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

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9 Mistakes to Avoid When Adding Spine Surgery to an ASC

By Rachel Fields

Many surgery centers are considering the addition of spine surgery, a specialty that can boost profitability due to its high per-case revenue. This specialty is particularly appropriate for surgery centers already performing orthopedics because much of the necessary equipment may already be in-house.

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4 Specialties and Procedures to Consider Adding in 2013

By Rachel Fields

Surgery centers should be looking to increase case volume and add lucrative procedures in 2013, and the time is ripe to consider several new specialties and cases — especially in the areas of orthopedics and spine. Here, three surgery center experts discuss four procedures that will move into the outpatient setting within the next year, as well as ideas for effective implementation.

1. Total joint replacement. Goran Dragolovic, senior vice president of operations for Surgical Care Affiliates, says his company has noticed increased interest and activity around total joint replacements in surgery centers. "There are now even indications that CMS is thinking about reimbursing for total joint replacement in the ASC setting,"

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11 Ways to Cut Overhead Costs in Surgery Centers

By Laura Miller

With increasing costs and decreasing reimbursements coming in the next year, it will be important for ambulatory surgery centers to cut overhead costs where possible to realize an impact on the bottom line. "Almost any cuts in overhead costs will flow directly to the bottom line as most facilities have fixed costs covered," says H. Thomas Scott, director of operations for Surgical Management Professionals. "Any expenses you can cut fall to the bottom line and have a huge impact on the distributable cash to the investors."

Mr. Scott and Charles Dailey, vice president of development at ASD Management discuss 11 ways for ambulatory surgery centers to cut overhead costs next year.

1. Examine and reorganize materials contract structures. Most ambulatory surgery centers are part of a group purchasing organization, either individually or with their management

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- 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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FEATURES

Publisher's Letter

This issue of Becker's ASC Review focuses on changes and improvements surgery centers can make in 2013, including adding specialties, cutting costs and preparing for national healthcare changes.

This issue also includes a list of 35 GI & Endoscopy-Driven ASCs to Know, as well as the top 10 patient safety issues for 2013.

Please join us for the 11th Annual Orthopedic, Spine & Pain Management-Driven ASC Conference in Chicago, from June 13-15. The conference will feature great surgeon and CEO speakers, as well as keynotes Mike Krzyzweski (Coach K), Brad Gilbert, Geoff Colvin, and Forrest Sawyer.

If you have any questions or if we can be of any help, please contact Scott Becker at scott@beckersasc.com.

Very truly yours,

Scott Becker

9 Mistakes to Avoid When Adding Spine Surgery to an ASC

(continued from page 1)

But beware: A surgery center that implements spine without careful planning can end up with dissatisfied surgeons, worried staff and high equipment costs. Here, Lisa Austin, vice president of operations for Pinnacle III, discusses nine pitfalls to avoid when adding spine surgery to an ambulatory surgery center.

1. Neglecting to create a unified and educated core team. In her experience, Ms. Austin indicates surgery center administrators often forget to speak with the surgeon and staff about their fears and concerns when adding new types of cases. She recalled a spine surgeon came to one of her ASCs in the middle of the year. She relayed to the ASC staff they would be performing spine procedures with this new physician but didn't realize the staff were verbalizing concerns to the surgeon that they were uncomfortable carrying out spine cases in an outpatient setting. While staff members had experience with these types of cases in the hospital, undertaking these cases in the surgery center would be a new experience for them which contributed to their fearfulness.

She says if she could do things differently, she would have sat down with staff members at large and said, "We're considering adding spine surgeries in our ASC. We would like to develop a team of spine specialists to become proficient in performing these cases with our spine surgeon. Who would like the opportunity to join this team?" That small team of specialists would have mastered the new specialty then acted as mentors to other staff members as case volume grew. She would have also included the surgeon in team meetings which would allow him to obtain a greater level of comfort in the new facility.

2. Starting with complex spine cases right away. It may be tempting to ramp up your new specialty right away, but Ms. Austin recommends starting with less-complex spine cases and moving to more complex cases once your staff obtains the necessary comfort level. "We typically start with disc replacement cases, fusions and anterior cervical discectomies," she says. "There tends to be a stronger comfort level with these types of cases and we work with the surgeon to identify appropriate patients for the ASC."

Ms. Austin recommends identifying a few cases that will be performed in the first month. Over a six-week period, scrutinize any issues encountered and figure out how best to address them. "Before we started adding high volume, we did case studies on every patient having these procedures," she says. "We had our top-notch spine team evaluate what the pre-op process was like, what the education aspect was like, and what needed to be addressed." She says the surgery center also examined case outcomes and determined where processes could be improved.

3. Neglecting to include your surgeon in equipment selection. Your surgeon may be coming from a hospital with access to equipment and instrumentation more suited to higher levels of care than what would be performed in the ASC, so make sure to discuss equipment needs required to provide quality care without exceeding the budget. First, look at the surgeon's preference cards and determine which supplies and equipment you will have to purchase. Then develop your shopping list with the surgeon. In some cases, you may be able to utilize existing equipment. "If the surgeon is used to using a particular type of spine-specific OR table, it may be possible to buy attachments for general, multi-functional OR tables to make them compatible with spine," Ms. Austin says. She notes her ASC was able to use their pre-existing microscopes and simply purchase a few attachments, rather than buying a spine-specific microscope.

4. Forgetting to market a new surgeon's services to the community. If you're recruiting a surgeon from outside your community, he may not have a pre-existing patient base in your town or city. Ms. Austin states it's important to have a marketing plan before you add spine to your ASC; you don't want to invest in the equipment and then find you have no case volume.

She suggests marketing include patient education about spine surgery in the outpatient setting, since it may be a relatively new development in your market. "Provide patients with a comfort level for receiving care in an ASC with a shorter length of stay than that typically experienced in a hospital setting," she says. Ask the physician to hold educational seminars at your surgery center to help the public understand the safety of these procedures.

5. Not giving thoughtful consideration to appropriate patient selection and education. "Patient selection is huge" in spine surgery, Ms. Austin asserts. Spine surgery in the outpatient setting is still relatively new in some areas, and surgeries should only be performed on patients who can recover without an extended stay or transfer to the hospital. Discuss with your surgeon the parameters he feels are pertinent in his selection criteria for his ASC patients. Set pre-admission guidelines with input from your anesthesia and spine specialty team that includes weight, co-morbidities and age that you can share with scheduling staff.

Ms. Austin says it's also important to educate patients about what to expect during their surgical experience. "This is a procedure that will be performed early in the day, so you should let them know what their afternoon and evening are going to be like," she says. "Let them know what to expect regarding their pain level, discomfort and activity level during their stay. When you help them manage their expectations, that advance understanding assists them in their recovery process."

6. Failing to discuss with the anesthesiologists the team expectations for spine surgery. Spine surgery may require different types of anesthetic blocks than are used for other cases, as well as more intensive airway management. "You have to ensure your anesthesiologists are comfortable with techniques the surgeon might request," she says. If your anesthesiologists are not comfortable with certain techniques for spine surgery, consider bringing in other providers for those specific cases or providing existing anesthesiologists with additional training.

7. Failing to perform a "dry run" before you start. Ms. Austin says she would recommend doing a "dry run" of your spine cases before you bring actual patients into the facility. This means going through every single step, from the time the patient checks in at the front desk to the time the patient is discharged. Everyone should be involved in the "dry run" and review the process as they go through each step.

8. Failing to get approval for new procedures. Ms. Austin says ASCs tend to forget that facilities have an approved procedure list that must be amended when new procedures are added. This means the administrator must, on behalf of the spine team, recommend to the medical advisory committee and governing board that these procedures be added to the procedure list and obtain approval for the change. This approval assures compliance with accrediting bodies and CMS.

9. Failure to negotiate managed care contracts. Ms. Austin states that often facilities get caught up in the clinical performance requirements and overlook the important task of ensuring reimbursement for these cases is secured prior to performing them in their centers. Meet early and often with your insurance carriers. You likely will need to collect case data and provide education in order to effectively negotiate optimum case rates, particularly in markets where these cases are relatively new. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

4 Specialties & Procedures to Consider Adding to Surgery Centers in 2013 (continued from page 1)

he says. "I'm referring to the daily briefing going back to Oct. 1, 2012. That is a strong signal or indicator of the directionality of this trend."

Along with CMS, he says more commercial payors are looking to negotiate contracts for total joint replacements in ASCs, as they recognize the opportunity for cost savings. He says the driver is a greater control over patient selection and recovery. "Initially, the chief medical officers of the payors were concerned that this type of procedure couldn't be done with adequate post-operative pain control in the ASC setting," he says. "Then publications were made about protocols on post-operative pain treatment, and ASCs have been very selective in taking the right candidates."

He says many surgery centers that already perform orthopedics should be able to bring in total joint cases from their existing partners. These centers should also be able to implement total joints without significant capital outlay. "The main issues will be implant issues that have to be addressed with the vendor," Mr. Dragolovic says.

2. Spine. Dan Connolly, vice president of payor contracting for Pinnacle III, notes commercial payors are increasingly adding commonly performed spine procedures to their grouper payment methodologies. "On one hand, this is good news," says Mr. Connolly. "It demonstrates that commercial insurers are progressively recognizing the efficacy of performing these procedures in the ASC setting — even though the procedures are not on the CMS ASC-approved procedure list. On the other hand, if reimbursement under your contract's grouper assignment is inadequate, the center will want to negotiate carve-outs for these procedures.

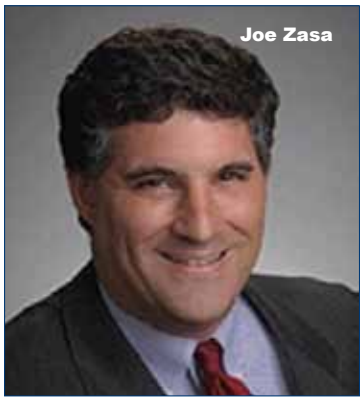
In his experience, reimbursement for spine cases can be lucrative even when under a grouper payment methodology. "Pinnacle III has added or is in the process of adding spine procedures to a number of the facilities we manage or consult with throughout the country. In the process, Pinnacle III is seeing some larger commercial payors grouping the more common spine procedures into their highest payment category," he says. "In some contracts, the reimbursement we previously negotiated for the highest grouper payment category was ample enough that a carve-out for the new procedures did not need to be negotiated."

However, Mr. Connolly adds, "With some payors, ASCs will need to negotiate carve-outs for the most commonly performed spine procedures. In addition, if looking at performing fusion and artificial disk replacement cases, you should expect to have to negotiate carve-outs for the primary and add-on procedures. Likewise, given the fact that some spine cases are implant intensive, if the center has not previously been successful in negotiating separate payment for implants, then a carve-out for implants is a must."

In some instances, a payor will only be willing to add spine cases to the center's commercial contract if an all-inclusive rate for each case type is negotiated. "If your ASC is required to negotiate all-inclusive rates, be sure your data accounts for all variable (staff, supply, and implant) costs prior to going to the negotiation table," advises Mr. Connolly. "This includes a solid understanding of the size, number, and frequency of use for each implant type and any extraordinary supplies associated with each case type." And there is the rub, says Mr. Connolly: "As many ASCs add these cases to their existing mix, they aren't properly equipped to negotiate prosperous at-risk arrangements." To combat this, Mr. Connolly recommends that the center consider hiring a seasoned negotiator who has successfully negotiated at-risk arrangements and who will recognize and be better equipped to understand all the moving parts.

Alternately, facilities would be wise to refrain from performing at-risk cases initially and focus on those cases falling under fee-for-service arrangements. Workers' compensation cases are generally a great place to start, as workers' compensation in most states still reimburses on a fee-for-service basis for both surgical procedures and implants. That way, the ASC can assemble the necessary utilization data before attempting to negotiate all-inclusive case rates."

Mr. Connolly says while adding spine cases will require a capital outlay for your center, the added investment should not be overly painful for centers already performing orthopedics. "If you're currently performing orthopedic cases, chances are your center already has a good portion of the instrumentation and equipment necessary to undertake spine procedures," he notes. "However, if starting from scratch, you will want to complete a comprehensive feasibility analysis to demonstrate the costs and benefits associated with offering spine services. In addition, the spine surgeon(s) looking at bringing spine cases to the center should have 'skin in the game,' thereby maximizing the chance that the center will see a return on its investment due to the new surgeon(s) delivering the projected case volume."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3. Robotics. Mr. Dragolovic says while it's still in the preliminary planning stages, robotic surgery may see a movement to the outpatient setting. Historically, robotic surgery has been performed almost exclusively in the hospital setting. "It's purely because of economics," Mr. Dragolovic says. "The cost of equipment and the disposables associated with robotic surgery make it cost-prohibitive." Facilities implementing robotic surgery must also be mindful of space; the equipment is generally large, meaning a small OR may not be appropriate for the investment.

Mr. Dragolovic believes robotic surgery may move into ASCs in certain markets where significant volume opportunities can be captured. Essentially, a surgery center would need a payor willing to offer a level of reimbursement that would create a feasible return on investment for the capital outlay. "If a piece of equipment costs more than a million dollars, you have to have adequate reimbursement at a significant volume," he says. He says this is possible because the reimbursement would still be less than the reimbursement at the local hospital, thereby providing meaningful savings to the payor.

4. Unicompartmental knees or hips. Joe Zasa, co-founder of ASD Management, says surgery centers could consider adding unicompartmental knees, hips and shoulders to an existing orthopedic program. He says it's important to implement these procedures in conjunction with recovery centers. "It's important that you don't transfer the patient to the hospital, so you work with recovery care centers and rehab centers that handle the patient after discharge," he says.

He adds that attaining the right pricing is crucial for unicompartmental knees, shoulders and hips. The procedures are Medicare-approved, but third parties pay so much for the procedures that pricing strategy and research are crucial. "Negotiate with payors and understand what they're paying at the hospital," he says. "They may be paying $30,000 to the hospital, and you can beat that price." He says while you should ideally build a program around these procedures with several dedicated physicians, reimbursement should be high enough to allow you to start with several cases a month. ■

ASC Roundtable: What to Do in Markets With Heavy Hospital Employment
(continued from page 1)

company. GPOs can help surgery centers lower materials costs by negotiating bulk contracts and restructuring old contracts so they are more beneficial to the bottom line.

"There is always room for improvement when we are watching how much we are paying for products at our centers," says Mr. Dailey. "A lot of centers are so busy that they don't look at how their contracts are organized and they could get better pricing if they reviewed those details. It takes some extra leg work, but it's worth it to jump from one price bracket into the next."

If you aren't part of a GPO, consider joining one. "A GPO can typically save you anywhere from 7 percent to 15 percent on materials costs," says Mr. Scott. "A good inventory system is a must so you can track costs of supplies and target the outliers to work with vendors for reduction in cost."

2. Focus on organization in inventory management. Materials managers at the surgery center should focus on organization when purchasing and maintaining inventory. Organization with stocked supplies is crucial because it leads to cost savings down the road.

"A lot of centers do inventory and purchasing by hand and eye, and things are lost," says Mr. Dailey. "It's hard to keep track of pricing. We encourage electronic inventory management systems. By partnering and recording inventory management there, it cuts down on their work load and decreases error, which yields cost savings. We see a significant reduction in our costs; there is a direct correlation."

3. Continuously renegotiate supply contracts. Dedicate one person at the surgery center or management company to track the most commonly used items at the center and review those contracts annually. Renegotiating high volume contracts stands to save surgery centers the most money in the future.

"We use a lot of sutures in our surgery centers, and they cost a lot of money," says Mr. Dailey. "We renegotiate those contracts all the time for better pricing. A lot of centers also have a high volume of eye implants. I make a special contract for those and look very closely at negotiating the best rate for our volume."

These renegotiations take a lot of focus, so zero in on a few items and develop a relationship with those manufacturers and distributors. Also work with physicians to streamline implant choices.

"Some vendors will provide you the device and assist you in informing and training your physician as to the benefits of the lower cost device," says Mr. Scott. "You can also put the surgeon in touch with other physicians and specialists in the area that are using a particular implant so they can talk amongst themselves about the benefits of a particular device. Keeping the physicians informed and getting their buy-in is what counts."

4. Reduce shipping costs with new contracts. Shipping costs are significant for surgery centers ordering implants or other supplies on a regular basis, especially when those supplies are shipped overnight. There are several independent companies that can perform audits of the shipping logistics and pricing to help you negotiate a better contracted rate with shipping companies.

"With one ASC in Florida, which had a high volume of orthopedics and pain procedures, we were able to save $60,000 in shipping costs annually after renegotiating their contract," says Mr. Dailey. "We forecasted this savings and showed it to the surgeons, which was huge. People take shipping costs for granted because it's important, but it costs so much."

Renegotiating these contracts can have a significant impact on the surgery center's bottom line.

5. Purchase implants wholesale. Several implants on the market today are considered commodities, which means they should be purchased wholesale from the manufacturer instead of from sales representatives at a mark-up. There are new companies forming to facilitate wholesale purchases of the most common implants for a lower price.

"They are like brand name pharmaceuticals because after the initial patent comes out they release the generic product," says Mr. Dailey. "The products are close to the same, but the generic costs less. There is a 60 percent cost difference per implant in some cases, which can make a big difference in overhead costs."

Not every implant will fit into this category, but surgery centers can save on implants and cases that do. "I think, over time, more people are going to use these quality implants because they are comfortable with them and the cost savings will be there," he says.

Physicians may be weary of switching from their name brands and sales representatives, so work with them to make sure the new devices are clinically viable. "Work with your physicians to identify supply choices that may have the same clinical results at a lower cost," says Mr. Scott.

6. Place drug orders electronically. Look at how your surgery center orders pain drugs and anesthetics to see where cost-savings could occur. Many centers order manually with paper, but there are new platforms available online to make electronic purchases which are more organized and limit user errors.

"These applications on the computer can also highlight when you are ordering a name-brand drug that has a generic equivalent so you can decide which one you want to order," says Mr. Dailey. "People may not know there is a generic drug, so we encourage our administrators to use these applications."

These programs can also calculate the savings surgery centers achieve when ordering generic implants, which adds up to a significant amount by the end of the year.

7. Reprocess materials when possible. Several implant companies — including large companies such as Stryker — have developed reprocessing branches. Take advantage of reprocessing services to lower implant costs and become more economical.

"There are companies that focus on reprocessing and they are safe," says Mr. Dailey. "The instruments are still effective after they are reprocessed, so you can get a second or third use out of them. This cuts down on the purchasing. I encourage people to take a closer look at reprocessing because there are services out there."

8. Refinance debt and renegotiate leases. Most surgery centers have high building and equipment costs that aren't necessarily fixed. If these costs are problematic, refinance your debt on them because interest rates are low and banks may be willing to work on a new contract for the future. Surgery centers can also renegotiate leases on equipment.

"One option is to restructure equipment leases to a per procedure cost structure," says Mr. Scott. "If you are not using the equipment pretty consistently, you may be able to work with your vendor to pay for the equipment on a per use basis instead of a flat monthly rate."

If you do restructure the lease to a per use basis, the vendor typically brings in the equipment on a scheduled basis and removes the equipment. This may present some scheduling issues with your physicians that use the equipment.

9. Reconsider employee benefit plans. Another way to lower overhead costs is to offer employees a health savings account instead of the traditional PPO plan. HSA premiums are typically lower than traditional PPO plans which will allow employers to save each month for each employee that enrolls in a high deductible health plan. The employee can also contribute to their HSA account on a pre-tax basis and the contributed amounts build up in the account unlike a flex spending account were the funds must be used within a calendar year.

"The cost savings from switching to a HSA account can be considerable and should be considered," says Mr. Scott. By involving the employee in the decision of how to spend their funds for healthcare has shown to reduce healthcare cost thereby helping to improve the surgery center's bottom line.

10. Send employees home on slow days. Give your work schedule some much needed thought. Do not over schedule staff on slow days and be open to sending employees home early if necessary. In exchange for leaving early, you can still always employees accumulate paid time off or comp time for hours that were cancelled.

"It's always good for employees to take time off," says Mr. Scott. "It's better for their mental health to have time off. By spending some time on the schedule, you can plan for that time off around the slow times thereby reducing your employee-related costs. Allowing employees to carry over two and three weeks of PTO instead of taking the time off can have a real impact on the center."

Surgery centers can also eliminate overtime for employees to improve the bottom line.

11. Benchmark and set goals for next year. It's difficult to benchmark a facility's costs because they are different depending on the types of procedures, location and surgeons involved. Find a system where you can drill down to cost data based on similar centers because you don't want to compare an orthopedic surgery center where surgeons perform scopes to ASCs where surgeons are performing joint replacement procedures.

"If you compare centers with different specialty mixes, you are going to get a different set of values," says Mr. Scott. "Supply costs per case are hard to compare, but you can use benchmarks from ASCA or similar facilities if you are with a corporate partner can provide a place to start digging deeper. Salary data can be a bit easier to benchmark using FTE's per case, cost per OR minute and other benchmarks."

Mr. Scott suggests benchmarks for salaries should generally be in the range of 25 percent of total net revenues. For cases per full time employee, you want to be around the 18 to 23 cases per FTE depending on the case mix. Try to keep billing and equipment costs around 25 of net revenues if possible. "The closer you can get to the 25 percent range or even below, the better," he says. ■

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Becoming a Better ASC Administrator in 2013: 5 Steps to Improve Your Leadership

By Rachel Fields

With the turn of the New Year, people are making resolutions related to their personal and professional lives — and surgery center administrators should be no different. Whether you want to get your finances in order, improve your quality outcomes, or boost staff morale, the beginning of the year is a great time to assess your weaknesses and create a plan for improvement. Here, Lori Vernon of Health Inventures discusses five ways administrators can improve themselves and their ASCs in 2013.

1. Focus on patient engagement. "Patient engagement is going to be really important in 2013," Ms. Vernon says. Surgery centers have historically reported high patient satisfaction rates because of short wait times, high quality and a more intimate setting — but as patient satisfaction becomes a hot topic in the industry, hospitals are jumping on the bandwagon too. "I think some of us have become a little complacent," she says. "It's time to refocus and re-energize around patient engagement."

She recommends reviewing your patient satisfaction surveys to hone in on your areas of weakness in 2012. You may need to improve communication between patients and nursing staff, or work on better preparing your patients for discharge. She says it may be important to focus on patient education this year, especially as more complex procedures move into the outpatient setting and patients require more extended surgery and recovery time. "Patients are more educated and they want more education, so we have to keep ahead of the game on preparing them to take care of themselves at home," she says.

2. Examine your transfer rates. Ms. Vernon says it's important for surgery centers to have low hospital transfer rates, one of the quality measures that ASCs must start reporting to CMS in 2014. Low transfer rates indicate a robust patient selection process and good quality outcomes, and they can also improve patient satisfaction. "Hospitals are highly focused on readmission rates," she says. "In the ASC world, we should focus on the patients that have to go to the ER or seek a higher level of care after discharge."

She says you may find that you need to be stricter in your patient selection process, choosing patients with fewer co-morbidities or a lower average weight. You may also find that your pain control process is inadequate, and that patients seek hospital care post-discharge because they cannot adequately handle their pain.

3. Set at least one goal related to clinical outcomes. Ms. Vernon says while it's important to set goals related to financial success, one of your goals in 2013 should relate to your quality of care. "We all take for granted that we want to provide the highest quality of care," she says. "To me, the new year means airing out and freshening up what we do." She says quality outcomes will only become more important as ASCs start reporting falls, wrong-site surgery, patient burns, antibiotic timing and transfers to CMS. She says example goals include decreasing post-op nausea and vomiting or decreasing transfers to acute care.

4. Develop a strategic plan. This is the time to look to the future, Ms. Vernon says. The healthcare industry is in a period of extreme change, as the federal government implements provisions of healthcare reform and hospitals look to acquire and merge to grow market share. "The next three years is more uncertain now than it's ever been in our history," she says. It's time to think about integrating with your physician partners, whether you're a physician-hospital joint venture, a surgery center with a management company or 100 percent physician-owned. "The physicians need to know about their business more than ever before," she says. "As hospitals look to set up physician integration models, it's much more important that physicians are involved in your center." She says whether you're political or not, it's important to know what's happening in the industry. Participate in your state ASC association and educate yourself on what Congress, CMS and HHS are doing to impact surgery centers.

5. Remember that "less is more." As the year starts, you may have a long list of improvements you want to make at your ASC. Ms. Vernon advises ASC administrators to prioritize several critical items instead. "2013 is going to be a year where we have to focus on prioritizing our efforts and using our energies to tap into growth resources," she says. Gone are the days when administrators had the budget to attend four conferences a year, she says. "Economically, that might not be possible anymore," she says. "You really need to focus on what's most beneficial to you." ■

Contact Rachel Fields at rfields@beckershealthcare.com.

Ideas to Achieve Positive Cash Flow at ASCs: Q&A With Andrew Schrage

By Laura Miller

Andrew Schrage of MoneyCrashers discusses how surgery centers can build and maintain a positive cash flow in today's healthcare market.

Q: What factors can add positive cash flow to a surgery center?

Andrew Schrage: The biggest factor that can add positive cash flow to a surgery center is effective collection practices. If payroll is impeding cash flow, surgery centers can also look to outsource some of their less vital work. Reducing what is spent on supplies can positively affect cash flow and having an efficient, effective work schedule for staff members can also improve it.

Q: How can a struggling surgery center strengthen those factors to achieve a positive cash flow?

AS: One way to improve a struggling center's cash flow is to outsource some of the work (such as accounting and payroll) to prevent the need to hire full-time staff members. Another idea is to review the surgery center's collection procedures to ensure that past due customers are being contacted for payment. Keeping supply costs at a minimum helps as well, as can reviewing employee scheduling to look for ways to trim hours.

Q: What techniques are important for maintaining a positive cash flow?

AS: One of the best ways to maintain a positive cash flow is to stay in touch with paying clients by sending friendly bill reminders. Discounts can also be offered to those who make early payments. Another key to managing cash flow is to reduce expenses. The less money going out, the easier it is to maintain a positive cash flow. In extreme cases, a business could also delay paying its vendors until more cash starts coming in, so long as late payment fees are not incurred.

Q: What steps can different types of surgery centers take to build a strong foundation for positive cash flow?

AS: Since it's safe to assume that rural and single specialty surgery centers generally have less traffic than urban and multispecialty surgery centers, this makes it even more important to manage and build a positive cash flow. On a good note, the staff at these facilities likely have a more personable relationship with their clients, which could make collections easier.

Unfortunately, it may become necessary to keep services at a minimum in order to manage cash flow. After all, it's better to remain open in a rural area or as a single-specialty center with limited services than to have to cease operations. Cross-training staff to reduce payroll is an option as well. A multispecialty surgery center or one in an urban area with a larger staff could improve cash flow by streamlining operations and instituting ore effective policies, reducing debt and possibly renegotiating managed care contracts. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

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8 Steps to Quicker Turnover Times in ASCs

By Laura Miller

Efficiency of room turnovers can make a big difference for a busy surgery center because quick turnover can mean extra cases and additional revenue for the center.

"I think you need people with really good critical thinking skills that understand if something happens where the patient or surgery is delayed, there is a ripple effect," says Mary Sturm, senior vice president of clinical operations at Surgical Management Professionals. "It doesn't just affect admissions if someone doesn't get through on time, but patients will be delayed all day. Staff members and surgeons have to see the big picture and use good decision making skills to appreciate how something might impact the surgery center."

Ms. Sturm discusses eight steps to tighten the turnaround time in an ambulatory surgery center.

1. Bring everyone on the same page with turnover time goals. Clearly define when the turnover starts and stops to measure the accurate timeframe and then set benchmarked goals for your staff to reach. When you are setting these goals, obtain input from the surgeons and staff members first.

"When someone says 'turnover time,' everyone should know what they are measuring and be measuring the same thing," says Ms. Sturm. "We find that some people think that turnover time starts when the surgeon leaves and scrubs out to when he comes back in again; others think it starts when the patient is brought into the PACU and the next patient is in surgery. Have a common description everyone agrees on before setting your goals."

The benchmarks for turnover time will be different based on surgical specialty. Gastroenterology and ophthalmology cases have a much quicker turnover time than orthopedic cases. "You have to look at the specialties you are performing at your surgery center and determine whether it's appropriate to come up with an overall average turnover time."

Continue a dialogue with staff members about meeting these goals and align their incentives appropriately. "I advocate for giving staff feedback on a regular basis and when they do meet goals, leaders should acknowledge them with a perk," says Ms. Sturm. "It could be something like sponsoring a lunch or just having ice cream. A lot of our centers are also fortunate because their employees participate in profit sharing, so there could be a financial incentive as well."

2. Streamline the admissions process. Surgeons, staff members and senior leadership must all be onboard with streamlining the admissions process to move patients through as quickly as possible. This means if there is a redundant form or test that really doesn't improve the quality of a patient care, consider eliminating that step and moving on to the next.

"For example, sometimes surgery centers have extra lab tests or an EKG that doesn't really impact the quality of patient care," says Ms. Sturm. "The decision to do these tests is driven by surgeon or anesthesiology preference. If those diagnostics are really going to be utilized to make decisions on the patient's plan of care, then they are important. However, sometimes they get ordered because they have always done those things and when people stop to think about it they don't use those results in the patient's care plan."

Audit your processes, either with internal personnel or hire an outside expert to look at workflow, and see where redundancies or unnecessary steps can be removed.

3. Improve communication between departments. One of the biggest factors in long turnover times is a lack of communication between different departments and disciplines within the surgery center. The front desk should be in constant communication with the pre-op area, operating room and PACU to make sure there aren't any patient delays.

"You want to avoid confusion and make sure everyone is on the same page about each patient," says Ms. Sturm. "Another thing that can interfere with quick turnaround times is when the patient is not ready in the pre-op area, wasn't admitted in a timely fashion or arrived late and still hasn't seen the anesthesiologist."

This all begins with efficiency in the preoperative area to make sure patients are prepped and ready to go when the OR is prepared. There are several different communication devices staff members and providers can use, with one of the most efficient being in-house cell phones.

"You can call in real time and have a conversation with the operating room staff about a specific surgeon or patient," says Ms. Sturm. "You can find out whether a surgeon is ahead of schedule to prepare patients to be brought in early. Real time communication among the charge people in each department brings everyone up to speed about the flow and how things are going."

4. Promote a dialogue between the OR and PACU. While communication throughout the ASC is important, it's particularly essential between the operating room staff and PACU. Sharp communication can mean a few minutes difference between each case because the staff members are alert to patient hand-offs and adequately prepared.

"If the PACU isn't ready to admit a patient and the anesthesia staff needs to wait around, that delays them getting onto their next case," says Ms. Sturm. "In our ASCs, the OR calls ahead to the recovery room when they are a few minutes away from bringing the patient. Then, the nurses are ready and waiting for us to admit the patient into the PACU."

Right after the anesthesiologist or CRNA hands the patient over to the PACU they can immediately go to admissions and retrieve the next patient.

5. Hire experienced anesthesia staff. Anesthesia impacts nearly every patient in the ASC. Ambulatory anesthesiologists must have high quality and efficient processes for working with patients.

"Your anesthesia staff should be comfortable and familiar with the routines in your surgery center," says Ms. Sturm. "They should be clinically good at what they do and put the patients to sleep and wake them up quickly. They are pulling on the rope like everyone else in being efficient."

It's important for the surgeons and other specialists to cooperate with the anesthesiologists and communicate effectively to ensure efficiency in the pre-op and post-op areas. "Good efficiency and quality anesthesia greatly impacts turnover times," says Ms. Sturm.

6. Cross train staff on turnover responsibilities. It's especially important to cross train staff members at ambulatory surgery centers because the team is lean, but every responsibility must be covered on a vacation or sick day. However, the cross training can also come in handy during regular days so staff members can recognize what needs to happen and complete the task, even if it is outside of their department.

"I think one of the things that is very effective for surgery centers is to create a culture where the different disciplines kick in for room turnover to get things done," says Ms. Sturm. "Sometimes in an OR in big hospitals, there are strict lines that nursing doesn't help anesthesia and vice versa; everyone has their job and they don't stretch out of that role. Surgery centers are encouraging staff to see what can be done and educating them about how to assist in getting it done."

With an extra set of eyes and helping hands, surgery center staff and providers can make sure everything gets done quickly and efficiently for the next patient.

7. Designate floaters if possible. The operating room should include experienced people who are very good at anticipating what the surgeon will need for surgery; however, sometimes they don't have enough time to do everything themselves. Have someone "float" from one room to the next to help people when necessary.

"One of the opportunities you have when people are designated to float in your surgery department is increased efficiency," says Ms. Sturm. "Those people can gather equipment for the next case and deliver information about where the patient is and how long it will be before they are ready for the next step in the process — it's a little bit of science and a lot of art."

8. Designate an extra room for surgeons. If your surgery center is in a position to provide surgeons with a second "flip" room, they can organize their surgery schedule to really improve efficiency. "If surgeons can do knees in one room and shoulders in another, that can be very efficient," says Ms. Sturm. "If you can't provide the surgeon with two rooms, you can give the OR managers a great deal of autonomy to arrange their surgery day in the most efficient manner possible."

Make sure that surgeries using similar equipment are all in a row so staff members aren't constantly moving equipment in and out of the OR several times per day.

As you can see, there are a number of opportunities to assist in reducing OR turnover time in your surgery center. If you don't feel that you have the internal resources to work through these processes, look at hiring an outside expert to assist in workflow design and to assist in identifying redundancies or unnecessary steps. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

10 Ways to Improve ASC Finances & Operations in 2013

By Rachel Fields

Stuart Katz, director of TMC Orthopaedic Outpatient Surgery, Chris Bockelman, administrator of Foundation Surgery Center of Oklahoma, Greg DeConcilis, administrator of Boston Outpatient Surgical Suites, and Joe Zasa, co-founder of ASD Management, discuss 10 ways to achieve success at your surgery center in 2013.

1. Create a generic preference card. Mr. Katz says his surgery center updated physician preference cards in 2012, creating a "generic preference card" that gets pulled for every case. For example, when physicians perform knee arthroscopies, every physician receives the same items, in addition to any "extras" requested by each individual physician. For knee arthroscopies, Mr. Katz says out of approximately 25 supplies needed for the case, 20 are standardized and five are physician-by-physician. One of the differences is always glove size, because physicians have different sized hands and must be supplied accordingly.

Mr. Katz says the initiative has been extremely successful in improving efficiency and cutting costs. "We started with 2,000 preference cards," he says. "We looked at the supplies used for each case, and all the things that were the same across the board automatically made the generic preference card." He says the physicians signed off on the initiative because they understood it would improve efficiency; staff are able to equip rooms much more quickly, and they don't open supplies that the physician won't use.

2. Prepare for ICD-10. ICD-10 will kick off on Oct. 1, 2014, according to a recent change by the Department of Health and Human Services. Starting on that data, anyone filing a claim with an insurer or government health program must use a new diagnostic coding system that increase the number of codes from 14,000 (under ICD-9-CM) to 68,000 (under ICD-10-CM). Under ICD-10, HHS believes providers will be able to document procedures with greater specificity, improving insights into the landscape of healthcare and making diagnoses clearer for payors. At the same time, the implementation of ICD-10 will likely not be easy.

Mr. Zasa says surgery centers should be preparing for the transition to ICD-10 now, even though it's not due for another two years. A transition to ICD-10 will require training for physicians, coders and business office personnel, probable upgrades to surgery center software and discussions with payors about any changes that will occur under the new system.

"You have to be budgeting for your people to attend seminars and classes," Mr. Zasa says. He also recommends setting aside money in case of payment delays, while payors adjust to the new system. "I think payors are going to struggle due to the voluminous nature of the change for them," he says. "It may be a real challenge."

3. Eliminate supplies you no longer use. Mr. Katz says his surgery center has also cut costs by eliminating supplies that are no longer used in the facility. "We've eliminated some stuff that we haven't used in two or three years," he says. He says the surgery center has traded in older trays that were used once or twice a year and received appropriate trays in exchange.

"We got the values back in trays we use constantly, so we have them available all the time, instead of waiting for a tray to get re-sterilized," he says. He recommends looking at your trays and determining whether you could eliminate some of them: If you have discontinued a procedure or only perform it once a year, you could probably dedicate those funds to another product.

4. Complete quality reporting requirements. Mandatory quality reporting for ambulatory surgery centers began on Oct. 1, requiring all Medicare-certified ASCs to start reporting quality data G-codes or face future Medicare payment reductions. As of Oct. 1, ASCs must report data on the following five quality measures: patient burn, patient fall, wrong side/site/patient/procedure/implant, hospital admission/transfer and prophylactic IV antibiotic timing.

Starting in 2013, surgery centers will be required to report an additional two measures: safe surgery checklist use in 2012 and 2012 volume of certain procedures. This means surgery centers must start collecting quality data immediately if they are not already. Because 2013 requires surgery centers to report data based on activities conducted in 2012, surgery centers should make sure they are using safe surgery checklists and have some kind of system to capture surgical volume data.

ASCs that do not successfully report data to the Medicare program by the specified 2012 deadlines will see their payments reduced by 2 percent in 2014. Mr. Zasa says this potential payment reduction — and the importance of proving quality care in the outpatient setting — means a focus quality reporting is absolutely necessary for ASCs in the coming year. "We [at ASD Management] have been preparing for this for two and a half years, so it's going smoothly for us," he says. "But we're hearing that not all ASCs are seeing it go so well."

5. Educate per-diems on cost-cutting initiatives. Mr. DeConcilis says surgery center leaders often fail to educate per-diem staff about the ways they can contribute to the center. "You really have to have a monthly

staff meeting where you're constantly talking about supply costs and physician recruitment," he says. "Make sure you invite all the per-diems, and pay them to come to the meeting." If the per-diems can't come to the meeting, print off detailed minutes and ask each staff member to sign off on them.

He says his surgery center actually audio-tapes the meeting and asks staff to sign off. "That can save you time, because the staff can listen to the tape on a slower day at the center," he says. While he says the surgery center tries to staff mostly full-time workers, per-diems are sometimes necessary, and it's important to keep them educated so that you don't drop efficiency and cost-cutting initiatives when they're working.

6. Invest in a third-party inventory management system. Mr. Zasa says surgery centers can cut costs significantly by focusing their attention on medical supplies, drugs and implants. He recommends investing in a third-party inventory management system that will help the ASC cut down on inventory on-hand and make sure the ASC is achieving the best pricing possible.

The system should also ensure that the surgery center is paying the prices listed in its vendor contracts. "These systems will pay for themselves, just by not keeping excess inventory on hand," he says. He adds that surgery center personnel should be trained in how to use the system to make sure the investment does not go to waste.

7. Improve pre-op education. Mr. DeConcilis says his surgery center has undertaken a project in the last year to improve patient pre-op education. He says it can be difficult for PACU staff to address patient questions and education about post-operative care after surgery, since they're often stressed and busy. He says instead, the surgery center started talking about those issues prior to surgery. The patient comes to the surgery center prior to surgery and answers a series of questions regarding their medical history, signs documents and undergoes a DVT risk assessment. The patient also has a phone conversation with a pre-operative nurse who goes over what to expect during the surgery. When the patient registers, they are also given an iPad, which they can learn to use about the upcoming surgery and what to expect afterwards.

"It keeps things moving in the post-op area because the staff doesn't have to spend as much time educating the patients," he says. He says patients are also more able to digest information when they're coherent and not recovering from anesthesia.

8. Make sure your supply storage is easily accessible. Mr. Bockelman says his surgery center completed a quality improvement study in 2012, focused on the facility's materials management process. "We created a living, working document on the total revamping of central supply and materials management, and we decided to create a lean environment for our inventory," he says. He says the surgery center had a large room for storing medical supplies, but the room wasn't organized efficiently and it was hard to set par levels. "We ultimately transitioned the room into a sterile environment, instead of using the long hallway down the backside of the OR," he says. Now, he says, the staff can view all the supplies when they walk into the room and easily ascertain order points and complete accurate counts.

He says the surgery center has also concentrated on managing the most-used items — the 20 percent of supplies that are used 80 percent of the time. He says the ASC has been vigilant about implant logs as well. "Make sure you capture every one of your implants and compare it to what you bill the insurance company," he says. If you track your implants properly, one that isn't covered by reimbursement will "stick out like a sore thumb," he says.

9. Assess equipment needs and future capital expenditures. As 2013 nears, surgery centers should be looking at their equipment needs for the next year, Mr. Zasa says. These considerations are essential to accurately budget for the next 12 months. For example, if your multi-specialty surgery center plans to add ophthalmology over the next year, do you have the money to invest in new equipment for your center? The femtosecond laser, used to automate the principle steps of cataract surgery traditionally performed by hand, costs around $400,000.

Some specialties, such as spine, have equipment that requires a good amount of space in a surgery center, meaning you may need to make modifications to your physical plant prior to implementation.

Even if you're not considering the addition of a new specialty, you should assess the state of your current equipment to determine what you may need to replace in the next year. "Stuff wears out, and it's not atypical for a center to have to purchase a $100,000-$125,000 piece of equipment every year," Mr. Zasa says. "You're going to have capital expenditures coming down the pike, and you need to be prepared for that."

10. Recruit new physicians. Physician recruitment is an ongoing challenge for most surgery centers, especially as hospitals continue the march towards physician employment and markets become more saturated with centers. Mr. Bockelman says his market is particularly challenging because, though it isn't large, it hosts three major health systems and numerous surgery centers. He says he has utilized the reputation of his current physicians in order to attract new providers to the surgery center. "You have to continue to have meetings focusing on quality patient care and take advantage of those opportunities," he says. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

8 Inexpensive Ways for ASCs to Boost Patient Volume

By Laura Miller

Here are eight inexpensive ways ambulatory surgery center administrators can boost patient volume.

1. Grow the surgeon's clinical practice. Increasing patient volume in the surgeon's clinical practices also increases the potential patient base for the ASC. Partner with the surgeons on initiatives to learn a new procedure or target more patients in their particular specialty. For example, work with orthopedic surgeons to learn more minimally invasive approaches to joint replacements so they can be performed in the ASC.

"We identify a disease state and a patient population that impacts a lot of people with a great potential patient volume," says Charles Dailey, vice president of development at ASD Management. "For example, osteoporosis is really big, along with obesity, so there are a lot of people suffering from compression fractures of the spine. Procedures like kyphoplasty can treat that, and we focus on bringing that patient base to our surgeons; that's how we grow our business."

You can also partner with GI physicians on direct-to-patient marketing efforts for routine procedures like colonoscopies. "Within our centers we not only want to help grow the ASC business but also the surgeon's business and practice," says Mr. Dailey. "We've identified certain areas of business that there could be growth and partnered with industry to explore them."

2. Engage in goodwill programs for patients. There are community initiatives across the country and national goodwill efforts to provide preventative and necessary care to underserved populations. To the extent possible, partner with those organizations to bring in new patients who wouldn't have had care otherwise.

"We partner with Colonoscopy Assist, which has a team work approach with the American Cancer Society, to raise awareness and education for patients to get colon cancer screenings," says Mr. Dailey. "They target patient populations who wouldn't normally be able to afford screenings and negotiate lower rates to encourage them."

The ASC negotiates lower rates for the colonoscopy which means bringing in less money. However, patient volume still increases and surgery centers still benefit. "It's good to help people who wouldn't have help otherwise, and I'd rather take half of something than zero of nothing," says Mr. Dailey. "It's also building patient population because the patients might have family members who need an operation and they've already formed a relationship with your center."

3. Educate primary care physicians on your quality. Primary care and referring physicians may not know about your surgery center or all procedures performed there. Make an effort to connect with them over dinner or educational sessions to raise awareness about your treatment options.

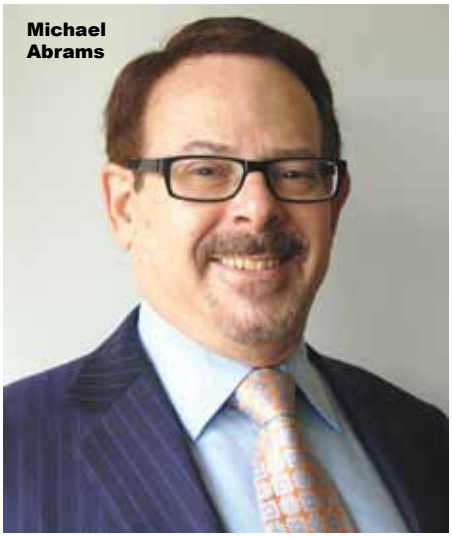
"Our physicians do education and awareness programs with primary care physicians and radiologists in the hospital to let them know we are an option for their patients," says Mr. Dailey. "When they have patients who could be treated at the ASC, we play matchmaker within the community and hopefully the patients will be sent to us. It's good for patient volume but also gives patients another option for treatment. I truly believe that business success comes from helping people."

One of the best ways to win over primary care referrals is by showing clinical success and patient satisfaction scores. Primary care physicians want to know their patients are taken care of at the ASC and the surgeons will give them updates after the procedure.

"If ASCs want to increase their share of available cases, winning the hearts and minds of referring physicians is their challenge," says Michael Abrams, co-founder and managing partner of Numerof & Associates. "Convince them you have something to offer by way of quality that they won't find anywhere else in the market. You also want to make sure that if there is something that constitutes value to them that you are doing it. They may want to check on the patient post-procedure, for instance. Figure out what the referring physician wants and give it to them."

4. Gain a reputation for high quality care. If they don't already, surgery centers must begin collecting complication, outcome and patient satisfaction data. The future for reimbursements, as well as referrals, is data-driven and ASCs should build a positive reputation in their community by numbers as well as word-of-mouth.

"Surgery centers will need to prove their value to referral sources by talking to those physicians and explaining that their outcomes are better and complication rates are lower," says Mr. Abrams. "Referral sources also want to be reassured that their patients will have a positive experience at the ASC. Everyone is looking for the best provider who does the best job. It's all well and good to say your surgeons have 27 years of experience on average and perform 300 cases annually, but these are measures of experience, not outcome."


Michael Abrams


Charles Dailey

It's difficult for most ASCs to collect data on the patient experience, especially if they wait until a week after the patient has left the ASC. However, this data can be very powerful. Give patients a survey about their experience before they leave the surgery center to the extent possible. Otherwise, connect via phone or email with patients a week later for feedback.

"It would be great to get information from the patient a week after the experience and find out whether their case was handled in a warm and responsive way and whether their needs were met," says Mr. Abrams. "Figure out whether everyone was friendly and if they would recommend the provider to family members. Pointing to strong results, even to just that question, can be very powerful because you can make the case that it's safer to refer patients to a particular provider. Proving your value to referral sources goes a long way."

5. Use clinical data in ad campaigns. Surgery centers that already have a marketing budget can use their quality and patient satisfaction data in marketing campaigns. Patients and referrals sources will respond to the hard numbers better than generic tag lines about the quality of your center.

"If they are collecting data out there, use the same data in advertising," says Mr. Abrams. "When patients need a procedure, they ask friends and people they know in the medical profession where they should go. These people search their memories for what they've heard, and if the ASC has made a compelling case about delivering a superior product — either patient experience or clinical outcome — that puts them in the running whereas they might not have been in the past."

Surgery centers can post this data on their website and social media outlets for direct-to-consumer marketing. "ASCs need to look at the model that has been created for LASIK and plastic surgery," says Mr. Abrams. "These are private pay models of care where providers have to win the hearts and minds of referral sources and direct-to-consumer advertisers to position themselves in the running for the business."

6. Encourage surgeons to bring in all possible cases. For various reasons, surgeons don't always bring all possible cases to the surgery center. They might have a day at the hospital and schedule outpatient cases there for convenience, or their block times weren't convenient for the patient. Figure out whether surgeons are bringing in all possible cases and encourage them to do so.

"If the surgeons aren't fully utilized, what can you do to bring in more business?" says Mr. Abrams.

Sometimes, surgeons leave scheduling up to the office managers who are more comfortable with scheduling at the hospital. Find a way to make scheduling easier for them at the ASC and build a foundation for a long-lasting relationship with those managers.

7. Add new procedures. Expand the number of specialties and types of cases possible at the ASC. This can be done without spending too much money on expensive new equipment by finding procedures related to those already performed at the ASC. For example, bring in interventional pain management physicians to ASCs where orthopedic or spine cases are already performed.

"There may be certain kinds of procedures that surgeons have always done in the inpatient setting, but now have been proven safe in the outpatient setting as well," says Mr. Abrams. "If possible, invest in new equipment to expand the portfolio of procedures surgeons can do."

Work with current physicians to see if there are any procedures they could perform in the outpatient surgery center with the right technology and support team.

8. Analyze referral sources. Conduct an analysis of referral sources to examine where referrals are coming from. Count all referrals from each referring physician and figure out whether you are receiving 100 percent of their cases.

"If you aren't receiving all their cases, figure out what you need to do to win a larger share of their referrals," says Mr. Abrams. "There may be situations where it makes sense to meet with and talk with the physicians about the experience and quality of your work at the center. You are building a relationship to assure the referral source that you will do a good job and are superior to other places in the market."

When you find a referral source that abruptly stops sending patients to the center, find out what put them off. "Anything you can do to correct that situation is a step in the right direction," says Mr. Abrams." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

5 Action Steps for In-Debt Surgery Centers

By Laura Miller

Robert Carrera, president and CEO of Pinnacle III, discusses five action steps for ambulatory surgery centers struggling with debt.

1. Rearrange space if the surgery center is overbuilt. One of the more common issues with surgery centers is overbuilding. Surgeons or developers forego a professional feasibility study and over-project potential patient volume during the planning phase, building too many operating rooms and purchasing too much equipment. These centers quickly find themselves with unmanageable debt.

"Some facilities are oversized or over-equipped because they were not planned properly from the beginning," says Mr. Carrera. "If the facility was designed for another group, it might encompass too much space for the current tenants. In this case, you could look at closing an OR but you are still stuck with the rent that goes along with it. Another option is to reconfigure the space to reduce square footage."

Reconfiguring extra space can be difficult and require upfront resources but may provide significant savings to the surgery center in the long run.

2. Bring on new partners or investors. When the surgery center needs additional cash flow, it may be time to bring on new physician partners or even partner with a hospital or management company. An additional surgeon bringing cases into the center will raise case volume but also increase expenses and lower the percentage of ownership each surgeon claims. When the surgery center needs a quick injection of cash, bringing in a hospital or corporate partner is often the best bet.

"Look at your options for bringing in additional partners and reducing your capital from those partners to pay down the debt," advises Mr. Carrera. "You can also look at some type of partnership with a hospital or corporate entity to purchase a reasonably large portion of the center and use the capital obtained to pay down the debt."

If new partnerships aren't available, surgery centers can consider working with banks or private equity to borrow money.

3. Refinance the surgery center. When surgery centers are underperforming and need to borrow money to get back on track, seek opportunities to refinance debt and spread the payments over a longer period of time. This is also a viable option for traditionally successful surgery centers that are having a difficult time meeting cash flow needs in today's economy or who may have taken out additional lines of credit.

"In this case, a turnaround plan is necessary to refinance the center's debt," says Mr. Carrera. "In some situations, looking for a large equity partner may be the only option. Look for a group that can assist you with the refinancing process and bring in some capital."

When you approach lenders about refinancing, you must relay why the surgery center was unsuccessful in the past and what you will do differently in the future.

"There is going to be an underwriting process that goes into the refinancing and you have to make the case for someone to refinance the center," says Mr. Carrera. "You will have to tell a positive story about what will change from now to the future that makes you a viable entity to receive the refinance."

Surgery centers financed before 2008 should think twice before refinancing. If you initially received non-recourse financing, existing partners may not be interested in guaranteeing the debt of the center going forward and you may have to consider keeping that deal instead of entering into a new one. "Refinancing an older center with debt on it might not make sense because the terms of the note beyond the interest rate are likely to change," says Mr. Carrera.

4. Renegotiate existing contracts. Surgery centers may find that renegotiating existing managed care, materials and building lease contracts provide them with better deals than they currently experience. Renegotiating contracts can be undertaken before seeking refinancing or cited as one of the steps to take after the refinancing is complete.

"The ability to renegotiate managed care contracts and bring in additional cases or specialties will add promise to the center," says Mr. Carrera. "The ability to renegotiate the building lease will assist the surgery center in becoming cash-flow positive."

Even surgery centers that haven't considered refinancing in the past are able to take advantage of the low interest rates available today and focusing on contract renegotiation is a great way to jump start that process.

"Lenders want to hear about what happened in the past and what changes need to take place to make the surgery center profitable going forward," says Mr. Carrera. "It is important for them to take a look at your previous performance, determine how that will transfer into the future and assess your future projections."

Renegotiating lease contracts may include personal guarantees. Some surgery centers may have avoided that in the past but they are becoming unavoidable today. "Personal guarantees are pretty much the way things are now," says Mr. Carrera. "They maintain everyone's interest in the center because they all have skin in the game. Older centers built prior to 2008 may have been financed with no personal guarantees and if you choose to refinance, there will be personal guarantees going forward."

5. Accelerate debt payment. Accelerating debt payments are an option for some surgery centers, but the paying down of principal doesn't benefit the surgery center from a tax standpoint. Have a clear plan to follow when accelerating debt payments and work with an expert to optimize this opportunity.

"Even if surgery centers are making accelerated debt payments, they are still taxed on funds used in paying the principal on the note," says Mr. Carrera. "Projections need to be undertaken on centers doing well to make sure distributions are going to be adequate enough to cover the tax liabilities going forward."

For centers with low debt interest rates, it is important to consider whether accelerating debt is a good option or if refinancing would be better.

"Some centers want to refinance their debt and keep it at the low interest rate while others, citing the potential uncertainty of the future, would rather reduce their overall debt load," says Mr. Carrera. "Just be aware that taxable income needs to be considered if you are looking at making more aggressive payments." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

5 Coding Tips for Spine Surgery at ASCs

By Laura Miller

Here are five tips for billing and coding for spine procedures at surgery centers from National Medical Billing Service's Senior Vice President, Coding Angela Talton.

1. Obtain correct physician documentation. Obtain full documentation for spine procedures, operative notes, anesthesia and medication list before you begin coding.

"You have to make sure all is in order before starting to code," says Ms. Talton. "There are several challenges, especially when we have more than one procedure. We have to ensure we are assigning the level of specificity for any spine procedure and the correct modifiers. Claims can be denied because modifiers are not affixed to the second tertiary procedure. That can be very costly and time consuming from a revenue cycle point of view."

This documentation will become even more specific after the transition to ICD-10 in October 2014. Surgery centers can provide physician education courses to make sure they are ready for the transition.

"Physician education is going to be critical during the upcoming days, weeks and months leading up to ICD-10 conversion," says Ms. Talton. "Physicians need to be made very aware of how they are noting procedures. They need to be very specific and aware of how they are wording their reports to avoid ambiguity in their operative findings. I suspect there will be physician queries when the operative notes are not clear, so if there is an opportunity for physician education, start now and continue through implementation. Otherwise, there is a huge drop in reimbursement because of that."

2. Code for add-ons when possible, but don't unbundle. Coders often miss opportunities to include add-on codes, especially with spine surgery. When procedures are performed on one level followed by a subsequent procedure, you can use an add-on code.

"The correct way to code multiple procedures is to code the first procedure and use an add-on for the second," says Ms. Talton. "However, they must be careful not to unbundle or bundle CPT codes because that's an unethical procedure."

Avoid unbundling if there are incidental services in the surgical package reported, which are included within the main procedure. "They should check each procedure code with CPT bundling edits and pay attention to CPT guidelines when they are coding," says Ms. Talton. "Query the physician to make sure the second procedure wasn't included in the main procedure."

3. Employing modifiers. There are a few spine cases that can be billed with modifiers. Coders must know when to use modifiers appropriately.

"If the second procedure was done in a separate area with a separate incision, then it could be separately billable," says Ms. Talton. "Otherwise, it's part of the main procedure. I would encourage coders to check the operative notes and procedure book carefully before using additional codes and modifiers. The most common coding error is the overuse of modifier -59, which is inappropriate in some situations."

4. Understand the coded anatomy. Coders should understand the anatomy of the spine before coding those procedures, especially as the codes become more specific after the ICD-10 transition. Carefully double check operative notes and documentation before beginning the claim.

"Make sure that the description of the report matches the procedure performed," says Ms. Talton. "Moreover, with ICD-10, it's going to be specific as it relates to anatomy. Coders need to be careful when assigning codes and make sure they understand what procedure the physician performed."

Inconsistencies in the operative reports and procedure described by the physician cause delays, and an inappropriately coded claim will lead to denials.

5. Continue coder education as procedures evolve. Spine surgeries have increasingly transitioned from inpatient procedures to minimally invasive outpatient surgeries. More will be performed in the surgery center setting in the future, as quality and cost-effective data is made available, and coders need to stay educated on new techniques.

"Having the procedure done in an ASC has higher quality than the hospital setting and with reduced cost and overhead," says Ms. Talton. "This saves the insurance company thousands per patient per procedure."

Some are adding 23-hour post surgical facilities to perform more complex procedures. New minimally invasive procedures allow patients to recover more quickly, and the surgery center is able to offer a more favorable nurse-to-patient ratio than the hospital for higher patient satisfaction.

"As technology advances and more physicians and surgeons are educated on technology, I see that performing spine cases will become more of a standard case in ASCs in the future than it is now," says Ms. Talton. "It's up and coming now, and I see it taking off rapidly in the future." ■

Contact Laura Miller at lmiller@beckershealthcare.com.

9 Tactics for Hospitals to Build Effective Surgery Center Joint Ventures

By Rachel Fields

Building a joint venture with a surgery center can be immensely useful for a hospital. The partnership can expand market share, build relationships with physicians, and create a low-cost, high-quality provider for patients seeking convenience. But the process towards symbiotic partnership can be tricky, and past tensions between hospitals and physicians can get in the way. Robert Carrera, president and CEO of Pinnacle III, discusses nine tactics for hospitals to build strong relationships with physicians as they move toward a joint venture partnership.

1. Present hard data on managed care contracting. One of the biggest challenges in building a joint venture between a hospital and physician group is gaining the trust of the physicians. If there is a history of poor communication or tense interactions between the two parties, the physicians will need a reason to trust the hospital and understand what it brings to the relationship.

Mr. Carrera says the hospital should present hard data on managed care reimbursement rates to prove the worth of the partnership to the physicians. "The hospital may have some lives they control that the ASC was previously unable to see," Mr. Carrera points out. "If it's a start-up ASC, there may be lives that could be contracted with that ASC." He says the hospital should present concrete data, rather than speaking in generalities about the upside the physicians may experience due to the partnership.

2. Investigate whether the hospital can direct referrals from primary care and occupational medicine physicians. In some cases, the hospital may be able to influence referrals from primary care or occupational medicine physicians who work with the facility.

"There's been some consideration from the OIG on how much influence the hospital can legally undertake," Mr. Carrera notes. "Legal advice varies. Some attorneys will tell you the hospital can only have so much influence while others will say the hospital is within its rights to exert as much influence as necessary."

He says it's important that the hospital investigate the level of influence it can exert, making sure to seek legal counsel. If the hospital can direct referrals towards the physicians in the surgery center, that flow of cases could boost the ASC's profitability.

3. Consider third-party management. Mr. Carrera asserts third-party management can go a long way toward reducing tension between a hospital and a physician group. "Third-party management is particularly useful if the relationship has been challenging in the past — or if it's been very good and they want to keep it that way," he says.

A management company functions as a neutral third party whose only concern is the performance of the center. Both parties can rely on the company to manage the ASC effectively without rehashing old issues. This is particularly helpful for hospitals that don't have prior experience running an ambulatory surgery center.

4. Address bad blood from the past. If the physician group and the hospital have come into conflict in the past, it's best to address those issues head-on, Mr. Carrera advises. "Physicians have long memories; so, good or bad, the hospital needs to be prepared to address any of the old issues upfront, because inevitably they will resurface," he says.

He notes when Pinnacle III goes into a hospital-physician joint venture, one of the first questions asked is if there are any interpersonal "landmines" to watch out for. The physicians and hospital administration should sit down (with the management company, if applicable) and talk candidly about any past problems and how to resolve them.

5. Involve C-suite executives in physician conversations. While mid-level managers in the hospital may start out the conversation about a joint venture, C-suite executives should be involved quickly, Mr. Carrera says. "From our hospital joint venture perspective, we have COOs, CEOs and CFOs involved in pretty much every one of our projects, and they occupy board positions in the new facilities," he states.

He says C-suite executives need to be present to give a sense of authenticity to discussions. "Physicians know who makes the big decisions, and they want to be dealing with those folks when they're looking at these projects," he says.

6. Determine how non-compete agreements will work. In some cases, hospitals and physicians sign non-compete agreements when they enter into joint ventures, meaning neither party can invest in an outside surgery center. Mr. Carrera says non-compete agreements can work in a number of ways: Either the physician group can have one, or the hospital can have one, or both, or neither.

He underscores it largely depends on the geography of the area and the presence of competing facilities in the market. "I think in most cases, the physicians are looking for equal treatment," he says. "If the doctors are going to be held to a non-compete, they feel the hospital should have an equal non-compete."

7. Decide whether the center will bring on new physician-investors. The hospital may have physicians who want to invest in the surgery center once the joint venture is established. Mr. Carrera says it's important to carefully consider every potential partner, as well as determine which physicians will be eligible for investment.

For example, the hospital may have employed physicians, who it may decide to exempt from possible ownership. "We've seen situations where the employed physicians are not allowed to have ownership, as well as situations where the hospitals say they can invest on their own," he says. In other cases, hospitals will allow some specialties to invest but not others.

8. Decide how cases will move from the hospital outpatient department to the surgery center. If the hospital is creating a joint venture surgery center from scratch, the hospital and physicians will have to move cases from its outpatient department into the ASC . He emphasizes it's important to work with the physicians to determine how cases will "ramp up" at the new facility.

"The hospital doesn't want to suddenly not have any cases," he says. "There's a transition process to be worked through." If the surgery center is planning to grow its case load over time, the hospital should determine the ultimate goal for case volume at the new center and work towards that number. Communication is the key to making this transition smooth.

9. Determine how the hospital's capital contribution will be used. "In a de novo situation, the physicians may want someone to share some of the risk," Mr. Carrera says. "The hospital may have good lending relationships, and they'll probably be looked at as credit-worthy for financing." This can assist the center in securing better financing. These funds will all go into start-up.

If the center is pre-existing and simply bringing on the hospital as a partner, the physicians may want to divest a portion of their ownership in order to experience a liquidity event. In other situations, it may be most prudent for the funds being infused by the hospital to be used for new equipment or to service debt.

Either way, the hospital can present an infusion of capital to the physicians as a reason for partnership. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

5 Steps for Surgeons to Resolve Liability Insurance Before Employment Transition

By Laura Miller

Here are five steps for spine surgeons to resolve medical liability and malpractice issues before becoming a hospital employee.

1. Purchase insurance to cover the "tail" after leaving physician practices. Most hospital systems are self-insured and most physicians are not. This must be reconciled when entering into an employment agreement. Medical liability claims are filed within a certain period of time after they occur. However, surgeons that become employed by hospitals usually cease their personal insurance coverage before the claim comes. In order to fix this situation, a physician will purchase a "tail" insurance policy that covers future claims from past acts.

"For most surgeons, if they are sued today for something that happened two years ago, their policy will cover it," says Tom Firestine of Calculated Risk Associates. "When they are leaving, there is a bucket of potential claims that could come from when they were in private practice, and hospitals don't want to bring outside exposure from the physician group onto their balance sheet."

The insurance policy is expensive and could become a bargaining chip between the physician and hospital.

"It comes up because when they are looking at the pool of compensation, insurance is going to be the biggest line item making this transition," says Mr. Firestine. "The hospital will give surgeons a large signing bonus and 90 percent will go to pay for the liability insurance. The more you can reduce that expense, the easier it will be for both sides to get the deal done."

2. Start looking for quotes early. The earlier surgeons can begin collecting quotes for insurance to cover the tail, the better position they will have at the negotiation table. In most cases, surgeons know they'll be making that transition months in advance, and they should take that time to do their research.

"The sooner you know this might happen, the better," says Mr. Firestine. "If you know you are going to take employment, start talking to insurance companies right then. The more time you have, the more you can prepare for this transition. Estimate the costs and negotiate these rates ahead of time. If you start looking two weeks before you become employed at the hospital, it's hard to get alternative quotes."

These policies can reach into six figures for an individual surgeon and potentially cost several million dollars for a larger group, so it's crucial to negotiate the best rate possible.

3. Pay attention to state-specific laws. Each state has different laws regarding liability insurance and medical malpractice, so work with someone who has a good understanding of the laws in your state. Some surgeons might require heavy coverage while others need less to safely make that transition.

"When you tail out of a standard insurance policy, some companies will offer a policy that lasts forever when you try to cover that tail," says Mr. Firestine. "You don't need that because most states have a statue of limitation on medical liability. You could work with someone who understands state laws to craft a policy so you aren't paying for more coverage than you need."

On the flip side, you don't want to purchase a policy that is so small it leaves coverage gaps. "When people look at your past insurance history, you don't want future employers to see an insurance gap that they could have a lawsuit over," says Mr. Firestine. "That slows the process and prevents the deal."

4. Understand the hospital's malpractice options. Spine surgeons should understand the hospital's malpractice options before signing the hospital contract and whether the hospital is self-insuring physicians. Around 80 percent of risk managers for hospitals employing physicians indicate that their hospitals self-insure their physicians, according to a recent study by Aon and the American Society of Healthcare Risk Management.

"This figure is up from last year and the fact that it continues to grow presents a unique set of challenges for hospitals that self-insure, including establishing and managing an adequate amount of capital assets to sufficiently address claims against physician employees," says Jack Meyer, senior vice president of The Doctors Company. "While the perception may be that self-insurance offers potential cost savings, unified claims defense and uniformity of system-wide risk management, there are challenges with so-called captives. The total financial commitment of the captive, as well as the commitment required of each member, can be significant."

The spread of losses over a small group of physicians is less predictable for insurers, so captives have to outperform the market. Spreading losses over a large group for a longer period of time is a more attractive option.

"Failure of any of the captive functions may cause the whole project to fail with physicians then running the risk of going bare and not being able to get prior acts coverage," says Mr. Meyer. "Physicians who retire and are concerned about the viability of a captive may need to consider tail coverage with an admitted insurer, which may not be available to them."

5. Look for key liability components in the fine print. Before signing the employment agreement, surgeons should run the contract through their legal team and pay close attention to the medical liability components. The hospital should cover the surgeon while employed and address what happens when the contract is up.

"When signing a contract that includes coverage for medical liability, surgeons should make sure that everything regarding the doctor's legal liabilities are clearly articulated upfront and run by legal counsel," says Mr. Meyer. "Surgeons should also make sure that if they leave the hospital's employment, the hospital will cover the claims exposure that they accrued while they worked there."

The physician should also make sure the hospital takes on liability for their practice's residual liability exposure and address adequate limits of liability, expenses outside of indemnity and financial solvency of the carrier, according to Mr. Meyer. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

6 Important Points on Recovery Audit Contractors

By Heather Linder

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 created the Recovery Audit Contractor Program to reduce improper Medicare payments, and since its inception, the program has collected more than $2.5 billion in overpayments, as of August 2012.

RACs will continue to crack down on Medicare payments this year, and their audits can be challenging for ambulatory surgery centers and healthcare providers. These government-contracted auditors are separated into four different regions across the country and paid a percent of the improper dollars they discover.

David Ebel, a director and senior CFO consultant at Warbird Consulting Partners, has more than 35 combined years of experience in finance and healthcare. He has worked with numerous healthcare facilities undergoing RACs.

Here are Mr. Ebel's six points on both avoiding and properly handling RACs.

1. Work toward complete documentation. The best line of defense is to get it right the first time, so physicians and coders should work to provide the most complete and accurate documentation and coding initially, especially with increased pressure from RACs.

Often issues singled-out by RACs are not fraud issues, but rather "judgment calls," Mr. Ebel says.

"It's possible for two different people with different motivations to look at the same data and say two different things," he says. "The more judgment involved, the more potential for disagreements."

Conflicting judgment calls cannot always be avoided, but extra vigilance with coding and billing claims can prevent some problems. Coders should strive to double check the diagnosis code, and physicians should include as much information as possible in the medical record. All parties should work to ensure claims support the work that was performed.

2. Know what RACs look for. RACs are limited to looking for issues they have specified in advance, though this is becoming less important, Mr. Ebel says.

The audit contractors must propose an issue to CMS, and once CMS agrees to it, it's posted online. Initially this list of focuses was helpful to healthcare providers, but now the list has grown exponentially.

"It doesn't help much to know the areas because it's almost covering waterfront," he says.

Despite the growing list of concerns, surgery centers and physicians should be aware of the RACs' main areas of interest and pay particular attention to avoiding those obvious pitfalls.

3. Be tough and transparent. To protect yourself or your practice from undue RAC attention, be the hardest dollars the contractors collect, Mr. Ebel says. Maintain the attitude that all of your billing decisions were worthy and correct, rather than doubting them as soon as an auditor questions the legitimacy.

"Your posture needs to be, 'Of course the coding is right. Of course the surgery was necessary,'" he says. "Tell them why you think whatever they are denying is in fact appropriate."

Don't second guess your decisions. ASCs that are quicker to back down on their billing judgment calls are quicker to get fined by audit contractors.

While being firm, centers should also be fully cooperative and transparent. If you participate in Medicare, you are legally obligated to provide RACs with the claims they request. Contractors are allowed to request up to 400 medical records to review every 45 days.

"You have to provide them with records," he says, "but the general principle is if you don't want a lot of attention, you want to be the hardest dollars they find."

4. Appeal all disputed claims. If an RAC brings any of your records into question, then the hardest decision should be not to appeal the denial, Mr. Ebel says, rather than why to appeal a case.

Many centers make the mistake of leaving the decision to appeal up to the coder, who may not want to expend the effort required for an appeals process, he says. The surgery center owners should intervene and insist all denials are defended.

"It is important to be sure your process is oriented toward defending what you have done until it's indefensible," he says. "There is effort involved, but it means you are the tougher dollars, and it will serve you well in the long run."

ASCs have many options for disputed claims. If a recovery contractor does not agree with your defense, the next step is a qualified independent reviewer. If the reviewer does not side with your case, then an administrative law judge can look at it. The next step is to take it to district court.

Government statistics show appeals have a 90 percent denial rate, but, according to Mr. Ebel, that number is misleading. Each level of a single appeal is counted as a separate denial, even if is the same case. Often, appeals are overturned and never reach the point of being ultimately successful. "The record is much closer to 75 percent of appeals being ultimately successful," he says.

There are obvious costs involved in undergoing an appeal, but it can be a good investment for centers being asked for large recovery payments.

5. Scour for additional supporting information. Any center pursuing an audit appeal needs to dig for additional supporting information that may not have been included in the submitted claim.

This information can include an office backup record, a nurse's notes, or anything else not taken into consideration by the auditor.

The first step should always be to go back to the attending physician and other clinical people involved. The administrator should find out if any details were left out of the report — or if staff members or physicians have notes to further support the claim.

"We ought to be looking at why shouldn't we appeal this," Mr. Ebel says, "rather than scouring records for things that might justify the denial."

6. Consider financial ramifications. ASCs choosing to undergo an appeals process should be aware that any money being solicited by the RACs will accrue interest while an appeal is underway.

Centers have the option to either pay back the requested money prior to appealing, with funds being restored for a successful appeal, or to hold off on a repayment until after the appeal concludes.

"You need to look at it closely," Mr. Ebel says. "If your appeal probabilities are not very strong, you may want to pay it back. In other cases, you know you are right, and you are not going to pay it back."

Consider it on a case-by-case basis, while keeping in mind that those interest rates for large sums of money may be significant. ■

Contact Heather Linder at hlinder@beckershealthcare.com.

5 Steps to Better Patient Collections at Surgery Centers

By Laura Miller

Here are five steps to increase patient collections at ambulatory surgery centers from Jim Devitt, an expert in healthcare revenue cycle management.

1. Devise a defined collections policy. It's crucial for surgery centers to have a defined collections policy that patients understand even before they arrive at the surgery center. If the patient knows what their responsibilities are and when payment is due, the ASC is more likely to collect.

"The ASC should have a written set of policies and procedures about handling the account from cradle to death," says Mr. Devitt. "There are some people coming in with $5,000 deductibles and you must have a policy from the minute they walk through the door on how you are going to handle collections."

Place importance on working with the patients for quick and easy payments. "It can be done in a nice way that keeps it clear and simple for the patients," says Mr. Devitt. "Define what is acceptable and what is past due. You may see some practices that keep billing statements 10 months after services are delivered, and that's a problem. Focus on patient responsibilities and the actionable steps you will take to collect."

In the policy, define how many written notices or letters patients will receive, how returned mail is handled and when statements are due. If you are too busy to manage the revenue cycle and go after delinquent patients, consider outsourcing these services.

2. Revise billing statements. Many surgery centers don't invoice patients properly or include unclear wording in their business statements. One of the biggest downfalls in billing statements is the breakdown of the aging budget; people see this and assume the payment isn't due until the last payment date.

"Shift statements to leave out the aging and include a specific date for the next payment," says Mr. Devitt. "Many practices also say the payments are due upon receipt. Patients think this means they can pay whenever they want."

Some surgery centers have trouble tracking down patients who move. These centers can use an address service request — a free service with the post office — which forwards the statement to the patient's new address. The post office will update you when the patient moves so you'll have the new address as well.

3. Go after late payments early. Surgery centers need to pursue late payments aggressively. The defined collections policy should outline a certain set of actions that occur when payments are late and ASCs must take these steps immediately.

"If you look at the research, the more you contact a person on the front end for payment, the better chance you have of getting paid," says Mr. Devitt. "It's unacceptable to send a statement every 30 days. You need a system with more contact early on in the process."

ASCs can't always have in-house operations pursuing these patients, but there are affordable systems available to automate this process. Ideally, ASCs should contact patients up to five times per month for payment. If this is not realistic, ASCs should consider outsourcing to focus on these collections.

4. Make appropriate phone calls for payments. The recent Consumer Protection Act prevents practice from contacting patients via cell phone unless they have specific permission to call that number. The problem is that people can switch cell phones or numbers and then the debt collectors are calling someone else. Become familiar with the Consumer Protection Act and set goals for the patients who you are able to call.

"Most people sit down and make the phone call and say 'You owe us money,' when someone picks up," says Mr. Devitt. "Instead, have a set of steps to reach a specific goal, like a payment plan, and discuss the patient's expectation of pay. There is a whole cascading process here that you should have in place. When dealing with the patient, make a connection and actively listen to them for clues about their situation to develop the best payment plan possible."

When going after delinquent payments, the ASC staff must be compassionate but also have a solution. Help the patient feel like they are not alone — there are several others who hare having difficulty paying — and work with them on the solution.

5. Train staff in money collection. Staff members at the surgery center should have special training to understand the rules and regulations of payment collection. If a mistake is made, the ASC must admit to it and work with the patients to make it right.

"The worst thing that could happen is the ASC tries to twist the mistake so fault falls on the patient," says Mr. Devitt. "If you make a mistake, admit it and correct it. Otherwise they could write a negative review on social media websites. Keep your patients happy and you'll drive increased patient volume."

If you are unable to collect from the patient, bring in a third party experienced at collecting this type of debt. "For some patient debtors, as soon as the third party is implemented, they will pay," says Mr. Devitt. "Sometimes people become very savvy in how to deal with payments and they know their credit won't be hit until they see the third party involved."

Third party contractors may accept a flat rate for working on the claims or take around 33 percent of collections. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

7 Priorities for ASCs and Anesthesiologists in 2013

By Rachel Fields

Meena Desai, MD, founder, president and CEO of Nova Anesthesia Professionals, discusses seven priorities for anesthesia providers and surgery centers in 2013.

1. The rise of accountable care organizations. Accountable care organizations are expected to play a greater role in healthcare over the next few years, as President Obama's administration continues implementation of the healthcare reform law. While there is no standard model for ACOs as of yet, the general idea is that the model would tie provider reimbursements to quality metrics and reductions in cost of care for an assigned patient population.

The facilities best-positioned for this change are probably large health systems, which can track a patient's care over a larger continuum than a practice or surgery center — and work with payors to negotiate rewards for improving outcomes. But Dr. Desai says surgery center providers need to think about their place in ACOs as well. "The bigger the hospital system you are associated with, the more likely you are to be incorporated into the ACO, "she says. "If you're part of a very small physician group, you might be left out in the middle of nowhere."

Though they may not have the clout to enter ACOs without hospital partnership, surgery centers are uniquely positioned to succeed in an accountable care organization. Small practices and ASCs are used to operating on a tight budget while providing high-quality outcomes; because their volume depends so heavily on referrals and reputation, they can't afford to make mistakes or waste money. This may prove useful as hospitals look for partners that can keep costs down while boosting quality metrics.

2. Measurement of quality outcomes. "The measurement of quality metrics and outcomes is going to be crucial, and anybody who is not doing that well needs to focus on it," Dr. Desai says. "I don't mean the 'mom and pop' measurements. You need to have a computer system that can provide sophisticated measures." She says measuring quality outcomes is very different for surgery centers and hospitals. Instead of looking at mortality and forms of morbidity such as heart attack and stroke, surgery centers are more concerned with patient satisfaction, speed of return to normal function and post-operative nausea and vomiting.

So far, there are only a few measures that Medicare requires surgery centers to track — in 2013, ASCs will be required to report instances of patient burn, falls, wrong site/side/patient/procedure/impact, hospital admission/transfer, antibiotic timing, safe surgery checklist use and volume of certain procedures.

Dr. Desai says surgery center should not stop with the Medicare requirements, since there are other benchmarks that can tell a lot about quality and patient satisfaction. "We are looking into what we can do about nausea and vomiting rates," she says. "Some surgery centers have rates as high as 30 percent, and others as low as 5. There is talk of putting a nausea score on everyone who comes into the center, so you know if you should do multimodal pain management." She says the Society of Ambulatory Anesthesia

has developed a database called SCOR that contains many different metrics against which anesthesiologists can benchmark their outcomes.

3. The disappearance of hospital stipends. Anesthesia practices that currently run on a hospital stipend may face the disappearance of those dollars, Dr. Desai says. "Generally the rule is, the more inefficient the hospital, the more the stipend," she says. "The stipend can range from 2 percent to 30 percent of hospital income, which means millions of dollars at some of these larger institutions." She says anesthesia practices should prepare for those stipends to be reduced or go away, meaning practices will have to run more efficiently in order to survive.

She says the easiest area to target for cost reduction is anesthesia staffing inefficiencies. "If your OR utilization of staff is not greater than 70-75 percent, you're not going to make it based on your own professional billing in most payor mixes," she says. She says practices should be looking at any "downtime" in the facility: What time are people arriving in the morning, what time are they leaving, and how quickly are they moving patients through the practice? "Every minute adds up to a lot of minutes over the year," she says.

4. Becoming indispensible as anesthesiologists. Dr. Desai says in 2013, anesthesiologists are going to have to become indispensible by integrating themselves into the organizations they work for. She says it's critical for anesthesiologists to become valuable as facilities move towards more integrated physician models and collaborative care. "We are the physicians on site every day, so we have to assume a leadership role," she says. "Even when surgeons are owners, they come and go. Hospital administrators come and go. Whether or not we want to go to committee meetings, we have to."

She calls anesthesiologists the "invisible provider" — the physician that is there for every case but that no one notices. She says anesthesiologists must work on becoming service-oriented, offering ideas and projects to the institution to make sure patient care is as high-quality as possible.

5. Drug shortages. Drug shortages are still plaguing facilities across the country, with up to 98 percent of participants in an American Society of Anesthesiologist survey reporting drug shortages in their facilities. Dr. Desai says despite efforts by the ASA and the federal government to relieve shortages, no easy answer is in sight. This means anesthesiologists must take initiative to set par levels and make sure necessary drugs are on hand for surgery.

She says anesthesiologists are also essential in a facility to designate substitutes for drugs the facility cannot attain. "These all need to be outlined ahead of time, since they might not be the drugs we typically use," she says. She adds that pre-op and post-op staff must be educated on the differences in side effects, since patients must be warned about the recovery experience.

6. Reducing anesthesia variability. Dr. Desai says it's important for anesthesia providers to work to reduce variability in their practice. This means that if a practice includes several different physicians, they may have different processes, recommendations and policies. For example, they may disagree on which patients are appropriate for treatment in an outpatient facility — how obese they can be, how many comorbidities they can have, etc. "You need to have a consensus among your providers," she says.

7. Peer review. A lot of anesthesia groups aren't willing to be involved in peer review, Dr. Desai says. "It's simply work, and they don't want to review the charts or set up their parameters," she says. She says anesthesiologists have to be willing to do peer review, since asking another specialty to monitor anesthesia performance is dangerous and ineffective. She says getting involved in peer review will also engage anesthesiologists in the metrics used by their facilities and the government. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

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- 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
- Spine Surgery - The Next Five Years - David J. Abraham, MD, The Reading Neck & Spine Center, Johnny C. Benjamin, MD, Pro Spine, Khawar Siddique, MD, MBA, Spine Surgery, Board Certified, American Board of Neurosurgery, Spine Center, Cedars-Sinai Medical Center, and Rafe Sales, MD, Summit Spine Institute, moderated by Gretchen Heinze Townshend, Associate, McGuireWoods LLP
- 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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PROGRAM SCHEDULE

Pre Conference – Thursday, June 13, 2013

11:00 - 5:00 pm	Registration Open
11:30 - 4:30 pm	Exhibitor Set Up
12:30 - 5:45 pm	Pre-Conference Sessions
5:45 - 7:00 pm	Reception, Cash Raffles and Exhibits

Main Conference – Friday, June 14, 2013

7:00 - 8:00 am	Continental Breakfast and Registration
8:00 - 5:00 pm	Main Conference, Including Lunch and Exhibit Hall Breaks
5:00 - 6:00 pm	Reception, Cash Raffles and Exhibits

Conference – Saturday, June 15, 2013

7:00am – 8:00am	Continental Breakfast and Registration
8:10am – 12:20pm	Conference

Thursday, June 13, 2013

11:00 – 4:30 PM
Registration and Exhibitor Set up

Concurrent Sessions:
Track A - Improving Profits
Track B - Spine
Track C - Pain Management and Spine
Track D - Orthopedics
Track E - Business and Profitability Issues; Revenue Cycle; Managed Care Billing, Coding and Contracting for ASCs
Track F - Quality, Infection Control, Accreditation, Management

12:30 – 1:10 PM

A. Keys to Keeping Surgery Centers Profitable Business
Robert Zasa, MSHHA, FACMPE, Managing Partner and Founder, ASD Management, Doug Golwas, Senior Vice President, Medline Industries, Inc., Michael J. Lipomi, President & Chief Executive Officer, Surgical Management Professionals, Jimbo Cross, Vice President Acquisitions & Development, Ambulatory Surgical Centers of America, moderated by Barton C. Walker, Partner, McGuireWoods LLP

B. Business Planning for Spine Driven Centers
Jeff Leland, Chief Executive Officer, Blue Chip Surgery Center Partners

C. Managing Pain Practice-Protocols, Branding and Other Tips to Improve Profitability
Vishal Lal, Chief Executive Officer, Advanced Pain Management

D. Bundled Contracting Inititiaves for Orthopedics and Spine
Marshall Steele, MD, Medical Director, Stryker Performance Solutions

E. Key Trends in Valuing Practice Acquisitions
Aaron Murski, Senior Manager, VMG Health

F. Developing the Right Clinical Environment for Complex Spine and Orthopedic Cases
Linda Lansing, Senior Vice President Clinical Services, Surgical Care Affiliates

1:15 – 1:55 PM

A. ASC Roundtable: Outlook for Investment and M&A Activity in the ASC Sector
Michael Stroup, Vice President of Business Development, United Surgical Partners International, Inc., Matt Searles, Managing Director, Merritt Healthcare, and Todd J. Mello, ASA, AVA, MBA, Partner, HealthCare Appraisers, Inc., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Moving Spine Procedures to ASCs- Key Business and Clinical Issues
Paul Schwaegler, MD, Seattle Spine Institute, PLLC, Richard Kube, MD, Chief Executive Officer, Founder & Owner, Prairie Spine & Pain Institute, moderated by Jeff Leland, Chief Executive Officer, Blue Chip Surgery Center Partners

C. Interventional Pain Management - New Concepts to Reduce ER Visits, Hospitalizations and Re-Admissions
Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

D. 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

E. Benchmarking the Financial Solvency of an ASC
Rajiv Chopra, Principal and Chief Financial Officer, The C/N Group

F. Risk Management as Applied to Adding Spine Procedures
Carol Hiatt, BSN, RN, LHRM, CASC, CNOR, Consultant and Accreditation Surveyor, Healthcare Consultants International

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2:00 – 2:35 PM

A. Utilizing Spine Cases to Improve the Profitability of Underutilized Poorly Performing ASCs

Chris Bishop, Senior Vice President, Acquisitions & Business Development, Blue Chip Surgery Center Partners

B. The Best Ideas for Marketing Spine and for Patient Development

Jimmy St. Louis, MBA, MS, PMP, Chief Executive Officer, Advanced Healthcare Partners, Bob Reznik, MBA, President, Prizm Development, Inc., Jeff Leland, Chief Executive Officer, Blue Chip Surgery Center Partners, Daniel Goldberg, Chief Executive Officer and Creative Director, Gold Medical Marketing, moderated by Peter S. Cunningham, President, CCO Healthcare Partners, LLC

C. Regional Market Strategies for Pain Management

Robin Fowler, MD, Chairman and Medical Director, Interventional Management Services, Stephen Rosenbaum, Chief Executive Officer, Interventional Management Services

D. Emerging Orthopedic Procedures in ASCs - Business and Clincial Issues

Michael R. Redler, MD, The OSM Center

E. Turnaround - Success Stories From the Field

Joseph Zasa, Co-founder and Managing Partner, ASD Management

F. Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs

Steven A. Gunderson, DO, Chief Executive Officer, Medical Director, Rockford Ambulatory Surgery Center, Accreditation Association for Ambulatory Health Care

2:40 – 3:15 PM

A. 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

B. Deuk Laser Disc Repair® as a Novel, Safe and Effective Solution for Symptomatic Cervical Disc Disease

Ara Deukmedjian, MD, Chief Executive Officer and Medical Director, Deuk Spine Institute

C. Intradiscal Biologics Injections for Mild to Moderate Degenerative Disc Disease

Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration Santa Monica, CA, President/CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, Spalding Surgery Center, Beverly Hills, CA, Board of Directors, American Board of Neurophysiologic Monitoring

D. Key Steps to Improve Profits in Orthopedic Driven ASCs

Rajiv Chopra, Principal, The C/N Group, Gregory P. Deconciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites, and Brian Brown, Regional Vice President of Operations, Meridian Surgical Partners, moderated by Molly Gamble, Associate Editor, Becker's Healthcare

E. ACO Network Models - Trends and Considerations

Thomas Dixon, Associate Director, Health System Strategy and Kara Fleming, Director, Healthcare, Navigant

F. Infection Control in ASCs - 10 Key Best Practices

Jean Day, RN, CNOR, Director of Clinical Operations, Pinnacle III

3:20 – 4:00 PM

KEYNOTE PANEL

A. 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

B. The Best Strategies for the Next 5 Years

Brent W. Lambert, MD, FACS, Principal and Founder, Luke Lambert, CFA, CASC, Chief Executive Officer, Ambulatory Surgery Centers of America, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

C. The Evolution of EMR - What Works for ASCs Today and How Can You Realize an ROI

Robert Brownd, Director of Business Development, Surgical Notes

D. Valuing ASCs and Physician Practices

Todd Mello, ASA, AVA, MBA, Partner, HealthCare Appraisers, Inc.

E. Great Ideas on Purchasing Smarter

Jon Pruitt, Vice President of Procurement Solutions, Provista Inc. and Robert Haze, Administrator, Institute for Orthopaedic Surgery in Las Vegas

F. Using Reprocessing to Reduce Costs

Timothy Merchant, Vice President of Sales, MEDISISS - Medline Industries, Inc.

4:05 – 4:50 PM

KEYNOTE PANEL: 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, Texas Spine and Joint Hospital, moderated by Brad Gilbert, former Professional Tennis Player, World-Renowned Tennis Coach and Analyst for ESPN

4:55 – 5:45 PM

KEYNOTE: Victory Through Teamwork and Leadership

Coach Michael Krzyzewski "Coach K", Head Men's Basketball Coach, Duke University and Winningest Coach in NCAA Division I Men's Basketball History

5:45 – 7:00 PM

Networking Reception, Cash Raffles and Exhibits

Friday, June 14, 2013

7:00 – 8:00 AM

Registration and Continental Breakfast

8:00 – 8:10 AM – Introductions

8:10 – 8:55 AM

KEYNOTE PANEL: 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, veteran Television Journalist and Entrepreneur in Innovative Healthcare

9:00 – 9:45 AM

KEYNOTE PANEL: 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

9:45 – 10:15 AM

Networking Break and Exhibits

Concurrent Sessions:
Track A - Improving Profits, Valuation and Transaction Issues
Track B - Spine
Track C - Pain Management & Spine
Track D - Orthopedics and Pain Management
Track E - Business and Profitability Issues; Managed Care and Contracting for ASCs
Track F - Quality, Infection Control, Accreditation, Management

10:15 – 10:55 AM

A. The Quantum Shift in Orthopedic and Spinal Implant Strategy
James J. Lynch, MD, FRCSI, FAANS, Board-Certified and Fellowship-Trained Spinal Neurosurgeon, Spine Nevada

B. Key Concepts to Improve the Profitability and Outcomes of Spine Programs
Kenneth Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center, Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, Larry Teuber, MD, President, Medical Facilities Corporation, and Stephen H. Hochschuler, MD, Texas Back Institute, moderated by Scott Becker, JD, CPA,. Partner, McGuireWoods LLP

C. 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, Nancy Bratanow, MD, Midwest Comprehensive Pain Center, moderated by Barton C. Walker, Partner, McGuireWoods LLP

D. The Best Ideas for Orthopedics Now
Blair Rhode, MD, ROG, Sports Medicine, Orland Park Orthopedics, Jack M. Bert, MD, Adjunct Clinical Professor, University of Minnesota School of Medicine, Cartilage Restoration Center of Minnesota, Minnesota Bone & Joint Specialists, Ltd., Michael Redler, MD, The OSM Center, Moderator, Amber McGraw Walsh, Partner, McGuireWoods LLP

10:15 – 11:35 AM

E. Cost Reduction and Benchmarking, 10 Key Steps to Immediately Improve Profits
Robert Westergard, CPA, Chief Financial Officer, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, Senior Vice President of Operations, Ambulatory Surgical Centers of America

10:15 – 10:55 AM

F. Designing and Implementing High Performing Orthopedic Centers of Excellence
Marcia A. Friesen, RN, BS, HIA, MHP, FAIHQ, FACHE, President, Orthopedic Advantage Healthcare Consulting, LLC

11:00 – 11:35 AM

A. Selling Your Practice or ASC, Valuation, Compensation, Non Competes Legal and Process Issues
Greg Koonsman, Senior Partner, VMG Health and Jack M. Bert, MD, Adjunct Clinical Professor, University of Minnesota School of Medicine, Cartilage Restoration Center of Minnesota, Minnesota Bone & Joint Specialists, Ltd., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Spine Surgery - The Next Five Years
David J. Abraham, MD, The Reading Neck & Spine Center, Johnny C. Benjamin, MD, Pro Spine, Khawar Siddique, MD, MBA, Spine Surgery, Board Certified, American Board of Neurosurgery, Spine Center, Cedars-Sinai Medical Center, and Rafe Sales, MD, Summit Spine Institute, moderated by Gretchen Heinze Townshend, Associate, McGuireWoods LLP

C. The Importance of Measuring Clinical Outcomes for Pain Management - The Use of Clinical Quality Outcomes to Measure the Best Value of Care
Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

D. Tough Coding & Billing Issues for Pain Management
Lisa Rock, President, National Medical Billing Services

F. Optimizing Case Mix for Profit and Growth
Julie Bell, Administrator, Hawthorne Surgical Center, Rob Midelton, Director, Strategy, Surgical Care Affiliates, and Robert Dugan, MD, Orthopedic Surgery, Hawthorne Surgical Center

11:40 – 12:20 PM

KEYNOTE - Talent is Overrated
Geoff Colvin, Senior Editor-At-Large, FORTUNE Magazine and Author, *Talent is Overrated*

12:25 – 1:05 PM

KEYNOTE PANEL:
Frank Phillips, MD, Rush University Medical Center, Midwest Orthopaedics, Tom Mallon, Chief Executive Officer and Founder, Regent Surgical Health, John Peloza, MD, Director, Center for Spine Care, moderated by Geoff Colvin, Senior Editor-At-Large, *FORTUNE* Magazine and Author, *Talent is Overrated*

1:05 – 1:55 PM
Networking Lunch and Exhibits

1:55 – 2:35 PM

A. New Initiatives in Spine and Pain Management
Robert S. Bray, Jr., MD, Neurological Spine Surgeon, D.I.S.C. Sports & Spine Center, Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine, ProCare Research, ProCare Systems, John A. Carrino, MD, MPH, Associate Professor of Radiology and Orthopedic Surgery, Johns Hopkins University School of Medicine, and Laxmaiah Manchikanti. MD, Chief Executive Officer and Chairman of the Board, American Society of Interventional Pain Physicians, Moderator Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Outpatient Cervical Disc Arthroplasty
Richard N.W. Wohns, MD, JD, MBA, South Sound Neurosurgery, PLLC

C. The Latest Development in Stem Cell Treatments as Applied to Spine
Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center

D. How a Hospital/Physician ASC JV Affects Physician Alignment and Investment Performance
Tom Mallon, Chief Executive Officer and Founder, and Jeffrey Simmons, Chief Development Officer, Regent Surgical Health

E. Orthopedic and Spine Contracting - A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors
I. Naya Kehayes, MPH, Managing Principal and Chief Executive Officer

F. Developing a Patient-Centric Business Model: Why Your ASC Needs to Put Patients First to Thrive in 2013
Dotty J. Bollinger, RN, JD, CASC, LHRM Chief Operating Officer, Laser Spine Institute

2:40 – 3:10 PM

A. Evolving Business, Clinical and Competitive Issues in Spine and Pain
John Prunskis, MD, FIPP, President and Medical Director, Illinois Pain Institute, Ara Deukmedjian, MD, Chief Executive Officer and Medical Director, Deuk Spine Institute, moderated by Holly Carnell, Associate, McGuireWoods LLP

B. Comparing the Reimbursement of Spine Procedures in ASCs vs. Hospitals
Richard N.W. Wohns, MD, JD, MBA, South Sound Neurosurgery, PLLC

C. Can ASCs Still Profit From Anesthesia? A Review of OIG Guidance, Models and Risks
Michael Simon, MD, North American Partners in Anesthesia, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

D. The 5 Most Important Issues Facing Pain Management
Laxmaiah Manchikanti. MD, Chief Executive Officer and Chairman of the Board, American Society of Interventional Pain Physicians

E. Orthopedics and Spine - Best Clinical Practices
David Rothbart, MD, FACS, FACPE, Medical Director, Spine Team Texas

F. The Conversion of an ASC to an HOPD - The Key Issues, The Pros and Cons and the Process
Kenneth Faw, MD, Evergreen Surgery Center, Neil Johnson, Senior Vice President and Chief Operating Officer, Evergreen Healthcare

3:10 – 3:40 PM
Networking Break & Exhibits

3:45 – 4:20 PM

A. Developing a Spine Driven ASC: The Essentials for Success
Kenny Hancock, President and Chief Development Officer, Meridian Surgical Partners

B. Complex Cervical Spine - Key Developments
Krzystof (Kris) Siemienow, MD, Adult and Pediatric Spine Surgery, Lutheran General Hospital, University of Illinois at Chicago

C. Getting Started with Spine Surgery in ASCs - 6 Key Concepts
John Peloza, MD, Director, Center for Spine Care

D. Intraoperative Monitoring for Spine Cases in the ASC Setting - Understanding the Technology and What a Surgery Center Should Pay for and Should Not Pay For
Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration

E. Assessing the Profitability of Orthopedics and Spine Cases
Andrea Woodell, Director of Managed Care and Matt Lau, Corporate Controller, Regent Surgical Health

F. Changing Anesthesia Providers - The Playbook for a Simple and Sustainable Transition
Charles Militana, MD, Director of Ambulatory Surgery Centers, North American Partners in Anesthesia, Dorothy & Alvin Schwartz Ambulatory Surgical Center, North American Partners in Anesthesia

4:25 – 5:00 PM
A. Physician Partnership Models
Christian Ellison, Vice President, Health Inventures, LLC

B. Current Issues in Minimally Invasive Spinal Surgery
Raqeeb M. Haque, MD, Columbia University Medical Center

C. New Concepts in Prescribing Opioids
Carlos Roman, MD, Arkansas Specialty Orthopaedic Surgery Center and Pain Care Center

D. Key Developments in the Spine Device and Implants Arena
Frank Phillips, MD, Rush University Medical Center, Midwest Orthopaedics and Nameer R. Haider, MD, Spinal & Skeletal Pain Medicine, moderated by TBD

E. Debunking the Myths of Out-of-Network Reimbursements
John Bartos, JD, Chief Executive Officer, Collect Rx

F. Emerging Issues in ASC and Healthcare Litigation
Jeffrey Clark, Partner, Richard T. Greenberg, Partner, David J. Pivnick, Associate, and James J. Schanaberger, Associate, McGuireWoods LLP

Roundtable Discussions
10:15 - 10:55 am
How Should Orthopedic Surgeons View Their Relationship With Their Center? Convenient, Financial and/or Clinical
Gregory P. DeConciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites, LLC, and Anthony Schena, MD, Orthopedic Surgeon

11:00 - 11:35 am
The 5 Most Common Hiring Mistakes and How to Avoid Them
Greg Zoch, Partner & Managing Director, Kaye Bassman

1:55 - 2:35 pm
Educating Your Staff Surgeons, What it Costs the ASC When They Enter the OR
Sev Hrywnak, MD, Chief Executive Officer, The Sev Group, LLC

2:40 - 3:10 pm
Orthopedic Instrumentation and Its Challenges for Reprocessing
Stephen Kovach, Educator, Healthmark Industries

3:45 - 4:20 pm
Documentation in an Era of ICD-10 and RAC
Tim Meakem, MD, Medical Director, ProVation Medical

4:25 - 5:00 pm
Electrical Anesthesia - A New Era in Pain Management
Frank Kousaie, MD, Crystal Clinic

5:00 – 6:00 PM
Networking Reception, Cash Raffles & Exhibits

Saturday, June 15, 2013

7:15 – 8:10 am – Continental Breakfast

8:10 – 8:55 AM
A. Orthopedic, Spine and Pain Management Practices and ASCs - 6 Defining Issues
R. Blake Curd, MD, Board of Directors Chairman, Surgical Management Professionals, C. David Geier, Jr., MD, Orthopedic Surgeon, Director, MUSC Health Medical University of South Carolina, Carlos Roman, MD, Arkansas Specialty Orthopaedic Surgery Center and Pain Care Center, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

B. Will Non Physicians Compete Aggressively with Pain Management Physicians- Key Legislative and Business Issues
Graf Hilgenhurst, MD, Chief Physician and Founder, Precision Pain Care

C. ACOSs and the ASC, How to Prepare to Enter One
Sev Hrywnak, MD, Chief Executive Officer, The Sev Group, LLC

D. Maximize and Leverage Your Vendor Relationships
Arthur Casey, BSBA, CASC, Senior Vice President of Business Development, Outpatient Healthcare Strategies, President, Board of Ambulatory Surgery Certification

8:55 – 9:30 AM
A. Recovery Care Services in Orthopedic and Spine ASCs
John D. Newman, Senior Vice President and General Counsel, Constitutional Surgical Centers

B. Legal Aspects of Spine Surgery
David Shapiro, MD,CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

C. The Emerging Use of Social Media in Orthopedics
C. David Geier, Jr., MD, Orthopedic Surgeon, Director, MUSC Health Medical University of South Carolina

D. Three Strategies to Control Labor Cost at Your Surgery Center
Thomas H. Jacobs, President & Chief Executive Officer, MedHQ

9:35 – 10:10 AM
A. Vendor Market Intelligence - An Industry Overview of ASCs
Susan E. Charkin, MPH, President, Healthcents, Inc.

B. New Advances in Sacroiliac Joint Problems
Richard A. Kube, MD, Chief Executive Officer, Founder & Owner, Prairie Spine & Pain Institute

C. Anesthesia For Outpatient Spine Surgery
David Paly, MD, Board Certified in Pain Medicine and Anesthesiology, South Sound Neurosurgery Brain & Spine Center

D. Key Tips for Quality Assurance and Infection Prevention
Nicole Gritton, MSN/MBA, Director of Nursing, Laser Spine Instutute

10:15 – 10:50 AM
A. How to Achieve Significant Savings With a GPO: Q & A
Amy Gagliardi, Vice President, Supply Chain, Regent Surgical Health

B. How Doctors Form ACOs - A Success Story
John Venetos, MD

C. 5 Key IT Issues for ASCs and Practices
Todd Logan, Vice President, Sales, Western Region, Source Medical Solutions

D. 15 CPT and Coding Issues for Orthopedics and Spine
Stephanie Ellis, RN, CPC, Owner and President, Ellis Medical Consulting, Inc.

10:55 – 11:30 AM
A. Handling the Crises with Compounding Pharmacies
Faisal Rahman, PhD, Chief Executive Officer and President, APAC Partners, LLC

B. Cervical Myelopathy
Fernando Techy, MD, Adult & Pediatric Spine Surgery, Lutheran General Hospital, University of Illinois at Chicago

C. Joint Ventures, What Works and What Fails
Katherine Lin, Associate, Helen Suh, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

11:35 – 12:20 PM
Key ASC Legal Issues for 2013
Scott Becker, JD, CPA, Partner, Holly Carnell, Associate, Gretchen Heinze Townshend, Associate and Katherine Lin, Associate, McGuireWoods LLP

12:20 PM – Meeting Adjourns

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- Keynote Mike Krzyzewski "Coach K" Head Men's Basketball Coach, Duke University and Winningest Coach in NCAA Division I Men's Basketball History
- Keynote Geoff Colvin, Senior Editor-at-Large *FORTUNE* Magazine and Author, *Talent is Overrated*
- Keynote panels led by Forrest Sawyer, Television Journalist and Entrepreneur in Innovation Health Care, and Brad Gilbert, former Professional Tennis Player, World-Renowned Tennis Coach and Analyst for ESPN
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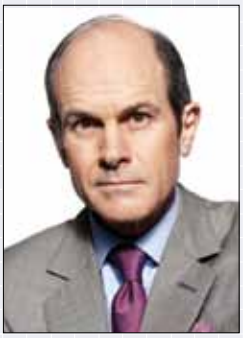
Mike Krzyzewski

Head Men's Basketball Coach, Duke University and Winningest Coach in NCAA Divisoin I Men's Basketball History

As head coach of the Duke Blue Devils for over 30 years, Basketball Hall of Famer coach Mike Krzyzewski has made a career of motivating people both on and off the court. Affectionately known as "Coach K," Krzyzewski coached both the 2008 and 2012 U.S. men's national teams to back-to-back gold medals in the Olympics. During his tenure as the head coach of Team USA, Coach K amassed an astounding 62-1 and returned U.S. men's basketball to dominance on the world stage.

In 2011, *Sports Illustrated* named Krzyzewski its Sportsman of the Year. In 2009, *Sporting News* also named Krzyzewski one of the 50 greatest coaches in any sport of all time. Krzyzewski also has an impressive resume as a best-selling author including *Leading with the Heart* which reached *The New York Times* best seller list in 2000. His two most recent books *Beyond Basketball: Coach K's Keywords for Success,* released in 2006, and *THE GOLD STANDARD; Building a World-Class Team*, released in 2009, were co-authored by his youngest daughter, Jamie Spatola



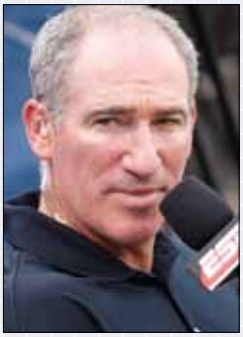
Geoff Colvin

Senior Editor-at-Large, *FORTUNE* Magazine and Author, *Talent is Overrated*

Geoff Colvin is an award-winning thinker, author, broadcaster, and speaker on today's most significant trends in business. As FORTUNE's Senior Editor-at-Large, he has become one of America's sharpest and most respected commentators on leadership, globalization, wealth creation, the infotech revolution, and related issues. As anchor of *Wall Street Week with FORTUNE* on PBS, he spoke each week to the largest audience reached by any business television program in America.

Colvin's groundbreaking bestseller *Talent Is Overrated: What Really Separates World-Class Performers From Everybody Else* received the Harold A. Longman Award for Best Business Book of the Year and has been published in a dozen languages.

Colvin is one of America's preeminent business broadcasters. He is heard daily on the CBS Radio Network, where he has made over 10,000 broadcasts and reaches seven million listeners each week. He has appeared on *Today*, *The O'Reilly Factor*, *Good Morning America*, *Squawk Box*, *CBS This Morning*, ABC's *World News*, CNN, PBS's *Nightly Business Report*, and dozens of other programs.



Brad Gilbert

Brad Gilbert is a former professional tennis player, world-renowned tennis coach and analyst for ESPN. Born in Oakland, California, Gilbert was a successful collegiate tennis player and reached the finals of the NCAA championship for Pepperdine University in 1982. He joined the professional tour that same year and went on to win 20 ATP top-level singles titles throughout his career.

Gilbert is the best-selling author of *Winning Ugly*, an instructional book geared towards recreational tennis players to help improve their mental game. In 2005 he released his second book, *I've Got Your Back*, in which he describes his coaching methods and what it takes to win under extreme pressure – on and off the court.

Gilbert has served as a tennis analyst for ESPN since 2004, covering major tournaments such as Wimbledon, the US Open, the French Open and Davis Cup play.

Forrest Sawyer

Forrest Sawyer has had a diverse career, first as one of America's most respected television journalists, and more recently as an entrepreneur in innovative health care.

Mr. Sawyer is today an advisor and board member of Edison Pharmaceuticals, the world leader in the study of mitochondrial disease. He is also a co-founder of Ampere Life Sciences, a newly launched company developing medical and functional foods targeting antioxidant deficiencies. In addition to unique research and development programs, both companies are building innovative communication platforms.

As a journalist, Mr. Sawyer has over 24 years of experience reporting from around the world. He is a veteran of ABC, CBS, and MSNBC. He has anchored the ABC magazine programs Day One and Turning Point, as well as World News Sunday, and Good Morning America. For a decade Mr. Sawyer was the primary replacement anchor on ABC's *Nightline.*

Mr. Sawyer is the founder of FreeFall Productions, an award-winning documentary production company. He has reported documentaries for ABC News, MSNBC, Frontline and the Discovery Networks.

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8 Steps to Implement a Successful Surgery Center Bonus Program

By Rachel Fields

A bonus program can incentivize good behavior and reward employees for meeting targets critical to a surgery center's profitability. Here are eight tips from MedHQ's John Merski Jr. on how to implement a successful bonus program that improves employee performance without breaking your budget.

1. Determine whether you can afford a bonus program. The existence of your bonus program should largely depend on whether you can afford one, Mr. Merski says. A substantial bonus will tell employees they are appreciated, but a very small bonus may well have the opposite effect: Instead of appreciating the money, they may be more dissatisfied than if you had given out nothing.

"If you're going to give out a few dollars, I'd suggest you reconsider even having a bonus program," Mr. Merski says.

2. Determine how much money should be set aside for bonuses. Look at your budget and set aside a reasonable amount of money to give bonuses to the whole center for the year. You may not end up giving out all this money if employees don't meet the targets you set, so don't be overly budget limited. The money should apply to every employee in the facility — "If you are exclusive with anyone," he says, "you will have weakened your program."

3. Divide your center's staff into groups. To build this type of bonus program, you'll need to divide your center into groups of people and then reward them based on specific metrics suitable for each group. For example, you may want to break the center into: business office staff, clinical staff and management, or management, non-management and management supervisors. This will depend on the make-up of your center; choose groups that can logically work together towards a certain goal.

4. Assign a certain percentage of the bonus pool to each group. Take the bonus pool that you determined in step two, and split it among the groups in your center. You will probably want to allocate more money for certain groups — for instance, management — than others. For example, one group might receive 40 percent of the pool, while the other two receive 30 percent.

Again, this doesn't necessarily mean that you'll give out 100 percent of the money you allocate for bonuses. It simply means that the management group, for example, has the chance to get 40 percent of the bonus pool, but could end up getting only 30 percent or 20 percent.

5. Create "clear" targets for each group and share them. You should create targets for each group based on meeting (or not meeting) a particular goal. For example, perhaps you want to decrease turnover times by two minutes in the OR. In this case, you would gather your clinical staff and explain the goal of reducing turnover times by two minutes. You would make it clear that the goal is set at two minutes — if the team accomplishes the goal, they will receive that portion of the bonus; if they do not meet the goal, they won't.

Mr. Merski says this philosophy differs from some other surgery centers, where staff are rewarded even if they meet a certain percentage of the goal. But in such instances the problem becomes: Where do you draw the line? Will you still reward your staff members with 50 percent of the money if they only meet 50 percent of the goal, and so on?

He says you should set a clear target and tie a specific dollar amount to that target. Make sure that the goal is realistic — Mr. Merski says your staff should be able attain goals set. Unachievable goals have quite the opposite impact of their intended purpose. A success rate of around 80% is achievable yet duty-bound.

6. Give staff members input on targets. Let your employees know that you're setting up a bonus program, and ask them for ideas for targets. If they say, "We all get the full amount if we come to work every day," you may want to ignore that idea. But most of the time, staff members will have great ideas for goals for the surgery center, and they may notice areas of inefficiency or failure that you didn't know about.

"The bonus plan should be made with input by the same people who are going to get the bonus," Mr. Merski says. "When they're invested in the design of the bonus program and they know that they have set achievable goals, they are their own worst enemy if they don't meet the goals."

7. Give out bonuses on a quarterly basis. You don't have to wait until the end of the year to give out bonuses, Mr. Merski says. "For the most part people have short attention spans," he says. Employees are no different. "If you want a bonus program to work for you, you have to reward people in a systematic and consistent frequency basis."

This means regularly updating staff members on how well they're doing and how close they are to meeting the goal — and giving out money on a quarterly basis. If you base your bonus in December on the employee's performance the previous January, they're unlikely to remember what they did or how to replicate the behavior.

8. Bring together staff members to announce bonus results. You should not keep the results of your bonus program a secret, Mr. Merski says. Meet with each group individually, and let them know that you achieved goals in sections one, three, five and seven, for example. "Make a big thing of their success," he says. If you make the results public, employees will be more likely to work hard to impress their peers. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

4 Things to Know About Implementing LED Backlight Technology in the OR

By Rachel Fields

Hospitals and surgery centers are increasingly implementing light emitting diode backlight technology in their operating rooms. This echoes the example of consumers, who have been flocking to replace their power-hungry LCD televisions with more cost-efficient LED versions.

NDS Surgical Imaging, based in San Jose, Calif., is a pioneer of LED backlight technology, having launched the world's first LED backlit surgical display in 2009. Here, Jens Ruppert, VP & GM of NDSsi's Surgical Business Unit discusses four important points about implementing LED backlight technology in the surgical setting — and the benefits that facilities can realize through the upgrade.

1. LED technology can positively impact surgeon satisfaction. Until recently, surgical displays used older CCFL (fluorescent tube) lamps, which draw more power and burn out faster than the new LED models. Because LED displays can produce a brighter image while running cooler, the surgeon enjoys an enhanced overall picture and a screen that doesn't heat up in the same manner as CCFL.

If a surgeon has an investment in the facility, he or she could also benefit through increased cost savings. "By eliminating fluorescent tubes and moving to LED technology, display designs are getting thinner, more lightweight, and promising a much longer product lifespan," Mr. Ruppert says. He adds that backlight stabilization means the luminance output will never change or dim over time, giving surgical staff a higher level of image consistency and quality.

2. It won't strain your budget. Hospitals and surgery centers must replace their CCFL technology as it ages, meaning a capital investment in visualization equipment is inevitable. "Even though it is a newer and more advanced technology, LED-based monitors remain price-competitive," Mr. Ruppert says. "Also, lower power consumption leads to lower energy bills."

3. LED is environmentally-friendly. Surgery centers can also benefit from the environmentally-friendly nature of LED backlights. "LED technology eliminates mercury-filled components found in the CCFL backlights of the past," Mr. Ruppert says. "This new technology allows medical-grade displays to conform to stringent RoHS certification requirements."

4. Practically no operational differences exist from prior technology. Hospitals and surgery centers often shy away from technological upgrades because of the fear of disrupting operations. But Mr. Ruppert says there are practically no operational differences between the LED and former CCFL technologies.

"This is an advanced step in image reproduction, without any additional burden on resources. The upgrade to LED should be nearly transparent to staff with no further training required," he says. He says there are no roadblocks to implementation because the operation and manufacture of displays are almost unchanged. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

10 New Ophthalmology-Driven Surgery Centers

By Laura Miller

An eye clinic in Wasau, Wis., announced it will open a 6,000-square-foot surgery center that will be ready for patients in early January 2013.

Construction has begun on a new ophthalmology surgery center in Wilton, N.Y., which will be a joint venture between local physicians and Glens Falls (N.Y.) Hospital.

Reed Eye Associates opened a new eye care center in Newark, N.Y., led by Ronald Reed, MD.

The Paul Phillips Eye & Surgery Center recently opened in Flemington, N.J., and is headed by Paul Phillips, MD.

Bascom Palmer Eye Institute has announced it will expand its Naples, Fla., location to construct a new treatment and surgery center.

Three Colorado practices focused on eye care have consolidated and announced plans to construct a 40,000-square-foot medical building and surgery center that is scheduled for completion in the summer of 2013.

Massachusetts Eye and Ear opened a new 90,000-square-foot outpatient surgery center in Boston and plans to include otolaryngology procedures in the future.

Massachusetts-based Nielsen Eye Center opened a new location in Weymouth.

Pennsylvania Eye Specialists of Ohio added a surgery center earlier this year which will offer cataract surgery, laser procedures, chemical burn treatment and corneal transplant, among other services.

Shepard Eye Center in Santa Maria, Calif., opened a new surgical suite earlier this year where surgeons will perform LASIK and facial cosmetic surgery. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

25 Statistics on Ophthalmology Revenue & Charges in ASCs

By Rachel Fields

Here are 25 statistics on ophthalmic revenue and charges in surgery centers, according to a VMG Health survey titled Multi-Specialty ASC Intellimarker 2011.

Gross charges per case: $5,964

Net revenue per case: $1,335

Discount to charges: 74.5 percent

Based on location

West
Gross charges per case: $6,063
Net revenue per case: $1,302

Southwest
Gross charges per case: $6,442
Net revenue per case: $1,312

Midwest
Gross charges per case: $5,861
Net revenue per case: $1,297

Southeast
Gross charges per case: $5,360
Net revenue per case: $1,198

Northeast
Gross charges per case: $4,116
Net revenue per case: $1,193

Based on number of ORs

1-2 ORs
Gross charges per case: $4,780
Net revenue per case: $1,201

3-4 ORs
Gross charges per case: $5,338
Net revenue per case: $1,249

More than 4 ORs
Gross charges per case: $6,745
Net revenue per case: $1,409

Based on case volume

Less than 3,000 cases
Gross charges per case: $4,966
Net revenue per case: $1,275

3,000-5,999 cases
Gross charges per case: $4,976
Net revenue per case: $1,235

More than 5,999 cases
Gross charges per case: $5,972
Net revenue per case: $1,285 ■

Contact Rachel Fields at rfields@beckershealthcare.com.

10 Top Patient Safety Issues for 2013

By Rachel Fields

2013 should be a busy year for patient safety experts at hospitals and surgery centers; as quality reporting requirements continue to go into effect, facilities will be expected to ramp up compliance programs and prove their progress. Here, three patient safety experts discuss the most pressing safety topics for the next year — and what facilities can do to make sure they're up to speed.

1. Utilization of surgical checklists. Atul Gawande, MD, is an American surgeon and journalist whose books include Better, Complications, and — most relevant to this subject — The Checklist Manifesto. He has advocated heavily for surgical checklists, arguing that the fallibility of human memory opens the door for serious, fatal errors when surgeons rely on their training alone. According to Dr. Gawande, the use of checklists dates back to the 1930s, when airplanes were gaining more sophisticated technology in the cockpit. Though the technology was intended to improve safety, it was widely considered too complicated for a lone pilot to manage, and the rate of airplane crashes soared.

In response to the climbing error rate, pilots developed checklists to ensure that every necessary task was completed prior to take-off. The instance of crashes dropped significantly. Dr. Gawande says in The Checklist Manifesto that the same results have been proven with surgical checklists: When an OR team goes through each item one-by-one, they are less likely to miss something serious. But healthcare has been slow to adopt the tool, in part because of ingrained theories about "good medicine." Surgeons, who have gone through years of training, often believe that good medicine is up to the talents of an individual physician — not the collective, systematic effort of a checklist.

Hospitals and surgery centers will be implementing surgical checklists throughout their facilities in 2013 to avoid reductions in reimbursement. According to Kim Haines, RN, certified OR nurse and vice president of clinical resources for Medline, implementation comes down to communication and education of staff. "You have to get staff to understand the goals and have that true buy-in, where they understand the list is used to improve quality of care," she says. She adds that surgical facilities must customize checklists — available through WHO, AORN and various other organizations — to make sure they fit the flow of the facility. "A lot of facilities role-play during training to make sure everyone understands what they're supposed to do and supposed to say," she says.

2. Implementing "time outs" in the OR. Similar to the idea of the surgical checklist is the concept of the "time out," which requires OR team members to stop prior to surgery to confirm the correct side, site, patient and procedure. Ms. Haines says implementing this process, which is required by the Joint Commission and other accrediting bodies, is a matter of breaking down barriers in the operating room. "From a speaking-up standpoint, there may be intimidating between nursing staff and a physician," she says.

Make sure the leadership at your institution clearly communicates the need for a time-out and implements rules to allow anyone to speak up. Certain institutions have "red rules," which mean that any provider or team member can stop the process and point out a problem. "You need to set a very clear methodology that takes the pressure off the nurse," Ms. Haines says.

3. Increasing hand hygiene compliance. Hand hygiene compliance has been promoted in surgical facilities for years; Lisa Spruce, RN, DNP, ACNS, ACNP, ANP, CNOR, director of evidence-based perioperative practice for AORN, calls it "the one proven concept that absolutely works for preventing infections." Despite progress in this area, however, compliance in hospitals hovers around 50 percent, according to the University of Geneva Hospitals in Switzerland. "Promotion of hand hygiene is a major challenge for infection control experts," wrote Didier Pittiet, of the University of Geneva Hospitals, in an article for the CDC. "No single intervention has consistently improved compliance with hand hygiene practices." Non-compliance can be attributed to a number of factors, but experts agree that staff apathy towards the practice is a big one.

Dr. Spruce says for many hospitals, monitoring staff hand-washing practices can improve compliance. "There's been some success with just watching people and seeing how well they're doing," she says. In some cases, the sinks are monitored through a video camera, and the tapes are reviewed every week or at random to determine how well people are doing. In other cases, a staff member is assigned to walk through the hand-washing area and note staff members who fail to wash their hands. "A wonderful way to improve the process is just to have someone monitor it and then talk to the team afterwards and explain what could be done better," she says.

4. Promoting collaboration between providers. The surgical team should be trained together to make sure everyone is on the same page about OR processes, Dr. Spruce says. Historically, the OR has functioned as a hierarchy, with the surgeon on top and the other providers at his or her service. This is a problem for patient safety, because nurses and other OR providers may be hesitant to speak up if a surgeon fails to wash his hands. Staff members should be educated together, and leadership should encourage the idea that OR providers are a team.

5. Implementing a "debriefing" after surgery. Dr. Spruce recommends that OR teams conduct a "debriefing" after surgery, which means they come together and talk about the surgery that just happened. "If they have that brief conversation, they're more aware and can talk about any issues and how to prevent them," she says. "If they don't have that conversation, they can't pass that information on."

She says even though debriefings are incredibly useful in predicting future problems and reviewing old mistakes, they are one of the "least used" patient safety tools. She says for instance, the team might discuss the surgery and discover through the conversation that the patient might have a bleeding problem during recovery. That information is essential to being prepared in case complications arise, so that staff can deal with them immediately.

6. Using evidence to educate. Evidence-based practice should be the foundation from which all surgeons practice, so that patients know they are receiving care proven to work, Dr. Spruce says. Some physicians, who have had years of training and experience in the operating room, may be hesitant to adopt a surgical checklist because they feel they already know what they're doing.

But the evidence doesn't lie: In a 2008 study from the University of Toronto, published in the Archives of Surgery, researchers found that communication failures per procedure declined from 3.95 prior to list use to 1.31 after list use. Thirty-four percent of surgical briefings demonstrated the utility of the list, including identification of problems, resolution of critical knowledge gaps, decision-making and follow-up actions.

Of course, the most effective education involves holding a mirror up to the providers themselves. This is why debriefings after surgery are so important — because they point out errors that would have occurred if not for the checks and balances in place.

7. Promoting sharps safety. In March 2012, AORN released a new Sharps Safety Tool Kit, which includes new resources to help perioperative professionals reduce the risk of sharps injuries in the OR. Patient safety issues involving sharps fall into several main categories:

- **Knife blades.** According to Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN, executive director of AORN, patient safety experts recommend nurses and surgeons implement a "safe zone," where the nurse can place the knife blade for the surgeon to pick up. This eliminates the danger of cutting the surgeon or the nurse by directly handing the knife blade from provider to provider.
- **Double-gloving.** Double-gloving can prevent needle sticks, as wearing two pairs of gloves is likely to prevent a needle from going straight through the glove material. Unfortunately, providers are still hesitant to double-glove because of decreased sensitivity.
- **Blunt suture needles.** Blunt suture needles are proven to be safe and effective for surgery, but surgeons have hesitated to embrace their use because they feel sharp needles are more appropriate. The use of blunt needles decreases the likelihood of puncturing a patient or staff member.

8. Eliminating wrong site/side/procedure surgery. In late 2012, Johns Hopkins University published a study in Surgery that totaled the incidence of wrong site/side/procedure/patient surgery over the last two decades. The numbers were staggering: Between 1990 and 2010, over 9,700 cases of retained surgical items, wrong-site surgery, wrong-patient surgery or wrong-procedure surgery occurred. Those numbers only include those cases that resulted in indemnity payments, meaning the real number (including unreported cases) is probably much higher. Study authors estimated that 4,082 of these surgical errors probably occur in the U.S. every year.

Wrong site/side surgery is entirely preventable, said Martin Makary, lead author of the Johns Hopkins study and associate professor of surgery at the hospital. Dr. Spruce says the key to preventing these errors is to educate from the top down. "Providers don't make these mistakes intentionally," she says. "It's a combination of things — system design, human factors and faulty equipment." She says it's important for hospital leaders to insist that OR teams implement a time-out, during which the providers can confirm the correct site of surgery, ask the patient to identify him or herself, and confirm the procedure with the patient's chart.

9. Retained surgical items. Dr. Spruce says Joint Commission reports are still showing the incidence of retained surgical items — and indeed, the recent Johns Hopkins found that surgeons left around 4,857 items in patients over the past two decades. In order to prevent retained surgical items, AORN recommends that the OR providers work together to count all items on the sterile field, including sponges, needles and instruments according to a list prepared for the case.

At the end of the case, those items are counted again to make sure everyone is accounted for. Dr. Spruce says this is important to think about, since a retained surgical item — or any other surgical error — can be disastrous for a patient's health. "We need to remember that the ultimate cost is to patients and family members, because we can cause them to die or be disabled for the rest of their life," she says.

10. Standardizing surgical language. If people are using different language to communicate in the OR, they may misunderstand each other, Dr. Spruce says. She recommends that all hospitals and surgical facilities work to develop a "common language." This means that if a nurse wants to stop the procedure, she knows whether to say, "Stop," or, "I want to invoke the red rule," or some other variation. ■

Contact Rachel Fields at rfields@beckershealthcare.com.

How ASCs Can Effectively Handle CMS Quality Reporting: Q&A With Allison Errickson of ProVation

By Laura Miller

Allison Errickson, CPC-H, director of coding compliance for ProVation Medical, part of Wolters Kluwer Health, discusses the biggest challenges for ambulatory surgery centers with quality reporting for The Centers for Medicare and Medicaid Services and what to watch for in the future.

Q: What are the biggest challenges ASCs face with the new Medicare quality reporting system?

Allison Errickson: I think one of the biggest challenges is the overall process change, not only for the nurses in terms of their documentation, but also for the coders and billers.

The quality reporting program requires ASCs to report five quality measures by submitting G-codes on the CMS-1500 claim form for Medicare patients. Documentation of the measures, which include patient burn, patient fall, wrong site/wrong side/wrong patient/wrong procedure/wrong implant, hospital admission/transfer, and prophylactic IV antibiotic timing, will most likely be found in the nursing documentation. Coders/billers are not in the habit of waiting for nursing documentation to complete the coding for a patient encounter. So ASCs need to ensure the coders/billers receive a copy of the nursing documentation to ensure the appropriate G-codes are included on the bill. These G-codes need to be included on the bill for Medicare patients even if none of the events occurred.

Sites really need to have a designated person monitoring this program to ensure they are staying ahead of the game. The five measures I mentioned are just the first wave of this program. Starting in 2013, there will be two new measures sites will have to report; safe surgery checklist use in 2012 and volume of certain procedures in 2012.

The 2013 measures are a great example of why it's so important to have a designated person monitoring this program. Even though these two measures don't have to be reported until 2013, the data that sites will report on is from 2012. They will have to report if they used a safe surgery checklist in 2012 and the procedure volume will be based on 2012 numbers. Sites that haven't been tracking this information in 2012 may have trouble when it comes time to report this in 2013. If sites are unable to report on this information, they'll face financial penalties down the road.

Another challenge is that the guidelines are not always fully specified or may change as the program evolves. For example, in 2012, ASCs are supposed to report the G-codes on claims where Medicare is the primary payer. But, starting in January, they need to include these codes on claims where Medicare is primary or secondary. This may make it a bit trickier for sites when Medicare is the secondary payor. Its possible primary payors may reject the claim based on the G-codes.

Q: How well have surgery centers managed the change so far?

AE: These measures have changed the workflow, which can be really difficult. There have absolutely been some growing pains with figuring out the most efficient way to get these codes on the bill and out the door to ensure accounts receivable aren't impacted.

What has been particularly helpful for many ASCs has been the information on the ASCA website about the changes. For example, they have a cheat sheet that gives clear and concise information about handling these claims. These types of resources are helpful reminders for coders and billers in particular.

Q: Are there any tricks for surgery centers to make sure they are submitting these claims correctly?

AE: It's really important for surgery centers to know that they have to code when something happens and also code if nothing happened. They must include a code no matter what.

Sites should ensure someone, most likely the coder or biller, is tasked with reviewing the remittance advice notices from CMS. This will help sites confirm if the G-codes were actually passed into the system. Data reports are incredibly useful as well. The threshold for reporting is 50 percent, meaning ASCs will not face the 2 percent payment reduction in 2014 if they successfully report the G-codes on 50 percent of their Medicare claims.

Q: What additional changes should ASCs be prepared for in the future?

AE: This is just one phase of the program. In 2013, we'll see the safe surgery checklist and procedure volume reporting. The mechanism they've been using to report the initial five measures will also change; starting in July of 2013, they will have to go to the CMS QualityNet website to report their total surgical care volume and use of a safe surgery checklist.

That means they have to have someone enter that information. Though ASCs don't have a lot of extra people sitting around with free time, having someone watching these measures will make sure they are on top of what is coming.

As of right now, reporting influenza vaccination coverage among healthcare professionals will be added as a measure in 2014 and most articles you read indicate that more requirements will be added in the following years.

For software platforms, the idea is that you are going to have to have the ability to report on these measures in some kind of electronic format. That is the best way to go, whether it's a product like ours or something else. You should be able to enter that information and pull a report based on data elements and not comb through handwritten nursing documentation. It's a big challenge for ASCs to handle. ■

Contact Laura Miller at lmiller@beckershealthcare.com.

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