INSIDE

INDEX

BECKER'S
ORTHOPEDIC, SPINE & PAIN MANAGEMENT REVIEW

April 2012 • Vol. 2012 No. 2 *Business and Legal Issues for Orthopedics, Spine and Pain Management*

208 Spine Surgeons & Specialists to Know

By Laura Miller

William Abdu, MD (Dartmouth-Hitchcock Medical Center, Lebanon, N.H.). Dr. Abdu is the medical director of the Spine Center at Dartmouth-Hitchcock Medical Center. He has a professional interest in spinal cord injury, spinal stenosis, spinal trauma and disc herniation.

Behrooz A. Akbarnia, MD (San Diego Center for Spinal Disorders). Dr. Akbarnia is medical director at the San Diego Center for Spinal Disorders. He has been president of the Scoliosis Research Society.

continued on page 22

11 Key Issues Facing Surgery Centers — 2012

By Scott Becker, JD, of McGuireWoods, and Laura Miller

1. Out-of-network. Centers continue to struggle with managed care contracting and with whether to stay in-network or provide services out-of-network. Certain chains and centers seem to still be making a lot of money by providing services out-of-network. However, it seems pretty clear that chains and centers must work with patients to manage or reduce co-payments significantly to still see patients. In contrast, many centers are either more conservative with out-of-network and/or have faced recoupment claims from payors' or other threats to physicians with respect to out-of-network patients and the payors efforts to push physicians to drive patients to in-network providers. This is an issue that will continue to evolve particularly as payors become tougher in their contract offers.

continued on page 19

8 Keys to Success in Sports Medicine From Dr. James Andrews

By Laura Miller

James Andrews, MD, founder of the Andrews Institute of Orthopaedics & Sports Medicine in Gulf Breeze, Fla., has trained some 300 sports medicine fellows during his career and taken care of professional athletes the world over, including the likes of Brett Favre, Michael Jordan and Roger Clemens. He is the team physician for the Washington Redskins and Tampa Bay Rays and past president of the American Orthopaedic Society for Sports Medicine. He continues to serve on the board of directors for AOSSM and was recently appointed to the medical advisory board for IntelliCell BioSciences, along with other partners in his practice. He is also the medical director for Auburn University interscholastic sports and senior orthopedist for the University of Alabama sports teams.

Here, Dr. Andrews discusses the most important elements for building a successful career in sports medicine.

continued on page 39

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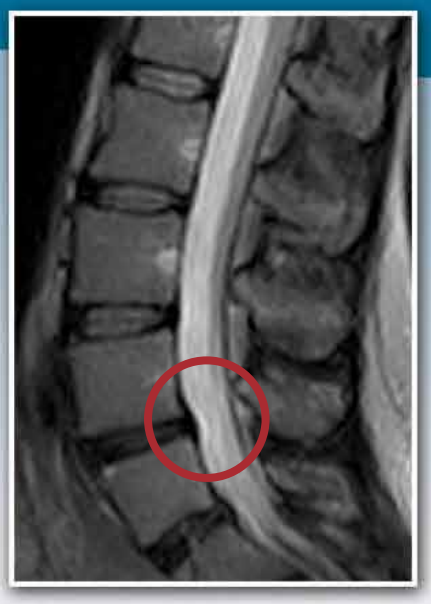

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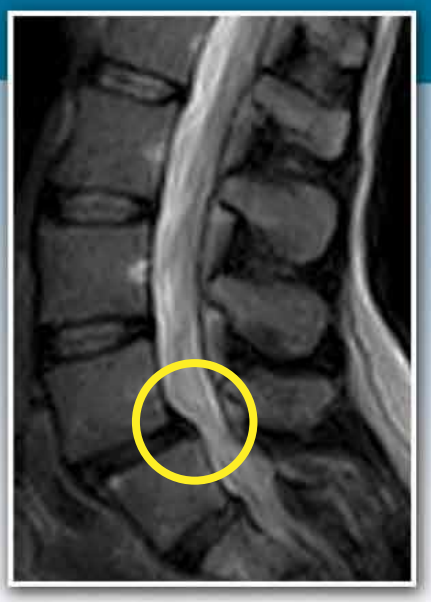

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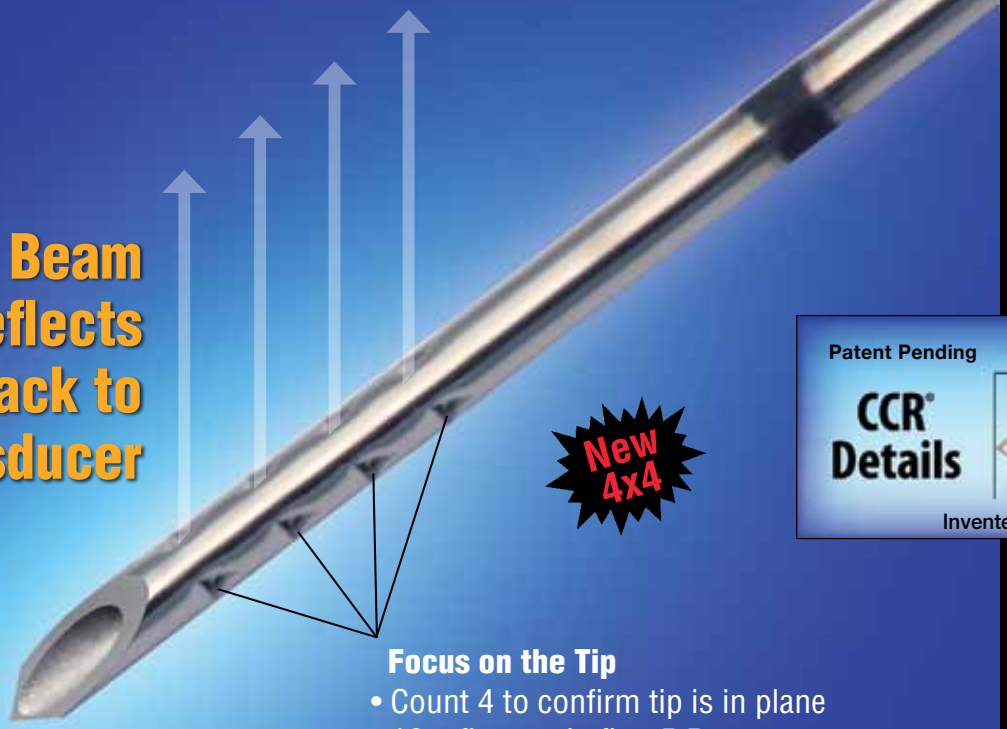

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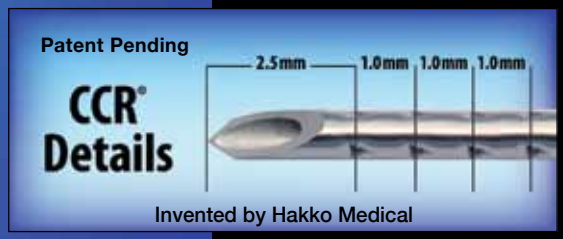

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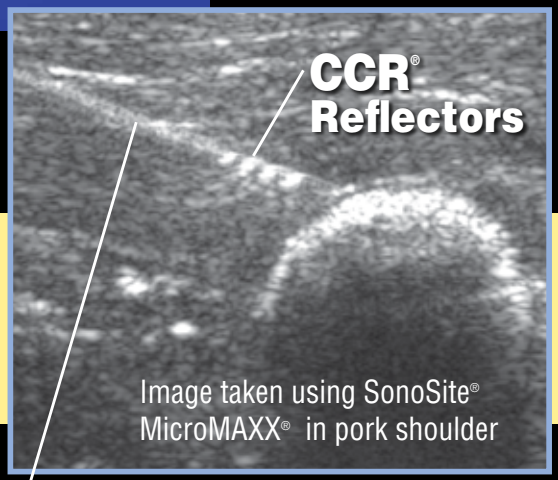

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FEATURES

Publisher's Letter

We hope you find the articles and columns included in the April issue of *Becker's Orthopedic, Spine & Pain Management Review* informative and insightful. We have sought expertise from some of the leading orthopedic, spine and pain management physicians on today's most important business issues and industry trends. This issue includes several feature articles, such as:

1. 208 Spine Surgeons and Specialists to Know—Our editorial team has compiled a list of 208 spine surgeons who hold leadership positions in their organizations, regularly conduct research, develop surgical devices and techniques and direct fellowship programs for the next generation of spine surgeons.

2. The State of Minimally Invasive Spine Surgery: Q&A With SMISS Co-Founder Dr. William Taylor—In this interview with SMISS co-founder and past president William Taylor, MD, he discusses the challenges facing minimally invasive spine surgical technique and the role it will play in the future of spine care delivery.

3. 8 Keys to Success in Sports Medicine From Dr. James Andrews—Renowned sports medicine physician James Andrews, MD, discusses how sports medicine physicians can rise to the top of the field by emphasizing quality of care and exhibiting high moral character in all activities.

4. 11 Key Issues Facing Surgery Centers—2012—This article outlines the key trends in the surgery center industry, including safe harbor issues, relationships with hospitals and contracting with payors.

5. Dr. Brian Cole: 3 Exciting Trends in Sports Medicine Research—Brian Cole, MD, head of the Cartilage Restoration Center at Rush in Chicago, discusses his latest research in sports medicine, orthopedics and biologic solutions.

This issue also includes a brochure for the 10th Annual Orthopedic, Spine and Pain management-Driven ASC conference, which will be held June 14-16 in Chicago. We will have 102 sessions with 134 speakers, including key note speakers Lou Holtz, Sam Donaldson and Tucker Carlson.

Should you have any questions or comments, please contact myself at sbecker@beckershealthcare.com or editor-in-chief Laura Miller at laura@beckershealthcare.com.

Very truly yours,

Scott Becker

P.S. For information on advertising or exhibiting in *Becker's Orthopedic, Spine & Pain Management Review*, or on any of the Becker's Healthcare websites, please contact Jessica Cole or *Becker's Orthopedic, Spine & Pain Management Review* at 800-417-2035.

4 Strategies to Prepare for Changes in Reimbursement

By Patrick Vega, M.S.. Principal, Vega Healthcare

There are four key strategies hospitals and physicians should use to prepare for upcoming reimbursement changes:

1. Develop medical staff-hospital collaborations that include both private and employed physicians
2. Develop integrated and comprehensive continuums of specialty care
3. Deliberately invest in and implement clinical and functional outcomes collection and reporting
4. Proactively define quality with payors and pilot alternative reimbursement models

Physician-hospital collaboration

As a result of market changes fostering unprecedented collaboration, physicians will have more opportunities for leadership and accountability in specialty program development, delivery and management than ever before. One common barrier is that of historical distrust between administration and medical staff. According to Michael J. Dacey, MD, FACP, SVP MA and CMO for Kent Hospital in Warwick, R.I., "Most doctors believe that very few administrators understand physicians and the problems they face. And most administrators at both hospitals and insurance companies would say the same thing about doctors. And both groups are correct." He further comments that in the current and near-future environment, hospitals and physicians are co-dependent for clinical and financial success. (HealthLeaders, 2/23/12)

The most successful collaborations will engage physicians, regardless of private or employed status, in mutually beneficial initiatives where benefits accrue to those willing to invest in program development that benefits patients, practices and specialty programming.

Hospital must lead with resources — almost without exception, every hospital and medical staff has a long-standing organizational skepticism. That is, when faced with or given the opportunity to engage in a new initiative, many will react with skepticism. It is not uncommon that new projects, initially bright and compelling, are discarded when faced with a lack of progress due to poor planning and implementation. Hospital staff and physicians are reluctant to invest their time and reputations in endeavors that do not arise out of a common vision, are not well planned and therefore have little chance of achieving key milestones and producing lasting change.

In the most successful health systems, administration actively seeks physician participation in service line development and management of clinical, financial and business development matters with decisions made based on shared vision and values. Carrie Willets, director of orthopedics at Sports Medicine & Rehabilitation at Rockingham Memorial Hospital in Harrisonburg, Va., can attest to the impact of alignment. RMH has experienced a dramatic growth in their total joint replacement program, in large part due to the institution of key elements of effective service line development. Vital among them is administrative support and the deep involvement of employed and private orthopedists in all aspects of the program.

In addition to the fundamentals of a comprehensive strategic plan, RMH challenged their medical staff to take leadership and accountability for both their patients and program quality as well. This included not only the orthopedic surgeon's involvement in leadership council but also leadership from anesthesia and radiology. All stakeholders review program operational, clinical and financial metrics regularly and manage the program from these metrics.

Develop integrated and comprehensive continuums of specialty care

While hospital-physician alignment and collaboration, exploration of alternative reimbursement models and mutually defining quality with payors are both important to prepare for the future, ultimately, each is fundamentally dependant on the organization and delivery of specialty care. Well-defined, standardized and reliable systems of care are inextricably linked with medical staff-hospital collaboration and quality, which set the stage for novel reimbursement pilots and models.

The commitment to effective systems, structures and resources for specialty care is a prerequisite for the future of orthopedics, spine and pain management. When preparing for any of these initiatives, it is not uncommon that systems must be redesigned and protocol developed to allow the organization/service to reliably perform at a remarkably high level, elevating the staff, patient and service above routine crisis, ultimately achieving consistently impressive patient outcomes, experience and metrics.

Clinical and functional outcomes to substantiate effectiveness

"One of these days we will be paid for our outcomes…" I recall that statement over 20 years ago from a hospital administrator as he chain-smoked in his office. Even then it made sense. Yet, aside from the development and use of standard assessment tools, surprisingly little has been done to bring measures of effectiveness to orthopedics and spine on a larger and national scale. That is about to change. Pay for performance and bundled reimbursement will dramatically alter care organization and delivery. According to the Dartmouth Institute, "Payor-driven shared-risk payment models will force increased hospital/physician collaboration on programs that reduce cost and increase efficiency without sacrificing quality care."

Collection, reporting and application of operational, clinical and functional outcomes data will emerge as a primary driver for contracting and reimbursement, and will increasingly become a source of comparative effectiveness for physicians and hospitals. When conducting assessments, we routinely ask medical and hospital staffs what they collect for outcomes. While virtually every hospital and physician will acknowledge they should be (and should have been) collecting outcomes, very few actually do. Most hospitals reply that they collect patient satisfaction and mandated measures. The most common physician response is that they (anecdotally) have high patient satisfaction. One surgeon shared that an Oswestry was collected on every surgical spine patient but the information was not used.

John Pracyk, MD, PhD, a neurological surgeon and medical director for the Center for Spine and Brain Health at Mercy Medical Center in Oshkosh, Wis., coined the term "surgical meritocracy" to denote a new culture of measurement. Because consistent and broadly based outcomes have not been collected, many surgeons are naturally skeptical of the means and uses of such data. Dr. Pracyk's experience is that measurement precedes understanding and provides a genuine basis for improving care and substantiating value. "The surgeon may believe they are good, but does someone who's keeping score or paying for care believe they are good? Physicians will be weighed, measured, and perhaps found wanting. Performance of all types, including the level of patient engagement and satisfaction are now, or will soon be, subject to measurement."

While this can be a challenging transition, Dr. Pracyk offered encouragement. "This is the new culture that could bring a new found honesty and satisfaction back to the practicing surgeon," he says. "Being able to translate outcomes data into actionable items is the next step."

At present there are few nationally established standards for collection of orthopedic, spine and pain care outcomes. Several professional associations have initiatives to define standards but none are universally accepted. This absence creates opportunities for physicians and hospitals to advance the definition of best practice for outcomes. When done properly, outcomes collection, reporting and application is a joint responsibility for hospital and physicians. Because of their operational infrastructure and resources, in most cases, initiatives should be resourced by hospitals and collaboratively managed by both hospital and medical staff.

Defining quality

With the advent of pay for performance and other reimbursement models, hospitals and physicians will increasingly measure and report data such as:

- Patient experience
- Functional outcomes (i.e., non-surgical, post-surgical/interventional results)
- Operational data (i.e., ALOS)
- Clinical indicators (specialty specific)
- Financial data (i.e., contribution margin, market share)

This data will be used to benchmark individual hospital and physician care against national, regional and payor data on a specialty specific basis. Additionally, data can be used to seek specialty certification, accreditation, preferred reimbursement, or in the mid- to long-term, inclusion or exclusion from provider panels. This will require investment now to yield long-term benefits.

Our perspective is that there will be a window of opportunity for hospitals and their medical staff to proactively and collaboratively define quality metrics with their payors. While the Centers for Medicare and Medicaid Services and other government agencies will proceed with quality and payment demonstrations; community, academic and private hospitals have an incredible opportunity to pilot with private payors on a small scale and proliferate novel and effective models of care and management.

Furthermore, rather than being dictated to, providers can collegially define quality and best practice. According to physiatrist John Hart, DO, of PeaceHealth Medical Group, "This is the time for institutions and hospitals to learn from their past and step into the future. By inviting the insurers, not only to the table, but into the living room and having a long discussion on what the ideal future should look like, proactive institutions and physicians can be fundamentally involved in constructing their future in matters of quality. Simply put, if we do not engage with payors, they will dictate the future to us ... and with reason." With the history between providers and payors being antagonistic, such proactive collaboration can result in trusted partnerships that lead to true innovations and sustained engagement.

Changes in reimbursement and greater physician-hospital collaboration will alter the landscape of healthcare. Those that accept that change is inevitable and proactively prepare for it can have a significant role in shaping their futures and avoiding the prospect of having change dictated. ■

The State of Minimally Invasive Spine Surgery: Q&A With SMISS Co-Founder Dr. William Taylor

By Laura Miller

William Taylor, MD, a spine surgeon at UC San Diego Health System, is one of the pioneers of minimally invasive spine surgery in the United States. He helped found the Society for Minimally Invasive Spine Surgery — which has grown tremendously over the past five years — and is a past president of the organization.

"Transitioning to minimally invasive spine surgery has been a long, slow process," says Dr. Taylor. "About 20 percent of the spine surgeons in the United States are performing minimally invasive surgery now, and that number will continue to increase. The demand comes from patients, doctors, hospitals and insurers. Minimally invasive surgery is preferable because there are fewer complications and a shorter recovery time. Most surgical specialties have adopted minimally invasive technique; however, spine has been a bit slower."

Dr. Taylor discusses the evolution of minimally invasive spine surgery and where the field is headed in the future.

Q: Minimally invasive spine surgery has been around for several years and some procedures indicate a clear advantage for patients over the open technique. Why have many surgeons been reluctant to adopt it?

Dr. William Taylor: If you compare spine surgery to other specialties — general surgery — spine surgeons have been relatively slow in adopting the technique. You won't see a surgeon perform an open gallbladder surgery instead of laparoscopy; surgeons who do seem like they are behind the times because patients have gravitated toward minimally invasive procedures. Spine surgery hasn't followed suit as quickly as other specialties. I can't understand the exact reason, but there are barriers in training, education and resources. Most surgeons who are currently practicing spine surgery didn't learn minimally invasive techniques in their residencies and it takes a great deal of extra training to become expert with the procedure.

Another potential barrier is the lack of standardization for minimally invasive spine surgery. For example, there is one way to perform an appendectomy and if you need that procedure, every surgeon will follow the same steps. However, when patients need a spine surgery for something

like L4-L5 spondylolisthesis, there are many different acceptable procedures surgeons can do — there isn't just one agreed upon standard.

Q: What factors will play a role in further spreading minimally invasive surgical technique?

WT: Right now, residents going into fellowship programs want to learn minimally invasive techniques for spine surgery. It's growing more quickly in academic settings and private practices than in large medical centers. More people are learning about minimally invasive surgery every year. Its growth clearly depends on surgeon, patient and insurer preference.

Minimally invasive spine surgery is a harder technique to perform and it occasionally takes longer in the OR until you overcome the learning curve. We also sometimes have difficulty receiving reimbursement for the minimally invasive procedures, all of which make them occasionally less appealing than the traditional open technique, despite its value for patients and other stakeholders

I co-founded SMISS with Choll Kim, MD — he's really the driver and standard bearer for the society. We started it five years ago because in the world of academics, there wasn't a place for papers or presentations on minimally invasive spine surgery. Now, other societies are starting to have a bigger interest in minimally invasive procedures, which helps spread the word.

Q: You mentioned one of the barriers to minimally invasive surgery is the lack of standardization among procedures. As the technique becomes more common, do you see a more standardized approach arising?

WT: No, I still think you are going to see a minimally invasive procedure variation. The variation will depend on the diagnosis and surgeon preference. Additionally, where the surgeon was trained, patient population and practice location will all impact this decision.

Q: Despite the variation, is there an umbrella definition surgeons can use to describe a procedure as 'minimally invasive'?

WT: "Minimally invasive" is a definition we have struggled with for a long time. Our definition for SMISS is an approach to the spine which satisfies the physician requirements for outcomes and complications but utilizes normal tissue plans that may avoid unnecessary tissue destruction and allows for outcomes that may be superior to traditional open surgery.

Depending on your technique, the definition could include using an endoscope or other tools to achieve the same goals, as long as the surgeon is minimizing approach related tissue disruption.

Q: There is a big push within healthcare right now to practice evidence-based medicine. Where is minimally invasive spine surgery in terms of proving effectiveness in the literature?

WT: You have to divide that into what we think minimally invasive surgery is now and where we think it will go in the future. It wasn't until the past few years that we knew surgery was better than conservative treatment for spinal stenosis. The Spine Patient Outcomes Research Trial showed, for the first time, this outcome as well as the idea that fusion for spondylolisthesis is better than decompression in the long run. These points have been argued back and forth, but SPORT gave us a foundation for our argument.

We can point to is less blood loss for minimally invasive procedures. There are some studies that don't show this outcome, but the weight of them indicate decreased blood loss, hospital stays, decrease in infection, faster return to work and fewer blood transfusions than with open procedures. In the future, we are hoping to find that outcomes are better for minimally invasive surgery, pain rates are less and patients have a lower risk for adjacent level disc disease.

Q: What are your goals for SMISS over the next few years?

WT: There are three main goals we are focused on:

1. Research — we are trying to prove the effectiveness of minimally invasive spine surgery and creating a database for those procedures. Surgeons who use it aren't conducting prospective, randomized, controlled studies, but they can mine the database for their research.

2. Education — we try to provide validated training courses for surgeons who would like to learn the minimally invasive technique. Many surgeons are taught by device companies to use their instrumentation; we want to better understand and validate the types and method of the education currently in use and how we can do a better job maximizing these efforts to produce better trained physicians. SMISS also provides educational courses. We have the largest minimally invasive spine surgery meeting every year and at the meeting we have separate courses developed to teach minimally invasive spine surgery techniques, along with the development of our CORE Curriculum and CME lecture series.

3. Advocacy — some surgeons have difficulty receiving reimbursement for minimally invasive procedures. Some procedures don't have CPT codes. Our goal as a society is to make sure surgeons have minimally invasive procedures available in their armamentarium when they are appropriate — which should be available to the patient and the surgeon, not a decision made by the insurance company. For example, the AxiaLIF procedure from TranS1 was developed 10 years ago and has been done 14,000 times — 10,000 times in the United States — it won't have a CPT code until 2013.

The idea that a procedure that has been done thousands of times over the past decade and proven in the literature still has difficulty getting approvals and reimbursement is disappointing. It means we are not doing enough as a society to ensure options for all patients. ■

8 Pillars of Success at Sonoran Spine Center

By Laura Miller

Spine practices can follow one of several different business models with a focus on either surgical cases, non-surgical cases or a mix of both. When founding his group, Sonoran Spine Center, Dennis Crandall, MD, chose a model that emphasized treating all different types of patients.

"We have chosen a model on purpose that embraces all spine disease in adults and children — operative and non-operative," says Dr. Crandall, who now serves as the practice president and CEO. "We don't want our referral physicians to think about whether their patients would fit our treatment style; we want them to send patients to us regardless of their condition and we can guide them to the best treatment."

Here, Dr. Crandall discusses the challenges and opportunities presented by this practice model and how his group has remained successful despite changes in the healthcare environment.

1. Make it easy for patients to come through the door. Sonoran Spine Center is a patient-driven practice, which means the surgeons depend upon a high volume of cases to keep the practice running. Since there are specialists in several different spine-related areas, the group can accept most patients coming their way; however, they must also focus on quality to encourage those referrals.

"We want to see everyone who walks through the door," says Dr. Crandall. "We need to have sufficient quality providers to meet our need for volume. Our care must be consistent with our patients' and referring physicians' quality expectations. We have to be able to take on surgical and non surgical cases, work-related issues, tertiary or simple cases."

Currently, the practice has four spine surgeons ranging in expertise from adult and pediatric scoliosis and other major deformity correction to caring for patients with degenerative and traumatic conditions. Additional medical specialists include a pain management physician, five physician assistants and one research nurse. In the future, Dr. Crandall hopes to add additional pain management specialists, tumor and spinal trauma surgeons to further extend coverage at the practice.

"We want to develop niche areas in spine we don't have covered right now," says Dr. Crandall. "It's hard for us to meet the needs we have right now and go after new business considering how busy we already are. However, this is an opportunity for the future and we are thinking about how to take advantage of it."

2. Develop additional ancillary service lines. Right now, the surgeons at Sonoran Spine Center accept any case almost regardless of the payor, which means accepting Medicare patients. Managed care plans continue to drop their rates, significantly decreasing profitability on those cases. Medicare reimbursement has been in a constant state of flux, with Congress threatening to dramatically decrease payments to physicians. As a result, Dr. Crandall and his partners are exploring ancillary services as a new way to bring revenue into the group. Sonoran Spine Center currently includes an in-house X-ray and physical therapy.

"Most practices have an X-ray, but since we do a lot of spinal deformity cases we have a machine that allows us to shoot 18x36 inch long spine films," Dr. Crandall says. "That's something that can't be done at just any outpatient radiology center, so we brought it in-house."

When it was time to bring in physical therapy, Dr. Crandall was initially skeptical of its profitability because overseeing the collection of $10-$20 copays can be onerous; the office staff spend time tracking down these small payments, which may not amount to much value. However, soon after incorporating those services the profitability became clear.

"It really has been a good, revenue positive decision to add physical therapy," he says. "We have tight control on the therapists and how the therapy is delivered. Our communication between the physicians' and therapists' offices is fantastic, which makes working together with a patient so much easier."

Now, when Dr. Crandall recommends therapy for the patient, he can call a therapist into the office during the patients' visit to discuss their treatment plan. This boutique level of care projects a positive image of the practice with highly integrated care.

3. Investment in a surgical hospital. Sonoran Spine Center invests in a surgical hospital dedicated to orthopedic and spine procedures. While the hospital offers a little extra ancillary revenue, Dr. Crandall said the most significant return on the investment comes from patient and physician satisfaction. "We have governance control on the way patients are taken care of and screened at the hospital," he says. "It's far more enjoyable from the patient's experience, as well as

the surgeons' standpoint, to have all the nurses, physical therapists and OR staff all on the same page with one goal: to make patients happy."

Since the staff is focused only on orthopedic and spine cases, they are more familiar with recovery process and can develop a closer relationship with physicians and patients. "For me, it's such a pleasure to walk on the floor and have the nurses approach me, telling me about a specific patient," he says. "I can tell the nurse has been closely involved with the patient, and patients feel like we are listening to them. The patient satisfaction surveys we get back at our surgical hospital are sometimes 20-30 percent higher than satisfaction surveys on the same surgeons at different hospitals."

Dr. Crandall says the strict focus on patient care has created a culture in the surgical hospital that promotes higher patient satisfaction and a better physician experience than at typical, non-specialty hospitals.

4. Strike a balanced payor mix. With declining reimbursement rates across the board, spine practices must analyze their payor mix and figure out how to recruit more profitable cases. For Sonoran Spine Center, this means doing an appropriate number of other cases, including workers' compensation cases, to balance Medicare rates. Workers' compensation cases pay higher rates than other cases, partially because there is extra work the physicians and specialists must complete for each episode of care. Some practices focus solely on workers' compensation cases — which is one example of an effective business model, but not one Sonoran Spine Center aspires to achieve.

"We don't want to do entirely workers' compensation cases, but we do want a good level of workers' compensation in our payor mix," says Dr. Crandall. "With that higher reimbursement, we can become more efficient."

However, if Medicare cases continue to decline at an unsustainable rate, spine practices may need to drop those cases in the future to stay profitable. "We haven't closed the door on Medicare patients yet because we feel it's important to care for this population," says Dr. Crandall. "However, we can't follow Medicare if rates keep declining. Many of our colleagues have already decided they can't see Medicare patients."

5. Hire quality providers to work with your patients. If providing high-quality patient care and promoting a positive patient experience is what differentiates your practice, then you want to attract and maintain "A level" staff and employees, says Dr. Crandall. High quality employees can boost patient satisfaction and promote better treatment outcomes.

"We don't settle for less than 'A level' providers because we think as the future evolves there will be more stress on getting patient volume through the door; in that environment, our best asset is our service quality," says Dr. Crandall. "If we have 'B level' or 'C level' people working for us, we won't be able to compete well."

The quality of care begins with the physicians, which is why Sonoran Spine Center only brings on like-minded physicians focused on providing a high level of service. "These are the type of people who enjoy interacting with patients and the private practice environment," says Dr. Crandall. "Our office manager is also completely in step with the overall patient care ethic we embrace as physicians."

With physicians leading the charge, the culture of excellent patient care becomes pervasive among the practice staff, especially when they are incentivized. At Sonoran Spine Center, employees undergo yearly evaluations and are rewarded with bonuses or raises based on how consistent their performance was with the group's overall outlook on patient care.

6. Focus on the patient-physician relationship. Healthcare legislation and regulation is constantly changing, which makes it difficult for providers to run their businesses. Despite these challenges, it's important to maintain a focus on the patient-physician relationship to provide a higher level of care. "I see significant changes regardless of who wins the election in 2012," says Dr. Crandall. "The healthcare economics of 2012 are going to require changes regardless of your politics. At the end of the day, healthcare delivery will still depend on physicians taking care of patients."

Some providers are forming accountable care organizations for shared savings, but Dr. Crandall doesn't see his group joining an ACO any time soon. Instead, the group plans to tackle today's challenges by devising new ways to capture outcomes and patient satisfaction data as well as strengthening relationships with referral sources.

"Our biggest referral sources are prior patients, so we want to make sure that doesn't change," says Dr. Crandall. "If that continues, we'll be in a good place for the future. We fully expect competitive pressure from other groups, but having a positive patient care experience can give our group the edge."

The group also takes time to thank referring physicians and is exploring new ways to build a relationship with those colleagues as well.

7. Project leadership through teaching and education. In the professional and local community, it's important to accept leadership roles. The physicians of Sonoran Spine Center are involved in teaching residents and spine training for the residency program in Phoenix. They also host community outreach educational programs and present research at professional society meetings.

"We want to continue to project leadership through teaching programs and the research presentations we give," says Dr. Crandall. Last year, the surgeons presented 22 different research papers based on their practice data at national and international meetings. Next year, the group is on track to present 30 or more papers, some with an average follow-up period of five years.

8. Initiate research and share results. Many of the physicians at Sonoran Spine Center engage in spine research, education and innovation in addition to their regular practice. The group includes Sonoran Spine Research and Education Foundation, which is an independent, non-profit organization that supports public awareness programs, spinal advocacy groups and research activities.

"Since we have the research foundation, our research costs aren't direct overhead for the practice," says Dr. Crandall. "They are handled under the foundation overhead. As a result, partners who aren't active in research don't feel the pinch on their salaries when they aren't participating in research efforts to the degree of other partners."

The surgeons gather data from their all patients at Sonoran Spine Center, regardless of their research intentions. This data includes patient outcomes and satisfaction scores. Then, two full-time research coordinators gather and organize data from the practice so the surgeons can easily analyze and present their findings.

"For us, the key is that every single patient on every single visit fills out research and outcomes forms," says Dr. Crandall. "We try not to make them long but still capture the data we need. When I ask my research coordinators to look up data on 15 projects on long term patient outcomes, they can easily pull the information from our database." ■

Dr. Frank Cammisa: 8 Top Challenges for Spine Surgeons This Year

By Laura Miller

Frank Cammisa, MD, chief of the spine service at Hospital for Special Surgery in New York City, discusses the biggest challenges for spine surgery heading into 2012.

1. Influence of insurance companies on access to spine care. Over the past few years, insurance companies have tightened their guidelines on spine coverage, making it difficult for surgeons to perform surgery in once-routine cases. More frequently than in the past, surgeons are being asked to speak with medical representatives in peer-to-peer reviews which often still result in coverage denial.

"I think the biggest concern is the influence of insurance companies on our ability to see patients," says Dr. Cammisa. "For example, there is a push not to authorize fusion-type surgeries for patients. In these cases, we must do a peer review. We spend a lot of time talking on the phone to insurance companies substantiating why we think a certain type of procedure should be done. It's onerous for the surgeon and the patient because it takes the physician/patient relationship and inserts a middle man who decides whether the patient will have surgery."

There is a perception among some circles of healthcare that too much spine surgery is being done and payors must control rates of surgery, says Dr. Cammisa. "Will we be able to independently recommend surgery for our patients or will there be an arbiter?" he says. "This is a concern for every medical specialty."

2. Dealing with regional differences in spine care. The perception of too much spine surgery has been propagated by several sources, including statistics showing rates of spine surgery are higher in some parts of the country than others. Dr. Cammisa says there are several factors contributing to this difference, including:

- How quickly new procedures are introduced
- When spine surgeons are willing to adopt new procedures
- Demographics — percentage of the population who are likely candidates for spine surgery

"It may be that one area is treating spinal conditions more aggressively, but another area might not have the resources available to perform the same procedures on their patients," says Dr. Cammisa. "There may be just as many patients needing surgery in both areas in terms of population percentage, but the care isn't as advanced. From the statistics, it's hard to tell whether surgery is being overused or underused in different regions of the country."

3. Minimizing peer reviews with insurance companies. Since conducting peer reviews is a time consuming process, most surgeons prefer to minimize these conversations whenever possible. "We try to make sure all the documentation is well outlined in our initial note to the insurance company," says Dr. Cammisa. "We send all the information so they know the patient had epidurals, physical therapy and other conservative care and everything is well outlined saying they failed non-surgical treatment — or that their care was an emergency."

In cases of an emergency, Dr. Cammisa's office sends electromyography confirmation of a severe nerve abnormality or other defect. "When the reviewer looks at our reports, they have all the information and dates in front of them," he says. "What concerns me is when I get on the phone with peer reviewers, they often aren't peers — they may be an internist, or another medical professional who doesn't specialize in spine surgery."

When reviewers don't have a spine background, they are more likely to stick to guidelines and staunch treatment pathways before approving surgery. "They don't understand that every patient is different and there are a lot of nuances in spine care," says Dr. Cammisa.

4. Proving the effectiveness of spine surgery in the literature. Approval for spine procedures depends on published outcomes data now more than ever. Strong evidence-based medicine is essential for specialists to show procedures they recommend will have a positive impact on the patient's life. Spine surgeons are more focused today on participating in strong studies and publishing their results.

"What I find particularly exciting is the fact that at one point spine surgery was considered a black box — we weren't sure whether something really worked for the better — but now we are coming out with good research to prove the effectiveness of our procedures," says Dr. Cammisa. "I participated in the SPORT study where we were able to show good outcomes for appropriately indicated surgeries. As we go on, we'll be able to recommend surgery when the patient will likely have a positive outcome and have the data to back that decision up."

5. Paying practice overhead. With declining reimbursements and more hurdles for seeking approval from insurance companies, many spine surgeons are having a difficult time paying practice overhead. In 2011, Congress debated physician fee fixes for the sustainable growth rate, but the big cuts were continuously postponed to a later date. Now, specialists are facing up to 27 percent decrease in reimbursement for Medicare cases if another solution isn't reached.

"Any physician is worried about reimbursement being fair," says Dr. Cammisa. "You have to pay your overhead. We need to be realistic about what it costs to run a practice when we think about reimbursement rates."

6. Maintaining efficiency in the practice. With an increased focus on quality and cost of care, efficiency has become a big part of successful practice management. In spine care, this means integrating operative and non-operative caregivers. "It's important to have an integrated practice because if you are trained to perform surgery, you need to spend time in the operating room," says Dr. Cammisa. "In my practice, we make sure operative and non-operative specialists are available so everything runs efficiently and the patient has a good clinical experience."

By having non-operative specialists on hand, patients who don't need surgery won't have to wait for a surgeon with a busy operating schedule. "Seeing patients in a timely manner gives them a good feeling about their care and they will refer you to their friends," says Dr. Cammisa. "The best referrals are patient-to-patient."

7. Figuring out how to support new innovation. Reform of the Food and Drug Administration's medical device approval process was one of the key initiatives in healthcare reform. The FDA's approval process is now stricter about the data needed for clearance, which is forcing companies to jump through several hoops just to put their products on the market. This is a concern for spine surgeons because it could slow the rapidly evolving field of spine innovation.

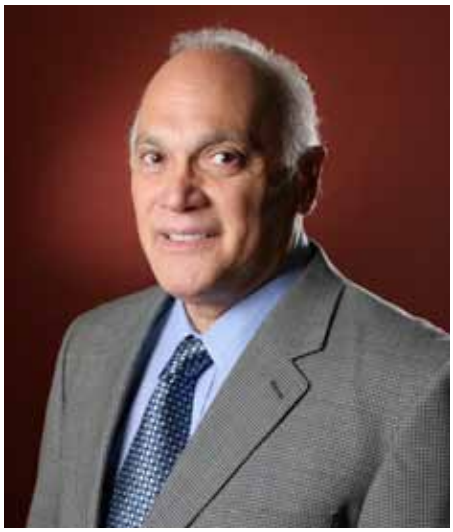
"It is becoming more and more difficult to get innovation from the bench because it's hard to get through all the regulatory hurdles," says Dr. Cammisa. "There is concern that innovation is going to slow down because of costs in today's regulatory environment."

8. Defining minimally invasive spine surgery. There are several spine surgeons around the country performing "minimally invasive surgery," but the term doesn't describe one uniform procedure; some procedures are proven in the literature as superior to open surgery while others may not have long-term success.

"What I think is important over the next few years is that we sort out what really works," says Dr. Cammisa. "There are several surgeons calling their procedures minimally invasive, but they have very little outcomes research to back up their use. I think spine surgery is going to improve because we will sort out what works and what doesn't. That's where we're headed in the future." ■

Dr. Stephen Hochschuler: 8 Changes to Ensure a Brighter Future for Spine Surgery

By Laura Miller



Stephen Hochschuler, MD, co-founder of Texas Back Institute and past president of the International Society for the Advancement of Spine Surgery, discusses eight changes for a more positive spine and healthcare environment in the future.

1. Consider other spine surgeons as partners instead of competitors. Physicians tend to see each other as competitors, which is one reason why they have trouble uniting behind one cause. During medical school, students are often pitted against each other to achieve the highest grades and top residency spots. In the field of orthopedics and spine, this is especially true for young surgeons who must achieve highly in their program just to warrant consideration for fellowships. Once surgeons are out of training, they compete with each other for patient volume.

"In medical school, the students who know most of the answers move up and the other guys switch to other programs; you go through your entire training like that," says Dr. Hochschuler. "At some institutions, they tell students a third of their classmates won't make it through the program at the very beginning. They are competing all the way through to their private practices, so there is no way they are going to win."

Uniting behind mutually beneficial causes is extremely crucial for physicians to hold influence over the future of the healthcare industry, but it will take a major cultural shift within the medical community.

2. Increase physician participation business and legislation. Traditionally, spine surgeons and other medical professionals have focused on the healthcare delivery aspects of their practice instead of the business side. They have also failed to garner influence among legislators in Washington, D.C. Other professionals, such as lawyers, have become much more proficient at running a successful business and lobbying lawmakers than medical professionals.

"Trial lawyers, hospital associations and insurance companies all have lobbyists and lobbyists have tremendous influence on what goes on in Washington," says Dr. Hochschuler. "Surgeons, in a sense, never got out of medical school; they never had to face the economics of their situation because they left that up to the people who were running their offices. Physicians never paid attention to cash flow and didn't learn how to run a business. When you don't have a strong lobby and don't know about economics, you are targeted."

While the American Medical Association and, more recently, the North American Spine Society, have engaged in advocacy at the national level, their efforts are handicapped by lack of donations and experience. "Other organizations might have 100 lobbyists and make huge donations to political campaigns while we have few lobbyists and don't know how to play the political game," says Dr. Hochschuler. "NASS is doing a good job, but we continue to be a day late and a dollar short."

3. Surgeons must maintain their independence. Due to the rising costs and uncertainty of the future healthcare environment, many spine surgeons are beginning to sell their practices and become employed by hospitals. Hospitals are willing buyers because they want to control as much of the market share as possible, but this could come at a cost for surgeons and their patients. Hospital-employed spine surgeons must comply with hospital rules and may face a decreasing salary when their contracts come up for renewal.

"Physicians are afraid if they don't sell their practices, they will be left out in the dark," says Dr. Hochschuler. "They have chosen to sell their practice instead of joining together with patients and contracting for care."

In the past, Dr. Hochschuler says many spine surgeons were entrepreneurially-minded and preferred to operate their own practice so they could make decisions about care. Now, he says some surgeons are more interested in securing fewer practice hours and better benefits and vacation time.

4. Perform more surgery outpatient. When surgeons began seeing reimbursement decreases two decades ago, they began looking for other sources of income. This includes ancillary revenue from services such as diagnostic imaging or physical therapy as well as physician-owned hospitals. Healthcare reform has now eliminated the physician-owned hospital option from any institution not already in service, so more surgeons may choose to become involved with ambulatory surgery centers in the future.

"Surgeons will look at surgery centers as ancillary revenue and doing more procedures outpatient," says Dr. Hochschuler. "I don't have a problem with surgery centers as long as the procedure is safe for the patient."

Recent technological developments and minimally invasive surgical techniques have made it possible for several specialists, including spine

surgeons, to perform their cases in ASCs. The potential for increased efficiency and capturing more income from the surgeries could make surgery centers an attractive option for spine surgeons in the future.

5. Equalize money made on spine cases. When Dr. Hochschuler was president of the ISASS, he analyzed where the money was going for spine cases. Over the past 10-15 years, he found spine surgeon income decreased 30 percent while the hospital's portion increased by 18 percent and the implant companies' portion increased by 155 percent. He presented these findings to other spine surgeons, but the country at large has yet to fully understand this data.

"The country sees surgeons as the reason for increased healthcare costs," says Dr. Hochschuler. "There have been unnecessary attacks on performing spine surgery. The vast majority of spine surgeons don't perform unnecessary procedures, but the ones who do are publicized in the media."

Without a focus on increasing spine surgeon income, Dr. Hochschuler says the country will find there are fewer people willing to train in the specialty. The potential physician shortage could mean physicians' assistants and nurse clinicians will play a bigger role in healthcare delivery.

"When I went into medical school, all the people at the top of their classes went there," says Dr. Hochschuler. "Now, the population is different because the people who really have brains are going into investment banking or working on Wall Street. The incentives are written on the wall; unless you really love taking care of patients, it doesn't make economic sense to go into medicine."

6. Settle on a fix for Medicare rates. Our current sustainable growth rate formula — the equation used to determine reimbursement rates for Medicare patients — is a point of high contention in both the political and healthcare worlds. Medicare reimbursement rates have been steadily declining over the past two decades and could see another 27.5 percent decrease if the current fix isn't extended. Spine surgeons can't maintain a profitable practice by treating a large number of Medicare patients, and some are beginning to limit their practices.

"Surgeons are on the fence not knowing how things are going to go," says Dr. Hochschuler. "Already, many surgeons aren't seeing Medicare patients any more. However, we might be forced to see these patients by government mandate despite losing money with each case."

7. Further integration between information technology and medicine. Information technology is an exploding field and has several potential benefits in healthcare. For example, surgeons can use telemedicine to monitor patients from a distance, which improves efficiency and decreases costs associated with traveling to the physicians' office.

"I think the next big thing in the venture world is marrying IT with medicine," says Dr. Hochschuler. "It's already occurring, but it will happen more and more in the future."

From a wellness standpoint, companies such as Nike and Jawbone have been on the cutting edge of this combination with the development of wristbands to measure personal health. The bands record how much a person walks, quality of sleep and caloric intake. "This is cheap technology being used for healthcare," says Dr. Hochschuler. "This whole arena excites me."

8. Bring medical tourism back home. In other parts of the world, physicians and hospitals have captured a growing market for medical tourism — patients who are willing to pay out-of-pocket for elite care and concierge medicine. In some cases, patients pay large amounts for a surgical procedure in foreign countries and recovery time in a secluded area. From Dr. Hochschuler's point of view, there isn't any reason why American physicians and providers can't capture some of those patients back and attract other patients from around the world.

"I think physicians are looking at medical tourism as a separate arena," he says. "Medical students still want to come here and train because our medical knowledge is superior. There is no reason why patients shouldn't want to come here as well." ■

7 Best Practices for Increasing Spine Center Profitability

By Kathleen Roney

How do you increase profits at a spine center? It might seem basic — bring in a higher volume of patients. However, reaching patients is not always easy. Additionally, there are other ways to increase a spine center's profitability such as decreasing costs and widening the specialties and services offered.

According to John Caruso, MD, a neurosurgeon with Parkway Neuroscience & Spine Institute, a private multi-specialty group in Hagerstown, Md., spine has the largest potential for growth in the outpatient and ambulatory surgery center market. By changing physician mentality, utilizing current innovations and welcoming changes in the healthcare market, spine centers can improve profitability and offer more cost-efficient, evidence-based care.

Here are seven best practices for increasing spine center profits.

1. Take ownership of healthcare dollars. A huge "don't" on improving spine center profits is allowing physicians to ignore efficiency as a benchmark of great care. A spine center cannot have physicians that want the latest and greatest — who want to spend healthcare dollars frivolously, says Dr. Caruso. Thinking of healthcare expenses as coming out of their pockets will help curb costs. Physicians should claim ownership of patients in two ways: in the treatment they prescribe and in the cost of that treatment.

When you look at old methods for healthcare, most actions came from a physician's pen. It is still that way. Most healthcare costs come from medications or treatments physicians prescribe or recommend to "There are some physicians who are not as conscientious of costs associated with treatment, therefore placing a high financial burden on the healthcare system," says Dr. Caruso. A surgical center makes physicians acutely aware of healthcare costs because they have ownership in the facility. This concept changes the approach to healthcare delivery and has the potential to lower costs on a grand scale. Those who claim ownership of healthcare dollars will become more informed physicians, and will improve the healthcare system, says Dr. Caruso.

2. Adopt a cost-container mentality. According to Dr. Caruso, a cost-container mentality is a key to success for any surgical or spine center. A cost-container mentality encourages physicians to consider methods for better, cost-efficient care. When nurses, medical staff and physicians open packages for OR cases or procedures and do not end up using the device, equipment or the implant, that expense goes to waste. Right in that moment, money is lost.

Each aspect of cost-containment and cost-wasting needs to be considered. Physicians who engage in that mentality are a benefit to a spine center or ASC. "Look at every single case to see how and where money is wasted. It boils down to each suture, each package," says Dr. Caruso. "If you want to increase profits by decreasing costs, you want physicians with the cost-container mindset at your spine center."

3. Make smart purchase decisions. According to Dr. Caruso, another great way to improve profits is to understand the implant market. "Do not purchase a certain implant or device because a friend or acquaintance sells it," says Dr. Caruso. "Evaluate and test the products, standardize and consolidate decisions."

Solid business decisions are made when multiple individuals have an input. The old mantra "two heads are better than one" is applicable when considering devices and implants because testing among the physicians is key. "You want the device and implant to be efficacious," says Dr. Caruso. "Aim for the best results at the best costs, and avoid redundancy."

4. Offer a great patient experience. Receiving healthcare service, whether it is a routine procedure or a life-threatening surgery, can be anxiety inducing and stress ridden for patients. According to Dr. Caruso, spine and surgical centers should provide great customer service to patients to help alleviate the tension and unease associated with healthcare treatment.

"It is all about the patient. The entire flow [of the experience] should be pleasant," says Dr. Caruso. "The goal should be to have a patient feel as if their time in the spine center was exceptional and that medical staff was warm and personable."

According to Dr. Caruso, spine centers can excel in this area and provide a better product than hospitals. "The ASC encounter should be a pleasant and continuous experience — from when a patient makes initial contact, through their pre-operative work-up, all the way to their release," says Dr. Caruso. "Administrators should think of the little details such as where visitors can park and how families will find their loved ones." If patients enjoy their treatment as much as is possible and have their anxieties mitigated, they will return and thus drive profits.

5. Collaborate and expand services. You improve profitability of a spine center by bringing in more cases. If you widen the specialties offered, there will be more reason for more patients to visit. Spine on its own is a profitable venue and according to Dr. Caruso, there will be more shifts pushing spine into outpatient arenas as time goes on. Expanding services and introducing more specialists could capitalize on future trends. While orthopedics and neurosurgeons may compete over spine services, a spine center that expands services to include collaboration between orthopedics and neurosurgery could see increased patient volume and increased profits. "For instance, a great expansion area is neuromuscular care, which inherently combines these great subspecialties" says Dr. Caruso.

Look to other spine centers or surgery centers for answers. Dr. Caruso recommends finding examples with similar provider mixes or similar practice dynamics. What have they done, how are they increasing profits? Additionally, look for surgical centers to partner or affiliate with. A spine center can complement larger ASCs or surgery centers. According to Dr. Caruso, spine, orthopedics and neurosurgery need to embrace a collaborative approach because collegial relationships build a competitive advantage and foster cost control.

6. Hire talented administrators and managers. In the face of current healthcare changes, spine centers need sharp administrators who can keep physicians and employees fiscally astute and who understand the bigger picture, says Dr. Caruso. As stated previously, the bigger picture is a focus on the patient and their care experience.

"There are a lot of talented individuals available but the key is to get an individual who aligns himself or herself with the business and understands the future of that business," says Dr. Caruso. "Historically physicians have wanted to make business decisions but they may not have all the information. That is why an administrator or business manager is essential."

Again, hiring a friend is not a best practice. Spine centers need someone with evidence-based experience and knowledge to run the operations and increase profits. "You have to have the right people who understand that right now is truly a unique opportunity to offer high quality care," says Dr. Caruso.

7. Engage in social media. Before social media, health information flow came only from physicians and healthcare groups. Physicians could, to an extent, dictate disease and treatment perceptions, says Dr. Caruso. Social media offers a wide-open arena and it is giving patients a voice in the healthcare information flow — they can engage in a dialogue about their aliments with other patients, with physicians and with healthcare organizations. According to Dr. Caruso, social media will push physicians towards better outcomes and more transparency, not just for the cost but the quality of the care.

Additionally, the social media community can help patients assuage their concern about diagnoses. For instance, breast cancer is a diagnosis that has seen a lot of social media activity. Jay Harness, MD, a breast cancer surgeon in California, launched a website to answer questions from breast cancer patients. The website now features over 200 YouTube videos from physicians who answer questions to frequently asked questions as well as questions patients submit online. The website now launches content via YouTube, Facebook, Twitter and Google+.

Although different from spine related diagnoses, physicians can still apply some of the techniques. Spine surgeons, neurosurgeons and orthopedic surgeons could maintain a social media presence and answer patient questions.

Social media is going to revolutionize how medicine is viewed in the country so spine centers need to be involved, says Dr. Caruso. Both physicians and spine centers should have social media outlets. A spine center will need to hire someone to coordinate the flow of information, says Dr. Caruso. "It is important for physicians to be a part of the information dissemination," says Dr. Caruso.

There are many strategies for improving spine center profitability. Overall, increasing patient flow and reducing costs are pillars in the best practice arena for profitability. Utilizing new technology, embracing different healthcare perspectives and hiring individuals that have the mindset and drive for success among healthcare reform are best practices that may guide a spine center to a better tomorrow. ■

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11 Key Issues Facing Surgery Centers — 2012
(continued from page 1)

2. Relationships with hospitals. Surgery centers often have a love/hate relationship with hospitals. Many of their physicians need to maintain affiliations with both the hospital and the surgery center. Further, many surgery centers have moved to or investigated joint venturing with hospitals. Even with the joint venture, it remains a love/hate relationship where the surgery center often is not certain if they are getting the benefit from the joint venture that they expected to receive. For example, the hospital may not be able to really help with managed care contracting. Further, the hospital may continue to employ physicians.

3. Employment of physicians by hospitals. This continues to be an evolving and challenging issue for surgery centers. As surgeons are employed by hospitals, the great majority of physicians may become unable or less able to work with surgery centers or remain owners of surgery centers. A loss of just a few physicians to hospital employment can be devastating to a surgery center.

4. Contracting with payors. This issue goes hand in hand with the out of network issues discussed above. Payors in some markets are making extremely low offers to surgery centers. Here, the surgery center almost has no choice but to deny the contract and attempt to see patients out-of-network. It is often the case that a surgery center or chain can benefit from the help of an experienced managed care contractor negotiator. However, even with help, this remains a challenging issue.

5. Hiring a great administrator. A great administrator must have a clinical and business mind, must be highly focused on results and must be recruiting physicians and cases all the time. Because surgery centers are not a static business, it requires an intelligent, driven administrator to help assure that a surgery center has a chance of great success. The situation where a surgery center relies on the spouse of a surgeon or the office manager of the practice, often leads to a bad situation.

6. Recruiting physicians. Surgery centers must constantly be recruiting new physicians to the center. Here, it is harder than ever to be able to just target specific specialties. Rather, surgery centers must be looking at all available surgeons in the market. There are often not a large number of available surgeons given other ASC investments by surgeons and employment by hospitals.

7. Adding cases. Surgery centers must constantly be working with their existing partners to add cases and examine what types of other procedures can be added to the center. They also must be constantly soliciting non-owners to work at the center.

8. Physicians leaving for other centers. As new centers continue to develop, and certain centers promise large returns, it is critical to keep surgeons from leaving to join another center. This competition for a limited number of surgeons is often a zero sum game. This can also lead to different disputes over non-competes and redemption pricing.

9. Safe harbor issues. There remains tremendous debate over the appropriate use of the safe harbors. Can a center rely on the 1) one-third tests, plus the qualitative tests, to redeem physicians 2) if it does so, it should do so on a consistent basis. Further, even if the center has the right to pay the adverse price, it is often legally advisable to pay the non-adverse price. Further, it should take other actions to assure that it is clear that physicians are being redeemed for compliance reasons not case generation reasons.

10. Statistics and benchmarking; keeping costs in line. Centers and their leadership must be great users of data. They must both receive great data on costs per case and compare costs to averages, and then use that data to cajole, persuade and work with center physicians and staff to bring costs into line with benchmarks. Expenses per case and as a percentage of revenue are impacted by numbers of cases and by reimbursement. That stated, centers really need to concentrate on the actual variable cost per case and the staff hours per case.

11. Redemptions and non competition disputes; without cause redemption clauses. Centers are constantly facing two kinds of disputes. Disputes relating to redemption and disputes relating to non-competes. Here, many centers have added in a "without cause" termination provision over the last few years simply to help reduce the amount of disputes over redemptions. Here, the physician is typically paid a non-adverse price versus an adverse price. The provisions is arguable not suppose to be used to redeem somebody based on volume or value of referrals. ■

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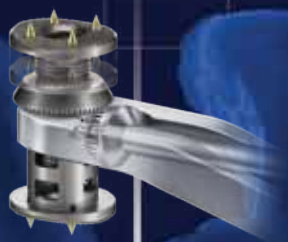

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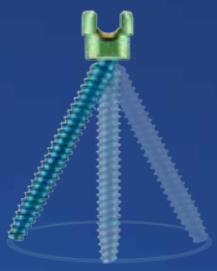

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208 Spine Surgeons & Specialists to Know

208 Spine Surgeons & Specialists to Know (continued from page 1)

Todd Albert, MD (Rothman Institute, Philadelphia). Dr. Albert is president of Rothman Institute. He has served as president of the Cervical Spine Research Society.

Christopher P. Ames, MD (University of California San Francisco Medical Center). Dr. Ames is director of spinal tumor and spinal deformity surgery at UCSF Medical Center and co-director of the neurospinal disorders program and UCSF Spine Center.

Howard S. An, MD (Midwest Orthopaedics at Rush, Chicago). Dr. An is director of the division of spine surgery and spine fellowship program at Rush University Medical Center.

Neel Anand, MD (Cedars-Sinai Medical Center, Los Angeles). Dr. Anand is an orthopedic spine surgeon at Cedars-Sinai Spine Center. He was one of the first surgeons to perform a combination of three minimally invasive procedures to correct adult lumbar degenerative scoliosis.

D. Greg Anderson, MD (Rothman Institute, Philadelphia). Dr. Anderson is the clinical director of the spine section of the Orthopaedic Research Laboratory at Thomas Jefferson University in Philadelphia. He is president of the Society for Minimally Invasive Spine Surgery.

Paul Anderson, MD (UW Health, Madison). Dr. Anderson is a professor of orthopedic surgery at the University of Wisconsin in Madison. He has a professional interest in spinal trauma and complex cervical spine disorders.

Gunnar Andersson, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Anderson is the chair of spinal deformities at Rush University Medical Center and practices spine surgery at Midwest Orthopaedics at Rush. He has authored or co-authored more than 250 academic papers.

Carmina F. Angeles, MD, PhD (The NeuroSpine Institute, Eugene, Ore.). Dr. Angeles has a professional interest in minimally invasive procedures for treating common spinal conditions, including degenerative diseases and stenosis. She is also trained to perform cervical disc arthroplasty and treats patients with more complex pathology.

Ali Araghi, DO (The CORE Institute, Phoenix). Dr. Araghi is the director of the spine division at The CORE Institute. He has served on the board of directors for the American Board of Spine Surgery and as spine section president of the American Osteopathic Academy of Orthopaedics.

Vincent Arlet, MD (Penn Comprehensive Spine Center, Philadelphia). Dr. Arlet is a spine surgeon and founder of Scolisoft. He attended medical school in Paris and was awarded the Scoliosis Research Society Traveling Fellowship in 1997.

Henry Aryan, MD (Sierra Pacific Orthopaedic & Spine Center, Fresno, Calif.). Dr. Aryan holds an academic appointment with the University of California, San Francisco's spine center and department of neurological surgery.

Hyun Bae, MD (Cedars-Sinai Medical Center, Los Angeles). Dr. Bae is the co-director of the spine fellowship program at Cedars-Sinai Medical Center. He has a special interest in minimally invasive spine surgery and artificial disc replacement.

Paul Baek, MD (Aurora BayCare Medical Center, Green Bay, Wis.). Dr. Baek has been with Aurora Bay Care Clinic since its inception. As a neurosurgeon, he focuses on neurotrauma, peripheral nerve surgery and spine surgery.

Richard A. Balderston, MD (Philadelphia Spine Center). Dr. Balderston is the chief of spine surgery at Pennsylvania Hospital. His research contributed to ProDisc total disc replacement surgery.

Robert J. Banco, MD (The Boston Spine Group). Dr. Banco is president of The Boston Spine Group and an associate clinical professor in the orthopedic surgery department at Tufts University School of Medicine in Boston. He has authored more than 150 publications and took part in 12 FDA IDE studies.

Gordon Bell, MD (Cleveland Clinic, Cleveland). Dr. Bell is the head of spinal surgery at the Cleveland Clinic and vice-chairman of the department of orthopedic surgery. He treats patients with cervical and lumbar spinal injuries, athletic spinal injuries and tumors.

Edward Benzel, MD (Cleveland Clinic, Cleveland). Dr. Benzel is chairman of the Cleveland Clinic's department of neurosurgery. His clinical interests focus on spinal disorders, complex spine instrumentation and spine tumors. He is one of the founding members of the Lumbar Spine Research Society, which formed in 2007.

Erica F. Bisson, MD (University of Utah Health Care, Salt Lake City). Dr. Bisson has a professional interest in spine surgery, neurosurgery, occipitocervical disease and spinal fusion. She treats patients with a variety of conditions, including spondylolisthesis and trauma.

Scott Blumenthal, MD (Texas Back Institute, Plano). Dr. Blumenthal is a partner and co-director of the Center for Disc Replacement at Texas Back Institute. He served as a principle investigator for the SB III Charite Artificial Disc and was among the first spine surgeons to perform a total disc replacement in the United States.

Oheneba Boachie-Adjei, MD (Hospital for Special Surgery, New York City). Dr. Boachie-Adjei is the chief of the scoliosis service at Hospital for Special Surgery. He is also the founder and president of the Foundation of Orthopedics and Complex Spine.

Scott Boden, MD (Emory Healthcare, Atlanta). Dr. Boden is the director of Emory Healthcare's Emory Orthopaedics & Spine Center. He is chairman and founder of the National Spine Network and a member of more than a dozen other medical societies.

Christopher M. Bono, MD (Brigham and Women's Hospital, Boston). Dr. Bono is chief of orthopedic spine service at Brigham and Women's Hospital. He is co-director of the combined orthopedic spine fellowship program between Harvard University, Massachusetts General Hospital and Brigham and Women's.

Charles L. Branch, Jr., MD (Wake Forest University Baptist Medical Center, Winston-Salem, N.C.). Dr. Branch is a professor and chairman of the department of neurosurgery at Wake Forest's School of Medicine. His clinical specialties include spinal disorders, stenosis and spinal tumors, among others.

Robert S. Bray, Jr., MD (DISC Sports & Spine Center, Marina del Rey, Calif.). Dr. Bray is the founding director and CEO of DISC Sports & Spine Center, which provides care for U.S. Olympic and Red Bull athletes. He was chief of neurosurgery for the U.S. Air Force at David Grant Medical Center.

Darrel S. Brodke, MD (University of Utah School of Medicine, Salt Lake City). Dr. Brodke has a professional interest in treating degenerative and traumatic spinal conditions. His research interests fall into the area of spinal biomechanics.

Evalina Burger, MD (University of Colorado Hospital, Aurora). This year, Dr. Burger was named to Cambridge's Who's Who list for her leadership and dedication to spine care. She is first female spine surgeon selected for the South African Orthopaedic Society's ABC fellowship in 2000.

J. Abbott Byrd, MD (Atlantic Orthopaedic Specialists, Virginia Beach, Va.). Dr. Byrd is the Ethics Committee chair of the Scoliosis Research Society. He has a professional interest in treating patients with complex spinal problems, scoliosis and trauma.

Frank P. Cammisa, Jr., MD (Hospital for Special Surgery, New York City). Dr. Cammissa is the chief of spine service at Hospital for Special Surgery and has treated professional athletes from the New York Knicks, New York Giants and New York Jets. He has a professional interest in minimally invasive spine surgery, computer assistance and microsurgery.

Andrew Cappuccino, MD (Buffalo Spine Surgery, Lockport, N.Y.). Dr. Cappuccino is an assistant team orthopedic surgeon with the Buffalo Bills. He is a fellow of the American Academy of Orthopaedic Surgeons and a member of the North American Spine Society.

Jeffrey R. Carlson, MD (Orthopaedic & Spine Center, Newport News, Va.). Dr. Carlson is an orthopedic spine surgeon at Orthopaedic & Spine Center. During his career, he has presented his research on several spine-related topics at professional society meetings.

Eugene Carragee, MD (Stanford Hospital & Clinics, Stanford, Calif.). Dr. Carragee is the chief of the spinal surgery division, medical director of the service quality and director of the orthopedic spine center at Stanford Hospital and Clinics. He has also served as the spine consultant for Stanford University's NCAA teams.

John R. Caruso, MD (Neuroscience & Spine Institute, Hagerstown, Md.). Dr. Caruso is a neurosurgeon who has performed numerous spinal procedures including minimally invasive procedures. He serves as chairman of the board and medical director of Parkway Surgery Center in Hagerstown.

Jens R. Chapman, MD (UW Medicine, Seattle). Dr. Chapman is the chief of the University of Washington Spine Service, where he also serves as a professor of spine surgery. Dr. Chapman has also been the interim chair of the department of orthopedics and sports medicine at UW.

Dean Chou, MD (University of California San Francisco Spine Center). Dr. Chou is a spine surgeon at the University of California San Francisco Spine Center. His practice focuses on treating patients with spinal deformity, tumors and degenerative conditions.

James Lloyd Chappuis, MD (Spine Center Atlanta). Dr. Chappuis is in private practice at Atlanta Spine Center and holds patents for several spine devices, including an internal pedicle screw insulator apparatus and facet fusion system.

Kingsley R. Chin, MD (Institute for Modern & Innovative Spine Surgery, Ft. Lauderdale, Fla.). Dr. Kingsley is the founding spine surgeon at the Institute for Modern & Innovative Spine Surgery and inventor of the FacetFuse Minimally Invasive Screw System and MANTIS minimally invasive pedicle screw system for spinal fusion.

Stephen S. Cook, MD (University Orthopaedic Associates, New Brunswick, N.J.). Dr. Cook is a spine surgeon with University Orthopaedic Associates and a clinical associate professor of orthopedic surgery at UMDNJ-Robert Wood Johnson Medical School.

Larry D. Cordell, MD (Midwest Spine Care, Overland Park, Kan.). Dr. Cordell is on the Board of Councilors for the Kansas Orthopaedic Society. He is a past president of the society and previously served in the United States Army.

Donald S. Corenman, MD (The Steadman Clinic, Vail, Colo.). Dr. Corenman has a professional interest in treating disorders of the lumbar and cervical spine. Along with his practice, he offers his clinical services to the U.S. Ski Team.

Domagoj Coric, MD (Carolina Neurosurgery & Spine Associates, Charlotte, N.C.). Dr. Coric practices with Carolina Neurosurgery & Spine Associates and serves as the chief of neurosurgery at Carolinas Medical Center. He is also the president of the North Carolina Spine Society.

Michael F. Coscia, MD (OrthoIndy, Indianapolis). Dr. Coscia is the spinal consultant for the Indiana Pacers and has served as a physician at numerous Olympic trials and the Indy 500. He has a professional interest in treating patients with spinal trauma, scoliosis, infections, tumors and spinal arthritis.

Dennis Crandall, MD (Sonoran Spine Center, Mesa, Ariz.). Dr. Crandall is the founder and medical director of Sonoran Spine Center. He also conducts research at the Sonoran Spine Research and Education Foundation.

Bradford L. Currier, MD (Mayo Clinic, Rochester, Minn.). Dr. Currier is an orthopedic surgeon and professor of orthopedics at Mayo Clinic in the department of orthopedic surgery. His research and articles have been featured in many publications.

Alan Dacre, MD (OrthoMontana, Billings). Dr. Dacre is on the Board of Directors for the Montana Orthopedic Society. He practices with OrthoMontana and has a professional interest in adult and pediatric spine care.

Rick B. Delamarter, MD (Cedars-Sinai Medical Center, Los Angeles). Dr. Delamarter is vice chair for spine services at Cedars-Sinai and co-director of Cedars-Sinai's Spine Center. He is also an associate clinical professor in the Department of Surgery at UCLA School of Medicine in Los Angeles.

Francis Denis, MD (Twin Cities Spine Center, Minneapolis). Dr. Denis is the president of Twin Cities Spine. He has a professional interest in treating patients with deformities and trauma.

Christopher J. DeWald, MD (Midwest Orthopaedics at Rush, Chicago). Dr. DeWald is a physician at Midwest Orthopaedics at Rush and has served as the chief of the section of spinal surgery and scoliosis at the Hospital of Cook County in Chicago. He performs scoliosis correction and adult reconstruction.

Ara Deukmedjian, MD (Deuk Spine Institute, Melbourne, Fla.). Dr. Deukmedjian is the founder and medical director of Deuk Spine Institute in Florida. He has contributed extensively to minimally invasive spine surgery and developed the Deuk Laser Disc Repair procedure.

Mohammad Diab, MD (UCSF Benioff Children's Hospital, San Francisco). With expertise in the treatment of musculoskeletal conditions in children and teenagers, Dr. Diab is chief of the division of pediatric neurosurgery at Benioff Children's Hospital.

William H. Dillin, MD (Kerlan-Jobe Orthopaedic Clinic, Los Angeles). Dr. Dillin is co-founder of the clinic's spine center. He is a spinal surgery consultant to numerous athletic teams in Los Angeles, including the Lakers, Dodgers and Kings.

Edward J. Dohring, MD (Spine Institute of Arizona, Scottsdale). Dr. Dohring is the medical director of Spine Institute of Arizona and treats a spectrum of spinal disorders. During his career, he pioneered an artificial disc replacement procedure.

Egon Doppenberg, MD (Northshore University HealthSystem, Evanston, Ill.). Dr. Doppenberg specializes in the treatment of brain and spine tumors and complex degenerative and traumatic spinal disorders. He serves as clinical assistant professor of neurosurgery at the University of Chicago Pritzker School of Medicine.

Andrew Dossett, MD (The Carrell Clinic, Dallas). Dr. Dossett is a spine consultant to the Dallas Cowboys, Texas Rangers and Dallas Stars professional hockey team. He also serves as a consultant to several Division I athletic programs.

Steven Dorsky, MD (New Jersey Spine Center, Chatham). Dr. Dorsky is a spine surgeon, founder of the New Jersey Spine Center and leader in spinal surgery and technique. He performs several procedures, including artificial disc replacement.

Randall Dryer, MD (Central Texas Spine Institute, Austin). Dr. Dryer is a spine surgeon with the Central Texas Spine Institute who focuses on treatment of the cervical and lumbar spine. Dr. Dryer is a past president of the Texas Spine Society.

E. Hunter Dyer, MD (Carolina Neurosurgery & Spine Associates, Charlotte, N.C.). Dr. Dyer is the president of Carolina Neurosurgery & Spine Associates. He has a special interest in transsphenoidal surgery, skull based surgery and endoscopic spine surgery.

Robert K. Eastlack, MD (Scripps Clinic, San Diego). Dr. Eastlack is a spine surgeon with the Scripps Clinic division of orthopedic surgery who has professional interest in cervical spine disorders and conditions. He volunteers as a clinical instructor at the University of California San Diego School of Medicine.

Walter Eckman, MD (Aurora Spine Center, Tupelo, Miss.). Dr. Eckman is founder of Aurora Spine Center and affiliated with North Mississippi Medical Center. He has committed much of his career to performing minimally invasive spine surgeries.

Eldan B. Eichbaum, MD (Santa Rosa Memorial Hospital, Santa Rosa, Calif.). Dr. Eichbaum is a neurosurgeon with a professional interest in spinal disorders and conditions. He is a member of the American Association of Neurological Surgeons and Congress of Neurological Surgeons.

Frank Eismont, MD (University of Miami School of Medicine). Dr. Eismont is chairman of the department of orthopedics and spine division chief at the University of Miami Leonard M. Miller School of Medicine. He is also the fellow education director at the University of Miami.

Sanford E. Emery, MD (West Virginia University, Morgantown). Dr. Emery is the president of the Cervical Spine Research Society. At West Virginia University, he is a professor of orthopedics and chairman of the department of orthopedics.

Thomas J. Errico, MD (Hospital for Joint Disease, New York City). Dr. Errico is the chief of spine surgery at New York University School of Medicine and Hospital for Joint Disease, both in New York City. He has participated in multi-institutional investigations and FDA trials.

David Fardon, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Fardon is a spine surgeon at Midwest Orthopaedics at Rush and assistant professor at Rush University Medical Center in Chicago. He is the co-editor of *Orthopaedic Knowledge Update for Spine II*.

Richard G. Fessler, MD (Northwestern Memorial Hospital, Chicago). Dr. Fessler, professor of neurosurgery at Northwestern, was the first physician in the United States to perform a human embryonic spinal cord transplant in 1997. He participated in the first FDA trial to test the use of embryonic stem cells in patients with thoracic spine injuries.

John Fickenberg, MD (Alvarado/Helix Orthopaedics and Sports Medicine, La Mesa, Calif.). Dr. Fickenberg practices with Alvarado/Helix Orthopaedics and Sports Medicine and serves as director of the Spine Center at Alvarado Hospital Medical Center. He has developed instrumentation used during reconstructive procedures.

Jeffrey S. Fischgrund, MD (Beaumont Orthopaedic Center, Royal Oak, Mich.). Dr. Fischgrund is a spine surgeon at Beaumont Orthopaedic Center in Royal Oak, Mich. He is a researcher on bone morphogenic proteins and cervical disc replacements.

Kevin Foley, MD (University of Tennessee, Memphis). Dr. Foley is director of the spine fellowship program at the University of Tennessee department of neurosurgery. He is also the director of complex spine surgery at Semmes-Murphey Clinic in Memphis.

Daveed D. Frazier, MD (East Coast Premier Minimally Invasive Spine Surgery, New York City). Dr. Frazier is an orthopedic spine surgeon at Long Island College Hospital and East Coast Premier Minimally Invasive Spine Surgery in New York City. He has served as president of the Orthopaedic Association of New York.

Anthony Frempong-Boadu, MD (New York University Langone Medical Center, New York City). Dr. Frempong-Boadu has medical expertise in minimally invasive surgery and endoscopic spinal surgery. He teaches spinal decompression and fusion techniques at national and international conferences.

George A. Frey, MD (Colorado Comprehensive Spine Institute, Englewood). Dr. Frey is founder of Colorado Comprehensive Spine Institute and has a professional interest in complex spinal disorders. He has focused on the development of new surgical techniques, spinal systems and implants.

Rolando Garcia, MD (Orthopedic Care Center, Adventura, Fla.). Dr. Garcia is a spine surgeon practicing at Orthopaedic Care Center. He has a professional interest in scoliosis care.

Mark Gardon, MD (Aurora BayCare Medical Center, Green Bay, Wis.). Dr. Gardon is a neurosurgeon and has been with BayCare Clinic since its inception. He is a consultant to members of the National Football League and has a professional interest in minimally invasive surgery.

Steven R. Garfin, MD (University of California San Diego Thornton Hospital, La Jolla). Dr. Garfin practices at University of California San Diego's Thornton Hospital along with UCSD Medical Center - Hillcrest in San Diego. He is chair of the orthopedic department.

Fred Geisler, MD (Chicago Back Institute at Swedish Covenant Hospital). Dr. Geisler is a neurosurgeon at Chicago Back Institute at Swedish Covenant Hospital. He was among the first surgeons in the United States to adopt anterior cervical plating and total disc replacement.

Daniel E. Gelb, MD (University of Maryland Medical Center, Baltimore). Dr. Gelb is a past president of the Maryland Orthopaedic Association, where he still serves on the board of directors. He is the co-director of the University of Maryland Spine Program.

Zoher Ghogawala, MD (CSI-Greenwich Neurosurgery, Greenwich, Conn.). Dr. Ghogawala is director of the Wallace Trials Center at Greenwich (Conn.) Hospital. He has served as principle investigator on several spine trials and received multiple research grants.

Federico P. Girardi, MD (Hospital for Special Surgery, New York City). Dr. Girardi is a spine surgeon at Hospital for Special Surgery with a special interest in spinal deformity, degeneration, fracture and tumors. His clinical research involves minimally invasive surgery, clinical outcomes of different procedures and imaging modalities of the spine.

Michael A. Gleiber, MD (Michael A. Gleiber, MD, PA, Spine Surgery, Jupiter, Fla.). Dr. Gleiber is a board certified orthopaedic spinal surgeon with a professional interest in the latest microsurgical, minimally invasive and motion preserving spinal procedures. He is President and CEO of Michael A. Gleiber, MD, PA.

Ziya Gokaslan, MD (Johns Hopkins Medicine, Baltimore). Dr. Gokaslan is the director of the spine center and a professor of neurosurgery at Johns Hopkins Hospital. His research focuses on chemotherapeutic delivery systems for primary and metastatic spinal tumors.

Edward J. Goldberg, MD (Rush University Medical Center, Chicago). Dr. Goldberg is a spine consultant for the Chicago Bulls and team physician for the Chicago White Sox. He is an assistant professor at Rush University Medical Center.

Jeff Goldstein, MD (Seaport Orthopaedic Associates, New York City). Dr. Goldstein is a spine surgeon with Seaport Orthopaedic Associates and director of spine service as well as associate director of the spine fellowship at NYU Hospital for Joint Diseases.

Charles R. Gordon, MD (Texas Spine & Joint Hospital, Tyler). Dr. Gordon is a neurosurgeon and co-founder of Texas Spine and Joint Hospital. He has a professional interest in the treatment of spine injury, deformity and degeneration.

Wesley E. Griffitt, MD (Aurora BayCare Medical Center, Green Bay, Wis.). Dr. Griffitt is a neurosurgeon with special interest in minimally invasive spine surgery and spinal reconstruction and fusion procedures. He has been a course instructor for minimally invasive spine surgery.

Purnendu Gupta, MD (Chicago Center for Orthopedics at Weiss Memorial Hospital). Dr. Gupta is medical director at Chicago Spine Center at Weiss and associate professor of surgery at the University of Chicago, where he also serves as director of the spine center.

Richard Guyer, MD (Texas Back Institute, Plano). Dr. Guyer is director of the Texas Back Institute Spine Fellowship Program. He is also the founder and chairman of the board at Texas Back Institute Research Foundation.

Regis W. Haid, Jr., MD (Atlanta Brain and Spine Care). Dr. Haid is a founding partner of Atlanta Brain and Spine Care and medical director of the Piedmont Spine Center at Piedmont Hospital in Atlanta. He developed numerous patents for spinal devices and technology.

Mitch Harris, MD (Brigham and Women's Hospital, Boston). Dr. Harris is the chief of orthopedic trauma at Brigham and Women's Hospital. He has a professional interest in treating spinal tumors, spinal arthritis, trauma and peri-articular fractures.

Richard Harrison, MD (Aurora BayCare Medical Center, Green Bay, Wis.). Dr.

Harrison is a neurosurgeon with fellowship training in spine surgery. He practices at Aurora BayCare Medical Center.

Mark Hartman, MD (Total Spine Specialists, Huntersville, N.C.). Dr. Hartman is a founding physician at Total Spine Specialists with a professional interest in minimally invasive spine surgery, trauma and tumor care. He is training in microendoscopic disc surgery and reconstructive spine surgery.

Robert F. Heary, MD (Neurological Institute of New Jersey, Newark). Dr. Heary is the director of the Spine Center at the Neurological Institute of New Jersey. He is also the director of the neurosurgical intensive care unit and a professor of neurosurgery. His major areas of interest include minimally invasive spine surgery, spine injury, spine tumors and spinal deformity.

Andrew C. Hecht, MD (Mount Sinai Medical Center, New York City). Dr. Hecht is the co-director of spine surgery at Mount Sinai and spine surgical consultant to the New York Jets and New York Islanders. He is the director of the NFL's Spine Care Program for retired players.

Michael Heggeness, MD (Baylor Clinic, Houston.). Dr. Heggeness is the president of the North American Spine Society and director of the spine surgery fellowship program at Baylor College of Medicine. He has a professional interest in cervical spine reconstruction and treatment of inflammatory arthroplasties.

John G. Heller, MD (Emory Orthopaedics & Spine Center, Atlanta). Dr. Heller has been practicing at Emory Orthopaedics & Spine Center since 1994. He has a professional interest in the research and development of cervical spine instrumentation for procedures such as disc arthroplasty and laminoplasty.

Harry Herkowitz, MD (Beaumont Hospital, Royal Oak, Mich.). Dr. Herkowitz is chief of orthopedic surgery at Beaumont Hospital in Royal Oak, Mich. He has participated on the editorial boards for *Spine* and *Journal of Spinal Disorders*.

Alan S. Hilibrand, MD (Rothman Institute, Philadelphia). Dr. Hilibrand is director of medical education for the department of orthopedic surgery at Rothman Institute and Jefferson Medical College. He is a deputy editor of the *Journal of Bone and Joint Surgery* and *Journal of the American Academy of Orthopaedic Surgeons*.

Michael Hisey, MD (Texas Back Institute, Plano). Dr. Hisey was recently named the medical director of Texas Back Institute. He also serves as the medical director of the SpineMark Clinical Research Organization at Texas Back Institute.

Stephen Hochschuler, MD (Texas Back Institute, Plano). Dr. Hochschuler is the co-founder of Texas Back Institute. He is the chairman of the Texas Back Institute Holdings Corporation and former president of the Spine Arthroplasty Society.

Ken Y. Hsu, MD (St. Mary's Spine Center, San Francisco). Dr. Hsu is co-inventor – with James F. Zucherman, MD, also at St. Mary's — of the X Stop Interspinous Process Decompression System. The process, FDA-approved in 2005, was first in the category of interspinous process devices.

Serena Hu, MD (University of California San Francisco Medical Center, San Francisco.). Dr. Hu is co-director of UCSF Spine Center. Her clinical interests include the prevention and treatment of adult scoliosis, while her research interests include the prediction and prevention of metastatic spine fractures and disc degeneration.

Russel C. Huang, MD (Hospital for Special Surgery, New York City). Dr. Huang is the director of the Hospital for Special Surgery Spine Clinic. Dr. Huang's areas of expertise include minimally invasive surgical techniques and treating scoliosis.

Richard A. Hynes, MD (Osler Medical, Melbourne, Fla.). Dr. Hynes is a spine surgeon at Osler Medical. He has participated in numerous FDA approved studies and has a professional interest in biologics and the use of stem cells in spinal surgery.

Robert E. Isaacs, MD (Duke University Medical Center, Durham, N.C.). Dr. Isaacs is the director of spine surgery at Duke and an expert in minimally invasive spine surgery. He was previously the head of minimally invasive spine surgery at the Cleveland Clinic Florida Spine Institute in Weston.

Plas T. James, MD (Atlanta Spine Institute). Dr. James practices with Atlanta Spine Institute and is a back and spine consultant for the Atlanta Falcons. He formerly provided spine care for the Atlanta Thrashers professional hockey team.

J. Patrick Johnson, MD (Cedars-Sinai Medical Center, Los Angeles). Dr. Johnson is a principle investigator for the Bryan Cervical Disc Prosthesis clinical trial. He established the combined neurosurgery and orthopedic fellowship program at Cedars-Sinai Institute for Spinal Disorders.

James Kang, MD (McGowan Institute for Regenerative Medicine, Pittsburgh). Dr. Kang is the vice chairman of the department of orthopedic surgery at the McGowan Institute for Regenerative Medicine. He also serves as the chair of the Ethics/Conflict of Interest Oversight Committee of the Cervical Spine Research Society.

Dean Karahalios, MD (NorthShore Neurological Institute, Evanston, Ill.). Dr. Karahalios is a neurosurgeon with NorthShore University Health System. He was appointed to the National Football League's Second Opinion Network of Neurological Surgeons for brain and spine injuries for Chicago.

Christopher Kauffman, MD (University Medical Center, Lebanon, Tenn.). Dr. Kauffman is a spine surgeon with University Medical Center. He is the chair of the Professional Economic and Regulatory Committee and sits on the board of directors for the North American Spine Society.

A. Jay Khanna, MD (Johns Hopkins University, Baltimore). Dr. Khanna is the co-director of the division of spine surgery at Johns Hopkins Orthopaedic Surgery at Good Samaritan Hospital. He also serves as the Clinical Director of the Johns Hopkins Center for Bioengineering, Innovation and Design (CBID).

Larry Khoo, MD (Good Samaritan Hospital, Los Angeles). Dr. Khoo, director of minimally invasive neurological spine surgery at Good Samaritan, is the co-founder of the Society for Minimally Invasive Spine Surgery and belongs to several national and international professional organizations.

Choll Kim, MD (Spine Institute of San Diego). Dr. Kim is an orthopedic spine surgeon at the Spine Institute of San Diego. He is the founder of the Society for Minimally Invasive Spine Surgery and director of the Minimally Invasive Spine Center at Alvarado Hospital in San Diego.

Youjeong Kim, MD (Orthopaedic Consultants of North Texas, Dallas). During her career, Dr. Kim has volunteered with Orthopaedics Overseas and has spent time treating patients in South Africa and China. She has also authored several book chapters and articles in professional journals about orthopedics and spine surgery.

Richard A. Kube II, MD (Prairie Spine & Pain Institute, Peoria, Ill.). Dr. Kube is founder and owner of Prairie Spine and Pain Institute. He currently affiliated with four different hospitals in southern Illinois and is a clinical assistant professor of surgery at the University of Illinois College of Medicine at Peoria.

Carl Lauryssen, MD (Olympia Medical Center, Beverly Hills, Calif.). Dr. Lauryssen is the director of research and education at Olympia Medical Center. He previously served as the director of research and education for Cedars-Sinai Institute for Spinal Disorders in Los Angeles.

Scott Leary, MD (Alvarado Hospital Medical Center, San Diego). Dr. Leary participated in the first clinical trial for the Charite artificial disc, and he will be serving as the principal investigator for the upcoming FDA clinical trial for the next-generation lumbar artificial disc replacement.

Casey K. Lee, MD (Spine Care and Rehabilitation, Roseland, N.J.). Dr. Lee is a spine surgeon with Spine Care and Rehabilitation and founder of Nexgen Spine, which developed the Physio-L Artificial Disc. He serves as chairman and chief medical officer of Nexgen Spine.

James T. Lehner, MD (Orthopaedic Center for Spinal and Pediatric Care, Centerville, Ohio). Dr. Lehner is membership co-chairman of the Ohio Orthopaedic Society. He has a professional interest in treating spinal trauma and fractures.

Mesfin A. Lemma, MD (Johns Hopkins Hospital, Baltimore). Dr. Lemma is the division chief of orthopedic surgery at Johns Hopkins and co-director of spine surgery at Good Samaritan Hospital in Baltimore. He has also served as the assistant residency director of orthopedic surgery at Johns Hopkins.

Lawrence G. Lenke, MD (Washington University School of Medicine, St. Louis). Dr. Lenke is the co-chief of the adult and pediatric scoliosis and reconstructive spinal surgery program at Washington University as well as a professor of neurological surgery and orthopedic surgery.

Isador Lieberman, MD (Texas Back Institute, Plano). Dr. Lieberman has a professional interest in minimally invasive spine surgery and scoliosis correction. He holds multiple patents for his technological innovations, including SpineAssist.

Steven C. Ludwig, MD (University of Maryland Medical Center, Baltimore). Dr. Ludwig, chief of spine surgery at the University of Maryland Medical Center, has a professional interest in a full range of adult spinal disorders with clinical interest in spinal tumors, infections and sports-related injuries.

James Lynch, MD (SpineNevada, Reno, Nev.). Dr. Lynch is a neurological surgeon who specializes in complex spine surgery, as well as minimally invasive spine surgery. He is the founder and CEO of SpineNevada and chairman and director of spine at the Surgical Center of Reno.

Steven Mardjetko, MD (Illinois Bone and Joint Institute, Morton Grove, Ill.). Dr. Mardjetko is a spine surgeon at the Illinois Bone and Joint Institute, where he specializes in spinal surgery, pediatric and adult spinal deformities and pediatric orthopedics.

Robert Masson, MD (NeuroSpine Institute, Orlando). Dr. Masson is the founder and president of NeuroSpine Institute and a retired Lieutenant Commander of the United States Naval Reserve. He was a developer of the iMAS surgical principles, techniques and products for Synthes Spine.

Joseph C. Maroon, MD (University of Pittsburgh Medical Center). Dr. Maroon is vice chairman of the department of neurological surgery at the University of Pittsburgh School of Medicine and team neurosurgeon for the Pittsburgh Steelers, a position he has held for 30 years.

Bryan J. Massoud, MD (Spine Centers of America, Fair Lawn, N.J.). Dr. Massoud is an orthopedic spine surgeon and has a professional interest in minimally invasive endoscopic spine surgery. He has more than 1,000 minimally invasive procedures under his belt.

Paul C. McCormick, MD (Columbia University Medical Center, New York City). Dr. McCormick is the medical director of the spine center at Columbia University Medical Center. He focuses on the evaluation and management of patients with spine and spinal cord disorders.

Geoffrey M. McCullen, MD (Neurosurgical and Spine Surgery, Lincoln, Neb.). Dr. McCullen is the secretary and treasurer of the Nebraska Orthopedic Society. He practices at Neurological and Spine Surgery and has a professional interest in adult and pediatric spine care.

Amir A. Mehbod, MD (Twin Cities Spine Center, Minneapolis). Dr. Mehbod is a director at large of the Minnesota Orthopaedic Society. He practices with Twin Cities Spine Center and has a professional interest in scoliosis, disc replacement and minimally invasive surgical technique.

Ehud Mendel, MD (Ohio State University Medical Center, Columbus). Dr. Mendel is a neurosurgeon with fellowship training in spine surgery and director of Ohio State University's spine program. He is also clinical co-director of the OSU Spinal Biodynamics and Ergonomics Laboratory.

Charles Mick, MD (Pioneer Spine and Sports, Northampton, Mass.). Dr. Mick currently serves as the first vice president of the North American Spine Society. He has been a NASS board member for 25 years and is active in health policy.

Srdjan Mirkovic, MD (Northwestern Orthopaedic Institute, Chicago). Dr. Mirkovic is a spine consultant for the Chicago Bears and Chicago Fire. He has served on multiple committees with the North American Spine Society and the Spine Arthroplasty Society.

William Mitchell, MD (New Jersey Neurosciences Institute at JFK Medical Center, Edison, N.J.). Dr. Mitchell is an attending neurosurgeon at JFK Medical Center and serves as director of Health Policy Co-Council with the North American Spine Society.

George Miz, MD (Bone & Joint Physicians, Oak Lawn, Ill.). Dr. Miz is a partner at Bone & Joint Physicians and has a professional interest in scoliosis care. He also works with patients who have degenerative spinal conditions and performs artificial disc replacement.

Alan Moelleken, MD (The Spine and Orthopedic Center, Santa Barbara, Calif.). Dr. Moelleken has published numerous articles and presentations on the treatment of spinal disorders and has been the chairman of the monthly Tri-County Spine Conference for the past 10 years.

James F. Mooney, III, MD (Medical University of South Carolina, Charleston). Dr. Mooney is chief of the division of pediatric orthopedic surgery at Medical University of South Carolina, where he treats pediatric patients with spinal deformities and fractures, among other conditions.

Daniel B. Murrey, MD (OrthoCarolina, Charlotte, N.C.). Dr. Murrey is a spine surgeon and has served as CEO of OrthoCarolina. He is a member of the American Academy of Orthopaedic Surgeons and Scoliosis Research Society.

Seth Neubardt, MD (Seth Neubardt, M.D. & Jack Stern, M.D., Ph.D., White Plains, N.Y.). Dr. Neubardt is the sole inventor of several medical patents, including one for a spinal procedure to safely insert screws which is now used at more than 25 hospitals in 15-plus countries.

Michael G. Neuwirth, MD (Spine Institute of New York, Beth Israel Medical Center, New York City). Dr. Neuwirth is director of the Spine Institute of New York at Beth Israel Medical Center. His areas of expertise include complex spinal deformities in adults and children.

Pierce D. Nunley, MD (Spine Institute of Louisiana, Shreveport). Dr. Nunley is the chairman of the American Board of Spine Surgery and director of the Spine Institute of Louisiana. He also serves as an assistant professor of orthopedic surgery at the Louisiana State University Health Sciences Center.

Patrick F. O'Leary, MD (Hospital for Special Surgery, New York City). Dr. O'Leary is the former chief of the spine surgery at Hospital for Special Surgery. He has a professional interest in cervical, thoracic and lumbar spine surgery with expertise in complex procedures.

Joan O'Shea, MD (The Spine Institute of Southern New Jersey, Marlton). Dr. O'Shea is a dually trained neurological and orthopedic spine surgeon. She has concentrated her training and dedicated her career to the surgical treatment of spinal disorders.

Andrew E. Park, MD (Texas Spine Consultants, Dallas). Dr. Park is a spine surgeon with interest in complex spinal disorders and minimally invasive spine surgery. He has published his original spine surgery research in several peer-reviewed journals.

John Peloza, MD (Institute for Minimally Invasive Surgery, Dallas). Dr. Peloza is the founding surgeon of the Center for Spine Care and Institute for Minimally Invasive Surgery, which was founded earlier this year through a partnership between local physicians and Meridian Surgical Partners.

Brian Perri, DO (Beverly Hills Spine Surgery, Beverly Hills, Calif.). Dr. Perri is an orthopedic spine surgeon with a professional interest in treating spinal deformity and tumors. He is the associate director of orthopedic spine surgery at Cedars-Sinai Institute for Spinal Disorders in Los Angeles.

Kenneth A. Pettine, MD (Rocky Mountain Associates, Loveland, Colo.). Dr. Pettine is a co-founder of Rocky Mountain Associates and a surgeon at Loveland Surgery Center. He is co-designer of the Maverick Artificial Disc and been chief investigator for FDA studies involving non-fusion spine technology.

Frank M. Phillips, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Phillips is the director of the section of minimally invasive spine surgery at Rush University Medical Center. He has a professional interest in cervical and lumbar reconstructive surgery as well as motion preserving and minimally invasive surgical techniques.

Steven C. Poletti, MD (Southeastern Spine Institute, Charleston, S.C.). Dr. Poletti is the immediate past-president of the South Carolina Orthopaedic Association, and member

of the executive committee directors. He is a member of North American Spine Society.

Gregory Przybylski, MD (JFK Medical Center, Edison, N.J.). Dr. Przybylski is a neurosurgeon with extensive fellowship training in spinal surgery. He is the director of neurosurgery at the New Jersey Neuroscience Institute at JFK Medical Center and a professor of neurological surgery at Seton Hall University in South Orange, N.J.

Sheeraz A. Qureshi, MD (Mount Sinai Hospital, New York City). Dr. Qureshi is an assistant professor of spinal surgery at Mount Sinai Hospital. He also serves as the chief of spinal trauma at Elmhurst Hospital Center in New York City.

Richard S. Rabinowitz, MD (Barrington Orthopedic Specialists Hoffman Estates, Ill.). Dr. Rabinowitz maintains a variety of professional interests, including minimally invasive disc surgery and artificial disc replacement surgery.

Raj D. Rao, MD (Medical College of Wisconsin, Milwaukee). Dr. Rao is a professor of orthopedic surgery and neurosurgery at the Medical College of Wisconsin. He is also on the board of directors for the North American Spine Society.

John Ratliff, MD (Thomas Jefferson Medical College, Philadelphia). Dr. Ratliff is a neurosurgeon with an interest in complex spinal surgery. He is a member of several professional societies, including North American Spine Society.

Bernard Rawlins, MD (Hospital for Special Surgery, New York City). Dr. Rawlins is a consultant for the New York Knicks and New York Mets, and serves as a professor of clinical orthopedic surgery at Weill Cornell Medical School in New York City.

Charles Reitman, MD (Baylor College of Medicine, Houston). Dr. Reitman is the chief of orthopedic spine surgery at Ben Taub General Hospital and interim chair of the department of orthopedic surgery at Baylor College of Medicine.

B. Stephens Richards, MD (Scottish Rite Hospital for Children, Dallas). Dr. Richards is the president of the Scoliosis Research Society. He also serves as the assistant chief of staff and medical director of inpatient services at Texas Scottish Rite Hospital for Children.

K. Daniel Riew, MD (Washington University School of Medicine, St. Louis). Dr. Riew is the chief of Washington University School of Medicine's surgical spine center and director of the university's Cervical Spine Institute. He performs minimally invasive procedures ant treats patients with complex spinal deformities.

Thomas F. Roush, MD (Roush Spine, Lake Worth, Fla.). Dr. Roush is spine surgeon with Roush Spine, which has four Florida offices. He is a member of several professional organizations, including North American Spine Society.

Michael Roh, MD (Rockford Spine Center, Rockford, Ill.). Dr. Roh is co-founder of Rockford Spine Center and one of the select core faculty members for the Prestige Cervical Disc. He has lectured across the country on spinal deformity correction and minimally invasive surgical technique.

Mike Russell II, MD (Azalea Orthopedics, Tyler, Texas). Dr. Russell is a spine surgeon at Azalea Orthopedics and president-elect of Physician Hospitals of America, a national trade organization representing physician-owned hospitals.

J. Rafe Sales, MD (Summit Orthopaedics, Portland). Dr. Sales is founder and director of spine surgery at Summit Orthopaedics' Summit Spine Institute. He is also the medical director of spinal trauma at Legacy Emanuel Hospital in Portland.

Andrew A. Sama, MD (Hospital for Special Surgery, New York City). Dr. Sama is a clinical instructor at Weill Cornell Medical College in New York City. He also serves as the director of orthopedic spine surgery at New York Hospital.

Harvinder S. Sandhu, MD (Hospital for Special Surgery, New York City). Dr. Sandhu is an assistant scientist in Hospital for Special Surgery's research division. His focuses on endoscopic spine surgery, computer-assisted spine surgery and biologics.

Rick Sasso, MD (Indiana Spine Group, Indianapolis). Dr. Sasso is president and co-founder of Indiana Spine Group. He pioneered the development of minimally invasive spine surgery, where he continues to innovate.

Thomas C. Schuler, MD (The Virginia Spine Institute, Reston, Va.). Dr. Schuler is the president, CEO and founder of The Virginia Spine Institute. He is the spine consultant for the Washington Redskins and frequently treats professional athletes.

David G. Schwartz, MD (OrthoIndy Northwest, Indianapolis). Dr. Schwartz is the director of OrthoIndy's Spine Fellowship and the inventor of the Anteres Spinal Instrumentation System, which is used for the treatment of spinal fractures, scoliosis and tumors.

James Schwender, MD (Twin Cities Spine Center, Minneapolis). Dr. Schwender has a special interest in minimally invasive spine surgery, spinal deformities and trauma care. He is past president of the Society for Minimally Invasive Spine Surgery.

Navinder Sethi, MD (Potomac Valley Orthopaedic Associates, Gaithersburg, Md.). Dr. Sethi is chief of spine surgery at Medstar Montgomery Medical Center in Columbia, Md., and runs an international fellowship program for spine surgeons.

A. Nick Shamie, MD (UCLA Health System). Dr. Shamie is the president of the American College of Spine Surgery. He is also the co-director of the UCLA Comprehensive Spine Center.

Khawar Siddique, MD (Beverly Hills Spine Surgery, Calif.). Dr. Siddique is a neurosurgeon with a special interest in spine surgery practicing at Beverly Hills Spine Surgery. He performs advanced minimally invasive spine surgery and correction for spinal tumors and deformity.

Hal Silcox III, MD (Peachtree Orthopaedic Clinic, Duluth, Ga.). Dr. Silcox is the secretary of the Georgia Orthopaedic Society. He previously served as chief of spine surgery at the Veterans Affairs Medical Center.

Allen Kent Sills, Jr., MD (Semmes-Murphey Neurologic & Spine Institute, Memphis, Tenn.). Dr. Sills is the founder and executive director of the Memphis Regional Brain Tumor Center and medical director of the Methodist Neuroscience Institute at Methodist University Hospital. He is the consulting team neurosurgeon for the Memphis Grizzlies.

Kern Singh, MD (Midwest Orthopaedics at Rush, Chicago). Dr. Singh has a professional interest in researching and performing minimally invasive, motion sparing spine procedures. He is the principal investigator in several FDA trials on motional preserving spinal technology.

Paul J. Slosar, MD (Spine Care Institute of San Francisco, San Francisco). Dr. Slosar is medical director of Spine Care Institute and president of SpineCare Medical Group. He is on the board of directors for the American Board of Spine Surgery.

Samuel E. Smith, MD (Front Range Orthopedics, Longmont, Colo.). Dr. Smith is the secretary treasurer and past president of the Colorado Orthopaedic Society.. He has a professional interest in treating spine and scoliosis disorders.

Richard Spiro, MD (University of Pittsburgh Medical Center, Pittsburgh). Dr. Spiro is the director of adult spine services at the University of Pittsburgh Medical Center. He has a professional interest in minimally invasive spine surgery.

Mark J. Spoonamore, MD (University of Southern California University Hospital, Los Angeles). Dr. Spoonamore is the medical director of the USC Center for Spinal Surgery at University Hospital. He also serves as chief of the spine surgery service at Los Angeles County Hospital.

Philip F. Stahel, MD (Denver Health). Dr. Stahel is the director of the department of orthopedics at Denver Health. He conducts research in spinal cord injury, management of complex peri-articular fractures and the pathophysiology of traumatic brain injury.

Brian R. Subach, MD (The Virginia Spine Institute, Reston). Dr. Subach is director of research at The Virginia Spine Institute. He has clinical expertise in non-operative and operative management of spinal disorders.

Fred Sweet, MD (Rockford Spine Center, Rockford, Ill.). Dr. Sweet co-founded Rockford Spine Center and currently serves as president of the practice. He developed a technique for performing spine surgery and continues to perform it in his practice.

Robert L. Tatsumi, MD (Pacific Spine Specialists, Tualatin, Ore.). Dr. Tatsumi is an orthopedic spine surgeon who has had extensive experience with minimally invasive procedures and motion preservation technology, such as artificial disc replacement for the cervical and lumbar spine.

William Taylor, MD (UC San Diego Health System). Dr. Taylor is the immediate past president of the Society for Minimally Invasive Spine Surgery. He is a clinical professor of surgery in the division of neurological surgery with the UC San Diego Health System.

Vincent C. Traynelis, MD (Rush University Medical Center, Chicago). Dr. Traynelis is the director of the neurosurgery spine service at Rush University Medical Center, as well as vice chairperson of the department of neurosurgery. He specializes in complex spine surgery, spinal deformity and spinal arthroplasty.

Nicholas Theodore, MD (Barrow Neurological Institute, Phoenix). Dr. Theodore is chief of spine surgery at Barrow Neurosurgical Institute and medical director of the Neurological Trauma Program at Barrow. He is also the Neurological Institute associate director of the neurosurgery residency program.

Eeric Truumees, MD (Seton Spine and Scoliosis Center, Austin, Texas). Dr. Truumees is Education Publishing Chair of the North American Spine Society. He is a member of the American Academy of Orthopaedic Surgeons.

Alexander R. Vaccaro, MD (Rothman Institute, Philadelphia). Dr. Vaccaro a founding partner of Rothman Institute and vice chairman of the orthopedic department at Thomas Jefferson University Hospital. He has been president of the American Spinal Injury Association.

Cathleen S. Van Buskirk, MD (Alpine Spine, Boulder, Colo.). Dr. Van Buskirk is on staff at the Minimally Invasive Spine Institute Outpatient Spine Surgery Center in Lafayette, Colo. During her career, Dr. Van Buskirk has published multiple teaching books.

Lawrence Vogel, MD (Chicago Shriners Hospital for Children). Dr. Vogel is the president of the American Spinal Injury Association. He is the chief of pediatrics, medical director of the spinal cord injury program and assistant chief of staff at the Chicago Shriners Hospitals for Children.

Jeffrey Wang, MD (UCLA Spine Center, Santa Monica, Calif.). Dr. Wang is director of the UCLA Spine Surgery Fellowship. He has authored more than 100 research publications and presented on various spine topics to audiences around the world.

William Watters III, MD (Bone & Joint Clinic of Houston, Texas). Dr. Watters is treasurer for the North American Spine Society, and was a founding member of the NASS Evidence-Based Guidelines Committee.

James N. Weinstein, DO (Dartmouth-Hitchcock Medical Center, Lebanon, N.H.). Dr. Weinstein is currently president and CEO of Dartmouth-Hitchcock Health System. He is founder of the spine center at Dartmouth-Hitchcock Medical Center and has been president of the Dartmouth-Hitchcock Clinic.

Stuart L. Weinstein, MD (University of Iowa Hospitals & Clinics, Iowa City). Dr. Weinstein is a professor of orthopedic surgery at University of Iowa. He is a former president of the American Academy of Orthopaedic Surgeons, American Board of Orthopaedic Surgery and the Pediatric Orthopaedic Society of North America.

F. Todd Wetzel, MD (Temple University Hospital, Philadelphia). Dr. Wetzel is the vice-chairperson of the department of orthopedic surgery and sports medicine at Temple University Medical School. His clinical interests include spine surgery and pain management.

P. Merrill White, III, MD (Tennessee Orthopaedic Clinics, Knoxville). Dr. White is the president-elect of the Tennessee Orthopaedic Society. He practices with Tennessee Orthopaedic Clinics and has a professional interest in spine surgery.

Richard Wohns, MD (South Sound Neurosurgery, Puyallup, Wash.). Dr. Wohns is the founder and president of South Sound Neurosurgery and founded NeoSpine, a spine ambulatory surgery center development company currently part of Symbion Healthcare.

Christopher E. Wolfla, MD (Medical College of Wisconsin, Milwaukee). Dr. Wolfla is the president of the Congress of Neurological Surgery and an associate professor at Medical College of Wisconsin. He also serves on the executive committee for the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves.

Michael J. Yaszemski, MD (Mayo Clinic, Rochester, Minn.). Dr. Yaszemski is a principle investigator of Mayo Clinic's tissue engineering and biomaterials laboratory and maintains his clinical practice in spinal surgery with a special interest in adult scoliosis.

Anthony T. Yeung, MD (Desert Institute for Spine Care, Phoenix). Dr. Anthony Yeung founded Desert Institute for Spine Care and developed the FDA-approved Yeung Endoscopic Spine System.

Christopher A. Yeung, MD (Desert Institute for Spine Care, Phoenix). Dr. Yeung has been the principal investigator in several FDA studies, including the Flexicore lumbar artificial disc replacement. He has also treated several professional athletes.

Ken Yonemura, MD (Lakeview Hospital, Bountiful, Utah). Dr. Yonemura focuses on spinal deformity, trauma, tumor and degenerative conditions of the spine at Lakeview Hospital. He is a member of North American Spine Society.

Jim Youssef, MD (SpineColorado, Durango). Dr. Youssef is the co-founder of SpineColorado. Dr. Youssef is also co-founder of the Evidence & Technology Spine Summit, a continuing medical education conference.

James Yue, MD (Yale Medical Group, New Haven, Conn.). Dr. Yue is the co-director of the orthopedic spine service and the director of the Yale Spine Fellowship at Yale University Medical Center. He treats spinal deformity, tumors and fracture management.

William R. Zerick, MD (Central Ohio Neurological Surgeons, Westerville, Ohio). Dr. Zerick has fellowship training in the treatment of degenerative and traumatic cervical, thoracic and lumbar spinal disorders. He treats patients with degenerative disc disease, disc herniation and spinal stenosis.

Jack Zigler, MD (Texas Back Institute, Plano). Dr. Zigler is a spine surgeon with Texas Back Institute. He has been president of the American Spinal Injury Association and Federation of Spine Associations.

Christian G. Zimmerman, MD (Idaho Neurological Institute, Boise). Dr. Zimmerman is the chairman and founder of the Idaho Neurological Institute. Dr. Zimmerman is a member of North American Spine Society.

James Zucherman, MD (San Francisco Orthopaedic Surgeons). Dr. Zucherman is inventor and co-developer of the X-Stop. He is also in the process of developing the Starflex motion preservation minimally invasive spine stabilization device. ■

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- Keynote Coach Lou Holtz, Legendary Football Coach, Analyst, ESPN
- Keynote Tucker Carlson, Contributor, FOX News, Editor-In-Chief, The Daily Caller and Senior Fellow, The Cato Institute - An Outlook on Politics and The Election
- The Best Ideas and Biggest Threats to Orthopedics and Spine - Tom Mallon, CEO, Regent Surgical Health, Brian Cole, MD, MBA, Professor, Dept. of Orthopedics, Dept. of Anatomy and Cell Biology, Section Head, Cartilage Restoration Center, Rush Division of Sports Medicine, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, and Jeff Leland, CEO, Blue Chip Surgical Center Partners, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News
- Healthcare Reform, Politics, and The Next 4 Years - Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians, Thomas J. Bombardier, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, John Caruso, MD, Neurosurgeon, Parkway Surgery Center, and Robert Zasa, MSHHA, FACMPE, Founder, ASD Management, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News
- Evolving Clinical Developments in Interventional Pain Management - Mark Coleman, MD, CEO, National Spine and Pain Centers, LLC
- Moving Spine Procedures to ASCs - Key Business and Clinical Issues - Panel Discussion with Paul Schwaegler, MD, Seattle Spine Institute, PLLC, Richard Kube, MD, CEO, Founder/Owner, Prairie Spine & Pain Institute, Devin Datta, MD, Melbourne Surgery Center, moderated by Jeff Leland, President & CEO, Blue Chip Surgical Center Partners
- Key Concepts to Fixing Physician Hospital Joint Ventures Gone South - Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America
- 10 Best Practices to Improve Billing and Collections - Lisa Rock, President, National Medical Billing Services
- Orthopedics Hospital Joint Ventures, Bundled Payments, 16,000 Cases and Are There Lessons That Can Be Applied to Other Facilities and Systems - James T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic Institute
- The Key Legislative Priorities of the ASC Industry - William Prentice, JD, Executive Director, ASC Association
- Hand Surgery – Key Business Issues for ASCs and Physician Owned Hospitals - R. Blake Curd, MD, Board Chairman, Surgical Management Professionals
- Developing a Spine-Driven ASC: The Essentials for Success - Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners
- The State of The ASC Industry - Andrew Hayek, President & CEO, Surgical Care Affiliates, and Chairman of The Advocacy Committee
- 7 Keys to Make Orthopedic and Pain-Driven ASCs More Profitable - Larry Taylor, President & CEO, Practice Partners in Healthcare, Inc.
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PROGRAM SCHEDULE

Pre Conference – Thursday, June 14, 2012

11:30am – 1:00pm	Registration
12:00pm – 4:30pm	Exhibitor Set-Up
1:00pm – 5:40pm	Pre-Conference Workshop • Concurrent Sessions A, B, C, D, E, F
5:40pm - 7:00pm	Reception, Cash Raffles and Exhibits

Main Conference – Friday, June 15, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:20pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:20pm – 6:30pm	Reception, Cash Raffles, Exhibit Hall

Conference – Saturday, June 16, 2012

7:00am – 8:00am	Continental Breakfast and Registration
8:10am – 12:30pm	Conference

Thursday, June 14, 2012

Track A Improving Profits, Valuation and Transaction Issues

1:00 – 1:40 pm
Key Concepts to Fixing Physician Hospital Joint Ventures Gone South
Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, Ambulatory Surgical Centers of America

1:45 – 2:15 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

2:20 – 2:50 pm
Utilizing Spine Cases to Improve the Profitability of Underutilized Poorly Performing ASCs
Chris Bishop, SVP Acquisitions & Business Development, Blue Chip Surgical Center Partners,

2:55 – 3:25 pm
7 Keys to Make Orthopedic and Pain-Driven ASCs More Profitable
Larry Taylor, President & CEO, Practice Partners in Healthcare, Inc.

3:30 – 4:00 pm
An Integrated Approach to Introducing Direct to Consumer Marketing to Your Practice
How it Can Deliver Superior Financial Results - Jimmy St. Louis, CEO, Advanced Healthcare Partners

4:05 – 4:35 pm
What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements, Valuations and Other Issues
Jen Johnson, CFA, Managing Director, VMG Health

4:40 – 5:40 pm - KEYNOTE
Leadership and Management in 2012
Lou Holtz, Legendary Football Coach and Analyst, ESPN

Track B – Spine

1:00 – 1:40 pm
Business Planning for Spine-Driven Centers
Jeff Leland, CEO, Blue Chip Surgical Center Partners, and Devin Datta, MD, Melbourne Surgery Center

1:45 – 2:15 pm
Minimally Invasive Multi-Level Fusions in ASCs
Richard Kaul, MD, Owner, New Jersey Spine and Rehabilitation

2:20 – 2:50 pm
Moving Spine Procedures to ASCs – Key Business and Clinical Issues
Paul Schwaegler, MD, Seattle Spine Institute, PLLC, Richard Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute, Devin Datta, MD, Melbourne Surgery Center, moderated by Jeff Leland, President & CEO, Blue Chip Surgical Center Partners

2:55 – 3:25 pm
The Best Ideas for Marketing Spine and Patient Development
Daniel Goldberg, Director of Business Development, New Jersey Spine and Rehabilitation

3:30 – 4:00 pm
Bundled Contracting Initiatives for Orthopedics and Spine
Marshall Steele, MD, Orthopedic Surgery, Marshall Steele & Associates

4:05 – 4:35 pm
Minimally Invasive Spine Surgery for Degenerative Spine Conditions
Miquel Lis-Planells, MD, Michigan Head & Spine Institute

Track C – Pain Management and Spine

1:00 – 1:40 pm
Evolving Clinical Developments in Interventional Pain Management
Mark Coleman, MD, CEO, National Spine and Pain Centers, LLC

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1:45 – 2:15 pm
The Best Ideas Now; Key Ways to Improve Physician Owned Hospital Profits
Larry Teuber, MD, President Medical Facilities Corp. Michael J. Lipomi, President & CEO, Surgical Management Professionals, Goran Dragolovic, SVP, Operations, Surgical Care Affiliates, moderated by Amber McGraw Walsh, Partner McGuireWoods LLP

2:20 – 2:50 pm
Managing Pain Practice Protocols, Branding and Other Tips to Improve Profitability
Vishal Lal, CEO, Advanced Pain Management

2:55 – 3:25 pm
Interventional Pain Management - New Concepts to Reduce ER Visits, Hospitalizations and Re-Admissions
Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago

3:30 – 4:00 pm
Keys to Successfully Establishing and Growing a Premier Pain Center
Stephen Rosenbaum, CEO, and Robin Fowler, MD, Medical Director, Interventional Management Services

4:05 – 4:35 pm
Intradiscal Biologics Injections for Mild to Degenerative Disc Disease
Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, President & CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, American Board of Neurophysiologic Monitoring Board of Directors

Track D – Orthopedics

1:00 – 1:40 pm
5 Key Steps to Improve Profits in Orthopedic-Driven ASCs
Gregory P. DiConciliis, PA-C, CASC, Administrator, Boston Out-Patient Surgical Suites, LLC

1:45 – 2:15 pm
Complex Hand Cases in ASCs, Business and Reimbursement Issues
Steven S. Shin, MD, Kerlan-Jobe Orthopaedic Clinic, and John Seitz, Chairman & CEO, Ambulatory Surgical Group, LLC

2:20 – 2:50 pm
Emerging Orthopedic Procedures in ASCs - Business and Clinical Issues
Michael R. Redler, MD, The OSM Center

2:55 – 4:00 pm
Orthopedic Practices – Why Merging Two Practices Can Help, What Are The Choices for Orthopedic Surgeons, Stay the Course or Sell
Leslie R. "Les" Jebson, Executive Director, University of Florida Ortho and Sports Medicine

3:30 – 4:00 pm
Hand Surgery – Key Business Issues for ASCs and Physician Owned Hospitals
R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

4:05 – 4:35 pm
Succeeding in the Face of Challenges, Dealing with Vendors, Focusing on Clinical Operations and Other Strategies from the Front Line
Charley Gordon, MD, Texas Spine and Joint Hospital

Track E – Business and Profitability Issues; Revenue Cycle; Managed Care Billing, Coding and Contracting for ASCs

1:00 – 1:40 pm
Selling Your ASC; What Price Can You Expect; What Are The Deal Terms?
Blayne Rush, MHP, MBA, President, Ambulatory Alliances, Patrick J. Simers, EVP, Principle Valuation, LLC, Thomas J. Chirillo, SVP Corporate Development, Surgery Partners, Matt Searles, Managing Director, Merritt Healthcare, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

1:45 – 2:15 pm
Keys to Transforming Surgery Centers Into a Profitable Business
Tom Yerden, CEO, TRY Healthcare Solutions, Jimbo Cross, VP Acquisitions & Development, Ambulatory Surgical Centers of America, Jeff Peo, VP Acquisitions & Development, Ambulatory Surgical Centers of America, moderated by Barton C. Walker, Associate, McGuireWoods LLP

2:20 – 2:50 pm
How to Smartly Use Technology to Become More Efficient in Operations
Scott McDade, Vice President, Surgery Centers, McKesson Medical

2:55 – 3:25 pm
A Step by Step Plan for Selling Your ASC – How to Maximize the Price, Terms and Results and How to Handle the Process
Luke Lambert, CFA, MBA, CASC, CEO, Ambulatory Surgical Centers of America, Introduced by Amber McGraw Walsh, Partner, McGuireWoods LLP

3:30 – 4:00 pm
The Key Legislative Priorities of the ASC Industry
William Prentice, JD, Executive Director, ASC Association

4:05 – 4:35 pm
Physician Owned Hospitals - Adding Ancillaries, Reducing Costs and Legal Compliance
Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Michael Weaver, Vice President, Symbion, Inc., Amber McGraw Walsh, Partner, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track F – Quality, Infection Control, Accreditation, Management

1:00 – 1:40 pm
Developing the Right Clinical Environment for Complex Spine and Orthopedic Cases
Linda Lansing, SVP Clinical Services, Surgical Care Affiliates

1:45 – 2:15 pm
The New CMS Quality Reporting System and What a Center Needs to Do
David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

2:20 – 2:50 pm
Most Common Accreditation Problems in Orthopedic, Spine and Pain-Driven ASCs
Nancy Jo Vinson, RN, RBA, CASC, Principal, NJM Consulting, Nurse Surveyor, AAAHC, Accreditation Association for Ambulatory Health Care

2:55 – 3:25 pm
Infection Control in ASCs – 10 Best Key Practices
Jean Day, RN, CNOR, Director of Clinical Operations, Pinnacle III

3:30 – 4:00 pm
10 Great Ideas for QA Studies
Mary Sturm, VP Clinical Operations, Surgical Management Professionals

4:05 – 4:35 pm
TBD

Friday, June 15, 2012

7:00 – 8:00 am –REGISTRATION and CONTINENTAL BREAKFAST

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

8:10 – 8:55 am - Keynote
An Outlook on Politics, Healthcare and the Election
Tucker Carlson, Contributor, FOX News, Editor-In-Chief, The Daily Caller and Senior Fellow, The Cato Institute

9:00 – 9:40 am – Keynote Panel
Healthcare Reform, Politics, and The Next 4 Years
Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians, Thomas J. Bombardier, MD, FACS, Principal & Founder, Ambulatory Surgical Centers of America, John Caruso, MD, Neurosurgeon, Parkway Surgery Center, and Robert Zasa, MSHHA, FACMPE, Founder, ASD Management, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

9:45 – 10:35 am
The Best Ideas and Biggest Threats to Orthopedics and Spine
Tom Mallon, CEO, Regent Surgical Health, Brian Cole, MD, MBA, Professor, Dept. of Orthopedics, Dept. of Anatomy and Cell Biology, Section Head, Cartilage Restoration Center, Rush Division of Sports Medicine, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, and Jeff Leland, CEO, Blue Chip Surgical Center Partners, moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

10:35 – 11:05 am – Networking Break & Exhibits

11:05 – 11:35 am
The State of The ASC Industry
Andrew Hayek, President & CEO, Surgical Care Affiliates, and Chairman of The Advocacy Committee

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Track A

11:40 – 12:20 pm
Orthopedics Hospital Joint Ventures, Bundled Payments, 16,000 Cases and Are There Lessons That Can Be Applied to Other Facilities and Systems
James T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic Institute

12:25 – 1:05 pm
Developing a Spine-Driven ASC: The Essentials for Success
Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

Track B

11:40 – 12:20 pm
Key Concepts to Improve the Profitability and Outcomes of Spine Programs
Kenneth Pettine, MD, Loveland Surgery Center, Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Larry Teuber, MD, President, Medical Facilities Corp., moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:25 – 1:05 pm
Spine Surgery: The Next 5 Years
David Abraham, MD, Reading Neck and Spine Center, Bob Reznik, MBA, President, Prizm Development, Inc., David Rothbart, MD, FACS, FACPE, Medical Director, Spine Team Texas, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track C

11:40 – 12:20 pm
The Best Ideas for Improving the Profits of Pain Management-Driven ASC Centers
Scott Glaser, MD, DABIPP, Pain Specialists of Greater Chicago, Girish Juneja, MD, West Michigan Pain, Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

12:25 – 1:05 pm
The Important of Measuring Clinical Outcomes for Pain Management
Fred N. Davis, MD, Clinical Assistant Professor, Michigan State University, College of Human Medicine

Track D

11:40 – 12:20 pm
The Best Ideas for Orthopedics Now
Michael Redler, MD, The OSM Center, Geoffrey S. Connor, MD, Orthopedic Sports Surgery, Alabama Orthopaedic Spine and Sports Medicine Associates, and Greg Horner, MD, Managing Partner, Smithfield Surgical Partners, LLC

12:25 – 1:05 pm
Strategies for Transitioning from Out of Network to a Contracted ASC Model
Greg Horner, MD, Managing Partner, Smithfield Surgical Partners, LLC

Track E

11:40 – 1:05 pm
An 80 Minute Workshop - Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits
Robert Westergard, CPA, CFO, Susan Kizirian, Chief Operations Officer, and Ann Geier, RN, MS, CNOR, CASC, Ambulatory Surgical Centers of America

Track F

11:40 – 12:20 pm
Physician Engagement and ICD-10: The Role of the Physician in a Succession Transition
Christy A. May, MS, RHIA, and Kathy Lindstrom, RHIT, ProVation Medical

1:05 – 1:50 PM – Networking Lunch & Exhibits

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

Track A – Improving Profits, Valuation and Transaction Issues

1:50 – 2:30 pm
Physician Hospital Alignment and Business Relationships
Allan Fine, SVP & Chief Strategy and Operations Officer, The New York Eye and Ear Infirmary, Charles "Chuck" Peck, CEO, Health Inventures, and Carole Guinane, Novant Health Ambulatory Care, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

2:35 – 3:05 pm
Assessing the Profitability of Orthopedics and Spine Cases
Andrea Woodell, Managed Care Manager and Matt Lau, Director of Financial Analysis, Regent Surgical Health

3:10 – 3:45 pm
How to Maintain Practice Independence While Effectively Partnering with Hospitals
Charles "Chuck" Peck, CEO, and Christian Ellison, Vice President, Health Inventures, LLC

3:45 – 4:15 pm - Networking Break & Exhibits

4:15 – 4:45 pm
The Best Ideas for Handling Out of Network Patients
Edward Hetrick, President & CEO, Facility Development & Management, Rebecca Overton, Surgical Management Professionals, moderated by Melissa Szabad, Partner, McGuireWoods LLP

4:50 – 5:20 pm
What Should Great Medical Directors, Administrators, and DONs be Paid?
Greg Zoch, Partner and Managing Director, Kaye/Bassman International Corp., Christopher Collins, RN, BSHCS, Administrator, Metropolitan Surgery Center, moderated by Rachel Fields, Editor In Chief, Becker's ASC Review

Track B – Spine

1:50 – 2:00 pm
Complex Revision Spine Surgery and ALIF's, TLIFs, DLIFs in ASCs
Lessons Learned, Mistakes to Avoid, Tips to Consider - Devin Datta, MD, Melbourne Surgery Center

2:35 – 3:05 pm
Complex Cervical Spine – Key Developments
Krzystof "Kris" Siemienow, MD, Adult and Pediatric Spine Surgery, Lutheran General Hospital, UIC

3:10 – 3:45 pm
Everything You Need to Know to Successfully Perform Spine Surgery in an ASC
Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm
Intraoperative Monitoring for Spine Cases in the ASC Setting "Understanding the Technology and What a Surgery Center Should and Should Not Pay For
Timothy T. Davis, MD, DABNM, DABPMR, DABPM, Director of Interventional Pain and Electrodiagnostics, The Spine Institute, Center for Spinal Restoration, President/CEO, Alpha Diagnostics, Intraoperative Neurophysiologic Monitoring Board of Directors, Spalding Surgery Center, Board of Directors, American Board of Neurophysiologic Monitoring

4:50 – 5:20 pm
Minimally Invasive Outpatient Lumbar Fusions – A Study on Clinical Outcomes in the ASC
Alan Villavicencio, MD, Boulder Neurological & Spine Associates, LLC

Track C – Orthopedics, Spine and Pain Management

1:50 – 2:30 pm
The Use of Implanted Epidural Catheters for Painful Orthopedic Procedures
Tim Lubenow, MD, Rush SurgiCenter

2:35 – 3:05 pm
Developing Spine Centers of Excellence
Bob Reznik, MBA, President, Prizm Development, Inc.

3:10 – 3:45 pm
Getting Started with Spine Surgery in ASCs – 6 Key Concepts
John Peloza, MD, Center for Spine Care

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

4:15 – 4:45 pm
Creating a Minimally Invasive Center for Spine and Orthopedics
Sev Hrywnak, DPM, MD, CEO, AASC, Inc.

4:50 – 5:20 pm
Pain Management – Is In-Office Pain Management or Investing in an ASC the Smarter Business Decision
David M. Thoene, Managing Partner, Medical Surgical Partners, LLC

Track D – Management and Development

1:50 – 2:30 pm
Physicians, Hospitals, and Management Companies – What It Takes to Make a Winning Partnership and ASC
Jeff Simmons, Chief Development Officer, and Nap Gary, Chief Operating Officer, Regent Surgical Health

2:35 – 3:05 pm
New Developments in Orthopedic and Spine Devices and Implants
Chris Zorn, Vice President of Sales, Spine Surgical Innovation, Kenneth A. Pettine, MD, Founder, The Spine Institute and Loveland Surgery Center and Bryan Massoud, MD, Spine Centers of America, moderated by Helen H. Suh, Associate, McGuireWoods LLP

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3:10 – 3:45 pm
23 Hour Plus Recovery Care in ASCs
Geoffrey S. Connor, MD, Orthopedic Sports Surgery, Alabama Orthopaedic Spine and Sports Medicine Associates

3:45 – 4:15 pm – Networking Break & Exhibits

4:15 – 4:45 pm
Third Party Device Acquisition in an Outpatient Pain Management ASC
Nameer R. Haider, MD, Spinal & Skeletal Pain Medicine

4:50 – 5:20 pm
Global Fees and Transparency in Healthcare
Nick Vailas, CEO & Founder, Bedford Ambulatory Surgical Center

Track E – Business and Profitability Issues, Managed Care and Contracting for ASCs

1:50 – 2:30 pm
Orthopedic and Spine Contracting - A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors
I. Naya Kehayes, MPH, Managing Principal and CEO, and Matt Kilton, MBA, MHA, Princpal and Chief Operating Officer, Eveia Health Consulting & Management

2:35 – 3:10 pm
Orthopedic and Spine-Driven Hospitals – Best Practices
David Rothbart, MD, FACS, FACPE, Medical Director, Spine Team Texas

3:10 – 3:45 pm
Evolving Business, Clinical and Competitive Issues in Spine and Pain
John Prunskis, MD, Bal Nandra, MD, President, Metro Anesthesia Consultants, LLC, Ara Deukmedjian, MD, moderated by Holly Carnell, Associate, McGuireWoods LLP

3:45 – 4:15 pm – Networking Break & Exhibitis

4:15 – 4:45 pm
How to Improve Profits – Billing Process Improvement 101
Bill Gilbert, Vice President, Marketing, and Brice Voithofer, Vice President Anesthesia and ASC Services, AdvantEdge Healthcare Solutions

4:50 – 5:20 pm
Health Insurance Plans Are Taking Notice in Fraud and Abuse of Surgical Implants - What Are They Figuring Out and How to Prevent It?
Steven Arnold, MD, Chief Medical Officer, Access MediQuip

Track F – Quality, Infection Control, Accreditation Management

1:50 – 2:30 pm
10 Best Practices to Improve Billing and Collections
Lisa Rock, President, National Medical Billing Services

2:35 – 3:05 pm
Reading the Tea Leaves – Assessing ASC Valuation Trends Utilizing the Latest Industry Data
Elliott Jeter, CFA, CPA/ABV, Partner, and Colin McDermott, CFA, CPA/ABV, Senior Manager, VMG Health

3:10 – 3:45 pm
Key Legal and Legislative Issues
Kristian A. Werling, Partner, McGuireWoods LLP, Bobby Hillert, Executive Director, Texas Ambulatory Surgery Center Society, Stephanie A. Kennan, SVP Government Relations, McGuireWoods Consulting, LLC, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

3:45 – 4:15 pm - Networking Break & Exhibits

4:15 – 4:45 pm
Selecting the Best Staff, Preparing and Training the Staff for Complex Spine Cases in the ASC
Nancy Boyd, Administrator of Crane Creek Surgery Center, and Gina Doleson, Vice President of Operations, Blue Chip Surgical Center Partners

4:50 – 5:20 pm
Maximizing ASC and Anesthesia Group Relationships
Charles Militana, MD, North American Partners in Anesthesia

5:20 – 6:30 PM - Cocktail Reception, Cash Raffles and Exhibits

Saturday, June 16, 2012

7:00 – 8:10 am – Continental Breakfast

Track A

8:10 – 8:50 am
Orthopedic, Spine and Pain Management Practices and ASCs – 6 Defining Issues
Michael Redler, MD, The OSM Center, Robert A. Vento, SVP Operations, Quorum Health Resources, LLC, James T. Caillouette, MD, Surgeon In Chief, Hoag Orthopedic Institute, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

8:55 – 9:30 am
Cervical Myelopathy
Fernando Techy, MD, Adult & Pediatric Spine Surgery, Lutheran General Hospital, UIC Chicago

9:35 – 10:10 am
Total Joint Reimbursement Strategies in the ASC
Rebecca Overton, Surgical Management Professionals

10:15 – 10:50 am
Healthcare False Claims and Anti-Trust Litigation
Jeffrey C. Clark, Partner, and David J. Pivnick, Associate, McGuireWoods LLP, moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

10:15 – 11:30 am
The Business of Spine Reimbursement and Coding Changes
Barbara Cataletto, MBA, CPE, CEO, Business Dynamics, Ltd.

Track B

8:10 – 8:50 am
Information Technology for Surgery Centers – Achieving Positive Outcome and Avoiding Complications
Michael Rauh, MD, UB, Orthopaedics and Sports Medicine, Marion Jenkins, PhD, Founder & CEO, QSE Technologies, Inc., moderated by Holly Carnell, Associate, McGuireWoods, LLP

8:55 – 9:30 am
10 Key Concepts from Top Performing Pain Management Programs
Amy Mowles, President & CEO, Mowles Practice Management

9:35 – 10:10 am
New Advances in Sacroiliac Joint Problems
Richard A. Kube, MD, CEO, Founder & Owner, Prairie Spine & Pain Institute

10:15 – 10:50 am
Managed Care Contracting - Tips to Succeed with ASC Contracting
Andrea Woodell, Managed Care Manager, Regent Surgical Health

10:55 – 11:30 am
Sell Your ASC or Stay the Course - 7 Key Considerations
Helen Suh, Associate, McGuireWoods LLP, and Scott Becker, JD, CPA, Partner, McGuireWoods LLP

Track C

8:10 – 8:50 am
Optimizing Your Revenue Cycle
Catherine Meredith, RN, BS, CASC, Vice President of Finance, Ambulatory Surgical Centers of America

8:55 – 9:30 am
Key Practices to Improve Infection Rates and Clinical Quality
Sandra Jones, MBA, MS, CASC, FHFMA, CEO, EVP, ASD Management

9:35 – 10:10 am
Challenges of Spine in a Multi-Specialty ASC and the Administrator's Role in Turning Around a Poorly Performing ASC – A Case Study
Nancy Boyd, Administrator, Crane Creek Surgery Center, and Gina Doleson, Vice President, Blue Chip Surgical Center Partners

10:15 – 10:50 am
15 CPT and Coding Issues for Orthopedics and Spine
Stephanie Ellis, RN, CPC, Ellis Medical Consulting, Inc.

Track D

8:55 – 9:30 am
HR Practices That Dramatically Improve Quality and Profits
Thomas H. Jacobs, President & CEO, MedHQ

9:35 – 10:10 am
Key Tips for Quality Assurance and Infection Prevention
Dotty J. Bollinger, RN, JD, CASC, LHRM, Chief Operating Officer, and Nicole Gritton, MSN/MBA, Director of Nursing, Laser Spine Institute

10:15 – 10:50 am
Key Implantable Device Benefit Management (DBM) Issues Facing ASCs
Robert W. Phipps, Pharm D., Vice President and General Manager, Eastern Division at Implantable Provider Group, Inc. and Lynne Stoldt, Administrator at Melbourne Same Day Surgery Center

GENERAL SESSION
11: 35 – 12:30 pm
Conducting a Compliance Review of Your ASC or Physician Owned Hospital
Holly Carnell, Associate, and Scott Becker, JD, CPA, Partner, McGuireWoods LLP

12:30 pm – Meeting Adjourns

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- Keynote Tucker Carlson, Contributor, FOX News, Editor-In-Chief, The Daily Caller and Senior Fellow, The Cato Institute - An Outlook on Politics and The Election,
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Lou Holtz has established himself as one of the most successful college football coaches of all time. Born Louis Leo Holtz on January 6, 1937, Holtz grew up in East Liverpool, Ohio, just up the Ohio River from his Follansbee, West Virginia, birthplace. He graduated from East Liverpool High School, earned a Bachelor of Science degree in history from Kent State in 1959 and a master's degree from Iowa in arts and education in 1961. He played linebacker at Kent State for two seasons before an injury ended his career. He has received 4 honorary doctorate degrees.

COACH

Holtz is the only coach in the history of college football to: 1) Take 6 different teams to a bowl game. 2) Win 5 bowl games with different teams. 3) To have 4 different college teams ranked in the final Top 20 poll. Despite never inheriting a winning team, he compiled a 243-127-7 career record that ranked him third in victories among active coaches and eighth in winning percentage. His 12 career postseason bowl victories ranked him fifth on the all-time list. Holtz was recently selected for the College Football Hall of Fame, class of 2008, which places him in an elite group of just over 800 individuals in the history of football who have earned this distinction. Approximate 1 in 5,000 people who played college football or coached it make it into the Hall of Fame.

ESPN Sports Analyst

Currently, Holtz serves as a college football studio analyst on ESPN. He appears on ESPNEWS, ESPN College GameDay programs, SportsCenter as well as serves as an on site analyst for college football games.

Sam Donaldson, a 44-year ABC News veteran, served two appointments as chief White House correspondent for ABC News from January 1998 to August 1999 and from 1977- 1989, covering Presidents Carter, Reagan and Clinton. Donaldson also co-anchored PrimeTime Live with Diane Sawyer from August 1989, until it merged with 20/20 in 1999. He co-anchored the ABC News Sunday morning broadcast, This Week With Sam Donaldson & Cokie Roberts, from December 1996 to September 2002. From October 2001 to May 2004, he hosted The Sam Donaldson Show - Live in America, a daily news/talk radio program broadcast on ABC News Radio affiliates across the country. In the three hour show, Donaldson tackled the day's top stories and important issues-taking comments from newsmakers, engaging listener calls and, of course, inserting his own unique experience and opinion.

Most recently, Donaldson hosted the show Politics Live on ABC News Now, the ABC News digital network. From 1999 to 2001, Donaldson also hosted SamDonaldson@abcnews.com, the first regularly scheduled internet webcast produced by a television network. On it, he interviewed former Presidents Jimmy Carter, Gerald Ford and George Bush, along with such diverse personalities as actor Sean Connery, comedian Janeane Garofalo, tech company CEO Jeff Bezos and sports great Willie Mays.

Donaldson has covered every national political convention since 1964 with the exception of the 1992 Republican Convention in Houston. He reported on the presidential campaigns of Senator Barry Goldwater, Senator Eugene McCarthy, Senator Hubert Humphrey, President Jimmy Carter, President Ronald Reagan and Governor Michael Dukakis. He also reported as an eye-witness on Spiro Agnew's no contest plea in a Baltimore courtroom that forced Agnew's resignation from the Vice Presidency.

In 2008, Donaldson received the AFTRA Media and Entertainment Excellence Award as well as the RTNDA Paul White Award. In 1998, Donaldson received the Broadcaster of the Year Award from the National Press Foundation. The Washington Journalism Review named him the Best Television White House Correspondent in the Business in 1985 and the Best Television Correspondent in the Business in 1986, 1987, 1988 and 1989. Donaldson has won many other awards, among them four Emmy Awards and three George Foster Peabody Awards.

Tucker Carlson is a veteran journalist and political commentator, currently working for the Fox News Channel. Carlson is also the editor-in-chief of TheDailyCaller.com, a news and opinion site. Carlson joined Fox from MSNBC, where he hosted several nightly programs. Previously he was the co-host of *Crossfire* on CNN, where he was the youngest anchor in the history of that network. During the same period, Carlson also hosted a weekly public affairs program on PBS. A longtime writer, Carlson has reported from around the world, including dispatches from Iraq, Pakistan, Lebanon and Vietnam. He has been a columnist for *New York* magazine and *Reader's Digest*. He currently writes for *Esquire* and *The New York Times* magazine. Carlson began his journalism career at the *Arkansas Democrat-Gazette* newspaper in Little Rock. His most recent book is entitled, *Politicians, Partisans and Parasites: My Adventures in Cable News*. In 2006, he appeared on ABC's Dancing with the Stars. Carlson is currently working on his third book.

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8 Keys to Success in Sports Medicine From Dr. James Andrews **(continued from page 1)**

1. Practice humility and compassion as the first step toward greatness. There are a number of qualities sports medicine physicians must adopt to build a foundation for success, with the most important being humility. "If you take too much personal credit for your successes and dwell on them, you are going to have a problem," says Dr. Andrews. "You aren't going to be good at medicine without humility."

In some cases, physicians have gained a reputation for being arrogant and under-serving their patients. Showing humility and compassion rejects this reputation and fosters respect and credibility.

"Humility and compassion are very important parts of your success," says Dr. Andrews. "You've got to show compassion for people who are injured. Remember that patients are always right, even if they aren't in the best frame of mind after dealing with a knee injury or chronic illness. You have to understand that situation and be compassionate for them; otherwise, they'll think you are arrogant."

2. Consider sports medicine a profession first, a business second. Taking care of patients and returning them to play should be the number one priority of sports medicine physicians; the economics of the business should be a distant second, according to Dr. Andrews.

"Orthopedic sports medicine is a people's business and in general deals with taking care of people with an active lifestyle of all ages," he says. "You've got to have a positive relationship with your patients. To think of the business of medicine as the cornerstone of your practice is wrong. For me, medicine is more of a profession than a business."

The definition of sports medicine is taking care of active, athletically engaged individuals of all ages and experience levels. Taking good care of patients could mean the difference between being healthy and active or abandoning activity for a sedentary lifestyle. While it's important to keep your sports medicine practice open, accruing high profitability should not be the physician's number one priority.

"I've never treated practicing sport medicine as a business and I've never tried to figure out the financial aspects of medicine," says Dr. Andrews. "Economics is important, but if you let that economic aspect overshadow doing what is best for your patients, you'll never be successful in any type of medicine. That's the key to how I would think about our profession."

3. Focus on public relations resources on research and education, not marketing. Everybody wants to build an outstanding reputation among their patients and colleagues, which means investing in public relations. However, instead of spending money on billboards or television advertisements, physicians at the Andrews Institute concentrate on research and education in orthopedics and sports medicine.

"You can't be criticized when you are spending your extra time developing young sports medicine physicians in a fellowship program," says Dr. Andrews. "I've spent my time over the past 40 years building a foundation in research and education to give young physicians an opportunity to excel in sports medicine. If you are involved in research and education, it will make you and others better. Research and education gives back to the field, which is key to our success at Andrews Institute."

In addition to training fellows, Dr. Andrews gives presentations at national society meetings. As for marketing, Dr. Andrews depends on the word-of-mouth technique, gathering referrals and reputation from one patient to another.

"We developed our practice patient-to-patient, athlete-to-athlete," he says. "Let someone else tell the good story for you and you won't be tempted to toot your own horn."

4. Make yourself always available. Availability is important because if you don't make yourself available to take care of patients, they will go somewhere else. This may mean working long hours — even on weekends — and adding extra patients into an already packed schedule, but it will build the foundation for a strong and well-respected practice.

"You can't tell patients you don't have time to see them or try to schedule them two months in the future," says Dr. Andrews. "You have to be available in sports medicine when things happen. You have to make time to take care of patients in an orderly and reasonable period of time — that's very important to your success."

As the practice grows, it becomes harder to fit everybody in. However, seeing patients in a timely fashion is still important, regardless of how successful you are. "You can never become too busy to see patients," says Dr. Andrews. "When I get a call about professional athletes or college athletes who get hurt on the weekends, I have to be available to see them the next day."

5. Build strong communication skills and strategies. When sports medicine practices fail, it's often because there is a lack of availability and communication for the athlete's treatment. Within the line of communication, Dr. Andrews says the number one priority is the player, followed by the player's parents. Once the players and their parents are updated, communication with the team coaches, management and ownership are required.

"You have to be able to communicate with your patients and those around you in sports medicine," says Dr. Andrews. "Especially important is communication with the athlete's parents. If the athlete's mother isn't happy, nobody is happy — that goes all the way up the professional ranks. You have to contact the athlete's parents and make sure to communicate with them; that's very important."

In addition to communicating with the players' parents and coaches, talking with their agents also becomes important in professional sports. "The further up the ladder an athlete goes, the more communication you have to consider," says Dr. Andrews.

6. Think positively throughout your career. Physicians are bombarded with negative situations in their practices, and negative thoughts can easily overtake them. Negativity is a hindrance to success in the medical field and sports medicine physicians must find a method for overcoming this stress. Dr. Andrews recommends physicians have a positive to negative thought ratio of at least 5-1, preferably 10-1.

"People that have positive thoughts are much more successful than those who have negative thoughts," says Dr. Andrews. "It's easy for physicians to slip into the negative category. Focus on positive thoughts and goals for your life and practice instead."

7. Exhibit confidence and moral character in all activities. Confidence is a key quality in medical professionals, especially for sports medicine physicians who work with athletes every day. Athletes are often very confident people and appreciate confidence in others, including their physicians.

"Physicians should exhibit confidence in their activities, thought processes and recommendations to patients," says Dr. Andrews. "You should be confident in your diagnosis and treatment recommendations. If you are wishy-washy to patients, particularly athletes, they recognize that. You still have to be realistic with them, but always display confidence."

Along with confidence, physicians must exude a strong moral and ethical character. "In medical ethics, if you do what is right for your patient, your ethics won't be questioned," says Dr. Andrews. "If you have a question about whether something is right for your patients, it probably isn't. If you don't have good ethics, sooner or later people will catch up with you and you will be unsuccessful in your medical career."

8. Be patient and persistent with career development. Orthopedic surgeons and sports medicine specialists are unique; only the top applicants are selected for medical schools and orthopedic residencies only accept the very best students out of medical school to complete their programs. Sports medicine fellowships are even more exclusive, which means anyone completing a sports medicine fellowship and earning certification is an unusually bright and highly motivated individual. However, once physicians begin their practice, they must be patient and build a foundation of good medicine before rising to the top of the field.

"Sometimes, if young physicians are too aggressive in moving up the ladder, they can run into trouble," says Dr. Andrews. "They have to build their reputation gradually, demonstrating quality in sports medicine. You can't expect to come out of training and take a spot at the top of the field. You have to continue to listen and learn throughout your career. The man who says he knows everything is headed for disaster, and young physicians must be careful not be a know-it-all because that leads to self-made controversy."

Dr. Andrews says that today's young physicians must have completed a sports medicine fellowship and a certificate of added qualification to become a leader in the field, especially if they are planning on serving with a professional athletic team. In addition to training, involvement with the American Orthopaedic Society of Sports Medicine and other professional organizations becomes a crucial aspect of career development. Begin by volunteering for committees and taking your place at the bottom of the ladder and be willing to work your way up to the leadership positions.

"It's those who are qualified who will be able to get involved and move up the ladder," says Dr. Andrews. "It takes 30-40 years to reach the elite levels of these societies. Young physicians have to realize it takes a lot of persistence — which is another word for success — but you must earn it. Becoming involved in AOSSM is crucial for young physicians to enter into the elite world of sports medicine." ■

Dr. Brian Cole: 3 Exciting Trends in Sports Medicine Research

By Laura Miller

There are several exciting research projects going on right now in sports medicine. Brian Cole, MD, head of the Cartilage Restoration Center at Rush in Chicago and team physician for the Chicago Bulls and co-team physician for the Chicago White Sox, discusses the different research projects currently engaging his team.

Orthobiologics

There are several different components making orthobiologics one of the most exciting fields in sports medicine. "Orthobiologics is one way to trick the body into healing more efficiently and completely through relatively easy treatment methods," says Dr. Cole. "We have access to stem cells and bone marrow, as well as the use of growth factors contained in PRP (platelet-rich plasma) to develop treatments in this field."

One of the biggest questions in sports medicine right now revolves around the effectiveness of platelet-rich plasma injections. Dr. Cole and his colleagues are conducting a randomized, double-blind, prospective trial comparing PRP with hyaluronic acid injections for tissue healing. The trial includes 100 patients with the diagnosis of osteoarthritis and symptomatic pain for at least one month before treatment.

Dr. Cole and his colleagues are studying the antioxidant resveratrol for delaying arthritis in an animal model. Physicians and researchers are using stem cells and bone marrow in addition to various scaffolds for treatments that could eventually lead to more reliable methods of healing. In rotator cuff repair, Dr. Cole and his team have developed a prosthetic augmentation device, designed like a patch, to enhance repair. The indications for its use continue to evolve.

"When collagen is bad, current treatments fail because the tendon comes off the bone," says Dr. Cole. "There is an interest in creating a high quality bone tissue interface to promote a durable repair with less chances of failure down the road."

Arthritis care

In arthritis care, some of the most cutting-edge developments focus on young patients with shoulder arthritis. Surgeons are now able to use various knee surgery techniques, including transplant, in the shoulder. Dr. Cole's team is working on unique methods to promote cartilage growth, for example, in the glenoid (the shoulder socket) in an animal model that can ultimately be translated into techniques to manage young patients with shoulder arthritis.

For patients with knee arthritis, research focuses on next generation techniques for cartilage repair, says Dr. Cole. He and his team are using an autograft implantation technique for cartilage repair in patients in a phase one of several FDA studies being performed at Midwest Orthopedics at Rush where they harvest pieces of the knee cartilage with an arthroscope and implant them back into the damaged site with a bioabsorbable scaffold.

Additionally, Dr. Cole and his colleagues are in Phase III trials for another cartilage repair technique with DeNovo Engineered Tissue (ET). In this technique, articular cartilage is harvested from juvenile donors. Within the DeNovo ET implant, chondrocytes divide and produce a matrix before being surgically implanted into the patient's lesion site and affixed to the subchondroal bone with fibrin during a mini-open knee arthrotomy. In 2012, Dr. Cole hopes to begin another FDA trial utilizing stem cells to augment a microfracture technique that is currently utilized to treat patients with localized cartilage disease in many different joints including the shoulder and knee.

Symptom variability

In addition to several ongoing biologics studies, Dr. Cole and his colleagues are focusing on symptom variability among their patients. "We are looking at why some people hurt and other people don't, given similar injury or condition environments," says Dr. Cole. For example, some patients with cartilage degeneration find the condition extremely painful while others don't report experiencing pain.

Another way to examine this problem is locating the pain generator in people who do report serious pain and comparing their symptoms to others. ■

6 Goals for Sports Medicine From Dr. Kevin Plancher

By Laura Miller

Last December, Kevin Plancher, MD, founder of Plancher Orthopaedics and Sports Medicine, chaired the "Emerging Techniques in Orthopedics Sports Medicine & Arthroscopic Surgery" conference, co-hosted by the Orthopaedic Foundation for Active Lifestyles and *The American Journal of Orthopaedics*. More than 400 physicians and medical professionals attended the conference to learn new techniques and discuss the latest trends in the field. During the conference, panel members from around the country were challenged to debate opposing sides to controversial issues in sports medicine, with honored professors Russell F. Warren, MD, and Richard J. Hawkins, MD, overseeing many of the debates.

"We made the faculty debate each other even if they agreed on principle so they saw the other side on fairness," says Dr. Plancher. "We wanted to create the debate so participants could see what was going on. Next December, we'll have more of an international faculty to gain a global perspective on clinical issues in sports medicine."

Here, Dr. Plancher discusses six goals for sports medicine this coming year.

1. Educating the public about injury prevention. A large portion of a sports medicine physician's patients suffer from overuse injuries. Many young athletes are pushed to overwork their basic skills while older patients are likely enjoying too much of one activity. Recreational athletes often don't consider cross training or doing the appropriate stretches to prevent overuse or acute injuries.

"Professional athletes, such as those heading to the Super Bowl, are learning yoga and doing Pilates, not just the same core drills over and over, because they know these other things are increasing their performance and decreasing the risk of injury," says Dr. Plancher. "The more we educate the public, the fewer of these types of injuries we will see."

The American Orthopaedic Society for Sports Medicine, along with other sponsoring organizations, promotes the STOP Sports Injuries campaign among youth athletes, and joining the campaign can provide valuable information for your patient base. Otherwise, single physicians can spread the word relatively easily through online articles stressing the importance of cross-training and stretches among all types of athletes.

2. Taking a multidisciplinary approach to sports medicine. An increasing number of sports medicine physicians and groups are partnering with other medical professionals to deliver care through a multidisciplinary approach. Physician practices often include physicians' assistants, nurses, primary care sports physicians and physical therapists who all have the same goal: to find the root of athletes' problems and return them to play.

Dr. Plancher's office includes all of these specialists as well as diagnostic imaging modalities. "We are going to treat you with dignity and thoroughness to find the problem, and then give our patients different treatment options," says Dr. Plancher. "We can do physical therapy to correct someone's biomechanics, fit them for a brace or perform arthroscopic procedures, returning them to play faster than was possible before."

3. Supporting a national joint replacement registry. Physicians and scientists are rapidly developing new technology with the potential to make sports medicine procedures more precise and heal patients more quickly. However, all new technology and treatments must undergo extensive clinical trials, and sometimes even then widespread use of the device can include unforeseen complications. Other countries have developed national joint replacement registries to monitor devices after they are released on the market, but the United States hasn't fully implemented a national registry yet.

"Some companies put out devices that are great ideas and then the clinical trial comes up and we realize they don't work as well in application," says Dr. Plancher. "We have to share information in a national joint replacement registry where it is okay for physicians compare outcomes among patients in similar situations. Other countries have great registries which allow for full evidence-based medicine and I would love to see that for orthopedics and sports medicine in the United States."

Beyond just including joint replacements, a national registry could also focus on other types of ligament and cartilage repair. For instance, one of the biggest controversies right now is the effectiveness of platelet-rich plasma. Anecdotal evidence shows it could have a positive impact with appropriate use, but some studies show it isn't clinically effective.

"We're hoping for some great evidence-based studies to see where PRP works," says Dr. Plancher. "We are finding it works in the elbow but not necessarily in the knee or shoulder. Regardless, it may lead to new products, enzymes and studies to help us enrich the mechanical repair of some minimally invasive procedures."

4. Fighting coverage denial from insurance companies. Most physicians, including sports medicine specialists, are experiencing push-back from the insurance companies on specific procedures and treatments — especially those with a high cost. Some companies deny coverage for procedures they deem "experimental," and others deny surgery in favor of conservative care, even when the patient has gone through the commonly-accepted treatment algorithm to become a candidate for surgery.

"Physicians and hospitals have to work together and not let third parties make all the decisions for us," says Dr. Plancher. "Sports Medicine physicians have felt this pinch for 10 years, and now patients are speaking up for themselves. I'm happy about that."

In some cases, Dr. Plancher has seen patients come in without a clear understanding of their healthcare benefits and realize they have limited services from their plan through employers. They'll watch him phone the insurance companies to extend coverage, which is sometimes successful and sometimes not. Regardless of the outcomes, the bottom line for the insurance companies is their bottom lines.

"People are making financial decisions, and I understand why, but we have to understand rationing healthcare is happening and I'm not sure we've found the best solution out there," says Dr. Plancher.

5. Containing the cost of healthcare. As the cost of providing care has gone up in the United States, reimbursement to physicians has gone down. There are several different payment models being discussed for the future, but without a solid structure physicians are unable to plan for the future. "We have to decide what payment system will prevail," says Dr. Plancher. "I know there are really smart people who can guide us and we have to meet somewhere in the middle so the patients are cared for but the physicians are also able to run their private practices."

Orthopedic surgeons are signing contracts for hospital employment at higher rates than ever before, due partially to the increasing cost of running a private practice. One of the biggest contributors to an independent practitioner's fixed fees is malpractice insurance, which physicians don't have to pay individually under hospital employment.

6. Inspiring others to enter sports medicine. Dr. Plancher says when he first began studying sports medicine, it wasn't a very popular subspecialty among physicians. Now, sports

medicine programs and fellowships (he is a director for two ACGME slots) are very competitive and include both clinical and scientific professionals. However, he still sees room for growth.

"I always encourage people to look into sports medicine — we need a lot of smart people in sports medicine," he says. "I support through The Orthopaedic Foundation for Active Lifestyles a unique program entitled Doctor for a Day. We teach kids about orthopedics and sports medicine from 9th to 12th grade. This particular program is completely funded by orthopedic companies and the foundation. It sponsors these high school students and experience in fixing a broken forearm." The program simulates an operating room setting and provides the students with the same drills, plates and screws surgeons use. Each group of four students is mentored by an orthopedic surgeon or health professional. The students take X-rays, make their cuts on their simulated cadaver, and perform the surgery.

"These kids are from all different walks of life and they do an amazing job," says Dr. Plancher. Some students come from inner city schools, others from private schools. "No matter what, we hope to get some kids so excited about going into science and orthopedics through this program." ■

4 Business Principles for Growing a Sports Medicine Center

By Laura Miller

After 20 years in private practice, Robert S. Bray, MD, a neurological spine surgeon based in Marina del Rey, Calif., founded DISC Sports and Spine Center. Established in 2006, DISC has been able to not only withstand the pressures of today's healthcare environment, but also flourish. DISC has also become the official medical care provider for the United States Olympic Team, Red Bull athletes and the Los Angeles Kings.

"You need a level of integrated care at your center," says Dr. Bray. "The hottest trend in sports medicine is the ability to deliver full service care no matter what."

1. Become vertically integrated. From the moment your patient walks through the door, you should be able to provide all services available for their episode of care. This means providing specialists in physical and occupational therapy, imaging services, nutritional specialists, anesthesiologists, surgeons and pain management, all under one roof. Becoming a multidisciplinary center is especially important for treating high level athletes who need quick coordinated care.

"At our practice, we saw 100 elite athletes last quarter," says Dr. Bray. "The reason they come to us is because we could provide complete care across the board. Surgeons must realize that in order to be a comprehensive sports center, you have to have everything, including services like acupuncture."

2. Provide patient care coordination. One of the reasons why DISC was able to contract with the U.S. Olympic Team and Red Bull athletes is their ability to provide quick coordinated care. The center has a VIP athlete coordinator to arrange each athlete's care before they arrive at the practice. Many times the athletes are flown in from locations around the country; once they arrive, the coordinator has their appointments with different specialists scheduled so the care is as seamless as possible.

"Our VIP athlete coordinator takes the call from Red Bull America or the Olympic athletes and coordinates their appointments," Dr. Bray says. "If a BMX Biker for Red Bull North America goes down, they want to call up and have the athlete imaged, diagnosed and treated the next day so they can return to practice as soon as possible. Many times, the treatments aren't surgical and we can provide them the same day. With that kind of concierge sports medicine, we were able to develop our relationships with elite athletes."

3. Invest in an outpatient surgery center. Even with the economic downturn, DISC's new multidisciplinary outpatient surgery center focused on orthopedics and spine care has been booming. Between the old and new surgery centers, DISC surgeons have performed more than 4,500 cases in the outpatient ASCs and never reported an infection. "Our surgery centers are built to really high standards and run very well," says Dr. Bray. "We are seeing high acuity, low volume cases becoming the mainstay for sports medicine surgery centers in the future. The center has to be built at a high level for these very complex cases and incorporated into the practice's overall business model."

DISC surgeons have been able to successfully perform knee and hip replacements, anterior lumbar interbody fusions, lateral lumbar interbody fusions and other spine procedure using pedicle screws. "We aren't just doing the little things; we are doing bigger surgical cases in the outpatient environment and seeing good outcomes," says Dr. Bray.

4. Broaden the types of specialists in the practice. Thinking outside the box is critical to achieving success despite the typical market challenges of the day. While some orthopedic and spine surgeons have spent a great deal of time defending surgical treatment as the only true method of care, DISC has embraced alternative care providers as patient demand has dictated.

"Athletes want soft tissue therapy, acupuncture, rehabilitation facilities, injury avoidance and biomechanics specialists as well as athletic trainers — not just a physician who will perform a knee scope," says Dr. Bray. "Incorporating all the different specialists has been the thrust of DISC for the past four years. You need to perform minimally invasive, top-quality surgery for your patients, but almost more than that you need the ability to provide all types of care." ■

The Future of Evidence-Based Medicine in Pain Management: Q&A With Dr. Laxmaiah Manchikanti of ASIPP

By Abby Callard

Laxmaiah Manchikanti, MD, is the chairman of the board and CEO of the American Society of Interventional Pain Physicians and the Society of Interventional Pain Management Surgery Centers; medical director of the Pain Management Center of Paducah (Ky.); and associate clinical professor of anesthesiology and perioperative medicine at the University of Louisville (Ky.).

Q: What will 2012 bring for evidence-based medicine in pain management?

Dr. Laxmaiah Manchikanti: [ASIPP] is worried that evidence-based medicine will be converted into a witch hunt through overly empowered insurers. This is manifested by comparative effectiveness research and Patient Centered Outcomes Research Institute. PCORI and comparative effectiveness research may appear patient friendly and innocuous; however, once they make a draft determination, insurance companies will pick it up and start using and essentially denying the care.

There are protections against PCORI and comparative effectiveness research abuses with Medicare and Medicaid; however, these protections do not apply or extend to third-party payors. In fact, recent CMS evaluations have shown that essentially none of the treatments work — that is why it is extremely important that evidence be assessed appropriately.

Consequently, with the support of ASIPP and its members, Kentucky Rep. Brett Guthrie (R-2nd) introduced a long awaited bill to repeal PCORI and comparative effectiveness research funding. HR 3827 was introduced in the House Jan. 25, 2012 and if passed, would repeal PCORI and maintain patients' access to the appropriate care and treatments that they and their doctor chose. The bill has been referred to the House Energy and Commerce committee and is expected to gain strong bipartisan support.

Evidence-based medicine, comparative effectiveness research and clinical guidelines are experiencing exponential growth, not only in terms of publications, but also in terms of funding with disagreements in the evidentiary basis of certain treatment as well as competing interests of payors, practitioners, health policy makers and third parties benefiting from development of the guidelines as cost saving measures. Guideline preparation has been described as based on prepossession, vagary, rationalization or congeniality of conclusion.

Q: Why is it important for treatment to be based on high level studies?

LM: For any aspect of human life you would want to have something which works the best, and, consequently, in the medical profession we want the best quality evidence before applying those techniques on human beings. Essentially, a high level of evidence means it works safely.

Evidence-based medicine conveys the idea that up-to-date evidence can be applied consistently in clinical practice, in combination with the clinicians' individual expertise and the patients' own preferences and expectations to achieve the best possible outcome. Even though 20 years have elapsed since the concept of evidence-based medicine originated, the benefits of evidence-based medicine have not materialized for numerous conditions including spinal pain. We expect to see strong evidence for almost everything.

Amazingly, for two-thirds of Americans with diabetes and half of those with hypertension — conditions with strong evidence-based guidelines — these conditions are inadequately controlled. There are also differences of opinion; some focus only on the randomized trials and the highest level of evidence, but there are multiple biases in these evaluations. These are considered hazards of evidence-based medicine which may actually reduce access, based on proclamation rather than evidence.

Q: What pain management treatments are currently supported by high level evidence studies?

LM: Theoretically, none of the pain management studies are supported by a high level of evidence. On the same token, neither the surgical interventions, physical therapy nor other medical interventions are supported by high level of evidence.

There is good evidence for the following procedures:

- Epidural injections in the cervical and lumbar spine, which incorporate caudal, lumbar interlaminar, cervical interlaminar, thoracic interlaminar and lumbar transforaminal epidural injections
- Facet joint interventions involving medial branch blocks and radiofrequency neurotomy with medial branch blocks in the cervical, thoracic, and the lumbar spine; with radiofrequency neurotomy, there is good evidence for cervical and lumbar spines only
- Percutaneous adhesiolysis in post-surgery syndrome and spinal stenosis
- Spinal cord stimulation for post-surgery syndrome and neuropathic pain

Q: Who sponsors these high level studies?

LM: Historically medical device companies and the pharmaceutical industry sponsored the studies. However, because most of the studies sponsored by them provided positive results, they are now considered biased and tainted. A new era is emerging, and now insurers are sponsoring the studies. There is also inherent bias in these studies sponsored by insurers. Further, unending bias and networking among these experts sponsored by one or another agency and even penetrating the government agencies is becoming more common. The problem with government agencies or any other agency is that these experts lack technical ability and continue to change the criteria based on their need.

Q: How can the healthcare industry support high level studies?

LM: Industry should give unrestricted grants to organizations which sponsor research and do not control it. If [industry sponsors] do control it, they have to stay out of it without controlling the data. These should be performed independently. Their involvement should be only for the protocol preparation and support.

Q: How do insurance companies use these studies and how does that affect care?

LM: Insurance companies attempt to use them in their favor, take only the negative rather than the positives and convert all the studies into negative evidence — most of the time. Insurance companies are unable to decide the difference between a simple, randomized trial or placebo-controlled, double-blind trial. They also request that these trials should be performed in highly specified academic settings as such.

If these trials are performed, [insurance companies] criticize that they are performed in specialized setting. In an active control group — essentially meaning that two treatments are tested against each other — insurance companies as well as methodologists tend to classify one group even though it is an active as a placebo and determine that there is no difference between the two groups. Instead they should be looking at baseline status and improvement or lack thereof with one or both the treatments rather than only the differences between the treatments.

Q: Is evidence-based medicine more challenging when dealing with a subjective finding such as pain?

LM: Pain is a subjective finding, but there are also objective features such as improvement in function, returning to work, reduction in medication and general well-being with improvement in the quality of life. Assessment of these aspects plays a significant role. If one says that only pain is improved, but function deteriorated or quality of life has not improved, then it becomes questionable. The treatment is not effective. It should be always functional status improvement rather than just pain.

Q: What is the role of pain management physicians in the push toward evidence-based medicine?

LM: Pain management physicians have substantial evidence. The issue is how they can collect the data and report it. More pain management physicians should come forward and conduct randomized, double-blind, controlled trials. It is not that difficult to conduct the studies when utilizing an active controlled design nor is it expensive since both groups are getting a treatment — but a different treatment. Further, it is imperative on all pain physicians to emphasize the importance of active control trials and also expose the deficiencies in methodological quality in determining the evidence and if necessary educate all parties.

Q: How can pain management physicians get involved with high level evidence studies?

LM: Physicians can get involved with high level evidence studies by designing their own studies or associating with others who do these. They can also associate with industries and obtain funding for the organizations which can sponsor these studies without becoming involved in critical aspects of the study. Pain physicians must maintain independence and avoid bias. ■

5 Procedures Pain Management Physicians Must Do in 2012

By Abby Callard

Scott Glaser, MD, is an interventional pain management physician and president of the Pain Specialists of Greater Chicago in Burr Ridge, Ill.

1. Basic interventional techniques using treatment algorithms. Although many new procedures are showing promise at treating pain, Dr. Glaser advocates a back-to-the-basics concept. "A lot of times people just want to do the sexiest procedure, the new kid on the block, and they forget about the time tested utility of the basic procedures," he says.

These are the bread-and-butter procedures that have been around — and successfully treating pain — for decades. "Doctors should be familiar with the algorithm of lower back pain," Dr. Glaser says. "The vast majority of patients with lower back pain can be adequately controlled using basic interventional techniques such as facet joint injections, medial nerve blocks, radiofrequency ablation, and interlaminar, transforaminal, and caudal epidural steroid injections."

2. Peripheral joint, ligament and nerve injections using ultrasound guidance. Dr. Glaser says adding peripheral joint and nerve injections using ultrasound guidance in his office has really enhanced his practice in terms of patient satisfaction, convenience, and safety. "With the ultrasound guidance, you increase your success rate because you can visualize exactly where you're putting the needle," he says.

Because the ultrasound equipment is expensive and the CPT code for ultrasound guidance will most likely be bundled into the code for certain injections, Dr. Glaser advises against thinking of these procedures as a "revenue enhancer" but rather another treatment option to offer to patients who do not respond to traditional treatment.

3. Neuromodulation. Although neuromodulation has been around since the 1980s, Dr. Glaser says the software and hardware of the implants gets better every year. Late last year, the FDA approved a Medtronic implant that automatically adjusts the level of stimulation depending on whether the patient is lying down, sitting or standing up. Older devices had to be manually changed. Another device approved last year from St. Jude allows physician to place leads for neuromodulation through a single entry point. This make the procedure even more minimally invasive, Dr. Glaser says.

Although the treatment is gaining popularity, the devices are expensive and treatment can be hard to gain pre-approval from insurers. "That doesn't change the fact that it's fantastic," he says. "The cost and difficulty in getting pre-approved should not dissuade pain physicians from doing these techniques in their practice. We are seeing amazing results with peripheral nerve stimulation especially for headaches."

4. Decompressive techniques. Dr. Glaser says two new procedures — minimally invasive lumbar decompressions and laser endoscopic techniques — have the potential to become "huge." He says the exciting thing about these techniques is that they are minimally invasive procedures but accomplish the goals of more invasive procedures without the risks. These more advanced procedures are good for patients who are not responding to the basic interventional procedures like injections.

5. Vertebroplasty. As the population ages and remains active, Dr. Glaser predicts an increase in vertebral compression fractures, which are often treated with vertebroplasty. During the procedure, bone cement is injected into the collapsed or fractured vertebra using an introducer needle. Dr. Glaser says patients undergoing this procedure are frequently admitted to the hospital but that it's really an outpatient procedure.

While some controversy surrounding its efficacy exists, Dr. Glaser says the studies questioning it have some serious flaws and were questioned by many in the specialty. "This procedure is here to stay," he says.

Additionally, payors are often reluctant to cover the procedure based on that research, he says. One key point is to make sure the procedure is used to treat a recent fracture and obtain proof of that to give to insurers. Dr. Glaser says insurers have become very aggressive about denying this procedure unless proof is present of its acuity. ■

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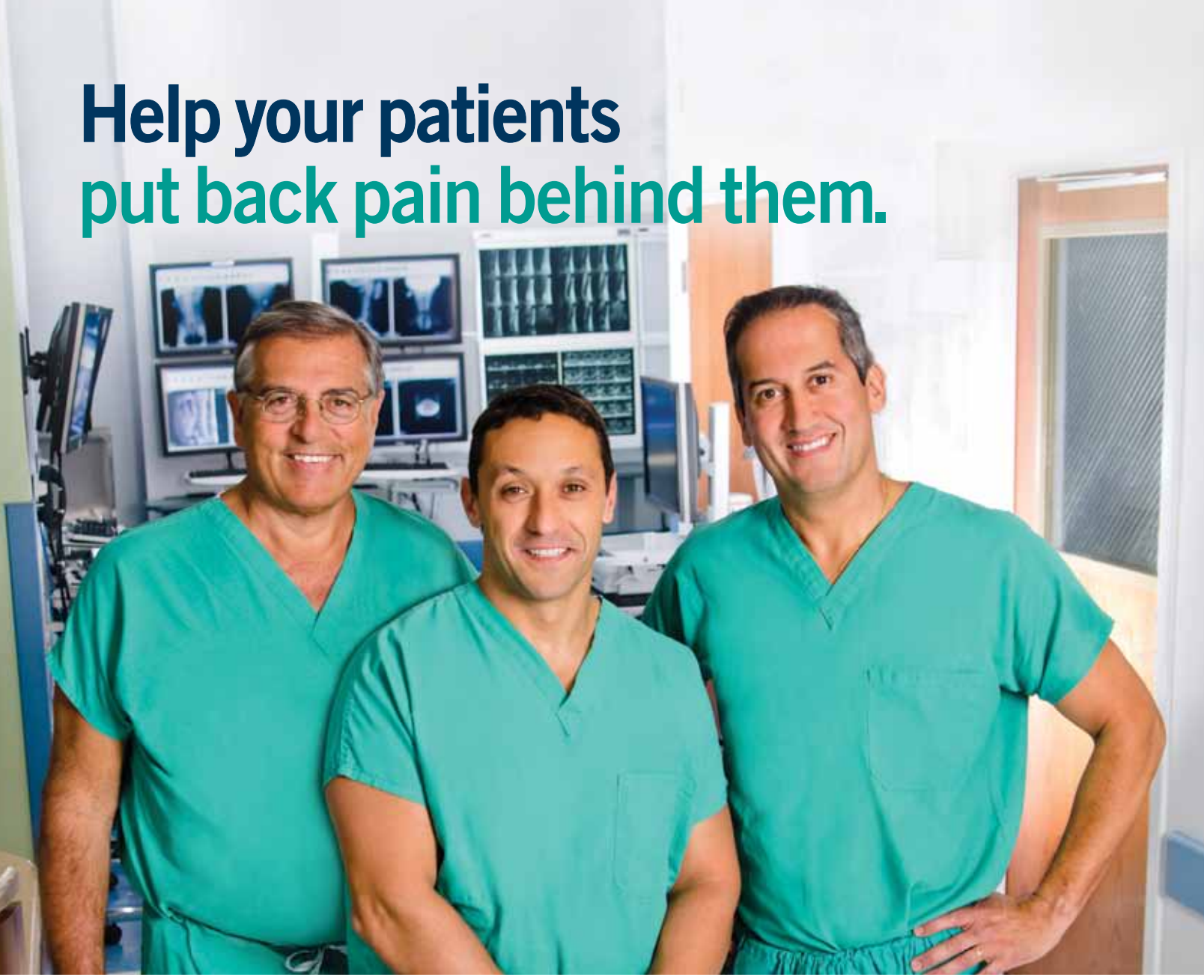

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25 Orthopedic Surgeons on the Move

By Laura Miller

Wallowa Memorial Hospital in Enterprise, Ore., welcomed sports medicine physician **Chad Burgoyne, MD**, who completed a fellowship at West Coast Sports Medicine in Los Angeles.

Midwest Orthopaedics at Rush welcomed **Brian Forsythe, MD**, an orthopedic surgeon and sports medicine specialist who currently serves as team physician for U.S. Soccer.

Daniel Anderson, MD, an orthopedic surgeon with a special interest in sports medicine and joint replacement, joined Mercy Medical Group in Folsom, Calif.

David Gallagher, MD, an orthopedic sports medicine physician, recently joined UHS Medical Group Orthopedics in Birmingham, N.Y. He completed a fellowship at SUNY Downstate in Brooklyn.

Hip and spine surgeon **John A. Gillen II, MD**, joined New Century Orthopedics of Pittsburgh.

Orthopedic sports medicine physician **Lynanne Foster, MD**, became the first female orthopedic surgeon to join Cleveland (Texas) Regional Medical Center.

Sports medicine physician **John H. Judd, MD**, joined Bluff Sports Medicine in Poplar Bluff, Mo.

Atlanta-based Southern Orthopaedic Specialists welcomed **Douglas Kasow, DO**, an orthopedic surgeon focusing on spinal pathology.

Hand surgeon **Kevin Lutsky, MD**, joined Rothman Institute in Philadelphia after previously practicing with Pennsylvania Orthopaedic Center in Paoli.

Houston Orthopedic and Spine Hospital in Bellaire, Texas, welcomed neurosurgeon **Amir Malik, MD**, orthopedic surgeon **Jerry Street, MD**, and spine surgeon **Navin Submaranian, MD**.

John Mahoney, MD, an orthopedic surgeon with an interest in sports medicine, joined Danville (Va.) Regional Medical Center.

Mark L. Mudano, MD, an orthopedic surgeon with a special interest in joint replacements, joined Effingham Hospital in Springfield, Ga., as part of the hospital's efforts to expand orthopedic services.

Phillip Mulieri, MD, an orthopedic surgeon interested in shoulder and elbow surgery, joined Danbury (Conn.) Orthopedics after serving as a visiting professor at Mayo Clinic in Rochester, Minn.

Hand and upper extremity surgeon **Joel B. Nilsson, MD**, joined the Orthopaedic and Spine Institute of San Antonio after spending time as an orthopedic surgeon in the U.S. Army.

Cape Regional Medical Center in Cape May Court House, N.J., welcomed **Ravi K. Ponnappan, MD**, who completed a spine surgery fellowship at the University of Pittsburgh Medical Center.

Elite Healthcare Medical Associations partner **Brad Raphael, MD**, joined staff at Crouse Hospital. He completed a sports medicine fellowship at Kerlan-Jobe Orthopaedic Clinic in Los Angeles.

Chris Reeves, DO, joined the medical staff at North Arkansas Regional Medical Center after finishing a fellowship at Beverly Hills (Calif.) Spine Group.

Sports medicine and orthopedic surgeon **Edward Rhomberg, MD**, joined Sparks Health System in Fort Smith, Ark.

Malo Clinic Health & Wellness in Rutherford, N.J., welcomed orthopedic surgeon **Michael H. Rieber, MD**, who completed a sports medicine fellowship at Penn State University and Hershey (Pa.) Medical Center.

Mark T. Ries, MD, an orthopedic surgeon and past president of the Washington State Orthopedic Association, joined San Gorgonio Memorial Hospital in Benning, Calif.

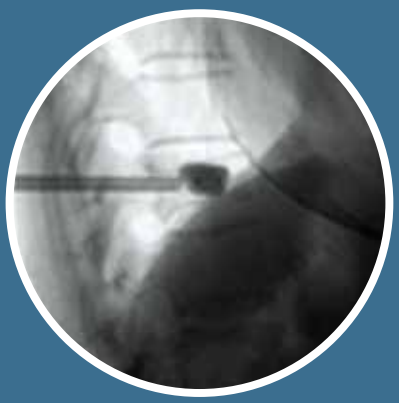
Orthopedic trauma specialist **Sudeep Taksali, MD**, joined Hope Orthopedics in Salem, Ore., after completing a fellowship at the University of Texas-Southwestern.

Richard D. Tombler, MD, former chief of staff at Cronwall Community Hospital, joined Claxton-Hepburn Medical Center in Ogdensburg, N.Y.

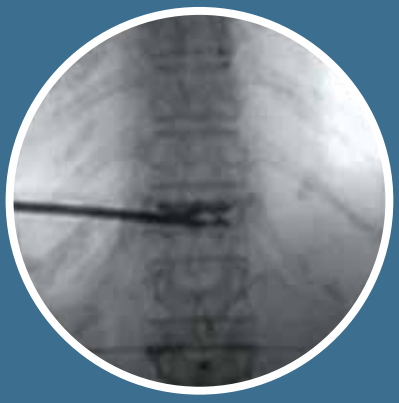
Joseph Scordino, MD, an orthopedic surgeon, joined Pen Bay Orthopaedics in Rockport, Maine.

Advertising Index

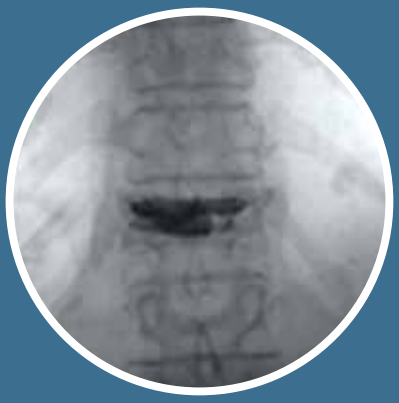
Note: Ad page number(s) given in parentheses



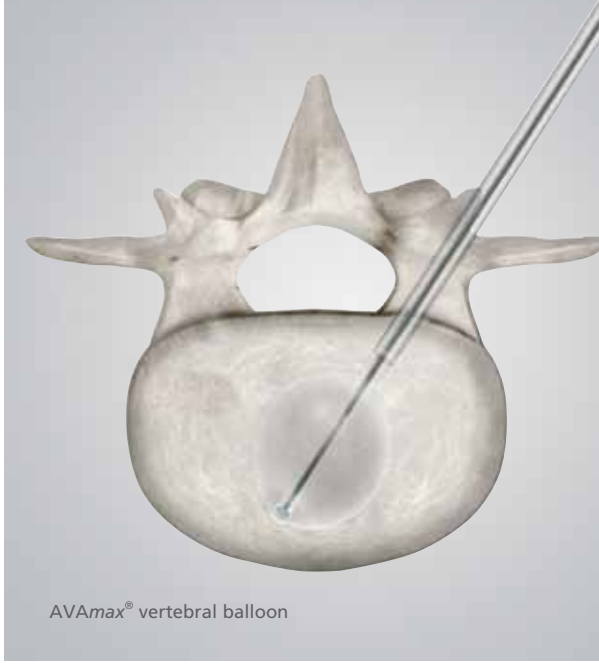
Access with vertebral balloon



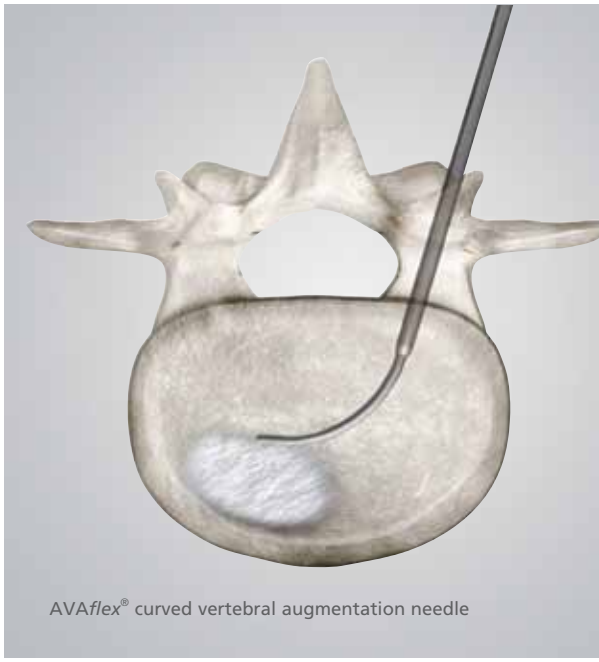
Targeted cement delivery with AVAflex curved needle



Complete fill of superior endplate fracture



AVA*max*® vertebral balloon



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