

Revolution and Renaissance: Part 2

Federal legislative and regulatory policy changes have created an environment in which vitreoretinal surgery should proliferate in the ASC.

BY MICHAEL A. ROMANSKY, JD



The Outpatient Ophthalmic Surgery Society (OOSS) is a professional medical association representing more than 1,000 ophthalmologists, nurses, and administrators who specialize in providing high-quality surgical care in ophthalmic ambulatory surgery centers (ASCs). OOSS' mission is to represent outpatient ophthalmic surgeons on federal legislative and regulatory matters and to promote the development and utilization of ophthalmic ASCs.

The remarkable changes that have occurred in ASC reimbursement must be viewed in proper context. The casual reader will focus only on the increased reimbursement. The intent of Centers for Medicare & Medicaid Services (CMS) in its ruling, however, is far more significant: The expanded access and linkage to hospital outpatient departments (HOPDs) recognizes and validates the services provided in ASCs as on par with those in a hospital setting. In order to achieve this recognition, a community of passionate and dedicated organizations was necessary. Foremost among those organizations is OOSS. I have had the privilege of working with Michael A. Romansky, JD, who serves as Washington Counsel and Senior Lobbyist for OOSS, for the past few years. His devotion to providing ophthalmologists with the tools to allow the best patient care is infectious.

In Part 1 of his contribution to this column (in the May/June issue), Mr. Romansky discussed the history and the evolution of the CMS' involvement with ASCs. Part 2 will address the current implications of the new ASC payment system.

—Pravin U. Dugel, MD

NEW ASC PAYMENT SYSTEM

As we discussed last issue, for the first quarter-century of the Medicare ASC program, OOSS and other advocates for the ASC industry argued that: virtually all ophthalmic surgical services are appropriate for conduct in the ASC; that ASC rates should be linked to those paid to HOPDs; and that ASCs should be afforded annual payment updates, just like hospitals. Effective January 1, 2008, the new ASC payment system provides as follows:

- All ophthalmic procedures are eligible for Medicare ASC facility reimbursement.
- ASCs are paid at the rate of 65% of the amounts paid to hospital outpatient departments (HOPD) for such services. This results in significant increases for retina services. For example, prior to 2008, CPT 67108, repair of detached retina, was paid at \$995; under the new pay-

ment system, when fully implemented, the ASC will receive \$1,540.

- Commencing in 2010, ASCs will be afforded an annual payment update equal to the Consumer Price Index-Urban (approximately 3%), ensuring that base rates will increase each year. Moreover, as part of the annual rule-making process for HOPDs, ASC payments will be further adjusted to reflect payments for technology and resources used in furnishing procedures.

- ASCs are now afforded the same additional payments that hospitals receive for new and innovative medical devices and pharmaceuticals.

- These new payment rates will be phased in over a 4-year period.

While retina might have been a "loss leader" in the pre-2008 ambulatory surgery center, the improved reimbursement climate renders vitreoretinal cases potentially

highly profitable in the ASC. At the very least, the retinal surgeon now enjoys viable choices as to whether to perform surgery in the hospital or ASC.

PHYSICIAN INVESTMENT IN ASCS

Historically, concerns have been raised about the potential for excessive use of health care facilities and attendant overspending when physicians refer patients to health care facilities in which they have an ownership interest. The ASC industry has argued from the outset that surgery centers are different from clinical laboratories, diagnostic imaging and other such facilities and that the potential for overutilization is mitigated by several factors. First, surgical services are less likely to be abused because patients will not submit themselves to unnecessary surgery. Second, ASC services are reimbursed through prospectively determined fixed rates

Unlike the internist's investment in an imaging facility or an orthopedist's ownership of a physical therapy business, the surgeon's investment in an ASC is not passive.

that encompass all related diagnostic and therapeutic items and services; hence, the facility has no incentive to order excessive tests. Most important, unlike the internist's investment in an imaging facility or an orthopedist's ownership of a physical therapy business, the surgeon's investment in an ASC is not passive; he is utilizing the ASC as an "extension of his office," and his ability to generate additional income is limited by his own time and availability. Moreover, surgical services are typically subject to peer review and/or precertification.

Policymakers' recognition of these differences between ASCs and other providers has led to a regulatory environment in which surgeons have substantial flexibility in the ability to own an interest in, and refer their patients for surgery to, ASCs.

Stark Laws. In 1989 and in 1993, Congress enacted two statutes, known as the Stark Laws, that imposed restrictions on physician ownership of about a dozen "designated health services," such as imaging, lab, and physical therapy facilities. The measures specifically excluded ASC services from the list.

Federal Anti-Kickback Law. The Department of Health and Human Services Office of the Inspector General, which is charged with interpreting and enforcing the anti-kickback law, has long recognized the benefits of surgeon-owned ASCs and has adopted a "safe

harbor" that exempts physician investments in ASCs from prosecution provided that certain conditions are met.

As such, under current law, proscriptions against physician self-referral are generally not applicable to surgeon ownership of an ASC.

NEW ASC CONDITIONS OF COVERAGE

For the first time in 25 years, CMS has proposed a rule to revise the requirements that ASCs must meet to secure Medicare certification and receive facility payments. Although the proposed changes are not particularly draconian, ASCs will be required, once the rule is finalized, to adopt some new policies and procedures regarding governing body and management; quality assessment and performance improvement; patient rights; infection control; and patient admission, assessment, and discharge. If the retinal surgeon is contemplating developing a new ASC, it is important that he or she be cognizant of these new requirements.

Are we in the midst of a health care revolution? Will the viability of vitreoretinal services facilitate a renaissance in the development of ASCs? Affirmative responses here might be overstatements. One thing, however, is certain. Heretofore, Medicare facility payments for retina surgeries were so low as to render vitreoretinal unattractive to most multispecialty and cataract-oriented ASCs. With Medicare reimbursement having increased by 50% to 80% for these services, with changes in technology that render vitreoretinal appropriate for the ASC, and with the growing patient demand for ASC services, progressive retina surgeons have a number of exciting options with respect to the site of surgery. ■

Michael A. Romansky, JD, is Washington Counsel and Senior Lobbyist for OOSS. He has practiced exclusively in the area of health law for 30 years, representing health-care providers, companies, and organizations before Congress and all federal agencies with jurisdiction over health programs.



Pravin U. Dugel, MD, is Managing Partner of Retinal Consultants of Arizona and Founding Member of the Spectra Eye Institute in Sun City, AZ. He is a Retina Today Editorial Board member. He can be reached at pdugel@gmail.com.

CONTACT US

Send us your thoughts via e-mail to
letters@bmctoday.com.