Part B Insider (Multispecialty) Coding Alert

Ambulatory Surgery Centers - MedPAC To Congress: End Surgery Center Payment List

Pushes payment freeze alongside move to expand categories

If your physician practices out of an ambulatory surgery center, or your office is connected to one, then the latest set of recommendations from the **Medicare Payments Advisory Commission** contains some very good news.

Yes, MedPAC did recommend a payments freeze for ASCs through fiscal 2005. But the commission also recommended two sweeping changes in the way Medicare handles ASC payments that could mean good things for physicians. MedPAC encouraged Congress to:

1. Revamp the payment system to bring the relative weights and procedure groups in line with the outpatient prospective payment system. Currently, procedures in ASCs are divided into nine payment groups, versus 700 groups for outpatient procedures. But Congress should ensure ASC payment rates don't exceed outpatient PPS rates for the same procedures, which they currently do for some procedures.

2. Replace the current list of procedures that you **are** allowed to bill in an ASC with a list of procedures that you **can't** bill in an ASC due to "clinical safety standards" or the requirement for an overnight stay. The **Centers for Medicare & Medicaid Services** is supposed to update the ASC-approved procedure list every two years, but has been lagging.

   Also, MedPAC urged Congress to collect ASC cost data from time to time to assess the adequacy of ASC rates and refine these relative weights. Then Congress could use the data to create a conversion factor that "reflects the cost of ASC services."

   Medicare saves $463 million per year by having procedures performed in an ASC instead of hospital outpatient departments, claims **Craig Jeffries**, executive director of the **American Association of Ambulatory Surgery Cente**rs, based in Johnson City, Tenn. In the case of the procedures that cost more in ASCs, the 2004-2005 payment freeze should wipe out that difference, he adds.

   Kathy Bryant, executive director of the **Federated Ambulatory Surgery Association**, is more cautious. "It really depends on how they do it. If they were going to do it at 100 percent of HOPD, it might be okay," but a severe discount from outpatient rates could prove crippling.

   Strategy: Allowing physicians to perform procedures in an ASC unless CMS explicitly bans them from that site would give power back to the doctors, Jeffries adds. It provides "the opportunity for physicians and beneficiaries to have more control over site of surgery."

   "The ASC community as a whole is wildly enthusiastic about the suggestion that the ASC approved list would be removed," says **William Sarraille**, a partner with **Sidley Austin Brown & Wood**, who represents the **Florida Society of ASCs**. As a "mainline provider of surgical services," ASCs should have new surgical services added automatically unless CMS determines that it's unsafe to do so, he adds.

   Eliminating the ASC-approved list would also remove one area of liability for doctors: Billing for services that aren't on the ASC-approved list but are payable in an ASC at the physician's in-office rate. The physician will receive more money for these services, because the office rate is intended to compensate for overhead as well as the physician's work, notes Sarraille.

Sometimes, an ASC will let a physician perform a non-Medicare-approved service on site as a courtesy, notes Bryant. But this isn't a widespread practice, partly because the site-of-service differential isn't enough to pay the ASC's expenses, except for some urology procedures. In such cases, Sarraille says the physician could face kickback concerns unless he's compensating the ASC adequately for the use of its facilities.