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7 Keys to Successfully Launching a Spine Program in the ASC

By Stephanie Wasek

Increased reimbursement for orthopedic and spine procedures under the new Medicare ASC payment system as well as rapidly developing minimally invasive technologies and techniques for spine procedures are driving a boom in outpatient spine programs. Whether you're thinking about building an ASC around spine or adding the specialty to an existing facility (it works best, say our experts, when you're already performing orthopedics or pain management procedures), there are several key clinical and business considerations common to both models.

Before you ever get into patient selection criteria or negotiating reimbursement, however, it is important that you have a thorough understanding of your state's ASC laws.

"Does it allow overnight stay with discharge within 23 hours? This is the single most important determinant to assess the degree of spine acuity that may be performed," says Jim Lynch, MD, a board-certified neurological surgeon and the director of spine services for Regent Surgical Health. "That is to say, if you have overnight capacity then you can potentially double your case volumes and allow more complex case selection, such as multi-level anterior cervical disc fusions, multi-level laminectomies and minimally invasive lumbar fusions. These types of cases lead to higher reimbursement and yield per case."

Once you have those questions answered, you can move forward with exploring the other aspects of a spine program. Here are the seven issues our experts say are most important to your success.

1. The right surgeons

Before you ever get to patient selection, you must select physicians who are comfortable practicing in the outpatient arena — or who are willing to do so — to build your spine program around. The neurosurgeons or orthopedic surgeons you work with must be motivated and must understand the enhanced patient outcomes and satisfaction rates an ASC-based program represents. Physicians must be comfortable with both surgical techniques and the shortened length of post-op care and modified discharge criteria; they can't hold up turnover because they won't sign off on discharge for patients who are, by objective measures, ready to go home.

"The first thing that we consider, when we're working in a market, are the surgeons," says Cathy Kowalski, RN, executive vice president and chief operating officer of Meridian Surgical Partners. "Are the surgeons currently performing outpatient spine surgery, either in the HOPD or a freestanding outpatient surgery center? Do they have a proven track record in taking care of spine cases on an outpatient basis?"

These questions must be answered in the affirmative if you are to determine that you can move forward with a group.

"I have seen centers bring in equipment and train staff only to find the acceptance has stalled," says Gary Kurth, VP, facility operations management, for SpineMark Corporation. "It's not that it's a bad thing to ramp up slowly, but the initial comfort level of the clinical medical staff has to be there."

Further, look to partner with physicians who have — or who are eager to have — an understanding of the business side of an ASC-based program.

"Surgeon partners need to comprehend efficiency and budget controls," says Dr. Lynch. "Do not rely on just attracting the busiest surgeons."

2. Understand patient needs

"The ability to recover patients from spine procedures is very similar in nature to other outpatient surgical procedures," says Mr. Kurth. "For example, an uncomplicated three-level cervical fusion has a typical recovery in the ambulatory setting of about three hours."

Patient selection falls into line, for the most part, with that for other orthopedic procedures — patients should be not necessarily younger but generally healthy, be classified as ASA 1 or 2 in terms of risk, and have a good home support system. Managing patient expectations of the procedure and, more to the point, the post-op and recovery periods is important.

"So many patients see spine surgery as something that's going to keep them in the hospital for a week," says Ms. Kowalski. "The physician needs to control expectations from the beginning and convey, 'It's minimally invasive surgery, you'll be home the same day.' You can even put them in touch with other patients who have had it done. The key is to get them comfortable with the idea of going home with good pain control."

As a result, you should carefully develop protocols for dealing with pain control.

"In addition to vastly improved technology, anesthesia has progressed, letting us do spine in the outpatient setting — anesthesiologists use shorter-acting anesthetics, and patients can go home with improved pain control, including programmable pain pumps," says Ms. Kowalski. "You must have good protocols and pathways for dealing with complications, recovery and pain control after discharge. Patients should be fully educated on what's normal and what's not, what to look for if they're having an issue and someone to call if they think they're having a problem. When you manage these factors, readmission rates will be incredibly low."

3. Provide staff with thorough training

"Ensure adequate resources are directed to education of ASC staff, perioperative and postoperative nurses, as well as providing leading technology for both staff and physicians to ensure the procedure transitions smoothly between a hospital practice environment to an ASC setting," says Dr. Lynch.

You might even want to dedicate some of your staff to spine procedures; or, if volumes are not sufficient, to have only certain staff work the spine cases.

"Hire staff that specialize in spine," advises Ms. Kowalski. "Oftentimes, the physicians know who these people are and can recommend staff already competent working in spine. It's also good to pair inexperienced staff with more experienced frontline staff on the spine team; that way you can train them, but make sure they're not working alone until they're very comfortable with all perioperative and postoperative aspects of the procedures."

4. Budget enough for equipment

Your budget will run anywhere from several hundred thousand dollars to over $1 million, depending on how many of the necessities you already have in place, and how high-end you want to go.

"If you're doing a fair amount of ortho and pain, by nature, spine fits in really well — you'll already have a C-Arm and a drill system," says Ms. Kowalski. "You already have some of the bigger pieces in place, though you might need to buy a microscope or a specialty table."

Here's a list of the basics and estimates of what you can expect to spend:

- neuro microscope (about $80 – $100,000)
- C-arm ($150,000+)
- pneumatic drill set ($30,000)
- headlamp ($3,000)
- cervical lumbar instrument trays ($50,000+ — you probably want at least two sets)
- cautery unit ($50,000)
- lumbar table ($35,000)

"When developing the ASC spine program you should aim at replicating the hospital OR equipment and environment, even exceeding it when possible, to ensure surgeon familiarity and comfort level remain high," says Dr. Lynch. "No compromise should be made on equipment purchase to ensure your spine program has state-of-the-art technology. Otherwise, your efforts will fail in retaining certain surgeons and maximizing utilization."

That's not to say that you can't be cost-efficient.

"It's going to depend on the managers and surgeons to develop products and techniques that will consolidate efforts around a product or vendor," says Mr. Kurth.

Further, notes Mr. Lynch, an experienced corporate partner can enable the lowest capital outlay by negotiating on behalf of several centers and obtaining group purchase rates for equipment and supplies.

5. Look to work with a variety of payors

"On the reimbursement side, so much is tied to payor mix," says Marcy T. Rogers, MEd, the president and CEO of SpineMark Corporation. "A lot of freestanding centers have a lot of competition with local area facilities, and this kind of procedure can set you apart to insurers in the marketplace. Seek out a contractual base with a balanced payor mix."

Dr. Lynch advises that you aim to contract with insurances that represent over 10 percent of your business. You could also develop an out-of-network strategy to deal with patients whose insurers have not contracted with your center. However, the model can be risky, and you might want to seek out expertise from someone suited to deal with these important financial issues, he says.

The key is to do your due diligence with current and potential payors and explore out-of-network strategies before you ever buy the first piece of equipment.

"As soon as we believe we can potentially add spine, we start looking right away at the current contracts a center has, what those contracts allow, what the reimbursement climate is in the region for

spine," says Ms. Kowalski. "Determining your payor mix should be part of the financial assessment, right along with talking to physicians and determining potential case volumes. You can't decide whether a spine program makes sense without having an idea of both the volume and reimbursement you can expect."

6. Take a hard line on negotiations

While acceptance of outpatient spine procedures is growing, spine procedures are not listed on the Medicare grouper list. This means you have the opportunity to negotiate a procedure that is not necessarily on the outpatient roster for all insurers and, consequently, private payors may try to reimburse poorly or not at all. That's no excuse, says Dr. Lynch.

"Do not sign every contract presented to you," he says. "An ASC should never contract with an insurance that doesn't cover the total cost of the procedure. You won't be able to make it up elsewhere. Skilled professional negotiating is an absolute must to avoid entering bad contracts, which are a death knell to a spine program."

Mr. Kurth suggests you take this opportunity to become more acquainted with your payors in an effort to negotiate appropriate reimbursement.

"Get your physicians involved and have a conversation with the payor about the savings and quality outcomes you can provide," he says. "Some payors might say they're locked into a claims processing system that can't handle new diagnostic or procedure codes outside their programming; that's when you have to be flexible. See if you can come up with appropriate coding so their systems can handle it and generate a reimbursement methodology. Engaging your medical director and the medical director at the payor will go a long way toward overcoming any hesitations."

Further, carve-outs for implant reimbursement should be made with the insurance company due to the potentially high cost involved, says Dr. Lynch. For example, three-level cervicals can involve extensive plating systems and devices that fixate and allow the spine to be manipulated while controlling disc space; these systems alone run in the thousands.

Dr. Lynch also suggests two strategies for keeping implant costs down and, therefore, making it more likely you can cover their costs: "Consider using a third-party implant device provider, as they have better negotiating powers with insurance companies and thus let you avoid the risk of carrying large implant outlays every month," he says. "An alternative is streamlining your implant choice for surgeons and negotiating a best price direct from the manufacturer. This potentially limits surgeon choice, however, which is not always optimal."

7. Jump on opportunities for profitability

"Spine cases have the potential to pay so much for a few cases, unlike a lot of pain, where you need quite a bit of volume to get a quarter- or half-million dollars back," says Ms. Kowalski. "With spine you can add a program to a center with a single surgeon, as a few cases a month can be a lucrative supplement; 20 or more cases a month per physician is outstanding."

Here are some quick tips from our experts on how to make the most of the cases you schedule.

• **Make use of your software.** "By continuously tracking accurate data on cost per case basis and revenue per case we have been able to reduce our costs and increase productivity while managing to retain our best staff," says Dr. Lynch. "Implementing a computerized supply inventory has markedly reduced our supply costs and outlay."

• **Track quality data.** "We have tried to create systems that make it easier for our ASCs to collect, pull and report data, both regarding the procedure and whether patients are doing well one week, six months, two years post-op," says Ms. Kowalski. "ASCs haven't been forced to track quality data yet, but they will, and it will only enhance their arguments toward payors, because doing so lets you demonstrate the quality outcomes and cost savings we know we provide."

• **Maximize the schedule.** While it varies by physician, the average procedure runs about 90 minutes in the OR, says Mr. Kurth, so you're looking at five to six procedures a day a few times a week.

"Focus on how you arrange the cases for each day," says Mr. Kurth. "Don't schedule cases requiring long recovery times at the end of the day, for example, because it creates more staff and resource expenses during the longer period of recovery. Work with the surgeon to maximize the schedule heavily earlier in the day, and maybe fill out the afternoon schedule with pain management procedures."

• **Mix the complexity.** The longer, more complex procedures are typically more costly to perform, but also reimburse more; on the flipside, you can do more lower-reimbursing procedures in the same period.

"Look at your surgeons' practice volumes over the past few years, determine how many of those procedures could have been done outpatient, and use that to determine your program's procedure mix," says Mr. Kurth.

A good balance will keep you from being too reliant on lower-volume cases for reimbursement, or from not making enough on lower-reimbursement procedures.

• **Streamline business services.** "We initially hired a corporate central office dealing with multiple centers to code, bill and collect," says Dr. Lynch, "but found over time that the best arrangement is to have local, on-site billing and collecting. We use corporate billing expertise for individual difficult cases that may require considerable insurance negotiation. This duplicate arrangement working in parallel ensures that cases are being properly billed and collected especially high-end complex spine cases with multiple procedure codes."

Seek out resources — and become one

Starting a program can be overwhelming; you don't have to walk through all these steps on your own, notes Dr. Lynch.

"Encourage your spine surgeons and staff to visit other ASCs with established spine programs to alleviate their apprehension and reluctance and enhance their comfort levels," he advises. "Knowledge is key, and visiting established programs that have mastered the process is a rewarding and worthwhile exercise. Or you can take advantage of the expertise of an experienced corporate partner with a spine pedigree; this can help your center achieve the desired financial success and avoid unnecessary pitfalls."

Once you are up and running, don't be afraid to market your center. Show potential referring physicians in the community that your surgeons have expertise in spine; make patients aware that the outpatient setting is a possibility, and the benefits of the ASC environment.

"A comprehensive marketing program promoting a Center of Excellence is essential to maximize physician utilization and office surgical scheduler acceptance," says Dr. Lynch. "Letting members of the medical community and the community at large know about your advanced capabilities and excellent outcomes are vital to any successful program." ■

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