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ASC GROWTH AND ALIGNMENT: *Key Legal Issues in Today's Market*



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AGENDA

- ASC Overview – Ben Murphy
 - ASC Ownership Structures and Specialties
 - Regulatory Considerations – Stark, Anti-Kickback Statute
- Ownership & Investment Issues – Jennifer Struck
 - Cardiology ASCs
 - Employed Physicians
 - CRNAs
- Legal and Business Challenges to ASC Management and Operations – Mark Adams
 - Challenges Identified by ASC Managers and Counsel
- Questions

ASC Overview



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ASC Overview – Key Drivers in Investment

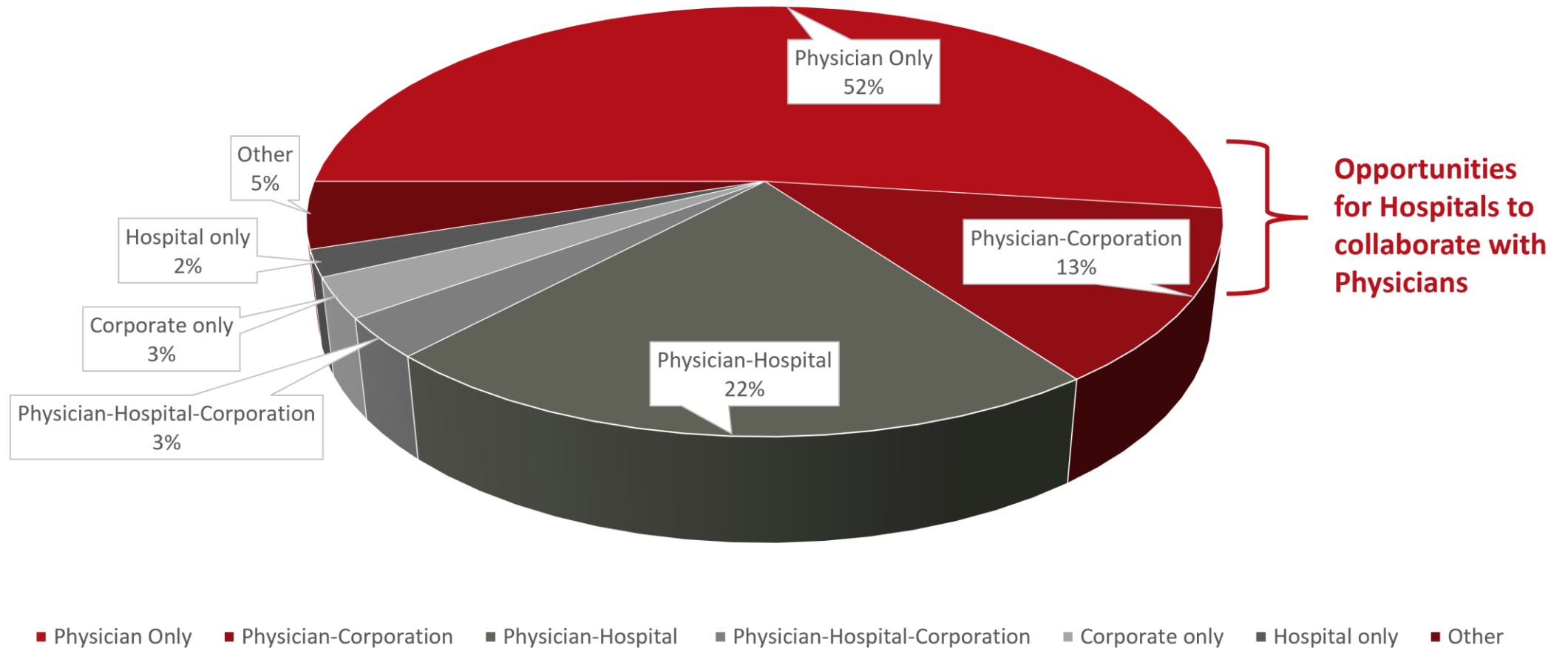
- Number of ASCs continues to grow year-over-year
- Expansion of the CMS ASC-covered procedure list
 - In 2026, CMS added 560 surgical procedures for a total of 4,100
- Increase in Medicare reimbursement
- Physician ownership permitted (unlike hospitals since 2010 ACA Stark changes)
- Patient and payor demand
- CMS' 3-year phase-out of the inpatient-only list (IPO)



Ambulatory Surgery Center Industry Overview

- Number of Medicare-certified ASCs in the country – 6,500+
- Annual ASC growth rate – 1.6%
- National average # of specialties served per ASC – 2.84
- Average number of ORs per ASC – 2.89

Ambulatory Surgery Center Ownership Structures

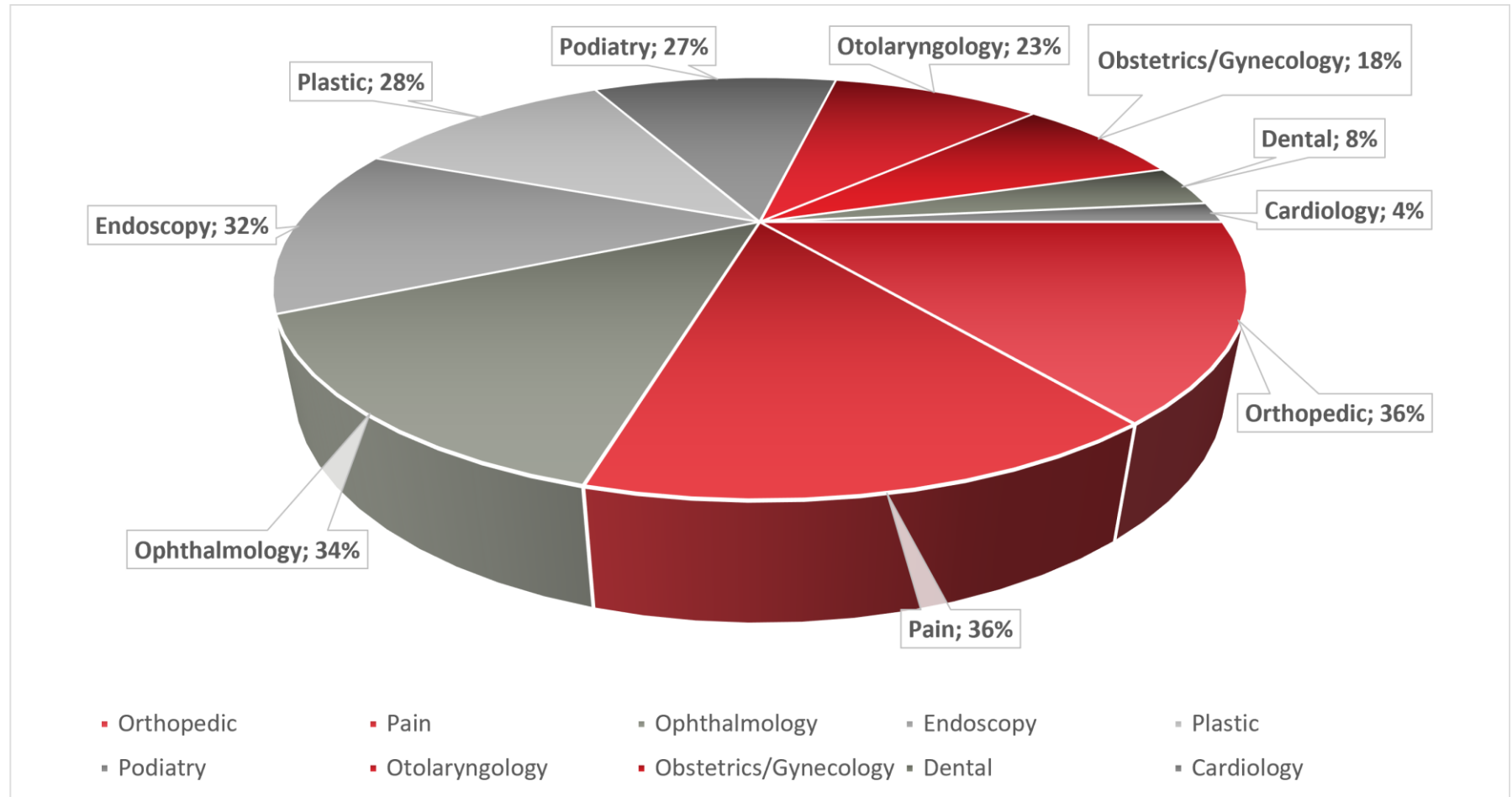


Source: Surgical Information Systems, *Ambulatory Surgery Center Statistics that Define the Industry*, available at: <https://blog.sisfirst.com/ambulatory-surgery-center-statistics-that-define-the-industry>

Medicare-Certified ASCs by Specialty Type

Percentages do not add up to 100 because centers may have more than one specialty.

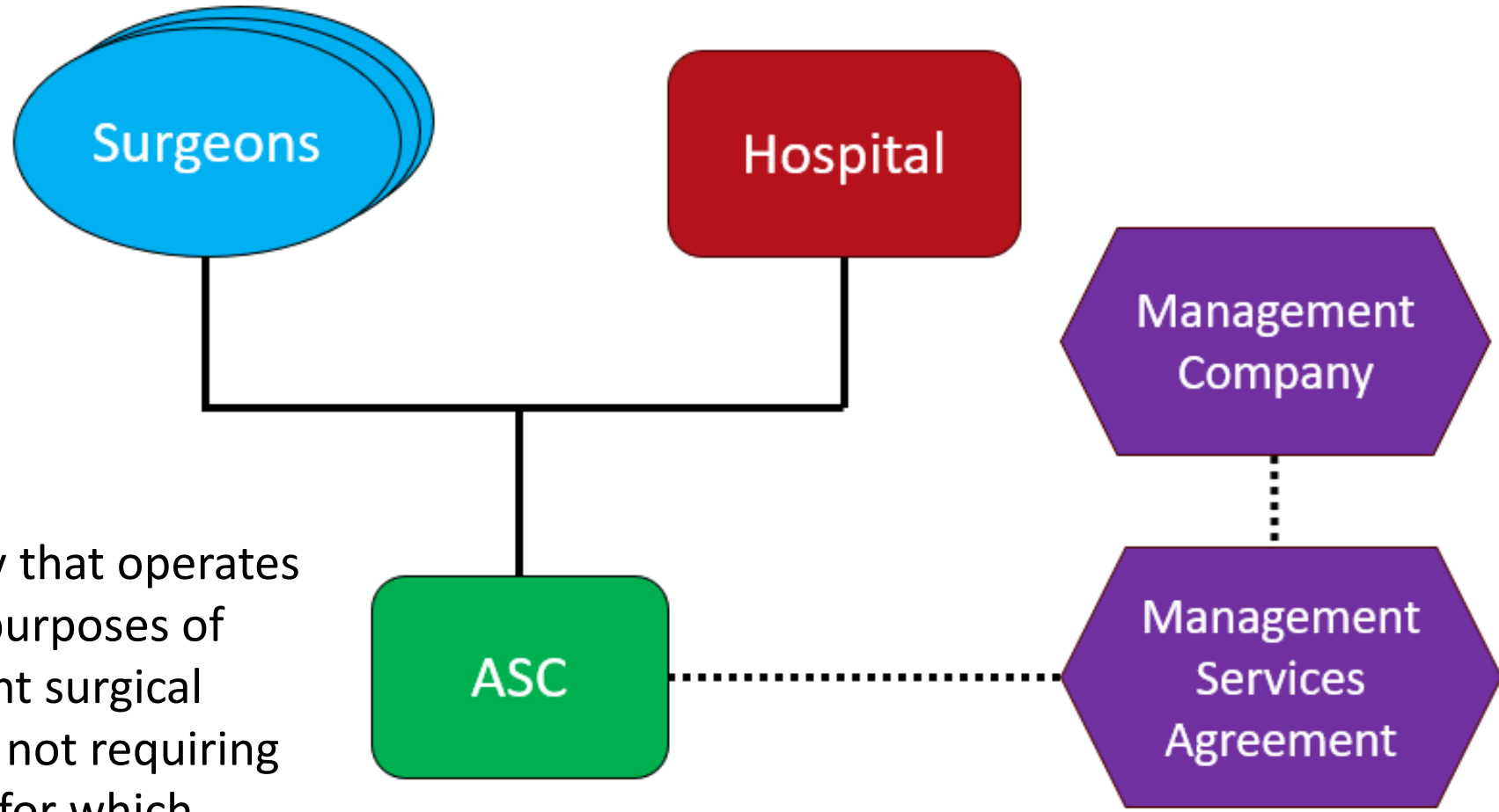
Note: Cardiology is currently the fastest growing specialty.



Source: Surgical Information Systems, *Ambulatory Surgery Center Statistics that Define the Industry*, available at: <https://blog.sisfirst.com/ambulatory-surgery-center-statistics-that-define-the-industry/>;

Becker's ASC Review, *ASCs' answer to the cardiology crisis*, available at <https://www.beckersasc.com/cardiology/ascs-answer-to-the-cardiology-crisis/>

Common Structure for Physician-Hospital Joint Ventured ASC



ASC = distinct entity that operates exclusively for the purposes of furnishing outpatient surgical services to patients not requiring hospitalization and for which expected duration of services would not exceed 24 hours



ASC Overview – Fraud & Abuse

- Stark Law
- Federal Anti-Kickback Statute
- Regulatory Guidance
 - Rulemaking commentary
 - OIG Advisory Opinions
 - Enforcement Actions

Stark Law v. Anti-Kickback Statute

| | Stark Law | Anti-Kickback Statute (AKS) |
|----------------------------|---|---|
| Citation | 42 U.S.C. § 1395nn | 42 U.S.C. § 1320a-7b(b) |
| Nature | Civil | Criminal |
| Prohibited Conduct | Prohibits a physician from <u>making a referral of a patient to a health care entity</u> for the furnishing of Designated Health Services (DHS) paid by Medicare or Medicaid if <u>physician</u> (or <u>immediate family member</u>) has a <u>financial relationship with the DHS entity</u> . | Prohibits anyone from soliciting, offering, paying, or receiving remuneration, directly or indirectly, to <u>induce or reward</u> arranging, recommending, or making a patient referral for any items or services paid in whole or in part under some federal health care program. |
| Scope of Application | Applies to: <ul style="list-style-type: none"> Only to physician referrals, and only when made to entities with which the referring physician, or an immediate family member, has a financial relationship. <ul style="list-style-type: none"> Only to DHS paid by Medicare or Medicaid. | Applies to: <ul style="list-style-type: none"> Any source of health care business referral, from anyone to anyone. Any items or services paid by any federal health care program. |
| Intent | Strict liability statute; No intent required. | Knowing and willful action. <ul style="list-style-type: none"> Includes acting with <i>deliberate ignorance</i> or <i>reckless disregard</i>. |
| Exceptions or Safe Harbors | Yes: statutory and regulatory exceptions exist. <ul style="list-style-type: none"> Arrangements covered by the Stark Law must fit within an <u>exception</u> to avoid violation. | Yes: statutory and regulatory " safe harbors " exist. <ul style="list-style-type: none"> These safe harbors ensure compliance but are not mandatory. |

How the Stark Law Applies to ASCs

- **Most ASC services are excluded from DHS by definition:**
 - An ASC service paid as part of the composite rate (e.g., outpatient prescription drugs or imaging paid as “covered ancillary services”)
 - X-ray, fluoroscopy, or ultrasound procedures needed to insert a needle, catheter, tube, or probe
 - Radiology and imaging services integral to performance of a medical procedure that on the CPT/HCPCS codes list as radiology or certain imaging services and the imaging service is performed immediately prior to or during the medical procedure or immediately following (when necessary to confirm placement)
 - Service-based exception: Implants are furnished by an ASC (e.g., intraocular lenses), by the referring physicians (or member of the referring physician’s group practice) and implanted during a surgical procedure paid to the ASC as an ASC procedure
- **Stark may apply to arrangements outside the ASC services such as:**
 - Anesthesia providers; Medical Directors; Space and equipment leases



Anti-Kickback Statute Safe Harbors

- Safe harbors **immunize certain payment and business practices** that are implicated by the Anti-Kickback Statute.
- To be protected by a safe harbor, an arrangement **must fit squarely** in the safe harbor.
- Failure to comply with a safe harbor provision does not mean that an arrangement is *per se* illegal.
- Compliance with safe harbors is **voluntary**, and arrangements that do not comply with a safe harbor must be analyzed on a case-by-case basis for compliance with the Anti-Kickback Statute.
- Parties who are uncertain whether their arrangements qualify for safe harbor protection may request an **OIG advisory opinion**.

Anti-Kickback Statute Safe Harbors

- **Investment interests:** No more than **40%** of the value of the investment interests of each class of investment interests may be held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity.
 - **ASC-specific safe harbors:** Protect certain investment interests in four categories of freestanding Medicare-certified ASCs:
 - Surgeon-owned ASCs (i.e., all general surgeons or all same specialty)
 - Single-specialty ASCs (e.g., all gastroenterologists)
 - Multi-specialty ASCs (e.g., a mix of surgeons and gastroenterologists)
 - Hospital/physician-owned ASCs
- 1/3 Income Test
- 1/3 Income Test and 1/3 Procedure Test



Anti-Kickback Statute Safe Harbors

- ASC-specific safe harbors - In general, *to be protected*:
 - Physician investors must be physicians for whom the ASC is an extension of their office practice.
 - Hospital investors must not be in a position to make or influence referrals (e.g., through hospital-employed physicians).

Ambulatory Surgery Center Safe Harbors

| Safe harbor conditions | Single-Specialty | Multi-Specialty |
|---|---|-------------------------------------|
| ASC certified under 42 CFR part 416 | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Disclosure of ownership interest | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Investment interests offered on terms not related to volume or value of referrals | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| No loans from ASC or other investors for purpose of investing | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Returns on investment must be directly proportional to amount of capital investment (including the FMV of pre-operations services) | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Ancillary services directly and integrally related to primary procedures performed at the ASC (and none separately billed to FHCPs) | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| No discrimination against FHCP beneficiaries (e.g., Medicaid) | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1/3 income test – at least 1/3 of investor’s medical practice income derived from performance of “procedures” (i.e., procedures on Medicare ASC covered list) | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1/3 procedures test – at least 1/3 of procedures performed by investor are performed in the ASC | -- | <input checked="" type="checkbox"/> |
| Notes: | <p>-Surgeon-owned and single-specialty are the same.</p> <p>-Hospital-physician joint venture ASC safe harbor requires all physicians to satisfy one of the first three safe harbors and requires: (i) the hospital to not discriminate against FHCP beneficiaries, (ii) the ASC to not use space, equipment, or personnel of the hospital unless the applicable safe harbor is satisfied, (iii) the hospital cannot include ASC costs on cost report (unless required by the FHCP), and (iv) the hospital to not be in a position to make or influence referrals or directly to the ASC or any investor.</p> | |

Ownership & Investment Issues



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Ownership & Investment Issues – Buy-In Pricing

- Buy-In Pricing for Acquisitions (Existing ASCs):
 - Must be FMV
 - Alternatives:
 - Formula amounts (EBITDA x multiple – long term debt) – predictable; confirm FMV periodically; consider a “floor” for start-up phase
 - Current valuations – gold standard; costly; take time
 - Fixed Fees – favored as “easy in/easy out”; often not FMV; insulates physician from business risks (OIG warning as disguised kickback)
- Buy-In Pricing for De-Novo Partnerships:
 - Initial capital contributions proportionate to equity interests
 - Watch out for hospital financing arrangements that create regulatory risk (e.g., using the hospital’s borrowing power to secure favorable financing)



Ownership & Investment Issues – Buy-Out Pricing

- Operating agreement redemption triggering events:
 - Adverse and non-adverse
 - Failure to comply with safe harbor / breach non-compete
 - Failure to remain affiliated with the hospital
- Full Redemption Payment versus Discounts
 - Reduction in price due to “adverse” events – common but associated risk (construed as a penalty for no ongoing referrals)
- Practicalities of buying out physician-owners:
 - Best practice: same as buy-in
 - Consistency is key (be careful of waivers of noncompliance)
 - Don't favor based on volume or value of referrals



Selection of Investors and Apportionment of Investment Opportunities

- Selection of Investors:
 - Referring physicians who use the ASC as an extension of their practice (personally performed services)
- Apportionment of Investment Opportunities:
 - Units available to each physician-investor should not be based on the anticipated volume or value of referrals.
 - Absent the need for capital, selling new units to existing physician-investors poses risks (e.g., offering units to reward utilization).



Ownership & Investment Issues – OIG ASC Advisory Opinions

| Issue | Favorable | Unfavorable |
|--|--|---|
| Inability to satisfy the 1/3 income test | 03-02 ¹ , 08-08 ² , 21-02 ³ | 03-05 ⁴ , 07-13 ⁵ |
| Acquisitions and unit price differs for certain subsequent investors | 01-21 ⁶ , 09-09 ⁷ | 07-05 ⁸ |
| Management company investment in ASC | 21-02 ⁹ | -- |
| Hospital-investor is in a position to influence referrals | 01-17, 01-21, 03-02, etc. | -- |
| Investing through a holding company | 01-17, 03-02, etc. | -- |

¹ In Adv. Op. 03-02, for a single-specialty (ortho) ASC, non-satisfying physician-investors would derive 1/3 of their income from procedures that are either ASC procedures or that require a hospital operating room.

² In Adv. Op. 08-08, for a single-specialty (ortho) ASC, non-satisfying physician-investors would use the ASC (albeit not “regularly”), would derive 1/3 of their income from procedures requiring a hospital operating room, and would rarely be in a position to make referrals for procedures performed by others at the ASC.

³ In Adv. Op. 21-02, for a multi-specialty (ortho and neuro), non-satisfying physician-investors would use the ASC as a regular part of their practice and derive 1/3 of their income from procedures requiring a hospital operating room. Cross-referrals would represent less than 1% of the ASC’s procedures.

⁴ In Adv. Op. 03-05, many physician-investors are non-proceduralists (e.g., primary care) and would never use the ASC.

⁵ In Adv. Op. 07-13, some physician-investors are non-proceduralists (specifically, optometrists) and would never perform procedures in the ASC. The fact that these non-proceduralists would sometimes assist with pre- and post-operative tasks in the ASC was insufficient.

⁶ In Adv. Op. 01-21, the hospital bought in after the ASC was operational and paid FMV as a going concern.

⁷ In Adv. Op. 09-09, investment would be based on FMV of tangible assets of each party (not valuing physician-investors’ ASC as a going concern).

⁸ In Adv. Op. 07-05, a hospital proposed to acquire units from orthopedists (but not gastroenterologists), which OIG found suspect because the hospital’s investment took the form of a purchase of units (rather than a capital investment in the ASC itself) and it was acquiring only from the orthopedists.

⁹ In Adv. Op. 21-02, management company would not make or influence referrals (directly or indirectly) to ASC or physician-investors, and there would be no physician ownership in Management company.

Compliance and Diligence Strategies: Ownership & Investment Decisions

- Safe harbor compliance:
 - Structure ownership to fall within a safe harbor if possible
 - Annual Attestations
 - Required case minimums - discouraged
- New investor / membership criterion:
 - How to determine if a new investor will be able to meet the “1/3 practice income test” and, if applicable, the “1/3 procedures test”?
- Highest risks involve “case-by-case” decision-making:
 - Purchase and redemption events/pricing
- Careless communications (“Dr. X’s productivity won’t make up for the dilution he/she will cause.”)



Compliance and Diligence Strategies: Key Fraud & Abuse Issues

- Ownership – cap table, transaction ledger, and distribution data:
 - Direct or indirect ownership?
 - If through group practice or holding company (HoldCo), how is compliance monitored?
 - HoldCo Operating agreement provisions requiring compliance
 - Ownership percentage – equal, if not, why?
 - Why did investors come and go?
 - Ownership disclosures for new investors
- Extension of practice
 - Annual attestations of physician investors
 - If outside safe harbors, documentation of how ownership is a true extension of physician's practice
 - Assess for cross-referrals between investors



Ancillary Services Arrangements & Risks

Physician-Hospital ASCs – Hospital provides services to the ASC:

- Space lease / finance tenant improvements
- Staff lease
- Equipment purchases and leasing (engineering services)
- Management services
- Sterile processing and maintenance of instruments
- “Loaning” when ASC has shortage – e.g., drugs, blood
- **GET A VALUATION.**

SMHA Healthcare Agreed to Pay \$910,000 for Allegedly Violating the Civil Monetary Penalties Law by Providing Remuneration in the Form of Space and Free Services

After it disclosed conduct to OIG pursuant to its CIA, SMHA Healthcare, Inc. f/k/a Memorial Health, Inc. Medical Center Services, Inc. Health"), entered into a lease agreement that resolves all disputes in the following manner: MPPG, lease provided free of charge to a joint venture

Ukiah Valley Medical Center Agreed to Pay \$1.6 Million for Allegedly Violating the Civil Monetary Penalties Law by Providing Remuneration to Physicians in the Form Uncollected Costs and Fees

After it self-disclosed conduct to OIG, Ukiah Valley Medical Center (UVMC), California, agreed to pay \$1,692,588 for allegedly violating the Civil Monetary Penalties Law provisions applicable to kickbacks. OIG alleged that UVMC paid improper remuneration to physicians who invested in a joint venture ambulatory surgical center with UVMC.

Ownership & Investment Issues Employed Physician Investors

- “To be or not to be, that is the question...” William Shakespeare
- ASC ownership becoming the expectation for recruitment and retention
- Compensation and ASC Distributions are separate
- Noncompetes:
 - ASC – ownership, management
 - Employment noncompetes
- Investor selection
 - Whistle-blowers all around



Ownership & Investment Issues: Cardiovascular ASCs



MAY 1ST 2025 | PRESS RELEASE

Katerina Dangas (Author)

Nationwide Study Finds Ambulatory Surgery Centers Treat 15% More Patients in Socially Vulnerable Areas for Cardiac Interventions

Coronary

Data From More Than 400,000 Patients Demonstrates Low Adverse Event Rates at 30 Days for PCI in ASCs and Hospital Outpatient Departments



WASHINGTON—The first study evaluating Medicare patients undergoing percutaneous coronary interver (PCI) in ambulatory surgery centers (ASCs) demonstrated good safety outcomes, such as mortality and ad event rates at 30 days, compared to outpatient hospital departments, but were less likely to use certain technologies. The late-breaking data were presented today at the Society for Cardiovascular Angiography Interventions (SCAI) 2025 Scientific Sessions.

Ambulatory surgery centers (ASCs) are non-hospital facilities that provide same-day surgical or procedural care to often low-risk patients. Since Medicare began providing coverage for certain PCI procedures in ASCs in 2020, more of these procedures are being done outside the traditional hospital setting. The shift to ASCs can primarily be attributed to the potential for cost savings, innovation in clinical diagnostics, and the growing aging population in need of care. *Between 2024 and 2034, ASC volume is anticipated to increase by 21%.* However, little is known about the patient and procedural characteristics and outcomes of PCI in ASCs.

January/February 2025

Facing the Hurdles in the Race to Develop Cardiovascular ASCs

With a focus on careful planning, technology investment, and patient safety, cardiovascular ambulatory surgery centers can revolutionize how cardiovascular care is delivered.



Cardiovascular ASCs - Benefits

- In 2026, CMS added 86 new CV codes, including several EP ablation codes, to the CPL
 - CMS did not add: Stand-alone electrophysiologic studies without ablation; transesophageal echocardiography (TEE) and certain pre-procedural imaging and planning codes that remain hospital-only services.
- Procedural throughput efficiency, patient satisfaction, and clinical team satisfaction, all reducing the burden on hospital-based cath labs and allowing them to focus on complex and acute cases.
- As cardiology transitions from the fee-for-service model to value-based care, ASCs also offer an opportunity to reduce costs compared to traditional inpatient stays, largely due to lower facility fees, fewer overhead costs, and greater efficiency.



Cardiovascular ASCs - Challenges

- Regulatory Compliance: Non-proceduralists as indirect owners

OIG Advisory Opinion No. 03-05 (Unfavorable Opinion re Multispecialty group ownership in ASC)

“Since the Group is a multispecialty group, there is a substantial likelihood of **cross-specialty referrals** for services performed in the ASC. Moreover, few of the Group Physicians will actually use the Surgical Center on a regular basis as part of their medical practice. In other words, **the Proposed Arrangement would allow those Group Physicians for whom the Surgical Center is not an extension of their office practices to profit from their referrals to the Surgical Center or to their partners who perform procedures there.** In this respect, the Proposed Arrangement poses the same risks as an ASC owned directly by surgeons and primary care physicians in the same community. In these circumstances, **the fact that the ownership of the ASC is held indirectly through a group practice whose membership includes both surgeons and other potential referring physicians does not reduce the risk that the venture may be used to reward referrals.”**



Cardiovascular ASCs - Challenges

- Regulatory Compliance: Non-proceduralists as indirect owners

OIG Advisory Opinion No. 07-13 (Unfavorable opinion re Optometrists investing in Ophthalmology/Hospital ASC)

“The Ophthalmologists and Optometrists are in distinctly different positions here. The Ophthalmologists personally perform surgical procedures at the Surgical Center ASCs, and such surgical business is effectively an extension of their office practices. For the Optometrists, however, the Surgical Center ASCs are not a comparable extension of their office practices. **As a result, the likelihood that they are using their investment in the Surgical Center simply as a vehicle for receiving remuneration for referrals of patients to the Ophthalmologists increases significantly.**”

As we have previously stated in the preamble to the 1999 Final Rule establishing the ASC safe harbor,

The gravamen of an anti-kickback offense is payment of remuneration to induce the referral of Federal health care program business. In the context of an ASC, our chief concern is that a return on an investment in an ASC might be disguised as payment for referrals. . . . [P]hysicians in specialties that typically refer to one another could jointly invest in an ASC so that they are positioned to earn a profit from such referrals or so that one physician specialty provides the ASC services and the other provides the referrals. In such cases, medical decision-making may be corrupted by financial incentives offered to potential referral sources who stand to profit from services provided by another physician. 64 Fed. Reg. 63518, 63536 (November 19, 1999).

Cardiovascular ASCs - Challenges

- Capital availability and steep investments
 - Catheter costs: \$10,000 - \$15,000 /case
 - Equipment
- Facility requirements
- State law restrictions
 - CON for percutaneous coronary intervention (PCI)



Investments in ASCs and Safe Harbor Compliance - Summary

- OIG focuses on whether each investor personally performs procedures at the ASC
 - Under the ASC safe harbors, ownership is expected to be tied to active participation, meaning the investor uses the ASC as an **extension of their own practice**.
- Indirect ownership through a medical group does NOT cure the problem
 - The unfavorable opinions make clear that even if the ASC is owned through a group practice or holding company, non-proceduralists still pose AKS risk.
- OIG views multispecialty or mixed-role ownership as increasing risk
 - The advisory opinions emphasize the risk of **cross-specialty referrals** and revenues generated from services the owner does not personally perform.
- Failure to qualify for the ASC Safe Harbor means heightened scrutiny
 - If non-procedural physicians cannot meet the “one-third income test” or “one-third procedures test,” the safe harbor doesn’t apply. While the arrangement is not automatically illegal, but it becomes a facts-and-circumstances AKS analysis, which is more subjective and more risk. OIG tends to view outside-the-safe-harbor structures skeptically when referral relationships are embedded in the ownership model.
- Revenue distributions must not correlate with referrals
 - The advisory opinions repeatedly warn that ownership cannot be a mechanism for rewarding, encouraging, or tying remuneration to referral patterns.



Use of CRNAs

- Privileging
- Physician supervision
 - States may “opt-out” of federal Medicare supervision requirements allowing them to practice independently and receive reimbursement.
 - 25 “opt-out” states: Alaska, Arizona, California, Colorado, Delaware, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, Washington, West Virginia, and Wisconsin
 - Often conflicts with state ASC licensure requirements for CRNA supervision



Legal and Business Challenges to ASC Management and Operations



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The Perils of an Equity Purchase versus an Asset Purchase

- Why do an equity purchase of an ASC? Primarily to preserve the licensing and C.O.N. status, but there are potential pitfalls.
- Undisclosed liabilities of the enterprise.
- Escrow money disputes and indemnification issues



ASC Federal Tax Issues and Challenges

- Most ASCs are limited liability companies (LLCs), which are generally treated as partnerships for federal income tax purposes.
- LLC Operating Agreements generally have some fairly complicated provisions regarding i) allocation of profits and losses, ii) member distributions, iii) capital accounts, iv) etc. It would be wise to have a partnership tax specialist vet the key income tax provisions in the Operating Agreement. “Minimum gain chargeback?”

MRA recently spent an hour on Teams with a client to explain the above-referenced issues with the 80% member in an ASC (a hospital) and they now (after over a year of operations) want to amend the Operating Agreement to change the way profits and losses are allocated among members.



Practical Tips for Representing an ASC as “Outside General Counsel”

- Remember, the entity, and not the Members or Managers are your client.
 - “A lawyer employed or retained by an organization represents the organization acting through its duly authorized constituents.” MRPC 1.13
- Prepare for competing and conflicting opinions, positions, and egos, and maintain your objectivity.

Noncompete covenants. Be very aware of state laws and market forces.



Practical Tips for Negotiating the Purchase or Sale of an existing ASC

- Selling the enterprise versus holding it and generating cash flow.
- Prepare for competing and conflicting opinions.
- Administer the negotiations via a unified method and message.
- Have only one designated person be the negotiator with the Buyer or Seller.
- Make it clear that if members engage their own attorneys, they are responsible for the fees.
- If selling a portion (typically at least 51%) of the equity interests to a third party, be prepared for lengthy, complicated and buyer-oriented transaction documents, including a new Amended and Restated Operating Agreement.
- At the beginning of the transaction document the ground rules for administering the transaction via Consent Resolutions of the Members and Managers.



Practical Challenges Raised by an ASC Manager this Week

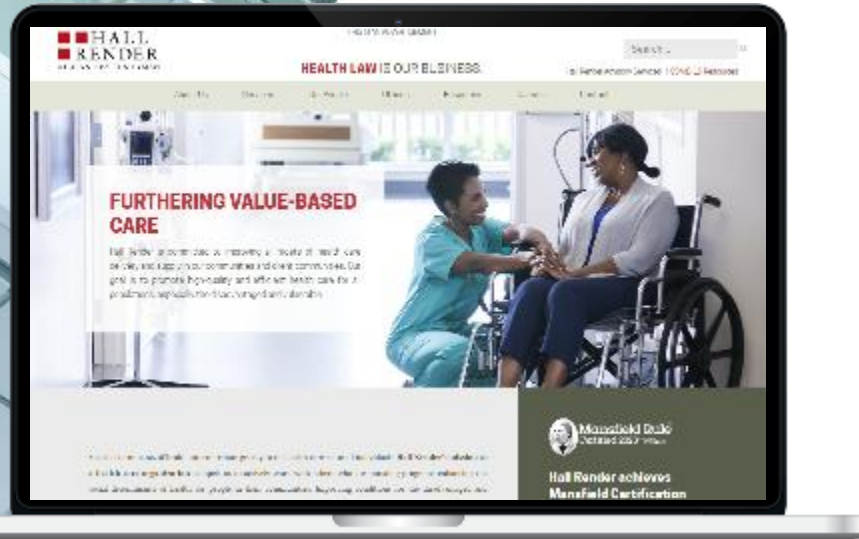
- **Authorization process.** Having a dedicated employee ensuring all procedures have the proper authorization. This has become so complicated and it's such a critical part of the process that we are having an employee dedicated to it at all new centers.
- **Commercial payors.** Some payors are reasonable and efficient, but others are not. Some payors are difficult to negotiate with and some payors pay so poorly that it may be better off not accepting that insurance at all. Some payors are trying to contract at rates as close to Medicare as they possibly can, which reduces profitability.
- **Anesthesia subsidies.** Anesthesia reimbursement has gone down and is not keeping up with supply and demand. Surgery centers are having to subsidize anesthesia providers by way of a monthly fees. In the past it was not budgeted for on the annual budget, and now it can be a big mistake not to allocate a budget for an anesthesia subsidy!



ASC Site Design and Layout Challenges – Bonus Section

- Waiting room and reception area.
- Pre-op room.
- Procedure or operating room (OR).
- Patient discharge/pick-up area.
- A main entrance that is separate from the patient post-procedure exit door.
- Examples of poor ASC layouts.





Questions?

For more information on these topics visit hallrender.com.



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