

HEALTH LAW

Update

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

In Today's Federal Register -- CMS Proposes Significant Revisions to Ambulatory Surgery Center Payment System

August 23, 2006

Under a proposed new rule contained in today's Federal Register, significant changes are underway with respect to Medicare reimbursement for procedures performed at free-standing outpatient ambulatory surgery centers (ASCs). The proposed rule, which was initially released by the Centers for Medicare & Medicaid Services (CMS) on August 8, 2006, substantially modifies both the procedures that may be reimbursed by Medicare at ASCs and the amount of that reimbursement. The proposed rule has not yet been finalized, and it is likely to generate a great deal of public comment in the coming months.

The proposed changes would align the ASC payment system more closely to the hospital outpatient prospective payment system (OPPS). CMS has stated that its intent is to eliminate "payment differences that inappropriately favor one outpatient setting over another and that may add to Medicare costs." In general, the proposed changes have the effect of expanding the list of reimbursable procedures at ASCs, while at the same time lowering the rate of reimbursement for a large number of procedures performed at ASCs. ASC industry associations have raised concerns about the extent to which ASCs, with a high percentage of their revenues attributable to Medicare beneficiaries, would be negatively impacted by the proposed changes. Some of the proposed changes would take place beginning in 2007, while the more significant changes would be phased in beginning in 2008.

2007 CHANGES

Under the proposed rule, as of January 1, 2007, an additional 14 procedures would be included on the list of procedures reimbursable by Medicare in an ASC setting. In addition, as of January 1, 2007, the payment rate to an ASC for a given surgical procedure would be capped at the OPPS rate for that procedure. This change, which is the result of a provision in the Deficit Reduction Act of 2005, would have the effect of reducing ASC reimbursement for approximately 274 procedures. Other changes that would be effective as of January 1, 2007 include a modified application and approval process for establishing new technology intraocular lenses (NTIOLs) furnished during or after cataract surgery.

2008 CHANGES

Increased Number of Covered Procedures

Beginning January 1, 2008, under the proposed rule, the list of procedures in an ASC setting that are reimbursable by Medicare would expand significantly. All surgical procedures would be included on the approved ASC list except those that are deemed to pose a significant safety risk or generally require an overnight stay. For example, procedures would not be reimbursable if they: are on the inpatient-only list; require a stay past midnight; involve major blood vessels; involve prolonged or extensive invasion of body cavities; involve extensive blood loss; are emergent or life threatening; or were performed more than 80% of the time in an inpatient hospital setting in 2005. As a result of this proposed expansion, more than 3,300 procedures would be covered by Medicare in an ASC. In addition, the ASC payment groups would increase from the current 9 payment groups to the 221 ambulatory procedure classifications (APCs) used under the OPSS. The range of payment rates would expand from the current range of \$333 to \$1,339, to a new range of \$3.68 to \$16,146.

Reduced Payment Rates

Although the proposed rule would expand the list of covered ASC procedures, the payment rates generally would be lower. For calendar year 2008, CMS estimates that the rates for procedures performed in an ASC setting would equal 62% of the corresponding rates paid for the same procedures performed in an outpatient hospital setting. CMS's rationale for the lower reimbursement rate is the fact that ASCs generally have lower costs than hospitals because, for example, ASCs do not operate emergency departments and are not open 24 hours a day, seven days a week. CMS proposes to phase in the lower payment rates under the proposed rule. For calendar year 2008 only, the ASC rate would be a blended payment equal to 50% of the 2007 rate, plus 50% of the new 2008 rate. Beginning in 2009, CMS would fully implement the new ASC payment rates. In 2010, the rates would be updated based on the consumer price index for urban consumers. Medicare beneficiaries would continue to pay a 20% co-payment on ASC facility services.

In addition, in order to minimize the incentive for procedures to migrate from physician offices to ASCs, CMS has proposed that when a procedure that is commonly performed in a physician's office is instead performed at an ASC, the payment to the ASC will not exceed the physician office payment rate. About two-thirds of the procedures being added to the ASC-approved list fall into this category. However, office-based procedures that are on the ASC list as of January 1, 2007 would be exempt from this payment limitation.

CMS will consider any public comments related to the proposed ASC payment system that are received by November 6, 2006. CMS expects to publish a final rule implementing the revised ASC payment system in the spring of 2007.

If you have any questions about this Health Law Update or would like to discuss the impact that these proposed rules might have on your business, please contact one of the Bass, Berry & Sims attorneys in the Health Law Practice Area shown on the following page.

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