

Part B Insider (Multispecialty) Coding Alert

ASCs: A Good Surgical Procedure Is One You Can Walk Away From, CMS Says

More procedures will be covered in ASCs, and planned cuts are canceled

Pressure from ambulatory surgery centers and Sen. Chuck Grassley (R-IA) won out over the Centers for Medicare and Medicaid Services' concerns on ASC-covered procedures.

The final rule on ASC procedures, published in the May 4 Federal Register, adds more covered procedures than the proposed rule, and deletes fewer procedures. CMS had planned to add only 25 procedures to the covered list, and delete 100 procedures. The **HHS Office of Inspector General** had identified most of those procedures in a 2003 report as costing more in an ASC than in an outpatient department.

But the final rule adds 65 procedures to the list and only deletes five. CMS received comments including "clear, clinical evidence" that deleting the planned procedures would have reduced patients' access and forced patients with complex conditions to undergo procedures in the physician's office rather than the ASC, CMS Administrator **Mark McClellan** said in a release.

The five deletions include 21440 (treat dental ridge fracture), 23600 and 23620 (treat humerus fracture), 53850 (prostatic microwave thermotherapy), and CPT 69725 (release facial nerve).

The additions include bronchoscopies and selected endoscopies, which doctors have been performing safely in ASCs for years under other payers, according to the **Federated Ambulatory Surgery Association.** FASA is still disappointed that CMS didn't add more procedures to the list, such as laparoscopic cholecystectomies, which were pioneered in the ASC setting.

FASA says it'll keep working to eliminate the list of ASC-covered procedures altogether. The **Medicare Payment Advisory Commission** has suggested replacing the list of what's covered with a list of what's excluded. CMS says it's already developing a new rule for ASC payments, as required by the Medicare Modernization Act.