Coverage Expanded for Procedures at ASCs

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Starting next year, federal health programs will cover any procedure performed at an ambulatory surgery center, with few but defined exclusions, according to final regulations released by the Centers for Medicare and Medicaid Services.

The payment formula for such procedures, to be phased in over 4 years, was also set by the regulations.

Previously, CMS covered approximately 2,600 procedures when they were performed at an ASC; now, an additional 790 procedures will be eligible in 2008. According to Dr. Charles Mabry, chairman of the American College of Surgeons' health policy steering committee and a member of the general surgery coding and reimbursement committee, as new procedures receive CPT codes, they, too will be covered, unless they are specifically excluded.

The Centers for Medicare and Medicaid Services will not pay for a procedure if it falls within the following exclusion criteria:

► It poses a significant safety risk to the beneficiary.
► It would result in the patient's requiring active monitoring or an overnight stay.
► It directly involves major blood vessels.
► It requires major or prolonged invasion of body cavities.
► It results in extensive blood loss.
► It is emergent or life threatening.
► It requires systemic thrombolysis.
► It can be reported only with an unlisted code.

The change means that more patients will likely be able to have procedures done in an ASC, said Dr. Mabry, who is also a shareholder in an ambulatory surgery center in Pine Bluff, Ark.

The question now: "Is the payment rate the right rate?" he said. (See box below.)

CMS also decided to limit payment for procedures performed in an ASC that are done in a physician's office more than half the time. "CMS does not want to create inappropriate payment incentives for procedures to be performed in ASCs if the physician's office is the most efficient setting for providing high-quality care," according to the agency.

However, the 2008 policy limits payment for procedures performed in ASCs that are usually done in a physician's office more than half the time.

FASA, the advocacy arm of the Foundation for Ambulatory Surgery in America, objected to this proposal and also to CMS's list of exclusions, arguing that the agency should pay for any procedure that is not covered under the inpatient system.

Under the new rule, Medicare will make separate payments for ancillary services, such as radiology, and for some drugs and biologicals considered integral to a surgical procedure. The agency will also make adjustments for procedures that have high device costs (that is, when the cost of the device accounts for more than half the median cost of the procedure).

Those high device–cost procedures include placement of neurostimulators, pulse generators, or pacemakers. The adjustment is already in effect under CMS's hospital outpatient payment system. ■

Payments to ASCs Proposed for 2008

In addition to setting the formula for how ambulatory surgery centers will be paid going forward, CMS has also issued proposals on how the formula will guide payments to ASCs in 2008, and on how much hospital outpatient departments will receive in 2008.

In 2008, the federal health agency has proposed that ASCs would be paid at 65% of hospital outpatient rates, a slight increase over an earlier proposal of 62%. Medicare and Medicaid expect to pay $3 billion in 2008 to about 4,600 participating ASCs, according to CMS.

In the proposed pay rates, orthopedic procedures would receive the greatest increases, whereas gastrointestinal procedures would be cut. Procedures involving the implantation of cardiac devices are mostly slated for increases, and payment for the implantation of neurologic devices would also increase.

The agency also issued its proposal for hospital outpatient payments, which is partially driven by the desire to keep beneficiary copays at 20%. In 2008, the overall copay will be about 26%, but for most procedures, beneficiaries will be liable for only 20%.

Hospitals will receive $35 billion under the proposed rule in 2008, about a 10% increase over 2007. CMS said "the current rate of growth of expenditures is of great concern," because of its effect on taxpayers and beneficiaries whose premiums fund 25% of Medicare Part B expenses.

Hospitals will get an automatic 2% cut in fees in 2009 if they don't report on 10 quality measures in 2008, including 5 measures on how well emergency departments handle myocardial infarction; 2 surgical care measures (the selection and timing of antibiotic prophylaxis); 1 heart failure measure (ACE inhibitor or angiotensin receptor blocker given); 1 on community-acquired pneumonia (empiric antibiotic); and a diabetes measure (poor hemoglobin A_{1c} control).

Policy & Practice

Women Lack Cholesterol Knowledge

Despite the best intentions to manage their cholesterol, fewer than a third of women know their cholesterol levels, according to a survey commissioned by the Society for Women's Health Research. The survey found that women are aware of the health risks of cholesterol. For example, 85% of women know that high cholesterol can lead to stroke. However, about 36% of women did not know that high cholesterol has no symptoms and nearly half of the women surveyed were not familiar with terms such as LDL and HDL cholesterol. "Clearly, strides have been made in educating women on the risks of high cholesterol, but the disconnect between awareness and action needs to be addressed," Phyllis Greenberger, president and CEO of the Society for Women's Health Research, said in a statement. The telephone survey included 524 adult American women.

Including Women in Research

The participation of women in clinical trials is essential to understanding how medical conditions and therapies affect men and women differently, according to a committee opinion from the American College of Obstetricians and Gynecologists. In the opinion, the ACOG Committee on Ethics outlined a number of recommendations for including women, and in particular pregnant women, in research trials. For example, the committee recommended that researchers evaluate protocols for their potential impact on both the woman and the fetus and make that evaluation part of the informed consent process. The committee also advised that only the informed consent of the pregnant woman is necessary for research. However, informed consent must be obtained from the father when federal regulations require it for research that could benefit the fetus only. The ACOG statement is an update to a committee opinion on research involving women, which was published in 2004. The committee opinion was published in the September issue of Obstetrics & Gynecology.

Distributing HPV Vaccine

The 7,500 publicly funded family planning clinics around the country may be a natural fit for providing education about the human papillomavirus (HPV) vaccine and distributing it, according to an analysis by the Guttmacher Institute. These clinics reach a large number of reproductive-age women and in particular those at high risk. In 2002, one-third of women aged 15-24 years who obtained reproductive health services received that care at a family planning clinic. "Clinics are an especially important source of health information and services for low-income women and minority women, who are at particularly great risk of developing and dying from cervical cancer," Rachel Benson Gold, the article author, said in a statement. However, these clinics will also face some challenges if they try to provide the HPV vaccine and related counseling, Ms. Gold wrote. Cost is one potential barrier. The three-shot regimen costs about $300 per individual, even with the discount provided to clinics. In addition, family planning clinics will have to decide what population to offer the vaccine to and how to ensure that women return for all three shots. The analysis, which appeared in the summer issue of the Guttmacher Policy Review, was supported by a grant from the Ford Foundation.

Infant Mortality Drops Slightly

The infant mortality rate was 6.79 per 1,000 births in 2004, a less than 1% drop from 2003, according to final 2004 data released by the Centers for Disease Control and Prevention. The small decrease in infant mortality was not statistically significant. With the exception of 2002, the infant mortality rate has decreased or remained steady from 1958 through 2004, according to CDC. In 2004, the 10 leading causes of infant death were congenital malformations, low birth weight, sudden infant death syndrome, maternal complications, unintentional injuries, cord and placental complications, respiratory diseases of the newborn, bacterial sepsis of the newborn, neonatal hemorrhage, and circulatory diseases. These 10 causes accounted for more than 68% of infant deaths in the United States in 2004.

Small Practices Fall to One in Three

Physicians are shying away from solo and two-physician practices, according to a new report from the Center for Studying Health System Change. Although these small practices are still the most common practice arrangements, between 1996-1997 and 2004-2005 researchers saw a shift from solo and two-person practices to midsized, single-specialty groups of 6-50 physicians. The percentage of physicians who practiced in solo and two-person practices fell from 41% in 1996-1997 to 33% in 2004-2005. During the same time period, the percentage of physicians practicing in midsized groups rose from 13% to 18%. The biggest declines in physicians choosing small practices have come from medical specialists and surgical specialists, whereas the proportion of primary care physicians in small practices has remained steady at about 36%. "Physicians appear to be organizing in larger, single-specialty practices that present enhanced opportunities to offer more profitable ancillary services rather than organizing in ways that support coordination of care," Paul B. Ginsburg, Ph.D., president of the Center for Studying Health System Change, said in a statement. The report's findings are based on the group's nationally representative Community Tracking Study Physician Survey.

—Mary Ellen Schneider

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