Medicare issued its final 2009 policies and payment rates for ambulatory surgery centers (ASC) Oct 30, 2008. The changes issued by the Centers for Medicare and Medicaid Services (CMS) are part of a large rule updating hospital outpatient and ASC payments and finalizing the ASC conditions for coverage (related article, p 22). The changes take effect Jan 1, 2009.

Next year will be the second year of transition of the new Medicare ASC payment system launched in 2008. The new system pegs ASC facility payments to the hospital outpatient department (HOPD) rates, though ASCs receive less than HOPDs for the same services. For 2008, ASCs were paid 63% of what hospitals received for the same services. For 2009, it’s estimated ASCs will be paid 59% of HOPD reimbursement for the same services, according to the ASC Association.

By law, ASC payments will not receive an inflation update for 2009.

Payment rate updates

As in 2008, the impact of the payment updates on your ASC will depend on the specialties you perform. Eye procedures—the highest volume ASC procedure—will see a 1% decrease. Orthopedics on the whole will see a 19% rise. But some lower volume procedures, such as ear surgery, will see payments go up in the aggregate (chart).

Changes to ASC list

In all, 27 surgical procedures are being added to the list of procedures Medicare will pay for in an ASC. These include 13 procedures with new CPT codes and 14 that were previously excluded.

As part of the new payment system, CMS adopted a new approach to the ASC list. The only procedures now excluded from ASC facility payment are those CMS determines pose a significant safety risk or would typically require an overnight stay. Formerly, procedures had to be added to the list by CMS to be eligible for payment, and updates lagged. The ASC list is now updated annually along with the HOPD payments.

Among ASC procedures added are:
- CPT 34490 (Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision)
- CPT 36455 (Exchange transfusion, blood; other than newborn)
- CPT 49324 (Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive materials if performed)
- CPT 49326 (Laparoscopy, surgical; with omentopexy).
CMS decided not to add CPT 31293 (Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression). The agency decided this is similar to 2 other nasal/sinus endoscopy codes, 31292 and 31294. Because CMS thinks all 3 pose safety risks in an ASC, it believes they should continue to be excluded.

In response to comments, CMS did add 4 codes for acellular dermal grafts (15170, 15171, 15175, and 15176) because these don’t pose a significant safety risk or require an overnight stay.

Some knee arthroscopies with grafts (CPT 29867 and 29868) were not added because of the postoperative care they require. Also not added, despite requests, was CPT 37205 for stent placement.

Eight procedures were added to the list of office-based procedures. These are paid the lesser of either the amount paid to physicians under their office fee schedule or the standard ASC rate. The purpose is to prevent Medicare from paying more for procedures performed in an ASC that are mainly done in the office.

In all, 12 codes were added to the list of device-intensive procedures because these procedures require use of a high-cost implant or other device. These include, among others, several codes for reconstruction of the elbow or wrist joint and knee joint revision.

More information on the payment updates is on the ASC Association website at www.ascassociation.org. Look under the Medicare tab.