Orthopedic and Spine Contracting
A Review of Cost Analysis for Orthopedic and Spine and How to Present and Negotiate with Payors

I. Naya Kehayes, M.P.H., Managing Principal & CEO
R. Matthew Kilton, M.B.A., M.H.A., Principal & COO

9th Annual Orthopedic, Pain Management & Spine Driven ASC Conference
June 10, 2011

EVEIA HEALTH
Consulting & Management ®

Overview

- Capturing total cost
- Common high cost orthopedic & spine procedures
- Defining the cost to the payor
- Data needed
- Developing revenue targets
- Presenting to the payor

Calculating the Cost of Adding Orthopedic & Spine to ASCs

Common Orthopedic High Cost Procedures:

1) ACLs / PCLs
2) Rotator Cuff Repairs
3) Bankhart Repairs
4) Open Reductions with Fixation Devices

Orthopedic Procedures Transitioning from Hospital to ASCs

1) Uni-compartmental Knee Repairs
2) Total Joints – Shoulders, Knees, Hips

Spine Surgery in ASC's

Spine Cases Transitioning from Hospital to ASCs

1) Anterior Cervical Discectomy & Fusion
2) Laminectomy
3) Laminotomy
4) Posterior Lumbar Interbody Fusion
5) Anterior Lumbar Fusion
6) Implantation of Spinal Cord Stimulator

Calculating the Cost of Adding Orthopedic & Spine to ASCs

Costs to Consider:

1) High Cost Implants & Supplies
   Screws, Allografts, Arthrowands, Bone Cement
2) Increased Labor Cost
   Extended O.R. & Recovery times
   Modifications to staffing
3) Rental Equipment / Use Fees?
4) Capital Expenditures

Capturing Cost – Spine Example

Capturing Cost- Spine Example

Time Commitment- Physician and case mix dependent

- Spine cases can be LONG
  - Simple Laminectomy 60 mins or less
  - Complicated ACDF/PLIF 2-3 hours
- Spines cases often need longer recovery times
  - First case of day, last case to leave
  - Nursing intensive post op with frequent neuro checks
- Physician Dynamics
  - Spine cases may disrupt or displace other, normally profitable service lines
    - Have detailed discussions with existing partners
    - Understand impact to block schedule

Capital Considerations – Spine Example

Capital Considerations - Very physician dependent

- Spine Table (if needed or requested)
  - Jackson Table ($100K +)
    - Free standing spine table
    - Large footprint, requires additional set up and break down time
  - Allen Frame ($25K to $40K)
    - Attaches to existing OR table to hold head/neck in place
    - Less rigid than Jackson Table
- Spine Microscope ($50k – 150K)
  - Surgeon may be able to use existing microscope in ENT or Ophtho facility

Capital Considerations – Spine Example

- Specialized Equipment Trays ($25K - $50K)
  - Instruments, drills, etc
    - May be able to get compared by vendor in exchange for agreement on implants/disposables
- Sterilization Equipment
  - Can existing sterilizers handle large spine trays?
- Head Gear, Space Suits, Video Systems ($10K – $25K)
  - Every surgeon has different preference

Adding Spine: Staffing Considerations

- Different nursing skill set in OR and PACU
- Many surgeons highly value existing team at hospital
  - ASC may need to bring on spine specific team to keep physician comfortable
  - Surgeon may request 1, 2, or 3 techs per case, depending on case mix, history, experience
- Equipment needs are extremely variable
  - Circulating RN must understand and anticipate needs for efficiency
- PACU RNs
  - May need to relearn/modify methods for long term recovery process
  - Extended recovery needs (food, entertainment, comfort) different from typical ASC process

Capture Total Cost!

Why is this so important?

- New orthopedic & spine services transitioning are costly
- Volume is typically low
- Reimbursement requirements are greater due to cost & inadequate payment methodologies
- Payors who do not pay implants separately, must have rates high enough to cover total cost of worse case scenarios
- Capital expenditures must be included in the analysis

Opportunities

Presenting Cost and
Negotiating with Payors

Opportunities to capitalize on shifting volume by demonstrating cost & savings to payors

ASCs continue to be a solution for payors when…

1) cost effectiveness can be demonstrated
2) facilities can move volume out of hospitals, thereby demonstrating cost savings
3) ASC provides transparency to the payor by sharing cost information via invoices or vendor price quotes
4) ASCs can validate cost savings opportunity for payor – patient examples, hospital locale, physician data

What makes high cost orthopedics & spine attractive to the payor in the ASC?

Examples of Average Hospital Cost to the Commercial Payor:

1) ACLs & Shoulder Repairs - $15,000 - $30,000 +
2) Total Joints - $30,000 - $100,000+
2) ACDFs - $25,000 - $50,000+
3) PLIFs - $60,000 - $100,000+

- ASCs can demonstrate significant cost savings even on low volume due to the magnitude of hospital expense

Payor Perspective

Common Payor Questions and Reactions...

1) Where are these cases performed today?
2) How much does it cost Payor to continue having them performed at those locations?
3) Is anyone else in the market/region/state performing these cases today?
4) What is Medicare's position?
5) How will the Medical Director respond?
6) How will the Hospital's react?
7) If they can perform these cases in an ASC, surely they must be inexpensive?

What makes high cost orthopedics & spine attractive to the payor in the ASC?

How does the ASC effectively present data to payors to present cost savings?

1) Hospital case examples from physicians that are looking to move volume
   a) Member ID
   b) Hospital Locale
   c) CPT codes billed by the physician
2) Hospital EOBs
3) Invoices
4) Vendor Price Quotes
5) Cases that present Highest Cost

Developing Revenue Targets & Negotiation Strategy

Developing Revenue Targets

How do you determine revenue targets?

- Profit Margin above cost, including capital outlay
- % savings compared to hospital
- *Break even analysis:* How much volume is needed and at what rate, to break even on total cost including capital expenditures?
- ASCs that can show a 30%+ savings to payors will typically get their attention

Developing Revenue Targets

Understand payment methodology options?

- Contract Reimbursement Methodology

  a) Case Rates
  b) Payor defined fee schedule
  c) APCs
  d) Carve Outs
  e) Implants paid separately
  f) Limited # of codes paid on multiples with no implants

Negotiation Strategy

Important Payment Methodology Questions to Answer…

- How does the payor reimburse procedures; are they allowed in ASC setting?
- If assigned a payment rate, how does it compare to cost?
- Does the payor have carve out capabilities?
- How does the multiple procedure logic impact negotiations?

Negotiation Strategy

How do you address methodology limitations with the Payor?

1) Code limitations to payor list - seek review with Payor Medical Director with key surgeons
2) If rate assignment is in adequate, educate payor with total cost information
3) If payor has carve out capabilities, and codes are not assigned, seek approval to negotiate rates as carve outs or create new "carve out" payment groups
4) Multiple procedure limitations must be factored into rate; if add on codes are reduced or limited, rates must be greater for codes that are reimbursed under payment methodology

Completing the Process

Summary of Points for Achieving Success:

- Does the payor understand total cost structure?
- Has your ASC captured all costs when developing revenue targets?
- Educate the payor and share data when appropriate
- Key physicians may need to assist with payor education
- Demonstrate to the payor how your ASC can reduce dollars by shifting cases from the hospital
- Working with the payor is critical to long term success