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a happy new year for ASCs?

A new payment system, with new rates, awaits ambulatory surgery centers on Jan. 1, 2008.

Come New Year's, some ambulatory surgery center (ASC) owners will be popping champagne to celebrate a new Medicare payment system and rates for ASC services that will substantially improve their bottom line. Others will be nursing a hangover and wondering what hit them.

AT A GLANCE

From a high-level policy perspective, the new ASC payment methodology includes many important and welcome improvements over the existing payment system. At ground-level, however, the new payment system will yield mixed results for ASCs. Some procedures will benefit substantially under this new system, while others will experience significant decreases in revenue.

On Jan. 1, 2008, the Centers for Medicare and Medicaid Services (CMS) will implement long-anticipated changes that will affect how—and how much—Medicare will pay ASCs for the facility component of surgical services furnished to program beneficiaries. The changes, once implemented, will profoundly revise payment rates for most every service, doubling payment for many services while halving it for others. ASCs should understand the new payment rules before Jan. 1 to avoid program violations and ensure that facilities are appropriately paid.

Background

Under CMS's current ASC payment methodology, Medicare pays ASCs on the basis of a fee schedule. All surgical procedures approved for the ASC setting are assigned to one of nine payment groups that range from \$333 to \$1,339 based on the resource "costs" associated with the procedure.

Under the revised system, CMS will replace the nine-group procedure classification system with the ambulatory payment classification (APC) system used to categorize items and services furnished to hospital outpatients, and used to pay hospitals under the hospital outpatient prospective payment system (OPPS). Under the hospital OPPS, each covered item or service is assigned to an APC, and each APC is assigned a relative weight based on procedure costs and other data and considerations. The APC relative weight is then multiplied by a standard OPPS conversion factor (plus other adjustments discussed later) to obtain the Medicare payment amount to the hospital.

For purposes of paying ASCs, CMS will use the same APC assignments used under the OPPS. For example, under the OPPS, CPT 66984 (cataract surgery with intraocular lens [IOL], 1 stage) is assigned to APC 0246 (cataract procedures with IOL insert). CPT 66984 will likewise be assigned to APC 0246 under the ASC payment system. CMS also will use the same relative weights determined for APC 0246 under the OPPS to calculate payments to ASCs.

However, ASCs will not be paid on par with hospitals. Rather, CMS will use a significantly lower conversion factor to determine the ASC payment for a procedure. Whereas the 2008 OPPS conversion factor is \$63.694, the 2008 ASC conversion factor will be \$42.401. Consequently, ASCs typically will be paid 65 percent of what hospitals are paid for corresponding procedures in 2008.

The percentage relationship will not be permanent. Under the new methodology, CMS will recalculate the two conversion factors each year, and the hospital-ASC payment relationship will vary annually accordingly.

Updates to ASC List

CMS likewise will significantly change how it determines which procedures will be payable when furnished in the ASC setting. Under the current payment system, Medicare pays for only the "covered surgical procedures" specified on its ASC-approved list. CMS decides whether to add or delete a procedure from this list based on whether the procedure can be appropriately performed in an ASC setting. To make this determination, CMS has historically relied on a series of objective criteria as well as subjective clinical judgment to evaluate whether a surgical procedure should be covered when it is performed in an ASC. Approximately 2,500 procedures have been approved using these criteria and are currently eligible for coverage when furnished in the ASC setting.

Under the new system, CMS will substantially revise its approach to determining eligibility for coverage. Rather than identify which procedures are suitable for the ASC setting, CMS will instead

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start with the notion that all surgical procedures are suitable, and then exclude those that it explicitly determines either require an overnight stay or are not safe when furnished in an ASC. Although this approach may appear to be a subtle difference without a distinction, it should operate to allow more flexibility with the list and more rapid addition of procedures in the future.

For purposes of determining coverage, CMS will define a "surgical procedure" as one that is described by CPT codes within the surgical range of 10000 through 69999—that is, a procedure with a Level II HCPCS or Category III CPT code that directly crosswalks or is clinically similar to procedures in the CPT surgical range.

CMS will review procedures on an annual basis (rather than every two years) to determine whether they should be placed on the ASC-approved list. Again, CMS procedures excluded from payment will be those that pose a significant safety risk when furnished in an ASC and those that require an overnight stay.

A surgical procedure will be considered to pose a significant safety risk if, among other things, it results in extensive blood loss, requires major or prolonged invasion of body cavities, directly involves major blood vessels, or is on the OPPS "inpatient-only" list. Although many of these criteria carry over from the current standards and will operate to similarly exclude procedures that CMS has traditionally regarded as not safe for the ASC setting, it is noteworthy that CMS has abandoned two major long-standing obstacles to coverage. The first is site-of-service criteria.

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CMS will no longer automatically exclude procedures that are predominantly performed in physicians' offices. The second is the duration of the procedure and recovery. These criteria were frequently cited by CMS as the basis for denying payment for numerous surgical procedures.

CMS will deem that a procedure requires an overnight stay if the typical patient must remain in the ASC past midnight on the day of surgery.

Effective Jan. 1, 2008, using these revised standards, CMS will add approximately 800 new procedures to the ASC list. However, nearly 270 surgical procedures will continue to be excluded based on CMS's determination that they either fail to satisfy the patient safety criteria or require an overnight stay.

Office-Based Procedures

Although the expansion of the ASC list is welcome news in theory, the practical effect is less exciting. CMS remains concerned about paying a facility fee for procedures that either require limited facility resources or are primarily performed in physician offices. As such, CMS will cap payment for "office-based" procedures for which payment of an ASC facility fee would be allowed under the revised payment system as of Jan. 1, 2008, at the lesser of the Medicare Physician Fee Schedule (MPFS) nonfacility practice expense payment or the ASC rate under the revised ASC payment system.

The cap will apply only to those procedures newly added to the office-based procedures list beginning in 2008. Procedures that are considered to

Effective Jan. 1, 2008, CMS will cap payment for office-based procedures under the revised ASC payment system. The cap will apply only to procedures newly added to the list of office-based procedures on or after Jan. 1, such as urine flow measurement (procedure code 51736).

The current regulatory definition of an ASC does not allow the ASC and another entity to mix functions and operations in a common space during concurrent or overlapping hours of operation.

be office-based, but that are already on the list, will be exempt from the cap and continue to be paid under the new ASC payment methodology. For example, the cap will apply to procedure 51736 (urine flow measurement), because this procedure will be newly covered in 2008; the cap will not apply to 51726, because this procedure is currently covered in the ASC setting.

Those procedures that do not yet have an MPFS nonfacility practice amount will have the cap implemented once that amount becomes available; until that time, such procedures will be paid using the standard methodology of the revised ASC system.

Procedures will be deemed to be office-based if they are furnished in the physician's office setting more than 50 percent of the time. Approximately 350 of the nearly 800 newly added procedures are subject to this payment cap and will be paid at MPFS amounts. Payment for many of the procedures subject to the cap may be too low to justify utilization of ASC resources.

Payment "Packaging"

Traditionally, Medicare's payment to an ASC is intended to pay the facility for most of the "overhead" costs it incurs when it hosts a surgical procedure. CMS is carrying this notion forward to the new payment system, but the agency also is

CAPPING PAYMENT FOR OFFICE-BASED PROCEDURES

	OPPS Rate	Discounted ASC Rate	Medicare Physician Fee Schedule Practice Expense Rate	Applicable ASC Payment Rate
51736 (Urine flow measurement)	\$69.11	\$46.16	\$18.14	\$46.16

making several changes designed to include or "package" certain additional items and services into the facility payment while further allowing ASCs to bill for a wider array of items and services for which they historically were not able to be compensated.

Specifically, the new facility fee payment is intended to pay the ASC for the following costs:

- > Nursing, technician, and related services
- > Use of the facility where the surgical procedures are performed
- > Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 certificate of waiver
- > Drugs and biologicals for which separate payment is not allowed under the hospital OPPS
- > Medical and surgical supplies not on pass-through status
- > Equipment
- > Surgical dressings
- > Implanted prosthetic devices, including IOLs, and related accessories and supplies not on pass-through status
- > Implanted durable medical equipment and related accessories and supplies not on pass-through status
- > Splints and casts and related devices
- > Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure
- > Administrative, recordkeeping, and housekeeping items and services
- > Materials, including supplies and equipment for the administration and monitoring of anesthesia
- > Supervision of the services of an anesthetist by the operating surgeon

CMS will now allow separate payment for the following ancillary services that are integral to a covered surgical procedure, yet are outside the scope of facility services as defined above.

Brachytherapy sources. CMS has decided to provide separate payment to ASCs for the brachytherapy sources implanted in conjunction

with covered surgical procedures billed by ASCs on the same day. The payment amount for the brachytherapy source will be the same as the OPPS payment rate without application of the ASC budget neutrality adjustment factor, nor with adjustment for geographic wage differences. If a specific OPPS rate is unavailable, the brachytherapy sources will be contractor-priced.

Implantable devices. Under the revised payment system, payment for implanted devices not eligible for pass-through payment under the OPPS will be included in the ASC services payment. Separate payment will no longer be available.

However, CMS will use a modified payment methodology when "device-intensive" procedures are involved. A device-intensive procedure is an ASC-covered surgical procedure that has an APC device cost greater than 50 percent of the median APC cost.

Devices meeting this definition are assigned to device-dependent APCs under the OPPS. There currently are 45 ASC-approved procedures that involve relatively expensive devices, and that are classified into device-dependent APCs; 17 of these procedures will be newly recognized for ASC payment beginning in 2008.

For all designated device-intensive procedures, CMS will isolate the non-device-related costs associated with the procedure by applying the OPPS device offset percentage (which can be found in Table 56 of the final rule, CMS-1392-FC) to the OPPS national unadjusted payment amount. CMS will then apply the uniform ASC discount factor to the service (non-device) portion, and add to that product the device portion (unadjusted by the uniform ASC discount factor) to determine the total payment amount. In other words, CMS will discount only the non-device portion, and pay the ASC the same as it pays the hospital for the device portion.

During the transition period, the transitional payment adjustments will apply only to the service portion of the ASC payment.

FEATURE STORY

TRANSITION TO A NEW ASC PAYMENT SYSTEM

	2008	2009	2010	2011
Current rate				
New rate				

CMS will phase in the new rates for the ASC payment system over a four-year period.

In those cases where the device is furnished without cost to the ASC or the beneficiary, or with a full credit for the cost of the device, such as in the instance of replacement devices, CMS will pay only for the service portion.

Under the new payment system, CMS will provide separate payment for devices that are eligible for pass-through status under the OPSS in the same calendar year that the devices are implanted during a covered surgical procedure that is billed by the ASC. Payments will be made at contractor-priced rates applicable in the quarter in which the devices were implanted; payments will not be subject to geographic wage adjustment or the ASC payment discount. At present, only two device categories—C1821 (interspinous process distraction device [implantable]) and L8690 (auditory osseointegrated device, including all internal and external components)—will be eligible for pass-through status in CY08.

Drugs and biologicals. CMS is also revising its position concerning payment for drugs and biologicals, and will allow separate payment for relatively costly drugs and biologicals that are integral to covered surgical procedures that are

In 2008, decreased Medicare payment for some high-volume ASC services will limit the ability of many ASCs to continue to provide these services. The exhibit reflects current and 2008 payment levels for five high-volume ASC services.

A NEW YEAR FOR ASC PAYMENTS

Code	Descriptor	2007 ASC Payment	Illustrative 2008 Fully Implemented ASC Payment
66984	Extracapsular cataract extraction, single lens		
45378	Diagnostic colonoscopy, flexible sigmoidoscopy		
62311	Excisional biopsy of skin lesion		
52000	Excisional biopsy of prostate gland		
64721	Excisional biopsy of uterine cervix		

billed by ASCs and whose payments are not packaged into the base OPSS payment rates.

Effective Jan. 1, 2008, Medicare will pay separately for all OPSS pass-through and non-pass-through drugs and biologicals that are paid separately under the OPSS when they are provided in association with a covered surgical procedure that is billed by the ASC to Medicare. Consistent with other policies, CMS defines a drug or biological as integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is provided in the ASC immediately preceding, during, or immediately following the covered surgical procedure. The payments for separately payable drugs and biologicals under the revised ASC payment system will equal the OPSS payment, which for 2008 generally equals average sales price for the drug, plus 5 percent, without application of the ASC budget neutrality adjustment nor the geographic wage adjustment.

Radiology services. As radiology and surgical procedures increasingly become intertwined, ASCs have faced a Medicare payment conundrum. The current regulatory definition of an ASC does not allow the ASC and another entity to mix functions and operations in a common space during concurrent or overlapping hours of operation. Historically, CMS has made an exception to this rule when the imaging services are integral to the performance of the surgical procedure. In such instances, if the ASC is also enrolled as an independent diagnostic testing facility (IDTF) and bills as that supplier when furnishing a radiology service that is reasonable, necessary, directly related to, and furnished in conjunction with a covered surgical procedure, the IDTF may bill and receive payment for imaging and guidance services, even though the services are being provided during the ASC's designated hours.

Under the final rule, CMS will provide separate payment to ASCs for certain ancillary radiology services when they are integral to the performance of a covered surgical procedure billed by the ASC on the same day, provided that separate

payment for the radiology service would be made under the OPPTS. CMS will regard a radiology service as integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and it is performed in the ASC immediately preceding, during, or immediately following the covered surgical procedure. The separate ASC payments for these radiology services will be made at the amount calculated according to the standard methodology of the revised ASC payment system or the MPF non-facility practice expense amount for the service, whichever is lower.

ASCs that previously enrolled as IDTFs to capture payment for these imaging services will now want to reconsider their IDTF status. Under the new policy, payment will no longer be available to IDTFs or any other supplier for covered ancillary

radiology services furnished integral to covered surgical procedures in ASCs; only an ASC can receive payment for providing the ancillary radiology services.

Transition to a Revised Payment System

CMS proposed to transition to the revised ASC payment system in 2008 using a 50/50 blend of the payment rate applicable in 2007 under the existing methodology and the payment rate determined under the revised payment methodology. Commentators complained that a two-year phase-in left facilities inadequate time to adjust. CMS concurred and decided instead to phase in the new rates over a four-year period.

Procedures added to the ASC list beginning in 2008 will be paid the full amount calculated under the revised payment methodology, rather than a blended amount.

Implications for ASCs

From a high-level policy perspective, the new ASC payment methodology includes many important and welcome improvements over the existing payment system. At ground-level, however, the new payment system will yield mixed results for ASCs. Those ASCs specializing in orthopedic procedures will benefit substantially under the new system, while those facilities specializing in gastroenterology and pain management will likely see dramatic (more than 20 percent) revenue decreases under the new system.

Although the new approach to defining covered surgical procedures permits many more procedures to be furnished in the ASC setting, the office-based cap limits the ability of many ASCs to furnish these services.

The changes to the ASC list further illustrate this tension. Although the new approach to defining covered surgical procedures permits many more procedures to be furnished in the ASC setting, the office-based cap limits the ability of many ASCs to furnish these services.

The final rule is available on CMS's web site at www.cms.hhs.gov, as well in the Aug. 2, 2007, *Federal Register* (CMS-1517-F). The final OPPTS and ASC conversion factors are available in the Nov. 27, 2007, *Federal Register* (CMS-1392-FC), as well as on CMS's web site. ●

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December, 2007, page(s) 64-69. Copyright
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