OR Manager Inc

OR Manager
Vol. 23 No. 7
July 2007

How will Medicare rates impact your ASC?

Timing will be everything for ambulatory surgery centers (ASCs) getting ready for Medicare's new ASC payment system. The biggest payment overhaul in 20 years is slated to take effect Jan 1, 2008. But the final rule is not expected until this month or later, giving ASCs a short time to adjust.

Under the new system, ASCs will be paid under 221 APCs, similar to the method used to pay hospitals for outpatient services. That's in contrast to 9 current ASC payment groups.

Key issues are still hanging from the August 2006 proposal by the Centers for Medicare and Medicaid Services (CMS):

- How many procedures will be on the Medicare list for ASC payment?
- What will be the final percentage for ASC payments relative to the hospital outpatient department (HOPD) rate?

CMS proposed paying ASCs 62% of what hospitals receive for the same procedure, but the ASC industry says the rate should be higher. The American Association of Ambulatory Surgery Centers (AAASC) has developed a model for budget neutrality it says justifies ASC payment at 73% of the HOPD rate, says Craig Jeffries, AAASC's executive director. The ASC industry has introduced legislation to that effect, but there will be limited time to get a bill through this year after CMS issues its final rule.

Budgeting for 2008 will be a headache because the Medicare reimbursement rates directly affect ASCs' budgets.

"You will not find out the rates until close to the end of the year. I'm encouraging centers to have all of the other pieces of their budget done. Then you can finish the revenue piece after the final rule comes out," advises Caryl Serbin, RN, BSN, LHRM, president of Surgery Consultants of America, Inc, Fort Myers, Florida.

She is stressing to her ASC clients the need to have a cash reserve to tide them over during the transition, adding, "you also need to educate the physicians that this is a time to be flexible about the budget."

ASCs will face software challenges as they move to the more complex APC system. Business office staff need to be made aware of the coming changes and how they will affect their activities.

Officially, the system will be phased in over 2 years, but in effect, the transition will take place over 1 year. In 2008, ASCs will be paid a blend based on 50% of the 2007 ASC group rate and 50% of the HOPD rate. In 2009, payment will move to the new system.

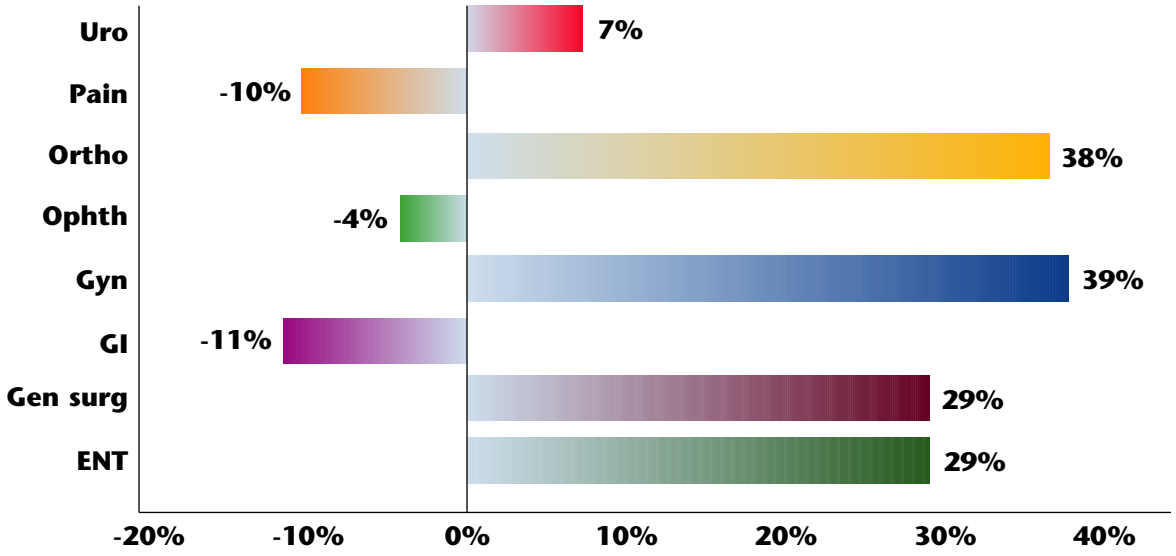
Impact depends on specialty

How your ASC will come out depends largely on the specialties your center performs.

Serbin gave ASC administrators a preview at the AAASC meeting in May in Denver. She outlined scenarios for the major specialties based on the 62% and 75% rates (illustrations). (The scenarios do not include HOPD relative payment weight and geographic adjustments.)

If you're in a multispecialty center with a good mix of general surgery, urology, orthopedics, and podiatry, you probably have a smile on your face. Reimbursement

2009 average change by specialty



Based on 62% of HOPD rates.

Impact of proposed reimbursement: GI procedures

CPT	Description	Current HOPD rate	2009 Proposed rate 62%*	Increase/ decrease	2009 Alternative rate 75%	Increase/ decrease
43235	EGD	$333.00	$316.98	-5%	$383.44	15%
45331	Flexible sigmoidoscopy, with biopsy	$333.00	$299.24	-10%	$383.44	15%
45385	Colonoscopy w/removal tumor/polyp, snare tech	$446.00	$334.17	-25%	$404.24	-9%

**Data source: ASC and HOPD Medicare rate comparison, AAASC, 2007.*

for those specialties is relatively favorable. But for centers specializing in GI or pain management, if CMS comes in at the 62% rate, payments will fall—by 25% or more for the most common procedures such as colonoscopy with biopsy (45380) and flexible sigmoidoscopy with biopsy (45331). At these rates, it's predicted 20% of GI cases could migrate out of ASCs, she says.

"For pain management and GI, we have to keep our fingers crossed for the 75% rate," Serbin says.

In pain management, procedures like lumbar epidural injection (62311) and cervical/thoracic facet joint injection (64470) would see payments fall by 27%. Though there will be some increase for pain, including pain pump procedures, some of the increase will be absorbed by the implant, which will be included in the payment, Serbin notes.

Ophthalmology, too, would see losses at the 62% rate, including a 7% reduction for cataract codes 66984 and 66982. The biggest reduction—57%—would be in after-cataract laser surgery (66821). For retina surgery, on the other hand, the payment almost doubles.

Orthopedics would do reasonably well, with a 38% increase overall, but some increases are for procedures with a low volume of Medicare patients, such as shoulder arthroscopy and arthroscopic anterior cruciate ligament repair, which would see payments rise by 240%.

Podiatry, urology, and general surgery would see overall gains, which is the good news for multispecialty ASCs.

Proactive steps

Proactive ASCs are getting ready by organizing task forces, developing their own scenarios, and making strategic adjustments. To gauge the impact, Serbin suggests setting up spreadsheets for high-volume CPT codes to compare current Medicare reimbursement with the proposed 2009 payment rates both at 62% and 75%. Then you can multiply the rates by the ASC's caseload to see the effect on total reimbursement for that procedure. ASCs can also play out scenarios to see what would happen if they increase their volume and/or lower their costs (illustration).

Once you've identified potential winners and losers, you can take steps to adjust. Some suggestions:

Improve revenue

Use the CPT analysis to determine which services you want to provide more of and which you want to usher out the door.

"This is a good time to look at your marketing plan," Serbin says. "What specialties should you be marketing to? If you are a single specialty, do you want to add a service? If you're multispecialty, look at your mix of procedures."

Eye centers, for example, might want to recruit a retina surgeon to garner the expected improved payments for retina repair. Payment for repair of a detached retina (67107), for example, would rise by 99% at the 62% rate. On the other hand, they'll probably encourage after-cataract laser surgery to be done in the office.

For multispecialty ASCs, general surgery might be a specialty to target. Reimbursement for laparoscopic inguinal hernia repair (49650) is proposed to rise by 163% to $1,660, at the 62% payment rate. Also up would be payment for removal of breast lesion, hemorrhoidectomy, and repair of a recurrent inguinal hernia.

Also consider your overall marketing strategy. Are you marketing to the community? Are you marketing to physicians, especially owners who are not using the center as much as they should be?

Reduce costs

Many ASCs are already diligent in managing case costs. But you'll want to redouble your efforts, particularly for procedures that will see reimbursement decline but that you still plan to continue doing. If you plan to continue GI procedures, for example, Serbin offers these ideas:

- Reduce the number of rooms used daily. "It's been my experience that GI physicians like to use 2 rooms and double the staff," she says. That will be a luxury under the proposed payment rates.
- Monitor block utilization. Make sure block time is utilized effectively. If not, make changes that will provide time for more revenue-producing cases.
- Assess service contracts for endo-scopy equipment. Talk to your peers about what they're paying for maintenance and repair. Consider rebidding these contracts.

Partner with vendors

Talk to your vendors to see if there are more ways to manage your supply and implant costs.

Colonoscopy with biopsy (45380): Medicare only

Example at 62%	Current Medicare reimbursement	Caseload	Change in reimbursement
2007	$446.00	2,000	$892,000.00
2009 (62%)	$334.17	2,000	$668,340.00
5% increase in caseload	$334.17	2,100	$701,757.00
Example at 75%			
2007	$446.00	2,000	$892,000.00
2009 (75%)	$404.24	2,000	$808,485.00
5% increase in caseload	$404.24	2,100	$848,909.25

Source: Analysis by Caryl Serbin based on ASC and HOPD Medicare rate comparison, AAASC, 2007.

"Now is the time to open dialog with your vendors about the potential impact of the final rule. How are they going to help you manage the impact?" suggests Serbin.

The strategies are familiar but worth reviewing.

- For orthopedics, see if vendors will place more of your implants on consignment.
- Join a group purchasing organization (GPO) or re-examine the value you are getting from your current GPO.
- Work with your GPO and distributor to make sure you are buying on contract and are getting the prices you should be.
- Work with the physicians to standardize on implants and other expensive equipment.

(More supply chain tips are in the May 2007 *OR Manager.*)

Prepare the physicians

Make sure your physicians understand the impact of the new payment system on your ASC. Most of the new codes proposed for addition to the ASC list are office procedures that will only be reimbursed at the physician practice amount. That means ASCs will no longer be eligible for a facility payment. You may decide you do not want to perform these procedures in your center. Serbin suggests preparing a list of those procedures to give to the physicians well in advance. Also alert their office schedulers to the list of procedures you do not wish to perform.

Take time to develop your fee schedule

Centers that base their fee schedule on a markup of Medicare rates will find setting fees is more challenging with 221 APCs.

"A lot of thought needs to go into this. This isn't a one-day project. It's a week or more," Serbin advises. She suggests involving not only the business office manager but the administrator, CPA, legal adviser, and clinical staff who know your costs.

In setting up the fee schedule, examine individual CPT codes, see which APCs they are tied to, look at the proposed reimbursement, and ask, "Is that enough?" Be aware some of the proposed payment rates are low—as low as $3.68 for 17003 (destroy lesion).

"You will need to establish a minimum charge," she notes, by analyzing your minimum costs to perform a case.

Check your managed care contracts

Check with your major payers to see if they plan to change their payments systems based on what Medicare does.

"I'm looking to see if there are clauses in our contracts that allow changes when Medicare changes," Serbin says. "So far, we have not heard they are going to make major changes. But you need to keep an eye on it." ❖

AAASC's Medicare Payment Comparison file is at www.aaasc.org/advocacy/MedicarePaymentAndComparison.htm
FASA has a rate calculator for the proposed 2008 rates at www.fasa.org/proposed/rates2008.xls.

Core issues in ASC payment

Answers to these questions won't be known until CMS issues its final rule.

How many procedures will be authorized for Medicare payment in an ASC?

The government has proposed adding 750 procedures to the ASC list. But about 500 are office based, and payment will be capped at the physician practice reimbursement rate. ASCs have asked CMS to expand the list to include all procedures safe to perform in an ASC.

What will the payment rate be?

The government has proposed paying ASCs at 62% of the hospital outpatient rate. The ASC industry says its analysis shows the rate should be in the 72% to 75% range.

How will the inflation update be handled?

ASCs will receive a payment update annually. But the update will be based on the Consumer Price Index-Urban. ASCs want the government to use the same update factor used for hospitals, based on a hospital "market basket."