Inside: 17th Annual Improving Profitability, and Business and Legal Issues for ASCs Conference Brochure (p. 17)

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BECKER'S
ORTHOPEDIC & SPINE REVIEW

Business and Legal Issues for Orthopedic and Spine Practices

September/October 2010 • Vol. 2010 No. 5

6 Key Issues and Trends Impacting Outpatient Services and Physician-Owned Facilities

By Scott Becker, JD, CPA, and Barbara Kirchheimer

This article briefly addresses six key issues impacting outpatient services and physician-owned facilities.

1. Covering more people will lead to the reallocation of limited healthcare dollars. With the goal of bringing insurance coverage to an estimated 30 million people, the healthcare reform law will necessarily reallocate some of the dollars spent within the healthcare system.

The individuals who will gain insurance coverage under the new law are likely to be low-paying, which means the system will have to absorb a

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Trends in Sports Medicine: Q&A With AOSSM President Dr. Robert Stanton

By Laura Miller

As Americans continue to place a high emphasis on fitness and athletics, sports medicine centers have developed around the need for orthopedics and rehabilitation specialized for active patients and serious athletes. Robert A. Stanton, MD, is an orthopedic physician with Connecticut's Orhtopaedic Specialty Group who was recently named President of the American Orthopedic Society for Sports Medicine. Dr. Stanton discusses recent trends in sports medicine and important aspects for successful sports medicine practices.

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13 Strategic Thoughts and Concepts for Orthopedic Practices: Developing a Strategic Plan and Allocating Practice Resources

By Scott Becker, JD, CPA

1. Develop a simple framework for strategy. There are several different frameworks that can be used to build a strategy. One concept as to strategic approach proclaims that an organization should assess (1) whether an enterprise wants to be a cost leader, (2) whether it wants to be the most dominant in a specific niche, or (3) whether it wants to be the most customer centric enterprise. Michael Porter, the noted author of Competitive Strategy, uses a similar framework and group's strategies into three generic strategies (i.e. strategies that are applicable across industries): cost leadership, differentiation, and focus. Michael Porter argued that to be successful over the long-term, a firm must select only

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 1. Lynch, J. (2009, May). Is It Time to Add Spine? Outpatient Surgery.
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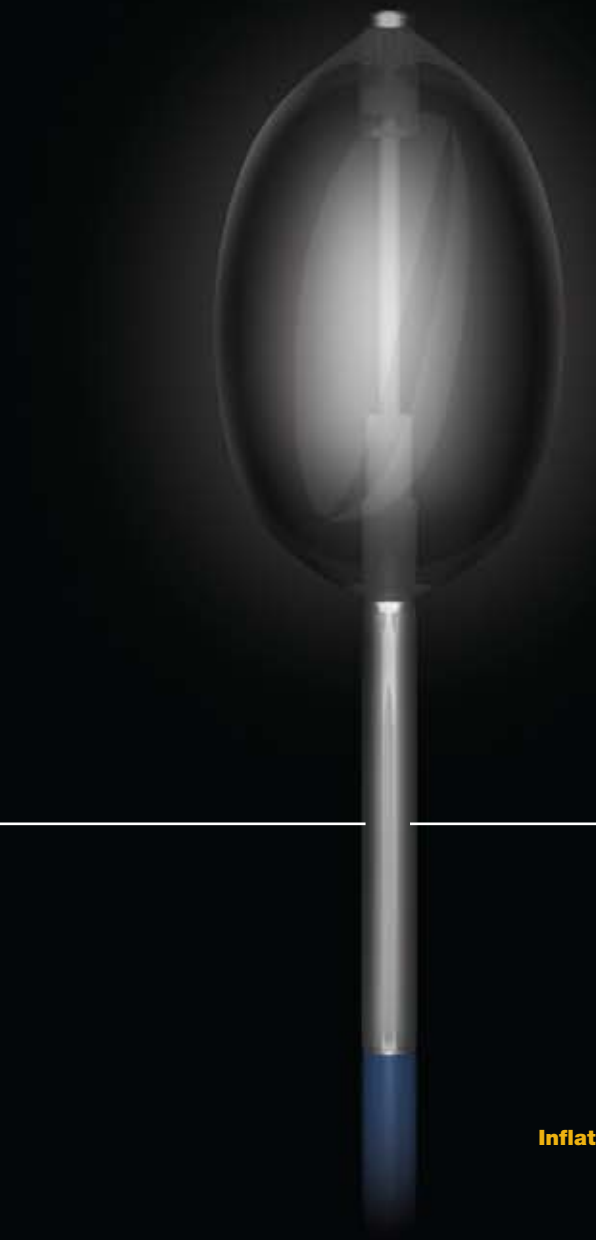

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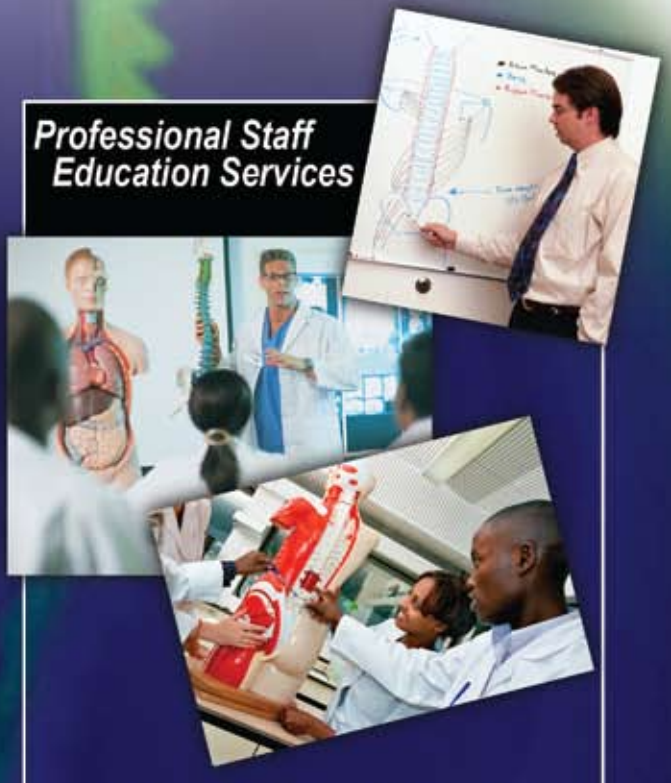

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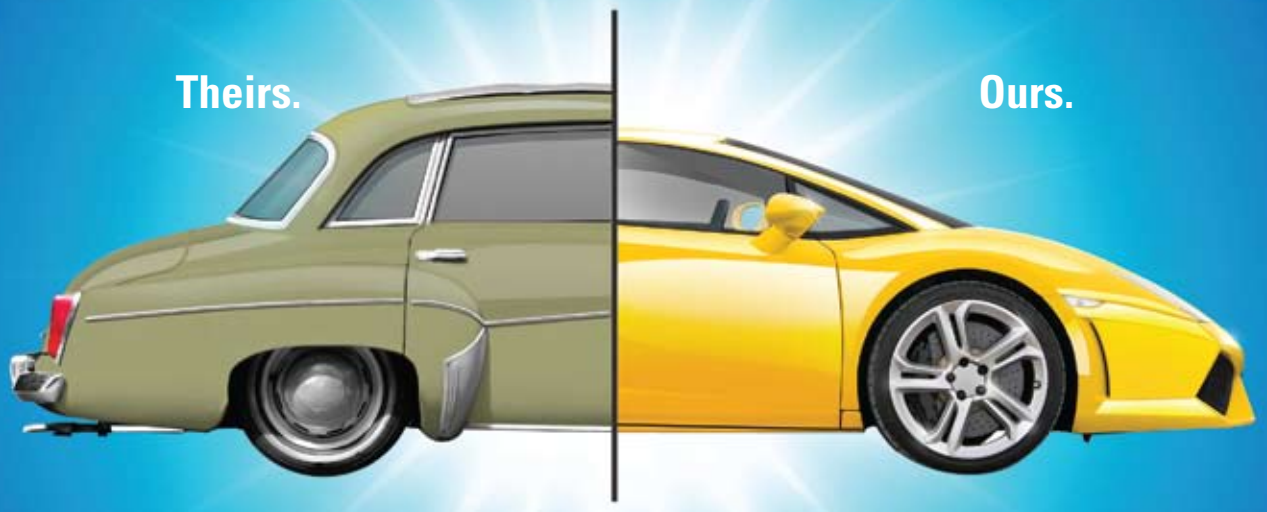

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BECKER'S
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FEATURES

Publisher's Letter

Greater Focus on Sports Medicine and Spine; 17th Annual ASC Conference: The Best Business Speakers in the ASC Business – Registration Discounts End September 1

We hope you enjoy this issue of the Becker's Orthopedic & Spine Review. Increasingly, the magazine focuses on sports medicine and on spine. A great deal of the discussion relates to procedures and concepts in these areas as well as a focus on leading surgeons and physicians in sports medicine and spine. In sports medicine, there is a great deal of coverage on items related to knees, shoulders and elbows.

In addition to sports medicine and spine, the magazine attempts to provide a good deal of coverage on the most significant implant and device companies and on implant and device issues.

Each electronic weekly includes coverage of spine, sports medicine, device and implant companies as well as the stock prices of the leading device and implant companies.

For more information on Becker's Orthopedic & Spine Review, please contact us at sbecker@mcguirewoods.com or Lindsey Dunn at lindsey@beckersasc.com or Laura Miller at laura@beckersasc.com.

Very truly yours,

Scott Becker

P.S. For information on our upcoming 17th ASC Conference on Improving Profitability and Business and Legal Issues for ASCs or a conference brochure, please go to www.BeckersASC.com or www.BeckersOrthopedicandSpine.com.

P.P.S. To sign up for the free Becker's Orthopedic & Spine E-Weekly, go to www.BeckersOrthopedicandspine.com or e-mail me at sbecker@mcguirewoods.com.

17th Annual ASC Conference: The Best Business Speakers in the ASC Business – Registration Discounts End September 1

We have put together an agenda that includes the best business speakers and the best topics in the ASC industry for our 17th Annual ASC Communications and ASC Association Conference. The conference is scheduled for Oct. 21-23 in Chicago on North Michigan Avenue.

The conference will include topics on co-management, joint ventures, increased OIG investigations, healthcare reform, accountable care organizations, benchmarking, improving revenues, managed care contracting and a broad range of issues relative to improving the business and profitability of ambulatory surgery centers. We will also include keynote speakers such as Coach Bob Knight and political commentator Tucker Carlson. We believe it will be a tremendous conference.

To receive the early registration discount, please register by Sept. 1. You can register in the following ways: Contact the Ambulatory Surgery Foundation at (703) 836-5904 or fax (703) 836-2090 or via e-mail at registration@ascassociation.org or online at https://www.ascassociation.org/chicagoOct2010.cfm.

To reserve your hotel room at Swissotel on North Michigan Avenue, please call (888) 737-9477 or online at https://resweb.passkey.com/go/asccommunications. We encourage you to stay at the Swissotel on North Michigan Avenue. ■

Spine and Sports Medicine Surgeons Top List of Highest Paid Orthopedic Specialties

By Rachel Fields

Here are seven statistics on orthopedic surgeon compensation by specialty from 2009 data, according to the MGMA *Physician Compensation and Production Survey: 2010 Report.*

1. The median salary for orthopedic surgeons specializing in spine surgery was $613,709

2. The median salary for orthopedic surgeons specializing in sports medicine was $599,759

3. The median salary for orthopedic surgeons specializing in hip and joint surgery was $564,139

4. The median salary for orthopedic surgeons specializing in trauma surgery was $526,501

5. The median salary for orthopedic surgeons specializing in hand surgery was $486,717

6. The median salary for orthopedic surgeons specializing in pediatric surgery was $485,283

7. The median salary for orthopedic surgeons specializing in foot and ankle surgery was $453,543. ■

6 Key Issues and Trends Impacting Outpatient Services and Physician-Owned Facilities (continued from page 1)

great number of additional covered lives with very little additional aggregate reimbursement. Most new patients will be covered at amounts close to Medicaid reimbursement rates.

Over the next three to five years, the new law does very little to take dollars out of the overall system. However, in the longer term, the reallocation of dollars from this influx of newly covered individuals is likely to increase the pressure to cut costs. The likely scenario five years out is a very different distribution of healthcare dollars and potentially significant tax increases.

2. Erosion of independent medical practice. Against this backdrop, the independent practice model is losing its appeal for many physicians. While aligning with a hospital does not directly reduce physicians' overall outpatient workload, it does affect the entrepreneurial side of their outpatient business.

Available statistics vary on the percentage of physician practices currently owned by hospitals, but it is clear that the number of physicians seeking hospital employment is on the rise.

Physician search firm Merritt Hawkins indicates the percentage of physician search assignments it conducted involving hospital employment rose to 45 percent in 2009 from 23 percent in 2005. Tommy Bohannon, Merritt Hawkins' vice president of hospital-based recruiting, says he expects that figure to jump to more than 50 percent on the firm's next annual survey.

In certain sectors, such as cardiology, the trend is even more pronounced. In his blog, *The Lewin Report*, American College of Cardiology Chief Executive Officer Jack Lewin, MD, took an informal poll asking whether cardiologists had integrated their practices with a hospital in 2009. Some 12 percent responded that they had, while another 21 percent said they had concrete plans to integrate and another 50 percent said their practice was thinking about doing so within the next two years.

"A cardiologist that's part of a hospital system, the revenues they can produce for that system can be very, very good because of the use of ancillary services," says David Gans, MSHA, FACMPE, vice president of innovation and research for the Medical Group Management Association. "Consequently the hospital can support the physician well."

These shifts are likely to affect the prospects for physicians' entrepreneurial business endeavors. Independent practitioners have generally been the lifeblood of ASCs, physician-owned hospitals and other types of freestanding healthcare entrepreneurial ventures. Even slight changes in the total number of independent physicians can have a huge impact on the economies of scale of surgery centers and physician-owned hospitals. These businesses, like any type of business, work with a fairly fixed set of costs. A large portion of their profit accrues after a base number of cases are brought in to cover basic fixed costs. Thus, incremental cases drive their profitability. If the incremental cases are taken somewhere else through employment arrangements with hospitals and other systems, the physician-owned facility is left in a much tougher position.

Several factors are driving this trend in physician employment. The top four are:

- Money: Hospitals can afford to pay physicians well due to the technical fees the physicians generate for hospitals. "The hospital can legitimately preclude its competition and bring those doctors in as admitters and users of ancillary services, so these are the same prac-

tices that are better revenue-generators for the hospital," MGMA's Mr. Gans says.

- Money: Physicians are very concerned about the uncertainty of future reimbursements.
- Money: Many physicians took a significant hit in the stock market and real estate crash and are seeking a perceived lower-risk practice environment.
- Work-life balance: Many physicians who graduated over the past decade seem more focused on work-life balance and more predictable hours than a business owner would have.

Scott Gottlieb, MD, a practicing internist, former CMS official and current fellow at the American Enterprise Institute noted this trend in a recent opinion piece in the *Wall Street Journal*. "Doctors, meanwhile, are selling their practices to local hospitals," Gottlieb wrote May 18 in the *WSJ*. "In 2005, doctors owned more than two-thirds of all medical practices. By next year, more than 60 percent of physicians will be salaried employees. About a third of those will be working for hospitals, according to the American Medical Association."

Dr. Gottlieb goes on to mention that a hospital with which he is affiliated recently formed a new subsidiary to purchase local medical practices. "Nearby physicians are lining up to sell — and not just primary-care doctors, but highly paid specialists like orthopedic surgeons and neurologists. Similar developments are unfolding nationwide."

According to Dr. Gottlieb's analysis, salaried physicians and further consolidation of medical practices will leave patients with fewer options and longer waiting times.

3. There are roughly 5,200 Medicare-certified ASCs. While the number of Medicare-certified ASCs increased by over 50 percent from 2001-2008, the rate of growth has slowed significantly. According to MedPAC's June 2009 Data Book, there were 5,174 Medicare-certified ASCs in 2008, up only 3.7 percent from 4,991 in 2007. By contrast, in 2007, the number grew 6.2 percent, in 2006 it grew 5.8 percent, and in 2005 it grew 7.3 percent.

An industry expert and founder of a leading ASC company recently hypothesized 2010 might be the first year in which there is a net loss in the total number of ASCs across the country. Of the nation's Medicare-certified surgery centers, 20 percent to 35 percent have a hospital partner, and another 20 percent to 30 percent are rumored to be losing money at any given time.

4. Revenues for outpatient services will be under tremendous pressure. As discussed above, the erosion of the independent medical practice will likely lead to either a deceleration in or actual reduced case numbers, which will contribute to the pressure on revenue for outpatient services. In addition, reimbursements for services from commercial payors and Medicare will face significant downward pressure.

The hospital industry and the pharmaceutical industry are among the projected winners in the healthcare reform legislation. Each have secured a substantial portion of the healthcare budget for the foreseeable future and are somewhat protected from significant reimbursement risk. Here, the Federation of American Hospitals and PHRMA made big bets that healthcare reform would pass, paid big dollars to hire Chip Kahn and Billy Tauzin to negotiate their positions with the White House and Congress, and by all accounts seem to have succeeded in their efforts. That leaves other healthcare sectors more vulnerable to reductions as these big areas remain somewhat protected.

Insurance companies will also be exercising more authority over physicians. As Dr. Gottlieb notes in his *Wall Street Journal* opinion piece, the pending standardization of minimum insurance benefits in 2014 and mandates on insurers to fully cover certain primary care services will make it harder for them to control their expenses.

"One of the few remaining ways to manage expenses is to reduce the actual cost of the products," Dr. Gottlieb writes in the *WSJ*. "In healthcare, this means pushing providers to accept lower fees and reduce their use of costly services like radiology or other diagnostic testing."

5. Co-management arrangements on the rise. These alternatives to traditional hospital-physician joint ventures seem to be gaining momentum as a way for hospitals to align themselves with independent physicians. Under these arrangements, hospitals either hire physicians or groups to manage service lines or they actually buy a business line from physicians and then have the physicians manage the area. For example, a hospital may buy up an ASC from physician-owners (or develop one) and convert it to a hospital outpatient department. The HOPD then commands higher reimbursement rates. Physicians give up equity but take on less financial risk.

It is not clear how long these co-management arrangements will continue to be the new hot thing. It is likely they will remain important for some time to come.

Co-management arrangements also carry with them some legal concerns. Those that are structured with "aggressive" payment arrangements may well need to be rethought and possibly restructured if the federal government intervenes and raises objections.

6. Great management. It is likely that well-managed firms will continue to thrive even in a much tougher economy for surgery centers, free-standing imaging facilities and other physician-driven businesses. Several leaders have shown that it is possible to thrive in a tough business line. One of the largest imaging companies, for example, continued to thrive at a time when most other imaging companies struggled to survive. At this time, it is more important than ever to hire great leadership and bring in top level management team. ■

How One Entrepreneurial Patient Helped Found a Chain of Leading Outpatient Spine Institutes: Q&A With LSI Co-Founder Bill Horne

By Lindsey Dunn

Bill Horne, CEO of Laser Spine Institute, discusses how a 2004 surgery prompted him, along with his physician, James St. Louis, DO, to launch Laser Spine Institute. LSI marked its fifth anniversary in March and has grown dramatically since the 2005 opening of its flagship location in Tampa. Today, LSI operates seven facilities in four states, including Florida, California, Pennsylvania and Arizona and performs more procedures per month than any other spine care facility in the world, with a total of nearly 16,000 surgeries completed to date.

Q: What prompted you to found LSI?

Bill Horne: In 2004, I received a life-changing minimally invasive spine procedure from LSI's chairman of surgery and founder Dr. James St. Louis. Prior to my procedure, I was experiencing severe neck pain for 30 years as a result of a college football injury. Just one week before I was scheduled to receive open back surgery at a different facility, I had lunch with a friend who informed me of his wife's successful experience with a minimally invasive spine procedure in an outpatient setting.

After a consultation with Dr. St. Louis and learning more about his techniques, I canceled my previous surgical appointment and underwent a minimally invasive, endoscopic procedure. Following my procedure, I formed a close friendship with Dr. St Louis. I realized that the procedures performed by these pioneering surgeons were incredibly innovative compared to traditional spine surgery techniques, and I wanted to be able to educate people on the advantages and alternatives of minimally invasive spine procedures. Dr. St. Louis and I, along with fellow founder and medical director Dr. Michael Perry, formed a business partnership to establish Laser Spine Institute, opening the doors in March 2005.

Q: Given that many spine surgeries were not performed in the outpatient setting when you founded LSI, did LSI face any challenges convincing patients about the safety and effectiveness of outpatient spine procedures?

BH: We realized that although outpatient, minimally invasive spine surgery is entirely safe and not considered experimental, the procedure is still misunderstood, even among physicians and back and neck pain sufferers. To combat this problem, we began offering free seminars in cities across the U.S. and Canada to help educate prospective patients and provide an opportunity for open forum discussions.

Based on patient feedback at seminars, LSI adopted the medical consultation center model to provide further convenience and empower patients with a quick and easy, yet thorough assessment of their MRI/CT Scan, medical history and symptoms. At the consultation, individuals meet with a board-certified physician and determine their candidacy for minimally invasive spine procedures. The physician and patient discuss pain levels, conduct thorough pre-operative assessments and expertly review scans to determine the best course of action.

Q: What about payors? Given that outpatient spine remains a relatively new concept to some payors, did you meet resistance in negotiations with them?

BH: A key tactic at LSI is educating the patient and managed care company on what exactly we do since our procedures are still relatively new. Our chief objective is to educate the managed care payor, even if an agreement cannot be achieved in the short term. LSI started as an ASC with a foundation built on in-house research. This led to incredible outcomes, which generated interest from payors and managed care companies desiring mutually favorable partnerships. Having our own medical research team follow patients post-operatively at pre-determined intervals provides valuable data for the managed care payors.

Managed care companies want to address financial issues. We address these concerns by sharing our statistics on patient satisfaction, surgical outcomes (re-surgery rates, complications, etc.) and costs associated with traditional spine procedures.

Q: How big of an impact are increasing out-of-pocket co-pays and co-insurance having on LSI?

BH: Over the last several years, the healthcare industry has seen a tremendous increase in cost-sharing with patients. LSI is experiencing the same obstacles as other providers, so to improve our time of service collections, we work with managed care companies and patients to determine what their out-of-pocket responsibility will be prior to surgery. We have also developed business relationships with external vendors who supply our patients with financing options independent of LSI. We are continuing to expand this payment arrangement so that even more patients can take advantage of this option. At LSI, we strive to offer patients every available option to enhance their patient experience.

Q: What has been LSI's number one key to success?

BH: As the leader in minimally invasive spine surgery, LSI has helped thousands of patients get back their lives through innovative and groundbreaking endoscopic procedures. Our incredible outcomes drive our success, with 91 percent of patients returning to work within 12 weeks of surgery.

Additionally, I believe LSI has been so successful because of the ultimate personal connection we have with our patients. We cultivate an environment that is patient centric, and through our superior service and incredible outcomes, we have earned the trust of our patients. Ultimately, this has led to the development of an institution that serves an increasing number of people while continuing to provide individualized care to each and every patient. ■

Learn more about Laser Spine Institute at www.laserspineinstitute.com.

42 Orthopedic and Spine Device Companies to Know

By Leigh Page

1. Advanced Biologics (Ladera Ranch, Calif.). The company's OsteoAMP exploits growth factors within allograft tissue. A proprietary process utilizes the osteoinductivity of autografts and the osteoconductivity of allografts from the same donor to enhance growth factors to higher levels. OsteoAMP won first place in the regenerative technologies category in Best New Technology for 2009 hosted by *Orthopedics This Week*. OsseoGEN is the company's line of allograft-derived stem cell technology. The company's OsteoMEM, an ultra porous shape memory scaffold, is not currently available in the U.S. market. www.advancedbiologicscorp.com

2. Aesculap USA (Center Valley, Pa.). Aesculap, a division of the German company B. Braun Melsungen, provides implants for orthopedics, neurosurgery and spinal surgery as well as surgical sutures, sterile containers, motor & navigation systems and products for cardiology. The division also operates the Aesculap Academy, which actively exchanges knowledge and numerous continuing education programs. In May, Aesculap Implant Systems launched S4 Element Pedicle Screw System for use in spinal fusion procedures. In March, it launched the Spyder Minimally Invasive Spinal Retractor System for use in the lumbar spine with Aesculap's S4 Pedicle Screw System. www.aesculapimplantsystems.com

3. Alphatec Spine (Carlsbad, Calif.). The company develops products for older spine patients, ages 65 years and older, who have disorders such as osteoporosis, scoliosis and spondylolisthesis. Product lines include cervico-lumbar, thoraco-lumbar, interbody/VBR, biologics, minimally invasive solutions and vertebral compression fractures. In the Best New Technology awards hosted by *Orthopedics This Week* in Dec. 2009, Alphatech Spine won two first-place awards for its OsseoScrew Expandable Screw for lumbar care and for its Guided Lateral Interbody Fusion system for minimally invasive care. www.alphatecspine.com

4. Amedica Corp. (Salt Lake City). Amedica is a spinal and orthopedic implant and instrument maker focused on silicon nitride ceramic technologies. It has brought various spinal implant products to market and products under development include reconstructive hip and knee implants. In June, the company received a patent for its hip implant featuring a monoblock ceramic acetabular cup for use in articulating joints for total joint replacement. The cup, currently under development, will be used as an ultralow wear-bearing component for motion-preserving implants. In March, Amedica received a patent for its ceramic-on-ceramic bearings for articulating joints used for total joint replacement and spinal disc applications. www.amedicacorp.com

5. Arthrex (Naples, Fla.). Founded in 1981, Arthrex develops sports medicine products and educational services for orthopedic surgeons. The company has introduced more than 5,000 products for arthroscopic and minimally invasive orthopedic surgical procedures. Its TightRope product, originally designed for ankle surgery, is also being used for minimally invasive shoulder surgery. In March, the company acquired iBalance Medical of Boulder, Colo., maker of the IBalance HTO System, which uses an implant placed within the tibia to align the osteotomy in both the coronal and sagittal plane. In June, the company launched the its new 2.9 mm Bio-PushLock with a reduced size to allow more anchors to be implanted around the glenoid for improved fixation. www.arthrex.com

6. Arthrocare (Austin, Texas). Founded in 1993, Arthrocare offers Coblation technology using radio frequency energy to remove soft tissue from the body, used in arthroscopic procedures to repair joints. At its Costa Rica factory, ArthroCare also makes ligament-repair, spinal-stabilization, and wound-care products. Its SpineWand surgical devices use plasma disc decompression, a minimally invasive procedure for patients with symptoms associated with a contained disc herniation who have failed conservative care and are not yet candidates for major surgery. The AccuMeter manometer provides a precise digital read out that records opening and maximum disc pressures for each level and prints the information on a sheet of paper. The company reported a more than 4 percent increase in revenues in 2009. www.arthrocare.com

7. Aspen Medical Products (Irvine, Calif.). The company makes upper and lower spinal orthotics. It was formed in 2000, when International Healthcare Devices, the product development and marketing arm for Aspen Cervical Collars and CTOs, merged with Fiji Manufacturing. Aspen Medical's Symmetrically Adjustable Cervical Collar won first place for Best New Technology in the cervical care category for 2009, hosted by *Orthopedics This Week*. Other products include the Aspen "Low Profile" LSO, Summit LSO, Aspen Pediatric Cervical Collar, Contour TLSO, QuikDraw RAP and Vista Collar. www.aspenmp.com/products/vista

8. Biomet (Warsaw, Ind.). Company products include reconstructive products for hips, knees and shoulders. It also makes bone cement systems,

orthopedic support devices and operating room supplies. Through its EBI subsidiary, Biomet sells orthopedic fixation devices, electrical bone-growth stimulators, and bone grafting materials. And Biomet Microfixation markets implants and bone substitute material for craniomaxillofacial surgeries. Biomet is controlled by LVB Acquisition, owned by a group of private equity firms. www.biomet.com/regions/northAmerica/unitedStates.cfm

9. ConforMIS Corp. (Burlington, Mass.). This company holds more than 250 patents and patent applications in imaging software, image processing, implant design, surgical techniques and instrumentation. But it has truly stood out for its patient-specific knee implants that have been shown to be a superior alternative to off-the-shelf knee implants. ConforMIS was a winner of the 2009 Medical Design Excellence Awards for its iUni and iDuo resurfacing implants. In April, ConforMIS received CE Mark certification to market its iUni G2 patient-specific knee replacement system in Europe. The iUni G2 is the only patient-specific unicompartmental knee resurfacing implant currently on the market. www.conformis.com

10. CONMED Corp. (Utica, N.Y.). About 60 percent of CONMED's revenues come from arthroscopy and powered surgical instruments for orthopedic surgery. Its arthroscopic products include reconstruction tools, scopes, implants, and fluid management systems. Brands include Linvatec and Hall Surgical. In Nov. 2009, its Linvatec arthroscopy unit released the Bullseye Anatomic Cruciate Reconstruction System, designed to precisely perform anatomic single bundle and double bundle cruciate reconstructions with a flexible and intuitive guide system. At the time, it also launched an expanded range of smaller sizes of Matryx Biocomposite interference screws for fixation of graft bundles. www.conmed.com

11. Corin (Cirencester, U.K.). Corin makes reconstructive orthopedic devices used in joint replacement procedures. In addition to replacement ankles, hips, knees and spinal implants, it is developing computerized surgical systems for joint replacements and other procedures. Products include the Trinity advanced bearing acetabular system, the MiniHip, the Cormet advanced hip resurfacing system, Metafix, the Uniglide triple radius unicompartmental knee system, the Rotaglide total knee replacement, LARS, the Zenith total ankle replacement and Hip Fracture Management Solutions. Corin was founded in 1985 and went public in 2002. www.coringroup.com

12. Covidien (Loughlinstown, Ireland). In addition to producing many medical products not related to orthopedics or spine, the company makes DuraSeal Spine Sealant to stop cerebral spinal fluid leaks after surgery. DuraSeal was launched in Nov. 2009 and it won first place in the for biomaterials category for Best New Technology for 2009 hosted by *Orthopedics This Week*. The company separated from Tyco International and changed its name from Tyco Healthcare to Covidien, a $10 billion company. www.covidien.com/

13. DFine (San Jose, Calif.). DFine's RF Kyphoplasty procedure with the StabiliT Vertebral Augmentation System, introduced in October 2008, uses site-specific cavity creation, controlled cement delivery and ultra-high viscosity bone cement. Radiofrequency energy is applied to energy-responsive bone cement to create an ultra-high viscosity cement, delivered into a cavity within the vertebra using a remote hand switch that limits the surgeon's exposure to radiation. Two recent studies in Germany showed radiofrequency kyphoplasty with StabiliT for vertebral compression fractures resulted in less cement leakage in patients than traditional vertebroplasty. www.dfineinc.com

14. DePuy (Warsaw, Ind.). DePuy, a division of Johnson & Johnson, includes DePuy Orthopaedics, DePuy Spine and DePuy Mitek. Its products are used for reconstructing damaged or diseased joints, caring for traumatic skeletal injuries, treating spinal disorders and deformity, and repairing injured soft tissue. DePuy's Confidence System, launched in 2008, provides directional high viscosity cement placement and allows for a longer working time than other systems. In May, DePuy launched two products. The Expedium Vertebral Body Derotation Set is for spinal alignment in patients with scoliosis. The Bristow-Latarjet Instability Shoulder System is an instrument set for open and arthroscopic Latarjet or Bristow procedures. www.depuy.com

15. Geistlich Surgery (Root Längenbold, Switzerland). Geistlich Surgery, a unit of Geistlich Pharma, sells products for cartilage regeneration, including natural matrix structures for long-term osteogenesis in orthopedic and trauma surgery and to treat spinal damage. It also makes natural biomaterials for sports medicine and orthopedics and provides therapy concepts for biological cartilage substitute solutions. Orthoss is a bone substitute made from the mineral part of bovine bone. It is structurally integrated into the surrounding bone and incorporated into the physiological remodeling process. www.geistlich.com

16. Eminent Spine (Georgetown, Texas). The company's motto is "Bad to the Bone." Co-founded in 2008 by Steve Courtney, MD, a Texas orthopedic spine surgeon, and David Freehill, an expert in manufacturing and product design, Eminent Spine makes bio-mechanically sound spinal implants. In 2009, it received FDA clearance for a full line of PEEK spacers and for its Fang anterior lumbar buttress plate. Market clearance for the Diamondback Pedicle Screw System with Boa Constrictor Crosslink and the King Cobra Anterior Cervical Plate is anticipated this year. www.eminentspine.com

17. Exactech (Gainesville, Fla.). Founded in 1985 by an orthopedic surgeon and a biomedical engineer, Exactech wants to make every day "a great day in the OR." Exactech provides orthopedic implant devices, related surgical instruments and biologic materials and services to hospitals and physicians. The company markets its products in more than 30 markets in Europe, Latin America, Asia and the Pacific. In May, it acquired Brighton Partners, the sole-source supplier of the direct compression molded poly-

ethylene bearings used in Exactech's Optetrak knee replacement system. In Oct. 2009, the company reported total revenue for the third quarter increased 12 percent over the same period the year before. It reported a 24 percent gain for hip implants, a 4 percent gain for knee implants and 7 percent gain for biologic and spine. www.exac.com

18. Implants International (Cleveland, U.K.). The company sells products for arthroplasty, trauma and spinal implant sectors. Its orthopedic products include Spinal Plif/Alif Cages and End Plates, the CP Titanium-CSLP Plate System, Ultra Low Profile ACP Systems with Dual-Lok Screws, the Secure S3 System, metal-on-metal ACD systems, metal-on-metal posterior approach lumbar systems. Its manufacturing process uses 3-D computer-aided design, computer-aided manufacturing, backed up by a range of computer numerical control manufacturing machines. Inspection is controlled via a ZEISS CNC co-ordinate measuring machine and other non-contact optical devices, housed in a temperature and humidity controlled environment. www.implantsinternational.com

19. K2M (Leesburg, Va.). K2M makes spinal stabilization and minimally invasive systems for treatment of complex spinal pathologies and procedures. Products involve motion preservation, annular repair, and nucleus replacement. John Kostuik, MD, its chairman and co-founder, is former chief of spine surgery at Johns Hopkins University School of Medicine. The company is beginning to market its products in Germany, the UK and Japan. Its Serengeti minimally invasive retractor system earned a Medical Design Excellence Award in 2010. In Nov. 2009, K2M launched the Terra Nova Minimally Invasive Access System and the Serengeti Disposable Kit. Terra Nova, which involves a small incision and uses a muscle-splitting technique, is used in conjunction with Serengeti, which features a flexible polymer retractor for screw-based retraction. www.k2m.com

20. Kinamed (Camarillo, Calif.). Established in 1987, Kinamed sells implantables and instruments for orthopedics and neurosurgery. With about half of its sales abroad now, Kinamed has been seeing double-digit growth for the past three years. Several products are FDA-approved and the Gem total knee system is approved for investigational use. Kinamed makes the CarboJet carbon dioxide lavage system for cleaning and preparing bone surfaces; the SuperCable Iso-Elastic Cerclage system, a polymer-based cerclage system; and the KineMatch Patello-Femoral Replacement, a unicompartmental joint replacement for patients with isolated, end-stage patello-femoral disease. www.kinamed.com

21. Lanx (Broomfield, Colo.). Founded in 2003 and led by medical professionals and engineers, Lanx's devices and systems are used for anterior cervical discectomy fusion, anterior lumbar interbody fusion, deformity correction of the thoracolumbar spine, lumbar fracture fixation, lumbar fusion, posterior cervical fusion, posterior lumbar interbody fusion, posterolateral fusion, thoracic fracture fixation and transforaminal lumbar interbody fusion. Its Silverton Spinal Fixation System is for use in the thoracolumbar spine region. Other products include the Fortis Allograft Interbody Spacers, Silverton-D Deformity System, and the Snowcap Anterior Cervical Plate. Lanx had backing from several institutional investors, including Chicago Growth Partners, Goldman Sachs Private Equity Opportunities Fund, Noro-Moseley Partners and Oakwood Medical Investors. www.lanx.com

22. Medtronic (Minneapolis). Medtronic controls more than half of the spine market, but the market is growing rapidly and future control is very much in flux, orthopedic surgeon John Cherf, MD, told *Becker's Orthopedic & Spine Review* last year. Medtronic's Spinal and Biologics business collaborates with surgeons and researchers to treat neurological, orthopedic

and spinal conditions. Products include bone grafts, minimal-access spinal technologies and image-guided surgical navigation procedures. In 2007, it launched the CD Horizon Legacy Anterior Spinal System. In 2008, it acquired Restore Medical, which makes devices to treat sleep-disordered breathing. Its balloon kyphoplasty system leads the market for compression fracture treatment. In Dec. 2009, Medtronic launched the Sovereign Spinal System, an intervertebral body fusion device. www.medtronic.com

23. NuOrtho Surgical (Fall River, Mass.). Founded in Sept. 2008, NuOrtho is an early-stage medical device company, focusing on treating damaged tissue and preserving healthy tissue. NuOrtho has three main product platforms: soft tissue treatment, agent delivery and bone fusion. Its first product launch will be Ceruleau, a technology for knee cartilage that is a surgical probe designed to preserve joint cartilage during surgical treatment for articular knee cartilage. The company's nine patents involve tissue preservation. www.nuorthosurgical.com

24. NuVasive (San Diego). NuVasive's products cover spine surgery procedures, implants and instruments. Its principal product, the Maximum Access Surgery platform, involves a lateral approach, eXtreme Lateral Interbody Fusion, which spreads the psoas muscle instead of cutting it. The MAS platform uses a software algorithm enabling the surgeon to see the nerve's location in real time. After going public in 2009, NuVasive's total revenue rose 48 percent from 2008 and it is projecting annual sales of $500 million for 2010. In March, UnitedHealthcare and Aetna began to cover Xtreme, which they had previously classified as unproven technology. The company is developing the MAS-TLIF system, allowing surgeons to compress and distract bones of the spine through a 1.25-inch incision. In Oct. 2009, the company posted third-quarter sales of $94.9 million, up 41.8 percent from the same period the year before. www.nuvasive.com

25. OMNIlife Science (East Taunton, Mass.). Founded in 1999, this orthopedic device company offers modular hip stem technology and total knee replacement systems. It sells the Apex Modular Hip System, the Apex K1 Hip System, the Apex K2 Modular Hip System and the Apex Knee Reconstruction System. In June, Orthopaedic Synergy, the holding company for OMNIlife Science, completed its acquisition of Praxim, a French company that develops automated systems, software and instruments for total joint arthroplasty. OMNIlife Science plans to extend its hip and knee product offerings and introduce of new products to complement its current product portfolio. www.omnils.com

26. Orthalign (Aliso Viejo, Calif.). OrthAlign makes surgical navigation products for precise alignment. Its palm-sized KneeAlign system addresses tibial alignment in total knee arthroplasty. It is a disposable unit for one-time use at significantly lower cost than large console CAS and does not require a CT Scan, MRI or additional x-rays. In March, OrthAlign received market clearance from the FDA for the latest version of KneeAlign. www.orth-align.com

27. Orthofix (McKinney, Texas). The company's product offerings include internal systems to lengthen bone, plating systems to reconstruct a deformity, soft tissue management for rehabilitation and cold therapy for post-surgical pain management. In June, Orthofix's Breg sports medicine division won the 2010 CIO 100 award for its Vision Advanced Inventory Management software, which automates management of in-house inventories of orthopedic bracing and other products. In May, the company launched three sports medicine products: a lateral stabilizer with hinge, the Polar Care Kodiak Intelli-Flo Hip Pad and a neutral hand accessory. The company collaborates on R&D with the Musculoskeletal Transplant Foundation, the Orthopedic Research and Education Foundation, the University of Medicine

and Dentistry of New Jersey and the National Osteoporosis Institute. www.orthofix.com

28. OrthoPro (Salt Lake City). Since 2003, OrthoPro has released several surgical foot and ankle products for podiatrists and orthopedic surgeons. Its first product was the Subtalar Spacer, a minimally invasive approach for flexible flatfoot deformity. It also makes the Cannulated Screw System for use in midfoot and forefoot surgeries, the Mini-Rail External Fixation Device and the Hemiarthroplasty Implant. Its Total Compression Plate System, released in 2010, has a variety of plate sizes and configurations. www.orthoprollc.com

29. Osseon Therapeutics (Santa Rosa, Calif.). This $14 million start-up company was launched by the University of Northern California. Osseon focuses on bone cement delivery devices and bone cement composite for treating symptomatic compression fractures of the vertebral spine. Its Osseoplasty 1.0, launched in Dec. 2008, features a curved delivery system that enables the physician to channel through the vertebral body, creating a void to house the injected bone cement. www.osseon.com

30. Pioneer Surgical Technology (Marquette, Mich.). The company's first product, the Songer Spinal Cable System, introduced in 1992, was designed to be superior to wire in ease of use, flexibility and strength. This surgeon-driven company in Michigan's isolated Upper Peninsula has expanded into orthobiologics and has exhanced its spinal implant offerings. Products include the Quantum Spinal Rodding System and nanOss Bioactive. During 2006, the company signed a distribution agreement with Regeneration Technologies and acquired Encelle, renamed Pioneer Surgical Orthobiologics, maker of E-Matrix, a sterile, injectable biopolymer for the repair of diseased or damaged tissue. www.pioneersurgical.com

31. RTI Biologics (Alacua, Fla.). RTI Biologics, formed by the 2008 merger of Regeneration Technologies and Tutogen Medical, provides allograft and xenograft implants for orthopedic and other specialty surgeries. In early 2010, the company launched one spinal implant and three implants for bone graft substitutes and general orthopedics. RTI makes BioSet demineralized bone matrix. In Oct. 2009, the company posted record revenues of $42.8 million for the third quarter, an 11 percent increase over the same period the year before. In the first quarter of 2010 revenues were up 2 percent over the prior-year period. www.rtix.com

32. SI-Bone (Cupertino, Calif.). This company has been pioneering the use of a minimally invasive surgical device to treat the sacroiliac joint. Its iFuse Implant System allows for a less invasive approach than an open surgical procedure. This simpler approach reduces OR time to less than one hour, produces fewer complications and provides a stronger construct than other sacroiliac joint fixation systems. SI-Bone has been working with several well-known spine surgeons with experience in low back pathologies. In February, the company launched a smaller, 4.0 mm size of its iFuse Implant System. www.si-bone.com

33. Siemens Medical Solutions (Malvern, Pa.). Siemens Medical Solutions provides imaging modalities for orthopedic surgery and neurosurgery. Products include flexible mobile C-arms, navigation, surgery tables and ultrasound. The company is part of Siemens Healthcare, which provides medical imaging, laboratory diagnostics, medical information technology and hearing aids. www.medical.siemens.com

34. Small Bone Innovations (Morrisville, Pa.). Formed in 2004, Small Bone Innovations has been acquiring companies in the small bone and joint market. Its product portfolio includes more than 40 devices and instruments in arthroplasty, fixation, trauma and biologic solutions. The company has acquired Avanta, which specializes in hand, wrist and elbow arthroplasty and trauma products; Fixano, specializing in hand, wrist, elbow and shoulder arthroplasty and trauma products; Envision, an implant manufacturer; Actipore, a porous metal technology company; Artelon, involved in biologically active and biodegradable technology; and Xtremi-T, which focuses on resorbable trauma technology. www.totalsmallbone.com

35. Smith & Nephew (Memphis, Tenn.). The Smith & Nephew Orthopaedics division makes Oxinium Genesis II and Profix Knee Systems, TriGen Intramedullary Nails, Synergy and Echelon hip operation systems, and the Exogen Ultrasound Bone Healing System. Recent launches include Oxinium material for hip and knee implants, the Birmingham Hip, BHR Resurfacing and the Journey Deuce knee. Other products include the Emperion Modular Hip System, the Legion Revision Knee System and Synergy Primary Hip Systems. Smith & Nephew research focuses on bioresorbable polymers, tissue and cell engineering and non-invasive stimulation. In May, the company reported first quarter revenues were up 9 percent from the same period the year before. http://global.smith-nephew.com/master/6600.htm

36. Spinal Motion (Mountain View, Calif.). Founded in 2004, Spinal Motion makes artificial discs for use in the spine. The company has applied for premarket approval of its Kineflex Disc, for lumbar cases, and its Kineflex C Disc, total disc replacements for cervical cases that preserve motion. These are weight-bearing, modular implants consist of two keeled endplates and one semi-constrained, fully articulating cobalt chrome core. In Nov. 2009, Spinal Motion announced it had secured $27.4 million in Series D funding and reached 20 percent enrollment for a laterally placed lumbar artificial disc clinical study. www.spinal-motion.com

37. Spine Surgical Innovation (South Easton, Mass.). SSI designs and markets the Holmed Swivel Port System, which is intended for posterior or lateral lumbar surgery. The SSI product line is categorized into three key sections: lumbar, cervical and instruments. SSI's products include a line of dilator products, swivel tip rod forcepts and nerve hook retractors and bayonets. www.spinesurgicalinnovation.com

38. Stryker Corp. (Kalamazoo, Mich.). Stryker is a seasoned player covering all key applica-

continued on page 23

BECKER'S ASC REVIEW
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PROGRAM SCHEDULE

Pre Conference – Thursday October 21, 2010

11:30am – 1:00pm	Registration
1:00pm – 5:30pm	Pre-Conference
5:30pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Main Conference – Friday October 22, 2010

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:40pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:45pm – 7:00pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday October 23, 2010

7:00am – 8:10am	Continental Breakfast
8:10am – 1:00pm	Conference

Thursday, October 21, 2010

Session A – Turning Around ASCs, Ideas to Improve Performance and Benchmarking

1:00 – 1:40 pm
ASC Strategies for the Foreseeable Future - A View of The National Landscape Trends Through the ASC Prism - Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, and Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America

1:45 – 2:25 pm
Selling Shares and Resyndication - Larry Taylor, CEO Practice Partners in Healthcare and Melissa Szabad, JD, Partner, and Elaine Gilmer, McGuireWoods, LLC

2:30 – 3:05 pm
10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them - Brian Brown, Regional Vice President, Operations, Meridian Surgical Partners, and Reed Simmons, Administrator, Treasure Coast Center for Surgery

3:10 – 3:45 pm
5 Steps to Have Your ASC Maximize its Profits - Chris Bishop, SVP, Acquisitions & Business Development, Blue Chip Surgical Center Partners

3:50 – 4:25 pm
What Every Surgeon Should Know; What Really Matters to Your Manager? - Lisa Austin, RN, CASC, Vice President of Operations, Pinnacle III

4:30 – 5:30 pm - KEYNOTE
Leadership and Motivation in 2010 - Coach Bob Knight, Legendary NCAA Basketball Coach

Session B – Spine, Orthopedics, Pain and General Surgery

1:00 – 1:40 pm
Business Planning for Orthopedic and Spine Driven Centers - Jeff Leland, CEO, Blue Chip Surgical Center Partners

1:45 – 2:25 pm
Keys to Great Success with Outpatient Spine Surgery in ASCs - Richard Wohns, MD, Founder Neospine and South Shore Surgery, Introduced by Michael Weaver, VP Acquisitions & Development, Symbion, Inc.

2:30 – 3:05 pm
Assessing and Improving the Profitability of Orthopedic, Spine and Pain in ASCs - Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America

3:10 – 3:45 pm
Building Outstanding and Profitable Pain Management Programs, Making Pain Profitable - Stephen Rosenbaum CEO, and Robin Fowler, MD, Medical Director, Interventional Management Services

3:50 – 4:25 pm
General Surgery in ASCs - What you Can and Can't Do - Bob Scheller, Jr., CPA, CASC, Chief Operating Officer, and Tom N. Galouzis, MD, FACS, President & CEO, Nikitis Resource Group

Session C – GI, Ophthalmology and Management

1:00 – 1:40 pm
GI - Centers What to Expect for the Next Five Years - John Poisson, EVP & Strategic Partnerships Officer, Physicians Endoscopy

1:45 – 2:25 pm
Benchmarking for GI Centers - Barry Tanner, President & CEO, and Karen Sablyak, EVP, Management Services, Physicians Endoscopy

2:30 – 3:05 pm
Using Ophthalmology as the Beach Head of a Center - Cataracts, Retina and IOLS Ophthalmologists as Leaders - Carol Slagle, Administrator, Specialty Surgery Center of New York, John Fitz, MD, Medical Director, Precision Eye Care, Joseph Zasa, JD, Partner, ASD Management, Moderator

3:10 – 3:45 pm
Dealing With Difficult Physicians - John Byers, MD, Medical Director, Surgical Center of Greensboro, Orthopaedic Surgical Center, Introduced by Holly Ramey, Vice President of Operations, Surgical Care Affiliates

3:50 – 4:25 pm
Tomorrow is Now, Prepare Your ASC for an Uncertain Future, Rajiv Chopra, Principal and CFO The C/N Group, Inc.

Session D – General Management and Accreditation

1:00 – 1:40 pm
How to Reduce Costs and Hours Per Case - Joyce Deno Thomas, RN, BSN, SVP Operations

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& Corporate Clinical Director, Regent Surgical Health and Nap Gary, Chief Operating Officer, Regent Surgical Health

1:45 – 2:25 pm
We Don't Need a Hospital or Management Company - Thriving as an Independent ASC - Keith M. Metz, MD, Great Lakes Surgical Center

2:30 – 3:05 pm
How to Recruit and Retain Great Talent - Doug Smith, President, BE Smith

3:10 – 3:45 pm
The Most Common Accreditation Problems - Raymond E. Grundman, MSN, CASC, former President, AAAHC, Edward Glinski, D.O., MBA, CPE, Heritage Eye Surgicenter of OK, moderated by Debra Stinchcomb, Progressive Surgical Solutions

3:50 – 4:25 pm
Infection Control in ASCs - Best Practices and Current Ideas - Cassandra Speier, Senior Vice President of Operations, NovaMed

Session E – Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Opportunities and What it Takes to Expand Services via a Collaborative Effort with the Payor - I. Naya Kehayes, MPH, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management, and Anna Gimble, VP Ancillary Services-West, United Healthcare Services, Inc.

1:45 pm – 2:25 pm
Information Technology - Key Ways to Improve Your Centers Operations - What are the Best Solutions? - Jennifer Brown, RN, Nurse Manager, Gastroenterology Associates of Central Virginia

2:30 – 3:05 pm
Meeting Today's Reimbursement Challenges: "A Case Study for Success" - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing, and Nancy Easley-Mack, LPN, Business Office Manager, Short Hills Surgery Center

3:10 – 3:45 pm
The Top 10 Reasons Claims are Being Denied - Lisa Rock, President, National Medical Billing Services

3:50 – 4:25 pm
EMR What Should It Cost; What System Should our ASC Adopt? Best Practices; Policies and Implementation - Patrick Doyle, VP Sales, SourceMedical

Session F – Valuation and Transaction Issues

1:00 – 1:40 pm
ASC Transactions, Current Market Analysis and Valuations - Greg Koonsman, Senior Partner, VMG Health and Jon O'Sullivan, Senior Partner, VMG Health

1:45 – 2:25 pm
Selling Your ASC - A Process and Plan - What Can you Expect? - Evelyn Miller, CPA, VP Mergers & Acquisitions, United Surgical Partners International, Inc. Michael Weaver, VP Acquisitions & Development, Symbion, Inc., Tom Chirillo, SVP Corporate Development, NovaMed, Jon O'Sullivan, Senior Partner, VMG Health, Scott Downing, JD, Partner, McGuireWoods LLP, Moderator

2:30 – 3:05 pm
Co-Management Relationships With HOPDs - Krist Werling, JD, McGuireWoods, LLP and Scott Safriet, MBA, AVA, Principal, Healthcare Appraisers

3:10 – 3:45 pm
ASC and Healthcare Transactions - The Year in Review - Todd Mello, ASA AVA MBA, Principal & Founder, Healthcare Appraisers, Inc.

3:50 – 4:25 pm
ASC Litigation, Non Competition, Employee Litigation and Other Kinds of Litigation, Key Thoughts - Jeffrey C. Clark, Partner and David J. Pivnik, Associate, McGuireWoods, LLP

5:30 pm
Cocktail Reception, Cash Raffles and Exhibits

Friday, October 22, 2010

8:00 am
Introductions - Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

8:10 – 9:00 am - KEYNOTE
Politics, Healthcare Reform and the 2010 Election - Tucker Carlson, Contributor, FOX News, Editor-in-Chief, The Daily Caller and Senior Fellow, The Cato Institute

9:05 – 9:45 am
The State of The ASC Industry - Andrew Hayek, President & CEO Surgical Care Affiliates

9:50 – 10:30 am
Healthcare Reform and Its Impact on ASCs - Brent W. Lambert, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, Tom Mallon, CEO & Founder, Regent Surgical Health, Marian Lowe, Partner, Strategic Health Care, Moderated and Led by David Shapiro, MD, Director of Medical Affairs, AMSURG

10:30 – 11:20 am
Networking Break & Exhibits

11:25 – 12:10 pm
General Session A
Developing a Strategy for your ASC in Challenging Times - Larry Taylor, President & CEO, Practice Partners in Healthcare, Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Joseph Zasa, JD, Partner, ASD Management, William G. Southwick, President & CEO, Healthmark Partners, Inc.

General Session B
Orthopedics - The Next Five Years - John Cherf, MD MPH MBA, President, OrthoIndex

11:25 – 1:00 pm
General Session C
An 80 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits - Robert Westergard, CPA, Chief Financial Officer, Susan Kizirian, Chief Operating Officer, and Ann Geier, RN MS CNOR CASC, SVP of Operations, Ambulatory Surgical Centers of America

12:15 – 1:00 pm
General Session A
The Best Ideas to Immediately Improve the Profitability of Your ASC - Thomas S. Hall, Chairman, President & CEO, NovaMed, I. Naya Kehayes, MPH, Managing Principal & CEO, Eveia Health Consulting & Management, Jeff Leland, CEO, Blue Chip Surgical Center Partners, Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing

General Session B
What Works and What Doesn't in Hospital JV's - Brett Brodnax, EVP and Chief Development Officer, United Surgical Partners International, Inc. and Scott Nordlund, Vice President, Catholic Healthcare West

1:00 – 2:00 pm
Networking Lunch & Exhibits

Concurrent Sessions A, B, C, D, E, F

Session A – Ideas to Improve Profits

2:00 – 2:35 pm
The Best Procedures for ASCs and What an ASC Should Get Paid - Matt Lau, Director of Financial Analysis, and Mike Orseno, Revenue Cycle Director, Regent Surgical Health

2:40 – 3:15 pm
Practical Tips for Recruiting Physicians - Dale Holmes, Administrator, Warner Park Surgery Center

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
10 Steps to Reduce Costs in ASCs - John Snyders, VP Operations and Anita Lambert-Gale, VP Clinical Services, HealthMark Partners, Inc.

4:30 – 5:05 pm
A Checklist Guide - 7 Steps to Take to Improve Profits Today - Kyle Goldammer, SVP Finance, Surgical Management Professionals

5:10 – 5:40 pm
Should 2 ASCs Merge? The Pros, the Cons and the Next Steps, Can 1+1 Make 3? - A Case Study Review - Tom Yerden, CEO & Founder, TRY HealthCare Solutions

Session B – Orthopedic and Spine ASC Issues

2:00 – 2:35 pm
Handling Complex Spine Cases in an ASC, Clinical and Financial Issues - Marcus Williamson, President, Symbion Neospine Division

2:40 – 3:15 pm
Orthopedics in a Changing Market - TK Miller, MD, Medical Director and Orthopedic Surgeon, Roanoke Orthopaedic Center and Joseph Zasa, JD, Partner, ASD Management

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Current Issues and Advances in Orthopedics - Jack Jensen, MD, Athletic Orthopedics and Knee Center, Michael R. Redler, MD, The OSM Center, John Cherf, MD MPH MBA, President, OrthoIndex, and Elaine Gilmer, JD, McGuireWoods, LLP, Moderator

4:30 – 5:05 pm
Key Thoughts on Urology, Orthopedics and Partners – Bryan Zowin, President, Physician Advantage, Inc., Rob Carrera, President, Pinnacle III, Herbert W. Riemenschneider, MD, Riverside Urology, Inc., Moderator Barton C. Walker, JD, McGuireWoods LLP

5:10 – 5:40 pm
Key Steps to Reduce Implant Costs - John Cherf, MD MPH MBA, President, OrthoIndex, John Seitz, Chairman & CEO, Ambulatory Surgical Group, and Kendra Obrist, SVP, Marketing & Product Development, Access MediQuip

Session C – GI, Opthalmology, ENT, Urology and Pain Management

2:00 – 2:35 pm
GI - How to Thrive in a Declining Reimbursement Market, Barry Tanner, CPA, President & CEO, Physicians Endoscopy

2:40 – 3:15 pm
Ophthalmology, ENT and Pain Management in ASCs - Current Ideas to Increase Profits- Tammy Ham, President, Surgical Specialty Division, and Reed Martin, Group Vice President, Nueterra Healthcare

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Taking Bold Steps to Build Case Volume - Our Direct Access, Screening Colonoscopy Program A Great Case Study - Cindy Givens, Executive Director, and Christine Corbin, MD, Medical Director, Surgery Center at Tanasbourne

4:30 – 5:05 pm
Using Anesthesia to Improve the Effectiveness of Your OR's, Marc E. Koch, MD, MBA, President & CEO, Somnia Anesthesia

5:10 – 5:40 pm
The Cost Benefit to Outsourcing Your Back Office Operations - What Can You and Can't You Outsource? - Tom Jacobs, President & CEO, MedHQ

Session D – Physician Owned Hospitals, Other Models of Physician Hospital Integration

2:00 – 2:35 pm
Healthcare Reform and Its Impact on Physician Owned Hospitals - What Does One Do Now? What are the Alternatives? - Brett Gosney, MD, CEO, Animas Surgical Hospital, and Molly Sandvig, JD, Executive Director, Physician Hospitals of America

2:40 – 3:15 pm
Adjusting to Married Life - Stories of JV Integrations with ASC Partners - Monica Cintado-Scokin, SVP Development, United Surgical Partners, Inc., and Michael Stroup, VP Development, United Surgical Partners

3:15 – 3:45 pm
Networking Break and Exhibits

3:50 – 4:25 pm
Lithotripsy Models and Current Issues with Lithotripsy ASC Relationships - Jay Sweetnich, NovaMed, Inc., Todd J. Mello, ASA, AVA, MBA, Principal, Healthcare Appraisers, Inc.

4:30 – 5:05 pm
Co-Management Arrangements - Valuation and Other Issues- Jen Johnson, CFA, Managing Director, VMG Health and Melissa Szabad, JD, Partner, McGuireWoods, LLP

5:10 – 5:40 pm
Partnership Restructuring A Case Study - Danny Bundren, CPA, JD, Symbion Healthcare

Session E – Managed Care, Revenue Cycles and Reimbursement Issues

2:00 – 2:45 pm
How to Assess if Your ASC Should be In or Out of Network - I. Naya Kehayes, MPH, Managing Partner & CEO, Eveia Health Consulting & Management, and Melissa Szabad, JD, Partner, McGuireWoods, LLP

2:40 – 3:15 pm
How to Handle New Pressure from Payors on Out of Network Issues - Tom Pliura, MD, J.D., zChart

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Ambulatory Anesthesia - Using a Management Company versus Employing an Anesthesia Team - Gregory Wachowiak, MHA, Co-Founder & President, Anesthesia Healthcare Partners

4:30 – 5:05 pm
Key Steps to Improve Billing and Increase Collections - Bill Gilbert, VP Marketing, AdvantEdge Healthcare Solutions

5:10 – 5:40 pm
10 Ways to Improve an ASCs Coding - Document Deficiencies, Financial Impacts and How to Work with Physicians - Cristina Bentin, CCS-P, CPC-H, CMA, Founder, Coding Compliance Management, LLC

Session F – Leadership, Competition and Legal Issues

2:00 – 2:35 pm
What Great Administrators Should be Paid and What They Should Do to Excel? - Greg Zoch, Partner & Managing Director, Kaye Bassman International

2:40 – 3:15 pm
The Most Common Medical Staff Issues and How to Handle Them - Thomas J. Stallings, Partner, McGuireWoods LLP

3:15 – 3:45 pm
Networking Break & Exhibits

3:50 – 4:25 pm
Medical Director 101 - What it Takes to be a Great Medical Director - Dawn McLane, RN, MSA, CASC, CNOR, Chief Development Officer, Nikitis Resource Group, and Jenni Foster, MD, The ASC at Flagstaff

4:30 – 5:05 pm
How to Develop a Successful ASC Joint Venture with a Hospital - Robert Zasa, MSHHA FACMPE, Founder, ASD Management

5:10 – 5:40 pm
How to Value and Sell an Under Performing ASC - Chris Bishop, SVP, Acquisitions & Business Development, Blue Chip Surgical Center Partners

5:45 – 7:00 pm
Cocktail Reception, Cash Raffles and Exhibits

Saturday, October 23, 2010

8:10 – 8:50 am
ASCs and Healthcare - An Overview of the Key ASC Trends and Large ASC Chains -Tom Mallon, CEO and Founder, and Vivek Taparia, Director of Business Development, Regent Surgical Health

8:55 – 9:40 am - KEYNOTE
Peak Performance - How to Achieve Peak Performance as a Person and an Organization - Lt. Colonel Bruce Bright, President & CEO, The Bright Consulting Group

Concurrent Sessions A, B, C, D, E

Session A

9:45 – 10:45 am
Physicians, Hospitals, and Management Companies - What it Takes to Make a Winning Partnership and ASC - Jeffrey Simmons, Chief Development Officer, Nap Gary, Chief Operating Officer, Regent Surgical Health

10:50 – 11:50 am
How to Start a Spine Focused Center - Jeff Leland, CEO, Blue Chip Surgical Center Partners

Session B

9:45 – 10:45 am
10 Keys to Great Performance as a DON - Sarah Martin, MBA, RN, CASC, Regional Vice President of Operations, Meridian Surgical Partners, Lori Martin, RN, BSN, RT(R), Administrator, Summit Surgery Center, Anne M. Remm, RN, BSN, Administrator, Miracle Hills Surgery Center

10:50 – 11:50 am
Accreditation 101, Everything You Need to Know About ASC Accreditation - Marilyn K. Kay, RN, MSA, HFAP Nurse Surveyor, fomerly Vice President of Patient Care Services and Chief Nursing Officer, Henry Ford Bi-County Hospital, HFAP

Session C

9:45 – 10:45 am
Why Develop an ASC and Why Now is a Great Time to Do So? Key Steps for Development - John Marasco, AIA, NCARB, Principal & Owner, Marasco & Associates, and Rob McCarville, MPA, Principal, Medical Consulting Group

10:50 – 11:50 am
Can You Split Up Shares Based on Value of Cases; Can you Redeem 1 Non Safe Harbor Doctor and Keep Others in? Can You Amend Your Operating Agreement to Require Safe Harbor Compliance - Scott Becker, JD, CPA, Partner, Elissa Moore, JD, Gretchen Townshend, JD, and Sarah Abraham Chacko, JD, McGuireWoods, LLP

Session D

9:45 am – 10:45 am
Making the Best Use of Information Technology in ASCs - Marion Jenkins, Founder & CEO, QSE Technologies, Inc., Todd Logan, VP Sales, Western Region, Ron Pelletier, Director of Development, SourceMedical

10:50 – 11:50 am
Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues? - Stephen Peron, Partner, AVA, and Todd Sorenson, Partner, AVA, VMG Health

Session E

9:45 – 10:45 am
Billing and Coding - A 60 Minute Workshop to Maximize Reimbursement - Caryl Serbin, RN BSN LHRM, President & Founder, Serbin Surgery Center Billing

10:50 – 11:50 am
How to Improve Coding for ASC Procedures - A Discussion of Orthopedic, Spine, GI and Ophthalmology Procedures - Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting, Inc.

General Session

12:00 – 1:00 pm
10 Key Legal Issues for 2010 - 2011 - Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

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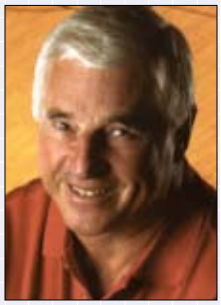
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- Tucker Carlson, Political Commentator
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42 Orthopedic and Spine Device Companies to Know
(continued from page 16)

tions, from hip, knee and upper extremity to spinal implants. Products include artificial joints, spinal rods and screws, artificial vertebral discs and bone cement. Its OP-1 is a biological product to grow bone. Stryker also makes video-assisted surgical systems for minimally invasive surgery. In April, the company announced it had made its one-millionth Exeter hip stem, developed by an orthopedic surgeon and an engineer 40 years ago to control aseptic loosening. In April, the company launched the iVAS inflatable vertebral augmentation system for vertebral compression fractures. In February, it released the Rejuvenate Modular Primary Hip System, designed to closely match the hip biomechanics of the patient. www.stryker.com

39. Tornier (Edina, Minn.). Tornier makes orthopedic devices such as the Aequalis line of shoulder arthroplasty prostheses and the Salto and Salto Talaris total ankle prostheses. It offers a portfolio of foot and hand products including the NexFix system for reconstructive foot surgery, the CoverLoc system for wrist fracture repair, the Piton shoulder anchor system and ArthroTunneler system for rotator cuff repair, and the Conexa tissue matrix for tendon and ligament repair. Tornier has collaborations with BioSurface Engineering Technologies, Bioretec and Tepha Medical Devices, providing access to non-metal technologies for unmet soft and hard tissue repair. In June, the company filed for a $205 million IPO. www.tornier-us.com

40. VertiFlex (San Clemente, Calif.). The company makes minimally invasive and motion-preserving spinal surgery technologies. Its Dynabolt Dynamic Stabilization System is a pedicle screw-based system to allow a full range of motion. The Superion Interspinous Spacer, still under clinical investigation, is for patients with moderate lumbar spinal stenosis. The Silverbolt MIS Screw System, introduced in 2007, serves as a surgery platform by supporting a mini-open approach through VertiFlex's Oracle Expandable Retractor. The Silverbolt MLR System percutaneously delivers two rods into a single screw for multilevel stabilization applications. The Octane Spinal Implant System uses an implant made from PEEK Optima and has radiographic markers to ensure accurate placement. The Mainframe Screw System is the foundation for the company's posterior spinal fixation systems. www.vertiflex.net

41. Wright Medical Technology (Arlington, Tenn.). Wright Medical Group makes surgical solutions for the foot and ankle market as well as hip and knee repair and reconstruction. The company recently launched the Xpansion Micrografting System for split-thickness skin grafting and Valor Hindfoot Fusion Nail for the treatment of skeletal deformity, late-stage arthritis or complications from diabetes. Other Wright products are the Charlotte family of reconstructive implants, Darco locked plating systems, Ortholoc polyaxial locking systems, the Bioarch subtalar implant, Side-Kick External Fixators, Cancello-Pure and Biofoam osteotomy wedge systems, Dart-Fire small screw systems, Graftjacket regenerative tissue matrix, and the Inbone total ankle replacement. www.wmt.com

42. Zimmer Holdings (Warsaw, Ind.). Globally, Zimmer controls 27 percent of the market for artificial knees, 21 percent of the market for artificial hips, 13 percent of the market for extremities, 5 percent of the market for trauma products and 3 percent of the market for spine. It makes the NexGen knee System, the bone-conserving Fitmore Stem, the Zimmer M/L Taper Hip Prosthesis with Kinectiv Modular Neck technology, the Zimmer Trabecular Metal Glenoid and the Zimmer Natural Nail System. In 2008, the company acquired Abbott Spine, maker of spine implants. In March, Zimmer launched a line of Zimmer Patient Specific Instruments, which use MRI technology and pre-operative planning tools to create customized cutting guides tailored to each patient's own anatomy. www.zimmer.com ■

Dr. Boyd Haynes: Q&A About Virginia's First Outpatient Total Knee Replacement

By Laura Miller

Boyd Haynes, MD, an orthopedic surgeon with Orthopaedic & Spine Center performed Virginia's first outpatient total knee replacement surgery in July in Newport News, Va. The procedure lasted a little over an hour and the patient was able to return home after spending less than 10 hours at Bon Secours Mary Immaculate Hospital.

After returning home, the 52-year old patient had access to in-home care from Bayada Nurses/Home Care Specialists. "The procedure was very successfully and she's doing very well. I look forward to the future," says Dr. Haynes. He feels a large percentage of total joint surgeries can become outpatient procedures.

Q: Why was it possible to perform the total knee replacement surgery as an outpatient procedure?

Dr. Boyd Haynes: I have been doing partial knee replacements as an outpatient procedure for 5-7 years. We extended the basic principles from partial knee replacements to total knee replacements and it is a fairly straight-forward transition. The surgery is minimally invasive compared to what we used to do years ago so recovery is quicker. We have also developed an Outpatient Total Joint Protocol which has helped along with advanced pain management and coordinated outpatient home healthcare. All of these have played an important role in outpatient total joint replacement becoming a reality in Virginia. All patients need to be motivated with supportive family.

Q: What led to your decision to perform this procedure now?

BH: I look at it as a natural progression. I try to look at and see how I can help my patients and what I would want if I were in their place. I would love to recover at home and not be admitted to the hospital for my joint replacement.

Q: What is the advantage to making this an outpatient procedure?

BH: My concern with joint replacement now is infection. If I can treat my patients as outpatients, I think their risk of hospital acquired infection should be less. I also use skin glue on all incisions and feel sealing the skin when they leave the OR should also decrease infection. At home the patients are able to sleep in their own bed which allows better rest (without nursing interruptions), get medications when they want and eat their own food. They do the same amount of therapy, lab work and vital sign checks as they do if they were in the hospital. They just recover at home instead of the hospital bed.

Q: What does making the surgery outpatient mean for the future?

BH: I think the procedure is not for everybody because you have the older population as well as the sicker population who need more help. For healthy motivated people, I think outpatient joint replacement surgery is a great option. There should also be some cost savings by doing them as an outpatient.

Q: Do you think other total joint surgeries can be outpatient?

BH: Yes. Twenty years ago, all total joint patients stayed in the hospital seven days. Now we are progressing to outpatient total hip and knee replacement. It's pretty outstanding what we've been able to do in past two decades. The future is bright. ■

Learn more about Orthopaedic & Spine Center at www.osc-ortho.com.

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3 Ways to Control Ancillary Service Leakage With OrthoCarolina CEO Dr. Daniel Murrey

By Rachel Fields

A couple of years ago, CEO Daniel Murrey, MD, and his staff at OrthoCarolina were experiencing a high level of leakage to other sites for ancillary services. After a few years of concerted effort to improve ancillary services and work around customers' schedules, his practice has seen a large decrease on leakages for physical therapy, MRI and DME. Here, he shares three tips on controlling leakage for ancillary services.

1. Invest in quality equipment. According to Dr. Murrey, it is essential that your physicians are confident in the quality of the products you provide. "Even though the physicians own MRI scanners, they won't send patients there unless they know the scan is as good or better than one you can get anywhere else and that the people who read the scans can give great reads," he says. Investing in quality equipment might strain your practice financially in the short-term, but you will benefit long-term because state-of-the-art products will attract more customers, and your physicians will feel comfortable recommending your ancillary services to their patients.

2. Keep scans within the practice. Because patients often travel to seek orthopedic treatment, a practice can control ancillary service leakage by ensuring that traveling patients can get MRI scans done while they're in town. "Sometimes it's just a matter of another relationship the patient may have, where they're contracted to be scanned elsewhere through worker's comp," says Dr. Murrey. "But with the things we can control, we try to make it easier for patients to be scheduled with us." This might mean keeping your practice open seven days a week like OrthoCarolina. Dr. Murrey says that his practice provides scans from 7 a.m. to 7 p.m. every day of the week to ensure that patients do not have to seek ancillary services elsewhere.

3. Be flexible and creative. It helps to go the extra mile to help your patients out. According to Dr. Murrey, OrthoCarolina offers two mobile MRIs so that they can offer scans in remote communities to patients who may not be able to travel. "It helps with geographic concerns and scheduling concerns," Dr. Murrey says. ■

Learn more about OrthoCarolina at www.orthocarolina.com.

13 Strategic Thoughts and Concepts for Orthopedic Practices: Developing a Strategic Plan and Allocating Practice Resources
(continued from page 1)

one of these three generic strategies. Otherwise, with more than one single generic strategy the firm will be "stuck in the middle" and will not achieve a competitive advantage.

He also states, "These generic strategies are not necessarily compatible with one another. If a firm attempts to achieve an advantage on all fronts, in this attempt it may achieve no advantage at all. For example, if a firm differentiates itself by supplying very high quality products, it risks undermining that quality if it seeks to become a cost leader. Even if the quality did not suffer, the firm would risk projecting a confusing image."

An orthopedic group may decide to be the absolute lowest cost provider, or it can attempt to be so good in specific areas within their geographic region or nationally and within a specific area of care that it is a magnet for patients, payors and the most sought after residents. I.e., it has established dominance in a niche. This dominance also can discourage competitors' efforts in such areas. For example, it can be the dominant 80 physician orthopedic group in an area where all other groups are five doctors or less. Alternatively, it can be the very best in a service line area such as sports medicine, hand surgery or spine where there can be a sustainable advantage.

Finally, a practice may choose to be the most customer centric enterprise. Here, the practice may see as its customer, either a hospital, patients generally, or specific payors and try and develop an extremely close relationship or working relationship with such party. For example, a group my decide it wants to develop a very close and customized relationship with the lead payor and be willing to sit down with the payor and try new risk offerings or recruit to fill gaps in the payors' coverage. Alternatively, a group may endeavor to develop a relationship with a hospital where it becomes the go to group to fill all hospital needs and positions. This may in turn allow the group to maintain the flow of referrals, reduce competitive recruiting, obtain compensation and realize other benefits. There, its essential mission will be to do anything it can for that customer base.

Looking at strategies through this prism, we tend to believe that it is likely not profitable nor fun or fulfilling to be the Walmart of orthopedic care. The Stanford Hospital Chief of Staff, Brian Bohman, M.D. states this well. He states, "We are not a low cost hospital and not likely to be one in the near future." To become a low cost provider, one could envision an orthopedic practice with a very high physician assistant to physician ratio or similar coverage model. Assuming one is not focused on being a cost leader, the concept becomes that one has to normalize costs but can't view its absolute goal as being the absolute cost leader. It may be a more profitable strategic alternative to aim to become great and dominant in an area or to become so customer focused and thus spend a huge percentage of time and efforts focusing the organization around those efforts.

In assessing strategy, we are big believers in exploiting existing strengths of the practice first. For example, you might add existing depth and strength to your most dominant geographic or specialty area first. If a practice has great or leading knee specialists and/or sports medicine program, or a leading business site or unit, it should generally invest first in marketing, equipment and recruiting for these strengths. A goal would be to be truly dominant in an area and not to sprinkle resources. E.g., if the group has a great hand surgeon, it may add to this area and both strengthen itself and discourage competition and invest here. Likewise, if the group is doing well with spine, it might make sense to attempt to develop a more dominant position in spine and add revenue there. This also, as a group develops critical mass, can discourage competition from attempting to allocate dollars to compete in such areas. Second, the group may diversify in an area that can be high growth areas and where the group has had some success to date. Here, another core tool that can be used for evaluating practice options for growth is the BCG matrix, a tool developed by the Boston Consulting Group essentially divides an entities' offerings into four areas – stars, cash cows, dogs and question marks. See, e.g., www.BCGMatrix.com.

Here, in assessing growth options, a practice may examine first the areas that are immediately adjacent to its strongest areas. This concept of building out from adjacent strengths is a theory developed by Bain & Company, Inc. in a well noted book titled *Profit from the Core* authored by Chris Zook. Bain and Zook note that successful companies focus on 1. Reaching full potential in the core business. 2. Expanding into logical adjacent business surrounding that core. 3. Preemptively redefining the core business in response to market turbulence. Instead of focusing on taking advantage of the next "hot industry", Bain directors recommend that companies focus on strategy, competitive position, reinvestment rates, and execution. They cite the example that the most successful sustained growth companies specialize in goods with lower growth, such as energy (Enron), beverages (Starbucks), and athletic gear (Nike).

In sum, a practice must first decide, with thorough examination of its current business and opportunities, what it desires to excel in and then dedicate a great majority of resources to such efforts.

2. Understand where your revenues are coming from. On a macro level, it is critical for a group to understand by service line — both by area of care and often by referral source or generator of business — what are the key sources of business. Here, if a practice has four service lines that comprise 85 percent of the business, a first goal of management is to align resources to focus efforts on those four service lines. Often this means deepening the strength in those areas and continuing to grow those areas. At the same time with the knowledge that the profitability of service lines changes over time, leadership also needs to have a keen eye on which areas are potential growth areas and then pick and determine a few of those areas to really concentrate a second set of resources on. Finally, there is a school of thought that essentially says a management team wants to spend zero or very little time on those areas that are true weaknesses and/or low growth and low revenue areas and to not divert its time from its core cash flow generating activities and high growth potential areas. Jim Collins in his noted book *Good to Great* states, "In a good-to-great transformation, budgeting is a discipline to decide which arenas should be funded and which should not be funded at all. In other words, the budget process is not about figuring out how much each activity gets, but about determining which activities best support the Hedgehog Concept and should be fully strengthened and which should be eliminated entirely." See also BCG matrix as to a similar concept as to dogs. This kind of discipline can be hard to manage in practice where you see leadership focus on ancillary outside efforts such as a market 30 to 50 miles away from a group's home base or a specialty with very little revenue potential for the system but that seemingly somebody cannot help themselves but be focused on. However, the results that come from such efforts are not nearly worth the cost and time that would have been better spent on the cash generating activities of the organization and the potential high growth areas for the organization. As an example, if a group regularly loses money in a specialty or site or with a payor, the smart move is to often wholly abandon that payor, specialty or site and allocate time and resources to the group's winners.

3. Normalize costs. Even if a group does not intend to be the cost leader, it is generally always a good time to assure that costs are minimized. Are staffing costs in line? Is the group cautious about long term additional buying of equipment, expanding real estate or taking on costs that will be "forever" costs? It is a great concept to consider in hiring that when you hire, you should not look at the new employee as simply a $40,000 to $200,000 a year cost but really you need to look at it as 10 years times that cost in that it is unlikely that once you hire a person, that you will quickly dispose of the person if economics change. In essence, to look at every hire not on a per annum basis but as a long term

cost basis. Here, the message is not to necessary be the low cost leader but to look very carefully at any significant expenses and to bench mark costs against the published data from MGMA, AAOS and other organizations.

4. Investing in technology. A group need not be a technology leader unless this is their key strategy. At that same time, it must have sufficient technology so it does not become a hindrance to either patient care or becoming dominant in a particular type of area. A group needs to have a minimum level or technology investment simply to be able to practice and thrive. Dr. Ken Austin of Rockland Orthopaedics & Sports Medicine said that coordinating an EMR with his practice's scheduling and billing components has significantly increased efficiencies by reducing the number of hours spent entering information into a separate system. With the increasing prevalence of EMRs, this kind of technology becomes essential for a practice to provide efficient, state-of-the-art care.

5. Maximize ancillary income. While a group must fully stay within all legal and regulatory bounds, as practice professional income shrinks, it becomes more important than ever to maximize ancillary income in a safe and smart way. Here, in looking at ambulatory surgery centers, imaging, physical therapy, and other areas, a core concept is to look at which areas have the least risk and can provide the maximum amount of return. This may include physician therapy, pain management, and imaging. Brent Lambert, MD, president and co-founder of ASCOA, says that the addition of a surgery center to an orthopedic practice can augment annual practice income by 15-20 percent. In an interview with Becker's Orthopedic & Spine Review, CEO of GO Partners Gina Volmert said physical therapy can be very profitable if done right. She said while five physicians might be able to support physical therapy services, a practice of ten doctors or more will reap the maximum profits. Invest first in ancillaries with relatively reasonable investment amounts and relatively strong prospects for income. This may guide against an investment in a $10,000,000 building enterprise or more that will return less than a few percent per year?

6. Determine areas of greatness. We are very familiar with a leading group that at one point in its life cycle career decided that it would really focus on doing solely four procedures and spend all its time marketing and focusing on doing those four procedures. The group decided that it was going to be the absolute leader in those procedures. If a group can take leadership or focus in such a manner and then aggressively market that expertise and both internally and externally, both to the general public and to the medical community, there are often excess profits to be made through such leadership.

7. Adopt a marketing strategy. A practice should adopt a marketing strategy that keeps it less vulnerable to changes in hospital attitudes. Orthopedic practices often draw patients from the general public as well as from typical referral sources such as primary care physicians and hospital emergency rooms. The more diversified the referral source, the more stable the group is. One of the great providers of strategies and services for marketing a healthcare practices is Healthcare Success Strategies (www.healthcare-success.com). A separate firm that works closely with healthcare businesses that is extremely smart in targeting messages and the use of different types of resources is CCO Partners (www.ccopartners.com).

8. Hospital relations: Keep one foot with the hospital relationship. In orthopedics, professional reimbursement is holding reasonably stable. At the same time, in certain specialties professional reimbursement has been decimated. Those specialties have found themselves absolutely needing to find a way to become employees of or otherwise partner with hospitals. Here, while orthopedics is not at this point right now, it is generally smart to maintain close relationships with the hospitals in both building brands, reducing external competition, and keeping the door open for further relationships and alignments.

9. Call coverage. If providing call coverage, seek to look to see if there is an ability to earn compensation for providing such call coverage. In many markets, being paid for call coverage has become absolutely the norm. The Sullivan, Cotter and Associates' *2009 Physician On-Call Pay Survey Report* states that 82 percent of the survey respondents currently provide compensation to non-employed physicians for call coverage.

10. Billing and collecting. One of the typical ways in which an orthopedic group can improve their results almost immediately is to spend more time on improving their billing and collecting. Often this means outsourcing billing and collecting to a great firm or making that a core strength within the group. The larger the group is the easier it is to make this an absolute core competency within the group. Excellence in billing and collecting can add 5 to 10 percent of revenues per year which has a huge impact on the ultimate profitability for the practice.

11. Use outstanding managed care experts. Most groups cannot afford to internally retain outstanding managed care experts. More often than not, a group should hire outside managed care resources that excel in handling managed care contracts for orthopedic practices. William Pupkis, CEO of Capital Region Orthopedics, told Becker's practices should consider their managed care contracts an "investment portfolio." He says, "Both provide economic returns, and the more diverse they are, the better. Both demand careful management." There are certain firms that really specialize in this for surgery centers and there are firms that specialize in this for orthopedic and spine practices. The difference in using an experienced managed care negotiator (a business person, not a lawyer) can be a huge determination in practice profits over the long run.

12. Ancillary services in-house. Determine whether or not to bring certain ancillary services in-house. This may include, e.g., physician therapy, pain management, and imaging. Practices with financial constraints can consider cheaper alternatives to expensive services. For example, new MRI equipment requires a $750,000-$1 million investment, a sum that is greatly reduced if the practice purchases used or refurbished equipment. Services such as electromyography can be offered for an investment of only $5,000. An equation to examine is can a group make a relatively reasonable investment and can it be paid off within 12 to 24 months. In order to decrease costs and increase efficiency, Jerry Magone of Orthopaedic Sports & Medicine Consultants upgraded his practice's MRI to a green machine, lowering his electrical bill and shortening the per-scan time to allow more patients through the scanner. The group also needs to examine the long term prognosis for reimbursement in the area. That stated, if the total cost to add ancillary services is reasonable, one might simply assess the fact that over time it may or may not be a profitable area but can excess profits be made in the short term. In some ways, groups have to be willing to surf from opportunity to opportunity and have a great team in place to be able to pursue and implement opportunities and retain a reasonable the debt and cost structure that allows them the reasonable ability to invest in new opportunities.

13. Build an outstanding team and retain great leaders. There are two great concepts in business. First, define a clear strategy. Second, retain and recruit the best people. If the group views as a core part of its overall vision to have the best people in place at every level, it is often the case that it can withstand and remain strong and be flexible and excel regardless of exact strategy and outside forces. Jim Collins in *Good to Great* notes as to people and their importance, "Those who build great companies understand that the ultimate throttle on growth for any great company is not markets, or technology, or competition, or products. It is one thing above all others: the ability to get and keep enough of the right people." Periodically, a party can end up in such a challenging market that regardless of the people in place, the business can be a debacle. However, in almost all situations, having the best people in place, intelligence, achievement orientation, and integrity, is the best single determinant of success outside of the total macro conditions for an area. ■

3 Steps to Improve Spine Efficiency and Cut Costs

By Rob Kurtz

Over the last eight months, Sierra Regional Spine Institute in Reno has reviewed its workflow and made several changes to help improve efficiency and cut costs. Penny Forbes, practice administrator, describes three of the most successful changes made by the organization.

1. Reassign staff responsibilities to maximize productivity. We reviewed front office job duties in both our physical therapy department and our clinic. We noticed the support staff in PT had several hours during the day that were "down time" hours. This position requires the employee to be present throughout the day to handle calls, scheduling and billing, but this employee is efficient and was often left with little to do for various periods throughout the day.

In contrast, on the clinic side our front office supervisor often runs out of time because her duties include editing dictation, daily scanning, helping with phones, check out and supervising five other staff members. She also covers each member of the staff when one is out on vacation or sick leave. During this coverage period the dictation and scanning duties are often delayed.

So we assigned the daily scanning to the PT front office staff member to fill her down time, and freed up the clinic supervisor who could then continue to cover not only in the front office but we were able to extend her reach to the x-ray desk and even to the clinic. We have thus enabled our employees to multi-task at a greater level without hiring additional staff.

2. Reduce work hours. Our next change to aide efficiency was to reduce work hours. We observed that during the time between 3:00 p.m. and 5:00 p.m. on Friday afternoons, our employees were extremely non-productive. Many employees would ask to leave early on Friday as well. So we decided to send everyone home early on Fridays, which forced the employees to be more efficient the balance of the week. The same work is being done, with two hours less a week than before. Thus, we cut our payroll expense (by approximately $30,000 per year) while maintaining work flow.

3. Provide better work space. Our practice has six physicians and four mid-level practitioners. At any given time we have four providers and six medical assistants in a very small area sharing nine patient rooms. To alleviate some of this crush we scanned all of our paper charts, pulled out the metal file system and have converted this area to a work space for our medical assistants. We rotate the MAs out of clinic on days the MAs don't support clinic patients, thus opening the clinic work space to those who do. In the end, we have effectively removed unneeded bodies from clinic, which has opened up space for providers with patients to work more effectively. ■

Learn more about Sierra Regional Spine Institute at www.sierraregionalspine.com.

Trends in Sports Medicine: Q&A With AOSSM President Dr. Robert Stanton
(continued from page 1)

Q: In your opinion, what does sports medicine encompass

Dr. Robert Stanton: Sports medicine is really basic musculoskeletal orthopedics. To a great degree, it's general orthopedics with a twist. There's a lot of psychology. Sports are so important to some people. When they injure themselves, it's hard for them to think they'll be able to play at the level they were before. We have to help them understand they can do what they used to.

Q: What is unique about practicing sports medicine as opposed to general orthopedics?

RS: What makes sports medicine unique is that athletes of all ages have a tremendous desire to get better so they are usually very willing to participate in whatever it is they need to do in order to get better. The patients tend to be healthier, fitter people. They have a higher predictability for getting better.

Q: How can a new practice attract patients?

RS: You have to go and stand on the sidelines at Friday night football games, little league games, youth soccer groups. Eventually the work will come your way.

Q: What are the key attributes of a top sports medicine practice?

RS: There are three things: availability, ability and affability. It helps to talk to people, to network in the community. It obviously is critical that you're good at what you do. But if you're not available, the athletes will go somewhere else. The coaches call all the time and you have to be available to them at all times, within reason.

Q: Is an ASC necessary for sports medicine centers?

RS: To build a sports medicine practice, an operating room is not necessary. Having an ASC is a huge benefit because you can do things so much more easily. But not everyone can have that.

Q: What are some challenges for sports medicine physicians?

RS: The biggest challenges are dealing with patients who have unrealistic goals. Young teenagers and college kids often think that they are invincible. The challenge is dealing with the physical and emotional strains of the injury. Sometimes with young kids, interacting with their parents is a challenge because they may expect their kids to earn college scholarships or become professional athletes. It's always a bad thing when you ask a question to the kid and the parent answers continually.

Q: Is there a difference between treating younger and older patients?

RS: Older patients often have the same goals and return to sports as younger ones. They often have some degenerative changes in the joint as well as other medical issues. This must be taken into account when devising a treatment plan. But as the baby boomers are getting older, they aren't giving up anything. Sometimes an 80-year-old tennis player is just as difficult to deal with as a college basketball player. They have the same goal.

Q: What are some of the most common procedures you do?

RS: I primarily do knee surgery, arthroscopic knee and shoulder surgery, removing pieces of torn meniscus, cartilage restoration, meniscal repairs. WE do a fair number for shoulder stabilization procedures, decompressions and labral repairs.

Q: What are some of the latest orthopedic surgical techniques?

RS: The newer and continuously evolving techniques are restorative procedures. Additionally, there have been improved techniques in meniscal repair, cartilage restoration and more anatomic shoulder procedures. There are new ways of doing these procedures in Europe and South America that aren't approved by the FDA so we can't do them in the United States. I hope the future for orthopedics is biology, not technology. ■

Learn more about AOSSM at www.sportsmed.org.

4 Ways to Improve Profits at Sports Medicine Practices

By Laura Miller

Orthopedic practices around the country are opening programs and facilities specifically focused on treating athletes with sports medicine. As a physician at Orthopaedic Specialty Group in Connecticut and President of the American Orthopedic Society for Sports Medicine, Robert A. Stanton, MD, discusses four techniques for improving profits at sports medicine centers.

1. Offer as much on-site treatment as possible. This is key, says Dr. Stanton. "The more parts of the puzzle you can control yourself, the more successful your sports medicine practice will be."

2. Become multispecialty. Sports medicine patients are attracted to practices with physicians who have diverse focuses. Being able to serve the needs for patients with a diverse range of injuries is important.

3. Become a multiservice practice. The most profitable sports medicine practices have the necessary tools and programs for their patients to fully recover from their injury. These practices provide radiology, bracing, physical therapy and in-office trainers who can take care of the athletes through each step of their recovery.

4. Work out of an ASC. While Dr. Stanton says it is not necessary for sports medicine centers to have an operating room, the most successful sports medicine practices have on-site surgical capabilities. Having the ASC is more convenient for the patients as they prepare for their surgery. "The more you can package under one roof so it's a one-stop facility, the better you can help people." ■

Learn more about Orthopaedic Specialty Group at www.osgpc.com.

5 Tips for Building a Successful Sports Medicine Center

By Laura Miller

Sports medicine-specific offerings within orthopedic practices continue to open across the country, serving a wide variety of patients. Professional athletes, recreational active athletes, as well as anyone who injures themselves during everyday activities can seek treatment options at sports medicine practices. "Sports related injuries go beyond what we traditionally think of as 'athlete injuries' thus, as providers, we should design our processes and services accordingly," says Les Jebson, executive director at The University of Florida Orthopedics and Sports Medicine Institute in Gainesville, Florida. "It's a highly competitive field and an essential component to comprehensive orthopedic offerings."

These practices are increasingly designed as comprehensive sports medicine centers which can include ASC/operating rooms, physical therapy, sports psychology and performance. For hospitals or surgeons looking to build a new sports medicine center, Mr. Jebson offers five key elements for consideration.

1. Keep weekend hours. Part of maintaining a successful practice is providing convenient open hours for the patients. Keeping weekend hours creates more time for patients visit at their convenience, or typically after acute injuries. This is especially important during the fall sports season, Mr. Jebson says. "Everything is designed around the optimal patient experience."

2. Research reputable programs. Take a look at what other leading sports medicine practices nationally are doing and decide whether any of their practices would fit with your practice philosophy. Additionally, look at the different orthopedic services and devices and marketing efforts they use to get a sense of cutting-edge possibilities.

3. Have specific team affiliations. Become the primary healthcare provider for sports teams in the area. Not in name only, but functionally. This affiliation can give physicians the chance to work specifically with athlete-related issues as well as links the practice with their community. "Experience and quality comes through volume — have affiliations helps ensure this" says Mr. Jebson. "We take pride in being the actual healthcare provider for many of Florida high school, collegiate and professional sports athletes and teams."

4. Acquire latest technology. For anyone in the orthopedic industry, keeping up on the latest treatments available for patient healing and satisfaction is necessary, especially in diagnostic and interventional radiology and other ancillary resources. The UF Orthopedics and Sports Medicine Institute has one of the largest motion analysis laboratories in the country, and are researching and examining concussion management technology software systems and laser therapy systems as other resources in their patient care arsenal.

5. Attract well trained clinicians. Sports medicine facilities should include physicians who have completed a reputable fellowship in sports medicine at a recognized program. Additional focused training for athletic trainers, physical therapists and other members of the clinical care team should also be encouraged. ■

Learn more about UF Orthopedics and Rehabilitation at www.ortho.ufl.edu.

5 Tips to Improve Recruitment of Spine Physicians and Staff

By Rob Kurtz

Nicola V. Hawkinson MA, RNFA, NP, CEO and founder of SpineSearch, offers the following five tips to help surgery centers and practices recruit great physicians and staff.

1. Don't hire too quickly or out of desperation. "Today's current job market and unemployment rate puts the employer at an advantage to find highly qualified people seeking entrance into healthcare."

2. Have a clear job description. "Before any hirer, having a clear job description is imperative so both the employee and employer have clarity of expectations of performance and productivity."

3. Prepare for the interview. "In addition to the job description, preparation should include previewing a candidate's resume and preparing questions that would help you predict the employee's performance in the practice setting."

4. Include valued members of your team in the process. "Involve your office/practice manager as well as other clinicians who have had a positive effect on your [organization] to help in the decision making of others who will join your team."

5. Utilize references. "Past performance is the best indicator of future productivity." ■

Learn more about SpineSearch at www.spine-search.com.

4 Statistics on Spine Surgeon Compensation

By Rachel Fields

Here are four statistics on spine surgeon compensation, according to the *2008* and *2009 Physician Compensation Survey* conducted by the American Medical Group Association.

1. The median salary for spine surgeons in 2009 was $641,728 — a 5.8 percent increase from $611,670 in 2008.

2. The median salary for spine surgeons in the western United States in 2009 was $661,978 — a 4.1 percent increase from $635,675 in 2008.

3. The median salary for spine surgeons in the northern United States in 2009 was $608,286 — a 3.09 percent increase from $590,000 in 2008.

4. The median salary for spine surgeons in 2009 was 34.7 percent higher than the median salary for general orthopedic surgeons in 2009. ■

Source: American Medical Group Association *2008 Physician Compensation Survey* and *2009 Physician Compensation Survey*.

Advertising Index

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5 Things to Know About the Global Orthopedic Implants Market

By Rob Kurtz

Here are five things you should know about the global orthopedic implants market, according to GBI Research's "The Future of Orthopedic Implants, Analysis and Forecasts to 2016 - Joint Reconstruction and Spinal Implants Creating Growth Opportunities."

1. The global orthopedic implants market is forecast to grow to $41.8 billion by 2016, a 7.8 percent compounded annual growth rate (CAGR) from 2009-2016

2. Joint reconstruction will remain the largest orthopedic implants category, which is expected to reach $22.9 billion by 2016, growing at a 7.4 percent CAGR.

3. The spinal surgery category is expected to reach $11.3 billion by 2016, growing steadily at 10.2 percent during 2009–2016.

4. The trauma fixation category is expected to grow to $7.7 billion at a CAGR of 6.0 percent.

5. The market will be driven by the aging population, technological advancements in implant designs and materials which are resulting in improved durability and younger patients undergoing surgery in the future. ■

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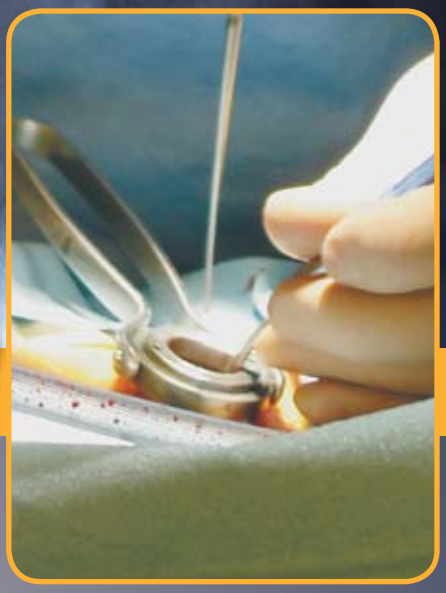

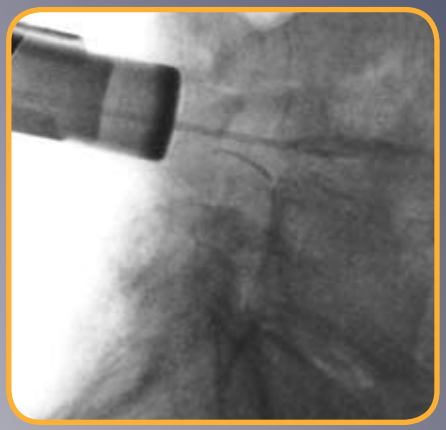

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