A proposed update of the ambulatory surgery center (ASC) list from the Centers for Medicare and Medicaid Services (CMS) received mixed reviews from the ambulatory surgery community.

The draft, posted Nov 19 on the CMS web site would add 25 procedures and delete 100 procedures from the list, which governs which procedures are eligible for a facility payment from Medicare when performed in the ASC.

The proposed list was published in the Federal Register Nov 26. Comments are due by Jan 25.

Despite the 25 proposed additions, the Federated Ambulatory Surgery Association’s executive vice president, Kathy Bryant, said FASA’s enthusiasm about the update “dissipated quickly when we realized that more codes were being deleted than were being added, resulting in Medicare beneficiaries having less access to ASCs.”

The American Association of Ambulatory Surgery Centers (AAASC) called the proposal a “mixed bag.”

Many of the proposed additions are ones ASCs have sought. But the proposed deletions include some procedures the industry says are commonly performed in ASCs.

Among codes that would be added are knee arthroscopy (29873) and repair bladder defect (57288), both of which FASA says have been performed in ASCs for patients with other types of insurance for some time.

Also in the draft are a number of procedures ASCs have been trying to add, including reconstruction of chin (21120), augmentation of lower jaw bone (21125), colonoscopy with stent (44397), and proctosigmoidoscopy with stent (45372).

But CMS declined to include many other procedures ASCs have encouraged the government to add, including ligation of hemorrhoid(s) (46221), ligation of hemorrhoids (46946), urine voiding pressure study (51795), intra-abdominal pressure test (51797), repair detached retina (67105), and treatment of retina (67145).

Many of the proposed deletions are based on recommendations of the Health and Human Services Office of Inspector General (OIG).

The recommendations are based on a study by OIG of variations in Medicare payments to hospital outpatient departments and ASCs for the same procedures. The OIG said that CMS’s failure to remove 72 codes from the ASC list was costing Medicare $8 million to $14 million.

CMS considered the OIG’s recommendations and proposed deleting 54 of the 72 codes.

Among the OIG’s rationales for deleting codes are that the procedure is performed more than 50% of the time in the physician’s office (meaning it costs Medicare more when the procedure is performed in an ASC); medical specialty organizations recommended the code be deleted for safety reasons; the procedure is performed primarily in the inpatient setting; or the OIG recommended the deletion, and CMS’s medical advisors concurred.

FASA and AAASC said they plan to challenge many of the proposed deletions.

They encouraged their members to send comments to CMS by the deadline of Jan 25. The associations also asked members to share their comments with them.
so they could consider the arguments in their responses to CMS.

The ASC industry is encouraging the government to take another approach to the list in a revised ASC payment system, which Congress requires CMS to implement by 2008. That revision is to be based on a report by the Comptroller General of the US, which was due by Jan 1.

AAASC says it would like to see the current ASC list, which is inclusionary, replaced by a list that instead states only the procedures Medicare would not reimburse when done in an ASC. The association believes that type of list would lead to ASCs being reimbursed for a broader range of services for Medicare patients and would make it easier for CMS to keep the list current. The last update of the ASC list was in March 2003.

The lists of codes CMS proposes to add and delete are in the proposed rule at www.cms.hhs.gov/suppliers/asc/.

For more information, visit www.fasa.org and www.aaasc.org