Inside: 17th Annual Improving Profitability, and Business and Legal Issues for ASCs Conference Brochure (p. 21)

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BECKER'S
ORTHOPEDIC & SPINE REVIEW
Business and Legal Issues for Orthopedic and Spine Practices
July/August 2010 • Vol. 2010 No. 4

8 Implications of Healthcare Reform on Orthopedic and Spine Practices

By Barbara Kirchheimer

The recently enacted healthcare reform legislation will affect all healthcare stakeholders — consumers, providers and employers — but sorting out the winners from the losers is an inexact science at best at this point. For physicians, especially those in specialty surgical areas, early signs are mixed. The potential benefits of having millions of new patients entering the healthcare system with insurance coverage might be dampened by reimbursement challenges and shortages among the ranks of physicians that could end up reducing patients' access to care.

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Call Coverage Payments: Trends, Regulations, Statistics and Valuation Considerations

By Jen Johnson, CFA, Managing Director, VMG Health

Establishing FMV for call coverage compensation is becoming increasingly difficult as arrangements are evolving and survey data is unreliable. The following will discuss recent trends in paying for call coverage, market statistics and the valuation considerations surrounding certain payment structures.

Growing expenses, industry trends driving call coverage payment growth

In the past, ED call coverage was typically provided by physicians in exchange for admitting privileges. Now, more physicians are demanding payments for call coverage due to:

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Independent Medical Practice: Does Healthcare Reform Mark the Beginning of the End?

By Barbara Kirchheimer

Declining reimbursements, uncertainties about the future and the hassles and costs of running a practice have all combined to make many of today's physicians yearn for some sense of security. In a growing number of cases, they have found it by giving up their independent practices in favor of employment arrangements.

With this trend already established, some observers say healthcare reform, while perhaps not driving the independent physician into extinction, will make it a lot more difficult or unappealing to practice medicine in the traditional way. The law's focus on quality, efficiency and accountability make alignments with hospitals more appealing and may make life even more difficult down the road for those doctors who choose to go it alone.

"I think the independent small medical practice, given the need for integration into delivery systems, given the expense

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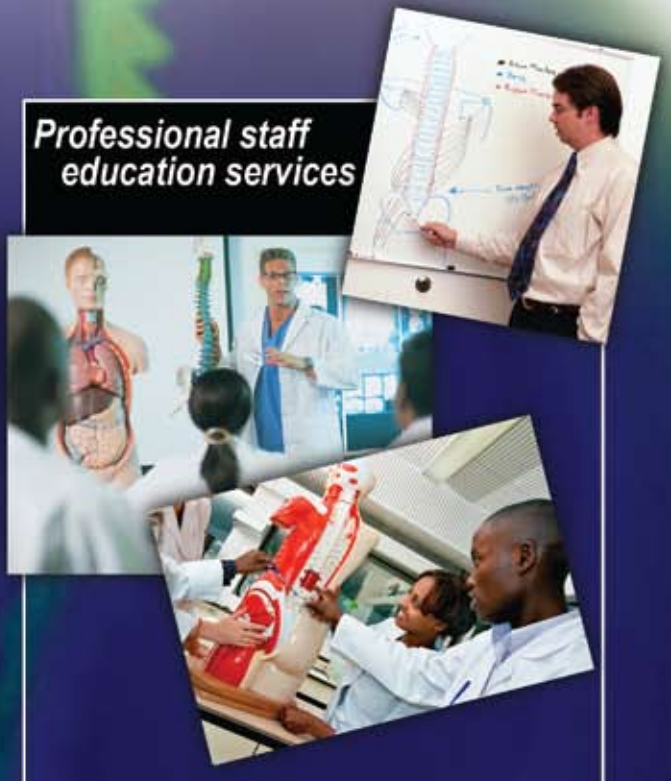

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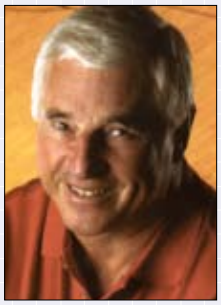
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EDITORIAL

Rob Kurtz
Editor in Chief
800-417-2035 / rob@beckersasc.com

Lindsey Dunn
Writer/Reporter/Editor
800-417-2035 / lindsey@beckersasc.com

Barbara Kirchheimer
Writer/Editor
800-417-2035 / lindsey@beckersasc.com

Leigh Page
Writer/Reporter
800-417-2035 / barbara@beckersasc.com

Renée Tomcanin
Writer/Reporter
800-417-2035 /renee@beckersasc.com

SALES & PUBLISHING

Jessica Cole
President & CEO
800-417-2035 / jessica@beckersasc.com

Kim Hursley
Account Manager
800-417-2035 / kimberly@beckersasc.com

Annie Stokes
Account Manager
800-417-2035 / annie@beckersasc.com

Mike Harris
Account Manager
800-417-2035 / michael@beckersasc.com

Lauren Sturm
Executive Assistant
800-417-2035 / lauren@beckersasc.com

Scott Becker
Publisher
800-417-2035 / sbecker@mcguirewoods.com

FEATURES

Publisher's Letter

A Review of 100 Anti-Kickback and Self-Referral Settlements and Cases; The Erosion of Independent Medical Practice; Outpatient Trends – Six Key Issues; 10 Legal Issues Facing ASCs; Bobby Knight, Tucker Carlson, Lt. Colonel Bruce Bright and 95 Other Speakers; Co-Management Agreements; Anesthesia Models Under Attack; Streamlining Spans and Layers

1. 100 anti-kickback and self-referral cases. We recently had the chance to review nearly 100 kickback and self-referral cases and authored an article related to these findings. The cases highlight an interesting distinction between cases and settlements where the provider or company paid more than $100,000 to settle allegations and those that paid less than $100,000. The distinction often lies in the amount of improper intent involved in the incident or incidents that drove the settlement. The article is entitled "A Review of OIG Self-Referral and Anti-Kickback Cases: 6 Categories of Non-Compliant Physician Relationships and 8 Recent Cases." For a copy of this article, please e-mail me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com.

2. Erosion of independent medical practice. There is likely to continue to be significant erosion in independent medical practice. This does not generally dictate less outpatient work but it does impact the entrepreneurial outpatient side of the business. There are different statistics but generally 40-45 percent of all physicians are now employed by hospitals. There is also anecdotal discussion in the cardiology sector, for example, that while there are 30-35 percent of cardiologists currently employed by hospitals, there are 70-80 percent of cardiologists in talks to become employed.

Independent practitioners have generally been the life blood of ambulatory surgical centers, physician-owned hospitals and several other healthcare free-standing entrepreneurial ventures. Even slight changes in the total number of independent physicians have huge impacts on the economies of scale of surgery centers and physician-owned hospitals. These businesses, like most businesses, work with a fairly fixed set of costs. A great deal of the profits in these businesses is made after a base amount of cases are brought in which cover the fixed costs. Incremental cases drive a great deal of the profits. If the incremental cases are taken elsewhere through employment by hospitals and other systems, this leaves physician-owned facilities in a much tougher predicament.

Several factors are driving the trend towards employment. The top four are 1) money, 2) money, 3) money and 4) life balance.

1) Hospitals can afford to pay physicians well due to the technical fees generated by such physicians for hospitals; 2) physicians are very concerned regarding reimbursement rates; 3) many physicians were hurt significantly by the stock market and real estate crash and are seeking lower risks in their practice; and 4) many physicians who graduated over the past decade seem more focused on life balance and more predictable hours than a business owner's lifestyle.

A statement in an article by Scott Gottlieb, a former CMS official articulates the trend pretty clearly. He states in his *Wall Street Journal* article "No, You Can't' Keep Your Health Plan":

> "Doctors, meanwhile, are selling their practice to local hospitals. In 2005, doctors owned more than two-thirds of all medical practices. By next year, more than 60% of physicians will be salaried employees. About a third of those will be working for hospitals, according to the American Medical Association. A review of the open job searches held by one of the country's largest physician-recruiting firms shows that nearly 50% are for jobs in hospitals, up from about 25% five years ago.
>
> Last month, a hospital I'm affiliated with outside of Manhattan sent a note to its physicians announcing a new subsidiary it's forming to buy up 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.
>
> Consolidated practices and salaried doctors will leave fewer options for patients and longer waiting times for routine appointments. Like the insurers, physicians are responding to the economic burdens of the president's plan in one of the few ways they're permitted to."

3. 5,200 Medicare-certified ASCs. There are now more than 5,200 Medicare-certified surgery centers. There has been a significant deceleration in the growth of surgery centers. In fact one prominent commentator has said this might be the first year in which there is a net loss in the total number of ASCs across the country.

Of the nations Medicare certified surgery centers, 20-35 percent have a hospital partner. Another 20-30 percent are rumored to be not making money at any one time.

4. Revenues under pressure. Revenues for outpatient services will be under tremendous pressure due to two distinct factors: 1) the erosion of independent medical practices which reduces case numbers (discussed above) and 2) the fact that commercial paid reimbursement is under tremendous pressure. The two bigger winners in the healthcare reform bill are likely to be the pharmaceutical industry and the hospital industry. Each have for the foreseeable future solidified a substantial part of the healthcare budget and protect themselves from significant reimbursement risk. This means that if healthcare costs are actually going to be reduced or stay somewhat steady, a great deal of the reimbursement reductions will come from a whole number of other sectors.

Further, insurance companies are exercising more authority over physicians. Here, Mr. Gottlieb says:

> "One of the few remaining ways to manage expenses is to reduce the actual cost of the products. In health care, this means pushing providers to accept lower fees and reduce their use of costly services like radiology or other diagnostic testing."

5. Ten Legal Issues Facing ASCs - 2010. Elissa Moore, Elaine Gilmer and I recently completed an article titled "10 Legal Issues Facing Ambulatory Surgery Centers – 2010." Please contact me at sbecker@mcguirewoods.com or Kirsten Doell at kdoell@mcguirewoods.com for a copy of this article. It outlines issues such as anti-kickback issues, healthcare reform, HIPAA, out-of-network arrangements and a number of other issues.

6. Co-Management Arrangements. Co-management arrangements for the time being seem to be the new thing as a means for hospitals to work with independent physicians. While it is not clear how long co-management arrangements will stay the new hot thing, there is likely to be some period of time in which they remain very important. Some of them appear to be done in "aggressive" ways in terms of payments. It may be that over time as government intervention occurs, these will need to be restructured. We will have three different talks on co-management relationships at our Fall ASC Conference, taking place Oct. 21-23, 2010, in Chicago (see item #10 below for more information).

7. Layers and spans. A very intelligent short article that I read recently was from Bain Consulting. Here, Bain Consulting talked about something they title "layers and spans." The article is titled "Streamlining Spans and Layers: Tuning Your Organization for Better Decisions." The core concept was that reducing the amount of layers in a company by some small degree and increasing a manager's span (for example from five direct reports to seven direct reports) can have a large positive impact on reducing an organization's costs. It was an interesting study, which included some great statistics, and was really informative. In essence, great companies must be modified at layers and spans and great managers ought to have a greater number of people they manage directly (and handle this extremely well). Of course, a key to managing a number of people well is often having "great people and engaging in great recruiting."

8. Outpatient Trends — Six Key Issues. For a copy of a brief article authored by Barbara Kirchheimer and myself titled "Outpatient Trends – Six Key Issues," please e-mail me at sbecker@mcguirewoods.com.

9. Anesthesia Models Under Attack. For a copy of an article entitled "Anesthesia Models Under Attack," please e-mail me at sbecker@mcguirewoods.com.

10. 17th Annual ASC Conference. We have completed the agenda for our 17th Annual ASC Conference. We will be at the Swissotel on Michigan Avenue in Chicago. The conference will include more than 90 sessions and keynote speakers such as Coach Bobby Knight (Thursday pre-conference), Political Commentator Tucker Carlson, and Lt. Col. Bruce Bright. It will also include nearly 95 sessions on business, legal and clinical issues for ASCs. t should be our largest and most interesting conference ever. Should you desire to receive a brochure for the conference, please contact me at 312-750-6016 or at sbecker@mcguirewoods.com.

11. Consolidation. We are seeing substantial consolidation in the hospital and surgery center areas. Consolidation discussions are occurring rapidly both amongst chains and in the acquisitions of hospitals and surgery centers. Prices seem relatively solid.

Should you have any questions, please contact myself at 312-750-6016 or by e-mail at sbecker@mcguirewoods.com.

Very truly yours,

Scott Becker

8 Implications of Healthcare Reform on Orthopedic and Spine Practices (continued from page 1)

Here are eight ways orthopedic, spine and other specialty surgeons believe their lives will change under the new healthcare reform landscape.

1. A greater number of insured patients will bring both benefits and challenges to practicing surgeons. Healthcare reform is expected to bring insurance coverage by 2019 to some 32 million people who currently do not have it. "Overall, I think we're excited about a lot of the things in healthcare reform, and the expansion of coverage for people who previously did not have coverage is pretty exciting," says Stuart Weinstein, MD, president of the American Academy of Orthopaedic Surgeons from 2005-2006. Dr. Weinstein, the Ignacio V. Ponseti chair and professor of orthopaedic surgery at University of Iowa Health Care, says that for the general public, this development is a positive one.

However, some orthopedic surgeons are concerned that insurance coverage will not necessarily guarantee patients access to care in their specialty. "It's very gratifying that a large chunk of the American population that was previously uninsured will have access to healthcare," says Raj Rao, MD, director of spine surgery at the Medical College of Wisconsin's Department of Orthopaedic Surgery in Milwaukee. "But the issue of access to specialty care is as yet unclear. Whether specialists continue to see these patients will be dependent in part on reimbursement rates and whether these rates adequately cover the costs of providing good medical care." If surgeons believe their costs are not going to be covered, they may decide that they are unable to continue to see these patients, he suggests.

2. Failure to fix Medicare's physician reimbursement formula is a major drawback for specialty surgeons. From the perspective of orthopedic and spine surgeons, "when you look at things that haven't been included and weren't addressed (in the healthcare reform legislation), those are problematic," Dr. Weinstein says. Near the top of the list of things that didn't make it into the law is fixing Medicare's sustainable growth rate (SGR) formula, which has been a top priority for physicians as their practice costs continue to rise. But with a price tag topping $200 billion, SGR reform didn't make it into the final bill. Instead of fixing the formula, Congress has been patching and putting off a 21 percent reimbursement cut in fits and starts, which gives physicians little sense of certainty about their financial futures.

The American Association of Orthopaedic Surgeons and other orthopedic groups outlined some of their major objections to the reform legislation in a Dec. 2009 letter to Senate Majority Leader Harry Reid. "By not repealing and replacing the flawed physician payment formula, this legislation severely threatens seniors' ability to access timely and appropriate care from their physicians," the letter states.

This assertion is bolstered by a more recent survey of surgeons released in March by the Surgical Coalition — an umbrella group including the American College of Surgeons and 22 other medical organizations — suggesting that if Medicare reimbursement cuts were to go into effect as planned, many surgeons would stop seeing Medicare patients altogether.

When asked what changes to their Medicare participation status they would make if Medicare payments were cut by 21 percent, 37 percent of responding surgeons said they would not participate in Medicare anymore. Some 29 percent said they would opt out of Medicare for two years and privately contract with Medicare patients. Overall, less than one-third of the 96 percent of respondents who currently participate in Medicare said they would be able to remain as Medicare participating physicians. Many also said they would have to stop providing certain services, reduce staff and put off purchases of new medical equipment, according to the survey.

Dr. Rao says his feelings and experience are in line with these survey results. "I think physicians want to do what's right for their patients," he says. "By virtue of being at an academic institution, I will continue to see patients who need my services, but I'm not sure I can say the same for my colleagues who are in private practice."

3. Specialty surgeons welcome insurance market reforms. In spite of major concerns about reimbursement issues not addressed in healthcare reform, orthopedic and spine surgeons say they favor the new law's insurance market reforms. Spine and orthopedic patients tend to have chronic medical problems, so the fact that they won't lose their insurance as a result of pre-existing conditions is a positive development for the continuity of their care and for the physicians who treat them, says Dr. Weinstein.

4. Lack of meaningful medical liability reform a blow to specialty surgeons. While the legislation includes funding for five-year state demonstration grants for malpractice reform pilot programs, the provisions are relatively restrictive and do not address the long-term and widespread costs of medical malpractice. "This is a problem that affects access and increases healthcare costs," says Dr. Weinstein. "In the bills, nothing meaningful has been done."

Spine surgeons, in particular, who practice in such a high-risk specialty, have a huge stake in malpractice reform, Dr. Weinstein suggests. "When the average medical student comes out of school with $100,000-$200,000 of debt, they are looking to protect themselves as well as care for the patient," he says. "So there will be unnecessary procedures and tests." This kind of defensive medicine ratchets up costs, and the failure of healthcare reform to tackle the broader problem "is a significant drawback," he says.

5. New Medicare advisory board lacks accountability. Several surgeons expressed frustration at the creation of a new Medicare advisory board as part of healthcare reform. Decisions about benefit policy and payments that are currently made by members of Congress, who are accountable to voters, will soon be made by an unelected group without the same kinds of checks, balances, oversight and specialty physician input, according to the orthopedic surgeons. While the law explicitly prohibits the "rationing" of care, it is unclear how costs will be cut, says Dr. Rao.

"Reduction of Medicare costs is either going to be by reduction in the number and types of services provided or by cutting reimbursements across the board," he says. "This is an area of concern, especially since this board has little or no congressional oversight or specialty physician input."

Dennis Maiman, MD, chairman of the Department of Neurosurgery at the Medical College of Wisconsin and director of clinical neuroscience at Froedtert & Medical College of Wisconsin, says this raises a broader issue about control of the medical profession. "The point is these guys are not reliable guardians of patients' health," he says of the government groups making decisions about the future of the healthcare system. "When we talk about spine surgery, we emphasize evidence-based practice, which should be determined by science."

6. Potential lack of surgeons to treat patients. Dr. Weinstein and others suggest there may be a contraction of services that results from declining reimbursements against the backdrop of escalating physician costs. "I think physicians will consolidate themselves, maybe offer less services, maybe screen patients a bit better," he says. "I think patient access will be a problem."

Dr. Maiman says he has conducted computer modeling in an attempt to predict the payment scenario under healthcare reform, incorporating payments at Medicaid rates for patients who currently have no insurance and making adjustments for the increased costs to physicians of doing business. The projected outcome, he says, is a 25-30 percent decrease in revenue in 2018 if healthcare reform unfolds according to plan. This would lead medical colleges to hire fewer faculty and physicians to spend less money, perhaps opting not to treat certain patients with bare-bones insurance. "I think it will be good for certain types of environments, like public clinics," he says, "but I don't think it will be very good for very many people."

In January, The Medicus Firm, a national physician search firm, surveyed 1,195 physicians in various specialties and career levels around the country, and nearly one-third indicated they would want to leave medical practice after healthcare reform was implemented. This is against a backdrop of an increase in physician jobs of more than 22 percent in the decade ending in 2018. "The reality is that there may not be enough doctors to provide quality medical care to the millions of newly insured patients," said Steve Marsh, managing partner at Medicus, in a news release.

7. Restriction of physician ownership of hospitals could reduce options for orthopedic surgeons. Many physician-owned specialty hospitals are either orthopedic or cardiac facilities, says Weinstein, and the new law's ban on new physician-owned hospitals and restrictions on existing ones will curtail their options. "In physician-owned hospitals, they have more control over quality and the efficiency of care they're delivering," he says. "We think that in those hospitals, the potential for greater patient satisfaction, success in delivering better outcomes and lowering costs all exist."

8. Focus on primary care physicians could hurt specialties. Weinstein and other specialty physicians have suggested that the healthcare reform law's increased payments to primary care providers could come at the expense of specialty providers. "We realize there is a shortage of primary-care physicians," he explains. "But there's a shortage of physicians across the board in different specialties." Among them are pediatric orthopedic surgery and general surgery, he says. "If you take funds away from those other specialties, you'll have even worse shortages across the board." ■

Contact Barbara Kirchheimer at barbara@beckersasc.com.

Call Coverage Payments: Trends, Regulations, Statistics and Valuation Considerations **(continued from page 1)**

- Rising costs associated with covering the ED
  - Growth in the uninsured patient population.
  - Fear of malpractice lawsuits.
  - Higher premiums associated with emergency departments.
- Fundamental industry changes
  - Work-life balance has become more important to today's physicians.
  - There is a decreasing physician supply.
  - Physicians are less reliant on hospitals to build practice with other options for office-based procedures and outpatient facilities.
  - Physicians are seeking equity with other physicians who are being paid for call coverage.

Although the majority of call coverage arrangements are based on a daily or hourly stipend, payment structures are evolving and are more often including additional payments for the uninsured patient population.

Call coverage payments: How industry-wide is it?

The Sullivan, Cotter and Associates' *2009 Physician On-Call Pay Survey Report* states that 82 percent of the survey respondents currently provide com-

pensation to non-employed physicians for call coverage. In addition, more than one-half of those surveyed reported their on-call expenditures have increased in the past 12 months and 20 percent of the respondents indicate they plan on implementing on-call pay within the next six months for physicians currently not receiving pay.

In addition to these recent trends, Sullivan Cotter statistics show overall expenditure for call payments has been increasing exponentially since 2006. From 2006-2009, the median expenditures increased by 546 percent for non-trauma centers and 141 percent for trauma centers.

Regulatory guidelines to consider when determining on-call payments

Since many healthcare organizations are currently considering on-call payments for the first time, a basic understanding of the regulations and payment models for on-call coverage are essential. Currently, there are two OIG opinions related to call coverage.

The OIG's opinions related to on-call payments have warned of a substantial risk that improperly structured payments for on-call coverage could be considered unlawful remuneration if the payments exceed fair market value. Therefore, when implementing an on-call arrangement, healthcare executives should start by understanding what the OIG has stipulated as factors to be considered low risk arrangements for fraud and abuse.

In determining if payments are at FMV, one should account for the burden of call. Factors affecting the burden of call include volume of call, payor mix and patient acuity. The OIG has stated that obtaining an independent third-party analysis to determine if the compensation reflects FMV for the services furnished is an important safeguard.

In addition, to ensure the arrangement does not appear to reward certain physicians for referrals, there are two important factors a hospital should consider. First, understand the history of call coverage and whether or not there is a legitimate, unmet need for on-call coverage. Second, offer compensation to all eligible physicians and make certain that physicians of similar specialties receive the same per diem payment.

On-call payment market data

Although on-call payment structures vary, the daily or hourly stipend is the most prominent model in the marketplace. There are currently two on-call industry surveys providing data for these stipends: *MGMA Medical Directorship and On-Call Compensation Survey (2009 Report Based on 2008 Data)* and Sullivan, Cotter & Associates' *2009 Physician On-Call Pay Survey*. However, essential valuation data is unavailable in these studies. Specifically, the following are important valuation factors relevant to call coverage payment data which are unknown in the surveys:

- Volume of call: in-person and via phone
- Payor mix associated with the patient population
- Physician's ability to bill and collect when seeing a patient
- Hospital's commitment to pay for the uninsured

Therefore, relying on market survey data alone will not provide a comprehensive valuation to determine fair market value. In addition, there is tremendous variance in reported on-call payment data and a low number of reported respondents in both surveys. However, the following lists the specialties for which survey data from both studies report similar median daily stipends:

- Orthopedic surgery median: $1,000 and $1,100
- Anesthesiology median: $750 and $800
- Invasive-interventional cardiology median: $775 and $800
- Ophthalmology median: $286 and $300

The above observed consistency in reported fees assists in determining a supportable valuation for these specialties. However, it is extremely important to note that factors such as volume, payor mix, acuity and specific terms of the arrangement are essential to determine if these rates are consistent with FMV. It is recommended that all of these factors be considered, as well as additional valuation methodologies.

Providing further challenges to the valuation of these arrangements is the fact that recently, more agreements are including an additional payment for the uninsured patient population.

Valuation challenges with the two payment on-call agreements

Industry observations indicate that on-call arrangements have increasingly been including an additional payment for the uninsured, or indigent patient population. This trend is expected to continue as the uninsured population is on the rise and physicians are less willing to take call.

It is important to note that when a hospital makes an additional payment to a physician for this patient population, it should be considered when determining the daily stipend. This type of arrangement guarantees the physician on-call will be compensated for his or her services when called in. From a compliance perspective, when the hospital obtains the risk of covering the uninsured for the physician on-call, the daily stipend should be less. Adjustments to the daily stipend for these additional payments should be based on the reimbursement guaranteed by the hospital and market reimbursement for professional services.

Working towards on-call compliance

If healthcare organizations are not careful in structuring call coverage arrangements, they risk non-compliance with healthcare regulations. In order to best document due diligence in ensuring the organization considered regulatory guidance in determining the on-call payment and structure, healthcare organizations should:

1. Understand FMV guidelines for determining call coverage payments.
2. Understand the OIG opinions related to on-call.
3. Document factors to show the burden of call.
4. Consider the compensation components of the arrangement.

If an on-call agreement between a physician and healthcare organization is audited by federal or state healthcare authorities, the analytical process and documentation to justify the payment is FMV will be essential in defending the compensation level.

This article is not to be construed as legal advice; it is to provide insight to valuation guidelines related to FMV. ■

Contact Jen Johnson at jenj@vmghealth.com.

Independent Medical Practice: Does Healthcare Reform Mark the Beginning of the End? **(continued from page 1)**

and need for healthcare IT, will not be able to afford to exist," says Patrick Breaux, MD, president of the Louisiana State Medical Society. "I think those will be a thing of the past."

Cardiology takes a hit

Dr. Breaux, a cardiologist and internist whose multispecialty group practice was lost in Hurricane Katrina, now is employed by Ochsner Health System and says many of his colleagues, especially those in cardiology, are joining integrated systems like his. "Within the last year, lots of doctors have been giving up independent practice," he says. "The cost and expense of running a cardiology practice is huge."

Recent Medicare reimbursement cuts to various cardiology procedures, especially those involving imaging, threaten to cut physicians' payments by 10-40 percent, according to the American College of Cardiology. This has led many cardiologists to join hospitals just within the past year. In fact, roughly half of cardiology practices have now migrated into hospitals, says ACC spokeswoman Amy Murphy. "Practices are going away, hospitals are gaining cardiologists, but the costs of the same procedure are higher in the hospital setting than in the practice setting," she says, which leads to higher costs to payors and higher co-pays for patients.

Cardiologists are not the only physicians embracing employment models. In 2003, 8 percent of the Medical Group Management Association's members were in hospital-owned practices. In 2008, that figure rose to 10 percent, a 25-percent increase, according to MGMA data. In that same time period, the size of hospital-owned practices grew from a mean of 64.3 physicians to 76.3 physicians.

Specter of accountability drives alignments

This trend is likely to accelerate under healthcare reform, especially among specialty surgeons such as gastroenterologists, orthopedic surgeons and other major users of ancillary services, predicts David Gans, MGMA's vice president of innovation and research.

Also of note, he says, is healthcare reform's promotion of so-called "accountable care organizations." In one policy brief by Urban Institute researchers Robert Berenson, MD, and Kelly Devers, PhD, an ACO is defined as a "local health care organization and a related set of providers (at a minimum, primary care physicians, specialists and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population."

Under healthcare reform, ACOs will likely be able to share in the cost savings to Medicare that they achieve. A hospital-physician integrated system is better positioned to take advantage of such opportunities than the independent physician, Mr. Gans says. "They already have the governance in place, the methodologies in place, and could take care of cost sharing and have a single contractual relationship with the government," he says.

Primary care physicians join hospitals

Kenneth Bertka, MD, FAAFP, CPHIMS, a director of the American Academy of Family Physicians, went from being in a small group practice for 20 years to becoming the chief medical information officer for the Northern Division of Catholic Healthcare Partners, a 34-hospital system based in Toledo, Ohio.

While Dr. Bertka says he is still "very passionate about private practice," he found he was able to better satisfy his interests in larger reform issues and engage in leadership roles within the AAFP by joining a system. Juggling these responsibilities and interests would have been far harder had he stayed in a small practice environment, he says.

While Dr. Bertka does not see independent medical practice going the way of the dinosaur, he says evidence suggests that 40 percent of primary-care physicians will be employed by hospitals or systems within the next two years, up from "the mid to upper 20s" today.

"The government and the private side want to switch from paying for procedures and volume to paying for outcomes and value," he says. "To do that you really need that team approach and clinical integration."

The current physician shift is partly the result of "psychological" factors such as uncertainty about the future, says Tommy Bohannon, the vice president of hospital-based recruiting at Merritt Hawkins, a physician search and consulting firm. "We don't really know what's going to happen, and it's going to be a long time before we do, so maybe it's better to be in a seemingly more stable environment with a hospital," he explains.

His firm got caught in the middle when it was hired to recruit for an independent physician practice that switched gears midstream and decided to align with a hospital. "Between the time we found (a candidate) and the interview a week later, the group had decided to enter into discussions with a hospital to acquire the practice," he says. "We had to change the spin to the candidate."

Jeffry Peters, chairman of the board of Health Directions, a consulting firm that focuses on hospital-physician strategies, says the combination of the expense of ancillary services, the sophistication of billing and collections processes, the depth of healthcare IT systems and increasing staff costs have driven physicians to seek out new models. Some 75 percent of all physicians coming out of medical school are looking for employment opportunities, and he expects private practice eventually to drop to less than 25 percent of all physicians and practices.

While independent practice may not become totally extinct, Mr. Peters offers another possible analogy. "It's going to go the way of independent grocery stores," he says. "They're still there, they still have a place, but it ain't what it was 20 years ago." ■

Contact Barbara Kirchheimer at barbara@beckersasc.com.

5 Best Practices to Improve Spine Efficiency in ASCs

By Nicola Hawkinson, MA, NP, CEO and Founder of SpineSearch

Spine surgery is performed with increasing frequency in ASCs around the country. As a result, ASCs are being forced to reexamine their approach to ensuring efficiency while maintaining appropriate levels of patient safety. The need to increase operating room efficiency is especially important given the current climate of rising costs and diminishing reimbursements. ASCs have been forced to reevaluate their current operations and develop strategies to maximize efficiency.

In contrast to other specialties, performing spine surgery with considerable efficiency can be extremely challenging. Spine procedures require a significant amount of expensive and unique equipment. Spine patients frequently place greater demands on ASC staff due to the complexity of their pathology. Employees of many ASCs may also be unfamiliar with nuances of spine procedures and caring for spine patients in the preoperative period. Thus, ASC administrators must invest significantly in training and education in order to maintain a smooth and efficient practice.

To maximize efficiency when performing spine procedures in an ambulatory surgery center, consider these five best practices and remember to think SPINE: Staff, Policies, In-service, Network and Evaluate.

Staff: The core of any organization is its employees. Your staff is undoubtedly your greatest asset. Spine procedures and techniques as well as patient care responsibilities may be unfamiliar to many ASC personnel. An investment in staff training and education is an essential part of improving efficiency and productivity. It is equally important to involve your staff in your plans to improve efficiency. Invite feedback from your staff. They know the issues of daily practice better than anyone else and can help improve workflow.

Policies: It is critical to develop standard operating procedures for all aspects of spine surgery, including preoperative evaluation, intraoperative case management and postoperative care. Create a manual detailing the manner in which your ASC intends to manage these complex patients. Such policies guarantee a consistent approach to patient care and provide a reference for staff to consult when necessary. Furthermore, the use of standard operating procedures ensures that different employees will complete the same task in the same manner.

In-service: Efficiency in your ASC cannot be accomplished without a commitment to staff education. Nurses, scrub techs and other staff members may not be familiar with complexity of spine patients, procedures and equipment. Before integrating spine surgery into your ASC, the staff requires a significant amount of education. Frequent in-services performed on a regular basis allow staff to remain up to date about new technology and surgical approaches. A well informed staff will quickly become an efficient staff.

Network: The administrators and management team of any ASC are as important as their employees in determining efficiency. It is critical to attend local and national conferences to learn the latest trends in ambulatory spine surgery. Current approaches to anesthesia, surgical techniques, pain management and patient care are rapidly changing. It is essential to say up-to-date to maximize smooth and safe patient turnover.

Evaluate: The only way to maintain and improve efficiency is to continuously evaluate how your staff and ASC are performing. Develop clear and specific methods to assess your staff and make sure that they know the criteria on which they will be judged. In addition, regular reviews of the staff as well as overall efficiency will ensure a constant movement towards financial success and patient satisfaction. Most importantly, it is essential to integrate the data gained through performance evaluation into daily practice.

Spine surgery is a dynamic field. New developments, including minimally invasive techniques, require specialized equipment, implants, and training. As the treatment of spinal disorders continues to evolve, the ability to perform spine surgery with great efficiency will become increasingly challenging. Investing in staff training and education, developing standard policies and procedures, using frequent in-services, networking and constantly evaluating performance will ensure the smooth running of your ASC as well as high levels of patient safety. ■

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

Building Strong Anesthesia Partnerships in Spine-Focused ASCs

Douglas H. Irvine, MD, PhD, is an anesthesiologist at East Portland Surgical Center in Portland, Ore.

Q: Many spine-focused ASCs struggle to recruit well-regarded anesthesiologists. How can ASCs make themselves attractive to such practitioners?

Dr. Douglas H. Irvine: With strict attention to high standards of care, a sufficient caseload, a favorable work environment and a consistent schedule, ASCs can successfully recruit well-established anesthesiologists from the local medical community. But it's just as important for the surgeons to understand the anesthesiologist's commitment to service and clinical quality before a working relationship is established.

Speaking for myself, the experience of being personally recruited by my surgical colleagues to provide anesthesia at their ASC was a great vote of confidence in the anesthesia care I have provided to their patients over several proceeding years. It is good to be consulted professionally, to be heard and to practice collaboratively with my colleagues. The key is for anesthesiologists to feel fully part of the team, not simply as outside service providers, which is the case at many surgery centers, I believe.

Q: Strong relationships between anesthesiologists & surgeons are a hallmark of successful ASCs. Can you comment on the level of partnership at EPSC?

DI: Trust, confidence and mutual respect are the keys. Seeing the direct influence of my professional standards in enhancing overall quality of care and professionalism within the entire ASC and seeing that high quality of care attract more surgeons and patients to the ASC is a gratifying addition to my anesthesia practice. The sense of commitment and partnership extends across the entire team and our whole operation — all the surgeons, the nurses, the office staff and our business partners — share a goal to deliver outstanding care and a great patient experience.

Q: When your center added spine cases, what were the main challenges in terms of anesthesia?

DI: The challenge for anesthesia in adding outpatient spine surgery to an existing ASC is the same as the challenge for the surgeons — namely, patient selection. In addition to screening for co-existing diseases, many spine patients, especially those with failed back syndrome, are on chronic narcotic therapy.

With many orthopedic procedures, such as shoulder and knee reconstructions, specialized techniques including peripheral nerve blocks and catheters can minimize pain and discomfort and permit more extensive procedures to be performed safely and economically as outpatient procedures.

Unfortunately, the nature of spine surgery precludes the use of many of these specialized techniques. For spine surgery, we must rely on individualized titration of intravenous, intramuscular and oral narcotics coupled with additional prescription adjuncts to promote safety and comfort in the PACU and at home after patient discharge from the ASC.

Q: Can you describe the scope of the advance planning and training effort?

DI: In advance planning we must pay particular attention to screening out patients with coexisting disease that may require hospitalization for postoperative management or screening out patients that may require intravenous narcotic therapy for pain management after surgery. It is best to start with conservative selection criteria, and gradually build experience and protocols that are highly reliable and successful. Inclusion criteria can be expanded as surgeons, anesthesiologists and staff demonstrate growing proficiency. Of course, no one can reliably predict the future, and any unplanned admissions always should be used as learning opportunities to refine guidelines for future patient selection.

We also completed a fair amount of education and communication on the clinical side before taking our first spine case to ensure everyone — including schedulers and staff at the surgeons' practices — were comfortable and confident handling spine cases in an outpatient setting. In particular, the lower sedation levels dictated by shorter recovery times were an adjustment for some anesthesiologists and nurses.

Q: What are the benefits for anesthesiologists in working at an ASC?

DI: The surgeons get proven anesthesia services for their patients and the anesthesiologists get a reliable caseload with more predictable work hours than at an acute care center. Both surgeons and anesthesiologists also gain the potential for greater autonomy and professional satisfaction. In that sense, the benefits for anesthesiologists are similar to those of surgeon-owners.

And of course, the patients receive many of the benefits as well. It is good to know that my patients are getting the best surgical and anesthesia care possible at the most affordable price. It is good to see that the value that this provides our patients and the healthcare system as a whole is sustainable. It is good to contribute to a long-term solution to providing affordable, high-quality healthcare.

Q: Speaking of patients, what are the most important factors in delivering great patient experiences at your ASC?

DI: I have been asked to duplicate our success at our freestanding ASC within a large acute care hospital where I have worked extensively. But often I have had to break the bad news to these large facilities that this type of request completely misses much of the point. The very nature of being a large and often impersonal facility makes it difficult to duplicate the personal service provided at a smaller, specialized, free-standing surgery center.

Every detail and touchpoint of the entire patient experience must be considered, and it's quite a long list: ease of calling on the telephone and speaking with a friendly and helpful voice, ease of scheduling, ease of locating and driving to the ASC (location, location, location), ease of parking, length of wait for any phase of the patient's or family's experience, privacy and welcomed access to support from family and friends, appearance and cleanliness of facility and equipment, professional appearance and demeanor of staff, maximizing safety and comfort, preventing nausea and vomiting, minimizing preoperative and postoperative fasting periods, keeping patients warm, preserving modesty, providing clear postoperative instructions in verbal and written form, and facilitating the filling of postoperative prescriptions. Every detail must be examined from the perspective of a patient who has entrusted us with their health and wellbeing. That attention to detail is what will allow surgery centers like ours to fulfill their potential. ■

Thank you to Blue Chip Surgical Center Partners for arranging this article. From 2005 to 2009, Blue Chip served as the business partner for the profitable East Portland Surgical Center with Drs. Joseph Stapleton, Irivne and other surgeon-owners. You can learn more about Blue Chip and read more surgeon stories at www.bluechipsurgical.com/insights.

6 Ancillary Services to Increase Your Orthopedic Practice Revenue

By Lindsey Dunn

As physician fees continue to be pressured by Medicare and other payors, it becomes more important than ever for physician practices to look at ancillary services as a possible means to generate additional revenue — simply increasing patient volume may no longer be enough to maintain or grow revenue.

"With looming Medicare pay cuts and sustainable growth rate pressures, it's becoming harder and harder for physicians to make money," says John Martin, CEO of OrthoIndy, an orthopedic practice of more than 60 physicians based in Indianapolis. "Ancillaries are key to the future success of physician practices. They're what's going to help doctors keep the doors open. Reimbursements keep going down, expenses keep going up and you can only make up so much of that with volume."

John Davis, MBA, principal of Medical Practice Consulting, a medical practice consulting firm based in Bantam, Conn., agrees. "With reimbursements squeezed, you have to look at all the various ways you might bring in additional payments. Providers have to look at how much care they provide themselves versus what they refer out and then decide how much else they would like to offer."

Ancillary services can significantly reduce overhead practice costs. Don Schreiner, CEO, of Rockford (Ill.) Orthopedic Associates, says his practices' ancillary services help cut the practice's overhead costs divided among physicians 50 percent.

Orthopedic practices interested in expanding their offerings should consider six key ancillary services, all of which can successfully drive revenue if operated efficiently and supported by adequate demand.

1. Physical therapy. Physical and occupational therapy is one of the most common ancillary services offered by orthopedic practices; however, there are still a number of orthopedic practices, especially smaller practices, referring out this service. Practices that do not already offer physical therapy can bring in substantial revenue to their practice by adding a program.

Glen Prasser, CEO of Beacon Orthopaedics and Sports Medicine in Sharonville, Ohio, says his practice has been offering in-house physical therapy since 1998. "While there is certainly a revenue aspect to this service, what is important to us is patient convenience. Patients come to Beacon and remain here for therapy and other services and don't have to travel outside these walls," he says. "It also helps to differentiate us from other practices. Our patients value the convenience, and they actually end up being an extension of our marketing efforts by telling their friends and family about their experience."

To reap the most profit, a practice would employ its own physical therapists and assistants and bill for their services. Generally, 1-2 therapists per physician are required to meet referral demand (though referral volumes do vary by subspecialty), and practices can expect to generate $100,000-$200,000 in collections annually per provider, with a 25-30 percent profit margin, says Mr. Davis.

"My thinking has always been that orthopods use physical therapy as a treatment modality as much if not more often than pharmaceuticals. If they use it so much, why don't they just provide it?" says Mr. Davis.

While other arrangements exist where an outside physical therapy business might pay rent to a practice to offer in-house services, Mr. Davis recommends practices employ their own physical therapists and use the same tax ID number for the program as their practice in order to reduce legal risk associated with referral laws.

2. MRI/imaging. More and more orthopedic practices are offering on-site imaging services, including MRIs. The most common arrangement orthopedic practices seem to use for this service is purchasing an MRI and then using a telaradiology service to interpret the images. In this scenario, the practice bills for the technical component of the MRI services while the radiology company bills for the professional fee. Mr. Davis says this arrangement is the "safest and cleanest" due to payor concerns about who is qualified to provide imaging care.

The investment required to offer MRI services in-office range from $250,000-$1 million, and savings can be found by purchasing used or refurbished equipment, which is readily available, says Mr. Davis. The cost of a new, high-quality open MRI will likely run practices between $750,000-$1 million, says Mr. Martin.

In order to determine if an MRI is a wise investment, practices should project their volume based on past MRI referrals and then determine likely payor mix as payments vary widely by payor, says Mr. Davis. For example, Medicare typically pays $350-$500 for an MRI facility fee while a private payor may pay significantly more.

Mr. Davis also suggests that if orthopedic practices decide to purchase an MRI, they purchase an open MRI as opposed to one designed for extremities only. "My personal thinking is that if you're going to go there, go all the way," he says. "An extremity MRI can't be used on someone's back or hip. These can't be done correctly without a full body MRI."

OrthoIndy is one practice finding success in offering MRIs, though it offers the services through its Indiana Orthopaedic Hospital. The practice is now considering offering orthopedic ultrasound, which can be used to diagnose some orthopedic conditions. "There was a lot of discussion at the AAOS meeting about this technology, and this has piqued the interest of many of our physicians. Staying on the cutting-edge is important to our practice so we can provide the highest quality orthopedic care," says Mr. Martin.

3. DME programs. Another ancillary service more practices are considering is durable medical equipment programs. Here, an orthopedic practice can either operate its own program, which would be most profitable, or bring in a DME company, which pays the practice rent, to manage a program, says Mr. Davis. Mr. Davis reports many practices operating their own programs house their DME services within their physical therapy departments.

Beacon Orthopedics offers DME and orthotics on site but has partnered with BioWorks, an outside company, to run the program and does so for the convenience of the patient, says Mr. Prasser.

Rockford Orthopedic Associates operates its own program, employing a manager to oversee the department, in addition to other departments, and a podorthist to custom fit braces and other orthotics. The practice is looking at hiring an orthoist in the future, allowing the program to make prosthetic limbs and custom braces as well. "Hiring a orthoist will allow us to offer more quality services to our patients as well as generate more revenue," says Mr. Schreiner. "We also think that in a couple years, insurance companies and the government are going to require certified orthoists to even do business as a DME company, so this will prepare us for that."

If an orthopedic group chooses to run their own DME service, Mr. Davis says it is important to run the program like a business. "If you run it like a business, there is some money to be made, but if all you have is a disorganized closet, you're likely to lose money," he says.

In addition to DME programs, some practices are dispensing products besides orthotics. For example, OrthIndy currently offers omega-3 supplements for arthritis patients and is looking into opening a pharmacy dispensary for workers' compensation patients, according to Mr. Martin.

4. Electromyography. Some practices are looking at offering nerve conduction studies, or EMGs, on site. These are typically referred out to physiatrists or neurologists but orthopedic practices are increasingly looking at offering this service through employing a physiatrist who would also perform other services, such as pain management injections, says Mr. Davis. Practices may also consider paying a provider an hourly fee to perform the tests on site.

Another option — and a viable one for any ancillary service — is renting out part of an office building, assuming the practice is the owner of the facility, or some of its own unused office space to a provider to provide these services. While employing a provider is probably a more profitable option if sufficient demand exists, renting at fair market value can be a

less time-consuming option for practice administration while still allowing seamless, convenient patient care.

The investment required for EMG equipment is relatively low, around $5,000, according to Mr. Davis, while a physician performing them can earn anywhere from $75-$100 or more per test, by some estimates.

5. Surgery center. As more and more orthopedic, and even spine, surgeries move to the outpatient arena, it has become more common for orthopedic surgeons and practices to consider investing in an ASC in order to gain a portion of facility fee payments that in the past would have gone to the hospital, not the surgeons.

"Physicians have been under fee pressure for many years, but maybe that pressure has hit later for orthopedic and other specialties," says Luke Lambert, CEO of Ambulatory Surgical Centers of America. "Owning an ASC is one of the best things surgeons can do to augment their practice income if they haven't done it already."

Brent Lambert, MD, president and co-founder of ASCOA, adds that ASCs are also a great recruiting tool for practices. "All physicians coming out of training are looking for ownership opportunities in an ASC. There's also a practice productivity benefit because a typical surgeon can perform sometimes twice as many procedures in the ASC because it's more efficient.

"It's not uncommon for surgeons to augment their annual practice income by 15-20 percent [through an ASC investment]", he says.

Ownership of a surgical facility also provides surgeons with more control over their schedules.

"While many physicians get into ASCs for the additional revenue, they find quickly that what they really love about it is controlling their days — not being bumped, scheduling cases the way they want and having direct influence over staffing and efficiency," says Mr. Davis.

6. Physician assistants. While not technically an ancillary service, practices that employ PAs to see patients and assist with surgery can generate substantial additional revenue. PAs typically command salaries of $70,000-$100,000, on the very high end, but are often able to generate 2-3 times more, according to Mr. Davis.

In order to generate the most revenue possible for a practice, Mr. Davis recommends PAs have their own schedules, treat patients and assist in surgery.

"I recently worked with a practice whose two PAs were generating $250,000-$300,000 annually in collections," says Mr. Davis. "While not every PA can collect this, if you let them treat patients and assist in surgery, they can be very profitable, even if you're paying them a $100,000 salary."

However, in order for PA revenues to cover practice costs, as opposed to supplement physician incomes, the practice would need an employed physician model since PAs bill under the supervision of a physician when treating patients in the office.

Other models for employing PAs include assuming their salaries as overhead costs divided among all physicians and then allowing the revenues they generate to be distributed to the physicians supervising them. This model is the one used by Rockford Orthopedic Associates, says Mr. Schreiner. However, he says other practices use a revenue-neutral model for employing PAs, where physicians who want a PA pay the PA's salary out of their own revenues but are able to keep the addition revenue generated by the PA. ■

Contact Lindsey Dunn at lindsey@beckersasc.com.

Note: This story is for informational purposes only. Please seek the guidance of legal council before implementing any of the ancillary services discussed here.

8 Statistics About Orthopedic Surgeon Compensation

Here is the median compensation for orthopedic surgeons for 2005-2008, according to the *AMGA 2009 Medical Group Compensation and Financial Survey*.

1. 2008 — $476,083
2. 2007 — $450,000
3. Percent change 2007-2008 — 5.08 percent
4. 2006 — $436,481
5. Percent change 2006-2008 — 9.07 percent
6. 2005 — $409,518
7. Percent change 2005-2008 — 16.25 percent
8. Dollar change 2005-2008 — $66,565 ■

To order a copy of the complete *2009 Medical Group Compensation and Financial Survey*, visit https://ecommerce.amga.org/iMISPublic/.

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18 Orthopedic and Spine Practice CEOs & Administrators to Know

By Lindsey Dunn

Patricia Brewster (Southern Orthopaedic Specialists; Atlanta). Ms.Brewster is CEO of 15-physician Southern Orthopaedic Specialists and has more than 25 years of healthcare management experience. She also currently serves as president of the American Association of Orthopedic Executives. Before joining Southern Orthopaedic Specialists, Ms. Brewster served as chief administrative officer at the Hughston Clinic in Columbus, Ga. She holds a master's in health administration and was the 2008 recipient of the Medical Group Management Association/American College of Medical Practice Executives' Harry J. Harwick Lifetime Achievement Award. In addition to being a member of the MGMA and AAOE, she is also a member of the American College of Healthcare Executives.

Darleen Caccavale (University Orthopaedic Associates; New Brunswick, N.J.). Ms. Caccavale is the administrator of University Orthopaedic Associates, a 12-physician practice. She has worked in orthopedic management for more than 20 years and has been with University Orthopaedic for the last 10. Under her leadership, the group is currently building a 40,000 square-foot office building, which is expected to open in 2011. In her role as administrator, Ms. Caccavale displays a high degree of integrity, responsibility and ambition, according to a colleague. "Her good judgment and sound outlook ensures a logical and practical approach to all her endeavors. She is also a wonderfully friendly, sincere and caring human being, respected and admired by patients, peers, subordinates and superiors alike," says the colleague.

Suzann M. Crowder (St. Charles Orthopaedic Surgery Associates; St. Charles, Mo.). Ms. Crowder is the administrator of St. Charles Orthopaedic Surgery Associates and has been with the practice since 2000. During her tenure, she helped oversee the implementation of various ancillary services including MRI and ASC billing. Before joining St. Charles Orthopaedic Surgery Associates, she served as assistant administrator at Premier Care (formerly Missouri/Orthopedic Sports and Trauma) in St. Louis. She began her healthcare career as a radiologic technologist. Ms. Crowder holds an MBA from Lindenwood University in St. Charles and is a member of the MGMA and a Certified Medical Practice Executive.

David Fitzgerald (Proliance Surgeons; Seattle). Mr. Fitzgerald is CEO of Proliance Surgeons, a medical group practice of more than 165 orthopedic, general and ENT surgeons headquartered in Seattle, with several clinic locations in the region. The practice also owns and operates 12 ASCs, six physical therapy sites and eight imaging centers throughout the Puget Sound region. Mr. Fitzgerald has more than 20 years of experience in healthcare, including serving as administrator and CFO of physician practices. He earned his MBA from the University of Utah in Salt Lake City and currently serves as a member of the board of directors of the Washington Ambulatory Surgery Center Association.

Jeff Goldberg (Resurgens Orthopaedics, Atlanta). Mr. Goldberg is the director of operations for Resurgens Orthopaedics, a 90-plus physician orthopedic practice in Atlanta. He previously served as Resurgens' director of rehabilitation services. He joined the practice in 2000 as a physical therapist and has 25 years of experience in physical therapy. His previous positions included clinic director for Georgia Physical Therapy and manager of clinical operations for NovaCare Outpatient Rehabilitation.

Bill Horne (Laser Spine Institute, Tampa, Fla.). Mr. Horne is CEO and co-founder of the Laser Spine Institute. LSI's flagship facility is in Tampa, Fla., and LSI has grown to include seven facilities in four states. Mr. Horne founded LSI in 2005 with co-founders James St. Louis, DO, and Michael Perry, MD. Mr. Horne underwent a minimally invasive spine procedure performed by Dr. St. Louis in 2004, which triggered his interest in minimally invasive spine care. Before founding LSI, Mr. Horne founded Club Operations and Property Management, a leading management company for country, city and yacht clubs.

Leslie R. Jebson (The Orthopaedics and Sports Medicine Institute, University of Florida Health System; Gainesville, Fla.). Mr. Jebson is the executive director of the Orthopaedics and Sports Medicine Institute at the University of Florida. After assuming the role four years ago at the new 130,000 square-foot facility, Mr. Jebson has been a driving force in the institute's momentous volume and market growth. The Institute has doubled its number of surgical cases and outpatient visits during his tenure — with over 100,000 patient visits and more than 6,000 surgical procedures performed. Mr. Jebson actively lectures and publishes on healthcare organization and quality improvement and is the editor of MGMA's Matrix magazine. Before joining the University of Florida, Mr. Jebson served as COO at Shawnee Mission Physicians Group in Kansas City, Mo. He earned a master's in health services management from the University of Missouri in Columbia and is a Certified Medical Practice Executive.

Bob Kahn (Orthopedic Specialists of Texarkana; Texarkana, Texas). Mr. Kahn is the CEO of the Orthopedic Specialists of Texarkana, a seven-physician group of general orthopedists. Mr. Kahn has more than 30 years of experience in healthcare administration and has served as assistant administrator, vice president of support services and COO, among other positions, at hospitals and physician practices. He received his master's in health and hospital administration from the University of Iowa School of Medicine in Iowa City. He is also a member of several professional societies including MGMA and AAOE.

Donald J. Love (Roanoke Orthopaedic Center; Roanoke, Va.). Mr. Love is the administrator of Roanoke Orthopaedic Center, a 13-physician practice that specializes in hand, adult joint replacement and reconstruction, sports medicine, foot and ankle surgery and trauma. The center is also a designated teaching facility by the University of Virginia Medical School. Mr. Love has more than 25 years of experience in healthcare administration. Prior to coming to Roanoke Orthopaedic Center, he served as hospital director for Carilion Roanoke (Va.) Community Hospital. Mr. Love has also served as administrator and vice president for specialty hospitals and nursing centers. Mr. Love is a fellow of the ACHE and a member of MGMA, ACMPE, AAOE and the Healthcare Financial Management Association. He received his master's in healthcare administration from the Medical College of Virginia in Richmond.

Randy Marcus (Orthopedic Center of Palm Beach County, Lake Worth, Fla.). Mr. Marcus is the CEO of the Orthopedic Center of Palm Beach County in Lake Worth, Fla., an 11-physician practice that is one of the oldest in the state. He joined the Orthopedic Center in Sept. 2009, having previously served as CEO of OrthoMontana in Billings, Mont. While at OrthoMontana, Mr. Marcus successfully managed the merger of two orthopedic groups, including the development of infrastructure, policies and procedures of the newly unified group. Mr. Marcus has more than 25 years of experience in healthcare administration, having worked with physicians' practices, the Philadelphia Department of Health and the Delaware Valley Hospital Council in Philadelphia. He received his education in healthcare management from the Wharton School of Business in Philadelphia and Cornell University in New York.

John D. Martin (OrthoIndy; Indianapolis). Mr. Martin is the CEO of OrthoIndy, the largest private, full-service orthopedic practice in the Midwest. Mr. Martin has more than 22 years of progressive financial management, strategic planning and operational experience within the healthcare industry. Prior to his position at OrthoIndy, he served as CEO of the Indiana Orthopaedic Hospital, where he oversaw the opening of a 42-bed inpatient unit and an ASC. He has also held positions, such as CFO and director of financial planning and business development, for hospitals and physician practices in Indiana. Mr. Martin is a graduate of Indiana University's Kelley School of Business in Bloomington. He is also an advanced member of HFMA.

Heidi Mattingly (OrthoMaryland; Baltimore). Ms. Mattingly is CEO of OrthoMaryland, a 17-provider orthopedic practice with three full-time locations in the Baltimore area. In her position, she also oversees the practice's physical therapy, DME, MRI and complementary medicine services as well as its one-OR, two-procedure room surgery center. Before joining OrthoMaryland in 2009, Ms. Mattingly served as the administrator of Southern Maryland Orthopaedic and Sports Medicine Center in Leonardtown, Md. She is an active lecturer and facilitator for AAOS and AAOE on practice management issues and is a Certified Medical Practice Executive. She is also a member of MGMA and a previous participant on the Maryland Senate and House Subcommittees on medical practice related legislation.

Debra L. Mitchell, RN (Children's Orthopaedic and Scoliosis Surgery Associates; St. Petersburg, Fla.). Ms. Mitchell is the administrator at Children's Orthopaedics and Scoliosis Surgery Associates, a private practice with five pediatric orthopedic surgeons and five physician assistants. The practice is located at All Children's Hospital in St. Petersburg and is the pediatric rotation for the University of South Florida orthopedic residency program. Prior to joining Children's Orthopaedics, Ms. Mitchell was administrator at Gastroenterology and Oncology Associates and the director of nursing at Bay Area Endoscopy and Surgery Center. She began her nursing career more than 30 years ago and holds a bachelor's of science degree in nursing and an MBA. She is also the current president for the BONES Society of Florida.

Dale Reigle (Rocky Mountain Orthopaedic Associates; Grand Junction, Colo.). Mr. Reigle is CEO of Rocky Mountain Orthopaedic Associates, a 17-physician practice that specializes in a variety of services including arthroscopy and sports medicine, total joint replacement and complex joint reconstruction, fracture care, hand surgery, pediatric orthopedics, foot surgery and the treatment of spinal disorders and injuries. He has been with the practice since May 1996. Under his leadership, the group has built a 24,000 square-foot office building and developed an ASC, a joint venture between the group and the local hospital. Mr. Reigle has more than 20 years of experience in the healthcare industry. Prior to joining Rocky Mountain, he served as CFO of Perry (Okla.) Memorial Hospital. He received his master's of science in management from the University of Southern California in Los Angeles.

Karen Reiter, RN (Diagnostic & Interventional Surgical Center/D.I.S.C. Sports & Spine Center; Marina Del Rey, Calif.). Ms. Reiter is the COO at D.I.S.C. Sports & Spine Center, a position she has held since 2006. Prior to joining D.I.S.C., Ms. Reiter served as the vice president of business development for Cleveland-based RSB Spine and, before that, as a staff nurse for a surgical spine surgeon in Los Angeles. A native New Zealander, she began her healthcare career as a nurse in New Zealand and Australia. She once served as a staff nurse in Dubai for six months as part of a team of nurses providing care for the sheikh. She moved to Los Angeles in 1989 and worked in the ICU of Century City Hospital in Los Angeles.

Barbara Sack (Midwest Orthopaedics, Shawnee Mission, Kan.). Ms. Sack has been executive director of Midwest Orthopaedics, a five-physician practice, since 1994. Prior to joining Midwest Orthopaedics, she worked for a hospital-owned practice and an academic medical center program. She has more than 25 years of experience in healthcare and has been an administrator for the past 17. She is the current secretary of AAOE and former president of Midwest AAOE. Ms. Sack has presented at the AAOS Practice Management Symposium, the American Orthopaedic Foot & Ankle Society Annual Summer Meeting and other medical association meetings. She holds a master's in health services administration from the University of Kansas in Lawrence.

Don Schreiner (Rockford Orthopedic Associates; Rockford, Ill.). Over the last 10 years, Mr. Schreiner has served as the CEO at Rockford Orthopedic Associates, a 21-physician, multi-specialty, orthopedic-driven clinic with more than 200 employees. During this period, he has overseen the addition of physical therapy, two MRIs, DME services, an outpatient surgery center, a clinical research department and 12 physician assistants. He also oversaw the implantation of the practices' EMR and PAC systems. Prior to this position, Mr. Schreiner was a managed care executive for 18 years working for organization such as John Deere Health, Blue Cross/Blue Shield and two large regional health systems. Mr. Schreiner holds an MBA from the University of Toledo (Ohio) and is current treasurer of AAOE and a member of MGMA.

Dennis Viellieu (Midwest Orthopaedics at RUSH; Chicago). Mr. Viellieu is the CEO of Midwest Orthopaedics at Rush, a 30-plus orthopedic physician practice. Mr. Viellieu has more than 15 years of experience in the healthcare industry. He was instrumental in the development of the practice's ambulatory surgical facility and helped to develop and start-up his current practice. Prior to his current position, he was CEO and CFO of Midwest Orthopaedics, which was later integrated into Midwest Orthopaedics at Rush. Mr. Viellieu graduated from the University of Indiana in Bloomington and from the executive financial management program at the Wharton School of Business at the University of Pennsylvania in Philadelphia. ■

Q&A With Dr. Alejandro Gonzalez Della Valle, Orthopedic Surgeon at the Hospital for Special Surgery

By Rob Kurtz

Alejandro Gonzalez Della Valle, MD, is an orthopedic surgeon specializing in hip and knee surgery at the Hospital for Special Surgery in New York.

Q: Is there a specific new surgical technique or technology that is most exciting to you and why?

AGDV: In the span of a decade, hip and knee surgeons have witnessed the development and introduction of new techniques, technology like minimally invasive surgery, materials that allow enhanced uncemented fixation of implants, modern metal-on-metal and ceramic-on-ceramic bearings and so called "computer-assisted surgery" or "computer navigation".

In my opinion, computer navigation is revolutionizing the way we think and approach joint replacement surgery. Adequate positioning of prosthetic components is essential for the joint replacement to function as similarly as possible to the natural joint and to diminish the natural wear and tear of the mechanical parts. The ability to properly position the different prosthetic components during total joint replacement increases with a surgeon's experience; however, even in the most experienced hands, there will be a proportion of patients with malpositioned components. This may result in early prosthetic failure and complications. With the proper use of computer navigation, the number of "outliers" has diminished, resulting in a more consistent positioning of the replacement parts. This technology is evolving at a fast pace and will eventually be easier to use and available to the high and low volume surgeon. Its systematic use will likely result in more consistent total joint replacement outcomes.

Q: Is there an initiative undertaken at Hospital for Special Surgery in the past year that has proven to be beneficial and that you are particularly proud of?

AGDV: Hospital for Special Surgery has been a pioneer in perfecting and streamlining the execution of total hip and knee replacement. The advances in anesthesia, surgical technique and perioperative care are based on extensive basic, applied and clinical research that has been performed in HSS over that last four decades. HSS physicians, researchers and allied healthcare professionals are committed to continue building upon the previously mentioned body of research to make hip and knee replacement even safer and more cost effective.

Q: What do you see as the biggest opportunities for orthopedics in the next few years?

AGDV: The number of hip and knee replacements performed yearly in the United States has increased exponentially in the last decade due to the baby-boomer effect, as well as the expansion of indications for surgery to the younger and to the sicker patients [1,2, 3]. However, the number of orthopedic surgeons specializing in joint replacement surgery has been declining [2]. By 2016, the United States is likely to experience a significant shortage of orthopedic surgeons willing to do total joint replacements. If these predictions are accurate, 72 percent of those who need total knee replacements and 50 percent of those who need total hip replacements will not be able to obtain them [2]. Consequently, the arthroplasty workforce will be unable to meet the needs of a growing arthritic population. Joint replacement surgeons and hospitals will face the challenge of efficiently coping with the increase in volume while maintaining safety standards. Surgeons and hospitals will need to work together to increase efficiency.

Q: What factors have been critical to your professional success and popularity with patients, as indicated by your receiving the 2008 Patients' Choice Award from Vitals.com for being one of New York's favorite physicians?

AGDV: Hip and knee replacement surgeons treat patients who usually require "elective" surgery. This means that the patient is the one who ultimately makes the decision to have his or her hip or knee replaced. I make it a priority in my practice to convey a balanced view of benefits and drawbacks of the surgical procedure recommended for each patient, and in addition, I try to set realistic expectations for recovery. I respect my patients' free will and trust their ability to make an educated decision for their own medical care. Allowing patients to speak and listening to their complaints and concerns have proven valuable in gaining my patients' trust.

Q: What are your professional goals this year and for the next few years?

AGDV: Based on the previously mentioned challenges and the changes seen in the last decade, my goal for the following years is to continue striving for an orthopedic practice that balances patient care, education and research, which, to me, are the three indispensable pillars for the growth of orthopedic knowledge. ■

Learn more about Dr. Alejandro Gonzalez Della Valle at www.hss.edu/physicians_gonzalez-della-valle-alejandro.asp.

References:
1. Memtsoudis S, Gonzalez Della Valle A, Besculides S, Garber L, Laskin R. Trends in demographics, comorbidity profiles, in-hospital complications and mortality associated with primary knee arthroplasty. J of Arthroplasty 2009;24(4):518-527.
2. Kurtz S, Lau E, Ong K, Zhao K, Kelly MP, Bozic KJ. National projections of younger patient demand for primary and revision joint replacement. 2009 AAOS Annual Meeting Podium Presentations #183.
3. Odum SM, Iorio R, Fehring TK. Joint replacement access in 2016: A supply side crisis. 2009 AAOS Annual Meeting Poster Presentations #P043.

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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, Principle 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 F. Grundman, MSN, CASC, former President, AAASC, 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
Managed Care Negotiation Strategies - 10 Key Tips - I. Naya Kehayes, MPH, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management

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 Adapt? 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 – Brian 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 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 Pliuria, 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 E – 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, Administrator, Surgery Center of Reno, 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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Q&A With Dr. Joshua Siegel, Director of Sports Medicine for Access Sports Medicine and Orthopaedics in Exeter, NH

By Rob Kurtz

Joshua A. Siegel, MD, is director of sports medicine for Access Sports Medicine and Orthopaedics in Exeter, N.H. He was recently named as a "top doctor" by *New Hampshire Magazine* for the sixth time.

Q: This is your sixth year you have been named to *New Hampshire Magazine*'s list. To what do you attribute your ongoing success?

Dr. Joshua Siegel: I have surrounded myself with good people who all have common goals and a shared philosophy. We all believe that the patient visit should be treated as sacred and if the service before and after the visit is stellar, the care will be outstanding. Although I am honored to be selected, the credit must be shared with my staff and organization for shaping the patient experience. I also believe that our ongoing efforts to provide new services and choices is pivotal in our success. Finally, as one of the last independent, non-hospital owned physician groups in the area, we can move quickly to develop services and campaigns that benefit the patient population in our area.

Q: What are your professional goals this year and for the next few years to maintain and build on your achievements?

JS: I would like to expand our offerings in various fields of orthopedics and continue to build on the outcomes we have had. I would like to develop some expertise in the delivery of occupational medicine services and consider opening an urgent care clinic to decrease the loads on the hospital EDs.

Q: Is there a specific innovation that is most exciting to you?

JS: Biologics in orthopedics is exciting to all of us. Cartilage is a very non-forgiving structure that once injured, has poor reparative qualities. Manipulating biology will open up a whole new era in orthopedics including growing new cartilage, assisting in tissue regeneration and augmenting tenuous repairs of ligaments and tendons.

Q: Is there a single initiative your organization has undertaken in the past year that has proven to be beneficial?

JS: Our accreditation of the MRIs through the American College of Radiology and the accreditation of our ASC through AAAHC. I believe the stamp of accreditation standardizes a minimum level of quality that all practices should strive for. The accreditation process itself is a great way to evaluate how each business is functioning. Accreditation forces large collaborative efforts within and between organizations which culminates in the better and safer services for our patients.

Q: What opportunities exist for your organization to grow and improve efficiency this year?

JS: I believe better use of electronic services can assist in our efficiencies. Web-based encounter forms and other types of EMR efficiencies would allow us to focus more time with the patient and less on gathering information.

Q: What are some aspects of your practice that you are particularly proud of?

JS: We invest heavily in our community. We are lead sponsors in many charitable causes and also provide many free services to the community such as pre-participation physical exams for all the area high schools, a concussion screening exam for safe return to play, and many others. We also have supplied athletic trainers to many local high schools to help subsidize these valuable services. Along with the various ancillaries such as our ACR accredited MRIs, our physical and occupational therapy center which have U.S. Olympic Committee designations and our AAAHC-accredited ASC, we can provide the full spectrum of quality care for nearly any orthopedic sports injury.

Q: What is the best professional advice you have received and who was it from?

JS: My father, David Siegel of Buffalo, N.Y., told me never to be so busy that I do not spend time taking care of the business side of my practice. He meant that sometimes the patient load can block out the time that is required to run the administrative and business side of medicine. I have always taken nearly one full day per week to understand the direction our business is going and read trade journals that help point out potential opportunities in the delivery of healthcare.

Q: What advice would you give younger doctors considering a career in sports medicine?

JS: Building a sports medicine practice takes time. I have seen many sports medicine trained docs try to start their career limiting the types of patients they will see, or trying too hard to replicate the practice they experienced in their fellowship. Taking time to develop a name as a caring and competent physician first and a sports medicine physician second allows for success more quickly. ■

Learn more about Access Sports Medicine and Orthopaedics at www.accesssportsmed.com.

9 Keys to OrthoCarolina's Success

By Barbara Kirchheimer

OrthoCarolina is an independent orthopedic practice based in Charlotte, N.C. With 80 physicians, 15 locations and 800 employees, it offers comprehensive orthopedic care including foot and ankle, hand, hip and knee, shoulder and elbow, spine, sports medicine and pediatrics. It was formed in 2005 through the merger of Miller Orthopaedic Group and Charlotte Orthopedic Specialists, two of the region's largest and oldest orthopedic practices.

Here are nine keys to OrthoCarolina's success, as described by spine surgeon and OrthoCarolina CEO Daniel B. Murrey, MD, MPP.

1. Strong physician governance structure. "Many people believe they can practice medicine and not be involved in managing the group or managing the business side of the practice, and the reality couldn't be farther from the truth," Dr. Murrey says. Physicians may not have to have a finance degree, but they do have to participate in and endorse their practice's governance structure for the practice to succeed.

OrthoCarolina's governance structure includes an executive committee made up of physicians and a number of subcommittees that review and endorse policy decisions. "Because our executive committee has taken the stance that they won't yield to every physician's desire, it allows us to be much more effective in moving the practice towards its vision," Dr. Murrey says.

2. Commitment to clinical quality. OrthoCarolina has invested in both improving and measuring quality and has developed data systems that document how well the practice measures up "on even the most mundane things," Dr. Murrey says, such as how often patients' allergies are documented in their charts and what percentage of surgical patients have had follow-up appointments.

The practice has a data warehouse that allows it to monitor quality daily and report back to physicians. "These are all things we've traditionally taken for granted, but it turns out if you don't shine a light on it and document it, it doesn't always happen," Dr. Murrey says.

3. Transparency. One corollary to the commitment to quality is transparency of data. OrthoCarolina's physicians have access to data about all aspects of the practice, including the number of patients seen, revenue generated, charges dictated, referrals made and payor mix. Each physician at OrthoCarolina has access to this information about every other physician in the practice, which has cut down on arguments about which physicians might be seeing a higher volume of patients or might deserve special treatment for one reason or another.

"When you have the data there, it really quiets those arguments," Dr. Murrey says. "If you don't have the data, then physicians will question the decision-making until you have the data available." Physicians also buy into the practice's vision more readily when they can see for themselves the outcomes in the database, he says.

4. Investment in the practice. OrthoCarolina has invested in its practice in a number of ways — from making its facilities more patient-friendly to updating technology to allow the more seamless transfer of information between hospitals, physicians and the practice. It has also invested in its leadership, Dr. Murrey says, and has been willing to commit to physician leadership of the organization.

5. Customer service mentality. In an ultra-competitive environment where hospitals are luring orthopedic surgeons away from independent practice and drawing in patients through primary care networks, independent practices like OrthoCarolina have to work hard to differentiate themselves. "For us to provide a meaningful alternative over time, we have to create a patient experience that is far beyond what they can get at a hospital-based physician practice," Dr. Murrey says. "Patients can't always tell the difference, frankly, in how good the clinical quality is. They only have their experience. They can judge service quality much better than clinical quality."

At OrthoCarolina, staff and physicians are trained in customer service, he says. The practice relies on patient satisfaction surveys, the data from which is distributed weekly to physicians and staff. "We're also trying to develop things that aren't available in other places, things that anticipate the needs of patients and their families," Dr. Murrey adds. Whether it's providing up front financial information about a procedure or helping patients figure out how much time they might need to take off from work for recovery, these extra efforts have an impact on the patient experience, he says.

6. Dedication to the community. For OrthoCarolina, serving the community means both the Charlotte, N.C. region and the broader community of orthopedists. Being part of a larger community means providing trauma coverage for nearby hospitals' emergency departments, providing residency and fellowship training to physicians, accepting indigent-care patients and trying to be progressive about giving to charities or other medical-related groups in the area.

"It's not enough to say we gave at the office," Dr. Murrey says. His involvement in the community includes serving on the county commission. "I challenge all of our partners to find a way to give back to the community."

7. Commitment to research. Through a separate, independent 501(c)(3) research institute, OrthoCarolina fosters scientific research in orthopedics and is currently involved in some 60 studies, according to Dr. Murrey. "That attracts talented young surgeons who want to work with us," he says. "Those that would go to places like the Cleveland Clinic or Mayo can come here and get a research opportunity."

8. Comprehensive array of services. Overall, the healthcare industry is still plagued by a compartmentalized approach, which can be confusing to patients who might have to fill out a new patient history each time they see a different provider or deal with multiple bills all related to the same medical episode. "We try to bring all that under one umbrella," Dr. Murrey says. "We find that comprehensive care is something our patients appreciate." Services offered at OrthoCarolina range from surgical procedures to physical therapy, MRI and post-surgical support.

9. Good relationships with hospitals. Finally, in spite of the competition independent specialty physicians often face from hospitals wanting to provide some of the same services, OrthoCarolina is committed to working with hospitals in the region. "They're competitors, but they're not the enemy," Dr. Murrey says. "We need to work together. My preference is to have a long-term stable relationship with our hospital partners. We need to figure out how we can provide value back to them and feel like they don't need to go out and hire a bunch of new orthopedists, that we're going to help them meet their goal, achieve their mission." ■

Learn more about OrthoCarolina.

Amedica Corporation is an emerging orthopaedic implant company focused on using its silicon nitride ceramic technologies to develop and commercialize a broad range of innovative, unique spine and total joint implants for the growing orthopaedic device market. It has brought to market various spinal implant products, while products under development include reconstructive hip and knee implants that represent a new standard of care in total joint implants based on superior performance, safety and efficacy.

Trends and Developments Shaping the Future of Spine: Q&A With Ben Shappley of Amedica Corp.

Ben Shappley is president, CEO and director of Amedica Corp., an orthopedic implant company focused on using silicon nitride ceramic technologies to develop spine and total joint implants. Mr. Shappley has more than 26 years of orthopedic and neurosurgical implant experience with management and senior management responsibilities.

Q: What kind of growth are you anticipating in spine over the next few years?

Ben Shappley: I still think we're going to see double digit growth in spine and I think we're going to continue to see that in the short- and medium-term time periods. The major reason is the older population keeps presenting with baby boomers. As we move forward, I think the trend of patients presenting with low back problems will continue and increase.

Q: What do you see as a major issue facing spine in the long-term?

BS: In the longer term, dealing with spinal fusion and degenerative disease, both of the cervical spine and lower back, I think we may see some issues dealing with outcomes. I think that the days of large failed back syndrome cases as a result of failed fusion may be somewhat limited because of pressures from the likes of Medicare, Medicaid or the UnitedHealthcare and Blue Cross Blue Shields. These are very expensive surgeries and I think the pseudarthrosis rate, the failed spine rate is certainly higher in low back applications than it is in any other area of orthopedics. And I think the industry needs to pay particular attention to that. The high failure rate could mean we need to diagnose low back problems better. CT scans, X-rays, MRIs, they're important and are, of course, fairly effective, but to date we don't really have anything to report on the physiology of the low back.

When we look at other areas of medicine, we do a patient history, we do patient exam, we do an anatomy study and we do a physiology study. In dealing with the lower back, we do patient history, we do MRIs, we do CT scans, we do physical exams but we don't get any real significant reports on muscle and nerve activity. I think we need to be a little bit more sophisticated down the road in diagnosing low back issues specifically pointed towards physiology.

Q: What are some of the major trends currently influencing the direction of spine?

BS: Materials, outcomes and costs. I think we will see minimally invasive techniques to spinal applications become more popular. Same with percutaneous procedures, such as percutaneous facet fixation, which is done through a small cannula that can buy a patient years of pain relief before you have to do a full interbody fusion. I also think you'll see more minimally invasive techniques that deal with stenosis and other issues that may not require a complete laminectomy. We need to start thinking as an industry about minimally invasive percutaneous approaches. The smaller the wound, the quicker the recovery, the less rehab time that the patient's not at work, the less drugs that the patient has to take over a period of time — the [demand for these approaches and outcomes] will continue, particularly for the treatment of those patients facing more government pressure from Medicare, Medicaid and workers' comp, and then throughout healthcare in general. We also need to be particularly careful and sensitive to costs of spine surgeries as, in my opinion, it will become a greater issue going forward.

Q: Your company, Amedica, focuses on using silicon nitride for implants. Can you touch on why you're using this material?

BS: Our technology is focused on advanced bioactive material (silicon nitride) for interbody spacers, vertebral body replacements and cages. Currently the market primarily uses a plastic material called PEEK, which is a polymer, and bone does not grow onto and into plastic. Implant materials that are more biologically kind to lend themselves to interbody fusions, such as silicon nitride, which has a bioactive surface and a very strong ceramic material, should yield a better outcome. ■

Learn more about Amedica Corp at www.amedicacorp.com.

NIH Releases New Conflict-of-Interest Rules for Medical Research Funding

The National Institutes of Health have released new rules for medical researchers seeking federal funding aimed at increasing transparency when it comes to relationships and conflicts of interests related to the drug and medical device industry.

The changes follow several high-profile incidents involving federally funded researchers who have received millions of dollars through relationships with pharmaceutical or medical device companies that have been revealed in the past year, according to the report.

The new rules reduce the minimum payment required for disclosure from $10,000 to $5,000, and universities, research institutes and other businesses that receive federal dollars will be required to follow the new limit. Information about relationships and conflicts of interest must also be posted on a publicly accessible website.

NIH officials acknowledged such relationships were necessary in biomedical research and, in most cases, researchers were not influenced by their relationships with outside companies; however, the new rules were designed to increase public trust and to ensure that research met with ethical and scientific standards.

The public will have 60 days to comment on the new rules, which are available in the Federal Register.

Learn more about the new rules at www.nih.gov/news/health/may2010/od-20.htm. ■

4 Orthopedic Implant and Device Developments

By Lindsey Dunn

Here are four recent technological trends involving orthopedic implants and devices.

1. Mobile bearing partial knee replacement. In a partial knee replacement, surgeons modify part of the patient's knee to improve function instead of removing and then replacing the full knee, and mobile bearing partial knees are the latest technology for this type of procedure. Currently, partial knee replacement procedures are being performed by orthopedic surgeons as a "bridge" to a full knee replacement, says Jay Ethridge, CEO of Implantable Provider Group.

One of the first mobile bearing partial knee replacements to come on the scene was Biomet's Oxford Partial Knee System, says David Ott, MD, a board-certified orthopedic surgeon with Arizona Orthopaedic Associates in Phoenix. Unlike traditional fixed-bearing knee replacements, partial knees are mobile-bearing devices, he says. While Dr. Ott acknowledges that partial knees are commonly thought of as bridge procedures, he says a recent study out of the United Kingdom found 90 percent of partial replacements sustained their longevity 20 years after surgery, suggesting they could be as effective as total knee replacements.

2. Less invasive total knee replacement. While a number of other trends for total knee replacement have surfaced, including computer navigation and gender-specific implants, Dr. Ott says their popularity has waned as research suggests these technologies do not outperform traditional replacements. However, he says one trend in total knee replacement has remained steady — less invasive procedures.

"While we may use the same general implants, what has transpired is that more and more [orthopedic surgeons] have looked at narrowing down the incision to reduce tissue damage, which can speed recovery time," says Dr. Ott. "Implants have been cut down a bit to make them easier to put in and instrumentation has gotten smaller."

3. Hip resurfacing. Just as a partial knee replacement seeks to avoid the full replacement of a knee, hip resurfacing is a bone sparing procedure sometimes used on younger patients as a means to possibly avoid a full hip replacement, says Mr. Ethridge. In this procedure, the "ball" of the hip is shaped and capped with a metal surface, as is the hip socket. Smith & Nephew's Birmingham HIP Resurfacing System is one of the most popular of these devices.

While this procedure is gaining popularity, Dr. Ott cautions that very few patients are actually considered candidates for the procedure and there is presently very limited research suggesting this type of procedure is advantageous.

3. Anterior approach hip replacement. Total hip replacements are also trending toward less invasive techniques, and implants and surgical instruments have evolved to the point where these procedures can be performed using 3-6 inch incisions. However, another technique on the horizon that further reduces recovery time and is just beginning to gain greater popularity is the direct anterior approach to hip replacement. In this approach, a surgeon places the hip implant using an incision on the front of the patient, which goes between muscle planes as opposed to through muscle planes, as is done in the traditional posterior placement. The technique reduces muscle damage and improves patient recovery time, says Dr. Ott. Patients undergoing the anterior approach typically are discharged from the hospital in 1-2 days versus the 3-4 typically associated with a traditional hip replacement, and the anterior approach also reduces complications associated with dislocations and unequal leg length following procedures. Further, patients undergoing anterior approach replacements also are able to fully recover more quickly, moving from walkers to canes and then on to full independence more quickly than patients undergoing traditional procedures, says Dr. Ott.

Surgeons who use this approach typically use slightly modified implants and instrumentation to aid in anterior placement. Dr. Ott recommends that surgeons who perform the technique use a surgical table that allows a patient to be placed on his or her back and then extends the leg behind them, such as the Mizuho OSI ProFX or HANA Table. While the approach provides numerous benefits to the patient, Dr. Ott says it is a time-consuming and frustrating technique to learn, requiring as many as 20 procedures to become proficient.

"It's not for everybody, but it can benefit your practice," says Dr. Ott. "We have people coming to us from all over because they are doing consumer research and finding that we offer this approach. The physicians of our practice used to do maybe 10 hip replacements a month, and we are now doing around 55. Physicians around the country doing these are seeing their hip volumes doubling and tripling."

4. Biologics. A final area in orthopedics that has recently increased in popularity is biologics. These types of therapies include the use of human tissue, or allografts, to repair damaged tissue, such as tendons. Within orthopedics, this therapy is most used in ACL reconstructions, says Mr. Ethridge. Another type of therapy growing in popularity is platelet rich plasma injections, where a patient's own platelets are injected to repair damaged areas, such as an inflamed tendon, says Dr. Ott. However, Dr. Ott is concerned there is not data to prove the effectiveness of such injections and cautions against using therapies without evidence of its advantages.

Growth in sector

As baby boomers age, more patients will be in need of orthopedic implants, and the implant sector is expected to continue to grow as a result, says Mr. Ethridge. He cautions, however, more clinical data is needed to help physicians make appropriate decision for their patients.

"From an industry standpoint, there needs to be a greater focus on providing more comparative effectiveness data regarding procedures and devices to substantiate these new procedures being performed," says Mr. Ethridge. ■

Contact Lindsey Dunn at lindsey@beckersasc.com.

Benefits of Not Carving Out Spine Implant Costs

Beth A. Johnson is vice president of clinical systems for Blue Chip Surgical Center Partners.

Q: There is a common belief among many surgery center operators that the best way to ensure profitability is to carve out spine implant costs. Do you agree with this strategy?

Beth Johnson: While some centers carve out these costs, it's much more favorable if you can negotiate good global rates. With carve outs, normally there is a requirement to send the insurance company implant invoices, which slows down payment. If you know your costs and have them up to date before negotiating global rates, you can benefit from this type of reimbursement. We feel it's more favorable financially to have all your cost data and then negotiate rates that cover your costs. ■

Learn more about Blue Chip Surgical Center Partners at www.bluechipsurgical.com.

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6 Trends in Minimally Invasive Spine Surgery

Minimally invasive spine procedures involving the use of facet fixation products are expected to grow faster than other sectors of the spine surgery market over the next five years, according to *US Markets for Minimally Invasive Spine Technologies 2008*. The high growth rate is due to increasing adoption of facet screws, bolts and allograft implants, says the report from Millennium Research Group, a leading provider of strategic information to the healthcare sector.

Here are 6 key statistics and trends in MIS covered by the report.

1. The U.S. MIS market, comprising minimally invasive spinal fusion implants, facet fixation devices, intradiscal therapies and discography devices, will expand at a compound annual growth rate of nearly 30 percent through 2006 to 2012.

2. Minimally invasive spinal fusion implants are the most-often-used technology in this area, followed by intradiscal therapies, facet fixation devices and discography devices.

3. The minimally invasive spinal fusion market was dominated by spinal implants in 2007, followed by interbody devices and access instrumentation. Growth in these procedures will be driven by "individuals with chronic back pain [seeking] a solution to their pain that allows them to recover as quickly as possible" and "MI techniques used in complex procedures, spanning more levels" are aided by "innovative products with the ability to span several levels," reports MRG.

4. The use of facet fixation devices is expected to increase by a compound annual growth rate of 60 percent from 2007 to 2012; the increased adoption is due to "innovative products … which feature greater ease-of-implantation and increased efficacy," says MRG. Further, use will increase as, "collectively, these new facet fixation technologies are successfully cannibalizing cases that would have been previously treated with pedicle screws, such as grade 1 and 2 spondyloisthesis."

5. Intradiscal therapies — comprising plasma disc decompression, intradiscal electrothermal annuloplasty and percutaneous disc compression products — "have had trouble obtaining national reimbursement coverage due to payor concern over the long-term efficacy of the technologies," says MRG. However, adoption is expected to grow steadily and the reimbursement atmosphere expected to become more favorable as "market leaders … continue promoting the benefits" heavily.

6. Over the next five years, the U.S. discography market expansion will be driven by "increasing numbers of spinal pathologies, such as DDD, that require accurate diagnosis due to the growing aging population suffering from age-related diseases and conditions," says the report.

A statistically significant survey of 72 U.S.-based spine surgeons was used to inform the analysis. Visit MRG's Web site at www.mrg.net to learn more about the company or to order a copy of the report. ■

Survey: 25% of Orthopedists Plan to Reduce Metal-on-Metal Hip Usage

A recent survey of 150 orthopedic surgeons found that 25 percent are planning to reduce their usage of metal-on-metal hip implants over the next 12 months, due, in part, to recent reports of metal debris and soft-tissue damage that led to revision surgery in some patients, according to a news release from Millennium Research Group, which conducted the survey.

Reports earlier this year from worldwide media outlets cited concerns over metal-on-metal implants, and DePuy issued a warning letter associated with its ASR acetabular cups. DePuy's and Biomet's metal-on-metal implants have been associated with the highest degree of surgeon satisfaction, according to the release.

Analysts from MRG said the 25 percent represented a small minority of orthopedic surgeons, most of whom were "devoted fans" of metal-on-metal implants due to a better range of motion, low revision rates and overall good success, according to the release. ■

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