Ambulatory Surgery Coverage to Expand

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Starting next year, federal health programs will cover any procedure done 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 meets 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.)

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.

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DR. MABRY

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

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.

CMS has proposed that in 2008, 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 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%.

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