The first of two articles.

With the biggest change in payment methodology in 2 decades, ambulatory surgery centers (ASCs) are facing a pivotal year. The new year brought the beginning of the new Medicare payment system for ASCs and the addition of more than 800 Medicare-approved procedures to the ASC list.

To help you take stock of the changes, this 2-part series analyzes the major ASC specialties for noteworthy procedure additions as well as procedures from the 2007 ASC list that saw a reimbursement increase or decrease from the new methodology. The articles also suggest how you can respond and benefit from the new payment system and expanded procedure list.

Note that the projected reimbursement rates beyond 2008 provided in this article are not adjusted to reflect changes in technology and increasing costs. Although there is no annual inflation update in 2009, rates for 2010 and beyond will include increases based on the consumer price index (CPI) for urban consumers. Also, in future years, the Centers for Medicare and Medicaid Services (CMS) will calculate new relative weights for each procedure, which will likely cause reimbursement for some procedures to increase or decrease. Finally, these rates do not take into account your ASC's local wage index.

A spreadsheet of the 2008 Medicare payment rates, along with 2007 payment rates, is at www.ascassociation.org/new/rates2008/. This spreadsheet also includes unadjusted rates in 2008 if there was no CMS-mandated 4-year transition period.

The transition requires procedures on the ASC list in 2007 to be reimbursed at a blended rate. In 2008, this rate is 75% of the 2007 rate and 25% of the 2008 fully implemented rate had the payment system been implemented without a transition period. In 2009, the blended rate is 50% of the 2007 rate and 50% of the 2008 fully implemented rate. In 2010, it is a 25%/75% blend, and in 2011, the rate will be solely based on the new payment system.

Orthopedics

Orthopedics has traditionally been a strong specialty for ASCs, and that continues under the new payment system, with increased reimbursement for most procedures, says Caryl Serbin, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing in Fort Myers, Florida.

Orthopedic procedures will, on average, see a 23% increase in 2008, factoring in the 75%/25% first-year transition blend, according to the association formerly known as FASA. (FASA merged with the American Association of Ambulatory Surgery Centers on Jan 1 and became the ASC Association.)

If there was no transition period, the average percentage change in 2008, at the fully implemented rate, would soar to 92%.

Arthroscopy

Despite the substantial increase, ASCs should not jump blindly to add what may seem like the most appealing procedures receiving an increase, Serbin says. Take, for example, “shoulder arthro-scopy/surgery” (CPT 29826) and “knee arthroscopy/surgery” (CPT 29888), which is an arthroscopically aided anterior cruciate ligament repair. Both paid $510 in 2007 but will pay $856 this year. Although this is a sizable
increase, if you consider the cost of supplies such as anchors and staff hours you may not choose to add them in 2008, Serbin says.

But look at your physicians’ history for these cases, she adds. Did they perform multiple procedures with multiple CPT codes? If so, your case costing should take this into consideration.

Depending on your case costing, you may decide to wait until the conclusion of the 4-year transition period when the projected reimbursement is approximately $1,900.

Case cost carefully

“ASCs must carefully case cost to determine whether they can turn a profit on these procedures before adding them to the list of procedures they perform,” Serbin says. “You should spend time doing the costing as to when you want to add these procedures.”

By estimating profit on these procedures during each year of the transition period (something you should do when considering any new procedures on the list in 2007), you can determine during which year it is most practical for your ASC to add them.

You may want to consider adding these procedures in 2008 if that would entice existing or new physicians to use your ASC more often, says Paul Skowron, corporate controller of Regent Surgical Health based in Westchester, Illinois.

“In the past, we tried to persuade doctors not to bring Medicare patients, but with a little more reimbursement in these categories, we no longer need to dissuade orthopedic surgeons from bringing arthroscopies because Medicare will (at least) cover their cost now,” he says. “It’s always better to be able to tell a surgeon that we want all of your cases.”

“Carpal tunnel surgery” (CPT 64721), a procedure performed by orthopedic surgeons and neurosurgeons, saw an increase as well. But not all common orthopedic procedures benefited from the new payment system. One, “wrist endoscopy/surgery” (29848), wrist arthroscopy with the release of transverse carpal ligament, will see a 3% decrease this year and an 11% decrease at the 2008 fully implemented rate. The new reimbursement for this procedure brings it on par with other arthroscopic surgeries, Serbin says.

Podiatry

Several common podiatric procedures also benefited from the new payment system.

“Repair of hammertoe” (CPT 28285–28286) and “correction of bunion” (28290, 28292–28294, 28296–28299) are seeing increases worth noting, says Robert J. Zasa, FACMPE, MSHHA, partner in Woodrum Ambulatory Systems Development based in Pasadena, California. “Removal of foot lesion” (28080) is another podiatric procedure seeing an increase that you may want to consider adding.

With a good volume of Medicare-eligible patients, podiatry is a strong area to focus on if you perform orthopedic surgery or are considering adding it.

General surgery

General surgery will see a strong positive impact from the new payment system, with an overall average increase of 20% in 2008 with the transition and a 79% increase at the 2008 fully implemented rate.

The big news for general surgery may be the addition of laparoscopic cholecystectomy (CPT 47562). This is the first year ASCs can receive reimbursement for lap choles in Medicare patients. The procedure is not phased in because it was an addition to the Medicare list for 2008, so ASCs can perform this procedure now and receive $1,885 per procedure.

“If you have general surgeons, they usually make money doing simple lumps and bumps that have low cost involved,” says Skowron. “They’ve wanted to do lap choles in the past, and you’ve wanted the commercial insurance, but not the Medicare. Now Medicare has added it.”

Make this news clear to the general surgeons—and their schedulers—who use
your ASC to encourage scheduling of more procedures at your facility. You can also use this information to recruit new surgeons.

"In the past, we’ve tried to be selective with general surgeons and say, ‘We’d really like you to come and do procedure A, B, C,’” Skowron says. “And they’d say, ‘You know, I really don’t like to have to go to the hospital and do my lap choles and then come to your facility and do removals of warts.’ This will help recruit new general surgeons.”

In addition to lap choles, general surgery also saw many smaller-lesion procedures that had been removed a few years ago added back to the ASC list, Zasa says. These are found in the CPT 11000 series.

Because the lesion procedures do not have a high reimbursement on their own, you should try to perform these with other procedures.

“You certainly don’t want to schedule them as the only procedure, but if you’re doing other, better-reimbursed procedures at the same time, they’re probably worthwhile,” Serbin says.

Some general surgery procedures already on the Medicare list saw notable increases. “Repair recurrent inguinal hernia” (CPT 49520) saw a 50% increase in 2008 and a 199% increase at the 2008 fully implemented rate. “Laparoscopy with initial hernia repair” (CPT 49650), saw a modest increase, up 7% in 2008 and 28% at the 2008 fully implemented rate. Inguinal hernia procedures are worth case costing as possible additions, Serbin says.

GI takes a blow

GI is probably the specialty most negatively affected by the new payment system. News got worse before the end of last year with the announcement from Aetna that it would no longer reimburse for monitored anesthesia care (MAC) for most routine GI endoscopies.

The new payment system reduced the average reimbursement of GI procedures by 5% in 2008 and 19% at the 2008 fully implemented rate. Seeing reductions were the most common GI procedures, including “colonoscopy with lesion removal” (CPT 45385). Reimbursement dropped to $426 this year from $446 in 2007; the reimbursement will be $366, or an 18% decline, at the 2008 fully implemented rate.

An even greater decline is seen in “sigmoidoscopy and biopsy” (CPT 45331), declining from $299 in 2007 to $277 in 2008, and down to $211, a 29% decline, at the 2008 fully implemented rate.

A few procedures benefited slightly, including “upper GI endoscopy, diagnosis” (CPT 43235), which is esophagogastroduodenoscopy (EGD), and “sigmoidoscopy & polypectomy” (CPT 45333), both with 2% increases in 2008.

At first, “colonoscopy with stent” (CPT 45387) appears to receive an increase at the 2008 rates, but the reimbursement includes the stent. Whether you can profit on this procedure most likely depends on how much your ASC spends on the implants.

Just when it looked like 2007 couldn’t end any worse for GI, Aetna announced on Dec 28 that it would no longer pay for MAC (monitored anesthesia care) for routine GI endoscopies beginning April 1, except for patients with sedation-related risk factors.

MAC is most often used when propofol (Diprivan) is administered. Propofol is favored by many GI physicians and patients because it induces sedation rapidly, and patients wake up quickly. Use of MAC can add $300 to $1,500 to the cost of a case. (See February OR Manager.) Similar announcements were made by WellPoint in 2006 and Humana in mid-2007. ASCs performing GI endoscopies must decide how and whether to perform these procedures on patients covered by Aetna.

“You will need to consider the cost for additional staffing, administration of the anesthesia, increased recovery time with the use of other medications, as well as safety and risk management,” Serbin says.

Says Zasa, “What I see is more GI doctors either trying to make their center more efficient by reduction of expenses, increasing volume, or more efficient use of rooms. I think we’ll see an increase of some GI physicians joining multispecialty centers to spread their costs over more revenue.”

—Robert Kurtz
Robert Kurtz is a freelance writer in Odenton, Maryland.

Procedures are described using the short descriptor provided by CMS with CPT codes, which are copyrighted by the American Medical Association.

**ASC Association decies proposed budget cuts**

President Bush’s proposed Medicare payment cuts to ambulatory surgery centers (ASCs) in his 2009 budget request are “totally unacceptable and should be rejected by Congress,” ASC Association President Kathy Bryant said Feb 5.

The budget proposal sent to Congress Feb 4 would extend the freeze on ASC annual updates through 2011 and then reduce the update in future years by 0.65 percentage points—an anticipated savings of $450 million for the federal government over 5 years, she noted. The proposal would cut payments to all providers by $12.8 billion in 2009 and $182.7 billion over 5 years.

Though the proposed ASC payment cuts mirror those proposed for some other providers, the impact on ASCs would be greater, she said.

“ASC payments have been frozen for 6 years while other provider payments have increased,” Bryant said. “During this time, nursing and medical supply costs have been escalating steadily. It is unthinkable that ASCs would be subjected to even more Medicare cuts at this time.”

She urged ASCs to contact their members of Congress, saying, “We need every member of Congress to understand that adopting policies, and budgets, that undermine ASCs is a huge mistake.”

*For more on ASC policies issues, visit www.ascassociation.org.*

*More on the President’s budget proposal is at www.budget.gov.*