

AN ANALYSIS OF THE LIKELY IMPACT OF THE PROPOSED ASC CHANGES

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On June 12, 1998, the Health Care Financing Administration (“HCFA”) released a Notice of Proposed Rulemaking (“NPRM”) which proposes to dramatically cut reimbursement for outpatient surgical procedures performed in ambulatory surgery centers. With several comment extensions now come and gone, HCFA is pouring over hundreds and hundreds of comment letters in an effort to restructure the payment of ASC services as ASC and other groups seek to have reimbursement changes delayed until the 1999 ASC cost survey is completed and tabulated. Because HCFA is seeking to implement the proposed changes sometime in the year 2000, ASC providers are struggling with how to respond to the changes when they are implemented.

Generally, the NPRM is designed to accomplish three objectives:

- amend and change the current rate setting methodology for ASCs;
- amend and update the current payment rates for ASCs; and
- add and delete procedures from the list of Medicare covered ASC procedures.

The HCFA review that preceded the issuance of the NPRM, which is required by statute on a biennial basis, has led the agency to propose fundamental changes to the way in which ASC procedures are paid. Currently, the 2,280 approved ASC procedures are paid under just eight ambulatory payment groups. Each group is paid in increasing amounts beginning at \$314 for Group 1 through \$928 for Group 8. The incremental increase from one payment group to another is roughly about \$75, depending upon the Group.

Under the NPRM, approved ASC services would climb to 2,499 procedures. These procedures would be arranged, however, into 105 ambulatory patient classifications (“APC's”) with new payment rates ranging from only \$53 to a high of \$2,107 for lithotripsy.

The recent move to a single conversion factor resulted in significant cuts to the professional component fees paid by Medicare for surgical procedures. With these cuts in reimbursement still playing on the minds of providers, the proposed reductions for ASC reimbursements have left surgeons who own ASCs reeling. Many had hoped to cushion the loss of steep reductions in professional fees, which will be cut even further as HCFA implements the practice expense RVUs, by relying on ASC facility payments. ASCs across the country are busy recalculating what their returns on their ASC investments would be under the proposed rates; some of them are deeply troubled by their analyses.

The proposed cuts are clearly significant, as evidenced by a review of some of the highest volume ASC procedures. The average proposed cut for the twenty highest volume ASC procedures is a reduction of 9.1 percent. When the five high volume procedures that actually secured proposed reimbursement increases are eliminated from the analysis, the remaining high volume procedures are targeted for an average cut of 19.4 percent.

A cluster of high volume gastro-intestinal services are among those that have been targeted for cuts. CPT 43239 (upper GI endoscopy, with biopsy, single or multiple) would be cut under the NPRM by 22.5 percent. CPT 43248 (upper GI endoscopy, with insertion of guidewire followed by dilation of esophagus) would be cut by 17.5 percent. However, a diagnostic upper GI endoscopy under CPT 43235 would be increased slightly by 4.1 percent. Since the annual Medicare volume of CPTs 43239 and 43248 are together in excess of 100,000, where the frequency of 43235 is under 30,000, the gain promised under 43235 will not offset the substantial reductions to be taken under the other two endoscopy codes.

Colonoscopy services were also a major target under the NPRM. The base flexible colonoscopy code under CPT 45378, with an annual frequency of over 70,000, would be cut 16.1 percent, as would flexible colonoscopy with biopsy, single or multiple (CPT 45380), which has a frequency of almost 40,000 procedures annually. Flexible colonoscopy with removal of tumors, polyps, or other lesions under CPTs 45384 and 45384, with a combined frequency in excess of 70,000, would each be cut by 4.0 percent.

A number of other services would be cut significantly as well. CPT 19120 (excision of cysts, fibroadenoma, or other benign or malignant tumor aberrant breast tissue), with a frequency of almost 6,000 procedures, would be cut by 14.7 percent. CPT 52000 (cystourethroscopy), with a frequency of almost 24,000, would be reduced by 32.5 percent. CPT 55700 (biopsy of prostate) would be slashed by 37.2 percent. The annual Medicare frequency of this code is almost 10,000. With a frequency of almost 40,000, CPT 62289 (lumbar or caudal epidural, separate procedure) would be cut by 23.2 percent.

Ophthalmology was hit particularly hard by the NPRM, with cataract surgeries under CPT 66984, YAG laser procedures under CPT 66821, and glaucoma procedures under CPT 66170 each being targeted for significant reductions. Under the NPRM, the reimbursement for YAG procedures, the second highest volume ASC procedure, would be cut from \$422 to just \$274, a reduction of 35.1 percent. With 174,160 such procedures reported annually, the net effect of the proposal would be a cut of \$25,775,680. Criticism of this particular cut has been muted somewhat, however, by the fact that many had feared that YAG procedures would be cut from the ASC list altogether.

The proposal also seeks to cut the reimbursement for CPT 66170, another high volume procedure, by 30.3 percent. Under the proposal, reimbursement for this procedure would be slashed to \$415, or \$180 less than the current, base reimbursement rate. With 13,060 procedures reported, the net reduction in reimbursement to providers would be \$2,350,800 on an annual basis.

With respect to CPT 66984, the single highest volume ASC procedure, HCFA is proposing to reduce reimbursement by \$65 per procedure to a base rate of \$863. This would result in a seven percent reduction in reimbursement. With 525,940 such procedures reported, the effect of the proposal would be to cut \$34,186,100 in annual revenues.

Although not among the twenty highest volume services, payments for corneal transplants under CPTs 65750 and 65755 have been the source of particular concern. With a proposed reimbursement of \$1,648, the payment for these procedures would barely cover the costs of acquiring the necessary tissue for the transplant.

HCFA has also indicated that it intends to make serious cuts in IOL reimbursement in the future. The agency contends in the NPRM that the current rate of IOL reimbursement (\$150) is inconsistent with undisclosed data that reportedly establishes that the “weighted mean list cost [for an IOL] was \$100.” HCFA further contends that, for ASC specializing in eye procedures, the weighted mean cost drops to \$82.

As indicated above, however, five high volume procedures were targeted for increases under the NPRM. Significant increases were proposed for arthroscopic knee surgery under CPT 29881 (+35.6 percent), carpal tunnel syndrome surgery under CPT 64721 (+42.2 percent), and repairs of inguinal hernia surgeries under CPT 49505 (+24.2 percent).

So, what does this all mean? Well, clearly the cuts will make operating a profitable ASC much more difficult. ASCs that are not fully utilized will be particularly vulnerable. Single specialty ASCs, such as ophthalmic ASCs, may be forced to consider diversifying the types of surgical procedures that they offer. There is likely to be increased competition for the five highest volume procedures for which reimbursement would increase under the NPRM and other procedures for which reimbursement will not be affected adversely by the NPRM. The danger with a diversification strategy, of course, is that it may undermine the ASCs efficiency in its “core” services precisely at a time when that efficiency is needed most to minimize the effect of the reimbursement cuts.

In an effort to attract additional business, ASCs may also seek to develop joint ventures and increase levels of physician ownership. Although these arrangements may be structured in appropriate and lawful ways, these strategies may also raise complicated anti-kickback, self-referral, and fee splitting issues which must be addressed carefully.

In addition, the potential for coding errors and the consequences of those errors, including government investigations and Civil False Claims Act lawsuits, could increase sharply under the NPRM. In going to 105 APCs where just 8 APCs have been used in the past, the NPRM would significantly complicate the coding process at a time when the harsh cuts in reimbursement might lead some ASCs to be more aggressive in their coding.

Many ASCs are angry about the NPRM because they believe it and HCFA's recently released prospective payment system for outpatient hospital department ("OPHD") services will continue to perpetuate an uneven "playing field." Although HCFA plans to use the APC system for both ASCs and OPHDs, Congress has required that the rates for these same APCs be tied to different data in the ASC and OPHD contexts. Consequently, there will be different rates for these two competing sites of service, with OPHDs generally receiving higher reimbursement rates for the identical services, unless Congress acts.

Preliminary reviews of the OPHD proposal have only led the ASC community to increase its attack on the proposed ASC and OPHD rules. For the twenty highest volume ASC procedures which also may be performed by OPHD, OPHD would, on average, be paid twenty-five (25) percent more than would an ASC, when payments by Medicare and by beneficiaries through co-payments and deductibles are considered. These comparisons have engendered a great deal of debate as the ASC and the OPHD proposals are evaluated by interested providers, Congress, and the public.

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