Pain is a growing business for ASCs

The technology of pain relief is improving constantly, and ambulatory surgery centers (ASC) are finding that staying abreast of this growing specialty serves patients as well as their bottom line.

For the increasingly complex orthopedic procedures that are migrating to the outpatient setting, pain management is a critical element. Sufferers of chronic pain or pain associated with lengthy recovery may make repeated visits to the ASC.

As consultant Amy Mowles summarizes: “The development of new technologies, such as MRI and CT scanning for accurate, noninvasive diagnosis of pain disorders, and sophisticated new treatments, such as spinal cord stimulation, intraspinal drug therapy, and radiofrequency ablation, have greatly increased the number of patients with pain disorders who can enjoy an improved quality of life.”

Pain management procedures are ideally suited to the ASC, she notes, paying well and building patient loyalty.

Mowles, president of Edgewater, Maryland-based Mowles Medical Practice Management, assists ASCs in developing pain management specialties. She has developed a total of 34 ASCs with pain management as their single specialty.

“The vast majority of ASCs do pain management,” she says.

A growing market

One is the Tucson Orthopaedic Surgery Center, which performed 2,800 pain procedures in 2010, in addition to its orthopedic specialty. The two specialties may be related from a patient’s point of view, according to administrator Stuart Katz: “Patients with chronic pain tend to put off surgery as long as they can, instead opting for pain management by injection. Then some have pain long after their surgery, which is not helped by medication, so these patients then return for an injection.”

More than half of Tucson’s patients are covered by Medicare. The market is increasing as the population ages, Katz notes: “It’s not exponential, but I predict more growth.”

The newer pain management technologies grew out of obstetrics. To help control labor pain, physicians used epidural injections. Now, they use imaging equipment to locate the source of chronic pain and can choose from 30 different procedures to control it, including spinal cord stimulators and a variety of methods to burn or freeze nerve endings.

Mowles notes that the cost of setting up the specialty is relatively low, and Medicare and other insurers pay readily. “Any ASC that does not have a pain component is missing the boat,” she says. “You should not have to fight to get it paid for.”
Follow the rules

Unlike treatment of surgery-related pain, which is the responsibility of the anesthesia provider, management of chronic pain is a medical specialty, subject to board certification.

State licensing rules may address space and other requirements. Medicare Conditions for Coverage rules apply. The national average payment is $294 per procedure, down from $333 in 2007. Medicare pays additional amounts for additional procedures, even if all take place during the same visit. Payment for facility use may also apply.

State regulations vary widely and vary in their financial impact. For example, in some states, the surgeon is permitted to operate the C-arm, saving the expense of an X-ray technician. However, an efficient technician might be better skilled and save the center time and therefore money.

Other staff include a registered nurse dedicated to monitoring the patient during sedation and a technician to arrange for supplies and room preparation. Some cases require use of an anesthesiologist, but Medicare and private insurers often deny additional payment for that function.

Mowles agrees that ASCs considering adding pain management need to research the regulations. "Some of my clients think Medicare rules don’t apply to pain management, but they do.” On the other hand, ASCs are more appropriate than physicians’ offices for pain therapy. In fact, she notes, New York and Pennsylvania do not allow those procedures in physicians’ offices. What physicians may do is to evaluate patients and then prescribe medication. If a more invasive procedure is called for, it must be done in an ASC.

Costs and benefits

The cost of adding a pain management practice depends on what equipment an ASC already has. According to the equipment vendor Xraytrader.com, the major capital investment would be for a C-arm and fluoroscopy table. The company estimates the equipment cost for furnishing a new procedure room at $125,000, covering:

- a refurbished C-arm
- a basic fluoroscopy table
- patient monitoring equipment
- transportable stretcher
- recovery recliners
- crash cart
- IV poles
- stools for clinicians.

Consumable supplies include an epidural tray, drugs, and contrast media. The other expense is for staff, which can account for 45% to 50% of overall operational costs for a pain procedure.

Medicare’s standard fee is $294 per procedure plus the facility fee as described above. The patient’s time in the facility averages 87 minutes (range 15 to 179 minutes), while the average procedure time is 8 minutes (range 2 to 23 minutes), according to a report from the Accreditation Association for Ambulatory Health Care (related article).

"Although professional fees paid by Medicare to ASCs are typically 20% to 30% lower than those paid to an office, this is frequently compensated for by the fact that the additional facility fee averages 65% to 80% of the professional fee,” Mowles explains.
The specialty also attracts patients with other insurance, such as workers compensation. Mowles estimates that private insurers reimburse at rates averaging 120% to 250% of Medicare rates.

“In short,” she says, “net incomes for ASCs average 40% higher than in offices.”

**Not like other patients**

ASCs need to consider one more factor before deciding to add pain therapy to their mix of specialties, according to Mowles. While the great majority of ASC patients visit the center only once for their surgery and from then on interact with their physicians in the office, that is not true of pain patients.

From the reception desk to the nurse managers to the billing department, staff must be aware that their initial interaction with the patient may well determine whether that patient returns. If staff members create a pleasant, comfortable setting during that first visit, the patient will return many times.

“You’ve got one chance to make them feel comfortable, because you’re not the only game in town,” Mowles says. “These are frequent flyers.”

---Paula DeJohn