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Should Medicare Allow Outpatient Knee Replacement? Doctors Are Deeply Split

By CHRISTINA JEWETT DEC. 20, 2016

Dr. Ira Kirschenbaum, the chairman of orthopedics at Bronx-Lebanon Hospital Center. Dr. Kirschenbaum, who replaces more than 200 knees each year, had knee replacement surgery himself as an outpatient. Credit Sasha Maslov for The New York Times

Five years ago, Dr. Ira Kirschenbaum, an orthopedic surgeon in the Bronx who replaces more than 200 knees each year, would have considered it crazy to send a patient home the same day as a knee replacement operation.

And yet there he was this year, as the patient, home after a few hours. A physician friend pierced his skin at 8 a.m. at a Seattle-area surgery center. By lunch, Dr. Kirschenbaum was resting at his friend's home, with no pain and a new knee.

“I’m amazed at how well I’m doing,” Dr. Kirschenbaum, 59, said recently in a phone interview, nine weeks after the operation.

What felt to Dr. Kirschenbaum like a bold experiment may soon become far more standard. Medicare, which spends several billions of dollars a year on knee replacements for its beneficiaries — generally Americans 65 and older — is contemplating whether it will help pay for knee replacement surgery outside the hospital, in either free-standing surgery centers or outpatient facilities.

The issue is sowing deep discord in the medical world, and the debate is as much about money as medicine. Some physicians are concerned that moving the surgery out of hospitals will land vulnerable patients in the emergency room with uncontrolled pain, blood clots or other complications.

But proponents of the change say it can give patients more choice and potentially better care, as well as save Medicare hundreds of millions of dollars. Already, an “overwhelming majority” of commenters said they want to allow the operations out of hospitals, according to recent rule-making documents.

The final decision, which could come within a year, would also act as a test of sorts for Donald J. Trump and his new administration. They will weigh whether to limit government controls, as Mr. Trump has often suggested, or to bend to pressure from hospitals and doctors, many of whom oppose the change.

“I think the question will come down to two things,” said David Muhlestein, senior director for research at Leavitt Partners, a leading health consulting firm. “It’s the balance of trying to reduce regulations and let the market function — and the competing interest of vested parties.”

Demand for total knee replacements is growing — 660,000 are performed each year in the United States. That number is likely to jump to two million annually by 2030, making this complex and expensive operation one of surgery’s biggest potential growth markets.

Even if the policy change was made, Medicare would still pay for patients to get traditional inpatient surgery. But with the agency also paying for the bulk of outpatient procedures, there would be a huge shift in money — out of hospitals and into surgery centers. Medicare could save hundreds of millions of dollars if it no longer needed to pay for multiple-day stays at the hospital. Investors at the outpatient centers could profit greatly, as could some surgeons, because doctors often have an ownership stake in the outpatient centers where they operate.

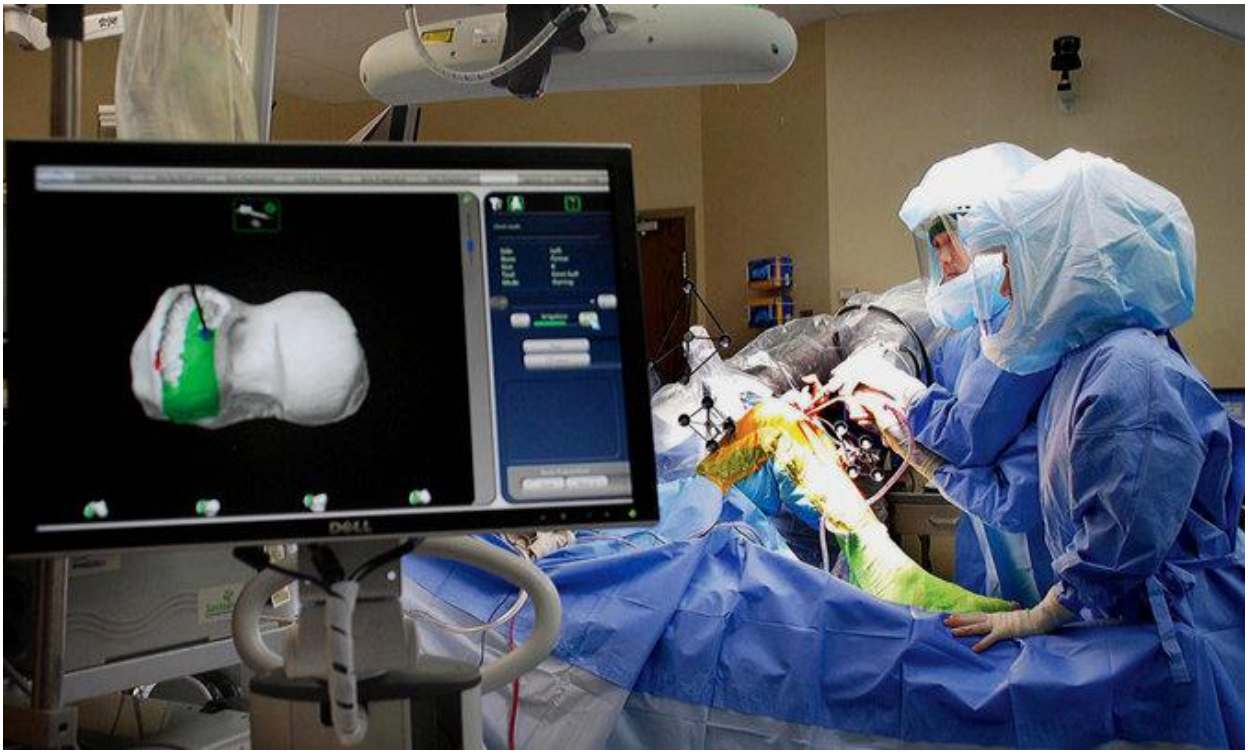
Whether the shift would be beneficial for patients remains an open question. Medicare patients tend to spend nearly three days in a hospital, data shows. Forty percent of Medicare patients also spend time in a rehabilitation facility for further recovery. The data, which reflects knee replacement operations from 2014, suggests that Medicare patients are taking advantage of the post-operation support at hospitals and aftercare centers. Given that, it is unclear what percentage of eligible patients would choose outpatient care.

But improvements in surgery — from new medicines to control bleeding to better pain management techniques — mean that, for some patients, the days of close medical supervision are no longer necessary.

Dr. Kirschenbaum, who is in favor of the change, acknowledged that outpatient surgery would be the right move for only a small subset of his Medicare patients — perhaps 10 to 15 percent — who have good caretaking at home and few chronic health issues. But it would not be for the people who are frail, live alone or in a dwelling with stairs, he said. The decision about whether surgery should be outpatient or inpatient tends to be made by the physician and patient.

"We want to make sure patients — when they go home, they're safe, no question," said Dr. Kirschenbaum, the chairman of orthopedics at Bronx-Lebanon Hospital Center and a founder of SwiftPath, a company that offers technical support to outpatient joint replacement centers.

Photo



Dr. Thomas Pevny, left, performing a partial knee replacement using a robotic arm at Aspen Valley Hospital in Aspen, Colo., in 2012. Credit Janet Urquhart/The Aspen Times, via Associated Press

Perhaps of equal concern to patients are the financial consequences, because even though less care is given, outpatient procedures require higher out-of-pocket costs. Medicare covers inpatient hospital stays, aside from a $1,288 deductible. An outpatient procedure would likely carry the same amount as a copay, but the outpatient would face additional fees, and Medicare would not cover aftercare at a skilled nursing facility.

The battle lines over outpatient knee replacements began forming in 2012, when Medicare first considered removing the operation from its "inpatient only" list of invasive and complicated medical procedures. Many orthopedic doctors and hospitals rose up in protest, calling the proposal "ludicrous" and "dangerous" and prompting Medicare to abandon the idea.

Dr. Charles Moon, who has performed knee replacement surgery at Cedars-Sinai Medical Center in Los Angeles, fired off a letter at the time saying that knee replacement patients stayed at his hospital for 2.5 days on average, and that it was "considered borderline safe" given the need to monitor patients' response to clot-busting medications.

Other objectors cited research showing that outpatients were twice as likely as inpatients to die shortly after knee replacements, and that even patients who stayed one day in the hospital were twice as likely to need a follow-up surgery as those who remained in the hospital longer.

"While we realize this can be good for some patients, it's not for all patients and all locations," said Dr. Thomas C. Barber, the chairman of the American Academy of Orthopaedic Surgeons' advocacy council.

Yet the proposal has gained renewed momentum, backed aggressively by some surgeons and surgery center investors who say that their accumulating experience justifies the change. In recent months, Medicare has signaled a strong interest in outpatient knee replacements, noting the potential for "overall improved outcomes" as well as the potential savings for the government program.

The final decision will be made by Medicare officials in the annual course of proposing changes, seeking public comment and announcing a final rule. If Medicare decides to make a change, it will probably not be put into effect until a year or so later.

In an interview, Thomas Wilson, the chief executive of Monterey Peninsula Surgery Centers, a for-profit outpatient clinic, said his doctors had replaced knees of hundreds of adults — 59 years old on average, but up to 82 — with low complication rates and sky-high satisfaction rates. He said advances in surgical technique, anesthetics and patient education made it possible.

Presented with such evidence, a panel that recommends hospital outpatient payment policies to Medicare officials unanimously recommended in August that Medicare remove the procedure from the inpatient-only payment list.

Mr. Wilson said that as a first step, doctors should use strict criteria like a low to moderate body mass index and a healthy heart and lungs in deciding whether patient is a good candidate.

A patient who meets the criteria is teamed with a friend or family member who works as a coach. The patient and coach attend an educational session before the operation, and the coach is also there to help afterward.

The patient is typically discharged after 23 hours in the outpatient center, and a home health service or private nurse follows up. Patients also go on to physical therapy.

“Our mix is like our regular mix of patients,” said Mr. Wilson, whose center advertises a knee replacement surgery for $17,030. “It’s not what we call unicorns, not 49-year-old marathon runners. These are average folks who need to have a knee or hip replaced, and they’re generally not sick.”

But Dr. Barber and others worry that moving the procedure outside the hospital could become a norm or an expectation, even though some patients, especially those with complicating conditions like diabetes and heart disease, need the added support of a hospital team. Patient safety could be compromised, they warned.

Dr. Kirschenbaum said that undergoing surgery had changed the way he approached patients. Now he can roll up his pant leg, show a scar and tell them: “You can do this, too.”

In the operating room, “with a knife in my hand, nothing has changed,” he said. “But what has changed is how we treat them before and after. The education, support and being available — it’s very important.”

Correction: December 31, 2016

An article on Dec. 21 about Medicare’s considerations as it weighs paying for outpatient knee replacement surgery misstated the amount patients would pay for such procedures. Medicare covers inpatient hospital stays, aside from a $1,288 deductible; it does not cover them at 100 percent. The outpatient cost for the procedure itself would be capped at the same amount as the inpatient deductible, but could involve additional fees and would include no coverage for aftercare at a skilled nursing facility, which, if needed, would add up to thousands of dollars; it is not the case that an outpatient procedure’s 20 percent co-payment would easily add up to thousands of dollars.

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