Part B Insider (Multispecialty) Coding Alert

Surgery: July Brings New ASC Procedures

Learn The Secrets Of Profitable ASC Billing

If your physician provides services in an ambulatory surgery center, then July 1 brought lots of new opportunities.

The **Centers for Medicare & Medicaid Services** rolled out a whole new list of services that it will cover in ASCs starting this month. The March 28 interim final rule included 288 new codes, but only some of them received more than the $333 minimum reimbursement Medicare pays for ASC services.

Knowing which codes provide a decent margin in the ASC could be the key to success in ASC billing, say experts.

The best news for interventional pain physicians came when CMS decided to add spinal injection code 62287 to the ASC list - and boost it from $427 to the maximum group rate of around $1337, according to the **American Society of Interventional Pain Physicians**.

CMS also added eight other important interventional pain procedures to its list, according to ASIPP: spinal injection **CPT 62281** ($333); epidural catheter removal code 62355 ($446); and neurostimulator codes 64553, 64573, 64577, 64580 and 64585, all of which reimburse the minimum of $333.

One surgery center administrator tells PBI her center is considering adding 53850 (transurethral destruction of prostate tissue; by microwave thermotherapy) to its list of services. The center had considered adding this procedure at its urologists' request earlier this year, but it didn't make sense to add it until Medicare covered it.

Medicare pays the highest reimbursement, an average of $1337, for this procedure, but the center is still trying to figure out if it can afford the "very costly" procedure.

The administrator says there are a few questions you should ask before adding a new procedure:
1) Are there enough people with this condition who are healthy enough to receive surgery in the ASC?
2) How long does the procedure take?
3) What do equipment, supplies and drugs cost?
4) What sort of outcomes will you achieve with this procedure?

"It's not just the CPT that says, 'Hey, you can do this,'" the administrator insists. A full cost-benefit analysis is necessary. And even if a procedure has the highest level of reimbursement, that doesn't necessarily make it cost-effective.