The Backbone of Growth

How to add and expand spine surgery in your ASC

BY ROBERT KURTZ | MARCH 2026

KEY LEARNINGS

- Consider both financial feasibility and patient safety
- Make sure your staff is comfortable and on the same page
- Tap your surgeons to provide education and share expertise

The Center for Spine Surgery in Wilmington, Delaware, has ambitious growth plans. The ASC opened in August 2023 and began slowly, performing a few cases each month as it secured Medicare certification and accreditation. Throughout 2024, it steadily increased its volume. By the end of 2025, the center was performing around 135 spine surgery cases each month.

“Spine in ASCs is the wave of the future, and I expect more facilities to focus on it,” says Pawan Rastogi, MD, president of the Center for Spine Surgery’s board of directors and one of its practicing surgeons. “With advancing technology and expanding coverage, I expect us to get to around 200 monthly cases within the next two years.”

Reaching this point has not been easy, nor inexpensive, Rastogi notes. “It costs a lot to bring in the technology. We have an O-arm, C-arms and microscopes, and are evaluating a potential robot. You need sufficient case volume to justify these investments and to demonstrate your capabilities to payers.”

Determining Your Readiness

Existing ASCs looking to add spine surgery should start with a comprehensive gap analysis, says Hannah Martinez, RN, clinical director at Cascade Outpatient Spine Center (COSC) in Bellingham, Washington. “Inventory what you have and what you need—supplies, specialized equipment, staff and storage. Evaluate your SPD [sterile processing department] and whether it can handle spine trays. That assessment should tell you if adding spine is feasible and how long it will take.”

Understanding the skill mix of your spine surgeons is equally important, says Jackson Poe, chief operating officer of the surgical division at Peachtree Orthopedics, which operates three ASCs in the Greater Atlanta, Georgia, area. “We are fortunate to have senior surgeons with niche fusion approaches who are very comfortable performing ALIF [anterior lumbar interbody fusion] and OLIF [oblique lateral interbody fusion] cases on an outpatient basis. We also have mid-career surgeons and younger surgeons exploring endoscopic spine.” A diverse surgeon mix can help generate the case volume needed for a successful spine program, Rastogi says.

After completing the gap analysis, your next steps should become clear, Martinez says. “Build a realistic timeline and show leadership what is required.”

Scaling the Program

Once a spine program is established, ASCs have several avenues to consider for growth, Martinez says, including capitalizing on the expanding ASC Covered Procedures List (ASC-CPL). For 2026, the Centers for Medicare & Medicaid Services (CMS) added more complex spine codes, such as posterior lumbar interbody fusion and combined posterior lumbar and posterior lumbar interbody fusion, to the ASC-CPL. CMS also has begun phasing out the inpatient-only list, a shift that will further expand what procedures ASCs can perform.

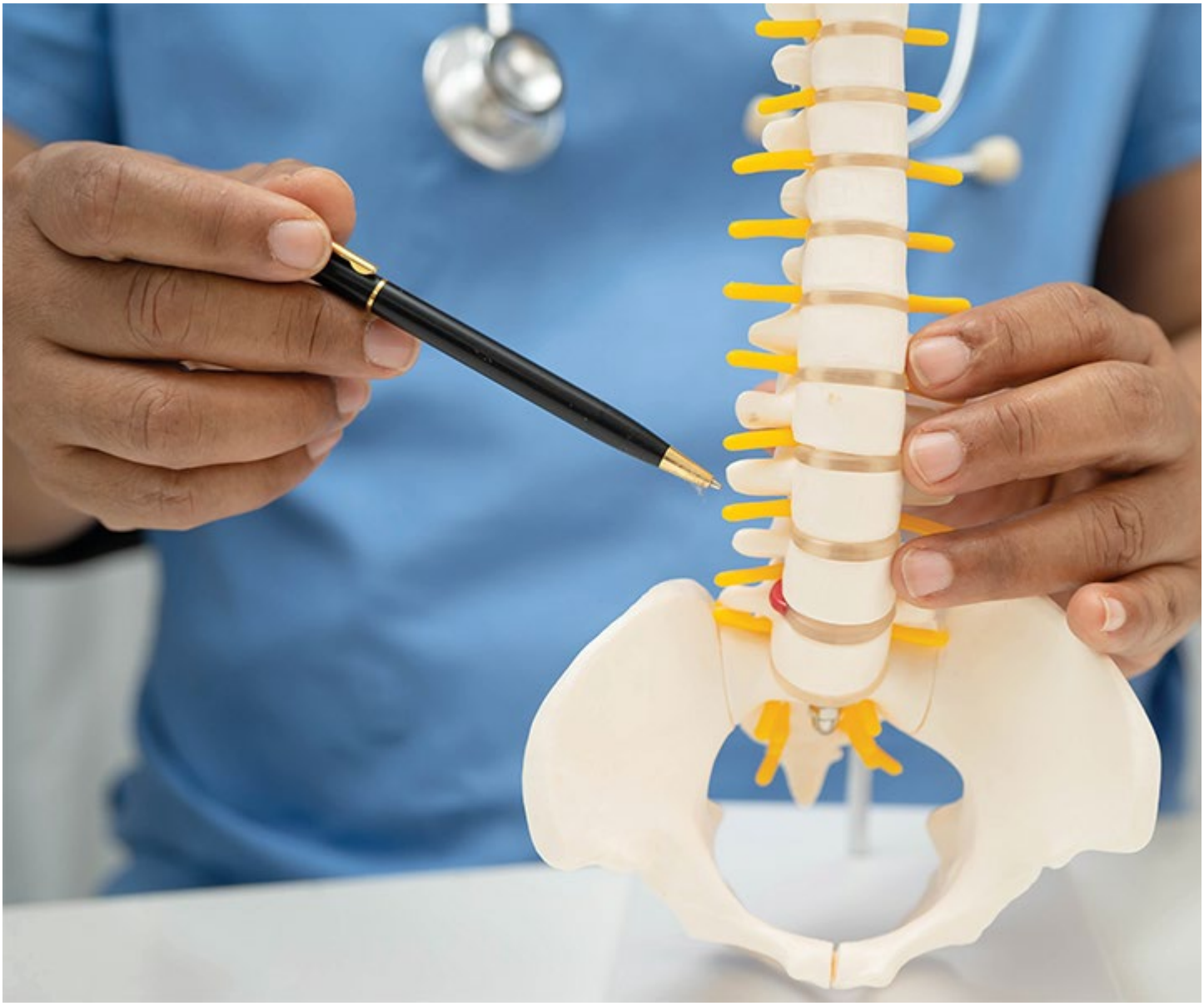
“We pay close attention to codes that become outpatient-eligible,” Martinez says. “Whenever a new CPT code related to spine surgery appears, we review it to determine whether it could be a viable option here.”

Peachtree is examining how its surgeons can support one another to drive procedure growth. “We are helping our younger surgeons build their practices and adopt newer techniques,” Poe says.

In addition, Peachtree is pursuing ways to expand its spine program in conjunction with its pain management services, Poe says. “We have spent considerable time evaluating what I call advanced pain procedures that can be performed by physiatrists but may require assistance from a spine surgeon,” he says. “We see this as a growing procedure category.”

COSC is pursuing a similar strategy. “Our pain management physician has a strong interest in newer long-term implants and stimulator cases,” Martinez says. “That has been one of our biggest sources of procedural growth as more of those CPT codes become approved for outpatient settings.”

As you identify procedures to potentially bring into your ASC, confirm that Medicare and your commercial payers offer adequate reimbursement, or evaluate whether alternative payment models can make the cases financially viable. (*Learn more about how to work with and around commercial payers at the end of this article.*)



To find new sources for patient volume, the Center for Spine Surgery is developing a direct-to-rehab program. Medicare does not require precertification or prior authorization for rehabilitation. As a result, select Medicare patients, such as those undergoing a one-level lumbar fusion, can be discharged directly to rehab rather than admitted to the hospital, Rastogi says. He cites a recent case involving one of his patients with a spinal fracture who failed conservative treatment and then underwent decompression and stabilization at the center before being transferred to rehab.

The Center for Spine Surgery has agreements in place with all major rehab facilities across Delaware and has completed more than 10 direct-to-rehab cases. The ASC is using the data to engage commercial payers. “We are proposing clinical guidelines and asking insurers to provide expedited prior authorization for these cases,” Rastogi says. “That could significantly expand the patient population eligible for outpatient spine surgery.”

COSC is looking beyond its local area to increase patient volume. “We are close to Canada, so we market to the Canadian population to let them know we can help them access care more quickly,” Martinez says.

Surgery centers should work to capitalize on patients’ willingness to travel for spine care, Rastogi advises. “We are located at the intersection of New Jersey, Pennsylvania and Maryland, which gives us access to a large regional patient base. Growth will come both from expanding our existing

practices and from sending physicians to southern Delaware, where population growth is significant and there is a shortage of physicians."

While the Center for Spine Surgery has done limited marketing to date, the ASC's growth plans are prompting new discussions, Rastogi says. One potential approach includes strategic co-marketing partnerships with spine equipment vendors. "If you offer the same advanced technology as a large institution and have a reputation for high-quality care, patients will come," he says.

Making Safe Decisions

When evaluating the viability of adding spine cases, ASCs must consider both financial feasibility and patient safety, Martinez says. "Your team has to be prepared to care for spine patients, many of whom have chronic pain," she says. "When we decide to offer a new procedure, I make sure staff is comfortable and understands what it entails. Our surgeons provide education sessions and share expertise."

At the Center for Spine Surgery, Administrator Judith Townsley, RN, has led efforts to elevate the patient experience through standardized care pathways. The goal is to ensure patients and their families are guided through each stage of preparation, surgery and recovery so they feel confident in their care plan. "Our nurses are empowered to take a lead role in patient education throughout the process and seek ways to improve the experience," Townsley says.

Every patient at the Center for Spine Surgery is evaluated by a physical therapist postoperatively to assess needs and address questions. The ASC also has hired a part-time physician assistant (PA) to support physicians who do not have their own PA. "The center does not receive additional reimbursement for that, but it is a value," Rastogi says. "The PA is extremely experienced and works well with both patients and physicians."

In addition, the Center for Spine Surgery recently launched a postoperative glucose monitoring program and is developing an in-house preoperative clinic to medically clear patients for surgery. "The clinic is designed to improve efficiency and avoid the care delays patients often encounter," Rastogi says. "It is part of our broader goal to continue evolving. We set out to create an ASC where we could perform nearly any case typically done in a hospital, as long as the patient's medical condition allows it, and we are achieving that vision." «

Work More Effectively with Payers

Since opening in August 2023, the Center for Spine Surgery in Wilmington, Delaware, has faced challenges securing fair payer contracts, says Pawan Rastogi, MD, president of the ASC's board of directors and a practicing spine surgeon. "It is amazing how difficult it is to get payers to save money on care. Without a reasonable contract, we will need to do procedures at the hospital, which costs payers more."

To help address those challenges, the ASC has pursued a multipronged approach to contracting—educating its commercial payers, sharing outcomes and cost data, and working with consultants—and most insurers are now in network, Rastogi says. Still, some rates lag behind expectations.

One contributing factor to suboptimal reimbursement is how commercial payers classify certain spine procedures, says Jackson Poe, chief operating officer of the surgical division for Peachtree Orthopedics, which operates three ASCs in the Greater Atlanta, Georgia, area. "Oftentimes, procedures that are still fairly new default into payer grouper rates that are far too low to make sense for us. In some instances, reimbursement is a fraction of the total case cost we would need."

In response, some ASCs are becoming more selective and tactical in their negotiations. At Cascade Outpatient Spine Center (COSC) in Bellingham, Washington, targeting carve-outs is a key payer strategy, says Clinical Director Hannah Martinez, RN. The ASC also is directing extra time and resources toward priority payers—those tied to the largest share of the center's revenue. "We closely monitor our payer mix so we know which contract negotiations are the most significant and important. Once negotiations are complete, we stay on top of contract timelines and performance so we are prepared to renegotiate using our most current data."

The Center for Spine Surgery also focuses on carve-outs to secure coverage for new procedures, Rastogi says. "Medicare rules are a limiting factor in terms of the procedures we can perform. We have secured good rates for some inpatient-only codes we can safely perform."

To strengthen its contracting efforts, COSC partners with a managed care contracting firm. "The contract negotiation company we chose has established relationships with payers and gives us a high return on our investment," Martinez says. "We meet with the firm regularly for updates, and I trust them to effectively represent our needs."

Ongoing frustrations have pushed Peachtree to pursue other ways to get paid. "Getting in front of the right person who can negotiate a reasonable rate or carve-out is way more difficult than it should be," Poe says. "We are making progress, but we are also prioritizing alternative strategies."

Over the past year, Peachtree has focused on direct-to-employer bundled payment contracts. "We started that work with our total joints and then expanded that to spine services. The more we can participate in an ecosystem where cost is a bigger consideration for what we are paid, the more we are going to benefit from that."

Rastogi says the Center for Spine Surgery also has considered a direct-to-employer model when traditional payer contracting proves limiting. "We want to continue growing, so it is important to understand all of our options and strategies."