Becker's 13th Annual Spine, Orthopaedic, and Pain Management Driven ASC Conference

Part 1: The Changing Healthcare Environment, Implications of Medicare and Modifications to Payment Systems

Adding Spine & Total Joints to ASC Contracts, Critical Steps to Achieving Success

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Current Environment – Medicare ASC Methodology Changes

Key Orthopedic Inpatient and HOPD Codes Approved for ASCs

Medicare Changes for ASCs

Add-on Codes Expanding
ORPS payment logic changes

Medicare Changes Impacting ASCs

Migration from "Inpatient Only" to HOPD to ASC approved list
Select Lami, Cervical & Lumbar Fusions added to ASC list
ASC code list expanding
Favorable & Unfavorable Implications on Commercial Payors
Key codes missing at "Case" level
Medicare Changes Impacting ASCs

Device intensive allocation reduced from 50% to 40% favorable – for Orthopedics
Approved Codes and Relative Weights & Rates, not Enough to Cover Cost
OPPS Payment Logic Changes
Presents increased or decreased opportunity with Commercial Payors
APC Weights have been adjusted for spine- but still may not be strong enough!

Medicare Changes Impacting ASCs

Key Codes in Fusion Cases Not Approved or Considered Add-on with No Additional Payment
Add-on Codes Impacting Spine, Pain Management & Orthopedics
Add-on Codes Have Potential Negative Impact on Commercial Payors
Add-on Codes Bundled Include Implant Intensive Cases and Added Cost for Providing Services

Common Orthopedic & Pain Procedures Impacted by Bundling

- ASC Medicare Approved “Add on” Code Examples
  - 29826: arthroscopy shoulder, in addition to primary
  - 64480: add’l level injection, cervical or thoracic
  - 64484: add’l level, lumbar or sacral
  - 64491: add’l level injection, 2nd level, cervical or thoracic
  - 64492: add’l level injection, 3rd or more, cervical or thoracic
  - 64494: add’l level injection, 2nd level, lumbar or sacral
  - 64495: add’l level, injection, 3rd or more, lumbar or sacral
Common Spine Procedures Impacted by Bundling

- Spine Code Examples of Add On Codes
  - 20930, 20931: allograft
  - 20936, 20937: autograft
  - 22552: each additional interspace (cervical fusion)
  - 22614: each additional vertebral segment (lumbar fusion)
  - 22851: application of cage
  - 22845: anterior instrumentation for 2 – 3 vertebral segments
  - 63035: spinal disk surgery add on
  - 63057: decompress spine add on

Spine Codes Not Approved for ASCs that are Commonly Part of a Case

- Allografts: 20930-20936
- Cages: 22851
- Instrumentation: 22842, 22845

ACDF Example – 1 & 2Level with Cage

Scenario: ACDF with multiples paid for add on codes, inclusive of implants vs. add on codes bundled
How do These Factors Impact Your Success with Adding Spine to an ASC Contract?

Critical Steps to Succeeding at Adding Spine to an ASC Contract
- Hospital Volume Review
- Implant Cost Review
- Confirm Case Code Combinations by Physician
- Commercial Payors Payment Logic & Options
- Bundling of Add On codes vs. Multiple Procedure Payment Logic
- Typically requires Carve Outs
- Implant reimbursement?
- Cost Analysis Critical to Determining Rate Targets
- Demonstrate Savings to Payors

Assess Opportunity with the Payor
- Do you have experience with other payors where you can show outcomes?
- Can you provide data to payors proving savings?
  1) Hospital EOBs
  2) Cost Data
- Are you really a Cost Savings to the Payor?
- What about the Payor’s Relationship with the Hospital?
How do you Achieve Success with the Payor?

- Share information
- Present data
- Prove savings
- Demonstrate quality
- Communicate to the payor
- Positive relationships = Success!

Adding Total Joints to ASC Contracts

Current Environment & Critical Steps to Achieving Success

- Total Joint Codes Approved by Medicare
- Review of 2015 Medicare Payments
- Current environment with Commercial payors
- What information do you need from your physicians?
- Payor Due Diligence – Commercial payor is aligned and willing to negotiate, how do you get there?
Common Primary Joint Arthroplasty Codes

✓ 23470 – Arthroplasty glenohumeral joint (hemi arthroplasty)
✓ 23472 – Primary total shoulder arthroplasty
✓ 25446 – Primary total wrist arthroplasty
✓ 27130 – Primary total hip arthroplasty
✓ 27446 – Arthroplasty, knee, condyle and plateau; medial OR lateral (partial knee replacement)
✓ 27447 – Primary total knee arthroplasty
✓ 27702 – Ankle arthroplasty

2015 Medicare Rates

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<th>CPT</th>
<th>Description</th>
<th>ASC Rate</th>
<th>HOPD Rate</th>
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<tr>
<td>23470</td>
<td>Reconstruct shoulder joint</td>
<td>$0</td>
<td>$10,224</td>
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<tr>
<td>23472</td>
<td>Reconstruct shoulder joint</td>
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<tr>
<td>25446</td>
<td>Wrist replacement</td>
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<td>Partial hip replacement</td>
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<td>27130</td>
<td>Total hip arthroplasty</td>
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<td>27446</td>
<td>Revision of knee joint</td>
<td>$7,844</td>
<td>$10,224</td>
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<td>27447</td>
<td>Total knee arthroplasty</td>
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<tr>
<td>27702</td>
<td>Reconstruct ankle joint</td>
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Note: National Rate, inclusive of implant

Current Reimbursement Environment with Commercial Payors

• Nationally, payors are demonstrating interest in finding ways to reimburse total joints

• Most are utilizing framework of their existing outpatient methodology, or some type of carve out

• Implants are being covered incrementally by some Payors, while other payors are including the implant in the procedure reimbursement
Current Reimbursement Environment with Commercial Payors

• Regional and local payors are demonstrating uncertainty with respect to reimbursement of total joints
• Experiencing significant variability from state to state and region to region.
• Regional and local payors often lack payment methodology that addresses total joint reimbursement
• When payment logic is present, reimbursement is often inadequate and inappropriate relative to cost

Why Payors are Struggling with the addition of Total Joints

• Perception of “generalists” performing specialized services
• Uncertainties and inconsistencies with respect to recovery, pain control, therapy
• Perception that clinical quality and safety may be overlooked with rates in favor of profitability

Examples of National Payor Clinical Policy Website

• Verify that the total joints you intend to perform have been approved by commercial payors
  • United Healthcare https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelid=6622891933913610&PrmYCM100000c520720a
What Information Do You Need From Your Physicians?

- Data to help identify them within the payors system
  - Name
  - License number
  - NPI
  - Location(s) of service where cases are currently being delivered

What Information Do You Need From Your Physicians?

- List of CPT codes surgeon(s) anticipate performing
- Anticipated case counts by procedure by payor
- Implant cost information

Next Steps

- Establish dialogue with Payor to determine if total joints can be added to your existing contract
- Contract due diligence – does your existing contract cover the service and at what reimbursement?
- Doing your homework is required before going to the negotiation table
- What Next?
Questions?

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