

# Orthopedic Surgery Service Line: Managing Prosthetic Cost and Quality

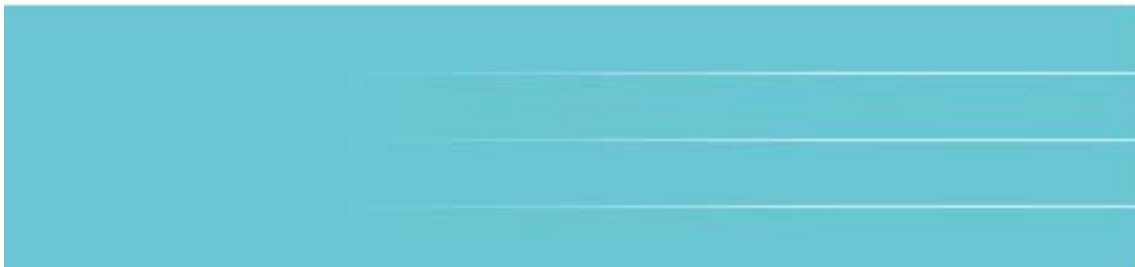
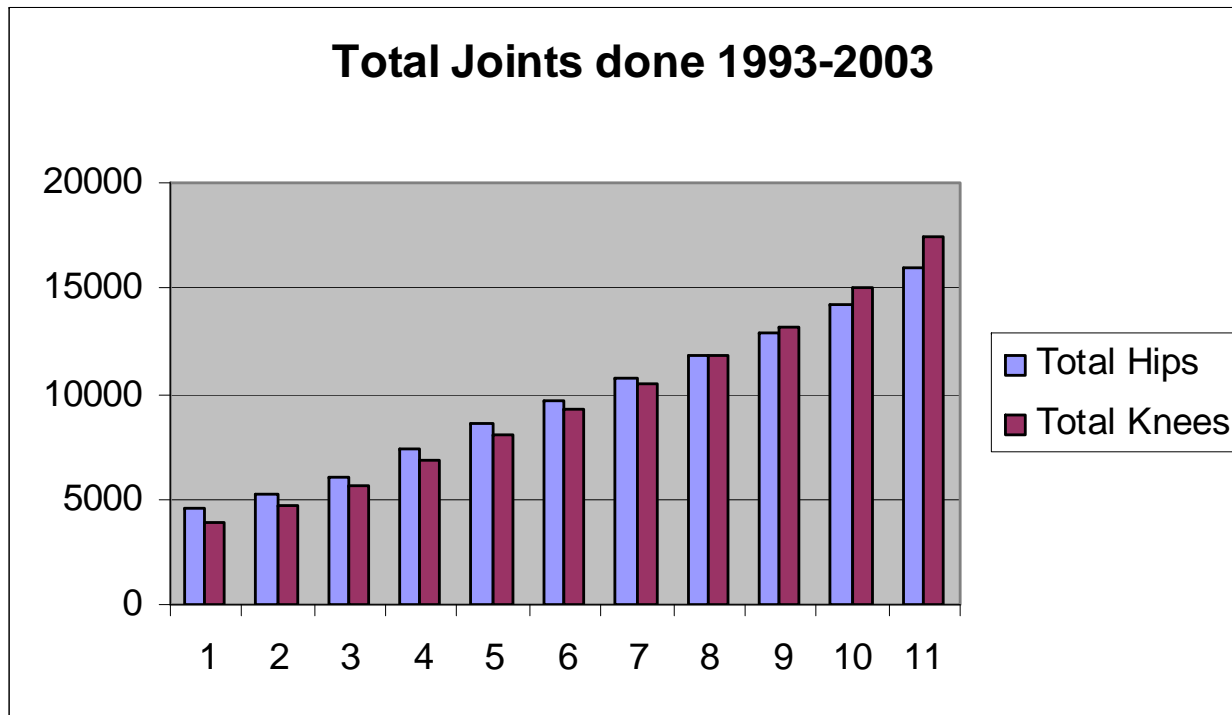
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# Landscape in Orthopedic Surgery: Payors

Volumes continue to increase, and costs rise with volumes:



Pay per diems so have allowed the hospitals to manage the prosthetic cost.

Have not paid attention to long term outcomes and survivability of prosthetics because the time frames are 10-20 years



# Landscape in Orthopedic Surgery: The Surgeons

KAISER PERMANENTE.

Each busy spine surgeon controls \$1 million to \$2 million dollars in prosthetic spend per year

Each busy total joint surgeon controls \$750,000 to \$1 million in prosthetic spend per year

Most surgeons are “loyal” to one company or another – most often due to relationships with their company representative

The use of new technology often allows for a competitive advantage

Attorney General’s actions against Vendors and their physician consultants.



Increasing use of new technology by doctors to stay competitive

Need to stay current on new technologies to stay competitive with other hospitals

Increasing cost pressures from payors – especially Medicare



Settlement with the Department of Justice by  
Zimmer, Depuy, and Smith and Nephew  
Changing Business Practices  
Have moved from a commodity business to a  
“premium” product business.



# The Kaiser Permanente Approach to Prosthetic Contracting KAISER PERMANENTE.

Industry Leading Contracts & Reduction of Prosthetic Cost<sup>†</sup>

National Clinical Contracting Team:  
6 Orthopedic Surgeons

Total Joint Registry

Conflict of Interest Policy



## Historical:

- One vendor
- Contracting for specific prostheses
- Single price

## Present

- High Compliance (>95%)
- 2-3 vendors, each with complete product lines
- Monitor results through vendor funded total joint registry



7 surgeons with representatives from each hospital region (NCAL, SCAL, Hawaii, Northwest)

Start by assessing usage

Move to quality – which vendors can deliver appropriate quality and support to all of our medical centers?



Once companies selected for quality, then an RFP is sent out based on parameters from the committee

Registry is not optional – paid for by 1% rebate on a quarterly basis



Pharma, Advamed

TPMG COI: much stricter no personal consulting arrangements, no financial interests in companies, no payment from companies for training unless covered in the contract.

Many outside surgeons living with conflict of interest issues





**Quality Monitoring: Recalls, Failures, Learning Curves**

**Research: Nationally leading research**

**Contracting: Monitoring types of prosthetics being put in at each facility, monitoring results relative to manufacturers claims, Clear picture of usage during contracting negotiations**



# Why do new technology disasters happen?

Good story and theory behind introduction

Early adopters are consultants and biased investigators

No post market surveillance so disasters aren't caught soon enough

Costs of revisions, failures are often not calculated in

“New technology” often NOT reviewed in depth by the FDA



Industry funded

2001-2007: 60,000 Total joint Replacements

4 Major Recalls

3 Contracting Cycles

8 Major National publications annually

Winner of the Vohs Award 2008



95% compliance to contracts

94% Registry participation on operative forms

Industry leading pricing on implants when  
measured by % off list price (up to 20% below  
what others get)

High Physician satisfaction



Vendors focusing more on high priced  
“premium” products



A strategic three pronged approach works  
Prosthetic registries are essential, and provide  
very valuable data  
Clinician leadership critical to the process



# NEW VENDOR AND CONTRACTING CHALLENGES

THE KISSER PERMANENTE.

Premium Products Replacing Standard Ones

These Products NOT Proven but Cost More

Some Not FDA Approved

Often Brought in to Our Medical Centers

Without Physician Knowledge or Approval

Sometimes Used Without Physician Knowledge



## BACKGROUND and Problem Definition

Total Knee Replacements

Cross Linked Polyethylene for TKR

Methylmethacrylate Precoating of implants

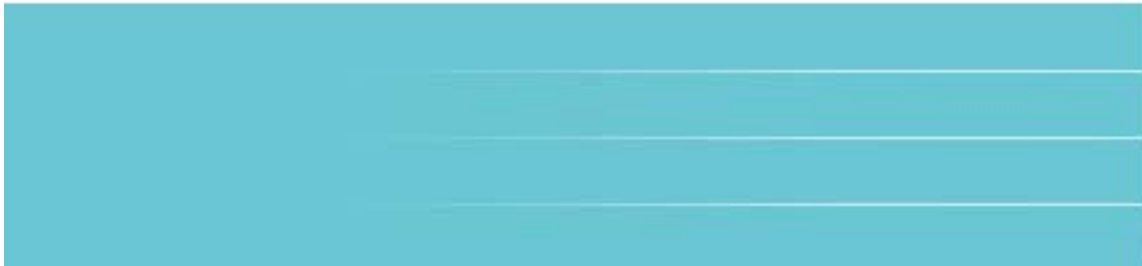
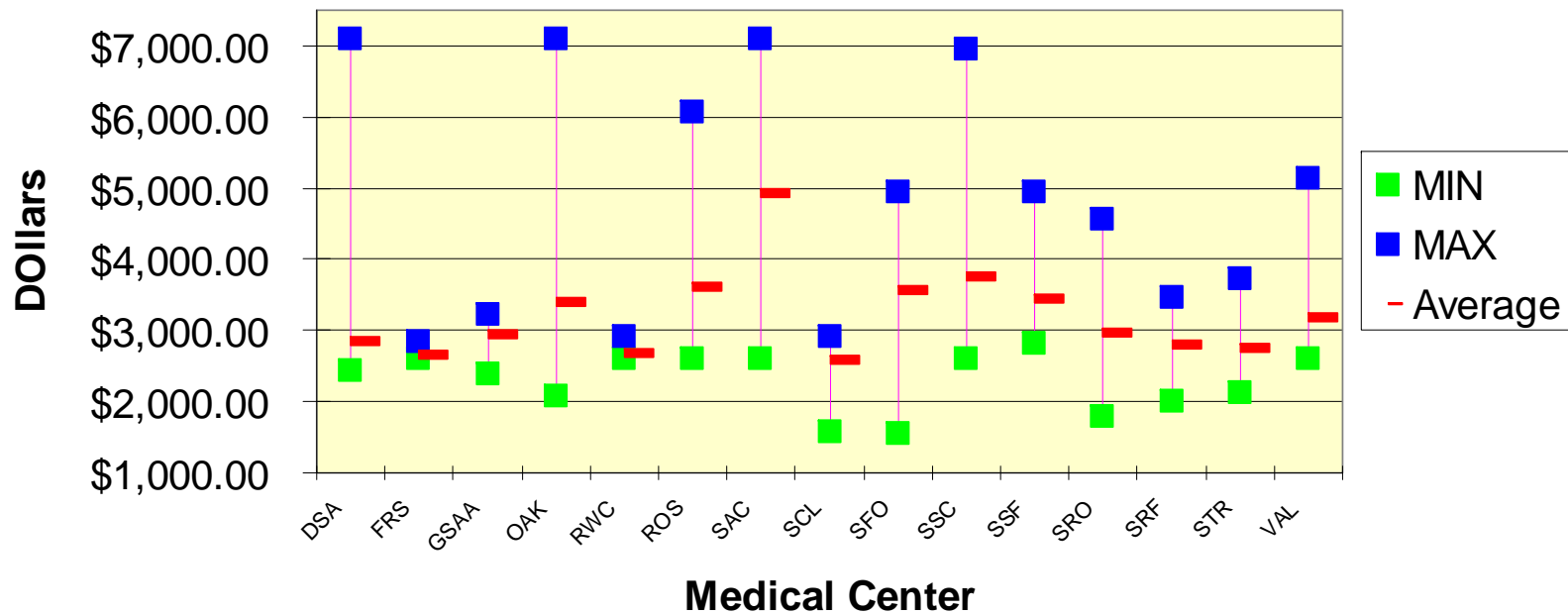
Alternative Bearing Surfaces THR

Head size THR



# Marked Variation in Cost by Medical Center

## Average Cost of a Primary Knee Prosthetic, NCAL



## Data sources

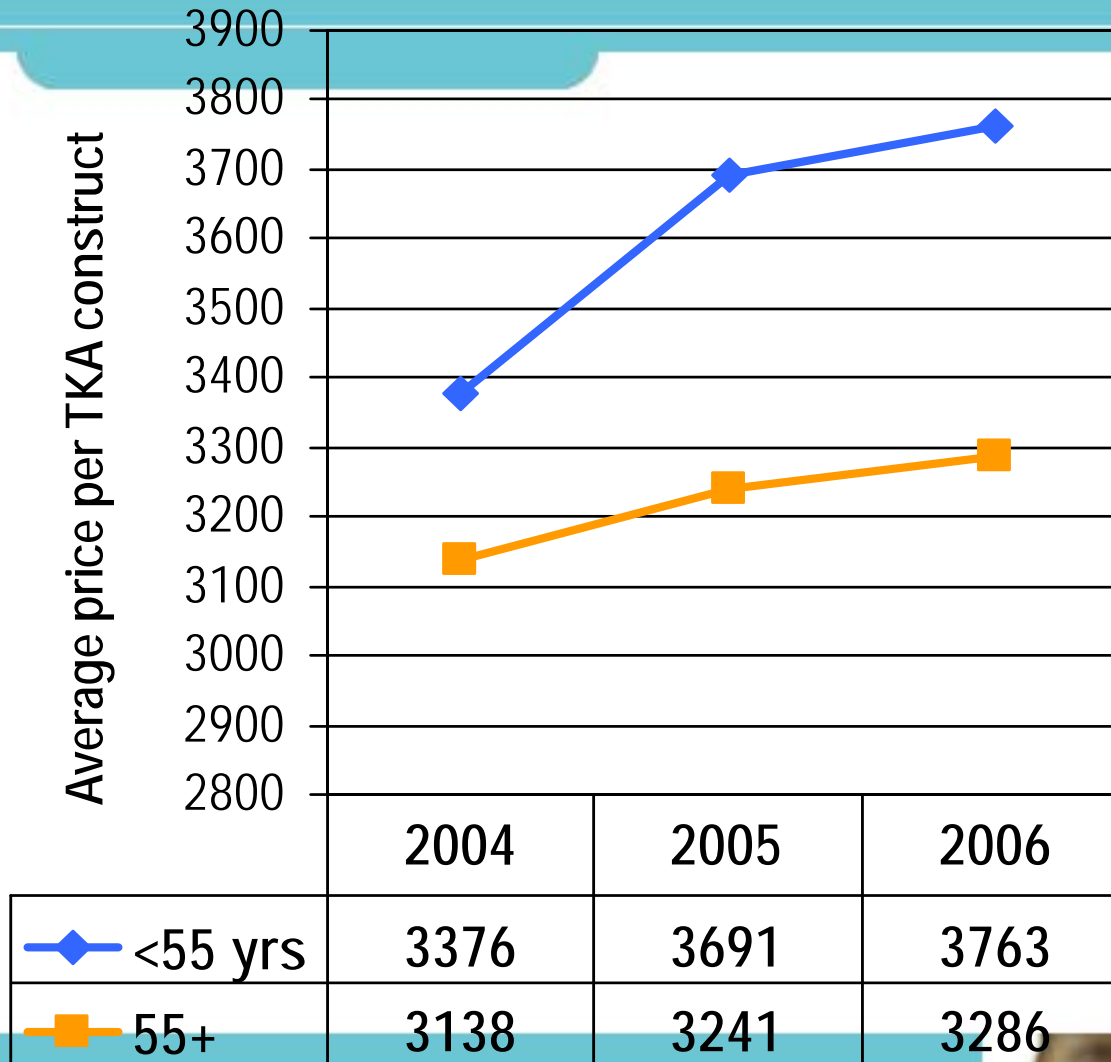
- Total Joint Registry
- Broad Lane price list
  - Construct categorized into <\$3,000, \$3000-\$4000, >\$4,000

## Inclusion Criteria

- Primary TKAs with OA as primary DX
- Implant sticker data available for all TKA components
- All Participating Regions
- Operative date between 1/1/2005 and 3/31/2006



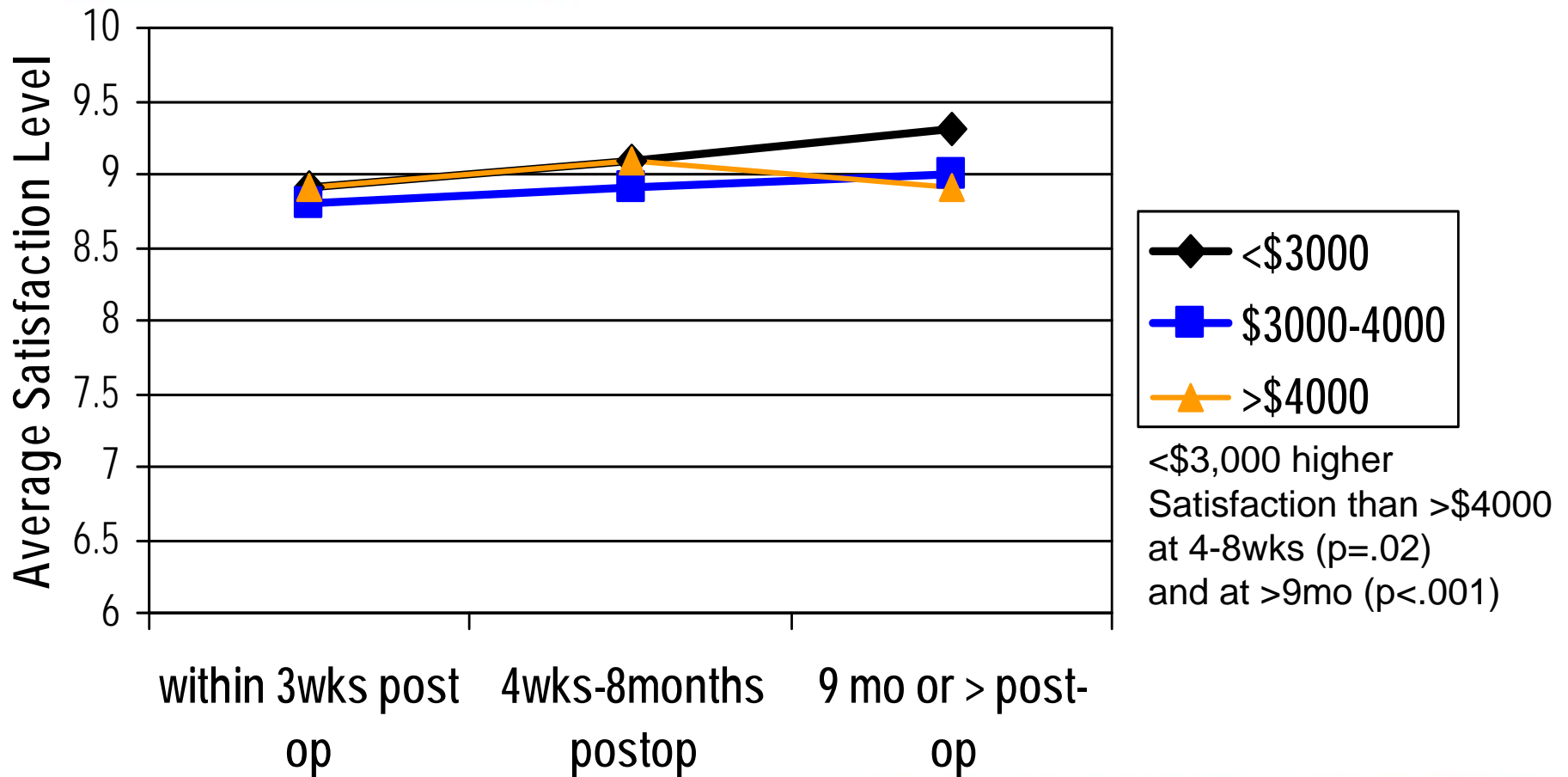
# Average TKA construct price across time



**Significant increase in TKA construct price from 04 to 05 ( $p=.001$ ) and 04 to 06 ( $p=.002$  <55,  $p=.04$  in 55+)**



# Patient Satisfaction by construct category ( $\geq 55$ year old)



Developed as a tool to control vendor abuse

Really is a “nonformulary”

Put together by a group of TPMG total joint surgeons



**Goal:**

**Best stuff for our surgeons and patients at best price  
without vendor pressure/abuse  
with surgeon choice and discretion  
but with surgeon oversight via peer surgeons and education (not "bean-counters")**



**It's what you'd want to put in your  
family member  
knowing that your family is picking up  
the tab**



- Control Quality**
- Control Cost**
- Prevent Vendor Abuse**



We already have a "formulary":

The Total Joint Contracts

**We picked Quality**

**We negotiated great prices**

**We shut out non-contract vendors**

**We obtained \*some\* control of  
contract vendors**



**But:**

**Contract is for everything in that  
vendor's catalog**

**whether it is**

- over-priced
- over-hyped
- over-sold
- and/or unproven.



**Vendor motivated to sell us more expensive "contract" items, even new, unproven stuff**

**"only have the precoat version available"**

**"everyone at UCSF is using a high flex knee, shouldn't you?"**

**"after all, it *\*is\** on contract, right?"**



# **Contracted Vendors' implants at great prices with exclusion of implants**

- surgeon-designated (that's us)
- unproven
- and/or over-priced



**“Non-Formulary” designation**

**Non-detailable**

**Non-stock items - not in hospital**

**Non-formulary exception process**



**Failure to follow exception process**

**Non-detailable status**

**Firm**

**Enforceable**

**Escalate with significant penalties**

**Similar to Pharmacy**



**Question: If cost were no object, what would you want to use?**

**Would you put hip resurfacing in everyone if the cost were no different? No**

**Would you use a ceramic head instead of a metal head if price was equal? Yes**

**Would use use MOM articulation instead of ceramic/poly if price equal? Discuss**



Question: If cost were no object, what would you want to use?

**Would you use a precoated TKA femoral?**

- Hmm, if it was free . . .

**Would you use a Precoat THA cemented femoral stem?**

- Not even if it was free, based on evidence



Question: If cost were no object, what would you want to use?

**Would you use highly cross-linked poly rather than regular poly in a THA?**

- Yes, in 2007, but maybe not in 2002

**Would you use highly cross-linked poly rather than regular poly in a TKA?**

- Not even if it was free as of 2007



## Total Knee Replacement Potential Savings

- Gender Specific (\$128,040)
- PreCoat (\$224,700)
- Trebecular Metal Tibia (\$325,632)
- Rotating Platform (\$167,600)
- Oxynium Femur (\$73,640)

Total Potential (\$1,101,713)



## Total Hip Replacement Potential Savings

- Zimmer Trebecular Metal Cup (\$128,334)
- TM CUP Liner (\$91,396)
- ASR Cup (\$135,222)
- ASR Head (\$56,086)
- BHR Cup (\$145,600)
- BHR Head (\$160,080)

Total Potential \$878,924



Requires tracking by facility

Can't use the Total Joint Registry

Requires exception process

Requires regular meetings of total joint group  
to update and monitor

Requires action by chiefs



A physician led process works

Conflict of Interest Needs to be controlled

Tracking of outcomes through a registry  
important

As premium products are pushed a formulary  
approach needs to be considered



Full Integration makes it easier (health plan, hospitals, and medical group)

A registry makes selective contracting possible

A formulary approach moving forward by hospitals and/or health plans makes the most sense given the move towards premium products

