Part B Insider (Multispecialty) Coding Alert

AMBULATORY SURGERY CENTERS: Gastro, Pain Management Docs Could Lose Money In ASCs

Tell CMS to reconsider the sweeping new ASC payment changes

Heads up: If your physician has a stake in an ambulatory surgery center (ASC) or performs a lot of procedures in one, then January could change everything.

The **Centers for Medicare & Medicaid Services** (CMS) issued a final rule spelling out how it will pay for services in ASCs starting next year. -This is the rule they-ve been waiting for forever and ever,- says **Laurie Castillo** with **Castillo Consulting** in Manassas, VA.

The good news: CMS will pay for an extra 790 procedures in ASCs. Medicare will only refuse to pay for a procedure in an ASC if the surgery involves a -significant safety risk,- or if it requires an overnight stay. CMS is also proposing to add several more surgical procedures to the covered list later on.

The bad news: CMS wants to cap ASC payments at around 65 percent of the payment levels in the outpatient hospital setting. (The level could be more like 67 percent, depending on what data CMS ends up using.) This reduced payment takes account of the lower costs of furnishing services in the ASC setting, CMS says. Medicare will phase in this new payment rate over four years, from 2008 through 2011.

And for any procedure your physician performs in the office, CMS won't pay more in the ASC than it would in the office.

CMS will pay for services not included in the list of ASC covered procedures using the facility practice expense amount, not the higher non-facility PE amount.

Also, for procedures involving -high cost devices,- where the cost of the device is more than half the median cost of the procedure, CMS will pay 100 percent of the outpatient amount for the device itself. But for the service cost, CMS will still only pay around 65 percent of the outpatient amount.

More good news: If your physician owns a stake in an ASC, he or she can still send patients to that ASC for radiology, imaging and outpatient prescription drugs. The doctor won't be violating the law by referring patients to the physician-owned facility for those services, CMS proposes.

Winners and Losers

If your ASC is a multi-specialty facility, then the new payment levels may be a wash, says **Kathy Bryant**, executive director of the **Federated Ambulatory Surgery Association** (FASA). But almost half of the 4,600 ASCs serving Medicare are single-specialty facilities. And the rule will be great for some specialties and not so great for others.

Gastroenterologists and pain-management physicians will see a reimbursement cut, if ASC payments drop to 65 percent of the outpatient level, says Bryant. But the same payment rates will mean an increase in reimbursement for most orthopedic procedures, she adds.

So single-specialty GI or pain-management ASCs may be in hot water, but orthopedic ASCs may prosper. Some procedures that have migrated to the ASC setting, such as screening colonoscopies, may have to move back to the hospital. Besides creating longer wait times for patients, this move could also raise their out-of-pocket costs. -We-re likely to lose some of the gains we-ve made,- Bryant says.

FASA has shown CMS data that proves the ASC payment system would be -budget neutral- if Medicare paid 73 percent of the outpatient amount. CMS insists on the 65 percent rate instead, but the percentage could still change in this fall's final outpatient payment regulation. -We are still engaging in talks with members of Congress and the administration,- says Bryant.

Out of the 790 procedures being added to the ASC-allowed list, around 500 are commonly performed in doctor's offices, says Bryant. That means Medicare will reduce payments for most of the new procedures to the physician office amount. And that, in turn, means doctors will keep performing those procedures in their offices instead of in ASCs.

Physicians want to perform procedures in the ASC instead of the office because they have extra facilities available. But Medicare refuses to pay extra for those facilities, Bryant laments.

Bottom line: These payment changes will make your physicians less efficient because they-ll be stuck performing procedures in hospitals instead of their own facilities, says Bryant.