

What surgeons should know about...

The revised Medicare list of procedures for ASCs

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Medicare has released a new list of procedures it will cover in ambulatory surgical centers (ASCs), effective for dates of service on or after July 5, 2005. The new list contains 65 additions and five deletions. A complete list of changes, including the amount the ASC is paid for the codes that have been added, is available on the College's Web site at www.facs.org. The patient is responsible for a 20 percent copayment for the facility payment and, of course, the deductible applies. This article reports on why the changes were made and discusses future changes to the payment rates.

What are the criteria for putting a code on the ASC list? How often is the list revised?

A medical or surgical procedure may be put on the ASC list if it can be safely performed in an ASC (but is not generally done in an office), requires a dedicated operating room or suite and generally requires a short-term postoperative recovery room, and is not otherwise excluded from Medicare coverage. (For example, cosmetic surgery is otherwise excluded from coverage.) Specific standards that have been developed are as follows:

- Procedures should not be on the list if they generally exceed 90 minutes of operating time and four hours of recovery time.
- The anesthesia may be general, regional, or local but generally may not exceed 90 minutes in duration.
- The procedure does not require major blood loss or major invasion of body cavities, does not directly involve major blood vessels, and does not involve procedures that are life-threatening in nature.

The Centers for Medicare & Medicaid Services (CMS) is required by statute to update the list every two years through the notice and comment process in the *Federal Register*.

How is the amount paid for a given procedure decided?

Each procedure code is grouped into one of nine payment categories (see list below), based on CMS' estimate of the costs to perform a procedure. The current rates are based on surveys of ASCs performed in 1986 and adjusted for inflation.

CMS initially proposed to delete a much larger number of codes than the five that were actually deleted. What happened?

CMS originally proposed deletion of approximately 100 codes from the list. Most were proposed by the Office of the Inspector General, who thought Medicare spending would be reduced

ASC payment rates

Group 1	\$333
Group 2	\$446
Group 3	\$510
Group 4	\$630
Group 5	\$717
Group 6	\$826 (\$676, plus \$150 for intraocular lens)
Group 7	\$995
Group 8	\$973 (\$823, plus \$150 for intraocular lens)
Group 9	\$1,339

substantially if the procedures were moved to the physician's office with payment based on the physician fee schedule. CMS did a detailed analysis of the comments received on 28 skin procedures and three urology procedures that had been proposed for deletion. The agency found that, in most cases, the procedures would not shift to the office but rather to the hospital outpatient department because the patients needed to be in an environment that has the capability to handle comorbidities, the sterile conditions found at an ASC, and so on. The CMS extended this reasoning to other procedure codes on the list, resulting in the deletion of only five procedure codes with very low ASC usage.

CMS must have been inundated with requests to add codes to the ASC list. How did CMS react to these requests?

CMS proposed to add 25 procedure codes to the list and received comments proposing to add nearly 200 more codes. In the final notice, CMS dealt with each code, explaining the rationale for accepting or rejecting it. Some of the suggested additions were very quickly dismissed by CMS, citing these codes' extensive use for office or inpatient procedures. Often, CMS did not have data because the code was new, but where the procedure would be performed was discernible by looking at analogous existing codes. Several codes were not added because those procedures are components of other procedures and typically not performed alone. As components of other procedures, they cannot be added to the ASC list. Ultimately, there were 65 additions to the list.

Were there any particularly noteworthy requests for additions to the ASC list that CMS ultimately rejected?

Yes, CMS declined to place three laparoscopic cholecystectomies on the ASC list because of the

chance that they would need to be converted to an open procedure, requiring a subsequent hospital admission. CMS wrote, "The potential jeopardy to the beneficiary resulting from undergoing an emergency transfer is significant and far outweighs any benefit of covering these procedures in ASCs. For this reason, we believe laparoscopic cholecystectomies should continue to be performed in a hospital setting (either inpatient or outpatient) as is the current practice" (*Federal Register*, 2005, codified at 42 CFR§416).

What services are included in the ASC payment?

Facility payments to ASCs include the following:

- Nursing, technician, and related services
- Use of the facilities where the surgical procedures are performed
 - Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures
 - Diagnostic or therapeutic services or items directly related to the provision of surgical procedures
 - Administrative, recordkeeping, and house-keeping items and services
 - Material for anesthesia
 - Intraocular lenses
 - Supervision of the services of an anesthetist by the operating surgeon

ASC facility services do not include items and services for which payment may be made separately, such as through physician services, laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure), prosthetic devices (except intraocular lenses), ambulance services, braces, artificial limbs, and durable medical equipment for use in the patient's home. They also do not include anesthetist services.

Are the facility fees paid to ASCs approxi-

Comparison of ASC and OPPS payment amounts

CPT* code	Procedure	ASC payment level	ASC payment amount	OPPS ambulatory payment class number	OPPS payment amount	OPPS payment-ASC payment
19160	Removal of breast tissue	3	\$510.00	0028	\$1,070.53	\$560.53
29881	Knee arthroscopy/surgery	4	630.00	0041	1,596.97	966.97
45378	Diagnostic colonoscopy	2	446.00	0143	490.01	44.01
49505	Repair inguinal hernia	4	630.00	0154	1,599.85	969.85
52601	Prostatectomy (trans-urethral resection of prostate)	4	630.00	0163	2,055.63	1,425.63
66984	Remove cataract, insert lens	8	973.00	0246	1,329.48	356.48

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are: © 2004 American Medical Association. All rights reserved.

mately the same as those fees paid to hospital outpatient departments?

No, they are not. The two payment systems have developed separately, each in a different context. Payment rates under the hospital outpatient prospective payment system (OPPS), which began in August 2000, are set to reflect hospitals' underlying costs. ASC rates, on the other hand, are based on special cost surveys conducted in the early 1980s and reflect the scope of services provided at that time. The ASC payment system, with only nine rates and a top rate of \$1,339, has not changed to keep up with the expansion of ASCs and the variety of services they now can provide. The table above shows the ASC and OPPS payment amounts for several high-volume procedures. The payment for a diagnostic colonoscopy is virtually the same, but all other procedures have a much higher payment if the procedure is done in an outpatient department than if it is done in an ASC. Several factors explain the differences. A hospital is a much more complex facility, requiring staff and equipment to treat a broad range of patients, with a higher case mix

and greater overhead. Hospitals with an emergency room must staff laboratory and diagnostic departments as well as surgical suites around the clock. Hospitals also tend to draw sicker patients (even for the same service) than an ASC, and therefore the resources used are greater. Finally, hospitals treat a large number of uninsured patients.

Medicare denies claims from ASCs for procedures that are not on the ASC list. Is there another way of getting the facility payment for these procedures?

There might be another way, but it is a convoluted process. The language of the physician fee schedule, not the ASC payment methodology, is important. The critical issue is whether there is a nonfacility practice expense for the procedure under the Medicare physician fee schedule. "Nonfacility" typically means the procedure is performed in an office, but it can also mean that the procedure is done in an ASC. If there is a nonfacility fee schedule amount, the pay-

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ment theoretically includes *all* practice expenses, including expenses used to actually perform the service. The surgeon can bill for the nonfacility rate and use the place of service code for an ASC (code 24). If the surgeon accepts assignment for the claim, the full Medicare fee schedule payment comes to him or her. Of course, the ASC is going to want a contract specifying that the payment will come from the surgeon and how much the payment will be.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requires CMS to develop a new payment mechanism no earlier than January 1, 2006. What is the status of this obligation?

MMA requires CMS to develop a new payment system that is effective sometime between January 1, 2006, and January 1, 2008. CMS has announced that it will take the maximum amount of time to develop the new payment system, so it will be effective on January 1, 2008. The General Accountability Office is expected to conduct a study of the appropriateness of using the groups of services and relative weights under the OPPS as the basis for the ASC rates, perhaps paying a percentage of the amount paid under OPPS. The General Accountability Office is also to consider the appropriateness of a geographic adjustment in the payment system. Of course, the new payment system will be published in the *Federal Register* as a proposal to give interested parties an opportunity for comment. Ω