**Ambulatory
Surgery Centers**

Making the most of Medicare payments

Part two of two articles.

Last month, we analyzed how the new Medicare payment system for ambulatory surgery centers (ASCs) and the expanded list of Medicare-approved procedures affect orthopedics, podiatry, general surgery, and gastroenterology. The new payment system took effect Jan 1, and more than 800 procedures were added to the ASC list.

This month we finish our analysis, discussing ophthalmology, otolaryngology (ENT), pain management, urology, gynecology, and neurosurgery. We also provide more expert tips and guidance to help you benefit from these significant changes.

Note that the projected reimbursement rates beyond 2008 provided in this article are not adjusted to reflect future changes in technology, increasing costs, annual inflation updates based on the consumer price index (which take effect beginning in 2010, assuming Congress doesn't change the date), the Centers for Medicare and Medicaid Services (CMS) calculation of new relative weights for each procedure, and your ASC's local wage index.

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

The transition requires procedures that were 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; in 2011, the rate will be solely based on the new payment system.

Ophthalmology

Ophthalmology sees almost no change in 2008 and just a 3% increase at the 2008 fully implemented rate. But there is an opportunity to find new profit in this specialty thanks to retinal procedures.

Many new retinal procedures were added (CPT 67101, 67105, 67110, 67113, 67145, 67208, 67210, 67220, 67221, 67225, 67228, 67229). The addition of 3 vitrectomy procedures (CPT 67041–67043) is also an area to potentially target for growth, says Robert J. Zasa, FACMPE, MSHHA, partner of Woodrum Ambulatory Systems Development based in Pasadena, California.

"The key is to have enough volume of retinal cases to pay for the equipment needed to do these retinal procedures and buckle procedures done by retinal surgeons," Zasa says.

Some existing retinal procedures saw reimbursement increases with the new payment system, such as repair of detached retina (CPT 67107), which saw a 29% increase in 2008 and will see a 115% increase at the 2008 fully implemented rate.

If you have retinal surgeons, carefully choose which of these procedures they perform because some of the procedures with increases still may not return a profit during the first year or two of the transition, says Caryl Serbin, president and founder of Surgery Consultants of America and Serbin Surgery Center Billing in Fort Myers, Florida.

"In determining which procedures to add, the center needs to figure out what its true cost is to add each procedure and compare it to the Medicare allowance," she says. "When determining cost, don't just think supplies—you also need to consider equipment, purchase price, and per-use rate, as well as additional OR and recovery room time needed."

Before making any decisions concerning adding retinal procedures, consider leasing the equipment to perform these cases and bringing in retinal surgeons on a trial basis to determine whether it's worthwhile to purchase the equipment and commit to the surgeons and procedures, Zasa says.

Unfortunately for ophthalmology, one of the highest volume ASC procedures, is seeing a significant decline. After-cataract laser surgery (CPT 66821) declines 8% in 2008 and 31% at the 2008 fully implemented rate. You should assess how you perform laser surgery to identify areas in which you can reduce cost or improve efficiency to offset this decrease, Serbin says.

ENT

ENT will see a good increase, up approximately 21% for 2008 and 78% at the 2008 fully implemented rate, according to Serbin. Most of the commonly performed ENT procedures in ASCs saw increased reimbursement, but this specialty does not have a high volume of Medicare patients. Still, there are several procedures worth considering as additions for your ASC.

"Revision of ethmoid sinus" (CPT 31254) and "removal of ethmoid sinus" (CPT 31255), which are sinus endoscopy with partial ethmoidectomy and sinus endoscopy with total ethmoidectomy respectively, saw strong percentage increases—84% and 31% at the 2008 fully implemented rate.

Removal of tonsils and adenoids for patients over 12 years of age (CPT 42821) will increase 7% in 2008 and 29% at the 2008 fully implemented rate.

Medicare has now bundled the reimbursement for the cochlear implant with the procedure for implanting it (CPT 69930). If you have the capability to perform this procedure and can negotiate a good rate on the implant (which may be more than \$18,000 depending on the type), the reimbursement of more than \$20,000 your ASC will receive may be worth pursuing, Serbin says.

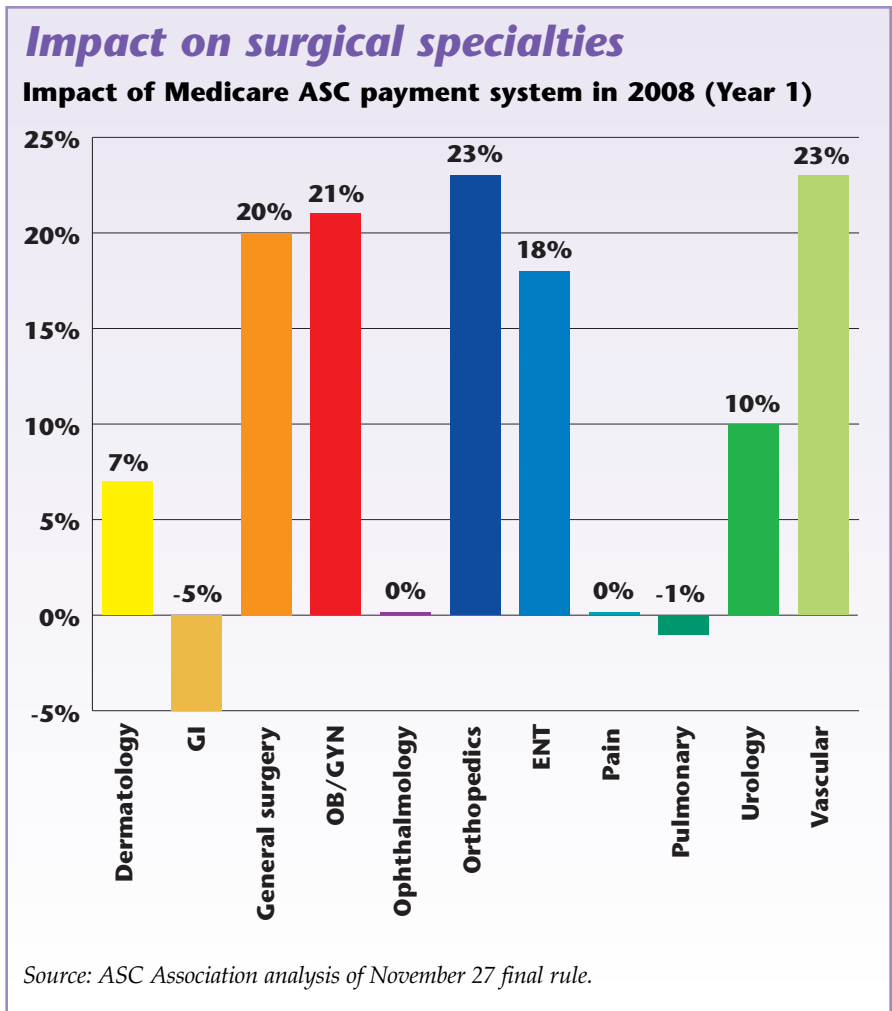
Pain management

Pain management took a significant hit with the new system. Although there is almost no change in the average reimbursement percentage for these procedures in 2008, the specialty will decline 15% at the 2008 fully implemented rate, according to FASA (now the ASC Association).

Some of the more notable declines are in basic spine injection procedures (CPT 62310, 62311, 62318, and 62319); paravertebral injection (CPT 64475); and transforaminal epidural injection (CPT 64483). These declines may be offset by the addition of several nerve block procedures (CPT 64400s) and the reimbursement increase for some pain pump procedures (CPT 62360–62362), Zasa says.

"Implants in these cases will be included in the fee, so you have to be sure that you negotiate a cost-efficient price for the pumps from the vendors so it is not costing you more than you will be paid," he says.

If your ASC performs pain procedures, work to decrease volume on some of the



procedures that have reimbursement declines to try to negate the reduction, Serbin says. To do so effectively will require a close evaluation of scheduling efficiency. Assess your managed care contracts for how much they reimburse for performing multiple procedures, and make sure to closely monitor the accuracy of your coders when coding multiple procedures, she says.

Urology

There are some enticing opportunities in urology thanks to a few notable additions and reimbursement increases.

Shockwave lithotripsy (CPT 50590) is a new procedure added to the list that is reimbursed at a rate of \$1,719.

“This will be much better for urologists who can schedule all their lithotripsy cases together now that they can do Medicare patients, too,” Zasa says.

The other significant addition is the brachytherapy source reimbursement. Prostate brachytherapy (CPT 55875) will have a modest increase for the procedure, up 3% in 2008 and 12% at the 2008 fully implemented rate. Medicare will now reimburse for the radon seeds (HCPCS C1716, C1717, and C1719) used during brachytherapy.

“There is a significant cost of these (seeds); Medicare will now reimburse for them,” Zasa says. “(Brachytherapy) is done a lot, so there are a lot of patients that can now be seen in an ASC for this procedure, especially with much better reimbursement from Medicare.”

A few common procedures on the list saw big increases with the new payment system. Payment for transurethral resection of the prostate (CPT 52601) increased 34% this year and increases 137% at the 2008 fully implemented rate.

“This is a common procedure, and with so many urology patients being Medicare, this will increase the number of cases urologists can do in an ASC,” Zasa says.

Cystoscopy procedures, such as cystoscopy with biopsy (CPT 52204) and cystoscopy with fulguration of a small tumor (CPT 52224), saw increases that should catch your attention.

“If you haven’t been doing cystos, it’s something you want to take a look at,” Serbin says.

Gynecology and neurosurgery

Two other specialties that will have reimbursement increases are gynecology and neurosurgery. For gynecology, most of the commonly performed ASC procedures will have increased reimbursement, but this is a specialty with a low volume of Medicare patients.

Neurosurgery is interesting to explore because it’s a relatively new specialty for ASCs to consider. In the past ASCs did not perform many neuro procedures because of their high level of risk and complexity, but advancements in technology now allow surgeons to perform the less complex neuro procedures, such as single discectomies, and Medicare will reimburse for them, Serbin says.

For example, the addition of a few percutaneous vertebroplasty procedures (CPT 22523–22525), which employ the X-STOP device, should catch the attention of ASCs performing pain management procedures.

“If you already have neurosurgeons doing pain management in your center, it’s something you need to look into,” Serbin says.

There were also reimbursement increases for percutaneous vertebroplasty procedures already on the list in 2007. These procedures (CPT 22520–22522) are now reimbursed more frequently, often by worker’s compensation, and are worth considering as possible additions.

Benefiting from the new payment system

The new payment system and additions to the list can provide you with numer-

Payment changes for selected procedures

CPT code	Procedure	2007	2008
66984	Cataract extraction w/IOL, 1 stage	\$973	\$977
66821	After-cataract laser surgery	\$313	\$288
45378	Diagnostic colonoscopy	\$446	\$426
64721	Carpal tunnel surgery	\$446	\$521
36561	Insert tunneled venous access device	\$510	\$681
64483	Inject foramen epidural, lumbral or sacral	\$333	\$323

Source: ASC Association, analysis of November 2007 final rule.

ous opportunities to grow your ASC. To help you benefit as a result of the changes, follow these suggestions from the experts:

Analyze before you move forward. Before you think about making any major changes, start by conducting a net gain/net loss analysis for your entire ASC based on your existing book of procedures, says Paul Skowron, corporate controller of Regent Surgical Health based in Westchester, Illinois.

"From there, start adding potential additions of new procedures that don't require too much capital investment," he says. "And then the third part—look at the kind of procedures that will require significant capital investment."

If you consider adding specialties, first conduct a thorough cost-benefit analysis.

"You have to have a sufficient base of referral of volume in place already before it makes sense to pursue those new specialties," he says.

Connect with the physicians and their schedulers. If you elect to add new procedures, schedule meetings with your physicians and their schedulers to introduce them to these new options, Zasa says.

"We're going back to the doctors and sending them the new Medicare-approved list, broken down by CPT code and by specialty," he says. "We're sending it to each one of them so they know they can do these new procedures in their center."

Use existing physicians to grow. If you want to grow your center by adding new physicians, ask your current physicians to suggest surgeons they think would make valuable additions to your ASC.

"The incentive for a noninvestor is that he can come in and add cases to his block schedule," Zasa says. "HMOs want him to do it there, and if Medicare is paying for it, then his patient has less out-of-pocket costs."

Use the new payment system as leverage with payers. You can benefit from the new payment system without even changing the procedures or surgical specialties your center performs. How? Use it as leverage with your third-party payers, Skowron says.

"Historically, ASCs have been a backwater negotiating exercise for the large payers," as many payers followed Medicare's lead and worked to restrict payments to the 9 categories Medicare used rather than consider alternative reimbursement methods that would benefit ASCs, Skowron says. "Only ASCs had this unique reimbursement methodology of 9 categories."

The major payers would then create their categories based on Medicare's groupers and lump the CPT codes into these categories. The new payment system eliminates the groupers and may give ASCs an edge.

"It puts ASCs on the same platform for negotiation hospitals are on," Skowron says. Schedule meetings with your payers to discuss your existing contracts and how the payers plan to change them now that Medicare has eliminated the grouper system. The payers will be slow in assimilating the new methodology, but the ASC industry must start beating the drum now.

"Remind them that ASCs are (reimbursed) like hospitals now," he says. "This puts us on a level field from a managed care negotiating standpoint with the hospitals."

Watch for accidental scheduling additions. Not all of the additions to the Medicare list are "A-list" procedures you want to start performing for Medicare patients. Many are office-based procedures with very low reimbursement. You will need to alert your scheduling staff to ensure these are not scheduled as single procedures.

"You probably haven't done these on Medicare patients previously because your scheduling staff knew not to schedule noncovered procedures, but now that these are covered, they may get on the schedule," Serbin says. ♦

—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.