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July/August 2011 • Vol. 2011 No. 3 Business and Legal Issues for Orthopedics, Spine and Pain Management

**6 Ways Evidence-Based Medicine Impacts Orthopedic and Spine Surgery****By Laura Miller**

The recent focus on evidence-based medicine throughout the medical field has prompted both challenges and opportunities in orthopedics. "I think there will be much more scrutiny in the future of the value of medical interventions," says Daniel Berry, MD, an orthopedic surgeon at Mayo Clinic in Rochester, Minn., and president of the American Academy of Orthopaedic Surgeons. "As orthopedic surgeons, we should welcome the opportunity to evaluate what we do and demonstrate its effectiveness." Orthopedic surgeons from around the country discuss six important issues surrounding evidence-based medicine and how the focus will impact orthopedics in the future.

**continued on page 8****AAOS President Dr. Daniel Berry: 4 Thoughts on the Future****By Laura Miller**

The American Academy of Orthopaedic Surgeons recently named Daniel Berry, MD, chair of the orthopedic surgery department at the Mayo Clinic in Rochester, Minn., as president for 2011. Dr. Berry succeeds John Callaghan, MD, an orthopedic surgeon at the University of Iowa Hospitals and Health Systems in Iowa City. Dr. Berry discusses his goals for the Academy over the next year and how orthopedics is changing in the face of healthcare reform.

**continued on page 10****50 Great Orthopedic Practices to Know****By Laura Miller**

*Orthopedic practices were selected for inclusion on this list based on practice size, services and reputation in their communities. This list was created after substantial research by our editorial staff. Practices do not pay and cannot pay to be included on this list. This list is not an endorsement of any organization's clinical abilities. We are continuously updating this list and if you would like to recommend a practice for future inclusion, please send practice name and information to Laura at [laura@beckersasc.com](mailto:laura@beckersasc.com).*

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**continued on page 19****REGISTER TODAY!****18th Annual Ambulatory Surgery Centers Conference — Improving Profitability and Business and Legal Issues**

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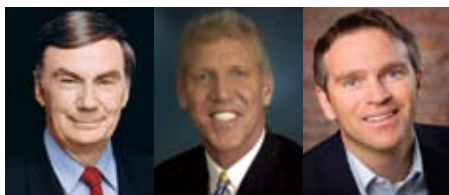
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# Publisher's Letter

## 18th Annual Ambulatory Surgery Centers — Improving Profitability and Business and Legal Issues Conference

### The Best Annual ASC Business, Legal and Clinical Conference

Included in this issue is a brochure for the 18<sup>th</sup> Annual Ambulatory Surgery Centers Improving Profitability and Business and Legal Issues Conference. We have an outstanding agenda this year, including three keynote speakers — Sam Donaldson, Bill Walton and Adrian Gostick. We also have 90 sessions in total featuring 132 speakers. We encourage you to register early. We have kept the price of the main conference the same and have reduced the price for people attending the main and pre conference to encourage people to join the entire conference.

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## 6 Ways Evidence-Based Medicine Impacts Orthopedic and Spine Surgery (continued from page 1)

**1. What evidence-based medicine could contribute.** There are many potential benefits of focusing on evidence-based medicine. High-level studies can help orthopedic surgeons prove their treatments are effective and identify treatments or procedures that aren't. "Some studies will show that the treatments and surgeries are beneficial to the patients and good value for the money spent on them," says Robert Berghoff, MD, an orthopedic surgeon with Arizona Orthopaedic Associates in Phoenix. "There are also some treatments that might not be worth it and we'll have to change them. We'll stop doing the things that don't hold up to scrutiny."

These studies can also aid surgeons in indicating the appropriate treatment for patients depending on their comorbidities. "The data is a big help for recommending treatment protocols when the physician has to make an ambiguous call due to conflicting or multiple diagnoses," says Scott Trenhaile, MD, an orthopedic surgeon at Rockford (Ill.) Orthopaedic. "Surgeons could also use that evidence to better explain to a patient that a treatment may not be completely effective because of their comorbidities. Now we can show them the objective data on patients with similar comorbidities and that helps the patient understand that other health conditions may be part of the problem and could affect the outcome of their treatment."

**2. Impact on technology and device markets.** Orthopedic surgeons are constantly looking for ways to improve technologies and procedures, but these innovations usually come at an increased cost. Many orthopedists are now employing minimally invasive surgical techniques, which often require expensive systems and instrumentation. Some of this innovation may not be cost-effective for the surgeon due to low reimbursement rates or for patients due to lack of evidence supporting the technology's value over other treatment methods or procedures. "It's important we monitor upgrades and improvements for patients to ensure there is meaningful justification for the cost," says Dr. Trenhaile. "We have a responsibility to make sure those dollars are well spent, yet continue to innovate."

Stricter regulations in the FDA approval process mean orthopedic and spine device companies need to conduct extensive studies to prove a new device is equally or more effective than products already on the market. "Just because a product is new doesn't mean it's better," says Dr. Berry.

**3. The trouble with requiring high-level studies.** Empirical evidence and experience might tell a surgeon that a procedure is effective, but the high-level studies don't currently exist to back up some of those claims. High-level evidence studies aren't common in orthopedics because they are expensive and difficult to conduct. "In the past, studies have been published without real strong peer review and analysis of the information," says Eric Berkman, MD, an orthopedic surgeon at Elite Orthopaedics & Spine in Houston. "Evidence-based medicine emphasizes level one studies, which have every bell and whistle to make sure they are done accurately with an emphasis on treatment for the patients. They are prospective, randomized, controlled, double-blinded studies and include objective testing analysis to make sure the study itself was done correctly."

One way these studies are funded is through orthopedic and spine device companies because these companies must conduct research to prove their device belongs on the market. When evaluating the literature, surgeons and other industry professionals also need to consider the study's source. "Even with a good study, you have to see what companies are sponsoring them," says Dr. Berkman. Surgeons should be critical of studies funded by device companies because they could lead to a bias among the surgeons participating in the study if the surgeon has a financial investment.

**4. Insurance companies and evidence-based medicine.** Insurance companies are using published studies to form their coverage guidelines for orthopedic and spine procedures. Many won't cover an MRI or treatment unless there is a level one or level two study proving it's necessary. Often, insurance companies will find studies supporting evidence that leads to a lower cost of care. "Insurance companies can find a study that says only six sessions of physical therapy after a shoulder strain is acceptable while another strong study might say you need 20 sessions," says Dr. Berkman. "It makes the waters a little muddied."

However, he says, surgeons who practice evidence-based medicine stand to save millions of dollars in healthcare spending by performing proven surgeries and treatments on appropriately indicated patients. This is especially true in spine surgery, where more than \$80 billion is spent annually treating back pain and all of the related modalities. Some insurance companies are scrutinizing requests for spine surgery coverage more closely after the number of surgeries performed over the last few years rose dramatically. "I've seen some surgeons who have very loose indications for spine surgery," says Michael Finn, MD, a neurosurgeon in the department of neurosurgery at the University of Colorado. "There's a lot more money to be made from fusions than discectomies. There might be some surgeons that are pushing the level of fusions and that's going to backfire. The payors are questioning everyone's motivation because of a few bad apples."

Insurance companies' approval guidelines run the risk of becoming too restrictive and hindering the patient's access to care, especially if the guidelines are created without physician input. "Surgeons, as experts, really need to be the ones in charge of finding the evidence and making the guidelines," says Dr. Berghoff. "I don't think insurance companies should figure that out for us."

Even when the insurance companies collaborate with physicians for approval criteria, the approving physician may not be an orthopedic or spine surgeon. Sometimes, the surgeon must speak with a physician from the insurance company to receive approval. "We are finding these physicians aren't experienced spine surgeons or orthopedic surgeons, but another type of physician," says Sumeer Sathi, MD, a neurosurgeon with Long

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Island Neurosciences. “They are following protocol and policy to see if the criteria fit for the patients to have surgery. I don’t have a problem with speaking with another physician for approval, but it would be helpful if it were someone who is an experienced spine surgeon who understands the conditions and can render helpful decisions.”

#### 5. Procedural guidelines’ impact on professional practice.

Guidelines set forth by professional organizations examine literature surrounding a specific procedure, such as rotator cuff repair, and devise recommendations for treatment based on the strength of the previously conducted studies, says Dr. Berghoff. Many of the guidelines focus on conducting non-surgical treatment first and using surgery as a last resort in patients without the need for immediate surgical intervention. “Sometimes, the guidelines from one society conflict with what another group has come up with,” he says. “Going forward, analysis of the evidence that is out there is going to be very helpful to justify the treatment of what we are doing.”

However, in some cases, the focus on non-surgical treatment could drain resources when it’s obvious in the patient’s individual case that surgery is necessary. “It can really slow down the process because it doesn’t allow patients to get surgery in a timely manner if it’s appropriate,” says Dr. Berkman. “If a patient has suffered a bad rotator cuff tear, they can’t work or function normally. The costs are sometimes higher if the patient goes through six weeks of physical therapy and injections and then goes on to surgery when it was evident they would need surgery in the first place.”

**6. What the future holds.** As the industry intensifies its demands for evidence-based medicine, orthopedic and spine surgeons will most likely be driven to conduct research in areas that are lacking evidence. “We’re going to have to come up with a little better evidence and a little better rationale if we want to keep getting paid for what we do,” says Dr. Finn. Electronic medical record implementation and the creation of a total joint replacement registry in the United States will make a large amount of data available for surgeons and researchers to evaluate patient outcomes. “I think orthopedics will be one of the more effective places to put resources,” says Dr. Berry. “We’re able to keep people active and healthy enough to continue to work and lead productive lives independently.”

However, some surgeons have patients who fall outside of the guidelines or evidence-based research and they may worry about malpractice suits because of the patient’s situation, says Dr. Berghoff. This level of worry already happens in some fields, such as pulmonary embolism, where conflicting studies and guidelines exist. “As knowledge improves and we learn more about the field, these types of conflicts will likely go away,” he says.

The assessment of a successful treatment could also change, as the evidence-based research is more focused on the patient’s perception of their outcome. Instead of examining MRIs or the surgeon’s assessment, the research will focus on the patient’s quality of life and his or her ability to manage daily activities, says Dr. Berghoff. ■

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**AAOS President Dr. Daniel Berry: 4 Thoughts on the Future**  
(continued from page 1)

**1. Goals for next year.** Over the past several years, AAOS leadership has worked on the continuation of long-term goals sustained from one president to the next, and this year will be no different. “Last year, Dr. Callaghan did a lot with furthering efforts in musculoskeletal quality care and we’ll work hard on continuing that this year,” said Dr. Berry. As part of the quality improvement efforts, the Academy will continue examining and setting forth appropriate clinical use guidelines. In 2010, the Academy produced guidelines on several procedures, including vertebroplasty and rotator cuff repair. The guidelines are based on strong clinical evidence and reviewed by medical professionals as well as AAOS leadership before the organization publishes them.

Dr. Berry also plans to lead the organization in examining communication and education efforts. “As technology changes rapidly, there are suddenly many ways we can help members learn,” says Dr. Berry. “This includes using new technologies to make orthopaedic education more accessible and more effective.”

**2. Promoting and expanding OrthoPortal.** AAOS created and recently launched OrthoPortal, a website that is intended to serve as a single access point for orthopedic surgeons and patients to access information about musculoskeletal care. “It’s an easy and simple place for people to gather information,” says Dr. Berry. “Whereas people used to have to fight to find information from several different sources, now they can go to one place and find the information and links they need. We think it can be a nice resource tool and we are working with professional journals so we can provide linked content for users who have access to those journals.”

**3. Healthcare reform challenges surgeons are facing.** Orthopedic surgeons, along with all other medical professionals, face several challenges as healthcare reform progresses. The legislation is still in the early forms of implementation and parts of it are still being written, which means even understanding the legislation can be challenging. “It will be important for people to stay tuned and understand what those rules have to say,” says Dr. Berry. “There are a lot of unknowns and people have to sort out how they will run their practices and their lives. It’s challenging to plan for the future when there are so many unknowns.”

**4. Evidence-based medicine in orthopedics.** Orthopedics has always been a fast-moving specialty with constant technological advances. However, a new focus on lowering the cost of healthcare emphasizes practicing evidence-based medicine, which means payors are asking for strong studies that prove a new procedure or technology is effective. “Just because a device or procedure is new doesn’t mean it’s better,” says Dr. Berry. “The Academy has been examining high-level studies to demonstrate what works most effectively. If we find something that isn’t so effective, we have to let people know that too.”

The high-level studies necessary for the Academy and other organizations to use when developing clinical guidelines are difficult and expensive to produce. However, this level of examination is important for orthopedic surgeons to prove which operative and non-operative treatments produce the best outcomes and are the most cost effective. “In orthopedics, we have a lot of outstanding treatments that have been proven to be highly cost effective, for example, hip and knee replacements,” says Dr. Berry. “Some treatments are more cost effective than others. As new methods develop, we’ll learn which are the most effective for patients and which are the most cost effective.” ■



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# 9 Points for Orthopedic and Spine Surgeons on Forming Positive Relationships With Hospitals

By Laura Miller

If you want to become part of the overall continuum of care in your community, forming a partnership or aligning with a hospital may be in your future, if it hasn't occurred already. Here, orthopedic and spine surgeons and industry professionals discuss what it takes to form a positive relationship with hospital executives.

## 1. Become a part of a larger group for leverage.

If you are a single physician or part of a small physician group, consider partnering or merging with a larger group to gain increased access to relationships with hospitals. "If you're a significant enough presence in the community and you have a skill set the hospital needs, it makes sense for you to get together," says Steve Fiore, CEO for Orthopedic Specialty Group, PC, in Fairfield, Conn. "It's often hard for small practices to have that leverage." Large groups in the community can be seen as competition for the hospital, and hospitals often are more motivated to work with those groups as partners instead of adversaries.

## 2. Know what is possible out of hospital agreements.

When selecting a hospital for an exclusive partnership, orthopedic surgeons and practices want to understand the financial and practice benefits they might realize from the exclusive relationship. Hospitals are limited in the ways they can compensate private practice surgeons. Sometimes a leadership or administrative role is available, but this is not always the case. "In considering which hospital to go to, surgeons want the administration to make a meaningful investment in the relationship," says George Rappard, MD, founder and director of the Los Angeles Brain and Spine Institute at Hollywood Presbyterian Medical Center in Los Angeles. "There are a variety of ways a hospital can work with physicians including developing facilities, equipment and staff to make the surgeons work in the hospital go more smoothly while providing excellent care to the patient. There may also be options for call coverage if the hospital is a trauma facility." It is important to note that hospitals and physicians should be careful to ensure any compensation relationships do not exceed fair market value.

Hospitals and physician groups might also enter into recruiting agreements. Under these agreements, hospitals provide a guaranteed salary to the new physician brought into the group.

**3. Appoint a contact representative to manage communications.** Individual orthopedic surgeons need to focus on their

medical practice, which means they don't need to be involved in every correspondence about the partnership between their group and the hospital. Larger groups often appoint a physician or practice administrator to coordinate with the hospital's administration. "To have someone who can be managing the process in terms of communications is going to be important," says Randy Shulkin, a consultant with Culbert Healthcare Solutions. "Having a representative of the physicians there who is visible is important to keeping these relationships on track." While communications might funnel through one person, that person can also bring in other physicians for meetings or other correspondence when necessary.

## 4. Approach the hospital as your customer.

Orthopedic surgeons are accustomed to hospitals looking at them for support, says Rick Wilfong of Rick Wilfong Consulting, but surgeons need to start looking at hospitals as customers as well. "Too often with physicians, it's more about 'what can you do to help me earn money,' and it needs to be 'here is what I can offer you,'" he says. "Surgeons need to be able to talk to hospital executives about what type of cases they have, case volume and their payor mix.

It shows the hospital that these surgeons are taking the partnership seriously." Hospital executives will be interested in knowing your practice metrics, such as cost for doing each procedure, recidivism rate and other quality indicators before entering into a committed partnership with you or your practice.

## 5. Steer clear of adversarial comments.

Partnerships between orthopedic surgeons and hospitals should be friendly, even in times of stressful negotiations. "Adversarial comments never help," says Neel Anand, MD, director of orthopedic spine surgery for the Spine Center at Cedars-Sinai Medical Center in Los Angeles. "There's no point in being adversarial with the hospital executives. At the end of the day, it has to be a compromise where you try to help each other understand what you are doing." One-on-one conversations instead of e-mails can help foster an open relationship that can work well for both parties.

## 6. Don't try to change the system over night.

Hospitals are racked with bureaucracy, and even the most optimistic orthopedic surgeons aren't going to immediately change the system through an alignment or joint venture. "A lot of surgeons believe you can implement

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changes quickly and hospitals should do something differently beginning tomorrow. The surgeon has to know the system and work through it," says Dr. Anand. Throughout these meetings and negotiations, it is particularly important that orthopedic surgeons help administrators understand their point-of-view through the lens of financial gain because most administrators don't have a medical background and may not understand medical implications driving a decision.

**7. Foster a good relationship with medical staff.** Respecting the entire medical staff is essential to forming a good relationship with hospital executives, especially if you are new to the team. Current medical staff is often concerned about competition for patients or operating room time, and you have to make sure you step in line with community values and seniority. "The most important thing is to be able to influence the medical staff so the administration's support for you is mirrored by the medical staff's support," says Dr. Rappard. "A hospital can form an agreement for a directorship, recruit the new surgeon, market the surgeon and if the medical staff is against him, his ability to succeed is going to be limited by his ability to suffer."

**8. Be faithful with exclusive relationships.** Trust is important in any relationship, including those between orthopedic surgeons and hospital administrators. "A hospital cannot maintain its sense of integrity with a physician if they have an agreement one day and then recruit the surgeon's competition the next," says Dr. Rappard. "On the same token, the physician's integrity could suffer if they have two agreements with different facilities. There's nothing wrong with competition, but when you try to foster a special relationship, there has to be a sense of exclusivity."

**9. Consider bringing in a third party.** An impartial third party can bridge the gap between orthopedic surgeons and hospitals. In the event of an existing adversarial relationship, the third party can help the other

two peaceably collaborate. The third party can smooth out technical differences between the hospital and orthopedists, such as cross pollinating the two billing process. The use of electronic medical records between the groups can also cause problems. Orthopedic Specialty Group and their hospital partner use two different electronic medical record systems, which are incompatible with each other. Culbert Healthcare Solutions helps bring the two together. "They come from a background with expertise in both systems," says Mr. Fiore. "Those of us in the practice management world have to recognize we don't have all the answers. Our job is to find the subject matter experts who can make the collaboration happen." ■



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## PROGRAM SCHEDULE

### Pre Conference – Thursday October 27, 2011

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

### Main Conference – Friday October 28, 2011

7:00am – 8:00am	Continental Breakfast and Registration
8:00am – 5:05pm	Main conference, Including Lunch and Exhibit Hall Breaks
5:05pm – 6:30pm	Reception, Cash Raffles, Exhibit Hall

### Conference – Saturday October 29, 2011

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

### Thursday, October 27, 2011

1:00 – 1:40 pm

#### A. Key Concepts to Fixing Physician Hospital Joint Ventures Gone South

Brent W. Lambert, MD, FACS, Principal & Founder, and Luke Lambert, CFA, CASC, CEO, ASCOA

#### B. Business Planning for Orthopedic and Spine Driven Centers

Jeff Leland, CEO, Blue Chip Surgical Center Partners

#### C. Benchmarking for GI Centers

Barry Tanner, President & CEO, John Poisson, EVP, New Business Development, and Karen Sablyak, CPA, EVP Management Services, Physicians Endoscopy

#### D. How Do You Value Your ASC For Sale? What is the Value in a Majority Sale Transaction? Can Hospitals Pay More if They can Convert to an HOPD or Apply Managed Care Contracts? What is the Value in a Sale of a Small Percentage to a Physician?

Jon O'Sullivan, Senior Partner, and Greg Koonsman, Senior Partner, VMG Health

#### E. Managed Care Negotiation Strategies - Using Transparency and Case Data to Show Payers How ASCs Save Them Money

I. Naya Kehayes, MPH, CEO & Managing Principal, and Matt Kilton, MBA, MHA, Principal and Chief Operating Officer, EVEIA HEALTH Consulting and Management

#### F. Infection Control in ASCs - Best Practices and Current Ideas

Phenelle Segal, RN, CIC, President, Infection Control Consulting Services, LLC

1:45 – 2:25 pm

#### A. Cost Reduction and Benchmarking - 10 Key Steps to Immediately Improve Profits

Rob Westergard, CPA, CFO, Susan Kizirian, COO, and Ann Geier, RN, MS, CNOR, CASC, Vice President of Operations, ASCOA

#### B. Developing a Spine Driven ASC: the Essentials for Success

Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners

#### C. Ophthalmology, ENT and Podiatry in ASCs - Key Thoughts and Trends

Jeff Peo, Vice President, Development & Acquisitions, ASCOA

#### D. Should You Sell Your ASC? - 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, ASCOA. Introduced by Scott Downing, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods, LLP

#### E. Should You Outsource Billing and Collections or Keep It in House?

Caryl Serbin, RN, BSN, LHRM, Executive Vice President and Chief Strategy Officer, Source-Medical Solutions, Revenue Cycle Solutions

#### F. Effective Clinical Benchmarking and Infection Control

Regina Robinson, Director, Peninsula Surgery Center

2:30 – 3:05 pm

#### A. 10 Statistics Your ASC Should Review Each Day, Week, and Month and What to do About Them

Reed Martin, Chief Operating Officer, Surgical Management Professionals

#### B. What Percentage of Key ASC Specialties Will be Employed by Hospitals Within 5 Years - Orthopedics, GI and Ophthalmology

Brian Mathis, Vice President, Strategy, Surgical Care Affiliates, Mike Lipomi, CEO, Surgical Management Professionals, Jimmy St. Louis, III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners, and moderated by Amber McGraw Walsh, Partner, McGuire-Woods LLP

#### C. Ophthalmology in ASCs - Current Trends and Issues

Michael A. Romansky, JD, Washington Counsel, VP for Corporate Development, Outpatient Ophthalmic Surgery Society

#### D. Physician-Hospital Joint Ventures - How to Resolve Conflict and Keep the Venture Thriving

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Dawn McLane, Regional VP, Health Inventures,  
and Tom Yerden, CEO, TRY Healthcare Solutions

### **E. Being a Great Administrator - Core Concepts to Develop Raving Physician Fans**

Joe Zasa, JD, Managing Partner, ASD Management, and Stephanie Stinson, RN, BSN, CASC, Administrative Director, Strictly Pediatrics Surgery Center

### **F. How to Determine When To Go In-Network vs. Out-Of-Network**

Rob Murphy, President, Murphy Healthcare Group

3:10 – 3:50 pm

### **A. Assessing the Future Demand for ASCs, A Panel Discussion**

Barry Tanner, President & CEO, Physicians Endoscopy, Brian Mathis, Vice President Strategy, Surgical Care Affiliates, and Vivek Taparia, Director of Business Development, Regent Surgical Health

### **B. Impact of Healthcare Reform on Physician Practices and ASCs**

Charles “Chuck” Peck, MD, CEO, Health Inventures

### **C. Key Thoughts From Great Medical Directors - Managing Expenses and Managing Physicians**

Alfred McNair, MD, Steve Schuelman, MD, and moderated by Nap Gary, Chief Operating Officer, Regent Surgical Health

### **D. Anti-Kickback and Stark Act Compliance - Common Issues for ASCs**

Scott Becker, JD, CPA, Partner, Melissa Szabad, JD, Partner, and Lainey Gilmer, Associate, McGuireWoods LLP

### **E. What Can Be Paid for Co-Management? Should You Enter Into a Co-Management Relationship? Co-Management Arrangements Valuation and Other Issues**

Jen Johnson, CFA, Managing Director, VMG Health

### **F. Meaningful Use, EMR and Other Key IT Issues for ASCs**

Marion K. Jenkins, PhD, FHIMSS, Founder, CEO, QSE Technologies, Scott Palmer, President & COO, Ambulatory Surgery Center Division, SourceMedical Solutions, Jeff Blankinship, President & CEO, Surgical Notes, Faris Zureikat, Administrator, North Texas Surgery Center, USPI, Holly Carnell, Associate, McGuireWoods LLP

3:55 – 4:30 pm

### **A. Orthopedics and Spine - Physician Payor Relationships and Evolving Changes**

John Cherf, MD, MPH, MBA, President, OrthoIndex, Steven H. Stern, MD, MBA, Vice President, Cardiac & Orthopaedics/Neuroscience, and Michael R. Redler, MD, The OSM Center, moderated By Scott Becker, JD, CPA, Partner, McGuireWoods LLP

### **B. Private Equity's Role in and View of the ASC Market**

Joe Clark, EVP & Chief Development Officer, Surgical Care Affiliates, David F. Bacon, Jr., CEO, Meridian Surgical Partners, Geoffrey C. Cockrell, Partner, McGuireWoods LLP

### **C. Revenue Capture for Endoscopy Centers - Best Practices and Great Ideas**

Linda K. Peterson, CEO, Executive Solutions for Healthcare

### **D. ASC Litigation - Can Non-Competes be Enforced? What to Do When the FBI or OIG Calls? How to Work with Payors**

Jeffrey C. Clark, Partner, and David J. Pivnick, JD, BBA, Associate, McGuireWoods LLP

### **E. What is Great and What is not Great Physician Leadership for Your ASC**

Brad Lerner, MD, Summit ASC

### **F. Evaluating the Return on Investment: Outsourcing Key Business Office Operations**

Kim Woodruff, Vice President Corporate Finance & Compliance, PINNACLE III

4:30 – 5:30 pm

### **Climbing Up the Mountain - One More Time**

Bill Walton, Former ABC, ESPN, NBC Basketball Announcer, Hall of Fame NBA Basketball Player

5:30 – 7:00,

Networking Reception, Raffles and Exhibits

## **Friday, October 28, 2011**

8:00 am

### **Introductions**

Scott Becker, JD, CPA, Partner, McGuireWoods, LLP

8:10 – 8:45 am - KEYNOTE

### **The View from Washington: Politics, Healthcare Reform and the 2012 Election**

Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

8:50 – 9:30 am – General Session

### **ASCs, Healthcare and Washington DC**

Brent W. Lambert, MD, FACS, Principal & Founder, ASCOA, Tom Mallon, CEO Regent Surgical Health, Michael E. Russell, II, MD, President, Physician Hospitals of America, Texas Spine and Joint Hospital, Tom Price, MD, U.S. Congressman, Moderated by Sam Donaldson, ABC News Veteran and former Chief White House correspondent for ABC News

9:35 – 10:20 am - KEYNOTE

### **A. KEYNOTE - How the Best Managers use Recognition to Accelerate Performance**

Adrian Gostick, Author and Global Thought Leader on Workplace Strategy

### **B. The ASC Association Legislative Priorities - and What We Will See for the Next Five Years**

William Prentice, JD, Executive Director, and Steve Miller, Director of Government and Public Affairs, Ambulatory Surgery Center Association

### **C. How to Evaluate & Implement New Profitable Services into an ASC**

Robert Zasa, MSHHA FACMPE, Founder, ASD Management, and Kenneth Austin, MD, Orthopedic Surgeon, Rockland Orthopedics and Sports Medicine

### **D. ACOs in Action**

11:25 – 12:10 pm

### **A. The State of the Unions for ASCs**

Andrew Hayek, President & CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee

### **B. Interventional Pain Management - What the Next Few Years Will Look Like**

Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians

### **C. Hospital and Physician Alignment in the Wake of Healthcare Reform - The Expectations for the Next Five Years**

Kate Lovrien, Senior Manager, Kurt Salmon and Associates

### **D. What are the Key Issues Facing Great ASC Administrators**

Kara Vittetoe, Administrator, Thomas Johnson Surgery Center, Tracey Hood, Administrator, Ohio Valley Ambulatory Surgery Center, Brooke Smith, Administrator, Maryland Surgery Center for Women, and moderated by Susan Kizirian, COO, ASCOA

12:15 – 1:00 pm

### **A. Developing a Strategy for Your ASC**

Kenny Hancock, President & Chief Development Officer, Meridian Surgical Partners, Mike Doyle, CEO, Surgery Partners, Richard E. Francis, Chairman & CEO, Symbion, Inc.

### **B. Endoscopy Centers - Key Trends and Issues**

Barry Tanner, CEO, Physicians Endoscopy

### **C. Orthopedics and Spine in ASCs - Key Trends and Ideas**

John D. Atwater, MD, Steven Hochschuler, MD, Texas Back Institute, Moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners

### **D. Anesthesia in ASCs**

David Shapiro, MD, CHC, CHCQM, CHPRM, LHRM, CASC, Partner, Ambulatory Surgery Company, LLC

### **E. Accreditation 101, Everything You Need to Know About Accreditation**

Bernard McDonnell, DO, Healthcare Facilities Accreditation Program

1:00 – 2:00 pm

Networking Lunch & Exhibits

2:00 – 2:40 pm

### **A. The Best Ideas to Improve Volume and Profits**

Bryan Zowin, President, Physician Advantage, Inc., John C. Steinmann, MD, Renovis Surgical Technologies, Robin Fowler, MD, Executive Director and Owner, Interventional Management Services, and Keith Metz, MD

### **B. ASC Turnaround Case Study, From Zero to Wow!**

Joseph Zasa, JD, Managing Partner, ASD Management, and Daniel C. “Skip” Daube, Jr., MD, FACS, Founder, Surgical Center for Excellence, Panama City

### **C. Is There Still Room for Joint Venture ASCs in the Physician-Hospital Integration Tool Kit - The Pros and Cons to ASCs**

Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, and Brandon Frazier, Vice President Development & Acquisitions, Ambulatory Surgical Centers of America

### **D. Should You Sell Your Practice to a Hospital? What Will the Agreement Look Like? What are the Key Issues?**

Kristin A. Werling, Partner, Geoffrey C. Cockrell, Partner, and Gretchen Heinze Townshend, Associate, McGuireWoods LLP

2:00 – 3:25 pm

**E. Managed Care Contracting - 1) How Do You Align Your ASC with Physicians 2) Update on CMS Payment System and How it Impacts on Negotiations 3) Fee Schedule Numbers and Ensuring Revenue Collection from Contracts**

I. Naya Kehayes, MHP, Managing Partner & CEO, and Matt Kilton, Principal and COO, Eveia Health Consulting and Management

2:00 – 2:40 pm

**F. CMS Inspections Surveys; Are You Ready?**

Tracy Hoeft-Hoffman, Administrator, Hastings Surgery Center

2:45 – 3:25 pm

**A. The Best Ideas for Physician-Hospital Alignment**

Allan Fine, Senior Vice President, Chief Strategy and Operations Officer, The New York Eye & Ear Infirmary, Charles “Chuck” Peck, CEO, Health Inventures, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals, Robert Boeglin, MD, President, IU Health Management, and moderated by Scott Becker, JD, CPA, Partner, McGuireWoods LLP

**B. Surgeon Hospital Partnerships Models**

Jeff Simmons, Chief Development Officer, and Bo Hjorth, Vice President, Business Development, Regent Surgical Health

**C. Developing an Outstanding ASC Quality Program That Can be Implemented and Makes a Difference**

Linda Lansing, Senior Vice President of Clinical Services, Surgical Care Affiliates

**D. Physician-Owned ASCs and Hospitals - The Best Strategies for the Next Five Years**

Michael J. Lipomi, MSHA, President & Chief Executive Officer, Surgical Management Professionals

**F. Governing Body Documentation, Meeting CMS and Accreditation Requirements**

Sandra Jones, FHFMA, LHRM, CASC, Ambulatory Strategies, Inc.

4:00 – 4:30 pm

**A. Extreme Makeover: Surgery Center Edition - Lessons Learned From a Dozen Turnaround Projects**

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

**B. Ophthalmology in ASCs, Key Issues**

Edward Glinski, DO, Healthcare Facilities Accreditation Program

**C. Endoscopy Centers - Taking Steps to Prepare an Endoscopy Center for Sale - How to Maximize Your Transaction**

Jonathan Vick, President, ASCs, Inc.

**D. Helping Large Specialty Physician Groups Navigate the Next Few Years**

Marc Steen, Market President, USPI

**E. Business and Financial Relationships with Hospitals - Co-Management, Joint Ventures and Employment - Key Valuation Issues**

Todd J. Mello, ASA, AVA, MBA, Principal & Founder, HealthCare Appraisers, Inc.

**F. Direct Marketing to Patients to Increase Case Volume**

Jimmy St. Louis III, MBA, Chief Corporate Operations Officer, Laser Spine Institute and CEO, Advanced Healthcare Partners

4:35 – 5:05 pm

**A. Q&A Panel: Will Evidence Based Medicine Kill Spine? Will Practice Acquisitions by Hospitals Kill ASCs? Should ASCs Employ Physicians? Where are the Profits in Pain Management?**

Terry L. Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital, Thomas J. Pluira, MD, JD, PC, Physician & Attorney at Law, zChart, R. Blake Curd, MD, Board Chairman, Surgical Management Professionals

**B. Physician-Owned Distribution Companies - Doing It The Right Way**

John C. Steinmann, MD, Renovis Surgical Technologies

**C. Urology Issues for ASCs**

Herbert W. Riemenschneider, MD, Riverside Urology, Inc.

**D. Trends in Buying and Selling ASCs: Mergers and Acquisitions of Surgery Centers**

Patrick Richter, Vice President Business Development USPI, Blayne Rush, President, Ambulatory Alliances, Michael Weaver, VP Acquisitions & Development, Symbion, Inc.

**E. Key Compliance Risks in ASC Billing**

Bill Gilbert, Vice President, AdvantEdge Healthcare, and Bruce Voecetet

**F. The Most Common Medical Staff Issues and How to Handle Them**

Thomas J. Stallings, Partner, McGuireWoods LLP

**Roundtable Discussions**

2:00 - 2:40 pm

**Physician-Owned Ancillaries - Device Companies, Anesthesia, Pathology and Pharmacy and More**

Steven Hochschuler, MD, Texas Back Institute, Richard Kube, MD, CEO, Founder & Owner, Prairie Spine and Pain Institute, John C. Steinmann, MD, Renovis Surgical Technologies

2:45 - 3:25 pm

**Capital Markets Update - Key Thoughts from Lead Investment Strategists/Managers**

Gregory D. Miller, Senior Investment Advisor, and Beata Kirr, Senior Portfolio Manager, Sanford C. Bernstein & Co., LLC

4:00 - 4:30 pm

**Metrics and Improving Performance**

John Seitz, CEO, Ambulatory Surgical Group

4:35 - 5:05 pm

**Are We Profitable? Driving ASC Performance Through Effective Financial Management**

Rajiv Chopra, Principal & Chief Financial Officer, The C/N Group

5:05 – 6:30 pm

Networking Reception, Raffles and Exhibits

**Saturday, October 29, 2011**

8:15 – 9:00 am

**A. The 5 Best and Worst Specialties for ASCs - An Outlook for the Next Five Years**

Larry Taylor, CEO, Practice Partners in Health-Care

**B. Improving Revenue Capture: Best Practices in Coding, Documentation and Charge Capture**

Rosalind Richmond, Coding Compliance Officer, and Yvonda Moore, Director of Implementation, GENASCIS

9:05 – 9:45 am

**A. The Role of the Medical Director and Physician Leaders in ASCs**

John Byers, MD, Medical Director, Surgical Center of Greensboro, Orthopaedic Surgical Center

**B. Optimizing Business Office Performance**

Paul Davis, CPA, CMA, Amblitel

**C. Infection Prevention in ASCs: Looking Ahead - What Does the Future Hold**

Marilyn Hanchett, RN, CIC, Senior Director, Clinical Innovation, APIC

**D. What Should Great Medical Directors, Administrators and DONs be Paid?**

Moderated by Rachel Fields, Managing Editor of Becker's ASC Review, ASC Communications, Inc.

9:50 – 10:30 am

**A. The Best and Worst Procedures for ASCs and What an ASC Should Get Paid**

Matt Lau, Director of Financial Analysis, Mike Orseno, Revenue Cycle Director, and Vivek Taparia, Director of Business Development, Regent Surgical Health

**B. Determining the Exact Cost of a Procedure**

Terry Woodbeck, CEO, FAHC, Tulsa Spine & Specialty Hospital

**C. Infection Prevention and the CMS Infection Prevention Mandate for ASCs: Key Strategies to Enhance Performance**

LoAnn Vande Leest, RN, MBA-H, CNOR, Chief Executive Officer, and Fawn Esser-Lipp, The Surgery Center, LLC

**D. How to Improve Coding for ASC Procedures - A Discussion of Orthopedic, GI and Ophthalmology Procedures**

Stephanie Ellis, RN, CPC, President, Ellis Medical Consulting

**E. The Future Is Now, Preparing You and Your Practice for a Changing Environment**

Pedro Vergne-Marini, MD, Founder and Managing Member, Physicians' Capital Investments

10:35 – 11:15 am

**A. 3 Core Orthopedic and Practice Group Initiatives - Hospitals and Ancillaries Service Line Management Agreements and Becoming Leaner**

John Martin, CEO, OrthoIndy

**B. Examining Every Aspect of the Supply Chain to Develop Great Cost Savings**

Scott Benglen, CEO, Via Novus Medical, LLC

**C. Infection Control**

Dotty Bollinger, RN, JD, LHRM, CHC, CASC, Chief Medical Operations Officer, Laser Spine Institute

**D. Cataract Surgery for the Revenue Cycle**

Bill Phillips, FACMS, CHC, Adjunct Professor, Healthcare Fiannc Health Service Management & Leadership

**E. Advanced Benchmarking of Financial and Clinical Results**

John Goehle, CASC, MBA, CPA, Ambulatory Healthcare Strategies, LLC

11:20 – 12:20 pm

**Key Legal Issues and Legal Compliance Boot Camp - The Core Elements of a Successful Compliance Plan**

Scott Becker, JD, CPA, Partner, Lainey Gilmer, Associate, and Amber McGraw Walsh, Partner, McGuireWoods LLP



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**Sam Donaldson**

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- Adrian Gostick, Author and Global Thought Leader on Workplace Strategy
- William Prentice, Executive Director, ASC Association
- Michael A. Romansky, JD, Washington Counsel, VP for Corporate Development, Outpatient Ophthalmic Surgery Society
- John Cherf, MD, President, OrthoIndex
- Robert Boeglin, MD, President, IU Health Management
- Brad Lerner, MD, Summit ASC
- Michael E. Russell, II, MD, President, Physician Hospitals of America, Texas Spine and Joint Hospital
- Michael R. Redler, MD, The OSM Center
- Laxmaiah Manchikanti, MD, CEO & Chairman of the Board, American Society of Interventional Pain Physicians
- David E. "Buddy" Bacon, Jr., CEO, Meridian Surgical Partners
- Andrew Hayek, President & CEO, Surgical Care Affiliates and Chairman of the ASC Advocacy Committee



**Adrian Gostick**



**Bill Walton**

- Bill Walton, Former ABC, ESPN, NBC Basketball Announcer, Hall of Fame NBA Basketball Player
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- Brent W. Lambert, MD, Principal and Founder, ASCOA
- R. Blake Curd, MD, Board Chairman, Surgical Management Professionals
- Caryl Serbin, RN, BSN, LHRN, EVP and Chief Strategy Officer, SourceMedical Solutions Revenue Cycle Solutions
- John Byers, MD, Medical Director, Surgical Center of Greensboro Orthopaedic Surgical Center
- Daniel C. "Skip" Daube, Jr, MD, Founder, Surgical Center for Excellence, Panama City
- Jeff Leland, CEO, Blue Chip Surgical Center Partners
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## 50 Great Orthopedic Practices to Know (continued from page 1)

### Alexander Orthopaedic Associates

(Largo, Fla.). Founder Vladimir Alexander, MD, is the inventor and developer of the LATKA system, a laser-assisted tool for knee arthroplasty. The practice also includes physicians who subspecialize in hand and upper extremity surgery and sports medicine.

### Anderson Orthopaedic Clinic (Arlington, Va.)

Founded more than 50 years ago, the Anderson Orthopaedic Clinic includes joint replacement, arthroscopic surgery, sports medicine, extremities and spine care. The physicians' research has led to the development of porous-coated, cementless hip implants, as well as orthopedic techniques and procedures.

### Andrews Sports Medicine and Orthopaedic Center (Birmingham, Ala.)

The practice was founded by James Andrews, MD, more than two decades ago and has served numerous professional athletes since then. Practice physicians currently work regularly for the Washington Redskins and Tampa Bay Rays. In addition to joint replacement and reconstruction, physicians also focus on extremities care, back and neck surgery and shoulder care.

### Ashland Orthopedic Associates (Ashland, Ore.)

Established in 1977 by John Maurer, MD, Ashland Orthopedic Associates includes several board-certified orthopedic surgeons who subspecialize in bone, joint, soft tissue and other musculoskeletal disorders. The surgeons focus on performing minimally invasive and arthroscopic procedures when necessary.

### Arizona Orthopaedic Associates (Phoenix)

Physicians of Arizona Orthopaedic Associates treat patients with all types of orthopedic conditions and injuries. The practice also offers a physical therapy department where specialists design a program to meet each patient's needs, whether it is therapeutic exercise, myofascial release, spine mobilization or tissue and joint mobilization.

### Aurora BayCare Orthopedic & Sports Medicine (Green Bay, Wis.)

Aurora BayCare Orthopedic and Sports Medicine includes sports medicine, knee, shoulder and extremities care, as well as the Green Bay Hand Center BayCare Clinic. Radiologists are also members of the practice, specializing in diagnostic services.

### Azalea Orthopaedics (Tyler, Texas)

Physicians at Azalea Orthopaedics subspecialize in several areas, including sports medicine, foot and ankle, spine, hand and elbow care. Additional services include physical medicine, rehabilitation and bone health. The practice also includes an Osteoporosis Clinic, and specialists also work on preventing fractures among older adults.

### Beacon Orthopaedic & Sports Medicine (Sharonville, Ohio)

Physicians at Beacon have a wide range of expertise, including unicompartmental knee replacement, regenerative and biologic orthopedics and reconstructive orthopedics. Among the four Beacon facilities there are two ASCs, imaging centers including a hologic delphi scanner, physical therapy services and a spine center for non-surgical treatment.

### Booth, Bartolozzi and Balderston Orthopaedics (Philadelphia)

Booth, Bartolozzi and Balderston Orthopaedics (3Bs) include surgeons who are former team physicians for professional athletes and offer minimally invasive and robotic surgery for their patients. In addition to their clinical practice, the physicians are also involved in research regarding advanced cellular transplantation technologies, pain management techniques and gender-specific knee implants.

### Canyon Orthopaedic Surgeons (Avondale, Ariz.)

Physicians at Canyon Orthopaedic Surgeons subspecialize in several different areas, including arthroscopic surgery, fracture management, hip and knee reconstruction, shoulder surgery, total joint replacement and sports medicine. Additionally, the surgeons provide minimally invasive and computer-assisted surgeries to their patients.

### Cincinnati SportsMedicine & Orthopaedic Center (Cincinnati)

Founded more than 30 years ago, the physicians at Cincinnati SportsMedicine & Orthopaedic Center treat patients with conditions of the knee, hip, shoulder, elbow, ankle and foot. Orthopedists in the different subspecialties welcome the opportunity to work with complex cases, and practice physicians are able to use the robotic MAKOpasty system with patients.

### Coastal Orthopaedics (Darien, Conn.)

The practice has four locations around Connecticut and includes acupuncture, imaging services such as digital X-rays, orthopedic bracing and occupational and hand therapy. In addition to sports medicine, physicians also subspecialize in extremities and spine care, providing minimally invasive surgical techniques for appropriate patients.

### Elite Sports Medicine and Orthopaedic Center (Nashville, Tenn.)

Practice physicians have current and previous affiliations as head team physicians for the Tennessee Titans, Nashville Predators and several local universities and colleges. All physicians are fellowship-trained in their subspecialties, which include sports medicine, arthroscopic surgery, shoulder, elbow, foot, hand and spine.

### Hughston Clinic (Columbus, Ga.)

Physicians at Hughston Clinic are committed to research, education, training and treatment of orthopedic and sports medicine injuries and dis-

eases. In addition to clinical offices, the practice includes rehabilitation and diagnostic services at multiple locations. Hughston Clinic's rehabilitation facilities encompass a wide range of exercise and testing equipment to accommodate patients of various orthopedic and sports medicine needs.

### Illinois Bone & Joint Institute (Morton Grove, Ill.)

The physicians and medical professionals at this practice focus on several aspects of orthopedics, including joint replacement, sports medicine, podiatry, rheumatology and pain management. The practice has more than 20 locations around the Chicago area and provides immediate care, diagnostic services, physical therapy and rehabilitation care.

### Jacksonville Orthopaedic Institute (Jacksonville, Fla.)

Physicians at Jacksonville Orthopaedic Institute have an expertise in hand, foot and ankle, joint replacement, spine and sports medicine care. Services include biomechanical analysis, physical and occupational therapy, spine and back education programs and sports and work injury rehabilitation.

### Jewett Orthopaedic Clinic (Winter Park, Fla.)

With its 30,000-square-foot flagship location, Jewett Orthopaedic Clinic offers orthopedic services in sports medicine, joint replacement, extremities care and spine services. Additional services offered at the practice include MRI, orthotic devices, occupational and physical therapy and electrodiagnostic studies.

### Kerlan-Jobe Orthopaedic Clinic (Los Angeles)

Founded by Robert Kerlan, MD, who was joined by current president Frank Jobe, MD, more than four decades ago, Kerlan-Jobe Orthopaedic Clinic physicians are dedicated to providing expert care in sports medicine. Prac-

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tice physicians are currently affiliated with several professional Los Angeles teams, including the Lakers, Dodgers, Kings, Angels, Mighty Ducks and Sparks.

**Methodist Sports Medicine/The Orthopaedic Specialists (Indianapolis).**

With four locations around Indianapolis, physicians at Methodist Sports Medicine/The Orthopaedic Specialists are able to offer several orthopedic services, including a walk-in clinic. All physicians are fellowship-trained in their subspecialties, which include sports medicine, pediatric sports medicine, spine, joint replacement, extremities and shoulder care.

**Midwest Orthopaedics at Rush (Chicago).**

Midwest Orthopaedics at Rush physicians are fellowship-trained in several subspecialties, including sports medicine, spine, joint reconstruction and upper extremities care. The practice also provides team physicians for the Chicago Bulls and the Chicago White Sox, as well as local university and high school teams.

**Minnesota Orthopedic Sports Medicine Institute (Edina, Minn.).**

In addition to standard orthopedics, physicians perform a variety of sports medicine procedures, including ar-

throscopy of the shoulder, hip and knee along with ACL and PCL repair and reconstruction. MOSMI is affiliated with several local teams as well as the U.S. men's and women's national soccer teams, the Minnesota Vikings and the U.S. Cup for mountain biking.

**Newport Orthopedic Institute (Huntington Beach, Calif.).**

Orthopedic surgeons at Newport Orthopedic Institute provide surgical and conservative treatment for sports medicine, extremities, spine, pain management and trauma conditions. The practice also includes physical, hand and massage therapy as well as digital diagnostic imaging technology.

**OAA Orthopaedic Specialists (Allentown, Pa).**

The 22 physicians of OAA Orthopaedic Specialists are all fellowship-trained and focus on foot and ankle, hand and upper extremity, sports medicine, spine and joint replacement care. The practice has three locations in Pennsylvania, along with a Diagnostic Imaging Center, which includes MRI, CT scan and ultrasound.

**Orlin & Cohen Orthopedic Group (Long Island, N.Y.).**

The board-certified and fellowship-trained physicians at Orlin & Cohen Or-

thopedic Group subspecialize in sports medicine, knee, shoulder, joint replacement, foot and ankle, spine and hand surgery. The multi-office practice also includes in-house diagnostic testing, physical and occupational therapy and pain management.

**OrthoCarolina (Charlotte, N. C.).**

Surgeons at OrthoCarolina subspecialize in foot and ankle, hand, hip and knee, spine, sports medicine, shoulder and elbow and pediatric orthopedic care. In the past year, OrthoCarolina has merged with several smaller orthopedic practices in the area to expand services in the community.

**OrthoIndy (Indianapolis).**

OrthoIndy offers 14 locations and more than 70 orthopedic surgeons strategically placed around the Indianapolis community. The orthopedic specialists are fellowship-trained in several areas, including bone tumor and soft tissue oncology, cartilage restoration, pediatric orthopedics, total joint replacement, spine and sports medicine.

**Orthopaedic Associates of Port Huron (Port Huron, Mich.).**

Practice physicians have a special interest in spine, sports medicine, extremities and joint reconstruction. For partial knee resurfacing, physicians are able to use



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**The Orthopaedic Center (Huntsville, Ala.).** The Orthopaedic Center includes services in foot and ankle, hand and upper extremity, joint replacement, knee and shoulder, trauma, spine and sports medicine services. Additional ancillary services such as orthotics and prosthetics, physical medicine, physical therapy and pediatric orthopedics are also offered at the practice.

**Orthopaedic Specialists (Davenport, Iowa).** A foot and ankle center, hand and upper extremity center, spine center, total joint replacement center and sports medicine center offer services at the practice. Many of the surgeons are fellowship-trained and are able to treat patients with minimally invasive procedures, including carpal tunnel surgery.

**Orthopaedic & Spine Center (Newport News, Va.).** Orthopaedic & Spine Center includes 24 patient exam rooms, three X-ray suites that include fluoroscopy, a Lunar DPX Bone Densitometer Room, an MRI center and physical therapy services. They perform several procedures, including total joint replacement, arthroscopic surgery, cervical disc arthroplasty and interventional pain management procedures.

**OSM: The Orthopaedic & Sports Medicine Center (Trumbull, Conn.).** The comprehensive musculoskeletal center provides diagnostic and treatment services for traumatic injuries, spine conditions and sports medicine. The practice also includes the OSM Therapy center with physical, occupational and hand therapy services as well as aquatic therapy.

**Proliance Surgeons (Seattle).** Proliance Surgeons is one of the largest practices in the community and includes more than 160 surgeons and 30 offices throughout Washington. The orthopedic surgeons have special training in sports medicine, joint reconstruction, arthroscopic surgery, spine surgery, fracture care and orthopedic trauma. Additional services include physical and occupational therapy and diagnostic imaging capabilities.

**ProSports Orthopedics (Brookline, Mass.).** With three locations around Massachusetts, ProSports Orthopedics offers several orthopedic services. Practice physicians are subspecialized in arthroscopy, joint replacement and sports medicine.

**Reno Orthopaedic Clinic (Reno, N.V.).** Founded in 1958, Reno Orthopaedic Clinic now includes seven office locations around northern Nevada. The physicians have subspecialty training in spine, hand, total joint, foot and ankle, sports medicine and orthopedic trauma care.

**Resurgens Orthopaedics (Atlanta).** Resurgens Orthopaedics, a comprehensive musculoskeletal center, includes the foot and ankle,

hand, spine, joint and sports medicine centers. In addition to orthopedic care, the practice has diagnostic and rehabilitative services.

**Rockford Orthopedic Associates (Rockford, Ill.).** Practice physicians have subspecializations in several areas, including extremities, sports medicine, trauma and pediatrics. There are also ancillary services at the practice, such as physical medicine and rehabilitation, prosthetics and orthotics, rehabilitation and diagnostic radiology.

**Rothman Institute (Philadelphia).** The practice offers specialists in all areas of orthopedics in 13 office locations around Pennsylvania and New Jersey. Specialists at Rothman are credited with pioneering artificial disc replacement and performing a high volume of total ankle replacements in their region.

**The San Antonio Orthopaedic Group (San Antonio).** The practice has seven locations in San Antonio, with two including imaging centers and The Orthopaedic Therapy Institute. The board-certified physicians perform several services at the different institutes, including The Arthritis and Joint Replacement Institute, The Sports Medicine Institute, The Foot and Ankle Institute, The Cartilage Repair Center of Texas, The Spine Institute and The Hand, Wrist and Upper Extremity Institute.

**Santa Monica Orthopaedic and Sports Medicine Group (Santa Monica, Calif.).** Physicians at SMOG are team physicians for the Los Angeles Galaxy and USA Chivas soccer teams. The practice also includes extremity and full body MRI as well as digital X-ray services. Practice physicians are involved in research and education through the Santa Monica Orthopaedic & Sports Medicine Group Research Foundation.

**St. Louis Orthopedic Institute (St. Louis).** Practice physicians have subspecializations in spine, shoulder, extremities, hip and knee care. They are also able to perform minimally invasive surgical techniques. Specialists at the practice also include physical medicine and rehabilitation professionals.

**The Steadman Clinic (Vail, Colo.).** The Steadman Clinic physicians are experienced in treating all types of patients, including professional athletes. The physicians have a subspecialty in hip, knee, shoulder, elbow, extremities and spine surgery. The clinic's co-founder, Richard Steadman, MD, and has contributed to the development of several treatments for knee disorders, and Marc Philippon, MD, has developed new surgical techniques for sports-related hip injuries.

**Steadman-Hawkins Clinic of the Carolinas (Greenville, S.C.).** Founded by Richard Hawkins, MD, formerly of Steadman Hawkins Clinic in Vail, Colo., Steadman-Hawkins Clinic of the Carolinas has seven locations around South Carolina. Practice services include pedi-

atric orthopedics, spine care, orthopedic oncology and sports medicine.

**Tallahassee Orthopaedic Clinic (Tallahassee, Fla.).** Tallahassee Orthopaedic Clinic was founded in 1972 and is one of the first medical practices in northern Florida specializing in orthopedics. The practice has grown to include physicians subspecializing in sports medicine, pediatric orthopedics, joint replacement, spine surgery, trauma and extremities care.

**Texas Healthcare Bone & Joint Clinic (Fort Worth, Texas).** Physicians at the Bone & Joint Clinic offer several different types of services, including spine, extremities and sports medicine care. The practice also includes onsite physical therapy, custom foot orthotics and bracing, splinting and casting supplies. The practice also includes athletic training and off-site imaging services.

**Towson Orthopaedic Associates (Towson, Md.).** Practice physicians offer hand, foot, sports medicine, joint replacement and spine care services. Additional services include the Osteoporosis Center, which has diagnostic imaging, nutritional guidance and support and physical and occupational therapy services.

**Twin Cities Orthopaedics (Minneapolis).** Twin Cities Orthopaedics provides diagnostic, treatment, rehabilitation and injury prevention services to patients at 30 clinics located throughout the Twin Cities. Practice physicians focus on joint replacement, hand and wrist care, foot and ankle care, orthopedic oncology and sports medicine.

**UB Orthopaedics & Sports Medicine (Williamsville, N.Y.).** Physicians at UB Orthopaedics & Sports Medicine are team physicians for the Buffalo Bills, Buffalo Sabres and Buffalo Bandits professional athletic teams as well as several local collegiate teams. Practice specialists see patients at 18 locations around New York, which include the Cartilage Restoration Center, Concussion Clinic, Spine Center, Foot and Ankle Center and physical therapy centers.

**University Orthopaedic Associates (New Brunswick, N.J.).** Fellowship-trained foot and ankle, spine, sports medicine, upper extremity trauma and general orthopedic surgeons make up University Orthopaedic Associates. Ancillary services at the practice include physical and hand therapy, radiological services and osteoporosis screening.

**UPMC Sports Medicine (Pittsburgh).** Physicians at UPMC Sports Medicine are the official sports medicine providers for professional Pittsburgh teams, including the Steelers, Panthers and Penguins. UPMC sports concussion researchers oversee the neuropsychological testing programs for the National Football League, National Hockey League and Major League Baseball. ■

# 70 Outstanding Hip Surgeons and Specialists

By Laura Miller

## Outstanding Hip Surgeons and Specialists

*The following hip specialists were selected for this list based on the awards they received from major orthopedic organizations, leadership in those organizations, work on professional publications and positions of service held at hospitals and practices. The surgeons are listed in alphabetical order by last name. All surgeons placed on the list have undergone substantial review from our editorial staff and orthopedic physician leaders. Surgeons do not pay and cannot pay to be selected as an outstanding hip specialist. This list is not an endorsement of any individual's or organization's clinical abilities.*

**Michael M. Alexiades, MD**  
(Hospital for Special Surgery, New York City)

**Wael Barsoum, MD** (Cleveland Clinic)

**Robert L. Barrack, MD**  
(Center for Advanced Medicine, St. Louis)

**Richard Berger, MD**  
(Midwest Orthopaedics at Rush, Chicago)

**Daniel J. Berry, MD**  
(Mayo Clinic, Rochester, Minn.)

**Robert Buly, MD**  
(Hospital for Special Surgery, New York)

**Charles Bush-Joseph, MD**  
(Midwest Orthopaedics at Rush, Chicago)

**J. Thomas Byrd, MD** (Nashville Sports Medicine & Orthopaedic Center, Tenn.)

**John Callaghan, MD** (University of Iowa Hospitals & Clinics, Iowa City)

**Michael Christie, MD** (Southern Joint Replacement Institute, Nashville, Tenn.)

**David J. Covall, MD**  
(Resurgens Orthopaedics, Cumming, Ga.)

**Hal Crane, MD** (Orthopedic Associates, Denver)

**John Cuckler, MD**  
(Alabama Spine & Joint Center, Birmingham)

**Charles M. Davis, III, MD** (Penn State Hershey (Pa.) Bone and Joint Institute)

**Craig J. Della Valle, MD**  
(Midwest Orthopaedics at Rush, Chicago)

**Lawrence D. Dorr, MD**  
(Dorr Arthritis Institute, Los Angeles)

**Charles A. Engh, MD**  
(Anderson Orthopaedic Clinic, Alexandria, Va.)

**C. Anderson Engh, Jr., MD**  
(Anderson Orthopaedic Clinic, Arlington, Va.)

**Thomas K. Fehring, MD**  
(OrthoCarolina, Charlotte, N.C.)

**Mark Froimson, MD** (Cleveland Clinic)

**Kenneth Greene, MD** (Cleveland Clinic)

**Wayne M. Goldstein, MD** (Illinois Bone & Joint Institute, Morton Grove, Ill.)

**Alejandro Gonzalez Della Valle, MD**  
(Hospital for Special Surgery, New York City)

**William L. Griffin, MD**  
(OrthoCarolina, Charlotte, N.C.)

**Carlos Guanche, MD** (Southern California Orthopedic Institute, Van Nuys)

**Kenneth Gustke, MD**  
(Florida Orthopaedic Institute, Tampa, Fla.)

**Tony Hedley, MD** (Arizona Institute for Bone & Joint Disorders, Phoenix)

**Edward J. Hellman, MD** (OrthoIndy, Indianapolis)

**Matthew L. Jimenez, MD** (Illinois Bone and Joint Institute, Morton Grove, Ill.)

**Frank R. Kolisek, MD** (OrthoIndy, Indianapolis)

**Bryan Kelly, MD**  
(Hospital for Special Surgery, New York City)

**James C. Kudrna, MD**  
(Illinois Bone & Joint Institute, Glenview, Ill.)

**Louis Kwong, MD** (Miracle Mile Outpatient Surgery Center, Los Angeles)

**Carlos J. Lavernia, MD** (Orthopaedic Institute at Mercy Hospital, Miami, Fla.)

**Kevin Lester, MD**  
(Center for Excellence, Fresno, Calif.)

**David G. Lewallen, MD**  
(Mayo Clinic, Rochester, Minn.)

**Jay R. Lieberman, MD** (University of Connecticut Health Center, Farmington)

**Adolph Lombardi, Jr., MD**  
(Joint Implant Surgeons, New Albany, Ohio)

**William Long, MD**  
(Dorr Arthritis Institute, Los Angeles)

**Henrik Malchau, MD**  
(Massachusetts General Hospital, Boston)

**William J. Maloney, MD** (Stanford University Hospitals & Clinics, Palo Alto, Calif.)

Joel Matta, MD (Saint John's Health Center, Santa Monica, Calif.)

Joseph McCarthy, MD (Massachusetts General Hospital, Boston)

Brian J. McGrory, MD (OA Centers for Orthopaedics, Portland, Maine)

David M. Mochel, MD (OAD Orthopaedics, Warrenville, Ill.)

John Moreland, MD (Santa Monica (Calif.)-UCLA Medical Center & Orthopaedic Hospital)

Michael Mont, MD (Rubin Institute for Advanced Orthopedics, Baltimore)

Mary I. O'Connor, MD (Mayo Clinic, Jacksonville, Fla.)

Dan Oakes, MD (University of Southern California Norris Cancer Hospital, Los Angeles)

Douglas E. Padgett, MD (Hospital for Special Surgery, New York City)

Wayne G. Paprosky, MD (Midwest Orthopaedics at Rush, Chicago)

Javad Parvizi, MD (Rothman Institute, Philadelphia)

Shiraz Patel, MD (The Orthopaedic Institute of Western Kentucky, Paducah)

Marc J. Philippon, MD (The Steadman Clinic, Vail, Colo.)

Chitranjan Ranawat, MD (Hospital for Special Surgery, New York City)

Eduardo A. Salvati, MD (Hospital for Special Surgery, New York City)

Thomas Sampson, MD (Post Street Orthopaedics & Sports Medicine, San Francisco)

Richard Santore, MD (Sharp Memorial Hospital, San Diego)

Thomas P. Sculco, MD (Hospital for Special Surgery, New York City)

Thomas Schmalzried, MD (Joint Replacement Institute, Los Angeles)

Ernest L. Sink, MD (Hospital for Special Surgery, New York City)

Peter F. Sharkey, MD (Rothman Institute, Philadelphia)

Van P. Stamos, MD (Illinois Bone & Joint Institute, Morton Grove, Ill.)

Allston Stubbs, MD (Wake Forest University, Winston-Salem, N.C.)

David Stulberg, MD (Northwestern Memorial Hospital, Chicago)

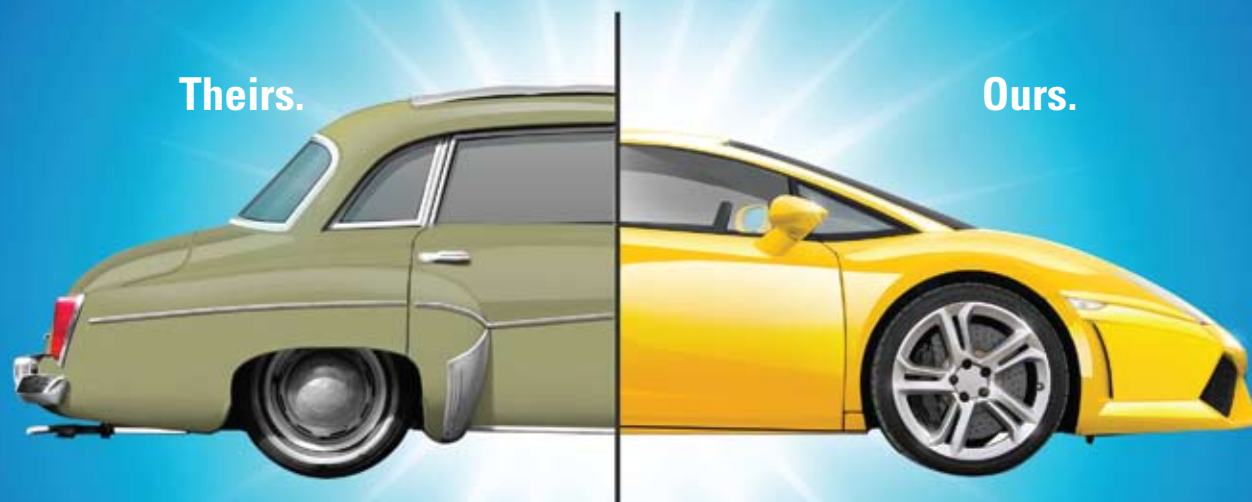
Bert Thomas, MD (UCLA Santa Monica Orthopedic Hospital, Los Angeles)

Robert T. Trousdale, MD (Mayo Clinic, Rochester, Minn.)

Thomas P. Vail, MD (University of California, San Francisco)

Erik N. Zeegen, MD (Valley Hip & Knee Institute, Tarzana, Calif.)

James M. Zurbach, MD (Premier Orthopaedic & Sports Medicine Associates, Philadelphia) ■



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# Zimmer's Cheryl Blanchard: 5 Points on the International Consortium of Orthopaedic Registries

By Laura Miller

**Z**immer has supported national joint replacement registries outside of the United States for several years. As a member of AdvaMed, a trade association representing medical device manufacturers, Zimmer is now participating in the development of the International Consortium of Orthopaedic Registries. The Food and Drug Administration held a public workshop on May 9 to discuss ICOR, and Zimmer was the only industry representative that participated on the panel. Cheryl Blanchard, PhD, senior vice president and chief scientific officer for Zimmer, discusses five points on the importance of joint registries and the future of ICOR.

**1. Why to support a registry.** Joint replacement registries are important for orthopedic surgeons, patients and device companies because data generated from the registries can help in assessing the ongoing efficacy of a procedure or device. "It's about our ability to ensure the continued efficacy of a device and use the data from the registries to improve outcomes for patients," says Ms. Blanchard. "It's not easy to generate the data for post-market studies because you need large data sets. If you are trying to gather a large amount of data through clinical trials, it can often be difficult to secure enough participants."

Joint replacement registries collect data from a large number of sources, and the data is part of a real-world situation. Clinical trials can be beneficial, but data from the real world may be more valuable going forward.

**2. Going beyond national registries.** The United States doesn't currently have an official joint replacement registry, although there are some large providers who collect joint replacement data from their physicians. The American Academy of Orthopaedic Surgeons has also been involved in creating the American Joint Replacement Registry, but data from a single country may not be enough to tackle all of the issues associated with robust post-market surveillance for joint replacements.

"The FDA is realizing that a large dataset in a given registry might not be enough to create a robust post-market study," says Ms. Blanchard. "You often have different experiences from one country to another and outcomes may vary from one country to another. Data is influenced by practice standards, training levels and geographic philosophies where a procedure is performed, as well as by the implants, and all of these can factor into outcomes."

**3. Benefits of an international registry.** There are multiple stakeholders who stand to benefit from the creation of an international joint replacement registry. Physicians and hospitals are able to mine their own data and compare it with others to see where they are leaders or need improvements. Device companies can also see data from their products for post-market surveillance and certification in other countries.

Patients, payors and the healthcare system also stand to benefit from national and international registries because countries participating in registries have lower revision rates. "With these registries, payors can really understand the cost/benefit ratios of these procedures, and seeing how well devices are performing can help facilitate decisions about surgery," says Ms. Blanchard. "Government entities will also benefit because Medicare has a vested interest in the performance of the devices, and so does the FDA."

**4. Appropriate use for registry data.** There is plenty of opportunity for different stakeholders to collaborate with ICOR on bigger datasets and harmonize the post-market surveillance requirements. "We ended the conference



feeling it was feasible for us to move forward and make things happen," says Ms. Blanchard. "The FDA felt all the multiple shareholders would benefit from it."

However, there is a potential for misusing registry data. The data isn't designed for making reimbursement decisions. "Registries typically collect Level 1 data, and you can glean a lot from that data, but it's difficult to extrapolate reimbursement decisions from it," she says. "You don't know the cause of a revision or the quality of the patient's life after surgery from the given information. The data is useful for finding trends and then building stronger studies upon it."

Additionally, one shouldn't use registry data to determine whether a device company should recall an implant, even if that implant isn't performing well. "There are multi-factorial reasons for implant results in a patient," she says. "The data just tells you when you need to look into something further and really understand it."

**5. Future of ICOR.** At the conference, the different stakeholders and registries got together and worked on demonstration projects to outline pitfalls associated with creating ICOR and how they might be overcome. For example, there are several information technology issues that will arise because ICOR brings together several different databases. Tackling those issues could be problematic but not impossible.

The next step will be to form a discussion around data use and to create data management rules, such as how long the different stakeholders will be able to see the data, before launching the registry. ■

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# 10 Biggest Trends in Spine Pain Management

By Laura Miller

**1. Increasing focus on diagnostics.** There has been an increasing focus on utilizing injections for diagnostic purposes in helping establish the correct diagnoses for patients with spine pain before moving forward with treatment. “As more is becoming known about the different sources of spinal pain, there is a decrease in utilization of non-selective interventions for conditions where we don’t know what we are treating,” says Jared Greenberg, MD, an interventional spine specialist with Meriter Medical Group in Madison, Wis. “Now, we are able to provide a real diagnosis for the pain.”

One way pain management physicians have traditionally located spine pain is through provocative discography, where the physician injects an irritating substance into the patient. However, instead of injecting an irritating substance, some pain management physicians are now injecting a numbing agent into the disc. The discogram can be performed in the lumbar, cervical and thoracic spine, says Eugene G. Lipov, MD, medical director of Advanced Pain Centers in Hoffman Estates, Ill., and is often done on an outpatient basis in ambulatory surgery centers. However, some states, such as California, won’t allow discography at all because of the potential complications associated with inserting a needle into the spine disc.

**2. Refinement in traditional interventions.** While there hasn’t been much change to the core of spine pain management interventions, the algorithms are constantly evolving. Furthermore, there may be a trend toward refining many of the procedures. More specialists are performing transforaminal epidurals, where the medicine is placed through the foramen on either or both sides of the spine, which provides a direct path for treating disc or nerve pain, says Dr. Greenberg.

Additionally, patients with facet joint pain who were traditionally treated with repeated facet joint steroid injections are now more commonly treated with radiofrequency neuroablation, which ablates medial branch nerves to block pain communication from the joints. This technique can offer longer standing relief of pain for nine months to one year.

**3. Performing vertebral body augmentation.** Some pain management physicians perform kyphoplasty and vertebroplasty for patients with vertebral body fractures and/or metastatic cancer to the vertebrae. “These procedures don’t require open surgery, and they are all done through needles, so the patients don’t have an incision, which means they could cause fewer problems for patients,” says Donald Roland, MD, a pain medicine physician at Kankakee (Ill.) Pain Center. Several different studies have been conducted to assess the effectiveness of spinal fusions, and while the differing outcomes of these studies are contentious, health systems and insurance companies continue to support and reimburse for these procedures when they are appropriate.

**4. Spinal decompressions.** Spinal decompression is another intervention some pain management physicians use with the appropriate patients. For patients with a herniated disc, surgeons and pain management physicians can perform a percutaneous decompression to reduce the herniation, resulting in pain relief, says Dr. Roland. Decompressions are cost effective because they are done in a surgery center or in the physician’s office instead of a hospital, and patients are often recovered enough to return to work in three weeks.

“A lot of things we used to do in medicine were done out of habit, and I think there is a better way — a more efficient and cost-effective way of treating patients,” he says. “However, it’s sometimes difficult for the insurance companies to get on board and cover these procedures.”

**5. Biologic solutions.** One trend that could be big in the future is biologic solutions for spine pain management. “The big thing is going to be stem cell therapies,” says Jeffrey Wasserman, MD, a pain management physician with Pinnacle Pain Management in Dallas. “We’ll be able to find out what the patient’s condition is and then we can inject stem cells in the spine to treat the discs and help the nerves heal. Stem cell therapies are very exciting for spine pain.”

There is research taking place where physicians are genetically manipulating the inside of the disc to promote cell growth. This technology is still in the development stage and several years away from coming to the market. Any potential biological solution for back pain would need to pass through the rigorous FDA clearance process before it would be an available solution for physicians.

“If you can put a needle into the disc and inject biological stuff to regenerate the nucleus, that would be fantastic,” says Dr. Lipov. “However, the FDA has become extremely difficult to work with, and any new development is going to be delayed significantly.”

**6. Fewer disc procedures.** Pain management physicians are performing fewer disc procedures, such as intradiscal electrothermy and percutaneous discectomies, in large part because the literature is mixed on the efficacy of these interventions. Insurance companies are also shying away from covering them, which make them even less attractive. “Healthcare reform certainly affects us because many of the procedures we do now won’t be permitted or reimbursed in the future,” says Dr. Wasserman. “There will be more responsibility placed on the patient to pay for the procedures than the insurance company.”

In different geographic regions, pain management physicians are already seeing a decline in spine surgeons ordering discography. “Early research suggests that by introducing a needle into the disc, it may result in advanced degeneration of that disc,” says Dr. Greenberg. “The debate continues as further research is conducted.”

**7. Declining reimbursements.** Pain management physicians have experienced a decline in reimbursement rates, as have most physicians across the board. The declining reimbursements affect many aspects of spine care, including potential technology and future advancement in the field. “It doesn’t matter how great of an idea you have if nobody is going to reimburse for it,” says Dr. Lipov.

Many payors are also demanding better standards for patient selection and that physicians be fellowship-trained in pain management before reimbursing for procedures, says Nileshkumar Patel, MD, a pain management physician with Advanced Pain Management in Greenfield, Wis. “For a successful practice, you want to choose people with fellowships and focus on patient experience and outcomes,” he says.

**8. Identifying indications for procedures.** As with many medical specialists, pain management physicians are working on refining the indications for different interventional procedures. “We are coming to identify the appropriate indications for each procedure so we don’t use them incorrectly. With more standardized guidelines, we would anticipate better clinical outcomes and improved data, which would be beneficial in supporting the efficacy and success of comprehensive non-surgical management of back pain,” says Dr. Greenberg. “There is becoming a greater responsibility on the physician’s part to employ these procedures correctly.”

Pain management physicians are also engaging in more research about the different interventions, a trend Dr. Wasserman sees continuing in the future. “We are certainly moving more towards evidence-based medicine,” he says. “Unfortunately, when it comes to these procedures, there aren’t many evidence-based studies out there.”

It’s hard for spine and pain management physicians to prove the efficacy of these procedures because the control group must undergo a “sham” procedure, which is difficult to coordinate and perform on patients who otherwise would be receiving surgery.

**9. Comprehensive spine care centers.** The first intervention a patient receives often depends upon which office they are referred to or visit first: a chiropractor, primary care physician, pain management specialist, physical therapist or spine surgeon. As focus increases on the cost and efficacy of spine care, specialists are coming together to form comprehensive spine care centers.

Physicians, such as anesthesiologists, pain management physicians, physical medicine and rehabilitation specialists and spine surgeons, are working in the same facilities to coordinate the patient’s care. “You’d like to see more comprehensive spine centers in the future that integrate physicians of different specialties and training backgrounds who can all work together in a coordinated fashion,” says Dr. Greenberg. “That will help standardize spine care and provide optimal treatment pathways for the patient.”

**10. Hospital partnerships.** Consolidation is a big part of today’s healthcare environment, and pain management physicians are increasingly choosing hospital employment or partnering with hospitals in some fashion. Especially as more hospitals integrate and employ more primary care physicians, positive relationships with hospitals have become important. “You can either fight this reality, or you can adapt to it by partnering with healthcare systems to achieve mutual gain,” says Dr. Patel. ■



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# 6 Studies Supporting Timely Surgical Intervention for Appropriate Spine Indications

By Laura Miller

**1. Kyphoplasty among fracture patients.** New research suggests that performing kyphoplasty for patients who sustained vertebral fractures as a result of an injury decreases the likelihood of death by 44 percent, compared with patients who are prescribed bed rest and pain killers. The research was comprised of 410,965 patients who suffered fractures and received either surgical or non-surgical treatment. Of the patients who received surgical treatment, there was a 74.8 percent survival rate after 24 months, compared with the 67.4 percent among those who underwent non-surgical treatment.

The surgical patients were also less likely to die of fracture-related complications, and those who underwent kyphoplasty were more likely to survive than those who had vertebroplasty. The research was presented at the spring meeting of the British Geriatric Society.

**2. Laminectomy soon after achondroplasia symptoms appear.** Patients who receive surgery more quickly after experiencing achondroplasia symptoms report a better long-term functional outcome, according to a study published in *Spine*. Researchers examined 49 patients with achondroplasia who underwent primary laminectomy for spinal stenosis. Patients who waited an interval of less than six months to undergo surgery after symptoms appeared were 7.13 times more likely to report improvement in walking distance and four times more likely to experience Rankin level improvement than patients who waited longer than six months.

Patients who waited 12 and 24 months to undergo surgery also experienced improved walking distances compared with those who waited longer intervals, but no statistically significant difference in Rankin level was recorded.

**3. Timely surgical intervention for adolescent scoliosis.** When children wait too long for scoliosis correction surgery, they are at higher risk for complication and may need additional surgery, according to a study published in the *Canadian Medical Association Journal*. The study followed 88 adolescent scoliosis patients who waited longer than six months and 128 patients who waited less than six months for surgical treatment. Of those who waited less than six months, 1.6 percent needed additional procedures, compared with the 15 percent who waited longer than six months for surgical intervention.

The study's authors suggested three months as the maximum wait time for patients with adolescent scoliosis who need surgical intervention to minimize the risk of complications and worsening curvature.

**4. Benefits outweigh risks of surgery for adult scoliosis.** The benefits of surgical intervention for patients with adult scoliosis outweigh the risks associated with the procedure in some cases, according to an article in *Spine*. For the study, researchers examined 260 patients who underwent surgical treatment for adult scoliosis and found that 17 percent of younger patients (age 25 to 44) and 71 percent of older patients (age 65 to 85) experienced complications as a result of surgery. However, both groups experienced significant improvements in disability, back pain and leg pain. The improvement in these scores was significantly greater among elderly patients than the younger patients.

**5. Resection of spinal tumors with Enneking Appropriate margins.** A study recently published in *Spine* found that the surgical resection of spinal tumors with Enneking Appropriate margins can significantly reduce the local recurrence of tumors and mortality. A multicenter ambispective cohort analysis of four tertiary spine care referral centers encompassed 147 patients who were placed in either the Enneking Appropriate or Enneking Inappropriate group. There were 71 patients who suffered at

least one local recurrence after an average of four years, and 57 of those patients were in the EI group.

The study also reported 48 deaths, with 29 from the EI group and 19 in the EA group, which the authors suggest shows a strong correlation between the first local recurrence and mortality.

**6. Professional football players report longer careers after surgery.** Professional football players with cervical disc herniation have a higher return-to-play rate after operative treatment than those undergoing non-operative treatment. The researchers identified 99 National Football League players who were diagnosed with cervical disc herniation and decided to receive either operative or non-operative treatment. Of those who chose surgical intervention, 72 percent were able to successfully return to play for an average of 29 games over a 2.8-year period. Those in the non-operative group reported returning to play 46 percent of the time for approximately 15 games over a 1.5-year period.

The athlete's age at diagnosis negatively impacted career longevity, and other factors, such as concomitant cervical stenosis, had an impact on the data as well. Researchers published the study in an issue of *Spine*. ■

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# 5 New Studies Influencing Sports Medicine

By Laura Miller

**H**ere are five new studies impacting sports medicine. The studies were published in *The American Journal of Sports Medicine*, unless otherwise noted.

## 1. Hyperhydration has risk of complications for NFL players.

While 75 percent of National Football League teams use pregame hyperhydration with intravenous fluid for an average of five to seven players per game, a study published in the *Clinical Journal of Sports Medicine* shows that the process may not meet the perceived efficacy and has the potential for complications. On average, players undergoing hyperhydration receive 1.5 liters of fluid for an average of 2.5 hours before game time, with the most common cited reason for the treatment being muscle cramps. The primary reason for administering the hyperhydration was recorded as player request, and two trainers reported mental dependence of their players on pregame hyperhydration.

Of the 27 head athletic trainers who used hyperhydration with IVF, 48 percent reported complications during the 2009-2010 season. These complications included superficial venous clots, air embolus, pulmonary edema, peripheral edema and arterial puncture. Nineteen of the athletic trainers felt that the hyperhydration with IVF was effective or very effective and eight felt the process improved the team's overall performance.

**2. Professional football careers are shorter among athletes with shoulder stabilization.** Using a database containing NFL statistics for athletes between 1987 and 2000, researchers identified 42 athletes with a history of shoulder stabilization and matched them with a control group. The stabilization group reported a shorter career (5.2 years) than the control group (6.9 years). The stabilization group also reported fewer games than the control group.

Linemen and linebackers were most likely to have had shoulder stabilization, and their careers were significantly shorter (4.7 years) than their counterparts in the control group (6.7 years).

**3. Rotator cuff tears likely to increase without surgery.** Full thickness rotator cuff tears in about half of patients who are 60 years or younger will increase if they aren't treated surgically. In a study of 61 patients with rotator cuff tears who were treated non-operatively, 49 percent experienced an increase in tear size at a two-year follow-up. For 25 percent of the patients, a new full-thickness rotator cuff was diagnosed at that time.

## 4. Shockwave therapy after ACL reconstruction beneficial.

Applying extracorporeal shockwave therapy to the bone tunnel can significantly enhance the early tendon-bone healing and decrease tibial tunnel enlargement after anterior cruciate ligament reconstruction. A study of 34 patients who underwent single-bundle ACL reconstruction with or without ESWT showed that patients in the shock therapy group had significantly better Lysholm scores than the control group one and two years after surgery.

There was no significant difference in the International Knee Documentation Committee scores, bone appearance and bone mineral density values between the two groups. However, patients in the shockwave therapy group reported smaller middle-third tibial tunnels two years after surgery, and their MRIs showed better integration of tendon graft to bone than the control group.

**5. Hip MRI of asymptomatic hockey players can predict future disability.** A study examining the MRI evaluations of 21 asymptomatic collegiate hockey players showed the potential for future disability. Adductor-abdominal rectus dysfunction was apparent in 36 percent, and hip pathological changes were reported in 64 percent of the participants. Overall, the researchers found evidence of hip or groin pathologic abnormalities in 77 percent of the hockey players. The inter-reliability was the lowest in reported hip osteochondral lesions and fluid in the primary clef. ■

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# What Percentage of Orthopedic Surgeons Will be Employed in 5 Years? 10 Responses

By Laura Miller

**A**ccording to the American Academy of Orthopaedic Surgeons' most recent census data for 2008, 44.3 percent of orthopedic surgeons were practicing in a private practice setting and 20.9 percent were in a solo practice. Only 6.7 percent of orthopedic surgeons were employed by a hospital or medical center and 8.5 percent at academic institutions. Economic and healthcare changes over the next few years are predicted to alter these statistics as more orthopedic surgeons are making the tough decision about where they will practice. "The AAOS study in 2008 shows that as of that time between direct hospital employment and academic medical centers, the number of employed orthopedic surgeons was approximately 15 to 16 percent in 2008," says Scott Becker, JD, CPA a partner at McGuireWoods. "As of 2011, given the uptick in the last few years, we would estimate that it's closer to 20 percent+ today."

Here, orthopedic surgeons and industry professionals discuss how the trend toward hospital employment is affecting orthopedic and spine surgeons, and what factors play a part in making the employment decision.

**Matt Ramsey, MD, orthopedic surgeon and vice chair of operations, Rothman Institute, Philadelphia:** I spent 11 years as a full-time faculty member of the University of Pennsylvania and left the employed model to go into private practice, which is contrary to the current trend. I don't know what percentage you're going to see in full-time hospital employment in five years, but I do think that number will rise. There are a couple of things driving this percentage up right now. A culmination of financial pressures in the market over the past two years has driven reimbursement down and we're at a tipping point. Orthopedic surgeons in a small practice (under four to six surgeons) are finding it extremely difficult to financially support a practice.

I think another factor is the uncertainty about what the future is going to bring with healthcare reform. Electronic medical records and other requirements under healthcare legislation are going to be impossible for small groups to handle when they are already under such pressure right now. These physicians go to an employed model instead of a large group practice because they've been in a small group for a while and they don't see advantages to larger groups. They think they won't be able to improve their position.

I see the value of becoming employed by a hospital if you're financially strapped and worried about making a living. You give up your autonomy and the way you practice medicine to some degree when you become employed. It's hard to leave a full-time employment model, and the challenge becomes what will happen if it doesn't meet your requirements. The foundation of orthopedics is in the solo practitioners and small group models. There are more small-group surgeons than large-group surgeons and more solo than employed, but these numbers are changing very rapidly.

**David Ott, MD, orthopedic surgeon, Arizona Orthopaedic Associates in Phoenix:** My crystal ball isn't better than anybody else's. I have no idea about what the percentage of orthopedic and spine surgeons employed at hospitals will be, but if I had to give a percentage, I'd say about 30-40 percent of orthopedic surgeons will be employed by a hospital five years from now. Private practice and solo practice for orthopedic surgeons isn't a recommended entity. They need to become part of established organizations, whether it be a large group practice, hospital, health maintenance

organization or specialty group. The concept of employed physicians is front and center, and it's been going on for a long time in many states. For example, Kaiser Permanente has been employing physicians for a long time, and it has worked well for many of those orthopedic surgeons.

There are always going to be guys that will be bought up by the hospital. There are three groups of people in this category: those who are new and want stability and are looking for a paycheck; older guys who are looking for a more hassle-free environment as far as business and a little less stress; and the final group that will be employed by hospitals are those surgeons who cannot be successful in the private practice for whatever reason.

The concept of an accountable care organization has pushed orthopedists into looking into employment models. My crystal ball says that in large metropolitan areas, there will be a large number of orthopedic surgeons who will remain in a practice and fee-for-service model. The surgeons will contract with ACOs, hospitals and insurance companies to provide services. It could be a traditional fee-for-service model, bundled model or another type of creative payment model.

**R.C. Shah, MD, FACS, general surgeon, Medical/Surgical Director at ARH Summers County Hospital and Medical Director, Beckley (W. Va.) ARH:** There will be more surgeons employed by hospitals in the future. Most of those in solo practice will leave because coverage is a problem. Solo practice surgeons must tend to office personnel, provide benefits for their staff, deal with practice billing, purchase supplies and buy their own malpractice insurance, all of which is expensive. The trend right now shows less reimbursement, and unless a group is very busy and innovative, it won't match the hospital's salary with the fringe benefits.

The benefits of being employed by the hospital include having a fixed number of hours to work per week. Most surgeons in private practice work several more hours and must be available almost constantly. These surgeons cannot always plan their week and often spend more time away from their families. At the same time, there is a need for orthopedic surgeons in every community, whether urban or rural, and that need is only going to increase.

**Robert Snyder, MD, orthopedic surgeon, Orthopaedic & Spine Center in Newport News, Va.:** In the past it's been about 80 percent of orthopedic surgeons were in private practice and 20 percent were employed by hospitals. The way things are going, it will probably be reversed and more like 80 percent of orthopedic surgeons will be employed and 20 percent will be in private practice. This percentage will vary regionally. Some of these areas that have very large hospital groups will probably have a higher percentage of orthopedic surgeons in the community employed because it will be harder for independent practitioners to survive, and they will be cut out of referral patterns.

I think down the road you will see a lot more orthopedic surgeons becoming employed for several reasons. Number one, when you are working for the hospital group, they don't have to invest money upfront and they don't have to worry about the economics of a practice. They won't have to keep up with the business side of the practice, which can include building a new facility, hiring and firing a staff member, employee pension plans and ordering supplies.



Secondly, a lot of people coming out of medical schools and residencies want to have well-defined jobs and be able to know that when they do have time off, it will truly be time off. If they aren't on call, someone else in the group will see patients in an emergency situation. Employed surgeons know they aren't going to make the same salaries as surgeons in private practice, but they are willing to forgo the extra compensation to have clarity and defined working hours. They know they will be making a certain salary and they won't have to pay malpractice premiums because their employer pays that. Surgeons employed at hospitals also have retirement plans. These types of things make it look like hospital employment is advantageous to them.

**Stuart Katz, FACHE, CASC, executive director, Tucson (Ariz.) Orthopaedic Surgery Center:** I would estimate that 10-15 percent of orthopedic surgeons would be employed by a hospital or health system by 2017, especially if the current payment methodologies of Medicare and Medicaid do not change. I think the younger surgeons — those just finishing residency — are more likely to consider employment than are physicians who are on the “downside” of their careers who have maybe two to four more years of practice and want to “retire in place.” I think one of the employment incentives that a hospital or health system could use is loan repayment, which for the younger surgeons could be a crucial factor in their decision-making process. Physicians working for the Public Health Service and in manpower shortage areas have “loan forgiveness” as part of their employment agreements, and I think this will be expanded in the future.

**Matt Kilton, principal and COO of Eveia Health & Consulting Management:** My general perspective is that the orthopedic surgery community will have less interest in being employed than specialists with a greater inpatient focused practice, such as neurosurgeons or trauma specialists. The hospital's true mission of performing inpatient tertiary work doesn't always align with the orthopedic surgeon's practice patterns as an increasing number of surgeries move into the outpatient setting. Exceptions to this would include joint replacements and spine surgery services where many patients still require an inpatient stay. Hand surgeons, sports medicine, arthroscopic surgeons and others who perform the majority of their cases in outpatient settings seem more inclined to remain independent.

Other factors I think will influence the decision include the orthopedic surgeon's access to ancillary revenue, such as an ASC, physical therapy or imaging services. The more diversified in terms of their revenue stream, the less likely it would seem they are to become employed. If surgeons aren't partnered with an ancillary service line, the benefits of becoming employed increase as their professional reimbursements continue to experience downward pressure.

A third influence in this decision is where a surgeon is in the life-span of their career. Are they in the early stages of their career, has their practice achieved a level of maturity or are they in the final phase of their practice? There is an attraction to employment for surgeons entering the sunset of their career, as it mitigates many of the risks associated with private practice. A fairly secure level of income, more predictable call coverage and limited worries and responsibilities with respect to practice operations and management are all benefits of the employment model offered by hospitals. Surgeons that are looking for an exit strategy or a gradual reduction in responsibilities may opt for hospital employment. This isn't necessarily the most lucrative option, but there is more certainty involved and less general oversight required as compared to working independently.

**Mike Lipomi, president and CEO, Surgical Management Professionals:** I think that the split in the next five years will be in the range of 30-35 percent of orthopedic surgeons will be employed, while the rest will be solo practitioners or in group practices. I think the younger physicians have a bias toward employment rather than starting a solo practice or

joining a group. While saying this, there are certainly a lot of new graduates who have completed a combined MD/MBA program and have entrepreneurial interests leading them away from an employment career. While the dynamic of reimbursement reductions, practice restrictions and investment limitations will all move more into the employment area, there will still be a majority of surgeons desiring to control their own destiny and practice parameters. I do think the ability to invest in an ambulatory surgery center and/or have some in-office services will be critical to this decision.

**Chuck Peck, MD, CEO, Health Inventures:** If we assume that there's not going to be any other option for physicians other than employment by the hospital, then the number might be 60 percent. But I think there are other options for physicians, especially by partnering with management companies where the physicians don't have to sell their practice. Many orthopedic surgeons are so panic stricken by healthcare reform that they think hospital employment is the only option. A lot of high-end physicians are doing that. I think it's clearly reimbursement issues that are driving the decision for hospital employment. Orthopedic surgeons are also afraid of the unknown because we don't know how healthcare reform is going to play out. Some don't understand the implications of bundling payments, and surgeons and hospitals are going to have to be more aligned so they can figure out how the payment will work. Additionally, physicians don't always have the tools for measuring outcomes for pay-for-performance, which will be important in the future.

The other option for orthopedic surgeons will be to join with other groups and become a larger group practice. If they made themselves larger and contracted or secured professional management, they'll have a greater ability to negotiate reimbursements and have control over their destiny. Right now, many are so panic stricken that they aren't considering other opportunities besides hospital employment.

**Ted Schwab, Partner at Oliver Wyman, former CIO at Alegent Health in Omaha.** Orthopedists will be the last bastion of independent physicians. Many health and non-academic health systems around the country have tried to employ orthopedic surgeons and failed miserably. They are one of the few specialists that have figured out how to stay independent, increase their income and reduce the cost of care all at the same time.

You may see 10 percent of orthopedic surgeons employed by hospitals in five years, but you'll find 50 percent in hospital joint management programs that are figuring out ways to take 30 percent out of the cost of orthopedic surgery.

**Name Witheld, Executive of an ASC Management Company:** I'm going to suggest maybe around 15 percent of orthopedic surgeons will be employed by health systems over the next five years, if the current trends hold true. There are exceptions to every rule, but when surgeons are choosing specialties during training, it's the alpha leaders that often self-select into the orthopedic specialty. I, for one (and I may be in the minority), am less pessimistic about rapid employment adoption by orthopedists. They relish their independence in many cases, and they don't feel that the hospital meets their needs or understands their concerns in the current independent arrangement. Why would the hospital better meet their needs, once they are employed? Keep in mind that most orthopedic physician groups including three or more physicians are often still led by an orthopedic surgeon who is 45 years old or older, not by surgeons who finished training in the past five to 10 years, which is where we are seeing a different personality.

I attended a meeting with a larger orthopedic practice where the hospital made an outright plea for employment, for which the orthopedic group respectfully declined during the meeting and disrespectfully mocked after the meeting. There is a healthy distrust between these two parties and the orthopedists do not need the hospital to achieve success, at least not to the same extent as other specialties, such as a general surgeon. ■

# 30 Orthopedic and Spine Surgeons on the Move

Danville (Va.) Spine Center, a division of Danville Orthopedic Clinic, welcomed **Leon Abram, MD**, a traumatic spinal disorder surgeon.

Sports medicine physician **Frank Alberta, MD**, joined the Malo Clinic Health & Wellness in Rutherford, N.J.

Orthopedic surgeons **Dennis Anderson, MD**, **Todd Bankhardt, MD**, and **David Clark, MD**, voluntarily resigned from All Saints Hospital's orthopedic department in Racine, Wis.

**Theodore Belanger, MD**, an orthopedic spine surgeon, joined Texas Back Institute in Plano after years of practicing in North Carolina.

**Samuel K. Cho, MD**, a spine surgeon, joined Montvale (N.J.) Health Associates, while he also remains employed at Mount Sinai Medical Center.

The Longstreet Clinic in Gainesville, Ga., welcomed sports medicine physicians **Amy E. Borrow, MD**, and **Stephen Fisher, MD**, to the clinic.

**Thomas Dulaney, MD**, a sports medicine, joint replacement, arthroscopy and traumatic injury surgeon recently joined Stewart Memorial Community Hospital in Lake City, Iowa.

Spine surgeon **Keith Eugene Girton, MD**, joined Laser Spine Institute in Philadelphia.

Former orthopedic surgery instructor at Stanford University, **Raymond Golish, MD**, has joined St. John Medical Center's InMotion Clinic.

After spending the past few years in practicing Wyoming, **Doug Hiller, MD**, an orthopedic surgeon, returned to North Hawaii Community Hospital in Kamuela.

**Greg Hoover, MD**, and **J. Mark MacNaughton, MD**, have joined Cumberland Medical Center in Crossville, Tenn., to provide emergency orthopedic service coverage.

Orthopedist **Ron Joseph, MD**, has joined Gulfcoast Spine Institute in Brooksville, Fla., and will head up the practices conservative or non-operative care.

Orthopedic trauma and arthroscopy surgeon **Bradford Matthews, MD**, joined Sanpete Valley Hospital Specialty Clinic in Mount Pleasant, Utah.

St. Luke's Hospital in Columbus, N.C., recently welcomed spine surgeon **Mark L. Moody, MD**.

**Stephen T. Onesti, MD**, a neurosurgeon with a special interest in spine surgery, has joined Neurological Surgery P.C. in Rockville Centre, N.Y.

Sports medicine physician **Jesse Sandlin, MD**, joined Henry County Orthopaedic Surgery in Paris, Tenn.

**Jeffrey Rosenberg, MD**, a sports medicine physician, joined Summit Medical Group in Berkeley Heights, N.J.

**Kevin Stanley, MD**, a sports medicine and joint replacement surgeon, joined OrthoCarolina at the practice's Mooresville, N.C., location.

Sports medicine surgeon **William Sterett, MD**, recently left The Steadman Clinic in Vail, Colo., where he was a partner.

After serving as an orthopedic surgeon in the military for 11 years, **Kevin Strohmeyer, MD**, joined Laughlin Memorial Hospital and Laughlin Medical Group in Greeneville, Tenn.

Orthopedic trauma surgeon **Jonathan Swindle, DO**, joined Fayetteville (N.C.) Orthopaedics & Sports Medicine.

Ocean Beach Hospital in Ilwaco, Wash., welcomed orthopedic surgeon **Ronald Teed, MD**, to the hospital.

Sports medicine physician **Fotios P. Tjourmakaris, MD**, and lower extremities surgeon **David Pedowitz, MD**, joined Rothman Institute in Philadelphia.

Pediatric orthopedic surgeon **Craig Shank, MD**, has joined Dayton (Ohio) Children's Orthopedic Center.

**David A. Weimer, MD**, an orthopedic surgeon with a special interest in knee and hip replacements, became partner at Youngstown (Ohio) Orthopaedic Associates. ■

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