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AN ORTHOPEDIC ASC - ADVISORY OPINION 03-2

Advisory Opinion 03-5 has generated much discussion in the ASC industry during the last few months. In that Advisory Opinion, the OIG commented negatively on a multi-specialty physician group investment in an ASC. In contrast, OIG Advisory Opinion 03-2, an advisory opinion deserving of attention, has generated little discussion. In Advisory Opinion 03-2, the OIG analyzed a medical center's proposed acquisition of an ownership interest in an established single-specialty ASC. In constructing its analysis, the OIG also analyzed the existing investment of an orthopedic group in the ASC. There, the orthopedic group received favorable approval from the OIG with respect to its investment in the ASC notwithstanding the fact that only approximately one-half of its physician owners were able to meet the one-third practice income test set forth in the ASC safe harbors to the federal anti-kickback statute (i.e., physician investors must generate one-third of their income from performing outpatient surgical procedures). The other eight physician owners of the orthopedic group were proceduralists who were unable to meet the one-third practice income test. The OIG listed in the Advisory Opinion five elements of the proposed arrangement that made it particularly susceptible to fraud and abuse. Specifically, however, the OIG commented positively on the ownership interests of the orthopedists who did not meet the one-third practice income test. It stated as follows:

> Second, eight of the Group Shareholders do not meet the one-third practice income test in the ASC safe harbor. However, each of the eight non-qualifying Group Shareholders derives more than one-third of his or her practice income from procedures that either qualify as ASC surgical procedures under 42 CFR §1001.952(r)(5) or require a hospital operating room setting. Like the one-third practice income test, this fact helps ensure that these eight Group Shareholders are physicians who routinely perform interventional procedures requiring at least an ASC level of support and, consequently, are more likely to be users of the ASC rather than passive referral sources for others.
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> Third, instead of the investment interest being held directly by the Group or by the individual Group Shareholders, the Group Holding Company holds the investment interest in the ASC. Intermediate investment entities could be used to redirect revenues to reward referrals or otherwise vitiate the safeguards provided by direct investment, including distributions of profits in proportion to capital investments. However, in this case, the use of a "pass-through" entity does not substantially increase the risk of fraud or abuse. The Group Holding Company is a wholly-owned subsidiary of the Group, which, relying on the Requestors' certifications, meets all of the requirements of the group practice safe harbor. Thus, the Group will receive a return on its Surgical Center investment that is exactly the same as it would have received if it had invested directly.

The OIG's position in this Advisory Opinion reflects its most relaxed stance yet on investment by physicians who cannot meet the two one-third tests set forth in the ASC safe harbor.

MANAGEMENT COMPANIES

Over the last few years, dozens of management and development companies that concentrate on ambulatory surgery centers (ASCs), surgical hospitals and health system management have emerged. As these companies proliferate, it is becoming clear that there is a great division between those companies that are able to provide the services that they sell and those that are unable to deliver. Often, the key distinction between the companies is the ability of a company to hire highly qualified and competent consultants and staffers to help provide its services. In short, a company that invests in hiring top quality personnel is more likely to provide high quality services. In contrast, a company that does not hire appropriately qualified personnel often finds itself in a position of being able to sell its services, but being unable to deliver the type of quality services that it desires and needs to provide.

An ASC or hospital should be cautious of those companies that offer their services at prices that are well below market. For example, if a management company offers to provide management services to an ASC for three to four percent of revenues, the ASC should be sure to investigate whether the company has the adequate support and personnel to deliver the promised services. Even if a management company consultant does not interact with the ASC face-to-face every day, a representative should interact with the ASC on a daily basis on a variety of other fronts. Moreover, an ASC should be very skeptical of those companies that propose to hire an administrator for the ASC at the lowest salary possible. We generally believe that ASCs are better served by operating with a combination of a highly qualified management company and a highly qualified, well paid local administrator. The entire management team must possess a certain level of competence in order to provide adequate support to the ASC or hospital. Thus, as the industry evolves, we expect that companies that intend to be in the management business for the long run will have to charge fees reflective of the services they intend to offer. In essence, companies that substantially discount their fees will be less able to provide high quality services.

Benchmarking Ambulatory Businesses

By: Robert J. Zasa
Partner, Woodrum/Ambulatory Systems Development

How do I measure up? Against what criteria? Who is the judge to say that we meet or not meet standards? Who establishes the standards? These are common questions when the topic of benchmarking is raised within the health services management community. It sounds good in principle, but how many managers really want to be measured. And if they do, how good are the measurements of the standards of practice? The purpose of this article is to describe a method that is an objective, yet practical method to use quantitative data to compare a healthcare organization's performance against a set of standards that will ultimately result in better financial and management performance for the health care organizations.

Benchmarking is a current phrase used to describe the activity of measuring one's performance against standards of performance. Many times it is hard to find such legitimate standards for similar businesses. If such standards exist, such as the MGMA Cost Report for group practices, these standards can be of great benefit to improve the organization. However, many times there are not standards for the operations of ancillary businesses such as surgery center, pain management, diagnostic, comprehensive women and men's health centers, complimentary and alternative care centers, or other new programs or, as I like to call them, ambulatory businesses. It is therefore important to first establish one's own benchmarks of performance and try to improve on them.

Each ambulatory care program should be developed and run like a freestanding business. At the Sloan School of Management at M.I.T., research was done on how businesses were run successfully. Being a business school based at an institution strong in engineering, many of the factors were quantified. What resulted in the studies was a remarkably simple, yet powerful tool called "Critical Success Factors" (CSF). CSF should be measured in each business. The premise is that in any given endeavor, including a business, there are no more than a dozen factors that are critical to the success of that endeavor. In examining managers and businesses that had been very successful, those managers identified and focused their and their management teams efforts on the basic principles of the business. It is like the Vince Lombardi School of Football. He was a great coach, motivator, and manager. The key to the Green Bay Packers success under Vince

Lombardi was that Lombardi took very complicated things and he simplified them. (Not over-simplified them.) He stressed performing basic tasks extraordinarily well. He said, "You know whoever runs the fastest, catches the most balls, makes the most tackles, monopolizes the time in the field with the ball usually wins the game." He practiced the fundamental skill sets and concepts of the game, and won a lot.

Dr. Warren Bennis, a professor at M.I.T., looked at various businesses, and he concluded that there was no more than maybe 10 to 12 critical factors for a business to succeed". He called them the Critical Success Factors. He proposed that, "If one does a very good job of those ten basic things, and executes those tasks well, and measures them routinely, the businesses usually succeed. It is significant to inculcate that thought process into all the people that are on the team. Those in an organization should share those same ten common denominators, and make them part of that organization's corporate culture.

I have applied CSF in five companies I have run, a 500 bed hospital with 95 different departments and eight, satellite ambulatory centers, a division of public company, a public company, two private firms representing over 150 different, ambulatory care businesses in 40 states in the U.S. The process really does work. It is a very inclusive process. There are educational pieces to it, and these factors do change based on the business. I've got ten factors for occupational medicine businesses that I have run which are different ones than for the surgery centers we operate. There is another ten for diagnostic and breast center ambulatory businesses. As you are measuring different aspects of the business, and every business its a little bit different than the other, there are different critical factors for success. Each business has it own nuances. It is the manager's role to identify those critical to the success of that particular business. One must build consensus around those factors by educating the staff and physician partners as to why those factors were selected, and then finalize those factors and make them part of the every day priorities of that ambulatory business.

In our case, we took a look at all of our surgery centers, and defined what twelve factors were critical financially to the success of a surgery center. I did this in 1979. Over the years, most of the factors have not changed except for managed care. We use the CSF at each center, explaining them in detail to the staff and the physicians that use the ASC. We emphasize that if we implement and focus on these factors to the best of our collective abilities, the smaller issues will take care of themselves and we will succeed. This has been a very successful tool for any ambulatory business where it has been applied.

The best part of the CSF system is that it focuses all the key players of the business on the important things. We stay on point. We all share in the joy of "exquisite execution" of those key factors. It simplifies work in a creative and productive way. It allows employees to measure their success objectively each month. We can jointly look at the factors at the end of the month and know how well we did or what areas in which we can do better. You cannot hit the bull's eye of a target unless you can see the rings clearly. CSF focuses all the team on the bull's eye.

Each year we ask ourselves what would be the things in this practice (ambulatory business) that would contribute most to its success. We then measure those factors. Many times the financial ones are very similar, such as man-hours per patient, net revenue per patient, cost of medical supplies and drugs per patient, inventory level, and revenue per square foot.

One needs to establish measurable, critical success factors. I will discuss the ones that we came up with for the surgery center business.

Every month, we review our financial results and every month we measure CSF. The critical success factors reflect staffing issues, quality issues, supply and contracting issues. All the variable costs one needs to control in a very volume sensitive business. We take the total number of patients, not procedures, as our base quantified number for an ASC. Procedures are how many CPT codes click on the computer, but the number of patients is really the variable that matters the most in an ASC. Patients or cases are number of people that were seen. Multiple procedures are done at the same time on a patient, but the patient is the common denominator.

When we examined our ASC business, there really was less of a correlation to the success factors related to procedures than patients. We measure procedures, because they are important as you will see later in this article, but they are not our base factor by which all factors are measured. In developing CSF, you have to dissect the business in this way to get the really critical factors.

In the ASC, we calculate the average number of patients per day. We want to know the number of procedures, because it is an intensity factor. It also helps us measure specialty mix. The more procedures per patient we had, the more acute and intense the treatment of our patients.

Financially, we measure both gross revenue and net revenue in our financial statements. We want to know what we are billing, and the net revenue after discounts. Net revenue per case is calculated from our contractual allowance and bad debt. We want to know how much we are writing off and if we need to raise prices or reduce managed care contracts. It allows us to identify a problem, and then go deeper into the business to find the solution. CSF serves as flags to tell you where to focus for solutions to problems in the business. We want to know the net revenue per patient; it is an important number. It also tells us about our specialty and patient mix. We are able to compare that number with our costs to make sure our profit margin stays intact. This is obviously important. Since net revenue per patient is a critical number for our budget, we really focus on it as a CSF. It is critical that we track it.

We look at total, worked (or productive, not paid) full time equivalent (FTEs) employees for staffing. Staffing hours per patient, and FTE's per patient (staff hours per patient) are both important measures. If it is too low, we know our patients are not getting the necessary attention. If it is too high, we are either overstaffed, we had a heavy mix of acute patients, or we incurred too much overtime. We balance this CSF with number of procedures to measure intensity and acuity of patients so we can see the whole picture of the business. CSF support one another. Key elements of an endeavor are interlocked. To start, we began looking at our own measures of staffing. We discussed this measure with the doctors and asked patients (via surveys) if they felt they had adequate attention and care. We then found a few other ASCs that were similar to us and asked them to measure the same staffing factor to gain an idea of their performance You find that there is a pretty narrow range of staffing per patient given a standard, multi-specialty ASC. There are different ranges for different specialties, and different caseloads, but for similar caseload (number of patients) and similar specialty centers, the staffing CSF ranges from the 11 man-hours per patient down to 9. It is not uncommon for a new center to experience 12-14 man-hours per patient because they just are not efficient with staffing and the doctors are not settled into their block times yet. The point is the staffing CSF helps you understand multiple, critical parameters of the business and what to focus upon when it is too high. As an aside, man-hours per patient runs 8-8.5 for some of the large patient volume surgery centers that are at the 5,000 caseload and above. Normally, a surgery center experiencing 2,500 cases is usually in the 11-12 range, 11 if it is well run. This includes a full business office. If the ASC is group practice based and the group has integrated the business office of the ASC into the group's business office (which is common) you take account for the FTE's in the business office when making your calculation.

Payroll expense as a percentage of net revenue is usually at 22-24% range, unless you're in rural areas, when it can be in the 18-19% range due to the low pay rate. This CSF is also a function of the revenue. So, if you have very high revenue, your expenses over-revenue is going to lower the CSF.

We also measure medical supply and drug (including anesthesia drugs) cost per patient, total expenses per patient, and accounts receivable days outstanding. We always try to be no greater than 50 days with a goal of 45 days. This is an achievable CSF due to electronic billing, especially with Medicare. Operating income, operating income per patient, operating margin and inventory are all CSF.

We want to keep the inventory down, and in all of our centers that are below 3,000 cases we try to keep the inventory below $40,000. Now with just in time inventory, we can actually do better than that. We make sure that the nurse doesn't buy 15 boxes this month and then nothing the next month. Critical to our success is cash flow management. Inventory is key to this. I tell our nurses to think of the supplies in Sterile Storage as $50,000 worth of cash on the shelf. If it is on the shelf, neither they nor the partners can access it for bonuses, nor can I use it to invest in the business or buy more equipment for them. If you are only seeing 10 to 15 patients a day, and you have $50,000 on the shelf, you are using up the group's cash.

The clinical analogy of CSFs is lab test ranges. A male between 25 and 35 should have a normal white count of a certain range. In a surgery center, a surgery center running 2,500 cases with a standard mix of specialties should have staffing in a certain range. If you're outside of that range, the CSF doesn't tell you that you're wrong, it says, you have to look at it. So, it is a way of measuring on a consistent basis and flagging those areas where your best practice may not be best. You want to go back and look so you can stay on your best practice target ranges as defined by first your own CSF and then

against others if such pertinent standards exist. First you define the CSF, and then you quantify them.

It is ideal if the group or ambulatory business owners will share the profit with the employees if the budgeted profit is met or exceeded. This reinforces the CSF as a management tool even more. In this way all involved with achieving the profit get to share in that profit. It's the American way. I've done that in almost every center, group practice or hospital in which I have worked and in both for-profit and non-profit organizations. It is good to take some portion of the profit and share the wealth with those who helped you make it. It could be only 1-2 percent; it doesn't have to be a

large amount of money. Even a $300 to $400 check at the end of the year if it's earned is meaningful, more obviously the better. One of the best parts about using CSF is that the employees and the doctors only make money if they did the right things.

Using Critical Success Factors to assist managing your ambulatory business is a valuable tool. It takes great thought to identify the truly critical factors for the success of your business. In this article, I have concentrated upon the business aspects that are critical to an ambulatory business. We are charged to create good value by making sure the business is on sound financial footing and motivating the employees and the medical staff to focus on issues that will ensure the success of that business. Critical Success Factors help us all focus on a few key points, allow us to measure our progress, and allow us to savor the effort which results in success of our joint efforts.

About the author:
Robert Zasa is a founder and Principal of Woodrum/ASD. He is experienced in all phases of business development and multi-service ambulatory care facilities, group practices, ambulatory surgery centers, and hospitals.

Riskier Times Ahead For Surgery Center Owners?
By Jon Vick, ASCs, Inc.

Will the future be riskier for owners of surgery centers? The headlines so far in 2003 suggest that we are entering a riskier period than the surgery center industry has experienced in over a decade:

- *HealthSouth: Too Good To Be True* (Business Week, April 14, 2003)
- *Surgery Center Partners of HealthSouth Mull Bailing Out* (WSJ, April 8, 2003)
- *California: Legislation Banning Physician Ownership of ASCs Proposed* (CASA Alert, April 7, 2003)
- *CMS: Medicare Removes 144 Procedures From ASC List* (Regulatory Update, March 24, 2003)
- *Congress Weighs Surgical Hospital Anti-Kickback Bill* (Outpatient Surgery, April 7, 2003)
- *OIG Says Sanctions Possible for ASC Joint Venture that Includes Primary Care Physicians* (ASC Compliance Insider, April 2003)

Looking at these headlines, any sane person would think twice before investing in a surgery center today. All of a sudden the industry looks like a minefield with risk coming from many directions: State and Federal Governments, Congress, OIG, and CMS. What happened to the praise for the ASC industry for being efficient, cost-effective, patient-friendly, and profitable?

In the ASC industry, just as in other industries, events happen in cycles. The ASC industry may be transitioning from a cycle of exceptional growth and prosperity to a cycle of increased scrutiny that requires new strategies for success. In the growth period of 1992 to 2002, more and larger ASCs were built, ASC procedure volume exploded, facility fees increased, and ASCs earned the highest EBITDA margins in the healthcare industry. Within the last 3 years this long-term success and vitality has attracted hundreds of millions of dollars of public and private investment capital and now there are many well-capitalized ASC companies acquiring surgery centers and operating multi-facility ASC networks. Many physician-owners of independent ASCs have sold a portion of their centers at attractive multiples of earnings and ASC companies, such as United Surgical Partners International, Inc. and AmSurg, consolidated revenues and earnings, went public, and trade today at over 20 times trailing earnings.

How and why is the industry changing and what are the implications to surgery center owners? As the ASC industry continues to grow and mature (since 1982 the industry has grown to over 3,500 Medicare certified ASCs), it assumes an increasingly important and established place in the healthcare system and comes under increased scrutiny. Procedures are migrating to ASCs because of the benefits they provide: patient friendliness, lower cost for payers, physician efficiency and cash flow. The ASC industry is estimated to generate $10 billion a year in revenues. In a competitive market, an industry this size will attract scrutiny by its customers (Government programs, insurers, patients), its competitors (hospitals), and Regulators (State and Federal). The headlines above highlight some implications of industry growth and scrutiny for ASC owners:

HealthSouth self-destructs: This seems to be a simple case of greed and extreme bad judgment. HealthSouth executives have pleaded guilty to falsifying accounting records that added $2.5 billion to earnings to meet Wall Street projections and thus to bolster the stock price. According to Business Week, "...HealthSouth faces an almost certain breakup. ...HealthSouth is about to be carved up and sold off to competitors." The physician-owners of the 203 HealthSouth ASCs may have the option of buying the portion of the ASC that HealthSouth owns, or attracting a replacement corporate partner to buy HealthSouth's interest.

New California legislation proposed: There is currently no ASC fee schedule in CA for workers compensation cases and excessive ASC facility fees (i.e. $10,000 or more for some procedures) have contributed to the failure of dozens of small worker's compensation insurance companies and an increase in claims handled by the State from $50 million a year to $900 million per year. "Sixty percent of ...costs go to outpatient surgery centers that aren't regulated by the state and aren't accountable to anyone." It appears that greed of a few ASC operators is causing increased scrutiny of all ASCs in CA. While this legislation was originally introduced to ban physician ownership of ASCs in CA, it has been modified to curb self-referral by prohibiting physicians from referring workers comp patients to ASCs in which they have financial interests.

Medicare removing 144 procedures from ASC list: On balance, Medicare is also adding 288 procedures to the approved ASC procedure list. Medicare will systematically add and delete procedures from the ASC list as procedures migrate to physician's offices and as new technology makes more complex procedures appropriate for surgery centers. The risk inherent in these changes primarily impacts ASCs that rely predominately on single specialties such as gastroenterology and ophthalmology.

Surgical Hospitals under intense scrutiny: Competitive forces being brought to bear by hospitals that fear losing profitable cases to surgical hospitals, and Federal and State regulator's concerns about potential self-referral issues, are causing increased scrutiny of surgical hospitals. Representatives Pete Stark (D-CA) and Jerry Kleczka (D-WI) "have introduced a bill that would prohibit physicians from referring patients to surgical hospitals in which they hold preferential interests." Mr. Stark says the bill is intended to plug loopholes in existing laws that allow physicians (including primary care physicians) who already are prohibited from referring patients to clinical laboratories and diagnostic centers they own, to invest in for-profit surgical hospitals. A similar bill was recently introduced and is under review in Ohio.

What can surgery center owners do to reduce their risk while increasing the value of their centers? The "value" of a surgery center is dependent on several variables: perceived "risk" to the buyer, the availability of buyers with investment capital, competition among buyers to acquire licensed ASCs with growth potential, and sustainable ASC profitability. Increased surgical volume and higher facility fees from more complex procedures promise continued increases in surgery center profits. However, the value of surgery centers depends on the continued demand for acquisitions by surgery center companies with capital to invest. From the activity in the marketplace, the following suggestions are worth consideration by ASC owners:

- Develop strategies to sustain and increase profitability (i.e. add new users, new procedures, advanced technology equipment, new contracts, etc.)
- Avoid dependency on single specialty or workers comp cases
- Develop an exit strategy as a part of your strategic and operating plans
- Consider selecting a corporate partner to purchase a minority or majority interest to diversify your investments and protect you against adverse legislation
- Consider affiliating with a corporate partner when there is plentiful capital and competition among buyers to acquire ASCs
- Choose a corporate partner that can help increase revenues and profits so that your remaining interest increases in value
- Select a corporate partner that will agree to buy-out retiring and non-productive physicians at a pre-determined multiple of earnings
- Choose a corporate partner with existing good partner relationships and a proven track record of distributions to partners

There is no question that as the ASC industry grows and prospers, there will be more scrutiny from Government regulators, competitors, and customers, and this can increase the risks of ownership. Surgery centers are expected to continue to prosper on a playing field that will become increasingly crowded and more complicated to play on. Diversification, growth strategies, sustainable profitability, and a planned exit strategy are key factors in success, increasing ASC value, and in the ASC owner's ability to realize and enjoy the value that has been created. To minimize risk and maximize value, ASC owners may want to plan an exit strategy with a corporate partner while it is still a seller's market.

For additional information and copies of articles on corporate partners for ASCs, contact: **Jonathan C. Vick**, the founder and President of **ASCs Inc.**, has assisted in development, merger, and acquisition transactions for over 150 physician-owned ambulatory surgery centers (ASCs) since 1984. **ASCs Inc**. can be reached at 760-751-0250; Fax 760-751-0263; e-mail: jonvick2@aol.com. More information can be obtained at website: www.ascs-inc.com

THE ASC AND HOSPITAL BOARD - THE USE OF INTERNAL INVESTIGATIONS

Over the last few years, it has become increasingly clear that hospital boards of directors and lead hospital executives can be liable for the misdeeds of employees and management of the hospital. For example, if an employee in charge of business development forms financial relationships with referring physicians, the liability for improper payment or improper recruitment incentives can lead back to the executive suite or the boardroom. Further, as a hospital's Chief Financial Officer develops means by which patients will be billed, whether for governmental programs, uninsured patients, or private payors, and these payment schemes end up raising legal concern, the fallout can reach the highest levels of the hospital system. These concerns are relevant for both private not-for-profit tax exempt hospital systems as well as publicly-traded health care companies.

Hospitals and ASCs, as a protective measure, are increasingly turning to the use of internal investigations as a means to ferret out and respond to potentially problematic activity brought to their attention. For example, in one recent situation, our firm was retained by a health care system to review certain allegations made with respect to physician recruitment. In a second situation, we were engaged to investigate the means of selecting and qualifying individuals for eligibility in a joint venture involving various physicians for purposes of determining compliance with Fraud and Abuse restrictions. This article briefly sets forth certain guidelines and observations related to the rising importance of internal investigations.

There are four core purposes that an internal investigation can serve:

1. Identify improper conduct in your organization. If the board or executives believe that there is a possibility of certain misconduct, an internal investigation can uncover whether such conduct is actually occurring.

2. Improve compliance and the conduct of your organization. The ongoing use of internal investigations into key compliance issues can improve the conduct of your organization and ensure an active compliance environment.

3. Protect the board and executive officers. A hospital or health system's board and executive officers have a duty of oversight that must be fulfilled. If hospital leadership is actively carrying out their legal responsibilities, they are often found to not be liable for improper conduct that occurred at lower levels.

4. Minimize chances of prosecution or penalties. By having the full range of information available from an investigation, a hospital system can reduce the chances that a hospital will be investigated and fined by taking corrective and other necessary action. History shows that the government is less likely to bring indictments if in fact hospital leadership has shown a systematic and proactive effort towards complying with health care statutes and regulations.

A successful internal investigation typically relies upon outside counsel to significantly increase effectiveness. Outside counsel is not the principal counsel used by the health system for its ongoing health care regulatory or transactional work. The use of outside counsel helps provide the investigation with a level of independence and also leads to a greater chance that the outside investigator would be comfortable bringing potentially negative findings to the board.

An internal investigation typically consists of three core stages. First, it is important that the internal investigator works with the person he or she is reporting to or the board to define the scope of the investigation. For example, will the scope be related to a specific type of conduct or allegation that has been raised or will the investigation be a broader effort intended to discover all types of potentially improper conduct. Here, to the extent the investigation will include a review of matters outside the specific expertise of the investigator, the board and the investigator should discuss up-front the types of external research and services that may be utilized. A common example of this may be the use of a consulting firm to review billing and coding practices.

Second, once the scope of the investigation is determined, the investigator will begin their review and investigative effort. This typically is comprised of two parts. First, the investigator and counsel will request key documents and information related to the investigation. This may include all documents and internal memorandum related to the conduct at issue. For example, in an investigation relative to impropriety in physician recruitment, this request may include recruitment guarantee agreements, letters and communication with the recruit, any fair market value analysis completed during the process and any other information that relates to the issue at hand. Second, the internal investigative team will conduct interviews, either by phone or in person with various different individuals involved in the issue. In the recruitment example, this may include a review of all people that interfaced with the potential recruitment candidate, interviews with each of the parties that were involved in the decision to hire the candidate, or interviews with other parties that had any involvement at all with the recruitment program.

The third and final step in the investigation process is the development of a report by the outside investigative team. This report may be orally delivered or provided in writing depending on the audience and goal of the investigation. Where the investigator believes that the party he or she is reporting to potentially has an improper bias or a conflict of interest, he or she will have to make difficult choices as to whether or not such a report must be provided to a higher level manager, executive or board member. The report should also analyze whether or not additional efforts are necessary with respect to the investigation. For example, if the investigation involves a material and significant matter, or if the health care entity is operating under a corporate integrity agreement with the Office of the Inspector General, different considerations must be given as to whether disclosure to the government should or must be made. Further, publicly traded entities may be under duties to disclose certain developments to the SEC and the markets.

As a general rule of thumb, a provider should expect to spend approximately $2,000 to $3,000 per interview and an additional amount on research and review of documents and related information. The internal investigation need not cost hundreds of thousand of dollars, but can often be limited to a $10,000 to $30,000 budget. This relatively minor cost paid up-front can help avoid large civil or criminal penalties that could be imposed for conduct that went undetected and addressed.

In sum, the internal investigation is becoming an increasingly important tool in this time of increased focus on corporate integrity and compliance in the healthcare industry. All hospital and health system executives and board members should be aware of the useful tool that an internal investigation can be in their position.

Should you have an interest in reviewing the potential for use of an internal investigation or discussing such issues, please feel free to contact Scott Becker at (312) 750-6016 or Email at scott.becker@rosshardies.com.

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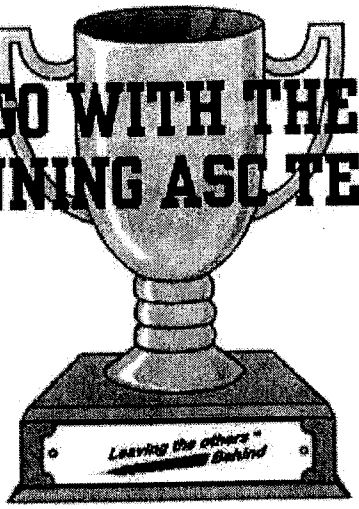

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BECKER'S **ASC REVIEW**
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BECKER'S ASC REVIEW

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