LIST INSIDE: 36 GI & Endoscopy-Driven ASCs to Know p. 23

INSIDE

INDEX

BECKER'S
ASC REVIEW
Practical Business, Legal and Clinical Guidance for Ambulatory Surgery Centers

March/April 2013 • Vol. 2013 No. 3

10 Strategic Initiatives for ASCs to Prepare for the Future

By Laura Miller

Here are 10 strategic planning initiatives to meet the upcoming challenges of healthcare reform from ambulatory surgery center administrators.

1. Take a hard line on supply costs. Implant costs, especially for orthopedics and spine procedures, are the most expensive supplies for many surgery centers. There are several strategies for cutting those costs, including exclusive deals with implant companies on streamlining supplies and purchasing wholesale implants where possible.

continued on page 10

200 Orthopedic- & Spine-Driven ASCs to Know

Here are 200 orthopedic- and spine-driven ambulatory surgery centers to know.

Adult & Children's Surgery Center of Southwest Florida in Fort Myers includes 21 physicians and is 30 percent owned by ASCOA.

Ambulatory Surgical Center of Somerset in Bridgewater, N.J., was founded in 1995 by the physicians of Somerset Orthopedic Associates.

Ambulatory Surgical Center of Stevens Point (Wis.) has two operating rooms and the capability to perform a variety of outpatient orthopedics procedures.

continued on page 39

Outlook for De Novo ASCs in 2013 and Beyond: Q&A With Luke Lambert of ASCOA

By Laura Miller

Luke Lambert, CEO of ASCOA, discusses the opportunities for new ambulatory surgery centers in the future.

Q: Is it still possible to develop de novo ambulatory surgery centers today? Where will there be the biggest opportunity for development in the future?

Luke Lambert: In the states where physicians can start surgery centers without needing to get a certificate of need, most of the markets have reached what I consider a saturation point. Most of the practices that want an ambulatory surgery center have one. In those environments, you only see new opportunities where there is a particular practice growing or newly organized where they can support one,

continued on page 16

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- Emerging Business Issues in Spine Surgery - Stefan Prada, MD, Orthopedic Spine Surgeon, Laser Spine Institute, Christopher Duntsch, MD, PhD, Clinical Director, Neurosurgeon, Texas Neurosurgical Institute, Patrick McCarthy, Chief Network Development Officer, Access MediQuip, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP
- Can ASCs Profit Through Spine and Orthopedics - What Works Business Wise and Clinically - Jeff Peo, Vice President Acquisitions & Development, Ambulatory Surgical Centers of America, Nader Samii, Chief Executive Officer, National Medical Billing Services, David Rothbart, MD, FAANS, FACS, Medical Director, Spine Team Texas, moderated by Brad Gilbert, former Professional Tennis Player, World-Renowned Tennis Coach and Analyst for ESPN
- The Mix of Business and Politics - Healthcare 2013 - Brent Lambert, MD, FACS, Principal and Founder, Ambulatory Surgical Centers of America, John Dietz, MD, Chairman, OrthoIndy, Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners, and Charles R. "Charley" Gordon, MD, Neurosurgeon and Co-founder, Texas Spine and Joint Hospital, moderated by Brad Gilbert, former Professional Tennis Player, World-Renowned Tennis Coach and Analyst for ESPN
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- The Changing Role of Spine Surgery - Richard N.W. Wohns, MD, JD, MBA, South Sound Neurosurgery, PLLC, Kenneth Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center, Jeff Leland, Chief Executive Officer, Blue Chip Surgery Center Partners, Stephen H. Hochschuler, MD, Texas Back Institute, moderated by Forrest Sawyer, Television Journalist and Entrepreneur in Innovation Health Care
- Succeeding in the Face of Challenges - Core Strategies from the Front Line - Charles R. "Charley" Gordon, MD, Neurosurgeon and Co-founder, Texas Spine and Joint Hospital
- Talent is Overrated! - Geoff Colvin, Senior Editor-at-Large, FORTUNE Magazine and Author, *Talent is Overrated*
- The Quantum Shift in Orthopedic and Spinal Implant Strategy - James J. Lynch, MD, FRCSI, FAANS, Board-Certified and Fellowship-Trained Spinal Neurosurgeon, Spine Nevada
- The Best Ideas for Improving the Profits of Pain Management Driven Centers - Key Developments in Pain Management, Scott Glaser, MD, DABIPP, Co-Founder and President, Pain Specialists of Greater Chicago, Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine, ProCare Research, ProCare Systems, and Nancy Bratanow, MD, Midwest Comprehensive Pain Care, moderated by Barton C. Walker, Partner, McGuireWoods LLP
- What Will Healthcare Reform Mean for Orthopedics, Spine, Pain Management and ASCs - James J. Lynch, MD, FRCSI, FAANS, Board-Certified and Fellowship-Trained Spinal Neurosurgeon, Spine Nevada, Luke Lambert, CFA, CASC, Chief Executive Officer, Ambulatory Surgical Centers of America, Robert Murphy, Chairman and Founder, Murphy Healthcare Group, A. N. Shamie, MD, UCLA Spine Surgery, moderated by Forrest Sawyer, veteran Television Journalist and Entrepreneur in Innovative Healthcare
- The Latest Development in Stem Cell Treatments as Applied to Spine - Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center

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FEATURES

Publisher's Letter

This issue of *Becker's ASC Review* focuses on ASC key specialties and includes two big lists: "200 Orthopedic- & Spine-Drive ASCs to Know" and "36 GI & Endoscopy-Driven ASCs to Know." Articles in this issue include expertise from several surgery center administrators and industry experts on improving operations this year and the outlook for ASCs in the future.

Key specialties featured in this issue include orthopedics, spine, ophthalmology, gastroenterology and anesthesia. The issue also features 30 statistics on ASC staff compensation.

Please join us for the 11th Annual Orthopedic, Spine & Pain Management-Driven ASC Conference in Chicago from June 13 to 15. The conference features 120-plus great CEOs, surgeons and industry leaders speaking on healthcare trends as well as keynote speakers:

1. Mike Krzyewski (Coach K), former basketball player and head coach at Duke University.
2. Brad Gilbert, former professional tennis player, TV tennis commentator, author and tennis coach.
3. Geoff Colvin, senior editor-at-large for Fortune Magazine and author of Talent is Overrated.
4. Forrest Sawyer, TV journalist and entrepreneur in innovative healthcare and founder of FreeFall Productions, and award-winning documentary production company.

Should you have any questions or comments, please contact me at sbecker@beckershealthcare.com or Editor-in-chief Laura Miller at lmiller@beckershealthcare.com or President and CEO Jessica Cole at jcole@beckershealthcare.com.

Very Truly Yours,

Scott Becker

P.S. For information on exhibiting or sponsorship at the 11th Annual Orthopedic, Spine & Pain Management-Driven ASC Conference in June, please contact Jessica Cole by email at jcole@beckershealthcare.com or by phone at 800-417-2035 or 312-505-9387.

10 Biggest Factors in Negative Cash Flow at ASCs & How to Turn Them Around

By Laura Miller

Having cash on hand is important for any business, especially healthcare providers in today's uncertain economic environment.

"The more cash that's in the pocket, the more time you can think strategically instead of reacting to the happenings of the day," says Patrick McCarthy, chief network development officer for Access MediQuip. "Forge relationships with major players in the business community and get inside their narrow networks. Keep the care local and serve your neighbors to increase quality."

Here are 10 big contributing factors to negative cash flow at ASCs and how you can turn these situations around.

1. Reimbursements drop. All providers are preparing for the trend of declining reimbursements to continue. Government payors and insurance companies will be looking for the highest quality providers at the lowest cost, which means aligning incentives could maximize cash flow even as reimbursement rates tumble.

"Physicians and staff must align their incentives with payors so everyone is focused on pay for performance," says Mr. McCarthy. "It's always important to pay attention to what the government is doing because commercial payors are piggy backing government programs within 12 to 36 months. Watch how those reimbursements change and keep a close eye on how physicians are reimbursed."

Review managed care contracts on an annual basis to see where there are opportunities for increase. "Understand your costs for procedures so you can compare reimbursement to your costs," says Reed Martin, COO of Surgical Management Professionals. "Any time it's close you want to target that procedure as an area for increase. Similarly, negotiate to get reimbursed for multiple procedures and implants whenever possible."

If the surgery center negotiates a multi-year contract, include escalators to adjust for inflation. Meet payor concerns about reimbursement rates with the other possibility: performing these procedures in the hospital at hospital rates.

"You need to provide information to the insurance company about why patients benefit from surgery at the ASC," says Mr. Martin. "Share your patient satisfaction statistics, clinical outcomes and reimbursement versus the hospital. If some of these cases are done on an outpatient basis, they are more cost-effective. At ASCs, there is also a lower complication rate, higher quality and higher patient satisfaction."

2. Overhead costs are too high. Beyond materials management, surgery centers may find that their expenses are too high. This includes contracts with service providers, facility rentals, equipment expenses and staff salary. Surgery centers should be flexing up when case volume is up and flexing down when it's low; try to avoid overtime hours and downtime for the staff.

"Labor and facility expenses are higher in an urban area, so anything they can do to increase case or throughput will assist with respect to cash flow for an urban facility," says Mr. Martin.

Controlling inventory is another tactic to keep overhead costs low. "Any supply items where you have an excess of one month inventory on hand is excessive," says Mr. Martin. "They can be returned to the vendor or utilized at another facility within your ASC management company's network. We can replenish stock far quicker than a month, so anything extra is actually money on the shelf that could improve cash flow."

Conduct an annual analysis of contracts for services such as housekeeping, equipment management, laundry services and anesthesia. "There are alternatives for all these services, so evaluate your contracts on an annual basis and make sure you are getting the best value as a combination of service and cost," says Mr. Martin. "Benchmark costs by physician and specialty to identify opportunities for value improvement."

Provide benchmark information for surgeons both from within the surgery center and from other facilities as well. When you present the information, blind the physicians so they can see where they stand without knowing who the other individual surgeons are.


Patrick McCarthy


Reed Martin


Joseph Zasa


Jim Devitt

3. Patient volume is under projected levels. Over estimating patient volume leaves surgery centers over-built and under-collecting. Investors should rely on conservative estimations on the number of cases they will bring into the facility and plan for a few less than projected.

"You have to have reasonable volume assumptions," says Joseph Zasa, co-founder and managing partner of ASD Management. "If you think you can bring in 100 cases per month, you will probably safely reach 70. To increase patient volume, make sure patients have a good experience at the center. Patient quality and care, physician and patient satisfaction, managed care contracts and business office functions all ensure a steady patient flow in the surgery center."

Examine each key area associated with patient volume and make sure your center is reaching critical benchmarks to ensure quality, safety, satisfaction and efficiency. "Use established benchmarks and obtain objective analysis," says Mr. Zasa. "Not what managers say, but what the objective facts say. You have to measure and verify what is going on, and bring in someone from the outside to help you take care of these issues."

Surgery centers can consider bringing in new specialties or services, such as 23 hour stays, to capture more of the patient population. "Anything that increases the revenue line helps cash flow in the long run," says Mr. Martin. "The first thing to look at is case volume, which relates to adding surgeons and specialties."

However, just bringing in more patients may not solve the issue. If the payor mix is bad and your center is bringing in less profitable procedures than projected, you'll still be in a negative cash flow situation.

"The major causes of negative cash flow are unpredictability for patient and payor mix when surgery centers don't control who is coming in because they get under water with less profitable procedures," says Mr. McCarthy. "They might need to be more choosey about which procedures and payors come into the ASC."

4. Overbuilt surgical facilities. Over the past several years many surgery centers over built their facilities and are now struggling to create positive cash flow. Some investors may have over-estimated the number of cases they could bring into the center on a monthly basis while others lost productive surgeons to retirement or employment over the past few years.

"When surgery centers are not successful, 90 percent of the time they are over built," says Mr. Zasa. "They might have had poor planning in the initial development, poor management over the years, lack of volume or no access to contracts that create cash crunches; undercapitalization is a problem. They need to hire an experienced developer and manager, and create a very detailed business plan with conservative assumptions for the future."

After overbuilding, the ASC has a few options. They can convert or close an operating room, but they are still paying for that space. A more profitable option would be to increase patient volume by bringing on new surgeons or merging with another local ASC to fill the extra space and generate new revenue.

5. Unexpected issues prove costly. Good businesses should prepare for the unexpected, and for surgery centers that might mean an economic downturn or the retirement of a senior partner. While the situation may be unknown, ASC administrators can prepare for the unknown consequences of these events by increasing cash.

"They need to raise enough cash to hedge against unexpected issues," says Mr. Zasa. "However, one thing you don't want to do is over leverage the facility by taking on too much debt. You want to inject real equity into the venture."

Administrators can also bring new revenue and cases into the center by adding new physicians and investors. Consider including a third party investor if your center doesn't already have one. Otherwise, you can recruit surgeon investors but make sure they fit within the center's existing structure.

"Know who you are and what you are good at to make a name for yourself so you can do physician recruitment for the procedures where there is most benefit for the patients and physicians," says Mr. McCarthy.

6. Implant costs go up. Supplies costs are one of the biggest expenses for surgery centers, and implant costs are constantly a concern. There are several tactics for surgery centers to lower implant costs, including streamlining devices, negotiating new vendor contracts and purchasing from wholesale suppliers.

"Costs of implants can be detrimental to cash flow for ASCs, so it's wise to keep costs low whenever possible," says Mr. McCarthy. "Use an outsourced implant device provider to purchase implants on your behalf. This will help you free up cash to use in more advantageous areas."

Surgery centers can also use group purchasing organizations to keep costs low. "Utilize GPOs and compare physicians with respect to what their costs are of a specific case," says Mr. Martin. "You can benchmark physicians against others within the facility as well as national benchmarks. Sometimes that provides other ideas to physicians about what supplies are appropriate and cost effective. You don't want to dictate clinical decisions, but sometimes their peers can show them lower cost supplies still have high quality."

7. Too many — or too few — accounts payable days. Accounts Payable is a delicate process and surgery centers can get in trouble if they take too long to pay their bills or if they pay them too quickly. Shoot for 25 A/P days to optimize cash flow.

"You don't want to pay the bills as soon as you receive them because that utilizes the cash too quickly," says Mr. Martin. "Pay at 25 days to avoid the penalties and shipment delays. If you pay at 10 days, increasing that to 25 days will produce 15 days' worth of cash."

8. High rate of claim denials. ASCs are losing money when they don't go after denied claims and spending extra resources when they do. Coding should be accurate from the beginning to receive the highest reimbursement as quickly as possible. If the surgery center doesn't have the resources to manage denied claims, consider outsourcing that function.

Surgery centers should also receive prior authorization for procedures to protect against denials in the future.

"One of the areas we are growing is by doing pre-authorizations to free up the front office staff for other patient responsibilities," says Mr. McCarthy. "This also gives patients one point of contact to work with throughout the process to align them with the insurance company, which can reduce claim rejections or denials on the back end."

9. Poor patient collections. Patients are more likely to have high deductible insurance plans today than ever before, which means surgery centers must go after patient responsibility payments at a higher rate. While the patient's portion of the bill may be small, over time missing these payments from several patients will have a huge impact on the center's revenue. Patients should know your center's payment policy and pay upfront if possible.

"Your surgery center should have a written set of policies and procedures about handling an account from cradle to death," says Jim Devitt, an expert in healthcare revenue cycle management. "Define an acceptable payment arrangement focusing on patient responsibility because that's going to be a big issue going forward. They should know how many written notices they will receive and how return mail is handled."

The actual billing statement ASCs send out may also deter prompt payment among some patients. When statements include the break down of an aging budget, patients think they can skip the first payments as long as they have everything in by the last. Similarly, when statements say payment is due upon receipt, patients think they can pay whenever they want.

"List a specific due date for the payment on each statement and only include the next payment due," says Mr. Devitt. If all else fails, consider bringing in a third party to collect this debt. Some people know their credit won't be hit until the third party collectors are involved, and they'll hold payments as long as possible.

Additionally, notify patients of their deductible and copay upfront and expect payment on the day of surgery, says Mr. Martin.

10. Turnover time is too long. Efficiency is key in any surgery center, and more difficult in multispecialty ASCs than single specialty. Devise processes to streamline room turnover as much as possible to cut the time between cases to increase throughput. "Also consider appropriately reducing the time per procedure," says Mr. Martin. "Benchmarking assists in this regard.

ASCs can also improve patient satisfaction developing scripts so the nurses are able to describe the procedures and processes to patients.

"They should do it in the same way every time so the patient doesn't feel rushed," says Mr. Martin. "It's important to have high patient satisfaction. You could implement scripting to describe the goals of privacy, infection control and quality control and how the clinical team and facility achieve these goals. It is important for the nurse to describe what he or she will be doing to the patient and why. Patients remember that and it does impact patient satisfaction."

Higher patient satisfaction has a trickle down effect that could make it easier to drive patient volume and recruit new physicians to the ASC. This will be important to surviving new healthcare delivery models in the future.

"Physician relations and recruitment are important, and those things are made easier if patients have a good experience at the ASC," says Mr. McCarthy. "Additionally, the evolution of accountable care organizations will mean something different in every market. Managed ASCs are affiliating with hospitals to leverage physicians and many ASCs have better specialization for surgery than hospitals do. They can bring value to the healthcare system." ■

10 Strategic Initiatives for ASCs to Prepare for the Future **(continued from page 1)**

"We are taking a very hard look at our vendors, our representatives and our contracts for implants and surgical supplies," says Evalyn Cole, CEO and administrator of Spine Surgery Center of Eugene (Ore.). "Our surgeons are having serious discussions about cost versus quality of implants."

There is an opportunity to carve out implant prices with some private payors, but Medicare's policy does not reimburse ASCs for implants in addition to the facility fee, which is already 65 to 70 percent less than hospital outpatient departments. "Our center is doing some hard negotiations with vendors about reduction on these items," says Ms. Cole.

Other providers are taking a new approach to equipment purchases. OA Centers for Orthopaedics in Portland, Maine, has jumped on the growing trend of medical E-bay, where facilities buy and sell instrumentation online.

"We look to see if anyone is selling the instrumentation we want," says Linda Ruterbories, ANP, ASC Director at OA Centers for Orthopaedics. "They're new items and if there is someone selling it online, we can purchase it there instead of from the vendor. Last year, we purchased all our instruments on E-bay for $5,000. If we had purchased them from the vendors, we would have spent $46,000. That's how we are keeping our costs down."

Surgery centers can sell parts — such as an unused monitor from an old system — and put the profits toward future purchases; even equipment as big as C-arms are bought and sold on E-bay.

2. Make prices more transparent. New payment models in healthcare are shifting more risk from insurance companies to providers and patients, and many people are choosing either high-deductible plans or cash-pay services. The Surgery Center of Oklahoma in Oklahoma City has capitalized on this trend by publishing prices online to attract medical tourism.

"We put our prices online in an attempt to draw patients directly to the facility using the transparent pricing as leverage in the marketplace," says Keith Smith, MD, co-founder and managing partner of the Surgery Center of Oklahoma. "We feel like we are more efficient and better quality than our hospital competitors. The best way to leverage that for our success is to show people the pricing."

The surgery center has drawn patients from across the country and Canada for routine procedures, such as knee arthroscopy. Price transparency will become a bigger trend as patients comparative shop for providers and accountable care organizations seek the lowest cost, highest quality setting for care.

3. Assist surgeons build their own practices. Surgery centers that are additions to physician practices, such as OA Centers for Orthopaedics, already have an intrinsic connection between the practice and ASC health. However, when surgery centers aren't associated with one specific group, there is less effort to promote the physician's practice; this needs to change.

"Looking into the future, we see our ASC as a practice builder for the surgeon to help remove some of the negative input third parties have had over them," says Dr. Smith, whose ASC drives patients by publishing prices online. "The patients find us on the internet when they are looking for medical tourism. This drives significant patient volume from places where single payor systems are failing. When they contact us we can send the patients to the appropriate surgeon affiliated with our ASC."

When the physician's practice grows, so does their case volume at the surgery center. "We are driving cases to surgeons who wouldn't normally have contact with these patients," says Dr.

Smith. "It is additional business and it's becoming a significant part of our surgeons' practices."

4. Contact big businesses for partnerships. As large hospitals have in the past, some surgery centers are now seeking partnerships with large businesses to provide care. ASCs can remove third party payors from the equation by inking deals with local companies to provide medical care for a set cost, which must be lower than they are able to achieve elsewhere.

"We are reaching out directly to large employer groups going around the third party payors, and we plan to continue with that strategy," says Dr. Smith. "We are able to carve out their care. More companies are interested in these carve out arrangements where they deal with us directly. The insurance companies aren't always acting in the best interest of large employers and we have basically redirected the patients to us, instead of the expensive hospitals where insurance companies want to funnel them."

OA Centers for Orthopaedics has also reached out to local businesses seeking partnerships, but change is sometimes hard to come by.

"We are finding an interesting problem because even though these businesses have talked for years about driving costs down, they are hesitant to make necessary changes," says John Wipfler, CEO of OA Centers for Orthopaedics. "As an example, they have been slow to step up and modifying their benefit structure to create incentives for employees to use preferred providers like ASCs. It is happening but at a slow pace. As reform efforts accelerate we anticipate a faster pace of engagement from employers. Creating incentives to move surgery from hospital settings to ASCs is such an easy way to create significant savings without compromising quality."

5. Figure out how to fit into new payment models. Accountable care organizations, bundled payments and other risk sharing arrangements are entering into markets across the United States.

"You have to take a look at what is happening in your part of the country," says Mr. Wipfler. "For us, there is a lot of consolidation between physician practices and hospitals as the hospitals are cornering a lot of the provider market. We are trying to position ourselves for changes and new payment models that come with healthcare reform, which is pushing people to create ACOs and medical home models. You don't want to be cut off from referral sources."

OA Centers for Orthopaedics has aligned with hospital partners and other providers in the community to position itself as a leader in orthopedic care.

"Most providers are engaged in conversations with other physician groups, healthcare systems and hospitals to explore new kinds of partnerships," says Mr. Wipfler. "Our enterprise must be aligned with other physician groups and hospitals to continue to thrive. Hospitals need specialists, and since ASCs cater to specialties we are all affected."

6. Plug into referral sources. Engaging primary care physicians and other referral sources around the community has become exceedingly important. However, traditional roads of communication may be closed as more primary care providers become hospital employees.

"We see hospitals owning more of the primary care physicians, which forces us to find new ways to partner with the hospital," says Mr. Wipfler. "There are still a number of independent practices, but they are moving toward ACOs and as a result trying in some instances to bring specialists in-house so they are under their control. We need to work on partnership strategies with these providers so they aren't able to replace us."

Additionally, more referrals are shifting from primary care and word-of-mouth to other sources who dictate care settings.

"Historically our patient volume came from happy friends and families, but now more insurance companies and employers are designing plans that go to preferred providers," says Mr. Wipfler. "ASCs need to make sure they are aligned within the new structure or positioning themselves to partner with who controls the patients."

7. Consolidate independent physicians. Just as hospitals are consolidating into health systems, physician practices are now becoming part of larger physician organizations and health systems. OA Centers for Orthopaedics is a founding member of the only specialty independent physician association in their region, which includes 15 different specialties.

"Our intention with the IPA is to be able to plug in and join an ACO in any community," he says. "We can provide 'one-stop shopping' for a coordinated set of specialty services. We are the solution to specialty medical care. That has created a lot of interest and I think holds significant promise as a model."

Providers all need to use data to show how using lower site of service can save the system and payors a lot of money. Moving cases from a tertiary care hospital to a community hospital is a significant savings for payors, be they insurers, government, self insured businesses or patients. It generates even more savings to move cases from hospitals to ambulatory settings.

8. Educate patients and other providers on ASCs. Surgery center administrators are very invested in the ASC industry and understand the potential for increased quality and decreased cost; however, in many communities, patients and even other providers don't understand their benefits.


Linda Ruterbories


John Wipfler


Dr. Keith Smith

"Surgery centers need to do a better job of educating people about the huge cost savings and quality benefit of moving into ambulatory surgery center settings," says Ms. Ruterbories. "For ASCs, it's about continuing to show that they are a lower cost site for service and high quality outcomes."

For most cases, performing procedures in a surgery center can save as much as 40 to 50 percent on the facility fee, with the same physicians performing those cases. "Payors have the data and they know what they are paying to whom," says Ms. Ruterbories. "It's interesting that they haven't come to the realization that there is a different cost per case in a hospital as opposed to the ASC. If they are aware of that we all need to push them to act on those cost differences. We need to shine a brighter light on that."

9. Automate wherever possible. Automation is the next wave of technological advancement for surgery centers, and new software can make collecting patient histories more efficient. OA Centers for Orthopaedics recently began using preopscreening.com, a program that asks patients to electronically enter their medial history.

"We know everything about their medical history before they walk in the door," says Ms. Ruterbories. "From the ASC perspective, there are certain cases we can do here and some we definitely can't. If we know early on in the process that one of our patients isn't a good candidate for our center, we don't book them at the ASC. Instead we have them go into a tertiary care center or another facility with 24-hour coverage."

When cases are canceled on the day of surgery because the patient isn't a good candidate for the ASC, you waste time and money preparing for the case. ASCs can save by knowing the patient's medical history in advance and ensuring it's scheduled in the right setting.

"We are really trying to screen our patients ahead of time and using this program has proven successful," says Ms. Ruterbories. "We've seen less day-of-surgery cancellations, which is a huge savings for our surgery center. It's also providing safer care for patients because we know more about them. If we see something that is of concern for us, we get the notes from their primary care physician."

The system used at OA Centers for Orthopaedics is flexible and Ms. Ruterbories was able to customize the program for their practice

"The program red flags certain medical conditions, so we know who might be at risk just from looking at the patient list," she says. "It also flags MRSA, which is something we didn't have to worry about in the past. Having done this for 25 years, I can see that the health of the patients coming to surgery centers is a lot more complex than 10 years ago and now we are dealing with that upfront, which is how it should be done."

10. Improve employee culture. One of the hot topics among ASC leaders today is employee culture. A positive patient experience is essential moving toward more consumer-driven healthcare, and cooperative staff members will enhance patient experience tremendously.

"You need to work on staff culture so the patients recognize staff members are happy in the workplace," says Ms. Ruterbories. "When a healthcare provider's attitude is such that they are smiling, even though patients are lying in bed in the recovery room, they notice how our staff members act."

Ms. Ruterbories holds staff meetings every two weeks to help build their team. "The team members are stepping up and presenting about what 'team concept' means to them," she says. "They talk about what they find value in as a team member and share that with the group."

At the heart of these initiatives, Ms. Ruterbories hopes a positive culture will build trust and communication across her team. "It doesn't matter how good protocols and equipment are, if you don't have teamwork you won't have a highly functioning system," says Mr. Wipfler. "Linda spent a lot of time building trust, breaking down communication barriers and getting people to work through issues in real time. If people are happy, you'll see better quality and more efficiency, and they'll be able to do their work better." ■

6 Crucial Strategies for Profitable ASCs From Regional SurgiCenter

By Laura Miller

Arvind Movva, MD, CEO of Regional SurgiCenter in Moline, Ill., discusses six key strategies for ambulatory surgery centers to prosper in the wake of healthcare reform.

1. Expand size to bring in more cases. Ambulatory surgery centers can set their sights on expanding, either physically or internally, to meet the coming challenges in the healthcare market. Consider adding new services, physicians or partnerships as well as purchasing new equipment or making more room in the ASC to service additional cases. More patients coming through the door can boost revenue if the cases are profitable.

"I would say the number one thing ASCs can do in 2013 is become bigger," says Dr. Movva. "It helps with contracting to have the economies of scale, so work with your current surgeons to bring in more cases — as many cases as they can. A lot of cases done at the hospitals can be done at the ASC for lower cost and higher quality. Getting bigger allows you to lower fixed cost and spread them around to more surgeons."

Optimize room utilization at your center to make room for more cases before turning to physical building expansions.

2. Prepare for bundled payments. Bundled payment programs are becoming a reality in many communities, and ambulatory surgery centers will become a part of them in the future. Fee for service reimbursement will likely go by the wayside as government and private payors seek to lower cost of care.

"A big issue going forward this year and in the future is preparing for bundled payments," says Dr. Movva. "People are fooling themselves if they think it's not coming, especially after 2014. We previously billed and were paid on a fee-for-service basis and now we are being asked to share the risk. However, the real risk is that your rate won't cover your costs and the margin you expect."

Administrators and surgeons must know the cost of care for each procedure and understand how their choices — such as materials used — will impact the center. For colonoscopies at Regional SurgiCenter, Dr. Movva calculates the cost of an episode of care from the moment the patient comes in the door; he knows how many gloves his team will use, what the IV kits cost, disposables, cost of medication and staff hours.

"Once you have a cost for each different case, compare that number with the contracted rate you have with payors as well as current Medicare rates and see if you are profitable with that procedure," says Dr. Movva. "Figure out where you can cut costs and still have a good margin."

3. Maintain stable and consistent anesthesia services. Anesthesia is an important part of all cases at the ASC, and working with stable providers will enhance your success with bundled payments and accountable care organizations in the future.

"People will want the whole episode of care bundled, so for a colonoscopy we are looking at the visit 10 days before the procedure, sedation, pathology and follow up so that we control every aspect of care," says Dr. Movva. "Since we are taking on risk, the more things we are controlling in the pipeline — the more we control the margin and risk costs — the higher our profits will be."

Anesthesia can be a big issue because if services aren't stable and consistent it will be more difficult to optimize overall bundled payment costs.

4. Meet and exceed quality measures. Ambulatory surgery centers have lower complication rates than hospitals already, but staff and surgeons must continue to diligently work at infection prevention. Exceeding the norms will position your center for success in the future.


Dr. Arvind Movva

"We are entering into the age of informed consumers," says Dr. Movva. "When it comes to ASCs, we are mostly performing elective or urgent cases, which mean the patient has a chance to look around. It's important to meet and exceed quality measures and relay that information to patients."

When people connect your center with high quality and patient satisfaction, they will prefer surgery there. "The more patients who want to come to our center, the better position we have with insurance companies to get better rates," says Dr. Movva. "It really helps to have an informed consumer because they will almost always pick the ASC over the hospital for lower acuity cases."

5. Optimize online direct marketing to patients. More patients, especially patients in the younger generations, are turning to the Internet for information about healthcare and medical providers. They are looking at physician and facility reviews to know about other peoples' experience.

"This has been somewhat difficult in healthcare because we've had a lot of websites without great data, but we can put our numbers out there with social media," says Dr. Movva. "We can also talk to local news outlets about our numbers. When people come in they tell me how wonderful the staff and facility is and they want to come back; now we need to get that message to them before they are making their healthcare decisions."

Let people in your community know they have an option for where their care is provided and build a relationship with referring physicians. Patients should be able to tell their primary care physician where they want their surgery and with which physician, not the other way around.

"We do a lot of things on Facebook and Pintreset and we are always speaking in the area about different issues and services we offer at our ASC," says Dr. Movva. "Quantifying the return on these investments is difficult, but we are asking people how they heard about us. Online marketing isn't expensive when you take advantage of social media and we are putting more effort there."

6. Sit at the table for ACO discussions. People across the healthcare spectrum are talking about accountable care organizations, but it's difficult to see exactly how ambulatory surgery centers will fit in the future. However, coming to the table for those discussions will ensure ASCs aren't left out of their community's network.

"I definitely believe that ASCs will have a space in the ACO market," says Dr. Movva. "ACOs are incentivized to shift cases to the lowest cost setting and improve outcomes, which is what ASCs do. Working against the ACO isn't the right attitude; the right attitude is to be in it from the beginning. Be proactive to work with hospitals who are trying to put this together."

ACOs will be different across the country depending on market needs and demands. However, if the goal is to improve care and lower costs, expertise from ASC administrators and physicians who have done this for years will be appreciated.

"When cases are moved from the hospital to the ASC, we will have saved the ACO money, and that's shared savings for all," says Dr. Movva. "When you share in savings, people are much more interested in costs. Don't be the one looking in from the other side of the glass as these ACOs are built in your community." ■

6 Ways to Slash Costs of Spine Surgery at ASCs

By Laura Miller

Spine surgery is increasingly moving into outpatient ambulatory surgery centers, which operate on a highly efficient and cost-effective basis. However, with regulatory changes and downward pressure on reimbursements, ASCs may need to dig deeper in cost-cutting measures.

"Every year more minimally invasive surgeries are being performed in the ASC instead of the hospital, and that will help reduce the cost," says Douglas Won, MD, director and founder of Minimally Invasive SpineCARE, based in Irving, Texas. "It's more expensive to operate in a hospital than the ASC. The nationwide healthcare costs related to spine surgery will come down, and I think we will see this become more of a trend in the future."

Here are six ways for ASCs to slash costs on spinal procedures.

1. Engage surgeon partners. Ambulatory surgery center administrators must engage partners and investors in the surgery center on cost-cutting efforts. This means going further than just examining the numbers and implementing new rules; the surgeons must be part of that process.

"Administrators are trying to make it enticing for surgeons by accommodating their schedules and giving them the materials they want so they'll operate at the center. However, that won't really help with costs and overhead for the facility. It's not cost-effective for the ASC or the healthcare system," says Dr. Won.

Call a meeting with all the surgeons — investors and non-investors — to help them really understand what makes the center profitable. From there, you can focus on areas with the most opportunity for cost reduction.

"They have to understand and they have to be involved," says Dr. Won. "If you just demand or dictate to the surgeons, they won't come back to the center. Engage the physicians and help them understand where you are coming from. If they are partners, they will want the ASC to be successful and profitable so they can see a return on investment as well."


Dr. Douglas Won

2. Streamline supplies. One of the quickest ways to decrease supply costs at the surgery center is by streamlining the implants. Work with the surgeons to consolidate supplies and choose one company to purchase from.

"If the surgeons are in line with the ASC and can work together to select specific implant companies or suppliers and decide what disposable supplies to utilize, I think the surgery center can negotiate better with vendors," says Dr. Won. "They have more purchasing power with implant companies, and where available they can purchase implants at a wholesale price."

ASC administrators can also renegotiate shipping and handling prices for supplies and drugs. Finally, bring anesthesiologists into the discussion as well to lower costs on the drugs they use. "Utilize generic products to help reduce the cost for the ASC," says Dr. Won.

3. Use refurbished supplies. In addition to cutting down on disposables, surgery centers should consider opportunities to re-sterilize their supplies. Refurbished equipment and instrumentation is available from several companies — including some of the biggest orthopedics and spine suppliers — and can make an impact on the bottom line.

"Consider using refurbished equipment because it can create a significant cost savings," says Dr. Won. "If you engage the surgeons and help them understand how these things can make the center more profitable and lower healthcare costs, that makes a big difference."

However make sure all providers are comfortable with the quality of refurbished and re-sterilized equipment before making the full switch.

4. Talk with surgeons about business. Most spine surgeons have never taken a business

class and may need training to think like a savvy business partner.

"Informing surgeons about best business practices can be very helpful," says Dr. Won. "Bring them all into a room and give them an idea of the big picture of the surgery center and where the costs are involved. Make sure the surgeons feel invested as true partners and once they are more involved, they are likely to assist administrators in cost-cutting initiatives."

The initial meeting about cost cutting may take a few hours to bring everyone up to speed, but after that administrative duties and check-ins shouldn't take more than a few hours per month.

"Once they are engaged in the ASC, they want to know about the health of their business," says Dr. Won. "This is something surgeons want to be involved in."

5. Arrange physician-to-physician conversations for outliers. Hopefully all surgeons will be onboard with cost-cutting initiatives from the beginning, but if one or two are resisting change then whole program could fail. Coordinate a meeting between the ASC's medical director or senior physician and the outliers so they can discuss their issues at the same level.

"If a surgeon is not cooperative, first you need to have him sit down for a one-on-one discussion with the surgery center's medical director because it's always easier when physicians speak to other physicians with the support of the administrator," says Dr. Won. "Reason with them and give them proof on how they need to assist the ASC."

This may be particularly challenging with non-investors because they don't have the same financial incentives to maintain a profitable ASC. However, instead of relaxing on cost-cutting initiatives, the administrator can work harder to accommodate them by providing high quality service to their patients and make their experience as surgeons better.

"Even with the non-investors, we are going to do due diligence on what implants they use and what their convenient hours are," says Dr. Won. "We'll ask them to schedule cases at a certain time and help us with negotiating prices with their vendors because physicians have a lot of influence over implant companies. If there is something they want to use, the ASC can negotiate those contracts, but it's easier if the surgeon is involved."

6. Consider case profitability. Profitability at the surgery center depends on spending resources wisely and performing cases where costs are lower than overall payment for services rendered. As a result, advise surgeons to perform unprofitable cases at the hospital instead of the ASC.

"For certain types of products we shared our costs per case with the surgeons and showed them we were losing money on those cases," says Dr. Won. "The physicians had no idea — they thought just bringing cases into the ASC was making it profitable."

Another important aspect of profitability is case scheduling. While it may be convenient for surgeons to obtain block time or schedule last minute cases at the ASC, it may not always make the most economic sense when running a business.

"Sometimes they want to schedule cases in late afternoon on Mondays or Tuesdays when all our other cases are in the mornings," says Dr. Won. "When this happens, the full team must be available all the way through the afternoon, which increases staffing costs. Staffing is a significant cost to the ASC, so we need the surgeons to understand how to schedule so it's convenient and cost-effective."

If all cases are finished in the morning one day, the staff can go home early. On the other hand, if there is a day when only a few cases are scheduled — such as on Fridays — the ASC can shut down one of the operating bays to save overhead costs. ■

Outlook for De Novo ASCs in 2013 and Beyond: Q&A With Luke Lambert of ASCOA (continued from page 1)

or they are expanding to a market where they didn't have a presence before.

However, when development is unrestricted practices often do better to buy into an existing surgery center. Given that surgery center reimbursement has been pretty static over the past decade and costs have crept up, most ASCs are trying to maintain profitability by growing case volumes and that comes from recruiting new surgeons to the centers. There are ample opportunities for surgeons to join existing centers, which can be more attractive than developing from scratch.

Q: What about surgery centers in CON states? Do they have a better outlook?

LL: In states where CONs are required, surgeons must figure out the conditions needed for approval. The approval process is a limiting factor and in some states the standards are objective enough that you can know whether you are going to get approval or not; however, most of the time it's a political process where if you have support of favored constituents you get it. Often joint venturing with the local hospital can be the ticket to approval.

However, in a significant state like Virginia, if the lawmakers decided to do away with the CON for ASCs, you would see a tremendous amount of ASC development in the state. More than a decade ago, Pennsylvania did away with the CON requirement and over the subsequent years many ASCs developed.

Q: In what situations are hospitals most willing to partner with physicians on new ASCs or enter into a joint venture?

LL: Usually hospitals need to see the project as giving them a direct help of some sort, such as a city hospital with constricted real estate. This hospital might be reaching capacity so instead of spending $20 million to $30 million on a project reconfiguring the hospital — which would be disruptive and costly — they might find it worthwhile to develop an ASC that's not on their campus where they can move smaller cases to free up their operating rooms for larger inpatient procedures. When hospitals are at capacity they often see the small cases as a nuisance and they're willing to move them into an ASC.

Hospitals are also excited to support and partner with surgery centers when they fit into their market share growth strategy. They might set up an ASC in their competitor's back yard, and in a cluster employing primary care physicians, specialists and develop urgent care centers, and imaging modalities. Building a surgery center can be a good way to co-op specialists and help realign them with their system as opposed to the competing system. Normally such surgery centers would be joint ventured with the hospital because co-management arrangements are not as attractive to physicians generally.

Q: If a specialty practice decides they would like to invest in a surgery center, how can they tell whether this is a smart move for their group?


Luke Lambert

LL: New groups that don't have an ASC already can develop their own if they have sufficient case volume to make it economically viable. That said, in most circumstances groups will find it advantageous to buy into an existing center. They are likely to have higher profitability that way because they are in the projects with existing surgeons who are sharing overhead costs and there is an enhanced potential for strong profitability.

Q: With the best opportunity being to join an existing center, do you think there will be a trend toward expanding centers to accommodate new specialists in the future?

LL: There are some centers we've had that expanded over the years. We also see centers that would expand if they could, but their real estate is situated such that they can't. Nevertheless, excess capacity is more the norm in the industry.

Q: What is the biggest challenge existing ASCs and specialty groups face in growing their centers in the future?

LL: One of the biggest challenges is hospital employment of physicians. Historically the users of surgery centers have been independent physicians. There are fewer independent specialists today because hospitals are employing them. This trend will limit the development of new centers and hurt the existing centers because cases are going back to the hospitals.

Hospitals get paid more per case, so it makes sense to have everything under the hospital's umbrella. From society's perspective, it doesn't make sense because it increases the cost of care. Healthcare reform is banking on integrated service delivery to realize savings, but in the short term there is less competition and that drives up costs.

When a health system gets paid more than other providers, surgeons find they can work for them and be paid more. Over time more and more care gravitates under their umbrella because they have better reimbursement. That's why you see hospitals purchasing surgery centers; they can buy them based on their current profitability and triple the profitability by converting them to a hospital outpatient department.

Q: Where do you see the trend of hospitals purchasing ASCs headed in the future?

LL: If payors don't compensate ASCs enough to perform their services, they won't provide them. The procedures will stay in the hospital or migrate back to the hospitals. ASCs aren't currently being paid enough in many markets and they have to revert back to hospital ownership where they can be paid more. Payors think they can squeeze these relatively unpowerful market players like ASCs to save money, but if they squeeze them enough they fall into the arms of the hospitals and insurance companies are back to paying more.

I think many policy makers believe that a system with fewer and larger players will be easier to control and to drive cost savings. For the foreseeable future, the concentration of services is leading to higher costs. As you feed the big systems and starve everyone else, you will just be left with the big systems. ■

30 Statistics on Surgery Center Staff Compensation

By Rachel Fields

Here are 30 statistics on surgery center employee compensation, according to VMG Health's *Multi-Specialty ASC Intellimarker 2011*.

All ASCs
Nurse staff: $32.12
Tech staff: $20.92
Administrative staff: $23.09
Total hourly wage: $27.03
Administrator salary: $109,184

West
Nurse staff: $36.61
Tech staff: $23.04
Administrative staff: $23.98
Total hourly wage: $29.25
Administrator salary: $114,109

Southwest
Nurse staff: $31.58
Tech staff: $20.64
Administrative staff: $21.36
Total hourly wage: $26.34
Administrator salary: $100,779

Midwest
Nurse staff: $29.79
Tech staff: $19.43
Administrative staff: $22.38
Total hourly wage: $25.83
Administrator salary: $104,372

Southeast
Nurse staff: $30.28
Tech staff: $18.95
Administrative staff: $22.78
Total hourly wage: $26.12
Administrator salary: $110,311

Northeast
Nurse staff: $32.58
Tech staff: $20.26
Administrative staff: $24.49
Total hourly wage: $27.48
Administrator salary: $109,268 ■

5 Reasons to Conduct Regular ASC Valuations

By Todd Mello, Partner and Co-Founder of HealthCare Appraisers, and Nicholas Newsad, Senior Associate at HealthCare Appraisers

Here are five reasons to conduct regular ambulatory surgery center valuations.

1. Partners can understand their investment value. It is important for the investors of any business to know the value of their investment. This applies to investors who want to know the current value of their ownership relative to what they originally paid, as well as prospective investors who need to decide how much ownership they want to purchase or if they want to purchase at all. Whereas physicians can instantly check the value of their investments in publicly-traded stocks based on prices paid on stock exchanges, privately-held companies, like ambulatory surgery centers, need to be valued periodically by a business appraiser.

Additionally, physician ownership in ASCs only complies with the Anti-Kickback Statute safe harbor when the terms on which the investment interest is offered are not related to referrals or other business generated by the physician. That requirement likely implies that investments must be priced at Fair Market Value, as an ASC that "under prices" ownership units could be construed to have offered units on terms that were related to the volume or value of the physician's referrals.

2. Unit pricing can impact physician recruitment. In terms of physician recruitment, unit pricing can pose problems for ASCs because FMV for ownership shares may result in units that are priced higher than some surgeons can afford. Some successful ASCs and surgical hospitals have realized great appreciation in their ownership shares to the extent that they are no longer affordable to prospective buyers. In some cases, single ownership interests (1 percent) have exceeded $100,000. In these situations, it may be necessary to perform a stock split to make a single unit represent a one-half percent interest or a quarter percent interest or sell fractional interests so that units are affordable for new surgeons.

Sometimes it is important to communicate to prospective surgeon investors that their return-on-investment is the same, regardless of whether they own a half percent of the ASC or 4 percent of the ASC. It is a common misconception among some physicians that only buying a small ownership interest will result in less return-on-investment then other physicians who own larger shares.

3. Taking on new investors requires an understanding of your value. Pricing the ownership units you are trying to sell is the first step in recruiting new physicians. When you meet with a potential physician investor, the two most common questions they will have are "what will the ownership units cost?" and "what are the returns?" A business appraisal answers both of these questions and affirms that a third-party has looked over the ASC's information and made an independent assessment of the business's projected financial performance.

Any person that is selling ownership or stock will have biases. This may include the seller's need to recoup their initial investment or to present an attractive investment opportunity. These biases may conflict with a prospective investor's preferences to buy-in as low as possible and assess the business's future performance objectively.

4. Independent valuations are more attractive to risk-adverse investors. An independent business appraisal creates a valid assessment of the business without the biases of the person selling the ownership interests. This adds legitimacy to the pricing of the ownership units and the projected financial returns. Risk adverse investors may be disinclined to invest in a private company that may only prepare its financial statements once or twice per year.


Todd Mello

A business appraisal provides a clear and objective picture of the business "as is" based upon information known or knowable as of the valuation date. From that point, a potential physician investor can more easily assess the relative impact his or her case volumes will have on the future of the business when they understand the current state of affairs. The old adage "buy low, sell high" is very relevant for ASCs because the instant a new physician invests, the value of the ASC typically increases.

For example, when an appraiser values a business, they look at the business as it is based upon information known or knowable as of the valuation date. This is not to say that an appraiser cannot factor in certain adjustments to revenue or expense expected to be realized in the future but not specifically related to the incremental revenue and case volume associated with the prospective physician investor. However, when a new physician invests in an ASC and becomes a meaningful user, there is an immediate impact on the business value.

5. Decreasing reimbursement escalators impact ASC value. Annual reimbursement increases or "escalators" from payors seem to have decreased or gone away altogether. Several years ago we often saw annual increases tied to Consumer Price Index, but we observe this less in payor contracts now. Unless an ASC can show evidence of such escalators in their contracts, we generally do incorporate substantial annual increases on an anecdotal basis alone.

Our 2013 ASC Valuation Survey indicates that 53 percent of respondents believe an ASC with over 20 percent of its revenue from out-of-network arrangements has exceeded their risk tolerance. This can be a difficult situation for ASCs that rely on OON revenue to break-even. Going in-network usually involves committing to reimbursement rates that are substantially less with possible increases in case volume.

We also see many ASCs that may have less than 20 percent of their cases in OON arrangements, but they still set their gross charges very high to maximize their OON collections. Such ASCs may have very low collection rates overall because their contractual write-offs are 90 percent or more of gross charges. ■

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ASC Valuation Analysis: 3 Biggest Opportunities for Improvement

By Todd Mello, Partner and Co-Founder of HealthCare Appraisers, and Nicholas Newsad, Senior Associate at HealthCare Appraisers

The three biggest variations we see among ASCs that can be controlled are related to information systems, liability insurance premiums and underutilization of facilities.

ASC Information Systems

As a general overview, good information systems are great tools for ASC owners to manage their business. The reporting tools alone are instrumental in effective management. You cannot manage what you cannot measure. We have encountered many ASCs without good information systems that have to endure a great manual labor effort just to tabulate basic metrics like case volumes by physician, payor mix or supply costs per case.

Our experience is that ASCs that utilize information systems intended for physician practices tend to under-realize their contracted reimbursement rates. Billing and collections can be managed much more effectively when ASCs use an information system that is intended for an ASC. For example, ASC-specific information systems tie supply usage to specific cases. ASC billing systems will automatically add billable supplies and implants codes to cases that used those items. The billing systems can also be used to track outstanding dictation reports, the length of time after surgery it takes to file claims and follow-up on unpaid balances.

ASC information systems are also critical to supply cost management. ASCs that don't log their supply usage on every case can't track the cost to perform these cases. Some ASCs save lots of money on inventory by getting implantable devices like intra-ocular lenses and orthopedic hardware on a consignment basis.

Liability insurance premiums

We also see a fair amount of variation in the pricing of liability insurance. Some ASCs are getting coverage for much less than their peers. We have seen premiums vary 200 percent to 300 percent from one ASC to another. Some of this variation could probably be nullified by conducting annual Requests for Proposals from several insurance carriers every year. We've observed that professional management companies are particularly good at reducing insurance costs.

Scheduling with excess capacity

Finally, there are substantial differences in profitability between ASCs with excess capacity. We have seen some of these ASCs rely on PRN staff and only open for surgery two to three days per week. Other ASCs maintain full-time staff and experience considerable "down-time." The ASCs that staff vertically and only open two to three days per week can often break-even or turn a profit on far less cases than ASCs that open every day with full-time staff. ■

Future Surgery Center Transaction & Acquisition Expectations: Q&A With Todd Mello of HealthCare Appraisers

By Laura Miller

Co-founder and Partner of HealthCare Appraisers Todd Mello discusses current surgery center acquisition expectations and the outlook for transaction trends in the future.

Q: What are the most important expectations major acquirers have for ASCs?

Todd Mello: It appears that consistent future growth is the most important expectation. Our 2013 ASC Valuation Survey indicates that 60 percent of ASC acquirers expect earnings to grow 3.1 percent to 6 percent per year while 40 percent of acquirers expect earnings to grow 9 percent or more per year after they buy an ASC. Acquirers typically expect to realize financial "upside" after the acquisition by making revenue cycle improvements, expense reductions, or by adding new surgeons. They look for potential improvements they can make during their due diligence process.

Clearly most major ASC management companies and health systems are subject to stringent capital planning and approvals processes to procure the funds needed for ASC acquisitions. The due diligence process for an ASC acquisition may be long and arduous, particularly if the ASC has not exhibited consistent growth during the years leading up to the sale. The acquirer's due diligence team has to concisely identify the risks and opportunities of investing in the ASC, while their capital planning committee has to compare numerous competing capital projects. The process may be longer for acquisitions involving large dollar amounts or acquisitions of distressed centers which may pose financial risks to the buyer.

It is also important to many buyers that physician owners stay vested in the ASC. Unless the ASC purchase is part of a related physician practice acquisition, the acquirers are going to probably expect most physicians to sell down rather than totally sell out. If physicians are being completely bought out, many buyers require the sellers to sign non-competes prohibiting the physicians from having a financial interest in another ASC for one to two years after they sell their shares. These non-competes typically preclude investment in competing ASCs within five miles.

Q: How can ASC physicians and administrators ensure they meet these expectations?

TM: Clearly communicate your expectations for the continued use of your ASC by each of your major physician users and all users over 60 years

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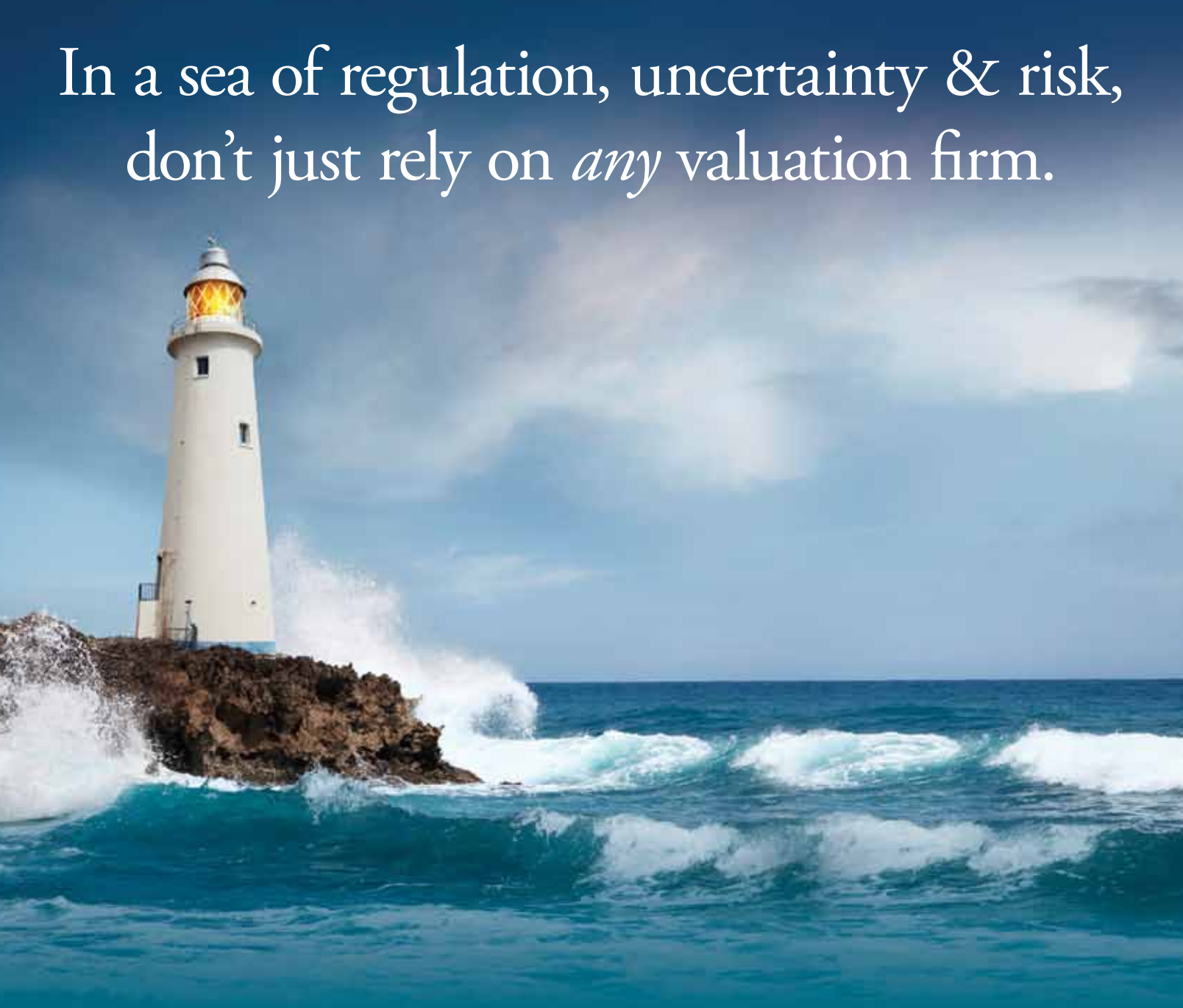

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old. ASC operators are very concerned about physician retirements and practice sales to hospitals. Many hospitals use physician employment agreements that restrict physicians from having ownership interests in ASCs. From an ASC's perspective, a practice sale to a hospital can be more problematic than physician retirements because hospital employment prohibits all physicians in a group from investing in the ASC. The retirement of a single physician can be easier to deal with because the retiring physician's partners are incentivized to absorb his or her case load. These concerns need to be addressed.

Similarly, if there have been irregularities in case volume, collections or expenses during the last several years, help the acquirer understand what was causing the irregularities and make some educated guess as to whether they were one-time events or fundamental changes that will continue.

Perhaps the most frustrating thing for an acquirer is to be told that an ASC will grow 5 percent to 10 percent per year when that has not been the recent trend, nor is there a clear plan for how such growth will be achieved. Be prepared to go through the case volumes for each physician as well as the reimbursement rates for each major type of case and payor.

Q: What issues might ASC leaders expect after a major acquisition?

TM: Seller disengagement is a major concern for major ownership acquisitions. Buyers have to assess who they are buying from and who they are buying out. We have seen many hospitals buy 100 percent ownership of a physician-owned ASC, only to have case volumes decrease immediately following the sale. Sellers should expect non-compete requirements whether they are being partially or wholly liquidated.

Seller disengagement is also a factor for distressed ASCs that have not been distributing cash flow for some time. In a distressed center, some physician investors may be more interested in recouping what they can of their original investment than participating in a long, possible turnaround. With respect to major ownership sales, physician sellers should expect a partial liquidation knowing that they will not be offered a total liquidation for several years.

If it is known that the ASC will procure financing for new equipment or facility improvements after the acquisition, all owners should expect that personal guarantees on such debt will probably be required on a pro rata basis. It is unlikely that a major ASC operator or a hospital will guarantee all an ASC's existing or future debts by itself.

Q: What opportunities do surgery center leaders have to make this transition smoothly?

TM: After a long negotiation and due diligence process that may have lasted six months to a year or more, it is not uncommon for the buyers and sellers to have had some tenuous moments. In fact, many prospective acquisitions do not emerge from the due diligence process at all. During the sales process, capital approval committees or an acquirer's senior leadership may change the terms of their purchase agreement, modify their original offer price, ask for time extensions, request more information from the seller, or back out of the deal altogether. These challenges during the sale process can definitely affect the relationship of the parties after the sale is consummated.

If a sale is completed, sometimes buyers will seek small post-acquisition "wins" to gain rapport based on quick fixes they identified during due diligence. For instance, professional coding and meticulous billing of implantable devices and billable supplies can yield immediate collections benefits. Similarly, setting up direct deposit payment remittances with major payors can also create easy, one-time bumps in cash.

Q: Where do you see ASC acquisition trends heading in the future?

TM: We expect to see more consolidation among national ASC chains as well as locally within communities. Many hospitals systems have established separate ambulatory surgery divisions to operate their ASCs like professional management companies.

The largest surge of new ASC openings was between 2003 and 2008 when over 2,000 new ASCs were Medicare certified. We have found that the typical ASC life cycle is nine to 12 years. We expect to see a healthy volume of acquisition activity as this swell of 2,000 ASCs ages and second generation operators buy many of these ASCs between now and 2020.

Major medical equipment usually needs to be replaced every 10 years too, so we expect many of those ASC owners will be taking a hard look at their risk profile when considering with major purchases. ASC owners who have experienced decreasing volumes or revenues may seek ownership changes as an alternative to debt financing for major equipment replacements. ■

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36 GI & Endoscopy-Driven Surgery Centers to Know

By Heather Linder

Here are 36 GI and endoscopy-driven ASCs to know.

ADC Endoscopy Specialists (Amarillo, Texas). ADC Endoscopy Specialists facility opened in 2006 to provide care and convenience for GI patients. The center is associated with the Amarillo Diagnostic Clinic, which was founded in 1968 by Tom Duke, MD; H. Wayne Smith, MD; and John Milton, MD. All seven physicians are board certified and perform colonoscopies, flexible sigmoidoscopies and EGDs.

Advanced Endoscopy Center (Bronx, N.Y.). Advanced Endoscopy Center opened in April 2007 as a joint venture between a group of physicians, Physicians Endoscopy and a local hospital in the Bronx. Twenty-two physicians use the facility, with 10 physicians owning interest in the center. In 2012, Advanced Endoscopy Center performed more than 12,000 procedures.

Alabama Digestive Health Endoscopy Center (Birmingham, Ala.). Alabama Digestive Health Endoscopy Center, a three-way joint venture between Tenet Healthcare's Brookwood Hospital, local physicians and Practice Partners in Healthcare, performs colonoscopies, EGDs and flexible sigmoidoscopies. The facility administrator, Jackie Harrison, RN, has been with Practice Partners since the opening of the center. The center's case volume increased from 7,926 in 2011 to 8,110 in 2012, according to Ms. Harrison.

Ambulatory Endoscopy Clinic of Dallas. The Ambulatory Endoscopy Clinic of Dallas opened in April 1993 as the first licensed free-standing surgery center exclusively for GI procedures in North Texas and is celebrating its 20th year of operation. The center currently has nine gastroenterologists using the facility's three operating rooms. The center schedules cases every 30 minutes with a turnaround time of three to five minutes, according to Administrator Pamela Hancock, RN.

Arkansas Surgery & Endoscopy Center (Pine Bluff, Ark.). Arkansas Surgery & Endoscopy Center opened in 1995, the project of sole physician owner Syed A. Samad, MD, FACP, FACG, AGAF. The single-specialty surgery center has two operating rooms and performed approximately 1,350 cases in 2012 with a turnover time of approximately one hour. He has achieved the CASC credential as well as his board certification in internal medicine, gastroenterology and managed care medicine and serves as a full adjunct clinical professor of medicine with University of Arkansas for Medical Sciences.

Amarillo Endoscopy Center (Amarillo, Texas). Amarillo Endoscopy Center is a Medicare-approved, GI-driven center that performs a variety of procedures, including colonoscopy, upper endoscopy, capsule endoscopy, hydrogen breath tests, urea breath tests and remicade treatments. The ASC features two GI physicians —Amit K. Trehan, MD, and Srinivas Pathapati, MD — and one nurse practitioner, Elisa Flores.

Barkley Surgicenter (Fort Meyers, Fla.). Barkley Surgicenter opened in 1993 as the project of a group of gastroenterologists. The center is currently owned by seven physician-owners — Nick Sharma, MD, Brian Feiock, MD, Brian Longendyke, DO, Michael Weiss, MD, Michael Bays, DO, Ramesh Koka, MD, and Srinivas Raju, MD. The center contains one operating room and three procedure rooms and is utilized by nine physicians, all in the field of gastroenterology.

Berks Center for Digestive Health (Wyomissing, Pa.). Berks Center for Digestive Health opened in 2001 and is currently owned by 11 physicians and Physicians Endoscopy. The center includes three procedures and 13 practicing GI physicians. According to administrator John Gleason, a strong relationship between the physicians' offices and the ASC leadership has enabled BCDH to drive strong volume to the center.

Burlington County Endoscopy Center (Lumberton, N.J.). Burlington County Endoscopy Center opened in Nov. 2008, a partnership between Gastroenterology Consultants of South Jersey and Physicians Endoscopy. Physicians Endoscopy had previously worked with the practice starting in 2006 and was involved with the physician group through the development process. The physicians perform colonoscopies, upper endoscopies and flexible sigmoidoscopies.

Bux Mont Endoscopy Center (Sellersville, Pa.). Bux Mont Endoscopy Center was founded by Bux Mont Gastroenterology Associates and is currently owned by four physicians — Jerome Burke, MD; William O'Toole, MD; Michael Cassidy, MD; and Ira Kelberman, MD. Three other physicians also practice at the center. The center averaged 325 procedures a month in 2012, with colonoscopies being the most frequent procedure. The center is run by administrator Penny Jacobs, RN, BSN and medical director Dr. Burke.

Digestive Health Center (Madison, Wis.). Digestive Health Center is a 50/50 joint venture between SSM Healthcare of Wisconsin and Dean Health System, the latter of which is 95 percent owned by

physician shareholders. It is Joint Commission and Medicare accredited. The Digestive Health Center opened in 2004 — initially performing only GI procedures but expanding to include pulmonology procedures in 2010.

East Bay Endoscopy Center (Emeryville, Calif.). An affiliate of Surgical Care Affiliates, East Bay Endoscopy Center performs approximately 3,000 cases annually, staffs 10 physicians and partners with two physician groups as well as Sutter Health. According to Laura Alexander, RN clinical lead, "Our facility's success is not only the result of quality patient care, but of our patients' perception of a cohesive, knowledgeable staff that makes them feel safe and well cared for."

Eastside Endoscopy Center (Bellevue, Wash.). Eastside Endoscopy Center opened in 1995 and specializes in upper endoscopies and colonoscopies, which are performed in three procedure rooms. The center, which is managed by Physicians Endoscopy, has been accredited by the AAAHC since 1996 and was the first endoscopy center in Washington to achieve AAAHC accreditation. The ASC recently implemented an electronic medical record, allowing staff to track times and easily identify areas of delays and target them for improvement.

The Endoscopy Center at Bainbridge (Chagrin Falls, Ohio). The Endoscopy Center at Bainbridge opened in Oct. 2007 and currently partners with University Hospitals, which owns a minority interest in the center, and management partner Physicians Endoscopy. The surgery center has six physician-owners who are currently the only providers to use the facility and perform colonoscopies and upper endoscopies. The center, which is an ASGE-recognized unit, received its AAAHC accreditation renewal in September 2011.

Fleming Island Surgery Center (Orange Park, Fla.). Fleming Island Surgery Center was founded in Jan. 2007 and currently performs approximately 8,000 cases per year, 65 percent of which are GI. The center is a multispecialty ASC, which features five GI specialists who routinely use the ASC and between four and five general surgeons who perform GI cases at the center. The center is accredited by the AAAHC and is affiliated with Borland-Groover Clinic, the largest gastroenterology clinic in the Southeastern United States.

The Endoscopy Center at Gateway (Edwardsville, Pa.). The Endoscopy Center at Gateway, which was purchased by Covenant Surgical Partners in July 2010, opened in 2007 and performs approximately 5,800 cases every year. The outpatient surgery center was designed to provide endoscopic procedures in a comfortable environment, according to the website. Physicians perform colonoscopies, endoscopies, peg tubes, bandings and dilations.

Hackensack Endoscopy Center (Hackensack, N.J.). The ownership at two-OR Hackensack Endoscopy Center has stayed relatively similar for the last 10 years, according to administrator Aaron Shechter. The center opened in 2001 and has stayed 100 percent physician-owned since then, performing an average of 7,000 procedures a year.

Jacksonville Center for Endoscopy (Jacksonville, Fla.). The Jacksonville Center for Endoscopy was established in 1998 and is currently a state-licensed, Joint Commission-accredited, AHCA-certified ASC owned and operated by the nearly 70 physicians of Borland-Groover clinic. The center, which has two locations in Jacksonville, performs colonoscopies, upper endoscopy and sigmoidoscopy and staffs only nurses trained specifically in endoscopy. The center performs more than 32,000 procedures annually.

Lincoln Endoscopy Center (Lincoln, Neb.). Lincoln Endoscopy Center opened in July 1998 to house the cases of physicians from Gastroenterology Specialties, P.C. The surgery center has three suites equipped with state-of-the-art Olympus equipment, and patients have individual restrooms and lockers in the pre-op and post-op bays. It was the first freestanding endoscopy center in the state of Nebraska.

Manhattan Endoscopy Center (New York City). Manhattan Endoscopy Center was opened by a group of 17 physicians and Frontier Healthcare in January, one of New York state's largest ambulatory surgical centers. The facility expects to see more than 15,000 patients in its first year. The center provides services such as colonoscopy, upper endoscopy and endoscopic ultrasound and brings together 20 gastroenterologists from hospital systems such as Lenox Hill Hospital, New York University Hospital and New York Presbyterian Hospital and has added new physicians in the last year.

Memorial Mission Surgery Center (Chattanooga, Tenn.). Though a multi-specialty center, Memorial Mission Surgery Center performs around 60 percent GI procedures — 6,600 out of 11,000 total cases in 2011. The center, which opened in 2003, is owned primarily by orthopedic, GI, ENT and general surgery physicians. Five of the physician owners are gastroenterologists. The center is owned 70 percent by physicians and 30 percent by the local health system.

Michigan Endoscopy Center (Farmington Hills, Mich.). Michigan Endoscopy Center opened in March 2003 as a joint venture between 16 physicians and corporate partner Physicians Endoscopy. The center includes three operating rooms and three procedure rooms and is used by 19 physicians — 15 GI physicians and four colorectal surgeons. MEC is a very busy surgery center, with average daily procedures at 62 and high-demand days at more than 80.

Midtown Endoscopy Center (Atlanta, Ga.). Midtown Endoscopy Center, a center affiliated with Atlanta Gastroenterology Associates, was established in 2001 and currently performs approximately 10,620 cases a year. The physician-owned center staffs 18 physicians and recently added hemorrhoid banding in 2008, liver biopsy in 2009 and Bravo pH in 2010.

Mirage Endoscopy Center (Rancho Mirage, Calif.). Mirage Endoscopy Center is a single-specialty endoscopy center managed by Health Inventures that opened in March 2003. The surgery center has two procedure rooms and is used by eight gastroenterologists. The center was recently successful with the help of Health Inventures' contracting department in renegotiating several of its key commercial contracts to achieve reimbursement increases for the next three years.

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New York GI Center (Bronx, N.Y.). New York GI Center is a single-specialty GI ASC in Bronx, N.Y. The center opened in March 2007 and has since earned AAAHC and Medicare accreditation and implemented electronic medical records. Twelve physicians practice at New York GI. The center contains five ORs and performs approximately 10,800 cases a year, according to NYGI president James. C. DiLorenzo, MD. He said the center's initiatives for 2012 included an expansion, which involved enhanced facilities for staff and patients and two additional ORs.

North Memorial Ambulatory Surgery Center (Maple Grove, Minn.). North Memorial Ambulatory Surgery Center is a multi-specialty surgery center with seven operating rooms. The center is a joint venture between physicians and the local hospital and is managed by Surgical Management Professionals. The center originally opened its doors in 2008, running four rooms with no endoscopy procedures. In Aug. 2011, the center integrated over 400 endoscopy cases per month from a center that closed within the same building.

Northwest Endoscopy Center (Marietta, Ga.). Northwest Endoscopy Center opened in Marietta in 2010 and has since received accreditation from the AAAHC. The physician-owned center staffs three physicians and contains three operating rooms, where the providers perform an average of 2,322 cases every year. The center is equipped with high-definition scopes and a fully functional electronic medical record, and propofol is always administered by anesthesia staff to improve patient care and quality. The surgery center expanded its list of services by adding hemorrhoid banding in 2010.

Northwest Michigan Surgery Center (Traverse City, Mich.). In 2004, 36 Northern Michigan physicians partnered with Munson Medical Center to create Northwest Michigan Surgery Center, an ASC that performs 17,400 multi-specialty cases per year aimed at addressing the expanding outpatient needs of the region. The center contains six ORs, three endoscopy suites and one minor procedure room, and eight GI specialists and nine general surgeons performed 9,500 GI procedures in the last year. The surgery center went live with EHR in 2011.

Physicians Endoscopy Center (Houston, Texas). A joint venture with HCA Ambulatory Surgery Division, Physicians Endoscopy Center has 20 physician owners and eight procedure rooms and performs around 1,100 cases every month. The ASC was founded by several physicians who wanted "a centralized, convenient and patient-focused center to perform procedures at lower cost than hospitals," said PEC administrator Nancy Le Nikolovski. The AAAHC-accredited center opened in Dec. 2002 and performs GI procedures exclusively. In 2011, the surgery center successfully added a hemorrhoid ligation clinic and propofol anesthesia.

San Diego Endoscopy Center (San Diego, Calif.). A limited partnership managed by Surgical Care Affiliates, San Diego Endoscopy Center consists of two physician groups: San Diego Digestive Disease Consultants, Inc., and San Diego Gastroenterology Medical Associates. The facility has 15 physician partners and six non-physician partners, performs nearly 4,500 cases annually and recently added esophagoscopy ablations to their standard list of GI procedures.

Skyline Endoscopy Center for Health (Loveland, Colo.). Skyline Endoscopy Center for Health opened in Dec. 2004, a joint venture between McKee Medical Holdings, a hospital that owns 25 percent, and Loveland Endoscopy Enterprises, a physician group that owns 75 percent. The center was developed by Pinnacle III and has been managed by the company since its inception. Skyline is a single-specialty GI/endoscopy center that performs colonoscopies, sigmoidoscopies and upper endoscopies. Its physicians performed 4,163 procedures in 2011.

Stateline Surgery Center (Galena, Kan.). Stateline Surgery Center started as a primarily orthopedic surgery center, until administrator Jenny Morris pursued a GI physician in the Joplin, Mo., area. "This practitioner was interested in using our center one day a week to perform GI procedures at our center," she said. "The managed care situation in the Joplin, Missouri area is restrictive due to exclusivity arrangements with the local hospitals and large payors, which prompted the discussions as the physician was interested in performing cases at an in-network facility." She says the center conducted a feasibility analysis to determine whether GI would be a good fit for the center, and the board voted to add the specialty.

Surgery Center at Tanasbourne (Hillsboro, Ore.). Surgery Center at Tanasbourne, which was opened in March 2009 by Providence Health and Services, is a free-standing, multi-specialty facility with four ORs and two procedure rooms. The center is managed through a joint venture with Blue Chip Surgical Partners and stands at around 17,000 square feet. The center features state-of-the-art medical technology and performs, in addition to GI, general surgery, orthopedics, gynecology, plastic surgery, pain management, spine and ear, nose and throat procedures.

Surgery Center of Joliet (Joliet, Ill.). The Surgery Center of Joliet opened in 2008 and specializes in colonoscopy, EGD and upper and lower GI diagnostics and screenings. The center houses two procedure rooms, two endoscopy rooms and three operations rooms and contains a portable endoscopy machine that allows patients to undergo endoscopic procedures in one of its ORs. According to Marge Schillaci, administrator of the Surgery Center of Joliet, the ASC keeps costs low by decreasing inventory of high-cost items.

Walnut Creek Endoscopy Center (Walnut Creek, Calif.). An affiliate of Surgical Care Affiliates, Walnut Creek Endoscopy Center staffs eight physicians and partners with two physician groups as well as Sutter Health. Approximately 3,900 cases a year are performed at the facility. The center provides MD MAC anesthesia and EMR, and has two procedure rooms and eight pre/post units.

West Metro Endoscopy Center (Douglasville, Ga.). West Metro Endoscopy Center in Douglasville opened in 2008 and staffs four physicians. The physician-owned center has three operating rooms and performs strictly gastroenterology procedures — approximately 3,350 every year. The surgery center is accredited by the AAAHC. The center expanded its list of services by adding hemorrhoid banding in 2008. ■

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10 Ways to Negotiate Better Rates for Orthopedics Cases in ASCs

By Laura Miller

More ambulatory surgery centers are performing orthopedic cases today, and those cases are increasingly complex. With the addition of these cases come new challenges for negotiating payor contracts, but surgery centers can still achieve good rates if they leverage their position.

"Given the fact that orthopedics cases are implant intensive, the continuing challenge is to ensure you are covering your costs and receiving the highest reimbursement possible," says Dan Connolly, vice president of payor contracting for Pinnacle III. "Knowing how to deal with this challenge will depend upon the payor's persona and the culture of the ASC. With our country's aging population, there is more demand for orthopedic procedures and payors will do what they can to ratchet down reimbursement to accommodate the demand. Payor consolidation is inevitable, whether through the more traditional exclusive provider network approach or another model, so do what you can now to ensure inclusion of your facility."

Here are 10 ways ambulatory surgery center administrators can negotiate better rates for orthopedic cases.

1. Figure out payor guidelines and address them. Insurance companies have guidelines for approving orthopedics and spine procedures, and every company has its own variation. Work with the companies to show you are optimizing the guidelines they have and performing a valuable service to their clients.

"ASCs want to show their care decisions are consistent with evidence," says Stephen Rothenberg, a consultant with Numerof & Associates. "Guidelines from surgical societies tend to be consistent in terms of diagnoses but may be inconsistent in terms of treatment, particularly in the case of spine conditions, so the payors can pick and choose in developing their payment policies. If you have different protocols at your ASC, present data to support the cost-effectiveness and quality of these procedures."

Before going into contract negotiations, be sure to clarify your goals, such as achieving higher reimbursement for a particular procedure.

"Once you have clear goals, you'll be able to determine what data you need to support them," says Mr. Rothenberg. "Then, you'll need to have the technology to support data collection and continue to upgrade these systems in the future."

2. Prove these cases are safely performed in an ASC. Insurance companies are sometimes unwilling to negotiate contracts for more complex cases, such as spinal fusions, performed in a surgery center. Medicare does not currently reimburse for any spine procedures in outpatient ambulatory surgery centers, and some payors follow suit. Show them quality data to prove these procedures are safe and cost-effective in the ASC.


Dan Connolly


Stephen Rothenberg

"Some payors hide behind the Medicare ASC-approved list and the majority of complex spine procedures aren't on the list," says Mr. Connolly. "In that case, you need to demonstrate the value and safety of performing these procedures in your center. Sometimes this will require the coordination of a meeting between the insurance company's medical director and the key surgeon(s) from your center to demonstrate the efficacy of performing these surgeries in the ASC."

Payors in some markets have begun adding orthopedics procedures to their proprietary grouper map. For example, laminectomies and partial knee replacements haven't historically been on the Medicare-approved list and therefore not on the proprietary grouper list, but they are increasingly showing up on proprietary grouper listings now.

"This is good news because by virtue of being on the grouper list, the payor recognizes that these procedures can be carried out safely in the ASC setting," remarks Mr. Connolly. "The bad news is if you have an existing contract, depending on where the grouper hits reimbursement can be seriously deficient."

3. Carve out implants. Often the biggest expense for outpatient orthopedics cases is implants. Make sure these costs are covered in the negotiated rate, and if possible carve them out. Otherwise the surgery center will lose money on those cases and they'll transition back into the hospital.

"You have to look at the hard costs for joint replacements and make sure you are covering the cost of implants so you won't lose money on the surgery," says Angela McComb, director of managed care with ASD Management. "What you don't want is to get paid $1,000 from the insurance company and use an implant that is $500. The reimbursement won't cover your fixed costs."

If the insurance company balks at the carve-out rate you propose, bring an invoice from the device company to the negotiating table. "Present invoice costs for knee replacements or other high cost areas that might lead to a disagreement," says Ms. McComb. "Show them what your costs are if you are truly at an impasse. You're going to have to be persistent and ask them for the carve-out."

Sometimes surgeons have a particular reason for using their specific implants. "If they use devices made by a company that has good data, a strong track record and studies to support the device's use, you can show why a more expensive device is needed," says Mr. Rothenberg. "Sometimes the surgeon achieves a lower failure rate with a specific device. You have to have the data at the negotiating table to get what you want."

Surgeons can also work to lower the cost of implants by negotiating more competitive pricing with their vendors or securing implants at wholesale prices. Insurance companies will notice your willingness to partner with them on lowering costs per case.

"Look at using different implants when an opportunity to reduce costs without reducing quality arises," suggests Mr. Connolly. "There is a growing market in non-brand name devices that is purported to provide equivalent outcomes at substantially lower costs. It's wise for surgeons and ASCs to consider using non-brand name implants when available."

4. Demonstrate clinical outcomes. Insurance companies are paying more attention to clinical outcomes than in the past and transitioning from fee-for-service to a pay-for-performance business model. As some orthopedics procedures, such as total joint replacements, are still relatively new in the outpatient surgery center space, it's important for surgery centers to collect data and demonstrate their positive clinical outcomes to achieve competitive reimbursement.

"The biggest challenge for surgery centers and orthopedic surgeons is to demonstrate their value, which requires outcomes documentation," says Mr. Connolly. "That's going to require following the patient more closely postoperatively because you can't manage what you don't monitor."

However, there are challenges to demonstrating quality outcomes. "Until insurance companies can come up with and agree upon a uniform measure of quality for ASCs, it will be very difficult for the companies as well as providers to agree upon the definition of a good quality provider. For this reason we fundamentally don't agree with the way the quality indicators are measured due to the lack of a consistent baseline," says Ms. McComb. "In some cases, one payor may rate you as a quality provider and one may not. This makes it very difficult for patients to figure out who actually provides the best quality of care in their area."

5. Collect data on patient selection. Providers are often so focused on cost and quality data they forget to demonstrate competence in patient selection. This is particularly important for surgeons performing cases in the ASC because not every patient will do well in that environment. Collect data to show your surgeons are making sound patient selection choices and leverage that for a better contract.

"Show that they are using the right procedure for the right patient at the right time," says Mr. Rothenberg. "Make that argument with supporting data. Figure out what you need in order to collect this data and examine where there is room for improvement. Then, the next time you negotiate with payors, make your argument."

Payors also tend to question new technologies and procedures performed in the outpatient setting. Collecting this data can show surgeons are making a good choice with the technology they use and it's worth the potentially higher upfront cost.

"There is a lot of push back in spine to new procedures that are performed at a higher cost,"

says Mr. Rothenberg. "Show that the technology is warranted for a particular indication without an increased risk of complication."

6. Leverage high demand for orthopedics procedures. While insurance companies will try to keep orthopedic rates low to accommodate the higher demand among an aging population, providers can also leverage the situation to achieve higher rates than in the past.

"Given the fact that we will have a greater demand for procedures and additional cost to perform them, there is more justification for increased reimbursement, or to preserve current rates that allow for a fair profit margin," says Mr. Connolly. "Don't assume pay increases will be the norm. While I saw substantial increases in some markets in 2012, I also had payors attempt to substantially reduce reimbursement in markets where payors had been reimbursing above the market rate."

Depending on several market factors, surgery center administrators can negotiate orthopedics as a high volume procedure going forward for better rates compared to other providers, such as hospitals or low volume orthopedic ASCs.

"If there are high volume procedures, you should be able to collect data showing consistent quality outcomes for patients that are cost-effective," says Mr. Rothenberg. "Collect data on key points in these procedures so you understand internally what is happening and you can discuss your performance with payors."

7. Compare rates with other providers. In addition to quality data, insurance companies may also respond to cost comparison data. While surgery centers are often a low-cost provider, they shouldn't negotiate themselves out of existence by accepting rates that are well under other providers in the community. Arrive at negotiations armed with economic data to show insurance companies your requested reimbursement is reasonable.

"Surgery centers are becoming more efficient at collecting cost data and determining direct and variable costs," states Mr. Connolly. "When possible, you should collect reimbursement data on other ASCs and hospital competitors in your market. Most of the time that data isn't readily available to you."

In recent negotiations, Mr. Connolly found that payors in one community were actually paying a lower rate at the hospital than at the surgery center because the hospital was able to take a pay cut on orthopedic procedures in favor of rate increases for other inpatient service lines. However, in most cases there is an opportunity to negotiate increased reimbursement while still saving the payor money.

"I've had consistently favorable results when I provide payors with blind data," notes Mr. Connolly. "In my most recent negotiation, I was able to secure a 14 percent increase with a payor that had historically not budged. I truly believe it was because we went at them with data right from the beginning."

Even if the payor is proposing reimbursing the surgery center at a multiple of Medicare, the reimbursement should cover the cost of implants. "Make sure you are getting paid adequately at the case level and carve out implants whenever possible," says Mr. Connolly. "For those payors that haven't historically paid implants separately and aren't even paying equivalent to Medicare, remind them that Medicare includes built-in reimbursement for implants and ensure that you get at least what Medicare pays. There have been substantial gains in reimbursement for some Medicare procedures over the last four to five years, so the difference could be significant."

In one surgery center Mr. Connolly advised, a payor was reimbursing at 10 percent under

Medicare on average without paying for implants separately. He was able to increase this rate by presenting cost data during negotiations. "Lay out your case and demonstrate, verify and validate what you are saying through the data you provide," says Mr. Connolly. "If they don't pay for implants and cover facility costs, those cases will continue to go to the hospital which means insurance companies will typically pay two to three times as much as they would if the case were performed in an ASC."

8. Justify rate increases. Tell the payor what it costs to perform orthopedic procedures in the ASC and show them what these procedures are worth. Justify rate increases by maintaining high quality service, patient satisfaction, outcomes and low complication rates. You can also compare your numbers with others in the market to close reimbursement gaps as much as possible.

"Sometimes what insurance companies are paying out as an average per case is not consistent with the market," says Mr. Connolly. "You want to leverage market parity, including what other payors for your surgery center are paying, so they know your requests are valid. If payors are willing to negotiate a rate increase, consider extending the contract for a longer term to preserve the relationship. I'm not for long term contracts generally, but in some cases it may make sense."

Surgery center administrators can also discuss the lower associated costs to justify a small rate increase in existing contracts.

"ASCs often have cost benefits compared to hospitals, so presenting that data will be important," says Mr. Rothenberg. "Surgery centers can have shorter lengths of stay, lower complication rates and lower readmissions. All of these aspects make the overall cost of care lower. In the future, insurance companies will increasingly pursue bundled payments for orthopedics and in that situation, understanding what is important to them will help you negotiate these contracts."

9. Understand the payor's needs in your market. Markets across the United States are vastly different, but payors are becoming more uniform in their desires and plans for the future. "When you go into a negotiation, you always need to have an idea of where you stand and if there are points where you can be more flexible to work on your relationship with the opposite party," says Mr. Rothenberg. "Also know how you will support your position. If you ask for something that the other party doesn't want to give you, there are ways you can persuade them. Understand the concerns of the other party and address them to meet your needs."

All insurance companies are concerned about overuse in certain procedures, treatment variations and cost-effectiveness. In some cases this means starting bundled payment programs or other payment models to pass risk on to patients and providers.

"I'm working with some payors that want to discuss some all-inclusive case rates. Taking on some risk may be necessary based on what's happening in the market," says Mr. Connolly. "However, if you don't truly know what you're getting yourself into, from a short term perspective, you'll want to stick to the fee-for-service and cost-plus model to avoid reimbursement losses. In the long run, however, everyone is going to get to the point where we are looking at bundled payments whether they are at the ASC or episode of care level because payors want to transfer risk."

Payors are also looking to narrow variability wherever possible and there are opportunities for providers to partner with insurance companies to achieve their goals. "Payors are now forced to narrow variability in implants and other aspects of the procedure because the only way they can succeed and sustain their business under new regulations is to narrow that variability and then underwrite the insurance around that variability," says Mr. Connolly. "Depending on your risk tolerance at the center level, you can work with payors on new payment initiatives."

The price should be fair when negotiating bundled payments and without quality and cost data administrators won't know whether the rates are too high.

"Depending on your situation, you may be able to expand a bundle more broadly," says Mr. Rothenberg. "If your surgery center includes postoperative pain management and physical therapy, you can model what including these services would require and create an appropriate bundle. Show how these services help strengthen and improve patient rehabilitation and reduces patient visits down the line so you can justify the upfront costs to the payor. Bundled prices are an interesting avenue for ASCs to explore in the future. By offering a bundled price that provides some consistency in costs for the payor, ASCs can gain a competitive advantage over hospitals in the same market."

10. Don't negotiate rates too high. It's important to consider both the long term and short term impact of negotiated rates. The healthcare market is constantly changing to reward high quality and lower cost, and what might seem like a victory today with rate increases may become a defeat tomorrow as insurance companies direct their patients to a lower cost provider in the community.

"You really have to look at the goal from both short and long term perspectives," says Mr. Connolly. "Be aware of the payor's needs. Every payor needs to meet a reduced cost, so work with them to make that happen in a mutually beneficial manner."

In the future, patients will also begin price comparing among surgical facilities and request the lowest cost setting for surgery. "If it's a common procedure, they'll be able to bring up facilities in the area and project the minimum/maximum charges," Mr. Connolly says. "Patients will see which facility is the cheapest and this may influence whether their surgeon will perform the procedure at that specific facility. When feasible, the surgeon will do what the patient wants. Don't negotiate yourself out of the market from the patient's perspective." ■

9 Ways to Increase Profit in Low-Reimbursement Specialties

By Rachel Fields

Surgery centers that depend heavily on specialties like ophthalmology, GI/endoscopy and pain management may struggle to remain profitable, as CMS institutes meager increases to reimbursement and commercial payors follow suit. Reed Martin, chief operating officer for Surgical Management Professionals, discusses tactics surgery center leaders can use to make up for low-reimbursement specialties — and how to profit even when payor contracts don't promise a windfall.

1. Create personal relationships with payors. Build a long-term relationship with your payors, and you'll find it easier to get increases in difficult years, Mr. Martin says. "It works best when we have personal relationships with the medical director and the negotiators at insurance companies, on a regional and national basis," he says. "In the past, it has been important for me to be on a first-name basis with the negotiator and medical director for the major payors."

He says this kind of familiarity sets the tone when you're negotiating and makes the interaction more friendly and honest. He also says surgery center leaders should make themselves available as resources on the ASC industry. "Payors have issues where they need to understand what's happening with ACOs, or the movement of neuro and spine into ASCs," he says. "It should be a two-way street."

2. Present your patient satisfaction scores during negotiation. "Put your best foot forward" and present your patient satisfaction scores upfront, Mr. Martin says. He says it's important to have patient satisfaction as an agenda item for quarterly board meetings and then to use this information with your payors.

The surgery center should be thinking about how to improve the patient experience on a regular basis — and payors want to know that. "ASC patients are managed care members, and payors want to know how your facility compares to other hospital systems or other ASCs," he says.

3. Understand how your charges and reimbursement compare with the HOPD. How do your charges and reimbursement compare with the local hospital outpatient department? Mr. Martin says this question is essential to effective contract negotiation.

"We know hospitals are paid 40 percent more by Medicare, and oftentimes considerably more by managed care," he says. "It's important to be able to discuss the lower reimbursement that ASCs receive, and translate that to savings to the members and insurance companies."

He says you can either estimate the amount the hospital receives, or you can work with patients who are willing to show you their EOBs. Payors may be more willing to give you a good reimbursement rate if they understand that you save them money when cases go outside the hospital.

4. Make Medicare "the floor." Medicare should be the lowest reimbursement level your facility accepts, Mr. Martin says. If a commercial payor tries to offer you a rate lower than Medicare, you should most likely consider an out-of-network strategy. However, he believes that most surgery centers should not run into this problem.

"I think in the long-term, insurance companies do look at what happens with Medicare, but it's not year by year," he says. "They realize that the two main areas of our costs — supplies and personnel — are increasing at a greater rate than 1 percent per year."

5. Target block time utilization and late case starts. Make sure your physicians are using their block time to full effect, Mr. Martin says. If one physician isn't using his scheduled block time — and another wants to bring more cases to the ASC — talk to the physicians and see if one will relinquish his time. You may want to bring the medical director into this conversation to smooth the process.

Mr. Martin says it's also important to release block time early, so that physicians can add cases in the empty slots before the date passes. "A good yardstick is to release block time five days before," he says. "If you're releasing time that's then not being filled, that's a problem."

He says it's also important to keep track of late case starts, which can push the whole day's schedule back and create dissatisfaction among physicians. "If the first provider is a habitually late provider, perhaps he or she should not have the first case of the day," he says.

6. Script your processes to create a calm atmosphere. Patients will feel more calm and cases will move more smoothly if staff can explain every step of the process as it happens, says Mr. Martin. "We work on training the staff to explain to the patient why they're moving from one room to another, how we evaluate them before they're released," he says.

This scripting helps in two ways: First, the patient feels calm and cared for because they understands what's happening. Second, staff can move through the steps efficiently because they're so used to repeating the same script every day.

7. Work to standardize implants. Implant costs can drag down net reimbursement very quickly, so make sure your physicians understand the importance of standardization. Mr. Martin says Surgical Management Professionals has found that comparing costs — without physician names included — can help spur healthy competition among providers.

"Having board support and medical director support is very effective in this regard," he says. "The ASC should have a supply value analysis committee that evaluates supply costs and includes a physician, some clinical management and the materials manager." He says this group should meet on a monthly or quarterly basis to discuss any "outlier" implants and chat with physicians about possible standardization or generic purchasing.

8. Look at contracts for laundry and maintenance. Make sure you look at your contracts for laundry and maintenance on an annual basis, at the least, Mr. Martin says. "You really don't know what's happening in the market unless you get a competitive quote," he says. Look at your bill and determine whether you need to be paying for everything in your contract.

9. Consider adding a more lucrative specialty. If you're highly dependent on a few specialties with historically low reimbursement, you might consider adding a specialty that aver-

ages a higher payoff per case, Mr. Martin says. For example, orthopedics generally provides robust reimbursement, as long as you can negotiate a carve-out for the expensive implants required. The issue with adding orthopedics is the significant capital outlay required for the specialty.

"You'd want to make sure you had a group of orthopedic surgeons who would commit to the facility," Mr. Martin says. "You'll have an additional cost in capital and supplies as well as the additional revenue." He says orthopedics is also very different clinically — and in terms of scheduling — than specialties like GI and ophthalmology, which depend on moving many cases through the ASC at a rapid pace. He says if a surgery center is already performing GI and ophthalmology, pain management might be an easier addition to start with. ■

6 Best Practices to Avoid Common ASC Coding Mistakes

By Heather Linder

Procedural coding errors can lead to lost revenue or unintentional upcoding at ambulatory surgery centers.

Bill Gilbert is the vice president of marketing, and Brice Voithofer is the vice president of ASC and anesthesia services for AdvantEdge Healthcare Solutions. Lolita M. Jones, RHIA, CSS, is an independent coding and billing consultant.

Here are Mr. Gilbert, Mr. Voithofer and Ms. Jones' six best practices for coders to maintain accuracy.

1. Host additional training. The fast pace of an ASC setting can hurt coding accuracy, Ms. Jones says. Centers may need to do periodic one-hour clinical overview sessions with physicians and coders. At the review sessions, physicians can go over techniques, medical necessity and documentation so the coders can understand what goes into certain operations and thus how to properly code them.

"You can go online and do research, but if a physician explains it to you, that's an extra layer of education that an ASC can sometimes prohibit from happening," Ms. Jones says.

2. Set and meet accuracy standards. The only way to know if your coders are staying accurate and timely is by setting an accuracy target and doing periodic audits to measure the accuracy rate.

Mr. Voithofer suggests asking coders to maintain at least a 95 percent accuracy rate and says up to 98 percent is reasonable and attainable.

Whenever new coders joins your center, they should be audited more frequently until all parties are confident in their abilities to perform at an expected level.

Accuracy may also take a hit if coders are simply entering what the physician checked off on the charge ticket, rather than actually coding the claim. Coders cannot rely on the ticket, Ms. Jones says. They can validate against the physician notes, but they should be coding as well.

3. Stay up-to-date with payor policies. Payors can change certain policies yearly, Ms. Jones says. Coders should be diligent to check the payor websites for any coverage determination or medical necessity policy changes.

"Your center can take a hit if the diagnosis that would justify a procedure isn't there for the particular payor," she says.

While patients may still need a procedure to be performed even if it will no longer fall under the purview of a payor's coverage, by staying educated with policies the coders are avoiding the shock of a denied claim.

"At least you'll know on the front end that you may be in trouble," she says. "You may be able to go to the physician and see if there is an aspect of the diagnosis they forgot to include. Even perfect coding could get dinged by a medical necessity problem."

4. Learn from denials. Mr. Gilbert suggests looking at all denials as they come in and developing a feedback loop for coders and physicians to understand what went wrong.

"If a denial comes in because the code was in the wrong sequence or the wrong modifier was in place, you can't appeal the denial, but you can make sure not to make the same mistake again," he says.

Studying denials is as important for high-volume cases as for high-dollar cases. In some GI procedures, for example, the lost money for one claim may not be significant, but a pattern of denials can add up, he says.

Communication is always the key to bridging the gap between the coder and the physician.

5. Know the managed care contracts. Many times, the payor and managed care contract in place will determine how a procedure should be coded, Mr. Voithofer says. For instance, one contract might pay for all screws over a certain diameter, whereas another contract might have a different threshold. "What's billable and what's not varies by contract because there are carve-outs and exceptions," he says.

To avoid losing revenue or having a claim denied by a payor, surgery centers should work with coders to ensure they know contract specifics, especially for high-volume procedures.

Implants with procedures can also be difficult to code since payable items on an implant procedure can change quickly. Coders should stay up-to-date on all payor regulations regarding implants to avoid costly denials.

6. Look at claims critically. Coders should not be afraid to question a physician's operative note if something does not make sense or appears incorrect.

"If something doesn't look right, put the brakes on it and ask questions," Mr. Voithofer says.

Physicians can make mistakes, but they also can change their methodology. When a physician learns a new technique or approach to care, it may require different documentation than the same procedure did in the past. Rather than risk miscoding, take the time to ask the physician about the change to see if it's related to an approach that requires different coding.

"Just ask questions," he says. "The worst case scenario is they tell the coder there is no problem and go on. In the best case scenario, the coder finds where they are losing revenue or stops the center from submitting a fraudulent claim." ■

5 Points to Consider Before Merging an Anesthesia Practice

By Heather Linder

Anesthesia practices nationwide have turned to consolidation as a way to thrive amidst the general uncertainty of the healthcare industry. Through mergers and acquisitions, hospital groups and private practices are seeking strength in numbers, a trend which continues to grow.

Josh Holmgren is a regional director for abeo Management Company, and he specializes in assisting anesthesia providers with group mergers and acquisitions. Mergers or acquisitions may be beneficial for many anesthesia providers, but all entities should perform due diligence before entering into any agreements.

Here are Mr. Holmgren's five aspects to consider before entering into a merger or acquisition.

1. Advantages of consolidation. Many anesthesia practices look to mitigate risk by growing in size, which is one of the many advantages of the recent uptick in consolidation. Becoming a bigger entity, both size and coverage-wise, means your practice could strategically be spread across multiple health systems. Groups with widespread coverage can more easily handle any changes that may occur within one system, Mr. Holmgren says.

"You mitigate the risk of being subject to just one health system and the ebbs and flows of that system," he says.

Diversifying your coverage area will also pay off as accountable care organizations form. "The ACO at one facility may not be the same as that of a hospital across town," he says, "but if your anesthesia group is covering both facilities, then you won't be stuck with the methodologies at one health system or hospital."

Consolidation also can bring an advantage to managed care contracts. Having more members and clients may result in more leverage with commercial payors for better rates, Mr. Holmgren says. However, this benefit is not certain to last as reimbursements continue to change and commercial payors look for ways to save money.

2. Challenges of consolidation. Any practice considering acquiring or merging with another group should be well aware of the realities of consolidation. Owners may need to give up some of their autonomy in exchange for the security of belonging to a larger entity, Mr. Holmgren says.

"The goal is to maintain the ability to work in a private practice and negotiate better benefits," he says. "Sometimes you have to give up a little — some of the culture and the history — when coming together with another group, but you gain security and the chance to retain your private practice status."

Practice owners and physicians should also keep in mind that not all associations can transfer to a consolidated group. Most likely, the new care entity will have one set of vendors, one retirement broker and one health insurance broker, for example.

"There may be some collateral damage in terms of who you work with," he says. "Try to go in with an open mind and focus on what's best for the new group as opposed to hanging on to all you had as a previous organization."

3. Potential partners. Picking a compatible organization with which to partner is essential to a successful merger or acquisition. A partner that will add value to your existing practice should have complimentary skill areas. For instance, if your physicians provide hospital-specific anesthesia services but not trauma, pediatrics or cardiac care, join with an organization that can bring those diverse skills to the mix.


John Holmgren

Also look for anesthesia groups with longevity because they are likely more secure, respected and established than newer organizations. "If they have been around for a long time, they have built relationships and done the right things to keep their practice going," Mr. Holmgren says. Aim to find a partner with a culture that meshes well with that of your practice.

However, he warns, be wary of any groups that financially survive on unjustified stipends from hospitals or other healthcare providers. Do your due diligence to make sure any stipend is warranted, he says. It can be risky to partner with a heavily stipend reliant anesthesia group because if the payment is revoked or decreased, then the group may be unable to survive.

4. Agreement specifics. The initial steps to pursuing a merger or acquisition include drawing up a letter of intent or nondisclosure agreement. In the letter, be sure to specifically identify the governance, staffing and compensation structure of the future anesthesia group, Mr. Holmgren says.

Be clear and concise on how decision-making powers will be divided and who will make up the board of directors. Make sure the compensation structure is clearly laid out and both parties mutually agree to any coverage requirements. It is also better to tackle staffing issues up front, such as requirements for hospital work and when vacations may be taken.

Being open with specifics in those three areas will give everyone involved a better understanding of what the consolidated group will look like and avoid unnecessary conflict down the road.

5. Legal assistance. Any anesthesia groups considering a merger or acquisition need proper advice to get through the process smoothly and economically, Mr. Holmgren says. Look for a third party consultant or experienced management company who not only knows the legal ins and outs of the process, but also who specializes in anesthesia.

"There are so many nuances with anesthesia," he says. "You need a good facilitator and adviser to help you through the merger."

He warns groups from simply hiring an attorney to handle the documentation because the costs and fees associated can be much higher than expected. He has worked with groups that have spent an exorbitant amount on fees from general advisers who were not able to work out anesthesia-specific issues.

"Don't undervalue a good adviser who can guide you through the process and who understands the importance of your merger," he says. ■

6 Smart Moves for Ophthalmology ASCs in 2013

By Laura Miller

Here are six smart moves for successful ophthalmology-driven ASCs in 2013.

1. Launch initiatives to increase patient satisfaction. Patient experience has always been important, but as insurance companies become more interested in pay for performance and patients review their experience online, a positive experience has become much more crucial.

"Patient experience is number one," says Cindy Young, administrative director at Surgery Center of Farmington (Mo.). "You want patients coming to your ASC instead of somewhere else, and patient satisfaction can make a difference. Physicians will bring cases in if their patients ask specifically for the ASC instead of performing them somewhere else."

Word-of-mouth is also an important tool for driving patient volume. Patients will tell their friends about their experience at the ASC, and the friends will be booking appointments before too long.

"Treat every patient like they are the only one," says Ms. Young. "Customer satisfaction is really key, not only in ASCs or eye surgery, but everywhere. You want to go to a place where people remember your name and went the extra mile to take care of you."

2. Train staff on a narrow focus. Jay Stallman, MD, is a partner with Georgia Retina and medical director of Georgia Retina Surgery Center. His ASC is a retina subspecialty referral practice, and surgeons only treat retina cases. While this is an unusual model, the narrow focus has allowed the physicians and staff to really refine their craft.

"Since we do just one specialty, our staff is trained to be very efficient," says Dr. Stallman. "There is a lot of uncertainty with upcoming changes in government regulation and we don't know what will happen to our reimbursement, but retinal surgery procedures have a higher per case cost than cataract surgery, so we have a lower per case profit. We have trimmed costs as low as possible and our staff has become very good at what they do."

3. Renegotiate with vendors to keep supply costs down. Ms. Young constantly renegotiates vendor contracts and buys all lenses and packs with a single company to receive a bigger rebate.

"The greatest challenge is that reimbursement from Medicare is going down and supply costs are going up," says Ms. Young. "I think we are constantly working on that, but we are mainly working with specific vendors to drive as much business as possible with them so we can reach the greatest rebate level possible."

Dr. Stallman and his partners also all use the same types of materials, which has improved efficiency and cut costs. "It's very important that everyone in the practice gets on the same page as far as establishing a degree of uniformity," says Dr. Stallman. "Each surgeon doesn't have different supplies — they can have preferences, but uniformity of instrument trays and procedures makes it easier to train the staff and simplifies the process of purchasing supplies."

4. Employ someone to float between ORs for optimized efficiency. Patient volume will be increasingly important in the future and surgery centers that increase efficiency will fit more cases in every day. When operating rooms already have a full schedule, hire someone to float between each room to help with turnover. This is Ms. Young's strategy at her surgery center.

"You want adequate staff and instrumentation so your team isn't waiting on a sterilizer to finish in order to start the next case," says Ms. Young. "I have five ophthalmologists, but I never have two here at the same time. Block time and the extra help is key to keeping things running well."

5. Promote teamwork between partners. Physician partners should work together on a successful ASC instead of placing individual success above the others. Some groups are highly competitive, but uniformity in treatment and opportunity develops a positive rapport among the physicians going forward.

"In our particular practice, our compensation model is such that we aren't competing with each other," says Dr. Stallman. "We send each other cases. If a patient comes in and I am in the clinic, I won't save that patient for myself at 7 p.m. that night; I'll send the patient to my partner who is at the ASC that day so the patient can be taken care of promptly. I won't feel like I'm losing out financially; that's a cooperative model where we all work together and keep volume at the ASC as high as it can be."

6. Focus on case and material selection to decrease risk. Surgeons must understand the profitability of each case and whether it can be clinically performed in the ASC or not.

"Case selection is very important and we do try to be cognizant of the fact that if we have a complex case that requires an expensive device or silicon oil, we take those to the hospital because we would lose money on them at the ASC," says Dr. Stallman. "We have a very thin profit margin so we also can't bring in cases that would take two to three hours and use expensive supplies."

Supplies can make a big difference in the case and surgery centers should also minimize complication and legal risks by only using dependable materials.

"Some ASCs reuse supplies and re-sterilize disposables," says Dr. Stallman. "That can increase their profits, but also their medical legal risk. We opted not to re-sterilize disposables for that reason." ■

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200 Orthopedic- & Spine-Driven ASCs to Know (continued from page 1)

Andrews Institute Ambulatory Surgery Center in Gulf Breeze, Fla., is a joint venture between local physicians, including James Andrews, MD, and Baptist Health Care.

AOK Spine and Pain Surgery Center in Little Rock, Ark., is affiliated with Arkansas Specialty Orthopedics.

Arkansas Specialty Orthopaedics Surgery Center (Little Rock) includes surgeon owners from Arkansas Specialty Orthopaedics who have a special interest in extremities care, sports medicine and spine.

Atlanta Sports Medicine Surgery Center includes former team physicians for the Atlanta Falcons and Atlanta Thrashers.

Baltimore Spine Center includes minimally invasive treatment for outpatient orthopedic and spine procedures.

Beacon Orthopaedics and Sports Medicine ASC in Cincinnati includes 23-hour stay capabilities.

Bellin Orthopedic Surgery Center in Green Bay, Wis., is a joint venture between Orthopaedic Associates of Green Bay, Green Bay Orthopedics and Bellin Health.

Bellingham (Wash.) Surgery Center opened in 1986 by physicians and has been acquired by Symbion.

Blue Bell (Pa.) Surgery Center is a four operating room ASC with a focus on orthopedics and spine, which opened in 2008.

Blue Ridge Orthopaedic & Spine Center ASC in Warrenton, Va., includes physicians who perform knee, shoulder arthroscopies and pain management.

Bluegrass Orthopedic Surgery Center in Lexington, Ky., was developed by Bluegrass Orthopedics and Hand Center in 2006 and is affiliated with Practice Partners in Healthcare.

Boston Out-Patient Surgical Suites in Waltham, Mass., opened in July 2004 and features 19 orthopedic surgeons from five practices, and AmSurg owns majority interest.

Boulder (Colo.) Surgery Center opened in 2005 and is a partnership between physician owners and Boulder Community Hospital.

California Specialty Surgery Center in Mission Viejo includes several orthopedics procedures and is led by Jerald Waldman, MD.

Capital Region ASC in Albany, N.Y., opened in 2000 and focuses on minimally invasive spine surgery, sports medicine and extremities care.

Carrillo Surgery Center in Santa Barbara, Calif., was founded in 2005 by Alan Moelleken, MD, and includes a variety of orthopedic procedures.

Cascade Orthopaedic ASC in Auburn, Wash., was established in 1999 by the surgeons of Cascade Orthopaedics.

Cedar Park (Texas) Surgery Center opened in 2011 and includes five operating rooms with orthopedics, spine and pain management.

Center for Ambulatory Surgery in Seneca, N.Y., includes four surgery suites where surgeons provide outpatient orthopedic care.

The Center for Orthopedic Surgery in Van Nuys, Calif., was developed by Southern California Orthopedic Institute and includes 32 physicians.

The Center for Specialized Surgery in Fort Myers, Fla., is located next to the Orthopedic

Specialists of Southwest Florida and affiliated with Regent Surgical Health.

Central Maine Orthopaedics ASC in Auburn is home to around 2,000 procedures annually and affiliated with the Orthopaedic Institute of Central Maine and Maine Spinecare.

Central Park Surgery Center in Austin, Texas, includes surgeons from Austin Sports Medicine, Austin Bone and Joint and The Spine and Rehab Center.

Charlotte (N.C.) Surgery Center opened in 1985 as a partnership between Surgical Care Affiliates and local physicians, and now performs more than 12,000 cases annually.

The Christ Hospital Spine Surgery Center in Cincinnati is a partnership between Mayfield Clinic, The Christ Hospital and USPI featuring 13 neurosurgeons.

Christiana Spine Center in Newark, Del., has been operating on the Christiana Hospital campus since June of 2000 and includes minimally invasive spine procedures.

Citrus Park Surgery Center in Tampa, Fla., includes two operating rooms and covers spine, orthopedics and pain management.

City Place Surgery Center in Creve Coeur, Mo., was founded in 2000 and now this orthopedics ASC is affiliated with Meridian Surgical Partners.

Commonwealth Outpatient Surgery Center in Fairfax, Va., sees an average of 4,400 surgeries per year between two ASCs.

Concord (N.H.) Orthopaedics Surgery Center was opened in 1995 in collaboration between Concord Orthopaedics and Concord Hospital.

Crane Creek Surgery Center in Melbourne, Fla., was founded in 2008 by physicians from Osler Medical Group and Blue Chip Surgical Center, and includes orthopedics and spine.

Creekside Surgery Center in Anchorage, Ala., began seeing patients in 2010, includes total joint replacements, and has 17 physician owners.

Delmarva Surgery Center in Elkton, Md., opened in 2008 and includes one operating room and three procedure rooms.

DISC Sports and Spine Center in Marina del Rey, Calif., opened in 2007 and is the official medical provider for US Olympic athletes and Red Bull America.

Doctor's Outpatient Surgical Center Beverly Hills, Calif., was founded by the physicians of Beverly Hills Spine Surgery and a pain management group, and includes TLIF and ACDF.

DuPage Orthopaedic Surgery Center in Warrenville, Ill., is owned and operated by OAD Orthopaedics Surgeons.

East Portland (Ore.) Surgery Center includes orthopedic, neurosurgery, general surgery and pain management, and is affiliated with Legacy Health and USPI.

East Surgery Center in Bradenton, Fla., includes physicians from Coastal Orthopedics & Sports Medicine | Pain Management.

Eastwind Surgical in Westerville, Ohio, was established by the physicians of Central Ohio Neurological Surgeons and became a Meridian Surgical Partners facility.

Edmonds (Wash.) Orthopedic Outpatient Surgery Center is the facility of Edmonds Orthopedic Center and includes physical therapy and MRI.

Englewood (Colo.) Surgery Center is located on Colorado Comprehensive Spine Institute's main campus and includes cervical disc replacement and spinal fusion.

Everett (Wash.) Bone & Joint Surgery Center was established in 2000 by the surgeons of Everett Bone & Joint, a Proliance Surgeons practice.

Evergreen Orthopedic Clinic Surgery Center in Kirkland, Wash., includes sports medicine, spine and extremities care.

Executive Woods ASC in Albany, N.Y., was established by Northeast Orthopaedics in 2008 and surgeons perform surgeries such as ACL reconstruction.

Fairfield (Conn.) Surgical Center is affiliated with Orthopedic Specialty Group and houses arthroscopic procedures.

First Choice Surgery Center in Baton Rouge, La., is the ASC of The Feldman Institute and was founded by Arnold Feldman, MD.

Fremont (Calif.) Surgery Center includes team physicians for the Oakland Raiders and San Jose Sharks, and has treated several elite athletes.

Front Range Orthopedic Surgery Center in Longmont, Colo., was founded in 1970 and was designed for orthopedic surgery.

Frontenac (Mo.) Surgery Center & Spine Care includes 11 physicians with a special interest in orthopedics, spine and pain management.

Gardendale Surgical Center in Birmingham, Ala., opened in May 2010 and is affiliated with Practice Partners in Healthcare.

Glendale (Calif.) Outpatient Surgery Center is a 9,000-square-foot facility with orthopedics and spine procedures and includes an overnight stay area.

GNS Surgery Center in Athens, Ga., is focused on spinal procedures and includes two operating rooms.

Greensboro (N.C.) Specialty Surgical Center includes an overnight stay area where patients can recover from spinal procedures performed at the ASC.

Greenspring Surgery Center in Baltimore was opened in January 2007 with 15 orthopedic and spine surgeons, and is affiliated with Blue Chip.

Hand Surgery Center in Clifton, Ohio includes eight hand surgeons and is a joint venture between Hand Surgery Specialists and TriHealth.

The Hand Surgery Center in New York City is led by Charles P. Malone, MD, and services approximately 10,000 patients annually.

Hawthorne Surgery Center in Libertyville, Ill., was opened in 1980 and includes physicians from Orthopod who perform procedures in its three operating rooms.

High Pointe Surgery Center in Lake Elmo, Minn., opened in 1999 and is now affiliated with Surgical Management Professionals.

Honolulu Spine Surgery Center includes orthopedic and spine surgeons, and is affiliated with Symbion.

Hudson Crossing Surgery Center in Fort Lee, N.J., was opened in 2005 and services at the facility include the AxiaLIF spinal fusion.

Hyde Park Surgery Center in Austin, Texas, opened in June 2008 and is a 100 percent physician-owned facility.

Illinois Sports Medicine & Orthopedic Surgery Center in Morton Grove, Ill., includes 18 orthopedic surgeons and four operating rooms.

Institute for Minimally Invasive Surgery in Dallas was opened in the fall of 2011 and includes an O-arm Spine Surgical Imaging, and is affiliated with Meridian Surgical Partners.

The Institute of Orthopaedic Surgery in Las Vegas was established by the physicians of Desert Orthopaedic Center in May 2002.

Kirby Surgical Center in Houston opened in 2004 and includes four orthopedic surgeons with an interest in sports medicine and other subspecialties.

Knoxville (Tenn.) Orthopaedic Surgery Center opened in 2010 and was founded by Knoxville Orthopaedic Clinic physicians as a division of OrthoTennessee.

KSF Orthopedic Surgery Center in Houston includes 12 physicians and was opened as a partnership with USPI.

Lake Ridge ASC in Woodbridge, Va., is joint venture between local surgeons and Sentara Potomac Hospital with Blue Chip affiliation.

Laser Spine Institute based in Tampa, Fla., includes three other ASCs focused on treating spinal conditions.

Lattimore Community Surgicenter in Rochester, N.Y., was established in 1990 and is one of the oldest freestanding ASCs in the area.

Leona M. and Harry B. Helmsley Ambulatory Surgical Center in Greenwich, Conn., hosts cases from surgeons with the Orthopaedic and Neurological Center of Greenwich.

Lewis & Clark Outpatient Surgery Center in Lewiston, Idaho, opened in 2004 and is owned by five physicians.

Lincoln (Neb.) Orthopaedic Center ASC is the facility of Lincoln Orthopaedic Center surgeons, which includes nine physicians interested in spine and joint care.

Linden Surgical Center in Beverly Hills, Calif., is managed by MedBridge and includes several types of orthopedic and spine procedures.

Long Island (N.Y.) Hand & Orthopedic Surgery Center was established by orthopedic surgeons Jerry Ellstein, MD, and Neal Hochwald, MD.

Loveland (Colo.) Surgery Center hosts around 3,400 orthopedic, spine and pain procedures annually and was an early adopter of the three-level Prestige cervical disc.

Main Street Specialty Surgery Center in Orange, Calif., was formed in 2000 and now hosts more than 7,000 procedures annually, including orthopedics and spine.

Marietta (Ohio) Surgery Center is operated by Regent Surgical Health and has seven physician owners, and merged with Marietta Memorial Hospital.

Manitowoc (Wis.) Surgery Center includes physicians from the Orthopaedic Associates of Manitowoc, who perform total hip and knee replacements.

Massachusetts Orthopedic ASC in Boston is a freestanding facility that includes sports medicine and extremities care, opened in 2006.

Mayfield Spine Center in Cincinnati was founded in 2005 as a freestanding, spine-focused ASC.

Memorial Spine & Neuroscience Center in Southbend, Ind., offers minimally invasive spine and pain management procedures.

Middlesex Center for Advanced Orthopedic Surgery in Middleton, Conn., includes a variety of orthopedics procedures and is owned by Middlesex Hospital and Orthos Holding Co.

Midlands Orthopaedics Surgery Center in Columbia, S.C., was founded by the physicians of Midland Orthopaedics as a freestanding center.

Midland Surgical Center in Sycamore, Ill., is a joint venture between a health system, five orthopedic surgeons and Regent Surgical Health.

Millennium Surgical Center in Cherry Hill, N.J., was opened in 2007 and includes minimally invasive spine surgery and partial knee replacement.

Minimally Invasive Spine Institute Health Campus in Dallas opened in 2011 and was among the first in the state to host endoscopic spine surgery.

Mississippi Valley Surgery Center in Davenport, Iowa, includes a total joint replacement program and spine surgery, with around 12,000 procedures per year.

Missoula (Mont.) Bone and Joint Surgery Center is located next to Missoula Bone and Joint and includes AAAHC accreditation.

Mobile (Ala.) Surgery Center opened in 1984 as a partner between Surgical Care Affiliates and local physicians with a special interest in sports medicine, orthopedics and spine.

Moore Orthopaedic Clinic Outpatient Surgery Center in Lexington, S.C., includes 14 physicians and is managed by Practice Partners in Healthcare.

Musculoskeletal Surgery Center in Tornton, Colo., was founded in 2001 and surgeons perform disc arthroplasty at the center.

Neurological Institute ASC in Savannah, Ga., includes 10 physicians credentialed to perform minimally invasive spine surgery, including artificial disc replacement.

NeuroSpine and Pain Surgery Center in Ft. Wayne, Ind., is a joint venture between neurosurgeons and pain management physicians and Lutheran Hospital of Indiana.

NeuroSpine Institute of Orlando ASC recently opened in March 2013 by practice founder Robert Masson, MD, and includes spine and sports medicine.

New Mexico Orthopedic Surgery Center in Albuquerque includes eight operating rooms for orthopedics and pain management.

Newport Orthopedic Institute in Newport Beach, Calif., includes a surgical center, physical therapy and imaging focused on orthopedics and spine.

North Meridian Surgery Center in Carmel, Ind., is a freestanding physician-owned surgery center where surgeons from OrthoIndy and Indiana Spine Group perform cases.

Northeast Surgical Center of Newington (N.H.) was established in 2000 as a freestanding ASC affiliated with Access Sports Medicine & Orthopaedics in Exeter.

NorthStar Surgical Center in Lubbock, Texas, was established in 2001 by area physicians, is affiliated with Symbion and includes total joint replacement.

Northern Wyoming Surgical Center in Cody includes total joint replacement and total shoulder surgery.

Northview Orthopaedic Surgery Center in Dahlonega, Ga., includes cases from Northview Orthopaedic Associates in sports medicine and spine.

NYU Langone Medical Center Outpatient Surgery in New York City has four operating rooms and focuses on orthopedics.

OA Surgery Center in Portland, Maine, was founded by the surgeons of OA Centers for Orthopaedics and includes two digital technology ORs.

OAK Surgical Institute in Bradley, Ill., was founded by local physicians and healthcare providers, and focuses on orthopedics.

Ohio Orthopedic Surgery Institute in Columbus includes four ORs where surgeons perform joint replacement, spine and other procedures.

Oklahoma Center for Orthopaedic & Multi-Specialty Surgery in Oklahoma City is an affiliate of USPI and partnered with local physicians and Integris Health.

Olympia (Wash.) Orthopaedic Associates Surgery Center is affiliated with Olympia Orthopaedic Associates and includes interventional pain management.

Orlando Orthopaedic Outpatient Surgery Center was opened in 2010 and includes orthopedics, spine and pain management.

OrthoGeorgia ASC in Macon was established by OrthoGeorgia and includes three ORs.

The Orthopaedic Institute ASC in Gainesville, Fla., was built in 2000 and includes five ORs designed for the 25 surgeons of The Orthopaedic Institute.

Orthopaedic & Spine Specialists ASC in York, Pa., includes five ORs and physicians are interested in sports medicine and spine.

Orthopedic Associates ASC in Oklahoma City was built in 1986 and is home to Orthopedic Associates in Oklahoma City physicians.

Orthopaedic Associates of Wisconsin Surgery Center in Waukesha, Wis., opened in 2007 and is designed for orthopedic patients.

The Orthopaedic Center at Springhill in Mobile, Ala., is affiliated with Alabama Orthopaedic Clinic and joint ventured with a local hospital.

Orthopaedic Outpatient Surgery Center in Des Moines, Iowa, is jointly owned by Des Moines Orthopaedic Surgeons and Iowa Health-Des Moines.

Orthopaedic South Surgical Center in Morrow, Ga., is operated by USPI and hosts orthopedics, spine and pain management.

Orthopaedic Surgery Center of Ashville (N.C.) includes three ORs were physicians from seven practices perform cases, including orthopedics and spine.

Orthopaedic Surgery Center of La Jolla (Calif.) is the orthopedic ASC of Surgery One and surgeons perform joint replacement and spine surgery.

Orthopaedic Surgical Center of the North Shore in Peabody, Mass., was the first independent orthopedics ASC in the state, opening in 2005.

Orthopedic & Sports Surgery Center in Appleton, Wis., features total joint replacement and is owned by Orthopedic & Sports Institute of the Fox Valley physicians.

The Orthopedic Surgery Center of Arizona in Phoenix is a physician-owned facility that includes 15 orthopedic surgeons and partnered with Cornerstone Surgical Partners.

Orthopaedic Surgery Center of San Antonio is the ASC of San Antonio Orthopaedic Group and includes sports medicine.

Optimorthopedcis ASC in Savannah, Ga., includes a full-service ASC, imaging center and physical rehabilitation.

Pacific Heights Surgery Center in San Francisco opened in 2003 and includes sports medicine and extremities cases.

Pacific Surgical Center in Longview, Wash., is part of Pacific Surgical Institute, backed by seven physicians and opened in 2006.

Parkways Surgery Center in Hagerstown, Md., was founded in 2006 by Parkway Neuroscience and Spine Institute physicians and is affiliated with Blue Chip.

Paulsen Street Surgery Center in Savannah, Ga., is owned by Memorial Health and includes surgeons from Chatham Orthopaedic Associates.

Peak One Surgery Center in Frisco, Colo., is a partnership between Summit Surgical Group and St. Anthony Summit Medical Center.

Peninsula Surgery Center in Newport News, Va., is a joint venture between physicians and Riverside Medical Center and includes orthopedics and spine.

The Physician's Surgical Center in Winter Park, Fla., was opened in 1993 as a partnership between Florida Hospital, Surgical Care Affiliates and physician practices.

Piedmont Surgery Center in Greenville, S.C., was developed by ASCOA and includes spine surgery.

Pointe West Surgery Center in Bradenton, Fla., includes surgeons from Coastal Orthopedics & Sports Medicine | Pain Management and is affiliated with ASD Management.

Prairie SurgiCare in Peoria, Ill., was added to Prairie Spine & Pain Institute in 2012 and includes spine and pain management.

Premier Orthopedic Surgery Center in Albany, Ga., is the ASC of Premier Orthopedics, which includes sports medicine, joint reconstruction and spinal care physicians.

Presidio Surgery Center in San Francisco was opened in 1989 and managed by Surgical Care Affiliates, and includes several orthopedic and spine procedures.

Ravine Way Surgery Center in Glenview, Ill., focuses on orthopedics and pain management, and is a joint venture between Illinois Bone & Joint Institute and NorthShore University Health Systems.

Reading Surgery Center in Wyomissing, Pa., hosts several orthopedic surgeries and includes three operating rooms.

Regional Hand Center of California in Fresno was incorporated in 1999 and founded by an independent physician.

Renaissance Surgery Center in Bristol, Tenn., is a Symbion facility and includes surgeons from Highlands Neurosurgery and Bristol Neurosurgical Associates.

Reno Orthopaedic Surgery Center was founded by Reno Orthopaedic Clinic surgeons who have a special interest in spine, sports medicine and joint replacement.

Roanoke (Va.) ASC was opened in 2002 and includes surgeons from Roanoke Orthopaedic Center, which is part of Carillion Clinic.

Rockford (Ill.) Orthopedic Surgery Center is affiliated with Rockford Orthopedic Associates and includes 18 orthopedic surgeons.

San Francisco Surgery Center was the first ASC to purchase MAKOplasty robotic equipment for partial joint replacement and covers several other orthopedic procedures.

Sheboygan (Wis.) Surgery Center is focused on orthopedic surgery and was opened in 2008 by local physicians, St. Nicholas Hospital and ASD Management.

Skagit Island Orthopedic Center ASC in Anacortes, Wash., is designed for orthopedic services and participates in Proliance Surgeons.

Slocum Center for Orthopedics & Sports Medicine ASC in Eugene, Ore., includes sports medicine, therapy, MRI and pharmacy in addition to surgical services.

SMI Surgery Center in San Diego includes outpatient orthopedics and spine procedures such as rotator cuff repair and disc neucleoplasty.

SOAR Surgery Center in Burlingame, Calif., is the exclusive provider of the Sports Orthopedic and Rehabilitation Group, which provides care for the San Francisco 49ers.

South Shore ASC in Lynbrook, N.Y., opened in 2002 and was founded by independent physicians, physician groups and a managing partner.

South Sound Neurosurgery Brain & Spine Center in Puyallup, Wa., is led by founder and president Richard Wohns, MD, and focuses on spinal services.

Southern Illinois Orthopedic Center in Herrin focuses on musculoskeletal services and operating partners include Southern Illinois Healthcare and Surgical Management Professionals.

Southern New Mexico Surgery Center in Alamogordo includes two orthopedic surgeons who perform minimally invasive techniques.

Southern Orthopaedic Surgery Center in Fayetteville, Ga., was opened in 2007 by the eight physicians of Southern Orthopaedic Specialists.

Southeastern Spine Institute ASC in Mount Pleasant, S.C., is a 41,000-square-foot facility dedicated to spine health and includes total disc replacement.

Spalding Surgical Center of Beverly Hills (Calif.) provides orthopedic, spine and pain management services.

Spine & Sports Surgery Center in Campbell, Calif., is affiliated with Spine & Sports Medical Center and includes pain management.

Spine Centers of America, founded by Bryan J. Massoud, MD, is based in Fair Lawn, N.J., and surgeons focus on endoscopic spine procedures..

The Spine Institute of Southern New Jersey in Marlton focuses on minimally invasive spine surgeries and includes spinal fusion.

Spine Surgery Center of Eugene (Ore.) was opened by Glenn L. Keiper Jr., MD, founder of KeiperSpine, along with his associates in 2007.

Sports Medicine Day Surgery Center in Renton, Wash., includes sports medicine services and arthroscopic surgery.

Squaw Peak Surgical Facility in Phoenix was founded by Anthony Yeung, MD, in 1998 to complement Desert Institute for Spine Care.

St. Louis Spine & Orthopedic Surgery Center in Town and Country, Mo., was opened in 2007 and includes total hip and knee replacement procedures.

St. Louis Spine Center includes neurosurgery and pain management, and was acquired by Meridian Surgical Partners in 2012.

St. Mathews Surgery Center in Louisville, Ky., was established in a partnership between Louisville Orthopaedic Clinic physicians and Baptist Hospital East.

Stateline Surgery Center in Galena, Kan., opened in 2010 and the facility also includes a gym and MRI services.

Surgical Center at Columbia (Mo.) Orthopaedic Group opened in 2008 and more than 20 surgeons perform procedures there.

SurgiCare of Miramar (Fla.) is a multispecialty ASC opened in 2010 that is affiliated with Surgem.

Surgery Center at Doral in Miami was opened in 2008 as a joint venture between Alejandro Badia, MD, and a management company.

Surgery Center of Allentown (Pa.) is a joint venture between physicians and ASCOA, which opened in 2007.

The Surgery Center of Easton (Md.) opened in 1997 and is currently a partnership between four orthopedic surgeons and Surgical Care Affiliates.

Surgical Center of Excellence in Panama City, Fla., has two operating rooms where surgeons perform orthopedic procedures.

Surgery Center of Kalamazoo (Mich.) was founded in 2004 by a group of physicians and ASCOA, and includes orthopedics and spine.

Surgery Center of Maryland in Silver Springs includes two neurosurgeons and 28 orthopedic surgeons, and is affiliated with ASCOA.

Surgery Center of Reno (Nev.) is a multispecialty ASC with 16 orthopedic surgeons and spine surgeon James Lynch, MD, serves as chairman of the board of directors.

Surgery Center of Wisconsin Rapids (Wis.) opened in 2006 by Wisconsin River Orthopaedic Institute and is managed by ASD Management.

Tallahassee Outpatient Surgical Center is a partnership between Tallahassee Orthopedic Clinic and Hospital Corporation of America.

Tallgrass Surgical Center in Topeka, Kan., is focused on sports medicine and includes pain management.

Texas Orthopedics Surgery Center in Austin was founded in 2002 and is operated by Texas Orthopedics physicians.

Texas Surgical Center in Midland was opened in 2003 and is owned and operated by 12 surgeons.

Trade Center Outpatient Surgery in Palmdale, Calif., was founded by Nick Alapour, MD, who focuses on minimally invasive spine procedures.

TRIA Orthopedic Center in Minneapolis is a comprehensive orthopedics facility including more than 40 physicians with an interest in sports medicine.

Tri-City Orthopaedic Center in Richland, Wash., is a USPI facility and affiliated with Tri-City Orthopedic Clinics.

Tri State Advanced Surgery Center in Marion, Ark., opened in 2012 and is co-owned by 15 physicians.

Tucson Orthopaedic Surgery Center opened in 2002 as a joint venture between Tucson Orthopaedic Institute and Tucson Medical Center, now wholly owned by TMC.

Two Rivers Surgical Center in Eugene, Ore., opened in 2006 with a focus on spine, and was acquired by Meridian Surgical Partners.

Upstate Orthopedics ASC in Syracuse, N.Y., is the ASC of Upstate Orthopedics and includes imaging and therapy.

Vail (Colo.) Valley Surgery Center is a joint venture between Vail Valley Medical Center and 21 physician partners focused on orthopedics.

Valencia Surgical Center in Newhall, Calif., is affiliated with Southern California Orthopedic Institute and includes three ORs.

Valley Orthopedic Associates ASC in Renton, Wash., includes physicians who perform nearly 4,000 cases annually and have an interest in sports medicine and spine.

Valley Surgery Center in Steubenville, Ohio, was opened in 2002 and is owned by 14 local surgeons in a partnership with Symbion.

Virginia Beach ASC opened in 1989 and is a joint venture between physician partners and Sentara Health System.

West Kendall (Fla.) Surgery Center was opened in 2003 by physicians and their business partner, and includes several orthopedics procedures.

West Park Surgery Center in Cape Girardeau, Mo., was formed with physicians from Brain & NeuroSpine Clinic of Missouri and Blue Chip.

Wildwood Surgical Center in Toledo, Ohio, is an 18,000-square-foot facility operated by ProMedica Health System and performs 6,000 procedures annually.

William B. Mulherin Surgery Center in Athens, Ga., was established in 2007 by the physicians of the Athens Orthopedic Clinic.

Wilmington (N.C.) SurgCare is a Symbion facility opened in 1994 that includes 20 orthopedic physicians.

Yakima (Wash.) Ambulatory Surgical Center opened in 1998 and includes orthopedics, spine and neurosurgery.

For full profiles of each center, visit www.beckersasc.com/lists.

5 Initiatives for Higher ASC Operating Margins

By Laura Miller

Central Maine Orthopaedics in Auburn, Maine, is a large orthopedics practice with an adjoined ambulatory surgery center. Last year, the group reported its highest operating margins in the center's more than 15-year history, largely due to key initiatives implemented over the past few years.

"We're very fortunate here because we have a strong surgery center in terms of quality and financials, but in the past year we've experienced the strongest operating margins we've ever seen," says Michael Cox, CEO of Central Maine Orthopaedics. "We've been remodeling our systems approach and it paid huge dividends for us last year. The only general rule we live by is that we wouldn't cut anything if it impacted quality and/or superior patient outcomes. We have really interfaced our business on both the clinic and ASC side, and that synergy has paid off for us."

Here are the five key initiatives that lead Central Maine Orthopaedics to report its highest operating margins ever last year.

1. Staff engagement and accountability. CMO requires a high level of commitment from their all members of their staff. The leaders engage clinical and administrative staff members alike to improve operations at the practice and surgery center.

"Our center is unusual in that our staff members have a voice in daily operations and performance improvement measures," says Anne Marie Kayashima, director of clinical and surgical services at Central Maine Orthopaedics. "Our staff members play a role in developing our strategic plan through ongoing initiatives and committees. If there is a problem we identify, such as volume changes, we can work with our staff members to identify the challenge, develop a solution and move the system forward."

Staff members are also encouraged to brainstorm ideas for improved efficiency at the practice and surgery center. Staff ideas have been implemented in the past for considerable cost-savings for CMO.

2. Cross train staff members. Central Maine Orthopaedics has cross trained staff members from the clinic and surgery center to address issues on both sides. This increased flexibility allows the practice to respond quickly to staffing changes in a cost-effective way.

"Over the course of the last few years we have been able to address costs and other strategic issues by cross training staff," says Jeffrey Wigton, director of operations at Central Maine Orthopaedics. "Through cross training we have been able to add clinical programs (and providers) while minimizing the increase in support staff costs."

Cross-trained staff can also help CMO maintain its position as the low cost, high quality provider in the marketplace. "That will keep us sustainable in the future," says Ms. Kayashima. "We've been a low cost leader for some time, but trying to maintain that position is a challenge."

3. Standardize implants. Over the past few years, CMO has implemented an aggressive value

analysis program to cut fat from their budget. Much of the extra expense lied within implant purchases, and the group has undertaken aggressive vendor price negotiations for gains in their bottom line.

"We worked with surgeons in the practice to organize a program where before bringing anything into the practice, it's vetted by the surgeons in the group until we have a consensus on what equipment and supplies we purchase," says Mr. Wigton. "This has allowed us to standardize our supplies and implants, minimize our inventory and bring new technology into the center in a responsible way."

Gaining consensus can be challenging among a large group of surgeons, but many are cooperative because they know in the future there will be supplies they'll want to introduce as well.

"It's a gradual process to develop a space where the surgeons feel comfortable to discuss supply options because nobody wants to tell another surgeon what they can and can't use," says Mr. Wigton. "However, we lay out very clearly the cost/benefit of any item and the surgeons are very sensitive to costs. When they sit around the room in an advisory committee meeting, they have their business hats on and they know how to make good decisions."

The trick often is making sure they can put their business hats back on when they are in the operating room when a vendor is showing them new devices. "They have to remember they are business owners," says Mr. Wigton. "It's one thing for them to agree to the consensus, but it's another to actually practice it."

4. Develop interdepartmental pre-operative case review. In 2012, CMO implemented a program aimed at developing a 'circle of accountability' across multiple departments. Each case is reviewed by the purchasing department and the billing department. This gives the purchasing department an opportunity to cross-check the current case against historical information, and at this time costs are studied and supplies volumes are check. If there are considerable cost increases, the purchasing department has a conversation with the surgeon to determine if the case can be done cost effectively without sacrificing a good outcome for the patient.

The purchasing department hands the information gathered to the billing department. The surgery authorization specialist cross-checks the costs with what insurance will cover. Generating this information prior to the case allows the billing department to educate the patient prior to surgery.

"We don't want the patient to be surprised after the fact. We want our patients to know what they can expect to pay out of pocket in advance of their surgery," says Jan Fournier, Chief Financial Officer at CMO. "Educating our patients upfront, whether uninsured, underinsured or adequately insured involves them in the process and together we have the conversation about what makes the most sense for them and for CMO. In rare cases, that may mean moving a case to the hospital."

Other benefits CMO has experienced include that equipment needs are known early on in the process so the purchasing clerk can make necessary arrangements in a timely fashion avoiding unnecessary scheduling delays. Surgeons also become more aware of the costs associated with their equipment and implant choices leading to more informed decision making.

5. Cost compare capital purchases. Over the next year, CMO plans to purchase new arthroscopy towers. Capital purchases add significant expense to the bottom line for surgery centers, but also present an opportunity to reduce operating expenses if the capital purchase can be used to leverage lower pricing on implants and disposables.

"We started working with one vendor and had all the big players come to the table," says Mr. Wigton. "This approach has significantly disrupted the market. We have arthroscopy vendors that do not have an implantable line team up with other vendors that do to pull together very creative proposals. This has taken on a life of its own. We now have several initiatives to decrease our costs for the both the capital equipment as well as disposables. What it will take from the surgeons is a commitment to a single vendor for a substantial portion of our business."

The practice may be able to save a significant amount of money on implantables in addition to savings on the arthroscopy towers.

"The market is consolidating and these large companies can sell you the whole package from capital equipment to implantables," says Mr. Wigton. "They can put together some pretty creative packages if you are willing to consolidate and contract with them. In the past we tried to beat up on vendors for better prices and we made some progress there, but I think this year we've found a new opportunity." ■

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