that any doctor should or can do. If a surgery center wants to develop a program, I would strongly recommend they seek out the best bariatric surgeons in community already doing these cases, and partner with them. Everything else will be easier; listen to your surgeons, be very careful on understanding the economics of this program, understand your costs for this program and perform cases that have higher reimbursements than the direct costs."

When the partner surgeon or surgeons come to the table with a high commitment level, it makes it easier to ensure they are aware of, sensitive to and highly involved with cost issues, which is especially important once the program is up and running.

"It helps align the surgery center and the surgeon toward a more efficient practice where everyone is trying to create the highest quality program without inefficient use of resources," says Dr. Sasse. "Surgeons with a vested interest in quality and costs will work to use less disposable instrumentation, strive to perform more efficient procedures with less OR time."

Undertaking a bariatric program

As with any specialty, there are two directions to go: single- or multi-specialty. Foundation Surgery Affiliates, for example, currently has two bariatric hospitals (among its 22 facilities) that exclusively perform both lap-banding and gastric bypass, and the company is taking the former into ASCs that are already in its established markets. The single-specialty approach is built from the ground-up, but weight-loss procedures can be integrated into multi-specialty facilities, which may be preferable for some, such as Regent Surgical Health.

"Like any successful business, whether it is healthcare or another sector, an ASC needs to be diversified so it withstands changes in reimbursement over time by various government agencies or private payers," says Mr. Simmons. "Given that premise, all of our surgery centers are multi-specialty, so we regard having general surgeons as partners a great asset to the partnership. And since it's general surgeons who perform bariatric surgery, it's a natural fit."

In addition, if laparoscopic general procedures are already being performed in your facility, it will save you about $100,000 in baseline costs. Mr. Simmons estimates that, from scratch, it costs about $250,000 to outfit an ASC with all the necessary equipment for weight-loss surgery, $100,000 of which is general laparoscopic surgery equipment. He recommends stocking 20 to 40 Lap-Bands, which come in two sizes, to start; at $3,100 a band, he estimates the initial outlay for this necessary supply would be at least $60,000.

You should budget at minimum $50,000 for non-surgical equipment that accommodates obese patients, such as larger chairs in the waiting room, gurneys with higher weight capacity, larger wheelchairs — even retrofitting for supported toilets.

"You shouldn't do this program inexpensively," says Mr. Simmons, which is why adequate procedure volumes are so important.

"If you're going to invest in $150,000 in equipment, you need some economy of scale," says Mark Mayo, the corporate director of ASC operations for Magna Health Systems. He estimates that adding on a bariatric program from scratch can cost up to $500,000. "It's different from the approach of just having a surgeon come in and do a handful of his cases a year when he needs a place to do them. You would want to perform between 50 and 100 cases per year, closer to 100 — that's several surgeons — because then you can start to get discounts on the Lap-Band itself, on tray set up fees, for everything that's on the table."

While they make up the bulk of the up-front costs, capital equipment and supplies aren't the only considerations. Fees to carry out a marketing campaign are important (as discussed in "Marketing to Enhance Your Weight-Loss Surgery Program" on p. 7.), as well as the cost of ensuring your surgeon can in fact perform weight-loss procedures.

"This might sound obvious, but it's not something you can just assume: Make sure that bariatrics is covered under your medical malpractice premium for the center," says Kenny Bozorgi, MD, of Day One Health in Chicago. "There might be a large cost differential, if it's not included, and you want to get it going on time."

Pursuing appropriate reimbursement

Once the initial capital outlay is made, having a handle on case costs before moving forward — and tracking them on an ongoing basis — is of the utmost importance for ensuring that you are reimbursed at a level at which you can turn a profit.

Regent's facilities reserve an overnight bed (for a 23-hour stay) every time a laparoscopic banding case is scheduled; about 60 to 70 percent of the time, the surgeon makes the decision that the bed won't be used, says Mr. Simmons, but every time, the bed is available and staffed.

"If you take into account that it costs a little over $3,000 for the Lap-Band, plus $1,500 for overnight nursing, then calculate what it costs to operate your facility on an hourly basis — assume at least $1,000 for the OR time — you're talking at least $5,600 of real costs," says Mr. Simmons. "If you have contracts, you need to negotiate higher than that; for self-pay patients, you'll have to set your fee above that number. In order to do that, you have to know your costs."

Private pay is the most hassle-free way to go, but you have to ensure that your fees are competitive within your market.

"That requires a thoughtful investigation of what if any self-pay programs are available out there, what's included in the programs and what the costs are," says Dr. Sasse. "For example, our program's self-pay fee includes one year of post-surgery band adjustments. Other programs may not have that, but ultimately you have to position yourself to give patients what they view as the best value for the dollar."

Not all patients will be able to pay cash, so it's a good idea to seek out a third-party credit organization that offers products for whom insurance is not an option and who don't have cash in hand.

"Partner with good organization with a solid reputation who can reliably give the money to patients," advises Dr. Sasse. This is especially important if you're "in an area where 90 percent of patients are paying out of pocket, which is what that investigation is for. But if you're in a population where there's a high pay rate from insurers, you want to maximize that situation in your contract before embarking on a program."

Mr. Simmons advises trying to secure a carveout agreement with insurers for weight-loss procedures. And, he says, "never even consider signing any contract unless you would get paid higher than your costs."

But how do you do so when the reimbursement atmosphere for bariatric surgery has been historically hostile? In the past, most insurers required (and many continue to require) a conservative approach that includes putting a patient on a restrictive diet and exercise program for six months to see if she loses weight. If she doesn't, she will be approved for surgery; if she does, however, she might risk denial.

"The problem is, patients don't put on the weight in six months, they're not going to lose it in six months," says Mr. Mayo. "But we have to go through those steps. Some insurers just won't pay for it at all, or they demand you go to a hospital. There's no unity in the insurance world and no unity on reimbursement rates."

As a result, rates are highly negotiable. While private pay remains easiest, negotiating with payors is getting easier as the designation of obesity as a disease becomes more accepted.

"I'd say 50 to 60 percent of insurance companies cover it," says Mr. Michaud. "Four or five states now say insurers must cover obesity as they would any other disease. At some point, probably after about a dozen states have taken that step, it'll become the norm. That's not to say the test of medical necessity is removed; the patient must need to have the procedure, same as if he needed any procedure."

It helps to have financial staff trained specifically in bariatric reimbursement, just as OR staff are trained specifically in carrying out weight-loss surgery. Billing and collections staff need to be up-to-date on each insurer's requirements and to have some type of relationship with the insurance company — they should have a contact person with whom they're in regular communication, whom they've told about the program.

"It's critical that business office staff have ongoing education to keep up on coding changes, payors' requirements for predetermination, and all those factors that are critical for success," says Dr. Bozorgi. "Staying on the cutting edge of billing really goes hand-in-hand with the empathetic approach to patients. Often, the financial side is equally difficult; paying can be as emotion-causing as the decision to have surgery itself. Business staff should be included in sensitivity training because they're the ones who, in many patients' eyes, are really the ones allowing this to happen."

Lastly, says Dr. Sasse, surgeons should not be removed from the reimbursement process: "Surgeons should dictate their notes immediately and clearly and be in communication with the business office if there are any unclear areas or ambiguous codes," he says. "Right now, there are emerging technologies in this field, and sometimes the coding lags behind the state-of-the-art for the procedures performed. So it certainly helps to have a surgeon engaged in the process, especially where there is some interpretation."

Right patients, right procedure, right time

The final key to ensuring a successful bariatric program is thorough screening for appropriate patients for the setting. In other words, an ASC can provide a platform for a major component of treatment, but if you're thinking of starting a bariatric surgery program, it must be part of an overall program that tackles obesity holistically and with a long view. If you're considering bariatrics, then, you should solidify your network of ancillary providers long before launching the program.

"With weight-loss surgery, you have to profile your patients for medical necessity and their ability to cope with the behavioral changes. Otherwise, while the technical component of your procedures is going to be fine, your outcomes at the end of the day are not going to be good," says Mr. Michaud. "It's a convenience for Lap-Band patients to have their procedures safely done in the surgery center environment, but you have to consider all aspects of the holistic program."

There are ways to get involved in the growing bariatric surgical market without pursuing the daunting activity of starting a weight-loss surgery program.

"If an ASC wants to be involved in the obesity market without going to that extent, there are options, for example, cosmetic surgery after the weight loss occurs. And about 30 percent of patients who have gastric bypass will need lap choles because bile is being handled differently by the gall bladder. There are ancillary instances in which ASCs can participate in the overall obesity program," says Mr. Michaud.

If you do choose to launch a program, it's a good time to put a toe in the pool, as the healthcare system as a whole continues to warm to the procedures, and the future for the market is bright.

"We're starting to see appreciation for the benefits of ASC-based bariatrics in terms of outstanding

patient care as well as decreased costs compared to other options," says Dr. Bozorgi. "It all snowballs into a decrease in costs for healthcare globally when we consider resolution of co-morbidities, less money laid out for medications, fewer days of work missed, and more active patients. All those things translate into money saved for the healthcare system." ■

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Marketing to Enhance Your Weight-Loss Surgery Program

Unlike with many ambulatory surgical procedures, weight-loss procedures are often private-pay and truly elective. That is, patients are making up their minds regarding how to spend their money; while they may be spurred on by health concerns, they are still consumers of a service. Thus, you can't discount the importance of marketing your bariatric surgery program, says Bret Petkus of Day One Health in Chicago.

He recommends taking this component seriously, which means developing a media plan and conducting market research. If you have the commitment and resources, hire an expert in this area.

"You have to ask, what's going on with competitive programs?" says Mr. Petkus. "Are you competing with hospitals? It's not likely other surgical centers, because this is so new for the ASC niche. Do you have a center of excellence hospital in town? Who are the competitive surgeons and programs?

"How big is your market? What is the percentage of obesity in your population? You have to really get to know your marketplace and, based on that, put a pro forma together over five years that includes a marketing component."

In order to successfully get the word out about your bariatric surgery program, says Mr. Petkus, you need to market to two channels simultaneously: direct-to-patient and physician-to-physician.

"This is where the relationship with and commitment from the surgeon comes in, because he's going to be involved funding the direct-to-consumer marketing campaign," he says. "Depending on your goals and resources, there are several media outlets to consider. TV commercials have proven effective, but then you need the infrastructure to manage the call volume appropriately. Even without a major campaign, who's going to respond to a first contact, the surgeon receptionist, the facility receptionist, a call center? To whom will they address frequently asked questions? You must consider the infrastructure to serve the patient."

A critical component for patient marketing is a comprehensive, informative, easy-to-use Web site.

"Web is top of the list: This patient population is very Internet-savvy and does a lot of research," says Mr. Petkus. "Even among the bariatric patient population, research indicates that the gastric banding population specifically is more likely to be Web-savvy. There's a lot of demand for information, they want to be assured they have the knowledge before they contact you."

Mark Mayo, the corporate director of ASC operations for Magna Health Systems, agrees.

"Because the patient may have been underserved medically, and socially may be a bit of an outcast, they might look for information online," he says. "Just as when patients started going through gastric bypass surgery, potential Lap-Band patients need to know there are other surgical methods for weight loss, including bypass, stapling and banding. You need to make it easier for them to decide what they may be interested in, to pursue it, to sit down with a doctor."

On the other side of the marketing plan, it's a matter of increasing awareness in the local medical community, as primary care physicians are the ones who would be potentially referring patients to the general surgeon or bariatric specialist who operates at your facility.

"The reason direct-to-consumer is working speaks to the fact that the medical community needs higher awareness; it'll likely recede as the medical community becomes more aware and can therefore direct patients to surgeons appropriately," says Mr. Petkus.

Physician-directed and -centered education, then, is the key.

"Surgeons across the nation who have built up significant programs call PCPs all the time, talking to them and educating them, conducting grand rounds and participating in different awareness events within the medical community," he says. "If a patient walks into a PCP's office, but you don't have a relationship with that PCP, that patient has to find and contact you independently. How will they hear about you? Developing a strong PCP referral program is the long-term road to building a successful program."

When starting this physician-to-physician marketing, "keep in mind that there are some strong biases within the non-surgical medical community that make referring for weight loss surgery very difficult," says Mr. Petkus. "For instance, there's still a strong belief that this is simply a willpower issue, and some PCPs won't refer. Interestingly, if a patient presents with cancer, it's not an issue: They get treatment. If they present with type 2 diabetes and have a BMI of 40, they receive a script for medicine and are told to 'lose weight.' That methodology does not serve this patient population.

"Five to 10 percent of the patient population qualifies for surgery, but there are lower rates of obesity in the medical profession, maybe 3 to 7 percent. So it's understandable that a medical professional would consider this a willpower issue unless they've been taught otherwise. There is peer-reviewed clinical literature out there on this topic and it is starting to hit the radar of many primary care physicians."

A third-party management company, ad agency and support staff can help with marketing efforts, but overwhelmingly, the bariatric surgeon must be actively participating in this facet of a program.

"There are a lot of little details that are going to make the whole thing run, but you've got to roll up your sleeves and start doing them," says Mr. Petkus. "If you're going to do a program, you can't do it in a partial manner. Make a commitment or you'll lose money."

— Stephanie Wasek

states. Its typical model includes a minority ownership interest plus a management and development agreement. ASCOA is one of the most highly competent companies in the ASC arena. For more information, visit www.ascoa.com.

4. AmSurg. AmSurg is one of the few pure-play publicly traded ambulatory surgical center companies remaining. The company recently hired a new CEO, Christopher A. Holden. It has traditionally focused on single-specialty centers, and is involved in many different specialties with its approximately 100 centers nationwide. For more information, visit www.amsurg.com.

5. Blue Chip Surgical Center Partners. Blue Chip Surgical was founded by ASC veteran Jeff Leland. It also has great leadership in Jay Rom, Beth Ann Johnston, RN, BS, Richard Roski, MD, FACS, and several others. With several highly profitable, physician-led centers in operation around the company and a number of projects in the works, it has been remarkably successful. The company has a reputation for delivering on its commitments and forging strong physician relationships. Blue Chip is focused on spine, ENT, sleep, radiosurgery and multi-specialty ASCs. It holds an equity stake in its projects and also serves as a managing partner. For more information visit www.bluechipsurgical.com.

6. Cirrus Healthcare. Cirrus has greatly expanded its growth and development over the past few years. The company, led by CEO Tim Parris, president John Thomas and general counsel Linda Moore, is on a rapid growth pace: It has several hospitals and surgery centers in operation and is expanding quickly. For more information, visit www.cirrushealth.com.

7. The C/N Group. Founded in 1980 by Ravi Chopra, the C/N group participates in the development, operation and ownership of outpatient healthcare facilities, including ASCs, diagnostic imaging centers and multi-specialty clinics. Family-owned and -operated, the company employs more than 200 people at its various facilities. Self-funded by members of the executive management team, including Rum Chopra and Raj Chopra, the firm has grown significantly over the last few years. For more information, visit www.thecng.com.

8. Community Health Systems. CHS, with the acquisition of Triad, has grown into a sizable operator of ASCs. While principally a hospital company, it also has increased leadership, such as Tim Bogardus, in the ASC arena. For more information, visit www.chs.net.

9. Foundation Surgery Affiliates. This company was founded by Tom Michaud, a pioneer in the ASC industry, who continues to oversee rapid expansion. The company operates centers in many states, many of which are very successful. It has branched out into the business of bariatrics and the operation of hospitals. For more information, visit www.foundationsurgery.com.

10. Global Surgical Partners. GSP operates eight multi-specialty ASCs in two states, with a ninth under development. The company's centers' activities are decentralized, but the administrators are employed by GSP, which takes a very hands-on approach financially and clinically. Headed up by J.A. Ziskin and Ken Arvin, GSP enters into long-term management agreements and acquires minority interests in its centers. For more information, visit www.globalsurgicalpartners.com.

11. HCA. HCA, one of the largest for-profit operators of hospitals in the country, continues to have one of the largest networks of freestanding ambulatory surgical centers. This network includes many centers that are "in market" as well as centers that are in markets that are not related to HCA hospitals. It remains one of the strongest operators of hospitals and health systems in the country. For more information, visit www.hcahealthcare.com.

12. Health Inventures. Health Inventures was one of the original non-equity management and development companies focused in the ASC industry. It is now often an equity partner in joint ventures as well as a manager and developer. Richard Hanley, Paul Davis, Dennis Martin and Peter Fatianow and a highly qualified management team continue to expand the mission of the company. For more information, visit www.healthinventures.com.

13. Healthmark Partners. Healthmark Partners is one of the true growth stories in the ASC industry. Over the past year, Healthmark Partners has added leadership and

ASCs at a fairly rapid pace. It provides a very hands-on approach to management and is willing to own either minority or majority interests in centers. Bill Southwick serves as CEO and president of Healthmark Partners, and Kenny Spitler serves as the chief development officer. Jim Corum also does an outstanding job helping to head up operations. The company has a great team of vice presidents. For more information, visit www.healthmarkpartners.com.

14. SCA. SCA is the company that acquired the HealthSouth ASC Division. Its typical model includes both majority ownership as well as, in certain situations, minority ownership. There are several professionals who lead SCA including Mike Snow, Brian Pope, Joe Clark and a host of others. Its management team is taking a very hands-on approach to management of its centers. For more information, visit www.scasurgery.com.

15. Instantia. This is a company founded by Jack Amormino and Lisa Freeman to provide ASC development and consulting services to surgical centers. Mr. Amormino has long been involved in the ASC industry as CEO of American Medical Buildings, a turnkey facilities developer. Ms. Freeman was a long-time leader with Aspen Healthcare. Instantia Health focuses on turnkey facility and operations development through Medicare certification and accreditation. For more information, visit www.instantiahealth.com.

16. Medical Facilities Corporation. MFC is a Toronto Stock Exchange company (trading symbol DR.UN). It was developed by the physicians of Black Hills Surgery Center and Sioux Falls Surgical Center in South Dakota. The company owns 51 percent or more of several hospitals and ASCs. It provides its member centers or hospitals with a liquidity option that does not involve giving up management. For more information, visit www.medicalfacilitiescorp.ca.

17. Meridian Surgical Partners. Merdian has completed several large acquisitions of several centers over the past 24 months. Just completing its second full year of operations, founders CEO Buddy Bacon, president and chief development officer Kenny Hancock and executive vice president and COO Cathy Kowalski, RN, along with John Wilson and Jim Uden head up an outstanding management team. The company has great experience with both surgical centers and hospitals. For more information, visit www.meridiansurg.com.

18. Mowles Medical Practice Management. Mowles Medical Management is one of the leading companies in the country with respect to the development of new surgical centers and office practices for pain management, as well as other specialties. CEO Amy Mowles has an expertise in pain management that is almost unequaled in the ASC industry. For more information, visit www.mowles.com.

19. National Surgical Hospitals. NSH is one of the leading surgical hospital companies in the country. By focusing the company principally on owning and developing hospitals with physicians, the very deep management team has been able to demonstrate proven results. NSH has taken a leadership role in the industry and made incredible contributions to the physician-owned-hospital trade association, Physician Hospitals of America. For more information, visit www.nshinc.com.

20. National Surgical Care. NSC, led by Sami Abbassi, Rick Pence and Greg Cunniff, has done a wonderful job completing ASC acquisitions. The company, importantly, has also provided outstanding management efforts after a transaction's close. It has acquired several centers this past year. For more information, visit www.natsurgcare.com.

21. Nikitis Research Group. This company was founded by the very entrepreneurial and intelligent Tom Galouzis, MD. Its leadership includes such industry veterans as Bob Scheller and Dawn McLane, RN, MSA, CASC, CNOR. The company has already begun to manage several centers and to develop other centers. We expect the company to have continued growth and success.

22. NorthStar Healthcare. This company was recently founded by chief officer Donald Kramer, MD, and a group of Canadian investors. It operates ASCs in Houston and Dallas. The company acquired the center owned by Dr. Kramer and other physicians as well as two other centers and three pain management clinics and is now looking to acquire additional surgery center companies. The company is traded under the symbol NHC on the Toronto Stock Exchange. For more information, visit www.northstar-healthcare.com.

23. NovaMed. NovaMed is one of the very few pure-play publicly traded ambulatory surgical center companies. Its leadership team includes outstanding people such as Tom Hall, Tom Chirillo, Jack Clark, Bill Kennedy and John Lawrence. It has an outstanding reputation as a high integrity company with which to do business. NovaMed is in the business of both developing de novo facilities as well as acquiring majority interests in existing ASCs. For more information, visit www.novamed.com.

24. Nueterra Healthcare. Nueterra is one of the most prolific owners and operators of surgery centers. It works with centers on a national basis and currently has a great deal of both ASCs and surgical hospitals in operation and development. With the help of a team with years of outpatient management experience, Nueterra is continuing on a substantial growth pace. In fact, the company has recently added more senior management to keep up with the pace. For more information, visit www.nueterra.com.

25. Orion Medical Services. Orion was founded by CEO James Cobb and has several leaders in its management team such as Scott McNulty, Robin Freeman, Ian McNickle and several others with extensive medical backgrounds. It provides a turnkey approach to all aspects of ASC development and management for surgery centers throughout the country. All key members of management of extensive medical backgrounds, helping them guide ASC partners to excellent profitability, high quality care and improved efficiency. The company currently has a number of centers on the West Coast — with specialized experience and expertise in neuro-spine surgery centers, and continue to evolve nationally. When partnering with Orion, surgeons own the majority share in the ASC. For more information, visit www.orionmedicalservices.com.

26. Ortmann Healthcare Consultants. Ortmann Healthcare, founded by Fred Ortmann, is a very busy and active player in the ASC industry. It works with both physician-hospital joint ventures as well as physician-only centers. For more information, visit www.ortmannhealth.com.

27. Pacific Surgical Partners. Pacific Surgical Partners was founded by Don Cook, a long-term surgery center veteran. He has started his new company with a few surgery centers in the Los Angeles area. His core goal is to become a leading development and management company focused heavily where they can impact managed care and other relationships in southern California. Mr. Cook is a terrific leader and business person. For more information, visit pacificsurgicalpartners.com.

28. Physicians Endoscopy. Physicians Endoscopy is probably the best and most focused company in the endoscopy area. Physicians Endoscopy has an outstanding core management team including Barry Tanner, John Poisson, Karen Sablyak, Melanie Gill and Carol Stopa, as well as board chairman Robert Gannan, MD, PhD. It focuses solely on GI and endoscopy centers, typically owning a minority interest in and managing its centers. It often also provides billing services to the centers. For more information, visit www.endocenters.com.

29. Pinnacle III. Pinnacle III is quickly evolving as a leading provider of consulting and management services to physician-driven surgery centers in the areas of hospital joint-ventures, turnarounds and hospital outpatient strategies. Pinnacle III has increased its management depth with the leadership of Rob Carrera, Rick Dehart and Scott Thomas. The company is on the short list of leading firms that provide both equity and non-equity models, though it is focusing on expansion of its surgical network through equity ownership. In addition to its development services, Pinnacle III provides a wide array of other services including, but, not limited to; ASC management, coding, billing and collecting, facility reviews, feasibility studies and financial forecasting. For more information, visit www.pinnacleiii.com.

30. Prexus Health Partners. Prexus Health Partners invests in and manages hospitals, surgery centers and imaging facilities. The company was formed by the remarkable Ajay Mangal, MD, MBA. Prexus has a deep leadership team that includes people such as Don Jannsen, Mike Griffin and Peter Laterza, who venture out beyond the company's Ohio headquarters. The company has almost no complaints from its physician partners and tends to do a very good job of managing and developing projects. The leadership team is very hands-on and working to grow at a fast pace. For more information, visit www.phcps.com.

31. Regent Surgical Health. Regent Surgical Health owns interests and manages physician-only centers, physician-owned hospitals, and physician-hospital joint venture ASCs. It has operations in approximately 12 states and is a leading operating company in the ambulatory surgical center industry. Founded by Tom Mallon, Regent has one of the best leadership teams in the country, one that includes Mike Karnes, Jeff Simmons, Nap Gary, Joyce Deno, Mike McKevitt and several others. It also has outstanding administrators. Regent Surgical Health was one of the first companies to focus on turning around surgery centers. For more information, visit www.regentsurgicalhealth.com.

32. Resurge Hospitals. Resurge Hospitals, led by Rusty Shelton, provides consulting and management to both physician-owned hospitals and physician-hospital joint venture hospitals. For more information, visit www.resurgehospitals.com.

33. RMC MedStone. RMC MedStone Capital and RMC MedStone Management were founded by R. Maurice Crowe and Mike Lipomi, bringing together many years' experience and leadership in both ASC and surgical hospital development, and operations, real estate acquisition, management and financing. The company recently acquired and invested in the Stanislaus Surgical Hospital in California and is seeking to partner with physicians on surgery centers and hospitals to acquire. MedStone is bolstered by chief investment officer Dodd Crutcher, JD, who trained as a lawyer, is a business management and investment genius and, accordingly, much, much smarter than your typical lawyer. For more information, visit www.medstonecapital.com.

34. Surgery Consultants of America. Caryl Serbin, RN, BSN, LHRM, the founder of this company, is one of the most focused and best people in the ambulatory surgical center industry. The leadership team is led by the remarkable Jo Vinson and outstanding Judie English. Ms. Serbin runs a company that is known for doing what it says it will do and providing excellent guidance. It works often with physician-hospital joint ventures and also with physician-owned centers. Surgery Consultants of America is often brought in to improve the billing and collections of centers and to provide turnaround management for centers that have the capacity to succeed. Ms. Serbin also founded a successful affiliate company that provides billing and collections services. For more information, visit www.surgecon.com.

35. Surgical Management Professionals. With a seasoned team of healthcare professionals, SMP specializes in the management and development of ASCs and surgical specialty hospitals. SMP is lead by industry veteran Doug Johnson, who is also the current president of Physician Hospitals of America (formerly the American Surgical Hospital Association). The company has the unique history of having been created by the Sioux Falls Surgery Center eight years ago and, as such, still has employees deeply involved in the clinical aspects of running a center. In recent years, the majority of its projects have been in the area of joint ventures between hospitals and physicians in CON states. These projects have served to integrate the medical communities in which they operate. For more information, visit www.surgicalmanprof.com.

36. Symbion. This company has one of the most stable and focused leadership teams in the country. The team at the top includes people such as Richard Francis, Cliff Adlerz, George Goodman, Ken Mitchell and Michael Weaver. It went public in 2004 and then private in 2007. It has enjoyed excellent growth through acquisitions and to a great extent through same-store growth. For more information, visit www.symbion.com.

37. Titan Health Corporation. Titan manages and develops specialty-focused surgery centers, with an emphasis on orthopedics, spine and neurosurgery, and pain management, on a national basis. Titan's leadership includes such industry leases as David Hall and Mark Jang. While it focuses principally on orthopedic, neuro and pain opportunities, it has a great variety of fully operational projects. Titan typically maintains a minority interest position and has a very nice reputation as a smart and trustworthy partner. For more information, visit www.titanhealth.com.

38. TRY Healthcare Solutions. Tom Yerden, ASC veteran and founder of TRY Solutions is principally involved in consulting with ambulatory surgical centers and hospitals. Mr. Yerden is currently doing the best work of his outstanding career and is making a deep and positive impact on the clients he serves. For more information, e-mail Mr. Yerden at tyerden@aol.com.

39. United Surgical Partners. USP combines the best mix of a core strategy with execution of the strategy better than any other company. It has a great leadership team including veterans such as Don Steen, Bill Wilcox, Brett Brodnax, Evie Miller, Jason Cagle, Andy Johnston, James Jackson and Monica Cintado. USP operates more than 150 different facilities, principally surgery centers, though it has a good number of hospitals as well. Most of its centers have a not-for-profit health system as a joint-venture partner. It continues to experience strong revenue growth through a combination of solid same-store sales growth, acquisitions and de novos. It is one of the most strategically smart companies in the surgery center market. For more information, visit www.unitedsurgical.com.

40. Woodrum ASD. Woodrum/ASD manages and assists physicians and physician-hospital joint ventures on a national basis; the company's principals have developed, owned and operated more than 155 ambulatory care centers throughout the United States. Woodrum/ASD is one of the larger privately held ASC firms and continues to add some very significant and top-notch professionals such as Sandra Jones and Paul Nylander to its roster of senior vice presidents over the last few years. The company is known primarily for two things: developing and managing hospital-physician joint ventures and physician-owned surgery centers; and its focus on ASC operations. Accordingly, it is increasingly doing ASC turnaround projects. Joe Zasa is the president of Woodrum/ASD and has done a great job of providing leadership to the company and to centers. Bob Zasa and David Woodrum, two of the founders of the company, are real leaders in the ASC industry and very actively involved in growing the company. Woodrum/ASD provides strategic services, operational and contract analysis, pre-development and development help, management and more to ambulatory surgery centers. For more information, visit www.woodrumasd.com. ■

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Seven More to Know

The following companies are not directly managers or developers of ASCs. They play an ancillary but important role, and are, therefore, companies you should also know about.

Access MediQuip. The nation's largest provider of outsourced medical implantable device management solutions, AccessMediQuip offers a device benefit management solution that includes expertise in the insurance authorization, inventory management, equipment procurement and claims processes. These services are said to eliminate device acquisition costs, minimize financial risk and increase accessibility to implantable devices, an outstanding benefit to orthopedics-driven ASCs when it comes to dealing with this major expense.

ASC Strategies. ASC Strategies, recently formed by ASC industry veterans Joan Dentler and Jessica Nantz, was built on the core belief that surgery center owners and their staff are more sophisticated and business savvy than ever before, and that they need only advice and oversight to stay on course. ASC Strategies mainly provides ASCs with operational assessments and ongoing operational oversight services. For more information, visit www.ascstrategies.com.

Eveia HealthCare. This company, founded by Naya Kehayes, MPH, in 1998, is the leading managed care contracting firm in the country. Matthew Kilton, MBA, MHA, joined the firm in 2004 as chief operating officer, and his contributions have been instrumental to the growth of the company. Ms. Kehayes is a Yale University graduate and extremely gifted. For more information, visit www.eveia.com.

Galil Medical. Galil Medical offers a cryotherapy platform for minimally invasive, targeted ablation procedures that can be beneficial additions to ASCs. For example, prostate cryotherapy, which will be reimbursed in ASCs beginning in 2008, can let multi-specialty facilities add a profitable, urology-driven procedure to their case loads, expanding their profiles and increasing the bottom line.

Ion HealthCare. Steve Burton formed Ion HealthCare to assist patients with diagnosing and managing sleep apnea and respiratory issues. Ion works with ASCs to arrange space, with Ion setting up either in the ASC, contiguous to the building or near the center, depending on the physical space available. Ion provides its own staff and equipment to perform billable, readily reimbursed testing procedures. The surgeon refers patients at risk for sleep apnea to Ion for screening when scheduling the surgery. There are two models for the program: a quality program that Ion provides at no charge to the center, or a joint-venture partnership that performs the quality program and allows the surgical center partners to participate in the revenues. For more information, visit ionhealthcare.mmaweb.net.

MedHQ. MedHQ is not a traditional manager or developer of surgery centers. Rather, it focuses its efforts on handling the back-office business operations of ambulatory surgical centers. It is lead by president Tom Jacobs and includes a very good team. The group has grown to provide back office services for dozens of surgery centers and some hospitals. For more information, visit www.medhq.net.

Somerset CPAs. Somerset CPAs, led by Steve Dobias and Mike McCaslin, provides a broad range of consulting services to ambulatory surgical centers, large physician practices and specialty hospitals. It has traditionally been very actively involved in the development of ambulatory surgical centers and specialty hospitals on behalf of orthopedic and other physician-driven projects. It does not generally provide ongoing management or have ownership in centers. For more information, visit www.somersetcpas.com.

— Scott Becker, JD, CPA

One Facility's Advice for Bariatric Success

By Stephanie Wasek

A year-and-a-half ago, the South Sound Surgery Center in Olympia, Wash., transitioned from a hospital-based outpatient surgery department to an independent ASC facility. General surgery made up about 30 percent of the multi-specialty center's procedures, so when a local bariatric surgeon, who has an office-based Center of Excellence, approached administrator Paul Wilkinson about adding laparoscopic banding, it was an easy transition to a successful program.

"The hospital was doing weight-loss procedures, and some of the staff shuttled back and forth between the [hospital and ASC], so some staff had experience with bariatric surgery," he says. "It's not that different from a lap chole on a procedure basis — one hour in the OR and same equipment, for the most part."

Mr. Wilkinson estimates South Sound Surgery Center spent about $10,000 on longer laparoscopic instruments and other surgical supplies especially for obese patients, and about $800 apiece for a couple of heavier-weight recliners (the older ones were only suited for up to 250 lbs.). The ASC already had OR tables that supported weights up to 500 pounds and motorized stretchers that supported up to 300 pounds.

"We'd already had a patient-exclusion criteria of up to 300 pounds, so we didn't need to change our criteria. Most of our patients are actually young and healthy with the exception of their weight," says Mr. Wilkinson. "Our surgeon, if he's got an especially sick patient or one who weighs over the limit, he just does them elsewhere. He self-selects which cases to do here, and knows which are going to do well. Selection is a key."

Here are five more keys to patient safety and a successful program, according to Mr. Wilkinson.

1. Anesthesia on board. The anesthesia team that serves South Sound has worked with the bariatric surgeon to develop specialized protocols for the procedures, and has embraced the challenges, such as airway management, posed by obese patients. "We have a team of 20 anesthesiologists who cover our ASC, and they had been doing these cases at the hospital, so it's not much of an adjustment for them," he says.

2. Developing patient expectations. The vast majority of patients are up and out of the center about three hours post-op. How can you improve your chances of that happening? Have the surgeon tell patients to expect such a length of stay, and have pre-op and post-op staff reinforce it. "When they're in the office, they're told they're not going to feel 100 percent, but they're going to feel well enough to go home a few hours post-op," says Mr. Wilkinson. "They spend about an hour in surgery, 45 minutes in PACU and another two hours in stage two recovery. You'll always have some who stay longer or shorter, but when you gear them toward that short stay, they're motivated to get out of there."

It helps that patients aren't slowed by heavy pain meds post-op: They are given liquid Lortab while in the facility and a prescription for the same to go home with.

"Patients just do better when they're able to relax at home in their own beds or on their own couches," says Mr. Wilkinson, noting that the system has led to excellent patient satisfaction scores — consistently 4.9 on a 5-point scale. "The ASC atmosphere appeals especially to our younger patient group."

3. Attention to staff and patient safety. Moving and transferring patients can pose an injury risk to both nurses and patients. Patients aren't presedated ("unless there's a good reason," says Mr. Wilkinson), so they walk to the OR and get onto the operating table themselves. When patients are sedated post-op, a hover-pad is used to transfer them to a stretcher.

"That does help, when you consider that even a 250-lb. patient is double the weight of some of our nurses," he says. "We also have two stretchers that are electronic, they move on their own, which prevents injuries from pushing the stretchers."

4. Guarantee the surgeon OR time. When you have a surgeon who's committed to his bariatric program and organized and motivated, reward him with proper block time. South Sound has two surgeons who perform weight-loss procedures, but one does the majority of them; in fact, it's all his practice consists of.

"We have five ORs, so we gave him a block once a week, and he typically does four cases in that block," says Mr. Wilkinson. "We've done five before, but that means the last patient might not be out of here till 5 or 6, so we try to keep it to four maximum. And, doing that has added about 125 cases this year to a relatively new center."

5. Figure out finances in advance. Mr. Wilkinson says that, because he knew the costs of doing a lap chole in terms of staff, supplies and OR time, it was easy to determine the cost for laparoscopic banding and to charge accordingly.

"I added in the $10,000 in equipment costs and the per-case cost of disposables he requested and the laparoscopic band, and came up with a figure. The surgeon and I negotiated and came up with a fair market value payment," says Mr. Wilkinson. All patients are self-pay, so the surgeon collects the fee up front from patients, then pays South Sound Surgery Center and anesthesia out of that fee. "He pays cash up front, so we're happy. And he's happy because it costs less than at the hospital." ■

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6 Keys to Caring for Obese Patients in Your Facility

By Stephanie Wasek

1. Surgeon, board and administration commitment

"With bariatrics, there's a more integral relationship with a committed surgeon because it does require careful coordination with their practice and the surgery center because of complexity of patients in terms of both financial and medical issues," says Kenny Bozorgi, MD, of Day One Health in Chicago.

Having an ownership interest in the surgery center lets the surgeon "play a participatory role in creating that high-quality experience," notes Kent Sasse, MD, the founder and medical director of the Western Bariatric Institute, a nationally recognized surgical weight loss center and ASBS Center of Excellence. "I think another key to success is having an ASC administration that really appreciates the far-reaching impact of bariatric surgery, and is ready and willing to support it.

Bret Petkus of Day One Health agrees: "There must be a solid institutional commitment from the board on down. Everybody has to be on board, and understand that this isn't a procedure, it's a program."

Expression of that commitment means optimal instruments and optimal facilities to accommodate overweight patients, says Dr. Sasse, as well as arranging for sensitivity training for staff, so they know how to talk to obese patients about weight-loss surgery.

2. Staff trained in sensitivity and technique

"Culturally you've got to educate the staff on the unique needs of these patients," says Jeff Simmons, president, Western region, at Regent Surgical Health, noting that weight-loss surgery patients have unique emotional and physical needs and may be reticent about treatment after years of marginalization and stigmatization by other medical professionals.

"In a lot of cases, they're viewed as having caused their medical conditions, so they're not taken seriously," says Mark Mayo, the corporate director of ASC operations for Magna Health Systems. "Staff need to have an understanding of weight gain, some of the reasons and rationalizations, the myths, the co-morbidities, and the fact that these people are primarily underserved in the medical community."

So every face the patient sees — from the receptionist to the post-op nurses — should be part of this training to ensure patient care is the highest level possible. Training in both sensitivity to the needs of the bariatric population and the medical and post-surgical needs of the bariatric patients should be ongoing.

Both outcomes and efficiency are enhanced when staff are trained for and concentrate on bariatric procedures, becoming more skilled at the technical side of the surgery, notes Dr. Sasse. Even the business staff should be included, says Dr. Bozorgi, because many patients view them as the gatekeepers to their procedures — after all, they ensure the patients with insurance can have their procedures reimbursed.

3. Facility outfitted for bariatric patients

In addition, your facility may need updating to accommodate obese patients.

"By the time the bariatric patient comes to your facility, she has been through months of meeting with doctors, months of trying to avoid surgery," says Jeff Simmons. "So by the time they hit your door, they're very pleasant to have around. They're looking forward to this, they're motivated, so you want to make the environment very comfortable for them."

To that end, you will need to buy non-surgical equipment such as larger chairs in the waiting room, gurneys with higher weight capacity, heavy-weight OR tables, larger wheelchairs and perhaps even retrofit some areas to have wider access or extra support, such as supported, ground-standing (rather than wall-mounted) toilets.

In terms of surgical equipment, you might need to purchase longer laparoscopes, video and other imaging equipment, Lap-Bands, longer trocars and other supplies. Then there's patient and staff safety: Moving and transferring patients can pose an injury risk to both nurses and patients.

"While our patients walk to the OR, we have a hoover-pad for post-op transfers from the OR table to the stretcher," says Paul Wilkinson, the administrator of South Sound Surgery Center in Auburn, Wash. "That does help, when you consider that even a 250-lb. patient is double the weight of some of our nurses. We also have two stretchers that are electronic, they move on their own, which prevents injuries from pushing the stretchers."

4. Multidisciplinary approach to protocols

There is a steeper learning curve with weight-loss procedures for all members of the OR team, say our experts.

"It starts with surgeons having criteria where patients are good or not good candidates for the surgeons — many people are inappropriate candidates for either the Lap-Band or for surgery on an outpatient basis," says Mr. Simmons. "So if patients are being selected appropriately, then the safety concerns are significantly minimized."

But careful selection doesn't eliminate concerns; obese patients are still high-risk for surgery of any kind, and your program must reflect that.

"It requires more and fine-tuning to the special set of circumstances brought about by the bariatric population in the ASC," says Dr. Bozorgi. "It's less relevant to a hospital-based situation or other experiences, so whereas you can transfer over skills from other specialties, this requires more attention."

It's advisable to work with anesthesiologists who are experienced in outpatient anesthesia or caring for obese patients — that base will give the anesthesia team a leg up on developing pre-op and post-op protocols to ensure patient safety. Physicians, nursing and anesthesia should collaborate to develop protocol that start with pre-op evaluation, extend through intraoperative medication and intubation protocols, and go all the way through recovery room milestones that need to be achieved during the patient's stay in the ASC and before discharge.

Dr. Sasse notes that, as a result of working closely with anesthesia, he's been able to operate on the "super-obese" and a patient who was scheduled for a lung transplant.

"A great system that emphasizes patient safety above all else, that begins with going over protocols and establishing criteria that everyone is comfortable with, helps a lot with safety and security," he says.

5. Embrace Center of Excellence

"Keep in mind that CMS sets the pace for payors' policies — CMS doesn't have programmatic criteria for lap choles, but they sure do for bariatrics — and meeting or exceeding center of excellence criteria as defined by CMS seems to be where the payers are going," says Mr. Petkus.

Proper patient selection; surgeon experience; psychological, emotional and nutritional support systems; transfer agreements; availability of other specialties to help clear and care for patients; post-operative outcomes tracking; and an outcomes-based approaches to decision making are all components of the center of excellence designation. A true, multi-disciplinary outcomes-based approach to caring for obese patients determines success to the patients and the center in the long run, say the experts we talked to.

Dr. Sasse stresses the importance of follow-up for demonstrating excellence in outcomes to payers and patients alike.

"We follow quality indicators: statistics for infection, patient satisfaction surveys and data on ancillary health outcomes," he says. "We follow up on weight, high blood pressure, sleeping disturbance, arthritis, tracking the resolution of all these problems. There's a lot of data, but it's all important."

6. Make a long-term investment

"Staff are used to doing a bunionectomy or a lap chole where the patient comes in, the procedure is done, follow up is done, and at discharge, that's the extent of exposure to the patient," says Tom Michaud, the board chairman and CEO of Foundation Surgery Affiliates.

But weight-loss surgery is more than just a procedure; it's a life-changing experience. Post-op phone calls aren't enough.

"We have patients come back to the center six and 12 months later, and they're unrecognizable — not just skinnier, but healthier, and that energizes staff," says Dr. Sasse. "We have an annual celebration, a big gala, and staff and patients are all invited. Last year, something like 600 people

attended; it's great just to see people come together, connect, create that enthusiasm."

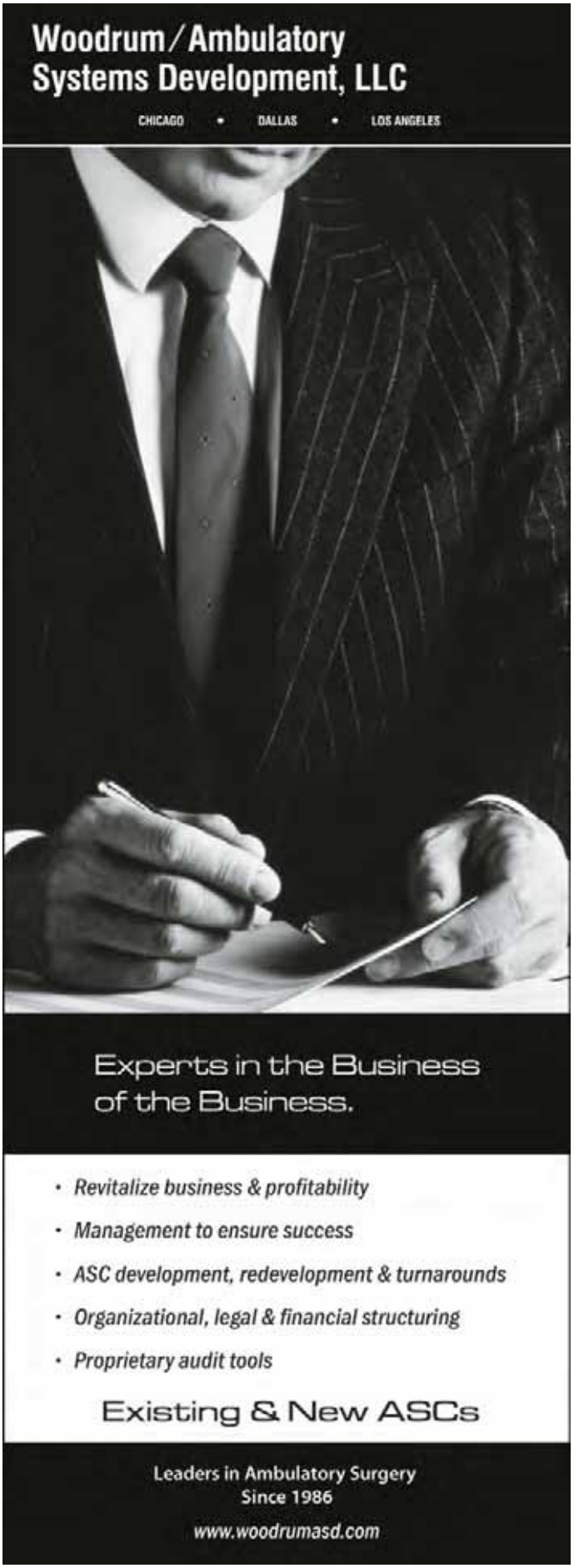
In addition to a cultivating the ASC as part of a multidisciplinary whole, work to create a welcoming social network, with the ASC as one of many bases.

"We have dedicated staff who are part of a support group, and in a couple of locations we have staff to keep patients apprised of needs for band adjustments, orientation about the changes in diet and food input, and to generally help them get through it all," says Mr. Mayo. "It's really a social support group — they arrange on their own to meet for walks, lunches, dinners and the like."

The best way to ensure that kind of long-term, self-sustaining network is to take charge and start it the day of surgery. Have pre-op patients meet former patients in advance, for example.

"In our facilities, someone from that team is meeting with the family while the patient is in surgery, just to find out how they're doing and letting them know what they can expect," says Mr. Mayo. "It's ongoing and we just keep adding patients to it on the post-op side." ■

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

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BECKER'S
ORTHOPEDIC & SPINE
MEDICAL DEVICE MARKET LETTER
Providing Business and Guidance on Orthopedic and Spine Medical Devices to Orthopedic Surgeons and Spine Surgeons and to Medical Device Companies

Three Strategies for Keeping Orthopedic Device Costs Down

By Marc Davis

Quality, simplicity, ease of use and the long-term efficacy of orthopedic implants and devices are of the utmost importance when choosing what your facility will purchase.

However, "For all that the device companies have done for orthopedics over the years — their innovations, particularly — they also evaporated significant profit out of orthopedic surgery," says orthopedic surgeon John Cherf, MD, MBA, MPH, who practices at the Neurologic & Orthpedic Institute in Chicago. "The high cost of devices is a problem."

So, assuming satisfactory quality, cost may be the most important factor in these decisions. Here are three strategies that can help your orthopedic-driven ASC or hospital in the constant struggle to keep expenses associated with orthopedic devices down.

1. Encourage business education

Currently, most ASCs and hospitals assign the responsibility for buying devices to either the director of orthopedics or the director of surgery, or to the purchasing department, according to Dr. Cherf, who has also been an advisory consultant on all sides of the industry — for practicing surgeons, ASC administrators, commercial payors and device providers.

Both models have benefits and drawbacks: The purchasing department will efficiently procure what is needed, but likely won't have as great an understanding of the products as a surgeon would. However, while the director of orthopedics' or director of surgery's knowledge can be key to deciding which devices and implants to buy, Dr. Cherf says that, as a rule, these purchasers struggle to keep orthopedic device expenses down.

The reason? A lack of formal business training.

"It's not part of medical school curriculum, not taught in residency, and so most surgeons don't have experience in managing costs," says Dr. Cherf. "[Physician-owned] ASCs and hospitals must become more sophisticated in managing their costs. A big first step is learning how to effectively negotiate. The fact is, you can negoti-

ate price with a device manufacturer. Many will give you volume discounts or other incentives."

Competition among device and implant manufacturers is stiff, agrees Larry L. Teuber, MD, a founder, managing partner and neurosurgeon at The Spine Center in Rapid City, S.D. Make it work to your advantage by arguing for clauses that will allow you to pay for low-volume items only after you actually use them or that will guarantee free or reduced-rate shipping.

"We take some devices on consignment," says Dr. Teuber, who is also the founder and physician executive of Black Hills Surgery Center in Black Hills, S.D. "The amount of inventory in some ASCs is staggering. Inventory is cash on the shelf, it costs money to hold it, and if your money isn't working for you, you're losing money. As for rebates, it's a game that the buyer loses. I strongly reject the rebate and pay cash on receipt of the orthopedic device."

As a result, it's recommended that you encourage physicians to seek out business knowledge, or choose a physician with some business background for the task of balancing the clinical and budgetary facets of purchasing.

2. Separate sales from surgery

While vendors can be an excellent resource for product information, limit their contact with surgeons who aren't involved in purchasing.

"We usually order directly from the company rather than from a vendor and, in most cases, we don't allow our surgeons any contact with vendors," says Dr. Teuber. "We don't allow vendors to set up in the corridors to sell their devices, or even to park in our parking lot. We don't like conditional relationships with vendors. They're sales people, and we understand that. Dealing directly with a company eliminates the commission and saves us money."

An exception to Dr. Teuber's no-contact with vendors rule is when new or more complex devices become available. When this occurs, Dr. Teuber allows a vendor to demonstrate their use to the surgical staff.

"Devices must have a low failure and complication rate, but they must be easy and simple to use as well," he says. "[Working with the vendors on an educational basis] lets us ensure everyone on staff is comfortable with the device" before any final decisions are made.

Further, limiting this contact to someone who will think about the business and cost implications goes hand-in-hand with perhaps the most critical step for keeping costs down: standardization.

3. Standardize wherever possible

Regardless of who handles the purchasing, one of the key priorities and ongoing goals of the position should be to standardize both vendors and devices, says Dr. Teuber. Although surgeons tend to prefer devices and implants they've been trained on — "If a surgeon switches to a new, unfamiliar device, he goes to the bottom of the learning curve," says Dr. Cherf — competent surgeons can effectively use any of the standard devices.

In addition, knee and hip devices are difficult to differentiate from company to company, according to Dr. Cherf.

"There's not much [qualitative] difference between them," he says. "Seventy-five percent of these implants are basically commodity products."

Further, notes Dr. Teuber, "All devices and implants have been approved by the FDA and, therefore, they meet bio-mechanical requirements, so quality may be generally equal."

The fact that quality will be similarly high among the top device makers is important to keep in mind and to stress to surgeons who may hesitate at standardization as, from a business perspective, the benefits of simplified ordering (only one company invoiced, fewer purchase orders issued, etc.) and lower costs (individual implants and devices cost less due to high volumes, free shipping, etc.) are enormous. Therefore, advises Dr. Teuber, have clear-cut selection criteria for devices and implants that makes cost a heavily weighted factor after quality is assured.

What's more, you don't have to eliminate the possibility of adding new devices or switching implant types; you just standardize your purchasing system to account for the possibility. And the savings from standardizing commodity devices can free up the budget for such additions. Dr. Teuber's Spine Center, for example, has a formulary for devices and implants, much like a formulary for prescription drugs.

"If a surgeon wants to use a device not on the formulary, he can tell us which one and why he wants it," says Dr. Teuber. "If he has all the facts and can persuade us that the increased cost provides a real clinical benefit, we'll OK it."

Who gets to be profitable?

Because so many of the device companies are publicly traded, it is understandable that they'd look to protect their profits as much as possible, even at the expense of purchasers.

"They're required to enhance shareholder value and that's exactly what they've done," says Dr. Cherf, who believes orthopedics-driven ASCs and hospitals can be profitable if they use their collective purchasing power in the marketplace (a role group purchasing organizations help play). "Ideally, for maximum profitability for ASCs, there should be a price negotiator representing a consortium of ASCs buying collaboratively. Then ASCs could buy in large volume, like Wal-Mart. That would increase profitability, although cut manufacturers' margins." ■

Mr. Davis is a freelance writer. Contact him at ***mark234@sbcglobal.net****.*

At a Glance: 6 Top Orthopedic Device Companies

Here are brief profiles of six manufacturers that are among the world's largest medical device companies; in addition, these six (listed alphabetically) are those from which orthopedic-driven ASCs and hospitals purchase much of their orthopedics-surgery-related products.

DePuy Orthopaedics (a division of Johnson & Johnson)

The largest and most diversified of the world's healthcare companies, Johnson & Johnson was founded in 1886. Today, with operations in 54 countries, and sales in more than 175 countries, it is

the premier purveyor of medical devices, including orthopedic and spinal products. J&J is also a global leader in the sales of pharmaceuticals and packaged consumer healthcare goods. Its stock is traded on the New York Stock Exchange (symbol: JNJ). The firm is headquartered in New Brunswick, N.J.

Medtronic

Founded in 1949, Medtronic is one of the leaders in innovative medical technologies and surgeries, with focus on the diagnosis, prevention and monitoring of chronic conditions. Among the firm's innovations of special interest to orthopedic surgeons are its bone graft and Minimal Access Spinal Technologies and image-guided surgical navigation procedures. The firm, headquartered in Minneapolis, Minn., sells its products in more than 120 countries. Its stock is traded on the New York Stock Exchange (symbol: MDT).

Siemens Medical Solutions

Siemens Medical Solutions provides a comprehensive mix of healthcare products, information technology and consulting services, including a variety of orthopedic-related devices and equipment. Among the innovative "firsts" developed by Siemens are the first X-Ray tube patent, the first hearing aid with amplification adjustability, the first real-time ultrasound, the first whole body fast volume Spiral CT, and the first PET-CT hybrid scanning system. Based in Erlangen, Germany, the firm was founded in 1877.

Smith & Nephew

Smith & Nephew's orthopedics division is a global provider of leading-edge joint replacement systems for knees, hips and shoulders, as well as devices for orthopedic trauma procedures. The specialist market helps drive the company's annual $2.8 billion in sales, according to the company, by continuously developing new materials and techniques to meet the growing demands of procedures and facilities for tougher, longer-lasting implants and less-invasive, faster-to-heal surgical products for use across patient populations. Smith & Nephew was founded in 1856 and is traded on the NYSE (symbol: SNN).

Stryker Corporation

Stryker Corporation, another industry leader, manufactures and sells a diverse product mix of medical and orthopedic devices in the domestic and global marketplace, including hip, knee and upper extremity replacement prosthetics, and spinal implants. The firm is also noted for its development, manufacturing and sales of video-assisted-surgical systems, powered surgical and collateral equipment and instrumentation for minimally invasive surgery. Among its innovative products is Endosuite, a functioning OR suitable for use in virtually all specialties. Stryker is traded on the NYSE (symbol:SYK) and has headquarters is in Kalamazoo, Mich.

Zimmer Holdings

In 2003, Zimmer Holdings acquired Swiss-based Centerpulse, and became Europe's leading orthopedic device company. With its U.S. base in Warsaw, Ind., the company markets its products in more than 80 countries. The company specializes in the development and manufacturing of reconstructive implants and devices for spinal applications, and for knee, hip, shoulder and elbow joints, and related orthopedic surgery products. The firm is noted also for its innovation and the fast-growing spinal segment of its business. Founded in 1927, Zimmer Holdings stock is traded on the NYSE (symbol: ZMH).

— Marc Davis

Top Medical Device Revenues

The top 12 medical device manufacturers by revenue, based on latest industry figures available.

1. Johnson and Johnson	$15.6B
2. GE Healthcare	$11.3B
3. Baxter International	$ 9.5B
4. Medtronic	$ 9.1B
5. Tyco Healthcare	$ 9.1B
6. Siemens Medical Solutions	$ 8.7B
7. Philips Medical Systems	$ 8B
8. Boston Scientific	$ 5.6B
9. Stryker	$ 4.3B
10. B. Braun	$ 3.8B
11. Guidant Corp.	$ 3.8B
12. Zimmer Holdings	$ 3.8B

— Marc Davis

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

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

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

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

KEYNOTE SPEAKER: Tucker Carlson

Tucker Carlson

Hear Tucker Carlson Speak Friday, June 20, 2008:

The Political Landscape, Healthcare and ASCs

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

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PRELIMINARY CONFERENCE AND EXHIBIT SHOW AGENDA

Thursday, June 19, 2008

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

Friday, June 20, 2008

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

Saturday, June 21, 2008

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

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CONFERENCE PROGRAM

THURSDAY, JUNE 19, 2008

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

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

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

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

2:00 – 2:55 pm

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

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

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

Tom Mallon, CEO/Founder, Regent Surgical Health

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

John C. Riddle, Managing Director, Dresner Partners

D. Reducing Operating Room Costs: An Overview – Special Attention to Implants and Devices

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

3:00 – 3:30 pm

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

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

3:00 – 3:55 pm

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

George Goodwin, Chief Development Officer, Symbion, Inc., and Brent A. Taylor, MD, The Orthopedic Center of St. Louis

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

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

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

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

3:30 – 4:00 pm

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

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

4:00 – 5:00 pm

A. Developing and Managing a Physician Hospital Joint-Venture

Joe Zasa, CEO, Woodrum ASD

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

Greg Cunniff, CFO, National Surgical Care

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

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

D. Developing a Spine-Driven ASC

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

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

FRIDAY, JUNE 20, 2008

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

General Session

8:00 am

Introductions

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

FRIDAY, JUNE 20, 2008

8:00 – 8:55 am

The Political Landscape, Healthcare and ASCs

Tucker Carlson, Noted Political Columnist and TV Commentator

9:00 – 9:40 am

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

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

9:45 – 10:35 am

Key Clinical Developments That Will Transform Orthopedic Surgery

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

10:35 – 11:20 am – Exhibits Open

11:20 – 11:55 am

Spine Surgery as a Core Driver in Multispecialty ASC

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

11:55 am – 12:30 pm

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

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

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

1:30 – 2:05 pm – Concurrent Sessions

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

Thomas Michaud, Chairman/CEO, Foundation Surgery Affiliates

1:30 – 2:45 pm

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

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

1:30 – 2:05 pm

C. Maintaining Successful Physician Investor Relationships Over a Long Period

Jack Jensen, MD, Athletic Orthopedics and Knee Center

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

Dennis Viellieu, Midwest Orthopedics at Rush

E. An Orthopedist's View of Changes in Healthcare

C. David Geier Jr., MD, Director, MUSC Sports Medicine, Assistant Professor of Orthopaedic Surgery, Medical University of South Carolina

2:10 – 2:45 pm

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

Tom Yerden, CEO/Founder, TRY Health Care Solutions

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

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

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

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

E. Healthcare Real Estate Decisions

Bruce Bright, Director of Business Development, The Sanders Trust

2:45 – 3:45 pm – Exhibits Open

CONFERENCE PROGRAM

FRIDAY, JUNE 20, 2008

3:45 – 4:20 pm

A. Revitalizing ASCs – A Case Study
Bill Southwick, President/CEO, HealthMark Partners

B. 5 Tips to an Outstanding and Cost Effective Staff: Staffing Strategies for ASCs
Ann Geier, RN, MS, CNOR, CASC, Vice President of Operations, Ambulatory Surgery Centers of America

C. Should You Sell Your ASC – Assessing Your Value and the Pros and Cons
Kenneth Hancock, President/Chief Development Officer, Meridian Surgical Partners

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

E. Ownership and Financing of Your Medical Real Estate – Finding the Optimal Solutions
Jack Amormino, President/CEO, American Medical Buildings, and John Daly, Vice President, Healthcare Services, McShane Construction Corporation

4:20 – 4:55 pm

A. How a Hospital Partner Can Add Stability and Help an Orthopedic Driven Center Excel
Tom Lorish, MD and Miriam Odermann, CEO/Administrator, Ambulatory Services Division, Providence Health System – Oregon

B. Successful Approaches to Investment and Portfolio Management
Robert S. Burnstine, Portolio Manager, Harris Associates, LP

C. Post Acquisition Success with a Corporate Partner
Richard D. Pence, President/Chief Operating Officer, National Surgical Care

D. Acquiring an ASC or Interests in an ASC – Due Diligence and Trouble Shooting
Darlene Johnson and Jeff Peo, Vice Presidents, Ambulatory Surgery Centers of America

4:20 – 5:30 pm

E. Legal Issues for ASCs – A 70-Minute Discussion – Regulatory Issues and Common Litigation Issues
Scott Becker and Jeff Clark, McGuireWoods, LLP

4:55 – 5:30 pm

A. How to Improve My Center Monday Morning: Leadership Tips from Industry Experts
Joe Zasa, CEO Woodrum ASD; Bill Southwick, CEO HealthMark; Kenneth Hancock, President, Chief Development Officer, Meridian Surgical Partners; Moderated by Tom Yerden, CEO/Founder, TRY Healthcare

B. Payor Contracting with Carve Outs for Orthopedic and Pain
Robyn Finnegan, Vice President/Managed Care, Prexus Health Partners

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

D. Core Tips and Strategies to Succeed with Orthopedics and Neurosurgery
Mike Lipomi, CEO/Founder, RMC Medstone

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

SATURDAY, JUNE 21, 2008

7:30 – 8:30 am – Continental Breakfast

8:30 – 9:10 am

How to Implement Macro Industry Trends and How to Assess and Implement Them on a Center By Center Level
Cliff Adlerz, President/COO, Symbion, Inc.

9:10 – 9:50 am

Current Opportunities and Challenges in the ASC Industry
Mike Snow, CEO, Surgical Care Affiliates, LLC

SATURDAY, JUNE 21, 2008

9:50 – 10:25 am

Building an ASC Around Orthopedics, Spine and Pain Management
Tom Mallon, CEO/Founder, Regent Surgical Health

10:30 – 11:00 am – Concurrent Sessions

A. Utilizing Customer and Patient Surveys to Enhance Operations
Larry Teuber, MD, Physician Executive, Black Hills Surgery Center, President, Medical Facilities Corporation

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

C. Advanced Case Costing: Using Case Costing to Implement Strategy and plans for Orthopedics, Spine and Pain Management
Susan Kizirian, Vice President, Ambulatory Surgical Centers of America

D. Develop and Operate a Successful Spine Center of Excellence in Any Setting
Marcy Rogers, CEO, SpineMark Corporation

11:05 – 11:35 am

A. 6 Keys to Making a Physician Hospital Orthopedic Joint Venture Successful Plus Handling Total Joints in ASCs
James Caillouette, MD, Orange County Orthopedic Surgery

B. Overview of the Medical Malpractice Insurance Market: The Use of Captives and Other Strategies for Orthopedic and Neuro Groups and Related Facilities
Pat Sedlak, Director, and Frank Dodaro, Chairman, AON

C. 10 Ways to Maximize the Use of Your ASC's IT System
Scott Palmer, Source Medical, and Melody Mena, Administrative Director, Surgery Center at Mount Zion

D. Using Financial Benchmarking to Measure and Enhance the Value of an ASC
Jon O'Sullivan, Senior Principal, VMG Health

11:35 – 12:10 pm

A. Physician-owned Hospitals: The Benefits and the Business Case
John Rex-Waller, CEO, National Surgical Hospitals

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

C. The New Jersey Codey Case and Other Attacks on Physician Ownership of ASCs and Hospitals – A Panel Discussion
Scott Becker, Amber Walsh and Gretchen Heinze, McGuireWoods, LLP

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

12:15 – 12:55 pm

A. Physician-owned Hospitals at the Crossroads: How to Stop the Government from Killing Innovation
Molly Sandvig, Executive Director, Physician Hospitals of America

B. Physician Owned Community Hospitals – How to Design and Complete a Hospital
Michael S. McCoy, Senior Vice President Operations, Neuterra Healthcare

C. Sales and Syndications of ASCs: Tips for Succes
Steven Rosenbaum, CPA, The Bloom Organization

D. ASC Real Estate: Understanding Your Options – What to Consider When Developing an Orthopedic Driven ASC or Specialty Hospital or Orthopedic Driven MOB
John A. Marasco, AIA, NCARB, Principal, Marasco and Associates, and Christopher M. Bowen, Chief Development Officer, Marshall Erdmann and Associates

1:00 pm – Meeting Adjourns

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MEDICAL DEVICE MARKET LETTER
Providing Business and Guidance on Orthopedic and Spine Medical Devices to Orthopedic Surgeons and Spine Surgeons and to Medical Device Companies

Sens. Grassley and Specter Introduce Legislation Requiring Medical Device Manufacturers to Publicly Report Pricing Information

By Scott Becker, JD, CPA, and Kelly A. Morgan, JD

Orthopedic and cardiovascular medical device manufacturers are increasingly subject to a great deal of federal scrutiny. Recently, several orthopedic and implant manufacturers, including Zimmer, settled claims for a total of more than $300 million; the Department of Justice had claimed that the manufacturers were improperly paying physicians for loyalty and use of their products. [*See United States v. Zimmer, Inc.*, Case No. 07-8130 (D.N.J. 2007).] Further, throughout the healthcare industry, there is tremendous concern about the amount paid by hospitals and other healthcare providers for high-technology devices.

Recently introduced legislation would require medical device suppliers to publicly reveal their pricing information, shifting the foundation on which contracts between these suppliers and their consumers — healthcare providers — have been based. Suppliers have relied on confidentiality agreements in these contracts to protect their pricing information and enable them to negotiate with hospitals while the hospitals have little knowledge of what others pay for the same services.

The new legislation has the potential to eliminate this strategy. The Transparency in Medical Device Pricing Act of 2007 would amend the Social Security Act to require any manufacturer of an implantable medical device to report the average and median sales price of each covered medical device. [S. 2221, 110th Cong. (2007).] The information would then be made publicly available on the CMS web site. It is highly unusual for a law to require public disclosure of pricing information, even when there is an interest in leveling the playing field, but proponents point to the need to control increasing costs of healthcare and the resulting pressures on hospitals, patients, and government payors as justification for this departure.

The bill is a response to recent manufacturer efforts to enforce confidentiality agreements through litigation. One such case sparked industry attention; Cardiac Pacemakers and Guidant Sales Corporation sued a healthcare consulting firm, asserting multiple claims that included various tortious interference counts, in part based on the confidentiality provision of its contracts with hospitals. [*Cardiac Pacemakers, Inc. v. Aspen II Holding Co., Inc.*, 413 F.Supp.2d 1016 (D. Minn. 2006).] Guidant had contracted with hospitals for the sale of implantable cardiac rhythm management devices; these contracts included confidentiality provisions prohibiting the hospitals from disclosing information about the contracts to third parties, including the agreed-upon price for the devices. Guidant claimed that Aspen Health Care Metrics interfered with Guidant's existing and prospective sales contracts by assembling confidential pricing information from hospitals and then using that data to advise other hospital clients on device contracts.

The court sided with Guidant, holding that Aspen's actions tortuously interfered with the contracts and their confidentiality requirements. It held that "Aspen was not an agent [of the hospitals] as a matter of law" since its consulting agreements merely gave it the power to review vendor pricing, not to bind the hospital clients to any contracts. (*Aspen*, 413 F.Supp.2d at 1024-1025.) Nor could Aspen claim justification for interfering with the confidentiality agreements based on its status as a consultant; "Aspen could not invoke an honest-advice privilege even if such a defense existed in Minnesota because obtaining Guidant's confidential pricing and using that information at other hospitals does not constitute honest advice." (*Id.* at 1026.) The court found that the hospitals breached their contracts with Guidant by forwarding the pricing arrangements to Aspen, an act induced by Aspen without justification.

In introducing the bill on Oct. 23, Sen. Chuck Grassley (R-Iowa) and Sen. Arlen Specter (R-Pa.) argued that price transparency is necessary if hospitals are to have the equal footing with device suppliers when it comes to negotiating prices. Confidentiality agreements prevent hospitals

from knowing exactly what the fair market value is, leading to some hospitals paying significantly more than others for the same device. Proponents also argue that this legislation is necessary to control government healthcare spending and prevent beneficiaries from paying more out-of-pocket than they should. When some hospitals are paying significantly more than a price that would be considered "fair market value," this in turn increases the ultimate cost of procedures using that device, an increase that either will be passed on to the patient, or will reduce the funds the hospital has to use for other expenses.

A closer look

Beginning in 2009, the statute would require medical device manufacturers to file quarterly reports for each "covered medical device" — which includes any device for which payment will ultimately be paid, either directly or indirectly, by Medicare, Medicaid or SCHIP — within 30 days after the end of each quarter of the fiscal year.

Such reports would include

- the name of the manufacturer of the covered medical device;
- the name of the covered medical device;
- the category type of the covered medical device (using a nomenclature specified by the Secretary of HHS for categorizing medical devices in order to ensure consistent reporting);
- the hospital inpatient procedure or hospital outpatient procedure identified [by the Secretary of HHS] with respect to which medical device was used during the quarter;
- the average and median sales prices of the covered medical device; and
- such other information as the Secretary of HHS requires, including the unit of measure used to determine the number of medical devices sold by the manufacturer.

This information would be compiled by the secretary, and beginning in April 2009, would be accessible to the public on the CMS website; the statute would require that the information be made "easily searchable, downloadable, and understandable."

The bill does contain certain caveats that could reduce the effect on price transparency and vendor-hospital relations, such as the discretion granted to the secretary to exempt certain sales from the computation of "average" and "median" prices. The legislation also would not require manufacturers and suppliers to disclose every price negotiated with every buyer, so buyers will never know exactly how high or low prices can range.

Compliance would not only be a condition of receiving direct or indirect payments under Medicare, Medicaid and SCHIP; the statute would also impose harsh monetary sanctions for failure to comply that have the potential to add up quickly. A manufacturer would be subject to penalties ranging from $10,000 to $100,000 for each compliance failure. The same penalty range applies to any misrepresentation a manufacturer makes, and can be assessed for each day the information remains on the web site.

The bill has been submitted to the Senate Finance Committee for consideration. ■

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17 Red Flags of HIPAA Security in ASCs

By Marion K. Jenkins, PhD

Depending on your point of view, HIPAA is either a boon or a bane: It's generated a whole new line of business for many consultants, but has probably presented a major pain for providers, or "covered entities." What started in the 1990s as a set of guidelines to allow patients more control over their healthcare destinies (the "P" in HIPAA stands for portability, after all) has generated hundreds of pages of government regulations, spawned dozens of books and seminars, and resulted in the deforestation of countless acres to make the paper required for all medical practices, hospitals and ASCs to produce and print HIPAA policy manuals.

HIPAA Privacy versus HIPAA Security

But most of the effort historically has concentrated on the HIPAA Privacy Rule, which protects paper records. The other, more nebulous half of the guidelines — governing protection of electronic patient records — is the HIPAA Security Rule, which didn't go into effect until April of 2005. But by that time, because most covered entities had been so busy addressing HIPAA Privacy, many were caught confused or unaware, or simply ignored the new regulations. Further complicating matters is the technical nature of HIPAA Security specifications, which require business, legal and technological expertise.

This combination of factors probably explains why an estimated 80 percent (according to some national estimates) of covered ambulatory healthcare entities are non-compliant with HIPAA Security. That doesn't mean ASCs aren't trying; many simply aren't equipped for HIPAA Security, which deals exclusively with EPHI, or electronic protected health information.

Don't be lulled into a sense of false security because you have HIPAA Privacy compliance manuals and use software labeled HIPAA-compliant. There are 42 specifications in the HIPAA Security Rule, broken down into three categories: administrative safeguards, physical safeguards and technical safeguards. Each of the specifications is categorized as either required or addressable. The term "addressable" is a bit of a misnomer, because you are still required to deal with each addressable specification, but you may be able to satisfy the compliance requirements of the addressable specifications simply by stating that it does not apply to your situation — that is, address the requirement one way or the other.

Note that the Security Rule is very generic; it doesn't require or recommend specific technology solutions. Any software or hardware vendor who claims its product is endorsed or recommended by the HIPAA Security Rule lacks integrity. And there is no single hardware, software or security product or service that addresses all specifications. Further, software that is technically HIPAA-compliant can be implemented and used in a manner that makes it completely non-compliant.

Also keep in mind that less than one-third of the specifications are even categorized as technical in nature, as there are also administrative and physical safeguard categories, which have nothing to do with software. And just to avoid confusion and point out a common misconception, even though the name administrative safeguards may imply some simple procedures and manuals, they are very critical and should not be overlooked.

Keys to compliance

So how do you tell if you are compliant? The process is actually fairly involved, in spite of any "Instant Compliance in a Box/in a Book/on a Website/in a Seminar" offers you might see out there. And it is also much more involved than simply relying on the HIPAA-compliant statements of your software provider. In many ways, it is easier to look for obvious non-compliance and then deal with those than try to start with the HIPAA Rule. The following list contains the most common non-compliance issues we see in ambulatory healthcare; if even one of these issues is present in your facility, you have a problem.

1. Workstations running anything other than the most current operating systems. That means Windows Vista Business (Service Pack 1) Windows XP (Service Pack 2) or Windows 2000 (Service Pack 4). (Therefore, Windows 98, Windows Me, Windows NT Workstation, XP Home, Vista Home, etc., are all non-compliant.)

2. Lack of a client/server architecture. If you are using a workgroup, where there is no domain controller to centrally control user security and permissions, you are non-compliant. Client/server architecture can be implemented with as few as five users.

3. "Weak" or shared logons/passwords (such as "staff" or "billing" or "front desk"). This also includes usernames/passwords posted on sticky notes on the monitor, keyboard or taped to the desk. If you are doing this to save on software-licensing fees, you face a double-whammy: The Business Software Alliance (BSA — not the Boys Scouts) can hit you with a fine of up to $3,000 per instance for this violation, on top of HIPAA sanctions.

4. No formal employee acceptable use policy (AUP) covering IT systems.

5. No written security incident reporting policy. You must have this — and about 10 other written policies/practices — in place to be fully compliant.

6. Lack of good data backup/disaster recovery system(s), including RAID data storage systems and rotation procedures. Taking the backup tapes home isn't a good idea. The news media is full of stories of loss/theft in this scenario, and we once worked on a medical practice where the practice manager was going through a messy divorce and the soon-to-be-ex-spouse stole the practice's backup tapes.

7. EPHI stored on local workstations and/or laptops, or on portable media like floppies, thumb drives or CDs. In fact, you should strongly consider disabling the ability to use those devices on workstations, as it makes it theoretically possible for someone to download all your data to portable media.

8. Any user account that has system administrator rights. We frequently see this situation because of some issue where the IT company is unable to make something work on the network without giving users admin rights.

9. Use of any "public" email address or domain name (such as AOL, MSN, Comcast). If you are using an email address with Gmail, MSN, Hotmail, Yahoo, etc., then you are non-compliant. This also governs any outside partner entities as well; we have seen practices and surgery centers e-mail dictation files to an outsider who was using an AOL e-mail address.

10. Not having a hardware firewall. Your Internet provider probably put a firewall when they installed your Internet circuit, but that's to protect them from you, not to protect you from the outside.

11. Lack of updated, business-class anti-virus, AND anti-spyware, AND anti-adware software. It's worth the cost, and it should be installed on the server and "pushed" out to all the workstations on the network.

12. Peer-to-peer/file-sharing applications. Allowing use of applications such as Kazaa, Morpheus, Limewire, Bit-Torrent and chat apps is like sharing a soda straw with others at the local bus station.

13. Most "free-ware." Do no allow staff to downloaded screensavers, weather apps, horoscopes, Internet search bars, etc., and even some anti-virus and anti-malware software. Only approved software should be used, and installed only by your IT professional.

14. Internet games such as partypoker.com, wildtangent.com, empirepoker.com, etc. Don't allow your facility's computers to be used for this purpose, no exceptions.

15. Unsecured WiFi (wireless), or WiFi with WEP security. This isn't a coffee shop; you need to ensure information is locked down, virtually speaking.

16. Laptops that move in and out of the facility (especially physicians' personal machines). These can too easily compromised by other users, loss or theft.

17. Using "remote control" software to access your desktop remotely instead of using a hardware/software VPN (virtual private network) solution. We aren't going to name names here, but there are several commonly used commercial software products in the marketplace that could easily allow your systems to be compromised.

Further resources

What should you do to determine if your facility is compliant, and what should you do if you find out (such as using the checklist above) that your facility may have issues? There are several good background resources available on the web, including www.cms.hhs.gov and www.hipaaadvisory.com. FASA has published a HIPAA Security manual. In our opinion, HIPAA Security compliance requires hands-on assessment and possible remediation by a combination of competent and experienced technical and business/operational resources. Our first suggestion, though, is to find out if your IT provider even knows how to properly spell HIPAA. If they spell it wrong, that should be a clue that you need to get a different provider. ■

*Dr. Jenkins (**marion.jenkins@qsetech.com**) is the CEO and founder of Englewood, Colo.-based QSE Technologies, a provider of IT consulting and implementation services to ASCs, physician clinics and medical office buildings nationwide.*

Three Reasons HIPAA Security Matters

Here are three very good reasons to pay attention to HIPAA Security.

1. Significant civil and criminal fines and penalties. These can range up to $25,000 for multiple violations of the same standard in a calendar year. If you allowed the compromise of hundreds of patient records, which could easily happen with a single hacker/intrusion event, it is not clear if this would be considered a single violation or multiple violations. There are also fines of up to $250,000 and/or imprisonment of up to 10 years for knowing misuse of information. Note that it is not necessary for you to know the information is being misused. According to the American Medical Association, the Department of Justice has interpreted the "knowing" element of the HIPAA statute as requiring only *knowledge* of the actions. That means that, if it could be proven that it is known that there are HIPAA Security issues, then the result of those issues could make the facility liable for the misuse of the information, whether it knows about the misuse itself or not. There are hotlines and web sites that allow for easy reporting. An unsatisfied patient, a disgruntled ex-employee, a former business partner or spouse can easily report a facility, and cause a great deal of time and expense, even to ultimately prove your compliance.

2. ASCs are in the spotlight — or, perhaps we should say, under the microscope. Just look at the negative publicity generated when a mistake is made in an ASC or physician-owned facility versus a hospital. Medical errors are fairly commonplace — and accepted — in the nation's "status quo" institutions, which are primarily hospitals. You may recall a recent news story where a hospital in Rhode Island was fined a mere $50,000 for performing brain surgery on the wrong side of a patient's head — for the third time in a year. Can you imagine what would have happened had that episode occurred in an ASC? The same holds true for HIPAA Security Rule violations. Any ASC that faces a HIPAA Security-related incident is going to find itself on the front page of the newspaper. It will be a public relations headache, to say the least. For the ASC industry to continue to improve its image, and to gain the support and positive recognition of regulators, legislators and insurance companies, it has to lead in this area.

3. The HIPAA Security Rule is just good business. Unlike the HIPAA Privacy standards, which one could reasonably argue subject a medical practice or ASC to a great deal of counterproductive and unnecessary administrative overhead, the HIPAA Security Rule specifications represent, for the most part, industry best practices related to technology systems. All facilities should take necessary security precautions to protect their business information systems from outside intrusion, and their business data from accidental or intentional loss or destruction. In the case of an ASC, this "business information" that needs to be protected represents its vital patient data.

— Marion K. Jenkins, PhD

Four Ways to Expand Your ASC's Business Reach

By Stephanie Wasek

Here's a look at three procedures across multiple specialties and one business opportunity that may be of interest to your ASC if you're looking to expand and boost the bottom line.

A new gold standard for spinal stenosis?

There are two schools of thought regarding spinal surgery: The more conservative one operates essentially only on compressed nerves, the more aggressive operates on various forms of back pain. The X-Stop, unlike other spine surgery technologies such as the artificial disc, is a device that both kinds of surgeons might be able to agree on. Designed to alleviate lumbar spinal stenosis, the titanium implant, made by Kyphon, decompresses the spine to alleviate leg and lower back pain. Lumbar laminectomy achieves the same result, but the X-Stop presents several key advantages, says David Abraham, MD, an orthopedic surgeon with Reading Neck and Spine Center in Wyomissing, Pa.

"What's interesting about it is that it's a 15-minute outpatient procedure, compared with laminectomy, where the gold standard is about 35 to 45 minutes," he says. "During laminectomy, the surgeon must identify the compressed nerve and remove parts of bones and joints. But when you use the X-Stop to separate the neuroframen, you don't see nerves, you decompress the nerve indirectly. While laminectomy is safe and efficacious, this is a smaller operation."

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

Cryoblation 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 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."

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.

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."

Sleep apnea screening. With the increase in overweight and obese patients having procedures done in ambulatory surgery centers, careful pre-screening has become all the more important. Ion Healthcare can help with one aspect: the screening and management of patients with sleep apnea who are referred to your ASC. Here's how it works, according to Steve Burton, PhD, the founder of Ion: The facility and Ion work out an arrangement for space, with Ion setting up either in the ASC, contiguous to the building or near the center, depending on the physical space available. Ion provides all its own staff and equipment to perform testing procedures that are "all billable and reliably reimbursed," says Dr. Burton. The surgeon refers patients at risk for sleep apnea to Ion for screening when scheduling the surgery.

"We like to try to touch the patients the day they're posted," he says. "The really nice side benefit is that we will build the ASC's screening into ours, making pre-op screening more efficient and reliable and taking the burden off already over-worked ASC nursing staff."

There are two models for the program, says Dr. Burton: "One is a quality program that Ion provides at no charge to the center. The second and preferred model is to form a joint-venture partnership and establish a new entity that performs the quality program; the surgical center partners can then participate in the revenues that are generated from the program." ■

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Spotlight On: Selling the Real Estate to Enhance the Surgery Business

An interview with Lt. Col. Bruce Bright

Stephanie Wasek: What is the property management model you follow?

Bruce Bright: Our business is to be a long-term holding company; our only focus is to develop, acquire and manage medical offices buildings and ASCs. We buy the real estate — the physical building and land — at full market value and lease it back to the ASC business entity on a long-term basis. Essentially, we become the landlords.

SW: For background, can you speak briefly about types of leases and how they work?

BB: On one end of the lease spectrum there's the triple-net lease. In that model, the tenants are responsible for everything. They pay a rent check each month to their landlord, and everything inside is their responsibility. The tenant manages electric, water, maintenance; they're in control and can keep expenses to a minimum.

On the other end is the full-service lease, where the tenant pays one rent check at the end of the month, but the landlord is responsible for everything. This may sound as if it's better, but the landlord has to charge in order to prepare for the worst-case scenario. As a result, the rent will be much higher, because the landlord is charging what he thinks the overall cost might be for all issues, major and minor. This arrangement is not typical in a single-tenant ASC building.

We prefer triple-net leasing, letting the tenant better control costs, even though we get a smaller rent check. There are a million ways to modify any part of a given lease to fit a group's specific preferences and needs.

SW: Isn't real estate ownership preferable?

BB: Well, there are pros and cons to both sides. While pride of ownership can be a rallying point and there is some appreciation in real estate, many issues in commercial building ownership overshadow those advantages. So, in most cases, I'd advise physicians to lease their building.

First of all, there is a risk in real estate ownership: Physician-owners have to ask themselves whether they're willing to put personal capital at risk on bricks and mortar, whether they're willing to sign a personal guarantee on a mortgage and be liable for that money.

They also have to ask whether real estate provides a better return on investment than other similar-risk ventures. ROI on real estate is about 8 percent, but you get more than that back on a surgery business itself; it's never that low. Physician-owners might, therefore, prefer to put that money into the higher-margin asset, the ASC business. Real estate ownership isn't essential to the delivery of healthcare; surgeon-owners might rather reinvest the money in higher-margin, mission-critical activity, such as MRI or other equipment.

Even if they have that capital and are willing to take the risk on bricks and mortar, there's also the matter of whether they're willing to tie it up long-term on an ill-liquid investment.

SW: What are the advantages to leasing?

BB: You eliminate long-term, personal guarantees on debt, which frees up cash flow and allows higher returns on the surgery center business.

You also eliminate the dissonance between real

estate owners and the non-participating practicing physicians. Over time, as the surgery center takes on junior physicians, they become tenants, and there can be resentment between surgeons when some feel as if they are simply paying the rent to the senior physicians, who are making more money as a result.

There are also issues of maintenance and upkeep — if you get into ownership of a building and mismanage it, it will depreciate. Most physicians are not familiar with how to build a building, and they shouldn't be; it's a separate profession. Further, does an orthopedic surgeon really want to be in charge of upkeep? A surgery center is a house on steroids, all the issues are magnified — we can step in as landlord and take care of that.

The last huge advantage, as I mentioned, is that a physician group that leases a building from us is in complete control of the building. We will manage it if they would like us to, though if they want to, that's fine with us, too. How they conduct their surgery business is, of course, still up to them.

SW: How can physicians decide which route to go down — owning or leasing?

BB: I would tell a physician group thinking about purchasing or building a building to do a few things. First, they should talk to a banker to find out how much they need to put down on the real estate in addition to the surgery business.

I'd also recommend that they consult with a commercial real estate lawyer, not a realtor from another part of their lives, and get information on all the ins and outs of the building process. There are Stark laws, the lease has to be at fair market value — all those factors should come into play in the decision to own the real estate.

Another good action would be to talk to their peers, doctors who have bought or built or sold office space or a surgery center, and ask how they handled their real estate and why. A good market search looking at the area where they want to buy build or lease is also necessary.

For a lot of ASCs we see, it's a matter of the timing and the situation. Normally, there are two separate entities: One owns the real estate, one owns the surgery business. Many times, physicians will come to us because 10 physicians bought a building, but it's time for some of them to retire and they want to cash out of both. It's tough to sell two-tenths of a building; so the group might decide to sell and take the liquid cash, even if not all are ready to retire.

SW: How much capital can be freed up as a result?

BB: Well, it's very typical for a group to have up to 30 to 50 percent of its capital in real estate. At start-up, on the other hand, you can take that amount the bank would want down on the mortgage, or the amount of the building costs and take that right off the top.

You could certainly build and hold for five or 10 years — but that's a long time to have nothing happen with that money. Look at it this way: If I gave you two options and said, OK, you can take investment A, or you can take investment B and get a higher rate of return, you'd have a tough time justifying taking option A and the lower return.

Surgeons are in the unique position of being able to take option B, because of their profession, and get the higher return. Surgeons are smart, but there are some things that go along with managing, filling, leasing and locating buildings that might not be in their purview, whereas that's all we do. By selling, they can concentrate on doing surgery, and let us concentrate on managing the bricks and mortar for them. ■

Lt. Col. Bright is the director of business development for The Sanders Trust, an Alabama-based healthcare real estate investment company that operates nationwide.

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