Ambulatory surgery centers (ASCs) see pluses and minuses in Medicare’s final rule for a revised ASC payment system, released July 16. The new system, mandated by Congress to take effect by Jan 1, 2008, will for the first time base ASC payments on the hospital outpatient prospective payment system (OPPS).

In a big minus, surgery centers would receive only about 65% of what hospital outpatient departments (HOPDs) receive for the same procedures. Though this rate is up from the 62% proposed last year, it is far lower than what ASCs had hoped. An ASC industry analysis showed a 73% rate was justified and could remain budget neutral to Medicare, as Congress required.

"Because CMS is still setting the rate so low, payments for some procedures will be cut significantly," said FASA President Kathy Bryant, referring to the Centers for Medicare and Medicaid Services.

Moreover, the rule postpones payment updates for 4 years, which she said “is likely to mean that some procedures now performed in ASCs will be forced back into hospitals, where those procedures will ultimately cost Medicare and its beneficiaries more.”

Craig Jeffries, executive director of the American Association of Ambulatory Surgery Centers, said the final rule “will force many centers to make difficult choices about whether to continue offering certain services in their ASC.”

The impact on your ASC will depend largely on the procedures you perform. Those specializing in orthopedics will do well. But those focused on GI and pain management will see a drop (chart, p 26). The system will be phased in over 4 years, which CMS says should give ASCs time to adjust, for example, by bringing in other types of procedures.

The American College of Gastro-enterology termed the cuts in endoscopy payments “draconian,” saying they could severely limit use of colorectal screening for Medicare beneficiaries. This year, the national average payment for a diagnostic colonoscopy in a freestanding GI center is $448, the college says. In 2008, it would be $427.78, falling to $373 in 2011 when the new system is fully implemented.

Gastroenterologists say it’s impractical to bring in other types of cases because their centers are often closely tied to their practices, and some state certificate of need rules don’t allow it.

CMS says the reason GI procedures are taking a hit is because current payments are close to HOPD rates now, so they will come down, while rates for other ASC procedures have been lower.

During a July 31 CMS audio conference, one GI physician said that with the new rates, by 2011, he would no longer be able to perform colonoscopies and endoscopies in his ASC.

“Those will have to go to the hospital, at substantial difficulty for the patient, increased costs for the patient, increased costs to Medicare, and a tremendous loss in efficiency and access. I think that’s a serious problem for CMS, and I don’t think you have seriously considered it,” he told the officials.

The plus side
There are some bright spots. FASA expressed support for parts of the rule that:

• expand the list of procedures Medicare will pay for in an ASC
allow Medicare payments for radiology services when integral to a surgical procedure

• provide payment for implants and other devices in a manner consistent with HOPD payments

• phase in the new system over 4 years, rather than 2 as proposed. In the meantime, ASCs will be paid a blend of the current and new rates.

As expected, some 790 procedures will be added to the ASC list. When a few additional procedures are added this fall, the list will total about 3,300 procedures, compared with about 2,500 now.

The downside is that many of the added procedures are performed primarily in physicians’ offices. To avoid creating an incentive to move those to the more expensive ASC setting, Medicare will cap payments to ASCs at the physicians’ practice expense amount. (This will not affect the physician’s fee.)

Medicare is also shifting its approach for determining which procedures are eligible for ASC payment. Until now, Medicare used a complex set of criteria to decide which procedures to add to the ASC list, and updates lagged. The final rule allows payments to ASCs for any surgical procedure except those that CMS determines are not safe to perform in an ASC or require an overnight stay.

Though the list is improved, the ASC industry says it still lags behind what commercial insurers will cover in freestanding surgery centers.

**Action on high-cost devices**

ASCs have been worried about how the new payment system would pay for expensive implants and other types of devices. In some cases, they note, the proposed 62% rate would not cover the cost of the implant, let alone other services provided.

In response to comments, CMS modified its approach so ASCs will be able to bill for these items generally in the same way HOPDs do. Jeffries called it a “strong signal that CMS is trying to level the playing field between ASCs and hospitals.”

But Bryant said it’s important to realize that “very few implants that aren’t currently paid for separately will be paid for separately” under the new system. “It’s not really true that ASCs will get implant payments when they didn’t in the past.”

What is important, she adds, is that CMS policy now treats ASCs and HOPDs virtually the same way with respect to implants, though the payment rates may differ.

The new approach is explained in a CMS fact sheet and a briefing by the law firm of McDermott Will & Emery (www.mwe.com):

• In general, CMS will continue its current policy of packaging into the ASC facility payment the direct and indirect costs related to a surgical procedure, including use of the facility, staffing, supplies, drugs not eligible for separate payment, anesthesia supplies, and so forth.

• CMS will no longer make separate payments to ASCs for implantable prosthetic devices and implantable durable medical equipment (DME). Instead, payment for most implants will be bundled into the APC payment, as it is for hospitals.

• Some exceptions will allow additional payment for certain high-cost devices and ancillary services if they are “integral” to surgical procedures. Among these are:
  —radiology services
  —brachytherapy sources
  —drugs and biologics.
Medicare will provide ASCs with separate payment for devices that have “pass-through” status under OPPS, meaning they qualify for additional reimbursement beyond the APC rate. For 2008, only 2 devices will continue on pass-through status:

—C1821: implantable interspinous process device (eg, the X-STOP)
—L8690: auditory osseointegrated device. The auditory device currently is payable in the ASC setting. The pass-through list is updated quarterly, so more codes may be added in the future.

Medicare will also provide a separate payment for “device-intensive procedures.” These are defined as ASC-covered procedures where the device cost is more than 50% of the median APC cost. There are 25 such procedures on the 2007 ASC list, and 15 more will be eligible for payment in 2008.

For these procedures, CMS will separate the payment into 2 parts—the device portion and the service portion. For the device portion, ASCs will be paid on the same basis as HOPDs; only the service portion will be discounted to 65%. Current examples of device-intensive procedures are insertion of a pulse generator, cryoablation of the prostate, and implantation of a spinal infusion pump. Examples of procedures to be added for 2008 are insertion of a pacemaker and upgrading of a pacemaker system.

CMS is proposing to revise Stark law definitions for imaging and outpatient prescription drugs so physicians would be permitted to refer these to ASCs, and ASCs could bill for them without violating self-referral prohibitions.

Getting ready

Medicare’s OPPS system with its 200-plus APCs is more complicated than the 9 grouper rates ASCs are used to. What should they do to get ready?

Education is the first thing, says Bryant.

FASA and AAASC are both holding seminars on the new system this fall.

“There are a lot of misunderstandings about how the hospital system works,” she notes.

ASCs will need to upgrade their computer systems to reflect the new system.

Bryant thinks the basics of billing and coding generally will be straightforward. ASCs will continue to bill by CPT code and use form CMS 1500, which they do now.

More than ever, it’s important to make sure coders “are completely up to speed,” she advises. With more payment groups, any errors in coding could be more costly to the ASC. Coding correctly for radiology services will also be critical because of the changes in payment for some of these services.

A bigger question is whether Medicare carriers will be ready.

“In the past, they haven’t been so good,” she says. She’s concerned that when ASCs call the carriers for information, they might not get the right answers.

Bryant encourages ASCs to call FASA instead. If FASA staff cannot answer the question immediately, they will research the answer. They can also spot trends in calls reporting incorrect answers from carriers. Bryant says she can then report the problem to CMS so they can correct it.

“Calling FASA not only allows us to help members but identifies ways in which Medicare can help us,” she says.

Seeking legislation

The ASC industry continues to pursue legislation to address what it sees as shortcomings in the final rule. HB 1823 has been introduced in the US House, and a Senate sponsor is being sought.

“The rule falls far short of offering Medicare beneficiaries the same kind of access that the bill provides,” Bryant says. “The payment rate of 65% is woefully inadequate. These are issues we are talking to members of Congress about.”

AAASC is holding a conference Sept 10 in Washington, DC, which Jeffries says is an opportunity for ASC leaders to meet with legislators and seek support for raising the 65% conversion factor.

“CMS has made its decisions, and absent specific direction from Congress, we will see no improvement,” he says.
Resources

American Association of Ambulatory Surgery Centers
Medicare 2008 payment resources.
Phone 423/915-1001
— www.aaasc.org

Centers for Medicare and Medicaid Services
• CMS-1517-F: Revised payment system policies for services furnished in ASCs beginning CY2008.
  — www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp
• CMS-1392-P: Proposed changes to the hospital prospective payment system and CY 2008 rates.
  — www.cms.hhs.gov/HospitalOutpatientPPS/HORD/
  — www.cms.hhs.gov/apps/media/fact_sheets.asp

FASA National Office
Phone 703/836-8808
— www.fasa.org/

McDermott Will & Emery
For ideas on how to prepare your ASC for the new system, see the July OR Manager.