



Spine surgery migrates to outpatient setting

More spinal surgery is moving to ambulatory surgery centers (ASCs) as spine surgeons look for the same control, efficiency, cost-effectiveness, and patient satisfaction that the outpatient setting has offered other specialties. As spine surgery migrates, hospitals are seeking ways to partner with surgeons to keep from losing the revenue from spinal procedures.

Overall, outpatient spinal surgery is expected to increase by 37% over the next 10 years.

Procedures that can be done minimally invasively, such as microdiscectomy and laminectomy, are expected to grow the fastest in the outpatient setting, increasing by more than 100%. Out-patient vertebroplasty and kyphoplasty are projected to grow by over 90%, according to consultants Sg2 (www.sg2.com), Skokie, Illinois (graphs, p 26).

How much of that growth will be outside the hospital isn't clear from the data, says Steve Miff, PhD, vice president at Sg2.

Among trends fueling the migration are minimally invasive techniques and surgeons' desire for more autonomy and a greater share of the revenue from their procedures.

"I believe the entrepreneurial spine surgeons will try to move these procedures into a joint venture ASC with the hospital or to set up a physician-owned ASC," says Ron Schmidt of DMI Transitions, a Cleveland-based consulting firm. "Not all spine procedures will migrate out of the hospital, but more will move into the outpatient setting."

Among surgeons, "it's almost a generational thing," notes Richard D. Guyer, MD, an orthopedic surgeon and president of the North American Spine Society. "The younger surgeons are computer and technologically savvy, and they're more willing to do this kind of surgery minimally invasively in an outpatient setting."

He believes it's better for patients to recover in their own homes where they're more comfortable and likely to ambulate sooner.

Twenty years ago, he recalls, anterior-posterior fusions were performed in 2 stages—operating on the front side one day and on the back side 7 days later. Patients spent at least 2 weeks in the hospital and took 9 to 12 months to fully recover. Now the same surgery is performed in just a few hours with minimally invasive techniques, and many patients go home the next day. With the addition of biologics such as bone morphogenetic protein (BMP), he says, patients are healed within 3 to 4 months.

Creative venturing

In some markets, hospitals and physicians are finding ways to collaborate, forming joint ventures, spine institutes, and other types of agreements.

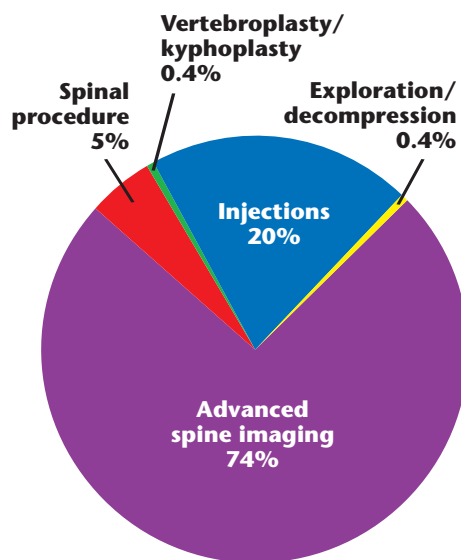
Dr Guyer is co-founder of the Texas Back Institute, with 7 locations in the Dallas area. Some physicians from the institute are in a joint venture hospital with the not-for-profit Presbyterian Hospital system.

An advantage of joint ventures for physicians is that they share the risk with the hospital and can draw on the hospital's resources to develop the facility. For hospitals, the advantage is that they keep at least some of the revenue from spine cases, rather than seeing it bleed out to physician-owned centers.

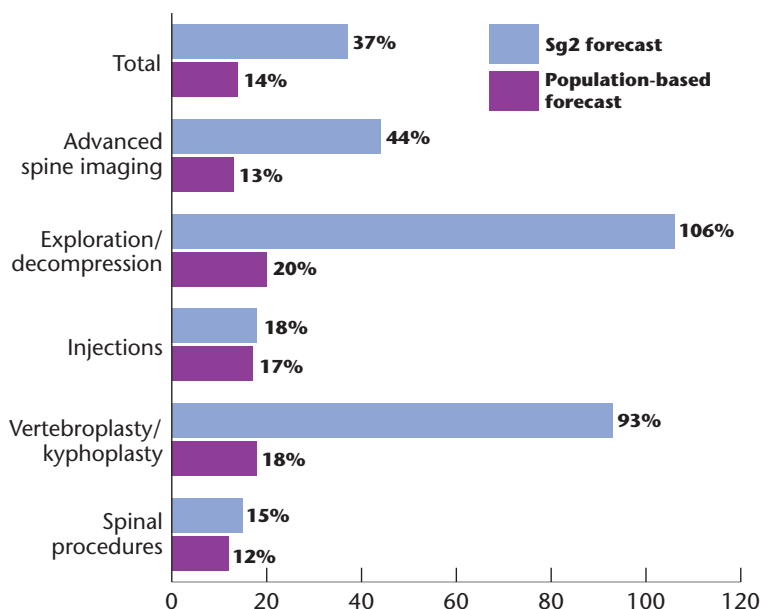
Spine procedures shifting to outpatient setting

Outpatient spine market 2007

Total volume: 14.3 million



Outpatient spine growth forecast, 2007-2017



Note: Population-based forecast is based on population growth and demographics. Sg2 forecast also includes factors such as technology, consumerism, and reimbursement trends.

Source: Sg2 based on Pharmetrics, HCUP, CMS, CDC, 2007. www.Sg2.com.

The major advantage of freestanding outpatient centers is “more autonomy for the surgeons,” who are seeing declining reimbursement, says Mick J. Perez-Cruet, MD, a pioneer in minimally invasive spine surgery and director of minimally invasive spinal surgery at the Michigan Head and Spine Institute, Providence Medical Center, Southfield, Michigan.

With their own spine center, he says surgeons can deliver spine care more efficiently, enabling them to treat more patients and increase revenue. They can also benefit from ancillary businesses like imaging, pain treatment, and rehab.

The drawback is that most surgeons don’t have the time or business background to develop such a complex enterprise.

Management companies, such as Nashville, Tennessee-based Neospine (www.neospine.com), are partnering with spine surgeons to develop surgery centers. They bring data, financial models, and experience in negotiating managed care contracts. Neospine to date has partnered with physicians in 7 ASCs and 4 imaging centers.

Challenge of reimbursement

Winning managed care contracts is a big challenge in setting up an outpatient spine center. It takes education, persistence, and data, says Neospine’s COO, Stephen Faro. The company’s representatives have traveled the country meeting with insurers like United Healthcare, Aetna, Cigna, and Blue Cross Blue Shield.

Surgeons and others who are developing centers need to gather data on their clinical outcomes so they can demonstrate that spine procedures can be performed safely in the freestanding setting, Faro notes. They also need to be prepared to educate insurers

about the costs of spine surgery. Insurers are used to paying ASCs \$2,000 to \$3,000 or perhaps \$4,000 for procedures like laparoscopic hernia surgery or anterior cruciate ligament repairs. But for an anterior cervical fusion, the cost alone is much higher.

Typically, he says, managed care companies have followed Medicare's lead on ASC payments, and spinal surgery CPT codes haven't appeared on Medicare's ASC list of procedures approved for coverage. So they don't have much experience paying for spinal surgery outside the hospital.

To help educate them, Neospine cross-walks the hospital DRG charges managed care companies are used to paying for spinal surgery with the costs for spinal surgery CPT codes performed in ASCs.

Says Faro, "They can look at the hospital charges and see that they charge for observation, recovery room time, pharmaceuticals, and so forth. We are charging them one fee for a CPT code."

By sharing cost data, he says Neo-spine has been able to get the payers to say, "OK, if it costs you X, and we are paying Y at the hospital, we feel comfortable paying you Z."

In addition to the cost data and presentation, the company brings its neurosurgeons in to meet with the insurers' medical directors.

"We get the contracting folks comfortable with it. From that, we have had good success in getting the managed care companies to come around," he says.

Neospine, founded by Richard Wohms, MD, MBA, a neurosurgeon on the faculty of the University of Washington, Seattle, has a clinical outcomes and patient satisfaction data base that it can draw on for presentations to payers.

Spine institute integrates care

The move toward pay for performance, coupled with its need for quality reporting, is bringing some hospitals and physicians together, observes Schmidt, who was formerly orthopedic administrator at the Cleveland Clinic. In pay for performance, part of reimbursement is based on improving on quality measures. Physicians need the data management services hospitals can provide, and hospitals need physicians' active collaboration to make improvements in clinical processes.

One model DMI Transitions has employed is an institute where surgeons and a hospital come together to develop an integrated care model for a service line.

In one such instance, a 2-hospital system in the Southeast developed an ortho-neuro institute with a group of neurosurgeons. One of the system's hospitals was fairly new and well located but wasn't making enough revenue to support itself, and no orthopedic or neurosurgeons were working there. The system and physicians negotiated an agreement to form the institute, which integrates the flow of patients from the physicians' office, through surgery and rehab, and back to the physicians' office.

The hospital set up a spine intake center plus a "joint camp" for rehabilitation of total joint replacement patients. Four ORs are dedicated to ortho-neuro procedures, and the hospital is developing joint ventures with the surgeons for 2 ASCs. Physicians are paid for institute-related administrative duties, such as developing clinical pathways, through a comanagement agreement.

An institute must be set up on a quality platform, Schmidt emphasizes. "I tell them right up front, this isn't just about money. You have to be willing to measure your quality outcomes—infection rates, complication rates, return to surgery, length of stay, costs per case, and standardization."

In considering this type of arrangement, Schmidt says, the hospital and physicians need to ask what their goals are and whether there is synergy. The answers depend on the local market, hospital-physician dynamics, and ultimately whether both parties can develop trust in one another. ♦

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