Is it time to stop performing colonoscopies and go full steam ahead with knee surgery? Maybe. According to the proposed Medicare Outpatient Prospective Payment System (OPPS) rule released July 1, 2009, colonoscopy reimbursement rates for ambulatory surgery centers (ASCs) will decline by 5.6% in 2010, compared with an increase of 15% for knee arthroscopy with repair of medial meniscus.

On the other hand, Medicare is proposing to reimburse 2 additional gastrointestinal procedures next year, providing an increase in potential business at some surgery centers.

Expect final rule in November

That is a small example of factors ASCs must weigh as they adjust their strategic planning. It is not all about Medicare payments, of course; the local market, staff specialties and preferences, and demographic projections play a role as well.

For ASCs serving a large elderly patient population, however, it will pay to keep an eye on the trends as the Centers for Medicare and Medicaid Services (CMS) issues its final rule in November. The rule will be effective January 1, 2010.

“You will need to review payment changes at the procedure level to determine the impact of the proposed changes on your particular ASC,” the Ambulatory Surgery Center Association reminds members in its summary of the proposed 2010 rates.

As an example, CMS plans to add 28 procedures to the list of those it will reimburse ASCs for next year. They include surgery to repair the tibia, at $1,775.48; repairing arterial or venous blockage, $1,990.24; and partial thyroid excision, at $1,926.01. For the complete list, visit the ASC Association’s website www.ascassociation.org.

‘Aligning payments’

On the down side, reimbursement for some of the most common outpatient procedures will decrease. The most dramatic example is injection of anesthesia into the spine to manage back pain (HCPCS code 64476), for which the proposed payment would decrease by 25.6%.

The rule covers both ASCs and hospital outpatient departments (HOPDs) but at different payment levels.

According to CMS, the aim of the 4-year transition period to the new ASC payment system, of which 2010 will be the third year, is to align rates for similar services for both types of outpatient facilities.

However, rates will be aligned at different levels, with ASCs getting a smaller share because of economic advantages ASCs are perceived to enjoy.

A complex system of weights and legislative compromises has resulted
in proposed rates that give ASCs on average 57.7% of HOPD payments for similar procedures, plus a hard-won inflation update of 0.6%. HOPDs would receive 2.1% toward inflation under the proposal. Under an earlier version of the rule, ASCs would have received no update for inflation.

According to CMS projections, total Medicare payments to HOPDs in 2010 will be $31.5 billion, while ASCs will receive just $3.4 billion. CMS estimates about 5,000 ASCs participate in Medicare.

An unfair system?

Is the new system unfair? ASCs maintain it is. In a recent presentation, ASC Association President Kathy Bryant asked, “How do we stop the bleeding?” She called on Congress at least to equalize inflation updates for ASCs and HOPDs.

Caryl Serbin, RN, BSN, LHRM, explains that based on a Government Accountability Office (GAO) review, the typical ASC cost for a procedure was 84% of that of an HOPD. Despite that, CMS originally planned to give ASCs 75% of the HOPD rates. In 2008, that was reduced to 65%. In 2009, the rate declined again to 59%, and in 2010, it is due to drop to 57.7%.

“If it costs ASCs 84% of what it costs HOPDs to perform a procedure,” Serbin says, “and ASCs get reimbursed 57.7% of what HOPDs get reimbursed, it sounds like the ASCs are losing money.”

Serbin is the owner of Serbin Surgery Center Billing, Fort Myers, Florida, a provider of outsourced coding, claims submission, and collections services.

The device factor

In one way, the Medicare payment rules recognize that ASCs, like their hospital counterparts, have become increasingly dependent on expensive, high-tech products they must purchase to treat patients, from orthopedic implants to laparoscopic instruments to cardiac catheters.

So while the new ASC payment rate for a service is a fraction of the HOPD rate, when devices represent more than 50% of the cost of a procedure, payments are equal.

The bad news is, once again, most payments are decreasing. A big exception is cardiology, where inserting a pacemaker lead will bring in more than 50% more (chart).

Specific rates could change in the final rule, but the trend represents little change from previous years and is unlikely to vary drastically.

In addition, though CMS plans to increase by 28 the number of procedures it will pay ASCs for, it also proposed to designate 6 other procedures as payable only at the lower rate applied to office-based procedures.

Another indication of the trend toward lower payments is the fact that the highest-volume ASC procedures will be paid less in the future. Refractive laser surgery will drop by 8.6%; upper GI endoscopy with biopsy will decline by 7%.

### Proposed ASC payment changes for device-intensive procedures

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Name</th>
<th>Proposed 2010 rate</th>
<th>2009 rate</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>24361</td>
<td>Reconstruct elbow joint</td>
<td>6,079.17</td>
<td>6,085.62</td>
<td>-0.10%</td>
</tr>
<tr>
<td>24363</td>
<td>Replace elbow joint</td>
<td>6,145.30</td>
<td>6,221.16</td>
<td>-1.20%</td>
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<tr>
<td>24366</td>
<td>Reconstruct head of radius</td>
<td>6,079.17</td>
<td>6,085.62</td>
<td>-0.10%</td>
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<tr>
<td>25446</td>
<td>Wrist replacement</td>
<td>6,145.30</td>
<td>6,221.16</td>
<td>-1.20%</td>
</tr>
<tr>
<td>27446</td>
<td>Revision of knee joint</td>
<td>6,401.02</td>
<td>10,921.17</td>
<td>-41.40%</td>
</tr>
<tr>
<td>29881</td>
<td>Knee arthroscopy</td>
<td>1,036.94</td>
<td>901.24</td>
<td>15.10%</td>
</tr>
<tr>
<td>33206</td>
<td>Insert cardiac pacemaker</td>
<td>6,939.30</td>
<td>6,938.76</td>
<td>0.00%</td>
</tr>
<tr>
<td>33224</td>
<td>Insert pacing lead and connect</td>
<td>12,694.82</td>
<td>8,123.29</td>
<td>56.30%</td>
</tr>
<tr>
<td>62361</td>
<td>Implant spine infusion pump</td>
<td>11,849.33</td>
<td>10,941.40</td>
<td>8.30%</td>
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<tr>
<td>64476</td>
<td>Paravertebral injection</td>
<td>158.13</td>
<td>212.55</td>
<td>-25.60%</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services.
Tighter constraints

According to Serbin, overall ASCs are facing tighter economic constraints. This is true, she says, not only because of lower payments but because the cuts are coming at a time when volume is down.

“Like all types of businesses in these economic times, we have already seen ASCs working reduced hours and laying off staff. There have also been reports of ASCs closing completely, doing joint ventures, or converting to HOPDs.”

Two specialties Serbin sees as especially vulnerable are pain management and GI procedures.

“In order to be profitable with single-specialty pain management or GI endoscopy centers, the volume must be exceptionally large and the costs well contained,” she says.

Medicare still rules

For some surgery centers, it may be tempting to withdraw from Medicare altogether.

But Serbin does not expect that to happen, especially in large multi-specialty ASCs, “because some specialties are increasing in reimbursement.” Instead, centers are likely to drop lower-paid procedures. One might be pain management, because patients tend to be younger victims of workplace or sports injuries and not covered by Medicare.

On the other hand, Serbin notes, “a lot of private payers require Medicare certification or accreditation, which also may require Medicare certification, in order to participate in their networks.”

For facilities specializing in GI endoscopy, there is even greater incentive to remain with Medicare because the majority of their patients are elderly.

A slightly different perspective comes from a study by KNG Health Consulting, published in June 2009 for the ASC Coalition, now part of the ASC Association. KNG found business shifting from hospitals to surgery centers in the past decade due to preferences of both physicians and patients. Ophthalmology, the largest-volume specialty for ASCs, the researchers found, has had the slowest growth since 2000. Meanwhile, the number of colonoscopies increased by 15% per year during that period.

At the same time, they note, the Medicare population has remained relatively stable. Increases in Medicare spending for ASC services were almost entirely due to additional services for current beneficiaries.

While the comment period for the proposed rule has ended, Bryant advises ASCs to continue communicating with their legislators in an effort to soften the impact of future cuts.

Pending legislation

Pending legislation is intended to help. US Representatives Kendrick Meek (D-FL) and Wally Herger (R-CA) have introduced the ASC Access Act of 2009 (HR 2049). One provision would freeze ASC Medicare payments at 50% of the HOPD rate, avoiding the downward trend that would otherwise continue in 2011. The bill was sent to the House Ways and Means Committee. The ASC Association supports the measure, but spokeswoman Kay Tucker says lawmakers are unlikely to take action before the wider issue of health care reform is resolved.

—Paula DeJohn