## Vol. 2005 No.3 BECKER'S Revie

AMBULATORY SURGERY CENTERS BUSINESS AND LEGAL UPDATE

#### Selling An Ambulatory Surgery Center

here are a number of key steps to successfully selling an ambulatory surgery center ("ASC"). This article briefly examines three core parts related to such effort.

Generally, when selling an ambulatory surgery center, the center should have clarity regarding 1) what its own goals are; 2) who the potential buyers are; and 3) what the key issues are to be negotiated.

#### I. Know Your Goals

The ASC which is planning to sell its center should attempt to general consensus among the group as to the plans and purpose for selling the center. Group leadership should understand that physicians vote with both their units (a percentage vote is needed to sell the center) and their cases (the center cannot be sold unless the key productive physicians are on board with the potential sale).

The three principal goals related to selling an ambulatory surgery center include: 1) obtaining a large price and cashing out of the ownership in part, 2) improving the operations of the center through the bringing in of a third party management company or other productive physicians, or 3) avoiding a catastrophic event such as bankruptcy. Again, the more that a group as a whole shares whichever goal is driving the plan to sell the center, the more likely it is to be able to consummate a transaction. In selling a center, is also well advised to know its own center well. For example, problematic issues which are discovered by the buyer can terminate a deal or lead to a lower price. A center should know whether it has accounts receivables problems and issues, whether it has coding and billing issues, whether it has other compliance issues. One is much better off disclosing types of

issues upfront than waiting for the buyers to discover them in due diligence. A center should also fairly evaluate whether it is over reliant on either a handful of physicians or on "out-of-network" business. Such issues can reduce the valuation of the center.

#### II. Know The Buyers

The companies which buy centers can be divided into four or five categories.

First, is the buyer in its early stages or an established company. An early stage buyer, meaning one that is early on in its own corporate development, may be willing to pay a higher premium as it needs to have a couple of deals under its belt to be a real company. However, an early stage company may not be stable and may be less likely to bring a transaction from letter of intent to closure. An established and mature company may be more disciplined in pricing a transaction, but also may be more likely to close the transaction.

Second, a buyer might be a traditional purchaser of majority interests or a minority interest purchaser. A traditional buyer of majority interests would include companies such as United Surgical Partners (Brett Brodnax at 972-713-3596), Symbion Inc. (Mike Weaver at 615-234-7912) and National Surgical Care (Tim Geary at 312-419-1033 or Tom Yerden at 303-589-8860). These are often the types of companies that one goes to when a center is trying to sell a majority interest in a center for a large capital gain. In contrast, a few companies specialize in buying minority interest in centers with the intent of helping the center to improve operations. These would typically include companies such as Ambulatory Surgical Centers of America (Brent Lambert at 781-258-1533) and Regent Surgical Health (Tom Mallon at 630-886-5530).

continued on page 2

#### **Ambulatory Surgery Centers—** Orthopedics, **Neurosurgery and Pain Management Driven ASC** Conference

e have recently completed the agenda for the June 9-11, 2005 Ambulatory Surgery Centers-Orthopedics, Neurosurgery and Pain Management Driven ASC Conference. This conference will focus on those three disciplines as they relate to existing and start up surgery centers. The conference will include a tremendous array of speakers including physicians who are owners of centers, a physician leader with a consult-

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#### Selling an Ambulatory Surgery Center continued from page 1

Each of these five companies are very good at establishing terms for a transaction and closing on the transaction as originally promised.

Third, companies can be divided into whether they pursue multi or single specialty centers. For example, the companies listed above all traditionally are interested in acquiring centers which are multi-specialty. They also may have an interest in single specialty centers. In contrast, companies such as Amsurg and Physicians Endoscopy (Barry Tanner at 215-589-9005) are much more focused on single specialty centers.

Fourth, one can also divide the companies into whether they are publicly traded companies or privately held companies. The publicly traded companies are almost required to periodically and consistently buy centers to fuel growth. In contrast, privately held companies, if intending to stay private, may be more disciplined in their buying mentality. In contrast, if a private company is trying to become a public company, it may be more likely to want to spend to grow the company through acquisitions.

Companies can also be divided as to their terms of business plans and buying strategy. For example, certain companies are extremely disciplined as to how they will price a transaction and to what percentage ownership they will buy. In contrast, there seems to be less rhyme or reason to the factors which influence the pricing by certain other companies.

We advise parties, in developing a process, to seek a handful of offers and to narrow the field to a few. Further, in terms of process, a typical process includes signing a letter of intent and then attempting to close the transaction by finalizing the purchase agreement, the operating agreement and the management agreement within 45 to 60 days thereafter. Throughout the process, we encourage centers to keep their owners and their board members fairly informed of the progress of the deal. In all situations, we advise the seller to keep their focus on their own business in that there is never a certainty that a transaction will close until it is actually closed. A number of the key issues that will need to be negotiated include:

- 1. Price. Here, price is usually set as a multiple of earnings before interest, taxes, depreciation, and amortization (EBITDA). A higher value center that has less vulnerability may be priced at six to seven times EBITDA for a majority interest. A smaller number will be paid where there is a substantial risk related to the center or with someone who is buying a minority interest in the center (often, 3 to 5 times EBITDA).
- **2. Percentage of Ownership.** Here, the parties will need to discuss how much ownership to sell to the national company. Further, the parties will need to discuss how dilution will be handled. For example, will the national company dilute down its ownership before the physicians are forced to dilute as well.
- **3. Post Deal Management.** The parties will need to determine whether the national company buyer will manage the center post-closing and what fee they will charge for management. For example, will it be paid a percentage of revenues? How much? 5 to 7% of collections?
- **4. Covenants Against Competition.** Typically, physician owners will be

bound to a covenant against competition for a period of time after the closing of the sale and for a period of time after they exit the operating company. These may be, for example, for five years after the close of the sale and for two years after the physician departs ownership of the operating company.

- 5. Redemption Pricing and Events. The new operating agreement will define the types of events that give rise to redemption of an investor and at what price an investor will be redeemed. A good deal of negotiation can be had over such points.
- 6. Split of Management Authority. The national company, if buying a majority percentage, will typically have significant management authority. However, the physician component of the venture will want to make sure that there are some checks and balances to this power. These are typically provided through "reserve rights".

Should you have additional questions relating to the potential sale of your surgery center, please contact Scott Becker at (312) 750-6016 or sbecker@mcguirewoods.com. ■

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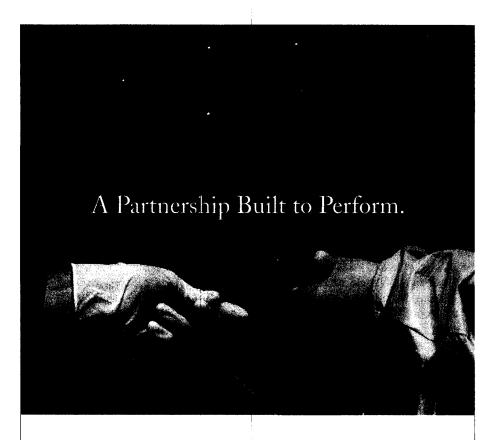
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## Anti-Kickback Statute—Sale of Shares in an Ambulatory Surgical Center

his article briefly discusses specific issues under the federal Anti-Kickback Statute relating to the sale of shares in an ASC. For purposes of this Memorandum, we have assumed that an ASC will be providing services that are reimbursable under a federal health care program.

The federal Anti-Kickback Statute (also known as the Medicare/Medicaid Fraud and Abuse Statute) prohibits, in relevant part, the knowing and willful solicitation, receipt, offer or payment of "any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind" in return for (i) the referral of patients covered by the Medicare and Medicaid programs, or (ii) the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by the Medicare and Medicaid programs. 42 U.S.C. §1320a-7b(b). Thus it is illegal to

(1) provide any party with remuneration or value in any form whatsoever, and (2) in exchange for a referral of Medicare/Medicaid or governmental business. Additionally, federal courts have held that the Fraud and Abuse Statute "one purpose of the payment was to induce future referrals." See, e.g. U.S. v. Katz, 871 F.2d 105 (9th Cir. 1989); U.S. v. Greber, 760 F.2 68 (3rd 1985).

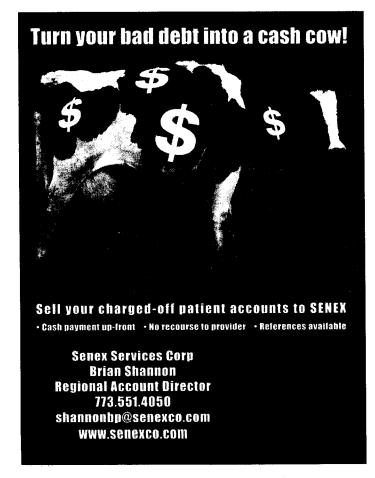
Under the Fraud and Abuse Statute, improper remuneration can be found in the provision of lease rates that are not fair market value, the provision of various services at rates that are not fair market value, the sale of any assets or shares at below fair market value, and several other situations. Generally, the return on an investment itself is not deemed improper remuneration.

In the ASC context, if a party that is a potential referral source to the ASC is offered the ability to purchase shares at below fair market value, the arrangement is problematic. There is therefore a serious risk that the government would find an arrangement to be illegal if shares are sold at below fair market value (assuming that the purchasers will be referring cases to the ASC). Selling shares at below fair market value would meet the first prong of the test for improper remuneration under the Fraud and Abuse Statute (i.e. that the sale is at below fair market value). We assume that the second prong will be met in that the purchaser will be bringing cases to the ASC for the first time or significantly increasing the number of cases brought to the ASC. Thus, the arrangement can be viewed as providing under-valued shares as an inducement for referrals. It is particularly important that there not be "value" in the offer to the purchasers in the form of below fair market value shares). Violation of the Fraud and Abuse Statute is a felony and carries with it the potential for large fines, suspension or exclusion from the Medicare and Medicaid programs and suspension or loss of licensure in addition to potential jail time.

For example, in one case decided last year, a physician was paid a small amount of money as a lease fee (\$400) in exchange for referrals to a laboratory. In that situation, the physician made one or two referrals before deciding that the arrangement was unlawful and that he was uncomfortable with the arrangement. Even after such relatively quick termination of the arrangement, the physician was sentenced to time in jail for the illegal kickback he received under the arrangement.

With the growth in the ASC market, the total number of ASCs has nearly doubled in the last five years (from approximately 2,500 to nearly 4,500), and some ASCs and ASC investors are acting carelessly or are not aware of the implications that surround this type of investment. Thus, it does not surprise me that certain parties are still selling shares at below fair market value or based on the volume or value of referrals that an investor can bring to the ASC. That stated, most experienced health care lawyers view this type of arrangement as illegal conduct prohibited by the Fraud and Abuse Statute.

Should you have any questions, please contact Scott Becker at 312-750-6016. ■



#### Sugery Center Marketplace

The surgery center marketplace was very active in 2004 and remain very strong in 2005. Four key trends seem to be emerging which may have a long term impact on the sector. First, there appears to be significant pressure on each the largest companies to achieve relatively high growth targets and on certain privately funded companies to obtain critical mass and grow their companies. This is leading to transactions being priced for the sale of surgery centers, specifically, majority interest transactions with management contracts, at strong multiples. Thus, subject to certain discounts discussed below, we are periodically seeing transactions in the 61/2 to 71/2 times EBITDA range.

Second, notwithstanding this trend, we are witnessing a number of transactions that, for a variety of reasons, are not command-

ing these multiples. Typically, we are seeing lower multiples where surgery centers are at risk of significant reimbursement decline, either because they are doing a substantial amount of business out-of-network, or for other reasons (e.g., very reliant on one payor, a few doctors, or one specialty). Thus, in many transactions, we are seeing multiples in the 5 to 6 range rather than in the 6½ to 7½ range.

Third, it appears that most hospital systems in the country have decided that they desire to have a joint venture surgery center with their surgeons. We have seen a radical shift in the view point of hospitals on this subject. While the temperature of certain executives on this issue changes as certificate of need or other prospects change in their state, the overriding tide seems to be towards doing increased numbers of joint ventures with physicians. This will lead to explosive growth in the total number of surgery centers over the next two to four years. It will mean more

competition, however, for a finite group of surgeons and patients.

Fourth, although we are seeing a greater number of surgery centers, the total number of outpatient surgical procedures being performed does not seem to be increasing at the pace it was several years ago. Thus, we are again returning to a situation in health care and particularly amongst surgery centers where there will be winners and losers. This will also tend to drive down the prices of many surgical centers.

#### Dialysis Market.

The dialysis industry has also seen significant growth over the last several years. Here, there has been a great deal of consolidation. However, there has also been growth in facilities from nearly 2,000 to 4,000 over the last few years. There, the great percentage of the business is Medicare business. Persons with end stage continued on page 12

Of great importance g valuable advice. 3. Having ading. or characteristics: a valuable friend. hal possession, such as a piece of jewelry high monetary value. Often used in the plural. ness n. -val/u·a·bly adv. val·u·ate (väl/yaō-āt/) tr.v. -at-ed, -at-ing, value for; appraise. [Back-formation from VALUAT] val·u·a·tion (väl/yōō-š/shan) n. Abbr. val. process of assessing value or price; an appraisal. 2. ue or price. 3. An estimation of worth, merit, or chahigh valuation on friendship. —val'u·a/tion·al ad val·u·a·tor (vāl/yōō-ā/tər) n. One that estimate appraiser. val·ue (val/yōō) n. Abbr. val. 1. An amount, as j ices, or money, considered to be a fair and suitable something else; a fair price or return. 2. Mong worth: the fluctuating value of gold and silver, liness or importance to the possessor; utility education. 4. A principle, standard. hile or desirable: "The speech 1 ues of restraint and re

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### **Ambulatory Surgery Centers—Key Risks**

We are seeing five key risks impact the development of surgery centers.

First, we are seeing the development of surgery centers by certain parties that are very difficult to justify. In short, it is our belief that a surgery center should be built only if there is a decent "margin of safety" as to the plans and projections. In essence, could you lose 20% of your cases and still break even. Could you be excluded from a certain percentage of payors and still do fine. Further, if reimbursement was 20% to 30% less than projected, what impact would that have on viability. Certain parties are building centers out of a "me too" drive that is leading to some challenging centers being built.

Second, throughout the country, there are increased efforts to rein in worker's compensation payments. Over the last

year, each California, Texas and now Michigan have adopted or reviewed proposals that will reduce payment for worker's compensation ASC cases.

Third, there is increased scrutiny of regulatory issues related to surgery centers. Again, surgery centers are still looked on with a certain sense of favor, however, the completely favorable view of surgery centers from the federal government is no longer present. An article on this topic will be in the next issue.

Fourth, antitrust risks are an increasing issue for surgery centers. There are two sides of this issue. First, certain physician-owned centers are being relentlessly attacked by hospitals. Certain of these actions by hospitals can lead physicians and their surgery centers to have good causes of action against the hospital for anti-competitive conduct. For example,

in the Rome ambulatory surgery center case, the court held that several of the surgery center's claims should survive a motion for summary judgment based on the market power of the hospital and a showing that the hospital engaged in predatory conduct. Further, in that case, the ASC was also able to withstand a claim to dismiss their claims which focused on the hospital entering into exclusive contracts with the payors in the community. Again, we expect there to be more antitrust actions in the next few years relative to surgery center than ever before. Second, in certain joint ventures where hospitals price their services together with the joint venture partner, this can raise issues from an antitrust price fixing standpoint particularly where the hospital controls a substantial part of the market.

Fifth, payors, and in some cases, states are increasingly challenging providers who are utilizing out of network strategies.

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#### PRELIMINARY CONFERENCE PROGRAM

## THURSDAY, JUNE 9, 2005 PRE-CONFERENCE WORKSHOP CONCURRENT SESSIONS (A & B)

#### 1:00-3:00pm REGISTRATION

3:00-4:15pm

#### A. ESTABLISHING AN ORTHOPEDIC DRIVEN ASC FROM FEASIBILITY ANALYSIS TO GROUP FORMATION TO FIRST PATIENT

Brent Lambert, MD, Founder Luke M. Lambert, CFA, CEO—Ambulatory Surgical Centers of America (ASCOA) David J. Abraham, MD, Spinal Surgeon The Reading Neck & Spine Center

#### B. DEVELOPING A PHYSICIAN-HOSPITAL JOINT VENTURE-A TO Z

Caryl Serbin, RN, BSN, LHRM President/Founder Surgery Consultants of America, Inc. & Surgery Center Billing, LLC

Charles Thomas, MD—Surgery Center of Pelham Raymond Shingler, Senior Vice President/CIO Spartanburg Regional Healthcare System

#### 4:15-4:30pm BREAK

4:30-5:10pm

#### A. START UP SUCCESS-TEN KEYS TO PAVE YOUR WAY TO SUCCESS

Thomas J. Mallon, CEO Jeffrey Simmons, Senior Vice President Regent Surgical Health, LLC

#### B. ASSESSING AND OBTAINING FINANCING FOR YOUR ASC

Jeffrey N. Fox, Vice President—CitiCapital

5:15-6:00pm

#### A. CONT: START UP SUCCESS-TEN KEYS TO PAVE YOUR WAY TO SUCCESS

Thomas J. Mallon, CEO Jeffrey Simmons, Senior Vice President Regent Surgical Health, LLC

B. NEW TRENDS IN TECHNOLOGY FOR ASCS Joseph Delligatti, Director—Stryker Corporation

#### FRIDAY, JUNE 10, 2005 GENERAL SESSION

#### 7:15-8:00am REGISTRATION AND CONTINENTAL BREAKFAST

#### 8:00-8:15am WELCOME AND INTRODUCTIONS

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

#### 8:15-9:00am REORGANIZING AN ASC WITH ORTHOPEDICS-A CASE STUDY

Robert J. Zasa, MSHHA, FACMPE, Founder Woodrum/ASD

Robert Kahn-Northeast Texas Surgery Center

#### 9:05-9:50am

#### CHANGES IN THE WORLD OF ASCS-A NATIONAL PERSPECTIVE

Greg Beasley, President Hospital Corporation of America

#### 9:50-10:05am BREAK CONCURRENT SESSIONS (A & B)

#### 10:05-10:45am

#### A. FLIPPING A HOSPITAL OUTPATIENT DEPARTMENT INTO AN ORTHOPEDIC DRIVEN ASC

Thomas R. Yerden, CEO, President Aspen Healthcare, Inc.

#### B. MIXING NEUROSURGERY AND PAIN MANAGEMENT-**BEST PRACTICES**

Ben Venger, MD, Neurosurgeon Surgery Center of Southern Nevada Jeffrey Simmons, Senior Vice President Regent Surgical Health, LLC

#### 10:50-11:30am A.THE ORTHOPEDIC DRIVEN ASC-KEYS TO IMPROVING PERFORMANCE

Andy Johnston, Vice President United Surgical Partners International, Inc. Randy Hardison, MD Arizona Orthopaedic Surgical Hospital

#### B. NEUROSURGERY IN AN ASC

Larry Teuber, MD, Founder Black Hills Surgery Center, Medical Facilities Corporation

#### 11:30-12:30pm **EXHIBITS OPEN**

#### 12:30-1:30pm

#### LUNCH AND PRESENTATION: SURGICAL HOSPITALS-A LEGISLATIVE UPDATE

Randolph B. Fenninger, President MARC Associates, Inc.

#### 1:30-2:10pm

#### A. THE ECONOMICS OF ORTHOPEDICS AND PAIN MANAGEMENT IN AN ASC

Luke M. Lambert, CFA, CEO—Ambulatory Surgical Centers of America (ASCOA)

#### **B. WASHINGTON UPDATE**

Kathy Bryant JD, Executive Vice President-FASA Craig Jeffries, Esq., Executive Director—AAASC

#### 2:15-2:55pm

#### A. OPERATING AN ORTHOPEDIC HOSPITAL

B. Don Burman, CEO The Orthopedic Hospital of Oklahoma

#### B. STAFFING, PLANNING, EMPLOYEE MANAGEMENT AND COMPENSATION

Sandra Jones MBA, MS, CASC, FHFMA, Principal, Director of Management Services Marjorie E. Vincent RN, MBA, CASC Woodrum/ASD

#### 3:00-3:40pm

#### A.THE FUTURE OF OUTPATIENT ORTHOPEDIC SERVICES-A BULLISH FORECAST

John Cherf, MD, MPH, MBA, Orthopedic Surgeon The Neurologic and Orthopedic Institute of Chicago

#### B. IN OFFICE VERSUS ASC REIMBURSEMENT FOR PAIN MANAGEMENT

Amy Mowles, President Mowles Medical Practice Management, LLC

#### 3:45-4:25pm

#### A. CONSIDERING EXIT STRATEGIES-THE BLACK HILLS STORY

Larry Teuber MD, Founder-Black Hills Surgery Center, Medical Facilities Corporation

#### B. BILLING AND CODING ISSUES FOR ORTHOPEDICS, PAIN MANAGEMENT AND **NEUROSURGERY**

Caryl Serbin RN, BSN, LHRM President/Founder Judith L. English, Vice President Business Operations—Surgery Consultants of America, Inc. & Surgery Center Billing, LLC

#### 4:30-5:10pm

#### A. CURRENT LEGAL AND REGULATORY ISSUES FOR ASCs

Scott Becker JD, CPA, Partner Morgan G. Moran, JD, Associate Krist Werling, JD, Associate-McGuireWoods, LLP

#### B. NEGOTIATION OF FINANCING FOR ASCS-EQUIPMENT, REAL ESTATE AND WORKING CAPITAL

Terry Gill, Vice President, National Sales Manager-CIT Healthcare Financial Services

#### 5:10-7:00pm

**NETWORKING RECEPTION AND EXHIBITS** 

#### SATURDAY, JUNE 11, 2005 **CONCURRENT SESSIONS (A & B)**

#### 7:45-9:00am

CONTINENTAL BREAKFAST AND EXHIBITS

#### 9:00-9:40am

A. THE FIVE LARGEST ASC COMPANIES-MARKET AND FINANCIAL OVERVIEW

Carsten Beith, Managing Director—Cain Brothers

#### B. MOVING YOUR PROCEDURAL PRACTICE FROM AN IN-OFFICE TO AN ASC ENVIRONMENT----AN INTERVENTIONAL PAIN MEDICINE CASE STUDY

Mark Jang, CEO—Titan Health Corporation Richard Lingenfelter, MD-Matrix Pain Management

#### 9:45-10:25am

#### A. FACILITY DESIGN, CONSTRUCTION AND **DEVELOPMENT**

John A. Marasco AIA, NCARB Principal Marasco and Associates, Inc.

John C. Daly AIA, Vice President Healthcare Services-McShane Construction Corporation

#### B. ADDING PAIN MANAGEMENT TO ASCs (Speaker TBD - PINNACLE III)

#### 10:30-11:10am

#### A. A WINNING ORTHO DRIVEN ASC JOINT VENTURE WITH A HOSPITAL-A CASE STUDY

Thomas R. Yerden, CEO, President Aspen Healthcare, Inc.

#### B. EVALUATING THE ADDITION OF ANCILLARIES TO THE ORTHOPEDIC PRACTICE-PT, MRI, MOB AND OTHERS

Stephen F. Dobias, CPA, Principal—Somerset CPA's, PC

#### 11:15-11:45am

#### A. THE PROS AND CONS OF A SINGLE VERSUS **MULTI SPECIALTY ASC**

Barry Tanner CPA, President, CEO Physicians Endoscopy, LLC E. Timothy Geary, Chairman, CEO National Surgical Care

#### B. HOW TO CREATE A SUSTAINABLE AND HEALTHY ASC PARTNERSHIP THROUGH EFFECTIVE PARTNERSHIP VALUATION AND PARTNER TRANSACTION MANAGEMENT

Elliot Jeter CPA, CFA, Partner Principal Value Management Group, LLC Todd J. Mello, MBA, AVA, Principal HealthCare Appraisers, Inc.

#### 11:50-12:30pm

#### A. THREE STEPS TO SELLING AN ASC

Scott Becker JD, CPA, Partner

Scott P. Downing, JD, Partner-McGuireWoods, LLP

#### B. DRIVING ASC VALUE THROUGH VENDOR **PARTNERSHIPS**

Jerry Goodman, Vice President, National Accounts Surgery Centers—Smith & Nephew Endoscopy

#### B. IMPLEMENTING AN ELECTRONIC MEDICAL **RECORDS SYSTEM**

Thomas J. Pliura, MD, JD, President-Zchart

#### MEETING ADJOURN 12:30pm

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## GENERAL INFORMATION HOTEL RESERVATIONS

The Chicago Marriott Michigan Avenue has set aside special group rates for conference attendees. Please contact the hotel directly to make your reservation. Be sure to mention you are attending the ASC Communications Conference in order to receive the discounted group rate of \$209

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Conference

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#### **CONFERENCE QUESTIONS**

For additional information or questions regarding the conference please contact the following:

#### Conference Director— Michelle Freeland

Phone: (858) 490-9015 Fax: (858) 490-9016

Email: michelle@meetings-unlimited.com

#### Exhibit/Sponsorship Director— Ken Freeland

Phone: (858) 490-9015 Fax: (858) 490-9016 Email: ken@meetings-unlimited.com

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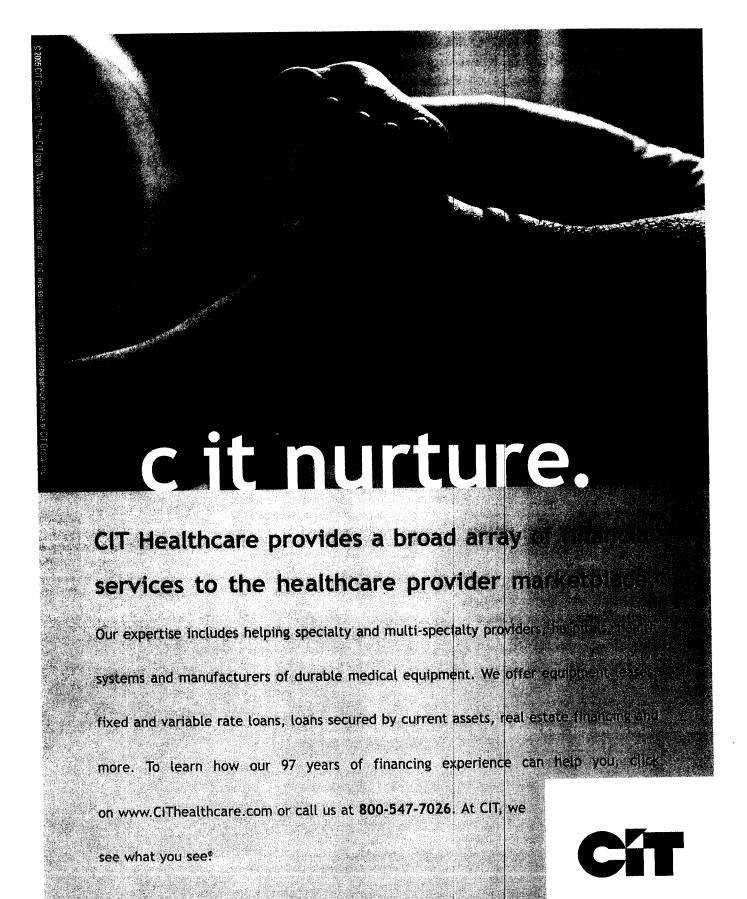
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## Ambulatory Surgery Centers— Orthopedics, Neurosurgery and Pain Management Driven ASC Conference continued from page 1

ing company has developed a forecast for outpatient orthopedics over the next ten years, neurosurgeons who operate surgery centers and surgical hospitals, a legal and regulatory update and several other topics. We also have three leading companies hosting a preconference session on establishing surgical centers, including one by Surgery Consultants of America on developing physician-hospital joint ventures. Separately, Ambulatory Surgical Centers of America, Regent Surgical Health and Surgery Consultants of America, Inc. will host sessions in the preconference on establishing physician-driven surgical centers. We also have excellent sessions related to the national view of ASCs from Greg Beasley at HCA, on "flipping" hospital outpatient departments into surgical centers by Aspen Healthcare and on reconstructing a surgery center around orthopedics by Robert Zasa of Woodrum/ASD and Robert Kahn of Northeast Texas Surgical Center. For information, visit www.BeckersASC.com or call Michelle Freeland at 858.490.9015. ■

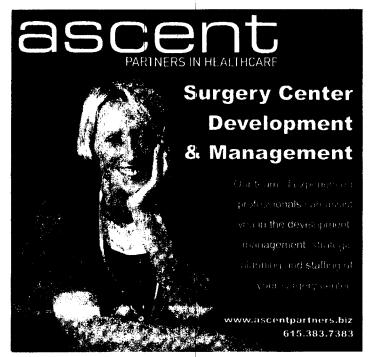
#### **News and Notes**

## GE Healthcare Financial Services Summit.

We are privileged to have been invited to participate on a panel relative to outpatient services at the 2<sup>nd</sup> Annual GE

Health Care Financial Services Summit. The conference includes speakers such as Jeff Immelt, CEO of GE, Uwe Reinhardt (a fenowned health care economist), Chris Matthews, Karen Ignagni, Nancy DeParle, a Medpac commissioner, and others.

continued on page 13







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#### Surgery Center Marketplace continued from page 5

renal disease are eligible for Medicare reimbursement after a short period of time regardless of age. Further, the Medicare payment rates have been essentially flat for many years. Thus, the ability to make larger profits through higher paid commercial patients is not as prevalent as it once was. Notwithstanding this fact, we still continue to see substantial growth in the dialysis business.

#### The Emergence of Quasi Joint Ventures.

Increasingly, hospitals are attempting to enter into quasi joint ventures with their physicians. Here, the evolving structures attempt to utilize a structure that will allow the hospital to bill under an outpatient department rate. Then, it pays the joint venture a per click fee relative to the services rendered by the joint venture. This concept grew out of language in the more recent Stark regulations that allowed "per click" relationships in certain situations. That stated, we believe that this type of structure raises very substantial risks from an Anti-Kickback Statute perspective, taxexempt hospital perspective (where an exempt hospital is involved in the venture), and a Stark Act perspective. Thus, we have been very cautious and have generally been discouraging clients from entering into such relationships. Nonetheless, there are a number of systems that appear to be embracing such efforts with little caution. For an article on this issue, please email me at sbecker@mcguirewoods.com.

Advanced Practice, Inc.

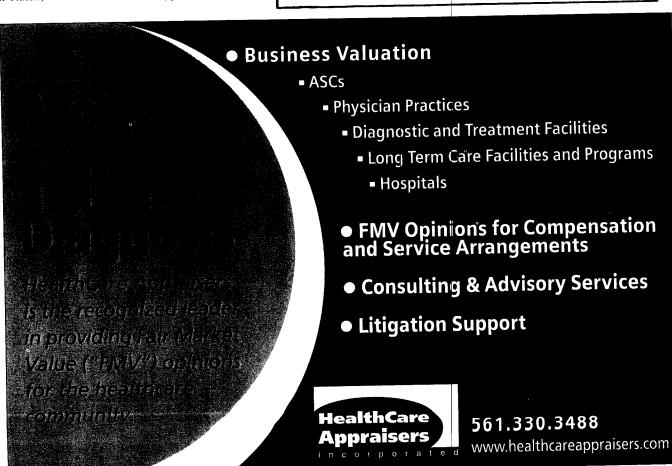
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## News and Notes continued from page 11 National Surgical Care ("NSC")/Aspen HealthCare, Inc. ("Aspen").

We congratulate NSC and Aspen on their recent combination. We expect Aspen and NSC to complement each other well and Aspen and Tom Yerden to help fuel the growth of NSC.

### Millennium Health Consulting, LLC.

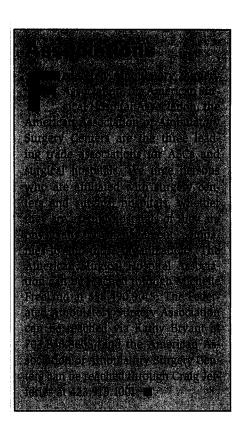
We congratulate Naya Kehayes, an ASC consultant for her analytical work related to managed care contracts for ASCs. She is very smart and a speaker at FASA's Annual Meeting on this subject.

#### HealthCare Financing.

Congratulations to Peter Myhre of MarCap Financial who has done a tremendous job at charging up the growth efforts of Mar-Cap. MarCap is a pleasure to work with and is both a smart and aggressive company.

We congratulate Jeff Fox on the growth of his group within CitiCapital. CitiCapital has re-emerged as one of the top two or three firms, if not the number one firm in the surgery center financing area over the last 24 months. It has taken tremendous effort for Jeff to convert the Copelco division into an integral part of CitiCapital and he has done a terrific job in making this a success.

Congratulations to Terry Gill who has relocated from GE Healthcare Finance to CIT Capital to head up their health care financing group. He has been a long term leader in the ambulatory surgery center and imaging financing business. He is as smart as anyone in the business. Moreover, he is a terrific gentleman and person. We wish him great success in his new position.



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## CMS Guidance On Hospital Compliance—Issues Of Import To ASCs

CMS issued additional compliance guidance related to hospitals on January 31, 2005. Many of the issues also relate to ASCs. A few of the key comments set forth in the CMS issuance are as follows:

#### A. Billing and Coding is the Biggest Risk Area

"Perhaps the single biggest risk area for hospitals is the preparation and submission of claims or other requests for payment from the Federal health care programs."

#### B. Use of Provider-Based Status

"Improper claims for incorrectly designated "provider-based" entities—Certain hospital-affiliated entities and clinics can be designated as "provider-based", which allows for a higher level of reimbursement for certain services. Hospitals

should take steps to ensure that facilities or organizations are only designated as provider-based if they satisfy the criteria set forth in the regulations."

#### C. Contractual Joint Ventures

"Contractual ventures with existing clinical laboratories and outpatient therapy providers, among others, are also potentially problematic, particularly if the venture is functionally a turnkey operation that enables a hospital to use its captive referrals to expand into a new line of business with little or no contribution of resources or assumption of real risk."

#### D. Payments to Physicians

"Are the items and services obtained from a physician legitimate, commercially reasonable, and necessary to achieve a legitimate business purpose of the hospital (apart from obtaining referrals)? Assuming that the hospital needs the items and services, does the hospital have multiple arrangements with different physicians, so that in the aggregate the items or services provided by all physicians exceed the hospital's actual needs (apart from generating business)?"

"Does the compensation represent fair market value in an arm's-length transaction for the items and services? Could the hospital obtain the services from a non-referral source at a cheaper rate or under more favorable terms? Does the remuneration take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties? Is the compensation tied, directly or indirectly, to Federal health care program reimbursement?"

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## E. Use of Space by Physicians without Charge

"In the case of physicians staffing hospital outpatient departments, are safeguards in place to ensure that the physicians do not use hospital outpatient space, equipment, or personnel to conduct their private practices? In addition, physicians working in outpatient departments must bill the appropriate site-of-service modifier. The hospital should take reasonable steps to ensure that physicians are aware of this requirements and should take appropriate action if it identifies physicians engaging in improper site-of-service billing."

## F. Determining a Patient's Financial Need

"The OIG recognizes that what constitutes a good faith determination of "financial need" may vary depending on the individual patient's circumstances and that hospitals should have flexibility

to take into account relevant variables. These factors may include, for example: (i) the local cost of living; (ii) a patient's income, assets, and expenses; (iii) a patient's family size; and (iv) the scope and extent of a patient's medical bills. Hospitals should use a reasonable set of financial need guidelines that are based on objective criteria and appropriate for the applicable locality. The guidelines should be applied uniformly in all cases. While hospitals have flexibility in make the determination of financial need, we do not believe it is appropriate to apply inflated income guidelines that result in waivers for beneficiaries who are not in genuine financial need."

#### **G. Free Transportation**

"The program was in existence prior to August 30, 2002, the date of publication of the Special Advisory Bulletin on Offering Gifts and Other Inducements

to Beneficiaries. Transportation is offered uniformly and without charge or at reduced charge to all patients of the hospital or hospital-owned ambulatory surgical center (and may also be made available to their families). The transportation is only provided to and from the hospital or a hospital-owned ambulatory surgical center and is for the purpose of receiving hospital or ambulatory surgical center services (or, in the case of family members, accompanying or visiting hospital or ambulatory surgical center patients). The transportation is provided only within the hospital's or ambulatory surgical center's primary service area. The costs of the transportation are not claimed directly or indirectly by an Federal health care program cost report or claim and are not otherwise shifted to any Federal health care program. The transportation does not include ambulance transportation."

