

Pain Management ASCs – Here to Stay in 2008 and Beyond

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While you might be hearing a lot of doom and gloom about pain management's future in ASCs after CMS's transition to HOPD-based facility fees, an assessment beyond a rudimentary sampling of the most common procedure codes reveals a significantly different picture. In fact, as the traditional "grouper-based" facility fees for individual procedures are being eradicated, there are new sources of payment previously unavailable in freestanding (non-HOPD) facilities.

Depending on the specific procedure volume and payor mix, pain management ASCs may see few adverse effects — and could, in fact, come through the transition just fine. To assess the impact of the new payment system, one needs to understand and evaluate the overall complexity for 2008 and beyond, from reductions in payment for some procedures, to increases for others, to payments entirely new to ASCs.

Identifying payment indicators

The road map to this understanding starts with grasping the payment indicators stipulated by CMS to guide the four-year transition (to be complete by beginning of 2011) to an HOPD-based system for all ASC services. Payment indicators specify the method and timing for application of revised payments; and there are 16 ways that is proposed to happen. Luckily, single-specialty pain management ASCs need only work with a few of them. They include the following;

- The **old groupers**, or procedures already classified as receiving facility fees in 2007, will make the multi-year prorated transition from the 2007 basis to 65 percent of the HOPD rate.

- **New procedure codes** not previously considered appropriate to office-based facilities (they were exclusive to hospital-based facilities) will be paid immediately (starting Jan. 1, 2008) at 65 percent of the HOPD rate.

- **Device-intensive procedures** (such as neurostimulators and drug-infusion pumps) will be paid according to the multi-year prorated transition to the HOPD basis plus an additional scheduled amount addressing the costs of the devices themselves.

- **Codes that were considered "office-based"** and did not previously qualify for a facility fee, but instead paid a higher professional fee if performed in the office setting. The difference between the enhanced fee and that paid to the surgeon if using someone else's facility is/was commonly referred to as the site-of-service differential and represented the minimum fee an ASC should be paid for use of the facility by the surgeon to avoid the appearance of subsidizing use of the ASC. These procedures are each being assigned a transitional value (different from the site-of-service differential) that is applied immediately (starting Jan. 1, 2008) as the facility fee.

- **Two new categories** for handling diagnostic radiology codes are applicable where a technical component is now payable in addition to related procedures (but many others remain "bundled" with the associated code); these fees are to be applied starting Jan. 1, 2008.

Understanding the reimbursement

If you look only at the prorated transition of the familiar groupers from the 2007 basis to the proposed 65 percent of HOPD rates, the outlook is indeed not good, with most facility fees reduced between 24 percent and 35 percent. But as seen above, that is only part of the picture. While the basic values for those codes are going down, ASCs can now be paid additional fees for some of the more expensive drugs and biologics used during qualifying procedures and, with a few procedures, additional fees for the technical component of ancillary diagnostic radiology services. Add to that the significant number of codes qualifying for new or higher payments and the situation brightens considerably.

For example, a large joint injection [20610] under the 2007 system only offered an ASC the office-based site-of-service differential amount as anticipated compensation: a whopping \$21.22, which is particularly offensive considering nothing additional can be charged for the drug administered. Under the HOPD system, the ASC will be paid a basic facility fee approximately 75 percent higher than the 2007 site of service differential plus separate payment for drugs.

No two codes previously practice-based are treated the same, however. The increase over 2007 site-of-service differential values for non-radiological pain management procedures ranges between 23 percent and 128 percent, but all those payments for the most common pain management codes are increasing, and additional payments will be made for drugs and biologic agents.

Then there are payments that "jump" codes to identify a facility fee, resulting in another gain for the ASC, such as cervical discography's [62291] new connection to radiological interpretation [72285]. Under the 2007 system, discography was treated as a practice-based code, meaning an ASC's anticipated compensation was tied to the site-of-service differential in professional fees. Under the HOPD system, the payment indicators direct the ASC to bill the technical component of the discography under a separate radiology

code that not only creates a defined facility fee, but increases payment by about 42 percent.

One of the important distinctions with the newly defined facility fees, higher and in lieu of site of the older service differential values for office-based procedures, is they will be paid directly to ASCs. While it was understood the practice-based differentials (as an absolute minimum) should be paid to ASCs, it was a political and/or cash flow problem for the ASC to collect payment from the operating surgeon because the amounts were paid directly to the physician as global professional fees. For ASCs used by non-owner surgeons, the new system eliminates the potentially unpopular process of extracting payment from part of a surgeon's professional fees and clearly defines the facility fee due directly from the CMS carrier.

Uncovering other new advantages

Office-based codes are not the only silver-lining with the new system. For example, vertebroplasty procedures will not only generate a facility fee for the procedure code (22520, 22521, or 22522) but also for the necessary diagnostic imaging technique (fluoroscopy under 72291, or CT under 72292). While the completed transition to a HOPD basis is projected to reduce the primary code's value by about 25 percent, the newly applicable diagnostic imaging technical component should help offset the loss.

Some other procedures, such as neurolytics, will fair better under the HOPD-based system because it accounts for the costs of expensive needles, probes and grounding pads — something the old system clearly did not. Stimulators and pumps (which have long involved extended negotiating and compromise to get paid for) are now included in the Ambulatory Payment Classification, offset by a “device percentage.”

The overall effect of these changes (transition to a HOPD rate basis) is highly dependent on the specific procedures performed. To give you a better idea, annualized procedure data for four unrelated pain management groups across the country were run through feasibility projections for 2007 through 2011. The resulting projections (no escalation of fees for inflation adjustments where assumed or applied, except as noted) yielded some interesting insights:

- CMS payments for ASC pain management procedures in 2008 will be up from 2007, with a weighted average increase slightly over 2.5 percent. They will then decrease annually as the transition to a purely HOPD basis progresses. Consequentially, investors who have delayed developing new ASCs while waiting to see CMS's final methodology have missed the strongest year for Medicare reimbursement in the recent past and foreseeable future.
- The net effect at the conclusion of the transition to the HOPD basis will be a weighted average reduction in payment a little under 6 percent — a far cry from the 35 percent or greater losses touted by inadequately informed resources.

- If HOPD rates are projected to increase a modest 3.5 percent to 4 percent annually for each year of the transition (except 2009 where blocked by CMS), the net effect will be an increase in weighted average payment of approximately 5.3 percent over 2007's. Though such a small sample of pain management groups is hardly extensive or statistically precise, it should serve as a wake up call for those fearing the worst case scenarios postulated elsewhere. The greatest point to be made however, is how insignificant those modest reductions can be in a well conceived and efficiently run pain management ASC.

Productive through 2011 and beyond

In the end, any pain management ASC with adequate patient volume to keep staff productive and equipment busy will be profitable (given a normal procedure mix). As long as that is the case, compensating for a 5.3 percent loss, even if from all payors, should be covered by roughly an annual procedure volume increase of less than 2.5 percent (comfortably within most groups' capabilities and expectations). Considering the likelihood that CMS is not the only payor, and is probably the lowest payor, the volume increase to cover the projected reduction should be even less.

A busy pain management ASC has long been an excellent investment for owner-surgeons, and the transition to the proposed HOPD basis will do little or nothing to change that. To get the most from their investment, pain management groups should size their facilities to be efficient from the onset but capable of supporting longer-term projected-volume increases — beyond a break-even level, each percent of volume growth can increase profit many fold. Single-specialty pain management ASCs tend to have an advantage pursuing efficiency increases compared to multi-specialty ASCs, simply because they avoid the down-time of adapting procedure room equipment and arrangement between cases, and have staff attuned to the relative high volume possible for the specialty.

A final push toward ASCs, and away from practice-based pain management procedures, may come from the regulatory side — and in fact already is in some states, such as Pennsylvania, where the health department has recently written opinion that the acuity of pain management patients and the procedures performed are only acceptable in licensed and certified ASCs. The transition to the more inclusive HOPD procedure list will only increase the acuity of patients treated and the risks associated with the more provocative procedures allowed. Then there are expectations of significant cuts in office-based procedure fees — but that is anyone's guess at this point, and another discussion entirely.

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