Ambulatory Surgery Centers:
Surviving Medicare Reimbursement Changes

By:

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Introduction

When Congress approved the Medicare Modernization Act of 2003 ("MMA"), they directed the Secretary of Health and Human Services to implement a new payment system for Ambulatory Surgery Centers ("ASCs"). In the statute, Congress granted the agency wide latitude for designing the new payment system.

As a result of this congressional mandate, the Centers for Medicare & Medicaid Services ("CMS") has released rules establishing ASC procedures and payment rates for Medicare ASC services. The final rule for calendar year 2007 was released on November 1, 2006 and affects all ASC services rendered on or after January 1, 2007. Additionally, CMS has also released a proposed rule for calendar year 2008, which will be finalized sometime this spring.

The final rule for 2007 has a less reaching impact than the proposed changes for ASC reimbursement in 2008. However, together these two regulatory reimbursement changes have a large impact on the ASC industry.

ASC Background

An ambulatory surgery center is a health care facility that specializes in providing surgery, pain management and certain diagnostic (e.g., colonoscopy) services in an outpatient setting. An ASC is also referred to as an outpatient surgery center or same day surgery center. Overall, the services provided at an ASC can be generally called procedures. In simple terms, ASC qualified procedures are considered procedures that are more intensive than that done in an average doctor's office, but not so intensive as to require a hospital stay after the procedure.

Medicare has provided benefits to ASCs for over twenty years. Medicare will only make payment to an ASC for procedures that are on Medicare's list of ASC approved procedures, of which there are approximately 2400 surgical procedures. The ASC will then bill Medicare using the CPT codes for the procedures performed, and Medicare's claims processing system then determines into which of nine ASC payment groups they are assigned. ASC payment rates are based on 1986 data and have not been rebased despite frequent proposals to do so.

In addition to the MMA congressional mandate, the Deficit Reduction Act of 2005 also mandated regulatory changes to the ASC industry. This statute requires CMS to implement a requirement of the Deficit Reduction Act of 2005 (DRA) that would cap the CY 2007 payment rate to an ASC for a surgical procedure at the OPPS rate for the same procedure. The statute also requires CMS to review and update the ASC list at least every two years. The last revision of the ASC list was published in the Federal Register May 4, 2005, and was effective in July 2005.

The current ASC payment groups with their respective payments are as follows:

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

The following sections detail the regulatory changes mandated by the Medicare Modernization and Deficit Reduction Acts.

2007 ASC Regulatory Changes

On November 1, 2006, CMS released the final rule establishing the list of procedures and payment rates for Medicare ASC services in 2007. This rule implements several important changes for ASCs. For any ASC services rendered on or after January 1, 2007 the following changes are applicable:

- **Addition of 21 new procedures to the 2007 procedure list**
- **Addition of 25 CPT codes**
- **Deletion of 22 CPT codes**
- **Implementation of Deficit Reduction Act cap, effecting 275 codes**

CMS adopted many of the recommended additions to the procedure list proposed by the American Association of Ambulatory Surgery Centers (AAASC) and the

ASC industry coalition, resulting in the addition of 21 new codes to the 2007 procedure list. Additionally revisions of the American Medical Association's CPT codes resulted in the addition of 25 codes and the deletion of 22. Therefore, as of January 1, 2007 twenty-one procedures have been added to the list of surgeries for which Medicare will make a facility payment to ASCs.

Furthermore, CMS did not make any changes to the current nine payment groups discussed above. Any newly added procedures have been assigned to one these existing payment groups. Thus, the October 1, 2004 group payment rates are continuing through CY 2007.

Section 5103 of the Deficit Reduction Act of 2005 (DRA) limits ASC payments to the lesser of either the Medicare Hospital Outpatient Prospective Payment System (OPPS) payment amount or the ASC payment amount for services.

Therefore, effective January 1st of this year, the DRA provision limits all payments for ASC procedures to the lesser of the OPPS rate or the ASC grouper payment. In other words, there is no longer any procedure that is more profitable to perform in an ASC than in a hospital based surgical setting. This statutory change affects 275 codes. The 275 procedure codes that are subject to this payment cap, along with the other final changes for ASCs in CY 2007 can be found at the following web address:
http://www.cms.hhs.gov/apps/ama/license.asp?file=/ascpayment/downloads/07asc_hcpcs.zip

The following chart reflects some of the procedure codes with the highest payment loss resulting from the implementation of the DRA cap:

Comparison of 2007 ASC Rates
Subject to DRA Cap with 2006 ASC Rates
(Based on ASC Rates Effective 1/1/07 and 2007 Outpatient PPS)
Prepared by Murer Consultants, January 2006

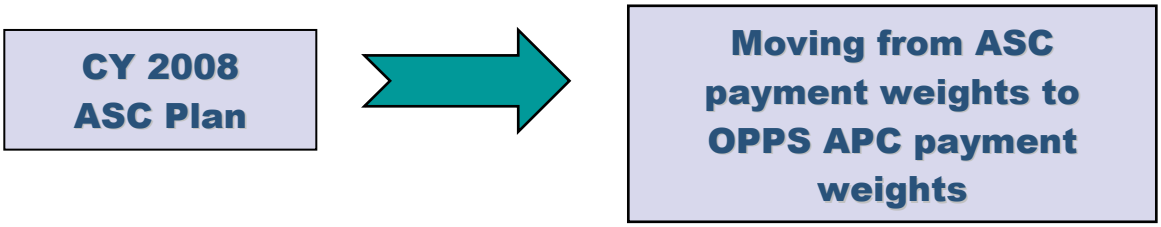
Procedure Code	Description	2006 ASC Rate	2007 ASC Rate and Hospital Outpatient Rate	ASC Decrease in Payment for 2007
20975	Electrical bone stimulation	$446	$38	($408)
21725	Revision of neck muscle	$510	$88	($422)
13121	Repair of wound or lesion	$510	$91	($419)
25605	Treat fracture radius/ulna	$510	$104	($406)
31233	Nasal/sinus endoscopy, dx	$446	$86	($360)
31720	Clearance of airways	$333	$48	($285)
12005	Repair superficial wound(s)	$446	$92	($354)
22315	Treat spine fracture	$446	$104	($342)

Proposed 2008 ASC Regulatory Changes

In January 2008, Medicare will implement the biggest change to ASC payment in over 20 years including fundamental changes in the ASC procedures lists. The final rule for CY2008 should be released sometime this spring.

Beginning in 2008, CMS is required to revise the ASC payment system. Consistent with the goals of quality, efficiency, and rational alignment of payment rates across payment systems, CMS is proposing to revise the ASC payment system using the Hospital Outpatient Prospective Payment System (OPPS) relative payment weights as a guide.

The revised ASC payment rates would be based on the ambulatory patient classifications (APCs) used to group procedures under the OPPS. Therefore, CMS is proposing to link ASC payments with the Ambulatory Procedure Classification ("APC") system utilized by Medicare to pay for services in the outpatient hospital setting. The ASC payment groups would increase from the current 9 clinically disparate payment groups to the 221 APCs used under the OPPS for these surgical services. APCs are homogeneous both in terms of clinical characteristics and resource use.



Not only will APCs be used to group procedures under the OPPS, CMS is also proposing lower payments in the ASC setting. The reasoning behind this is that CMS believes that a procedure performed in an ASC setting has a lower cost than the performing the corresponding procedure in the hospital outpatient department.

ASC payment rates under the revised system for the expanded list of approved surgical procedures would range from $3.68 to $16,146.03, compared with a range of $333 to $1339 under the current payment structure. Under both the OPPS system and the revised ASC system, payment weights are assigned to each procedure and then multiplied by a conversion factor in order to compute national payment amounts. Payment weights represent the relative resource uses of procedures. Procedures with higher resource use have higher weights and procedures with lower resource use have lower weights. The ASC payment weight for a procedure under the revised ASC payment system would in general be set equal to the OPPS payment weight for the APC containing that procedure.

The conversion factor for ASC services would be less than for OPPS services, because of the greater efficiencies typical of ASCs and the generally lower costs incurred by ASCs. For example, unlike hospitals, ASCs do not have to satisfy EMTALA requirements, do not run emergency departments, and do not have to be open 24 hours a day, seven days a week. Due to the statutory ASC budget neutrality requirement, CMS estimates the CY 2008 ASC conversion factor would be 62 percent of the estimated CY 2008 OPPS conversion factor. CMS currently estimates the CY 2008 ASC conversion factor to be $39.688.

For CY2008, CMS has estimated that the revised ASC rates would be 62 percent of the corresponding OPPS payment rates. However, given the significant payment changes for some procedures under the revised payment system, CMS is also proposing a two year transition from the current ASC payment rates to the new payment rates. CMS proposes to phase in the new ASC payment rates as a blended payment amount equal to 50 percent of the applicable CY 2007 payment rate plus 50 percent of the applicable CY 2008 payment rate. Beginning in CY 2009, CMS would fully implement ASC payment rates calculated under the proposed methodology for the revised payment system.

Prudent Operator Strategies

As evidenced by the recent regulatory changes effecting ASCs, today's dynamic healthcare environment is characterized by sweeping changes in regulation and reimbursement. Therefore it is essential for prudent healthcare operators to position their products and services in this new era.

The goal of sound healthcare management is to identify market oriented strategies to moderate reimbursement changes. The first step for being prepared for adopting prudent operator strategies is to be fully apprised of all of the details and nuances of the regulatory changes affecting the ASC industry.

Some strategies for prudent operators to manage the regulatory changes include the following:

- **Identify steps to take now to prepare for the 2008 reimbursement changes**
- **Analyze the new payment system's affect on your specialties**
- **Prepare your business office for any and all changes**
- **Code correctly to ensure you receive the reimbursement you deserve**
- **Stay up to date with all new regulations and make sure to have a clear understanding of new regulations and their implications on your practice**
- **Spot missed reimbursement opportunities**
- **Utilize case management and case costing processes to ensure that the most financially reasonable procedures are being utilized in the ASC**
- **Assess proposed cuts in ASC rates for certain procedures**
- **Analyze the proposed changes to the 2007 ASC list**
- **Assess the financial impact of the proposed ASC payment system**
- **Plan for your facility to take on new cases allowed by the 2008 expanded procedure list**
- **Update all budgeting to account for the changes to the ASC procedure lists and payment system**

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Ultimately it is essential for all healthcare providers to adapt to the federal regulatory environment and manage all regulatory changes in a well informed and prepared manner. By utilizing the prudent operator strategies outlined above, most Ambulatory Surgery Centers should endure these regulatory changes unscathed.

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