

# ASC BECKER'S Review

PRACTICAL BUSINESS AND LEGAL GUIDANCE FOR AMBULATORY SURGERY CENTERS

## Experts Weigh-In on the Key Elements and Challenges to Overcome in Developing a Successful Spine/Ortho Program

By Dana Kulvin, J.D., M.P.H.

Five experts offer tips on how to develop a successful spine/ortho ASC and overcome related inherent challenges. The tips cover, but are not limited to, issues related to managed care contracting, Medicare reimbursement, pain services and hospital partners.

### 1. What are the key elements to developing a spine ASC?

**Teuber:** A successful spine ASC ideally merges the specialties of neurosurgery and orthopedics with three key elements. First, comprehensively market the program to include non-invasive conservative care, pain management including all varieties of needle treatment (e.g., injections, diagnostic, therapeutic and ablations) and surgical techniques. Second, standardize surgical treatment including supplies, equipment and implants. Regarding implants, surgeons should use a single approved implant for each application (e.g., cervical plates, pedicle screws and associated hardware and various allograft applications). Third, ensure that all surgeons are trained to use all new devices and perform new techniques keeping in mind that established techniques and implants generally yield greater success, lower complications and minimum cost.

**Simmons:** A good spine ASC is developed with a mix of orthopedic and neurosurgeons and utilizes two key practices. First, an ASC's surgeons should be accustomed to and comfortable working in an ASC environment. An ASC will find greater success with surgeons who are experienced working in an out-patient setting and with more stringent efficiency controls and fiscal oversight than typically found in a hospital. To ease the transition for hospital surgeons, ASCs must provide fully staffed overnight facilities giving surgeons the option to keep a patient in recovery overnight that is more typical of a hospital. Second, an ASC must not scrimp on equipment and instead invest enough capital in order to obtain state-of-the-art spine equipment for the entire ASC.

**Hancock and Kowalski:** Four elements must be met in developing a successful spine ASC. First, evaluate the payor market and ensure sufficient reimbursement. If adequate reimbursement is not an option, development of the ASC should be reconsidered. Second, review the start up costs and determine that ample capital is available. Certainly, adding a spine program to an existing orthopedic ASC will be far less costly than building anew. Third, target surgeon partners and hire nurses and technicians comfortable and experienced in an out-patient environment. Surgeons may be uneasy about performing some spine procedures in an ASC and experienced nurses and technicians can help ease their trepidations. Lastly, become involved in patient selection, preparation and education so that patients will be comfortable and knowledgeable about having their surgery in an ASC. One good approach is to educate patients pre-operatively at the surgeons' offices.

**Kehayes:** The most important issue to resolve is whether payors will contract for the spinal and/or orthopedic services. Private payor reimbursement can be difficult for many reasons. First, many payors are reticent to work with spine ASCs for fear that competing hospitals will demand payors to increase contract rates on other hospital services in order to offset the losses that will result by moving spine cases to the ASC. Second, as many spine and

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orthopedic procedures are not included on public and private payor approved lists, payors are concerned about an ASC's ability to meet the payor's credentialing criteria for those particular procedures. Even when an ASC can demonstrate to a payor that it meets the criteria, payors do not want to have inconsistent credentialing policies between ASCs. Some payors fear that credentialing one center to perform spine cases requires them to credential all centers.

**2. What are the risks involved in providing pain management?**

**Teuber:** There are no risks in developing centers that also provide pain management services and the best spine centers include them.

**Simmons:** Pain management services are necessary in a spine ASC and generally have a good profit margin, but there are some risks to avoid. An ASC must adequately balance its pain procedures with other surgeries by providing enough post-operative beds to accommodate all the patients. With an average pain procedure lasting seven minutes, an ASC with a large volume of these procedures and inadequate space can be quickly overwhelmed and left without beds for its recovering surgical patients. Clearly this would result in a logistical and quality of care quandary. In the absence of post-operative bed availability, an ASC can schedule surgeries only in the morning and dedicate the afternoon to pain procedures, freeing up post-surgical beds. Alternatively, the ASC can have a dedicated pain day. This may become more critical as Medicare pain reimbursement decreases.

**Hancock and Kowalski:** There is no downside to providing pain services and they, in fact, nicely complement spinal surgeries. Injection work in particular is quick, low-cost and effective. However, it will be important to monitor Medicare's reimbursements for pain procedures, as they are expected to decline in the near future.

**Kehayes:** Pain management reimbursement is expected to decrease as much as thirty percent for a majority of high volume ASC injections under the proposed Outpatient Prospective Payment System ("OPPS") ASC reimbursement methodology, scheduled for implementation by next year. However, there is perhaps worse news. With the implementation of Medicare's site-of-service differentials, physician compensation increases for office-based pain management services. With this financial incentive, physicians may opt to move their pain management cases from the ASC back to the office setting and payors may advance this shift [See Sidebar on page 7].

**3. What are the managed care challenges?**

**Teuber:** The greatest payor challenges arise from monopolistic hospitals that, in vie for market control, use their influence and leverage to

exclude competing smaller niche centers from payor contracts.

**Simmons:** Two main payor challenges exist. First, the multitude of spine procedures not listed on the Medicare grouper list are similarly not provided for in private payor contracts. As such, payors may not reimburse non-grouper procedures or will reimburse them insufficiently. To assure adequate payment, ASCs must negotiate specifically for carve-out payments for procedures not on the grouper list. Second, most payors will not separately reimburse orthopedic and spinal implants. As these implants cost anywhere from \$3,000 to \$25,000, ASCs must carve out their implant reimbursements. Lastly, an ASC should walk away from a contract with an insurer that is unwilling to carve out these reimbursements.

**Hancock and Kowalski:** One big managed care challenge is non-reimbursable implants. Following Medicare's lead, private payors may not reimburse ASCs for implants making many procedures utilizing implants financially unattractive to perform. While an ASC may sometimes be able to obtain carve-outs for particular implants, it may not be enough. However, relief may be in sight as proposed cost pass-through legislation exists within the Centers for Medicare and Medicaid Service's ("CMS") New Medicare ASC Payment Systems Proposed. For example, CMS proposes including pass-through payments for implantable durable medical equipment and prosthetics (under the existing ASC reimbursement system payment falls under the overall facility fee). In addition under the proposed legislation, orthopedic payments could rise by as much as thirty-eight percent. See the proposed legislation at [http://www.cms.hhs.gov/ASCPayment/06\\_CMS1506P.asp#TopOfPage](http://www.cms.hhs.gov/ASCPayment/06_CMS1506P.asp#TopOfPage) and go to [www.fasa.org](http://www.fasa.org) to read further analysis.

**Kehayes:** Three main challenges exist. First, the Medicare grouper methodology is often used as the basis for private payor reimbursement which does not reasonably group orthopedic and spine procedures for compensation. To be successful, ASCs must negotiate for non-standard options, such as carve-outs, to be sufficiently reimbursed. This usually requires upper level payor approval, which can be difficult to obtain. Second, in the near future as CMS and payors migrate to the OPPS methodology, ASCs will be faced with greater challenges due to the inclusion of prosthetics and implants in global reimbursement under the APC payment. Under OPPS, there are cases where the surgical reimbursement rates are not adequate to cover the cost of the prosthetics and implants. Third, due to prompt payment laws and claims processing challenges that result from prosthetics and implants, many payors are moving to case rate type methodologies that do not provide additional compensation for prosthetics and implants.

**4. Clinically, what procedures should be done in an ASC that are now done at hospitals?**

**Teuber:** All pain procedures should and can be done in an ASC. In addition, lumbar discectomy (first time, recurrent or far lateral), lumbar laminectomy, lumbar fusion (with two nights of observation), simple lumbar tumors, ACF, cervical plating and cervical laminectomy can all be performed in an ASC. Due to the risks involved, esoteric procedures and patients with unique anesthetic risk are better served in a hospital.

**Simmons:** As long as it is performed safely and on a medically safe patient, any procedure that can be performed in a hospital in less than twenty-three hours and fifty-nine minutes is clinically appropriate for an ASC. However, the location a procedure is performed is more directly related to reimbursement. For example, Medicare does not reimburse lithotripsy in an ASC and therefore an ASC may not want to perform it on a Medicare patient.

**Hancock and Kowalski:** While simple discectomies (levels one and two) are commonly performed in ASCs, other multi-level procedures and fusions are still mostly performed in a hospital. This may be related to clinical factors but also often to the level of physician and patient comfort in an out-patient center, as well as reimbursement. With changing technologies, peer education, clinical success and a broader realm of reimbursements, in time more and more spine procedures will be performed in ASCs.

**5. Should a spine ASC have a hospital partner?**

**Teuber:** Determining whether an ASC should have a hospital partner requires an analysis of four issues. First, if the political landscape of the local medical community is conducive to joint venturing. Second, whether the hospital has historically demonstrated its willingness and ability to compromise and perform in good faith in a joint venture. Third, if the hospital is able to recognize that an ASC functions differently than a hospital and that an ASC's success is dependent on its operational efficiencies. Lastly, whether the hospitals' interests are aligned with the physicians and that it is not merely interested in controlling the operation.

**Simmons:** Hospital partners are often advantageous and in fact, about twenty-five percent of Regent Surgical Health's ASCs have them. Partnering with a hospital makes the surgeon's work easier. An ASC surgeon will typically not work solely in an ASC but will also perform surgeries in a hospital. In fact, for every spine surgery performed in an ASC, that surgeon will likely perform three to five spine surgeries in a hospital. By partnering with a hospital, the ASC facilitates an amiable relationship between the surgeon and

the hospital. In order for the arrangement to work for an ASC, the ASC must maintain control of the operation and not permit the hospital to become the majority owner or manager.

**Hancock and Kowalski:** While partnership with a hospital can be beneficial in regards to physician relations and managed care contracting, it is not always necessary and certainly not wise if the hospital intends to control management of the ASC. If a hospital is not truly motivated to work with the ASC, then the negotiating period is generally a big waste of time. However, in certificate-of-needs (“CON”) states where there are enormous barriers to entry to the market, partnering with a hospital is usually essential.

**Kehayes:** A new spine or orthopedic ASC can pose a financial threat to a hospital and the hospital may employ competitive measures against the ASC to protect itself. Consideration of a hospital partner may eliminate this opposition, especially in a CON state.

#### 6. What specific tips can you provide to those wishing to develop a spine ASC?

**Teuber:** Assuming that the ASC is providing high quality medicine that exceeds the standard of care, the success of the ASC is ultimately measured by its

profits. To achieve those profits, an ASC must have an adequate number of surgical procedures performed at the center, strong payor contracts, and optimal operational costs. Optimal operational costs are ideally achieved through the standardization of input goods (especially implants) and aggressive vendor negotiation.

**Simmons:** ASCs should focus on quality care as spine surgery is very complicated. Since it is a high acuity program, only the best surgeons and staff in the community ought to be practicing in the ASC. If the best surgeons are not available as partners, the ASC should not be developed. If necessary, ASCs should recruit experienced nurses and technicians from regional hospitals.

**Hancock and Kowalski:** An ASC should perform a good financial assessment before developing a program to ensure that there is ample reimbursement available and that the capital and operating costs can be met. In addition, an ASC must not underestimate the pre-operative preparation and education of a patient, who may have unrealistic expectations.

**Kehayes:** First, ASCs should perform payor due diligence to ensure payors are interested in doing business with the ASC and willing to offer sufficient reimbursement. Six to twelve months prior to opening, ASCs should begin negotiating

with payors because contracting can take time. Second, an ASC should resist pressure to sign an insufficient contract. It is important that *de novo* ASCs have adequate working capital lines of credit to permit the time necessary to negotiate an acceptable contract. The greatest opportunity for maximizing reimbursement rates is at the inception of contracting. Trying to renegotiate later is usually not an effective strategy to maximize reimbursement. Although there is a lot of pressure to finalize contracts, the first contracts negotiated generally set the pace for the ASC's future financial performance. Third, maximize working capital lines of credit in order to cover operating expenses during the start-up year while negotiating contracts.

#### 7. Any other pearls of wisdom?

**Teuber:** The keys to any successful business are enthusiasm, vision, access to reasonably-priced capital, discipline, risk tolerance, sound execution, the ability to respond to competition and evolve and performance surveillance. Specifically for an ASC to be successful, it must “cross-pollinate” itself with the best business practices of many diverse industries and not rely on the traditional hospital operational methods and corporate culture.

**Kehayes:** Although Medicare does not cover spine services in ASCs, many private payors have experience with ASCs performing spine surgery

and see their value. To this end, educate payors on spine surgery in an ASC and the tremendous cost savings that could be obtained. Have the ASC's spine surgeons work with the payor's medical directors when seeking approval for cases. In addition, the new OPPS methodology affords opportunities for increases in orthopedic reimbursement. Understand the future compensation scheme and educate payors so that the ASC can benefit. ■

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