SOCIETY FOR AMBULATORY ANESTHESIA
Outpatient • Office Based • Non-Operating Room

ASC Medical Directors & Leaders Virtual Summit
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How to Build a Successful Total Joint Program in your ASC

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Objectives

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1. Discuss the landscape of Total Joint Arthroplasty
2. Recognize the benefits of moving total joint arthroplasty to the ambulatory surgery center
3. Discuss the keys to building a safe and successful total joint arthroplasty program in your ASC
4. Understand the payer landscape and the considerations for maximizing reimbursement
5. Identify outcome monitoring tools for your total joint arthroplasty program

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Total Joint Arthroplasty Landscape in 2022

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- Sg2, a healthcare strategy and advisory firm, projected 37 percent of total joint surgeries would be outpatient by 2022, with that number rising to 51 percent by 2026
- Total knee replacement became eligible for Medicare payment in the ASC setting in 2020, and Medicare added total hip replacements in 2021. Still waiting for Total Shoulder Arthroplasty to be added to the ASC list

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ASC Total Joint Procedures

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Year	2012	2013	2014	2015	2016	2017	2018	2019	2020
No. of ASC total joint procedures	5	37	359	1,096	2,325	3,498	5,409	9,226	14,281

The number of total joint procedures performed in ASCs has grown exponentially between 2012 and 2020 and has increased by 55 percent since 2019.

AAOS American Joint Replacement Registry 2021 Annual Report

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Age of Patients

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- Mean Age of Patients Undergoing Arthroplasty Procedures, 2012-2020 (N=2,171,930)
  - Total Knee Arthroplasty 67.0
  - Revision Knee Arthroplasty 65.5
  - Partial Knee Arthroplasty 64.4
  - Primary Total Hip Arthroplasty 66.1

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Case Breakdown

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- Hip Arthroplasty – 81% are Primary THA (Total Hip Arthroplasty) and 35% of all TJA (Total Joint Arthroplasty) are Primary THA
- Knee Arthroplasty
  - Primary TKA (Total Knee Arthroplasty) makes up 52% of all TJA
  - Revision TKA – 4%
  - Partial Knee – 2%

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Benefits of Performing TJA in the ASC Setting

- Procedures are less invasive than they have been historically
- Cost – patients typically pay significantly less to have this done in an ASC
- Authorization – easier to get if done in an ASC
- Health and comfort of the patient
- Faster recovery
- Less chance of surgical site infection

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Keys to Setting Up Your Outpatient TJA Program

- Physician Champion
- Multidisciplinary approach to planning
  - Anesthesia
  - Surgeons/PA's
  - Physician Office Staff
  - Clinical Staff
  - Managed Care
  - PT
  - ASC leadership

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Key Items to Include in Plan

- Patient Education
  - Classes
  - Booklets
  - Videos
- Total Joint Coordinator
- Clinical Pathways
- Anesthesia
  - General
  - Spinal
  - Blocks (which kind)
  - Patient Selection Criteria

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(Cont)

- Postoperative
  - Home Health?
  - Physical Therapy?
  - Overnight Stay
  - Home Considerations
- Equipment
- Financial Analysis
- Marketing

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Arthroplasty CPT Codes

23472	TOTAL SHOULDER (GLENOID AND PROXIMAL HUMERAL REPLACEMENT)
27130	TOTAL HIP ARTHROPLASTY, ACETABULAR AND PROXIMAL FEMORAL PROSTHETIC REPLACEMENT, WITH OR WITHOUT AUTOGRAFT OR ALLOGRAFT
27446	UNI-KNEE ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL OR LATERAL COMPARTMENT
27447	TOTAL KNEE ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL AND LATERAL COMPARTMENTS WITH OR WITHOUT PATELLA RESURFACING

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Tremendous Pricing Variability exists for Inpatient vs. ASC Procedures, Allowing for Value Generation in Case Migration

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Financial Considerations

Medicare

Uni-knee replacement : approximately $8500 inclusive of implant

Total Knee: $8600

Total Hip $8650

Total Shoulder still on inpatient only list

Establish pro-forma based on actual rates, actual projected costs, volume estimates, changes in patient flow assumptions (i.e. recovery care costs), etc.

Cases take 1-2 hours in the OR; 2-4 hours in recovery without overnight stay and then sent home with home health (nurses, PT, etc)

Confirm financial viability of Total Joints for Facility

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Understand all of your costs:

- Pain Pump or Exparel
- Cement and cement mixer
- Drill rental (if you do not own)
- Laminar system hoods - disposable
- Instrument trays (can get vendors to bring in)
- Thrombin
- Can run $4000 and up for implants
- Other supplies: Approximately $1000-2000
- Length of stay - staffing

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Payer Engagement

- Document all anticipated procedure costs, incl. physician-preferred implants
- Prepare documentation of *who* specifically will be performing those procedures, NPI#, and where they are doing them
  - Can use billing data to ID procedures where LOS < 2 days
  - Physician champions may be asked to contribute to payer discussions
  - Prepare data on projected volumes of selected procedures
- Gather Data:
  - Costing data – from Administrator
  - Patient Selection Criteria – prepared by Administrator & Physician(s)
  - Quality, Outcomes Data if available
- Engage major payers and determine which will be willing to reimburse at a profitable level for the center
  - Physician Champion and Anesthesia provider may need to engage

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TJA Outcomes Monitoring

	Procedure								
Description	Revision of Total Knee 27486	Partial Knee 27446	Total Knee 27447	Total Hip 27130	Total Shoulder 23472	Hemi Shoulder 23470	Event Total	Events per 1000 patients	% of Total Case Volume
admit < 30 days									
admit 30-90 days									
Admissions									
Return to OR < 30 days									
Return to OR 30-90 days									
Return to OR									
DVT's									
Falls*									
Pain									
SSI's**									
Superficial									
Periprosthetic Jt									
Event Total									
Patients Involved									
% of Procedure Case Volume									
Total Procedure Case Volume									

* Includes all falls and assisted to ground

** Per CDC definition - Infection that occurs after surgery in the part of the body where surgery took place. SSI can sometimes be superficial infection involving the skin only

Rate for Primary total Joint Procedures (DRG 470) 30-day Admission (all cause) is 3.91%. 90-day Admission (all cause) 5.23%. Source: Crimson Clinical Advantages Continuum of Care 2/17/19. The Complication of Care metric is based on the AHRQ (Agency for HealthCare Research and Quality) clafficiation system for complication codes.

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Appendix – Sample Pt Selection Criteria

Patient Medical Factors:

- Must not have any systemic infection or communicable disease
- Must have ASA Physical Classification Score of 3 or less, and determined appropriate for procedure through collaboration of anesthesia provider and physician
- Obstructive Sleep Apnea (OSA) requires evaluation by anesthesia
- BMI < 40
- No known significant cardiac condition (i.e., Coronary Artery Disease, CHF, Uncontrolled hypertension, Arrhythmia, Pacemakers, AICD)
- No significant evidence of pulmonary disease (i.e., COPD)
- No significant history of significant GI issues – such as post-op ileus
- No significant history of liver disease – (i.e., Cirrhosis)
- No significant renal failure
- No significant hematology issues (i.e., HGB > 13)
- No significant elevation in Hemoglobin a1c
- No significant gyne-uro issues (History of urinary retention)
- No major neurological issues (History of dementia or post-op delirium), Prior CVA
- No history of major organ transplant
- No documented history of MRSA
- No history of malignant hyperthermia
- No active substance abuse or unmanaged chronic pain
- No poorly controlled anxiety or depression

These guidelines can be modified at any time and are at the discretion of the operating surgeon and anesthesia provider.

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THANK YOU!

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