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CMS sets final 2008 ASC payment rates

For 2008, ambulatory surgery centers (ASCs) generally will be paid at 65% of hospital outpatient department (HOPD) payments, under a final rule issued Nov 1 by the Centers for Medicare and Medicaid Services (CMS). The rule, effective Jan 1, 2008, sets rates for the first year of the new ASC payment system, the most significant change in Medicare ASC reimbursement in 20 years.

The same rule updates the hospital outpatient payment system, resulting in an average overall outpatient payment increase of 3.8%. From now on, ASC payments will be updated jointly with the hospital outpatient payments.

The new rule does not make changes in the ASC payment system itself; those rules were final in August.

The new payment system patterns ASC payments after the hospital outpatient system. As such, ASCs will be paid according to rates set for APCs (ambulatory payment classifications) rather than the groupers ASCs are used to. But CMS will report payment rates by CPT code so ASCs will not need to determine which APC a CPT code belongs to, FASA notes in an overview of the rule on its website (www.fasa.org).

The Nov 1 rule also finalizes at 3,390 the list of procedures payable in the ASC setting in 2008, which is 819 more than the current list.

As part of the new payment system, CMS adopted a new policy that will allow ASC payments for any procedure not specifically excluded from the list. Excluded procedures, in general, are those that are on the CMS inpatient list, typically require active medical monitoring and care after midnight on the day of the procedure, or are deemed to pose a safety risk for Medicare patients in ASCs.

Under the new policy, Medicare will now pay for laparoscopic cholecystectomy in ASCs. FASA argues that lap chole should have been included on the list even under the old system.

In response to public comments questioning the safety of some procedures in ASCs, such as balloon angioplasty of the peripheral vessels, CMS says its medical experts did a comprehensive review. As a result, CMS decided to leave on the ASC list iliac and venous angioplasty (CPT 35473 and 35476) but to exclude femoral-popliteal angioplasty (CPT 35474) for safety reasons.

A list of the excluded procedures is at www.cms.hhs.gov/ASCPayment. On the left, look for CMS-1392-FC. Scroll down to Appendix EE.

Four-year phase-in

Payment rates under the new ASC system will be phased in over 4 years for procedures currently on the ASC list, giving ASCs time to adjust. Procedures added to the list will transition immediately to full payments under the new system.

FASA said it would post on its web site the national 2008 ASC payments plus what rates would be if the rates were fully adopted in 2008. FASA will also post a rate calculator ASCs can use to determine what their local payments will be.

Why will ASCs be paid 65%?

CMS says the 65% amount was set to keep the ASC payment system budget neutral. FASA explains how this was determined: CMS sets payments for each APC based on the APC's relative weight, a measure CMS uses to rank the costs of per-

forming procedures in one APC compared with the costs of other APCs, plus a uniform conversion factor that applies to all APCs. The relative weights for each APC are determined using hospital cost reports. The relative weight is then multiplied by a uniform dollar conversion factor to get the national HOPD rate.

In 2008, the relative weights for calculating ASC payments for each APC will be the same as the relative weights used for HOPDs. The process for calculating the payment rates will also be the same, except different conversion factors will be used for ASCs and HOPDs. In 2008, the ASC conversion factor will be 65% of the hospital conversion factor. Local adjustments are also applied.

This is the percentage CMS believes is budget neutral, meaning that even if the new ASC payment system was not implemented for 2008, CMS figures the overall ASC payment rates would still total 65% of the HOPD rates.

Because of differences in the annual updates, ASCs believe payments between surgery centers and HOPDs will continue to diverge over time. The ASC community is seeking legislation to remedy that. A Senate bill was introduced in October that would set ASC payments at 75% of HOPD payments. ASCs maintain this would allow them to provide more services at a lower cost to Medicare patients than what hospitals provide.

Procedures not paid at 65%

There are some procedures that will not be paid at 65% of the HOPD rate, FASA notes. These include the following:

Device-intensive procedures

ASCs will be paid more for procedures that require use of a device that costs more than 50% of the total APC reimbursement. For these, ASCs will be paid the same as HOPDs for the device, with the 65% discount for ASCs applied to the rest of the APC reimbursement. In all, 45 procedures are designated as device intensive for 2008. Examples are insertion of pacemakers, pulse generators, and pacing or defibrillator leads; insertion of male slings; cryoablation of the prostate; implant of spinal infusion pumps; and implant of cochlear devices.

Some commenters asked CMS to include other procedures with expensive implants in this category. One is injecting implant material into urethral or bladder tissues for incontinence (CPT 51715). But CMS declined, saying its payment policy is final for 2008.

Procedures frequently performed in physician offices

ASC payments for 365 procedures performed more than 50% of the time in physician offices will be less than 65% of HOPD payments. For those, CMS limits payment to the lesser of the payment rate determined using the 65% methodology or to the cost of the physician's practice expense when performed in the office. CMS set these limits to discourage procedures performed most of the time in the less expensive office setting from migrating to the ASC. ❖

FASA and AAASC have information and tools for gauging the impact of the new payments on your ASC at www.fasa.org and www.aaasc.org.

The final payment update rule is at www.cms.hhs.gov/ASCPayment. The rule was scheduled to appear in the Nov 27 Federal Register, *which will be posted at www.gpoaccess.gov/fr.*

Bill seeks higher pay rate for ambulatory surgery centers

A new bill (S 2250) introduced by Sen Mike Crapo (R-ID) on Oct 26 seeks to improve the reimbursement system for ambulatory surgery centers. The bill, a companion to House Bill 1823, would continue to link ASC payments to the hospital outpatient rate, as in the current CMS rule. But the bill seeks to set ASC payments at 75% of what hospital outpatient departments receive rather than the 65% provided for ASCs in 2008.

Sen Crapo said the bill would allow ASCs to provide more services, encourage competition, and generate savings for Medicare and its beneficiaries.

For more, visit the FASA website at www.fasa.org.

Key facts on ASC 2008 payment rule

- For 2008, ASCs will generally be paid 65% of hospital outpatient department (HOPD) payments.
- A total of 3,390 procedures will be payable in the ASC setting in 2008, up by 819 from the current list.
- There is a 4-year phase-in to the new payment system for procedures currently on the ASC list.
- New procedures added to the list will be paid under the new payment system immediately.
- Some procedures are not affected by the 65% ASC discount: from HOPD payments:

  —Procedures requiring a device that costs more than 50% of total APC reimbursement.

  —Procedures frequently performed in physician offices, for which the ASC payment will be the lesser of the payment rate determined using the 65% methodology or the cost of the physician's office expense for the procedure when performed in the office.

Sources: Centers for Medicare and Medicaid Services, FASA.