Coverage Expanded at Ambulatory Surgery Centers

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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.

CMS will not pay for a procedure if it falls within these 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.)

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.

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. ■

Payment Proposals for 2008: More Increases Than Cuts

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. An upper GI endoscopy with biopsy (CPT code 43239) would be cut by 13%, from $446 in 2007 to $387 in 2008. A small-bowel endoscopy with biopsy (CPT code 44361) would be cut by about 11%.

The American Gastroenterological Association said in a statement that it "intends to aggressively fight the [proposed] rule's implementation, through congressional action, if necessary."

The group argued that by setting a uniform rate of 65%, an ASC will not be able to cover the costs of many procedures, including luminal stents for gastrointestinal cancers and endoscopic ultrasound. ASC payments should be tied to the hospital outpatient market basket factor, not the consumer price index, as CMS is proposing, according to the AGA.

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.

Procedures involving the implantation of cardiac devices are mostly slated for increases: from 5% for bare-metal stents to 14% for drug-eluting stents, and 3%-20% for defibrillators.

Payment for the implantation of neurologic devices would also increase under the proposal. For instance, implantation of a neurostimulator would rise from $11,500 in 2007 to $12,500 in 2008.

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

CMS is accepting comments on the 2008 proposals until mid-September. The final regulations will be published in November.

CMS Proposes Severity-Adjusted Inpatient Device Payments

Under the just-proposed Medicare final inpatient payment rule for fiscal 2008, many procedures to implant medical devices would see substantial payment increases, a development that has physicians and surgeons cautiously applauding.

A year ago, when the Centers for Medicare and Medicaid Services unveiled its inpatient payment proposal for fiscal 2007, it was met with dire predictions that access to crucial technologies such as implantable cardioverter defibrillators and drug-eluting stents would be diminished. Interested parties argued that the agency's reliance on outdated cost data would end up chopping reimbursement for some procedures by as much as 30%.

The deep cuts disappeared in the final rule, however, and more recent data were used to calculate 2007 payments. For the next fiscal year, CMS is still using a cost-based method but with updated data, and is proposing to adjust payments based on illness severity with a new set of Medicare Severity diagnosis-related groups (MS-DRGs). Those 745 new DRGs—which have three levels of severity—replace the 538 current DRGs, which have only two levels.

As a result, payments for some procedures will rise if the rule is adopted.

For instance, payment for insertion of an implantable cardioverter defibrillator will increase about 19% in the next fiscal year for a patient with acute myocardial infarction (AMI), heart failure, or shock and major complications or comorbidities. Payment falls by almost 12% if those complications are not present, according to reports from Washington Analysis.

To prevent hospitals from upcoding, CMS proposed about a 2% reduction in overall payments.

The bottom line: Even with the upcoding offset, hospitals will receive a 3.3% payment increase. To receive the full increase, hospitals must report to CMS on 27 quality measures, 6 more than last year. Some of the new measures are:

- ► Whether venous thromboembolism (VTE) prophylaxis was ordered for a surgery patient.
- ► Whether VTE prophylaxis was given within 24 hours before or after surgery.
- ► Whether antibiotics were given prophylactically for surgery patients.
- ► 30-day mortality for AMI patients.
- ► 30-day mortality for heart failure patients.

Under the proposed rule, hospitals will also now have a way to account for the receipt of free replacement devices sent by manufacturers after a recall.

In the past, Medicare has paid for the devices because there was no way to cull them from the DRG for the replacement procedure. The new accounting method will also require hospitals to keep closer track of how often recalled devices are replaced.

In addition, hospitals will have to report secondary diagnoses present when patients are admitted. This is to fuel an effort to stop paying for conditions that develop in the hospital as a result of poor-quality care, such as surgical infections. Beginning in fiscal 2009, CMS will not pay for some of these conditions under a higher DRG rate unless they were present at admission.

AdvaMed, a trade group for the medical device industry, said it was generally happy with the proposed final rule.

"The MS-DRGs maintain improvements to the patient classification system that have been made over the last few years to acknowledge rapid advancements in medical technology while improving the ability of the system to more precisely reflect the costs of more severely ill patients," AdvaMed president and CEO Stephen J. Ubl said in a statement.

In a briefing with reporters, Mr. Ubl said that CMS's proposal still creates "charge compression," by which the cost of low-technology devices is overstated and that of high technology understated.

The organization is also uncertain how hospitals will compensate when payments are reduced in some areas—a concern echoed by a spokesman for one surgeons' group and by the Heart Rhythm Society.

"On the face of it, it does make sense to pay hospitals more for patients who are sicker," added Amy Melnick, vice president of health policy for HRS. The group is pleased with what it has seen so far, but is still reading through the proposal to analyze its potential impact, Ms. Melnick said.

CMS will publish a final rule before Oct. 1. ■