



## FEDERATED AMBULATORY SURGERY ASSOCIATION

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May 27, 2003

Mr. Thomas A. Scully  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1885-FC  
PO Box 8013  
Baltimore, MD 21244-8013

Re: Update of ASC List of Covered Procedures Effective July 1, 2003

Dear Administrator Scully:

The Federated Ambulatory Surgery Association (FASA) appreciates the opportunity to comment on the final rule issued by the Centers for Medicare and Medicaid Services' (CMS) entitled "Update of Ambulatory Surgical Center List of Covered Procedures Effective July 1, 2003." FASA is the nation's largest ambulatory surgery center (ASC) organization representing more than 1,000 ASCs and nearly 5,000 professionals, who provide care and services in such centers.

FASA is delighted that CMS has issued a final rule updating the ASC list. These updates will enhance Medicare beneficiaries' access to ASCs. Not only will Medicare beneficiaries benefit by gaining a choice of where to have many procedures performed and a reduction of out-of-pocket expenses, the Medicare program will also benefit from lower program costs.

We appreciate the dedication CMS staff had to publishing this final rule expanding access to ASC services. Through our numerous conversations, emails and meetings about these issues, we gained an understanding of the efforts that it took to produce a final rule. During the almost five years that it took to finalize this rule, CMS encountered many challenges and FASA commends the staff for their efforts. Although we differ with CMS on some decisions reached, we have the utmost respect for the efforts they extended to improve the services Medicare beneficiaries receive.

### ASC LIST

With the implementation of this list, Medicare beneficiaries will move closer to the same access that private pay patients have. However, with the many technological improvements and changes in health care delivery that have taken place since 1998 – many of which are not reflected in this update – Medicare patients will still be denied access to ASCs for procedures that many other patients are routinely receiving in ASCs. Not only does this deny Medicare beneficiaries a choice of where to obtain services, but often requires them to pay higher copayments. ASCs throughout the country have outstanding patient safety records while achieving high rates of efficiency and customer satisfaction, a combination rarely realized. ASCs

achieve these goals at a savings to Medicare as well as private insurers. The ASC list is based upon outdated and obsolete rules, which do not take into consideration the particular needs of the patient. By only reimbursing ASCs for a limited list of procedures, Medicare prevents physicians from selecting the best environment for the care of our senior citizens. Medical assessment of the patient, capability of the facility and likely risks for the patient should determine if a patient can receive care in the ASC setting, not a list.

After two decades of experience with the ASC list, FASA believes that as long as this type of list is used Medicare beneficiaries' access will always lag behind that of the private sector. Even if CMS could accomplish the biannual update mandated by Congress, that still means Medicare is two years behind.

By comparison, hospital outpatient departments (HOPDs) are reimbursed for any service that is not on the "inpatient only" list. There is no medical justification for allowing a patient to have a procedure in an HOPD and go home the same day, but not allowing that same patient to have the same procedure in an ASC and go home the same day. Both settings are designed to treat patients who do not require overnight hospital stays following surgery.

We recognize that the list is a statutory requirement and thus CMS cannot eliminate the list by regulation. However, as Medicare's administrating agency, CMS has a responsibility to inform Congress when the statute interferes with effective administration of the program or impedes beneficiaries from having access to services. FASA suggests that CMS consider evaluating whether the ASC list serves a benefit today and if not recommend that Congress eliminate this requirement. When created in 1982, the ASC industry was in its infancy and some uncertainty may have existed regarding the procedures that could be performed and the overall role of ASCs in our health care delivery system. Now that the ASC industry is a mature industry it appears that the list is no longer needed.

Costs were an issue when the benefit was established as some were concerned that without a mechanism to stop procedures that should be performed in physician offices from being performed in ASCs, Medicare program payments would rise. Evidence now shows the list is not needed for this purpose. Hardly any of the procedures that CMS is deleting because it finds them to be physician office procedures are being billed to Medicare by an ASC. This would appear to demonstrate that when the physician's office is an appropriate location for a procedure, physicians are performing the procedure there.

We recommend that CMS evaluate whether the benefits received from having a list outweigh the costs of maintaining and utilizing such a list. If CMS finds the benefits outweigh its costs, we ask that adequate resources be allocated to keeping the list up-to-date as required by statute. As an alternative, we suggest that CMS develop a list by exception of those very few procedures that are allowed to be performed in HOPDs, but should not be allowed to be performed in ASCs, along with a rationale for the exception.

## **IMPACT OF CMS DECISIONS ON PRIVATE PATIENTS**

Although CMS's primary focus in updating the ASC list is the effect on Medicare beneficiaries, CMS, as a part of the nation's foremost health agency, should not ignore the impact its decisions have on other patients. The ASC list affects private pay patients in varying ways depending on their insurance. In some parts of the country it is not uncommon for private insurers (and other government insurers such as workers' compensation or Medicaid) to pay a percentage of the Medicare rate for procedures on the Medicare ASC list and use a different methodology for setting rates for those procedures not on the ASC list. Such methodologies include a percent of charges, a negotiated amount, the amount paid to the hospital or a discount off the amount paid to hospitals. Therefore, the addition of some procedures to the Medicare ASC list results in decreased reimbursement to some ASCs. For example, a FASA member indicated that for procedures not on the ASC list his contract pays 75% of his charges. However, if that procedure is on the list, he is paid a set based upon a percentage of Medicare. On July 1, the reimbursement he receives from a private insurer for arthroscopy rotator cuff repair (CPT 29827) decreases from \$2504.88 to \$1469, a reduction of more than \$1,000 per case. Other insurers will only reimburse ASCs for procedures on the Medicare ASC list. For private patients covered by such insurers, not adding a procedure to the ASC list CMS denies private pay patients access to ASCs. Because of these impacts beyond Medicare we urge CMS to use extreme care when making adjustments to the ASC list and assigning procedures to groups.

### **ADDITIONS TO THE ASC LIST**

Increasing the procedures on the ASC list will expand Medicare beneficiaries access and save both the program and its beneficiaries' money. FASA supports this expansion but believes it did not go nearly far enough. There are many additional codes that Medicare beneficiaries should have access to in an ASC. These comments provide many examples of procedures that should be on the ASC list. However, this is not intended to be a comprehensive list of all codes that meet the criteria for being on the ASC list. When CMS begins to prepare a proposed rule for its next regular update, FASA will submit a complete list.

#### **Codes Created Since 1998**

CMS specifically sought comments on additions made to the list resulting from code changes occurring since 1998. FASA agrees with the addition of the following new codes:

15351 Skin homograft add-on	15401 Skin heterograft add-on
24345 Repair elbow med. ligament w/tissue	27347 Remove knee cyst
28289 Repair hallux rigidus	29827 Arthroscopy rotator cuff repair
29899 Ankle arthroscopy/surgery	30465 Repair nasal stenosis
31623 Dx bronchoscope/brush	31624 Dx bronchoscope/lavage
31643 Diag bronchoscope/catheter	36831 Open thrombect av fistula
36870 Percutaneous thrombect av fistula	38570 Laparoscopy, lymph node biopsy
38571 Laparoscopy, lymphadenectomy	38572 Laparoscopy, lymphadenectomy
43201 Esoph scope w/submucous inj	43231 Esoph endoscopy w/us exam
43232 Esoph endoscopy w/us fn bx	43236 Upper GI scope w/submuc inj
43240 Esoph endoscope w/drain cyst	43242 Upper GI endoscopy w/us fn bx
43256 Upper GI endoscopy w/stent	43653 Laparoscopy, gastrostomy
44370 Small bowel endoscopy/stent	44379 S bowel endoscope w/stent

44383 Ileoscopy w/stent	45335 Sigmoidoscope w/submub inj
45340 Sig w/balloon dilation	45381 Colonoscope, submucous inj
45386 Colonoscope dilate stricture	50947 Laparo new ureter/bladder
50948 Laparo new ureter/bladder	52341 Cysto w/ureter stricture tx
52342 Cysto w/up stricture tx	52343 Cysto w/renal stricture tx
52344 Cysto/uretero, stone remove	52345 Cysto/uretero w/up stricture
52346 Cystouretero w/renal stricture	54690 Laparoscopy, orchiectomy
57023 I & D vag hematoma, non-ob	58546 Laparo-myomectomy, complex
58550 Laparo-asst vag hysterectomy	58560 Hysteroscopy, resect septum
58562 Hysteroscopy, remove fibroids	61886 Implant neurostim arrays
64821 Remove sympathetic nerves	69714 Implant temple bone w/stimul
69715 Temple bone implant w/stimul	69717 Temple bone implant revision
69718 Revise temple bone implant	G0260 Inj for sacroiliac joint anesth

In addition, FASA recommends that the following new codes be expeditiously added to the ASC list.

Repair, complex, trunk; each additional 5 cm or less (CPT 13102): Added in 2000, this code is used in conjunction with CPT 13100 (complex repair of trunk wound 1.1 to 2.5 cm) and CPT 13101 (complex repair of trunk wound 2.6 to 7.5 cm) for wound closures in excess of 7.5 cm. Both 13100 and 13101 are on the ASC list.

Repair complex, scalp, arms and/or legs; each additional 5 cm or less (CPT 13122): The same situation exists with CPT 13122 as with CPT 13102 except that it is for wounds on a different part of the body – scalp, arms and/or legs.

Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet each additional 5 cm or less (CPT 13133): Like the two previous codes, CPT 13133 except that it is performed on wounds located on forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet.

Knee arthroscopy with lateral release (CPT 29873): Prior to the creation of CPT 29873 in 2003, such procedures were appropriately coded with CPT 27425. CPT 27425 is on the ASC list and ASCs have been performing lateral releases for years. With the addition of a specific CPT code for lateral releases through arthroscopies, CPT 27425 can no longer be used to code arthroscopic lateral releases. By not adding this new code, CPT 29873, for a variation that was previously coded CPT 27425 to the list, CMS is in effect removing a procedure from the ASC list. More than 60 other types of arthroscopies, including 16 types of knee arthroscopies, are on the ASC list. Like other knee arthroscopies, CPT 29873 meets all the criteria for being on the ASC list. The average OR and anesthesia time are approximately 60 – 90 minutes with an average recovery time of 60 minutes. This procedure does not involve extensive blood loss, major or prolonged invasion of body cavities, or major blood vessels. It is not generally emergent or life-threatening in nature. It would make no sense to have the open surgical lateral release on the ASC list and not the arthroscopic version. Given that the issue here is actually a coding change and not the addition of a new procedure, FASA suggests that you handle this through a program memorandum as some coding changes have been handled in the past.

### **CMS 1998 Proposed Additions**

Many procedures that CMS proposed to add to the ASC were not included in the final rule. FASA believes that in several cases CMS erred in not adding procedures as it initially proposed.

**Procedures Not Meeting the Criteria for the ASC List.** For several procedures, CMS indicated that a commenter said that the procedures were hospital procedures and should not be on the ASC list. After re-reviewing the procedures with CMS's medical staff, CMS agreed and did not add the procedures to the ASC list. FASA objects to the process and the result. The regulations spell out the criteria for a procedure being on the ASC list. Nowhere in this criteria does it say that “hospital procedures” cannot be on the ASC list. To the contrary, one of the criteria for being on the ASC list is that the procedure is “commonly performed on an inpatient basis in hospitals.”

The procedures discussed below are routinely performed on an outpatient basis. Procedures that can be safely performed on an outpatient basis in the hospital can also be safely performed in an ASC that meets the Medicare conditions of coverage.

We recognize that in some situations procedures that can safely be performed on an outpatient basis (in an ASC or HOPD) may not meet the specific criteria for being on the ASC list. For example, procedures that may safely be performed in the outpatient setting may require anesthesia for more than 90 minutes and thus not meet the ASC criteria. However, CMS did not indicate how the procedures below failed to meet its criteria for being on the ASC list.

FASA is also troubled that in conducting a review of the safety of a procedure in ASC, how long a procedure takes in an ASC, and affecting ASCs that ASC medical experts were not consulted once it was suggested that it was not appropriate in an ASC. Given the specificity of medicine today and how rapidly it is changing, it is virtually impossible for physicians to be on top of their own field let alone that of other specialties. FASA would be happy to assist CMS in identifying the medical experts in the ASC industry with regard to any procedure. If CMS uses a process that gives our industry the opportunity to make its best case and we are unable to convince you that it is in Medicare beneficiaries' best interests that the procedure be on the ASC list, then it may not be. We have, however, less confidence that the process of internal review alone is the best method for learning about current medical practice in a particular arena.

Extensive surgery of the throat (CPT 42842 & 42844): In FASA's view, these procedures meet the criteria for being on the ASC list. A dedicated operating room is required. The average OR and anesthesia time are approximately 60 minutes with an average recovery time of less than 90 minutes. These procedures do not involve extensive blood loss, major or prolonged invasion of body cavities, or major blood vessels. They are not generally emergent or life-threatening in nature. In addition, Medicare volume data show that these two procedures were performed on an outpatient basis 45 and 57 percent of the time, respectively. Thus, the argument that these are “hospital procedures” does not appear valid.

Repair bladder defect (CPT 57288): We also believe that the argument that this is a “hospital procedure” is invalid. Volume data shows that this procedure is performed on an outpatient basis almost 30 percent of the time. In FASA’s view, this procedure meets all the requirements for being on the ASC list. It requires a dedicated operating room. Experienced surgeons can complete the procedure in 90 minutes with a recovery time of just under two hours. This procedure does not involve extensive blood loss, major or prolonged invasion of body cavities, or major blood vessels. It is not generally emergent or life-threatening in nature. Technological improvements, especially the use of a tension-free device, make the objections raised in 1998 inapplicable. However, unless CMS provides a much higher reimbursement rate than the \$601 proposed in 1998, adding the procedure to the ASC list would not increase beneficiary access. This rate is simply too low for ASCs to perform the procedure. Another indication that the rate is excessively low is that Medicare reimburses HOPDs almost four times as much for performing the procedure.

Partial thyroid excision (CPT 60210): In FASA’s view this procedure meets the criteria for being on the ASC list. It requires a dedicated operating room. Approximate average OR time is 90 minutes with two to three hours recovery time. This procedure does not involve extensive blood loss, major or prolonged invasion of body cavities, or major blood vessels. It is not generally emergent or life-threatening in nature. Volume data shows that this procedure is performed on an outpatient basis almost 39% of the time. However, given the maximum payment in an ASC is \$1,339 it is unlikely that adding the procedure to the ASC list would increase beneficiary access. This rate is simply too low for ASCs to perform the procedure.

**Reimbursement Rate Less than \$333.** Most of the procedures that CMS had originally proposed to add but did not had a proposed payment of less than \$333. According to CMS these were not added to the ASC list as the lowest payment in ASCs is \$333 and at this rate Medicare would be overpaying for the procedures. Although we understand CMS’s rationale, we have some concerns about this approach. The criteria for a procedure being placed on the ASC list are delineated in the regulations and the procedure costing less than \$333 to perform is not one of the criteria. We understand CMS not wanting to overpay for procedures, but an averaging system will always result in some overpayment for low cost items and underpayment for high cost items. FASA’s other concern is that CMS underestimated the costs of performing these procedures so some may actually cost near or more than \$333 to perform. Since result of errors in cost calculations in this case is not simply a slightly lower payment, but rather beneficiaries being denied access it is even more crucial that CMS’s cost estimates be accurate.

**No Explanation Provided.** For some codes that CMS did not add as originally proposed, no explanation was given for the change. We believe that CMS erred in not adding the following procedures and should reconsider this decision.

Augmentation of the head and facial bones (CPT 21120 & 21125): A dedicated operating room is required to perform these procedures. An average OR time of 90 minutes and less than four hours of recovery time. These procedures do not involve extensive blood loss, major or prolonged invasion of body cavities, or major blood vessels. Nor are these procedures generally emergent or life-threatening in nature.

Cystourethroscopy (CPT 52301): This procedure meets the criteria for being on the ASC list. An operating room is required as the patient receives general anesthesia. The OR time averages 60 minutes with a recovery time of 60 minutes. This procedure involves minimal blood loss and does not involve major or prolonged invasion of body cavities, or major blood vessels. The procedure is not generally emergent or life-threatening in nature.

Partial excision bone; phalanx of toe (CPT 28124): This procedure was proposed to be added in the proposed rule, but was not added. No explanation was provided in the accompanying comments. The procedures relating to this code are all on the ASC list including CPT 28120, CPT 28122, and CPT 28126. FASA urges CMS to add this code to the ASC list or at least examine why this code was not added.

### **FASA 1998 Recommendations**

FASA continues to believe that four procedures that we recommended adding in response to the 1998 proposed rule should be on the ASC list. We believe these codes meet the ASC list requirements and moreover that Medicare beneficiaries would benefit from having access to these procedures in an ASC. We find CMS's arguments to the contrary unpersuasive.

Laparoscopy surgical cholecystectomies (CPT 47562, 47563 & 47564): In response to the 1998 proposed rule, FASA and others recommended these codes (then CPT 56340, 56341 and 56342) be added to the ASC list. In our comments we recognized that at that time these procedures were "generally thought of as an inpatient procedure." We went on to note that "the advancement of medical technology and anesthetic agents in recent years have allowed these procedures to be performed safely in an ASC setting. Numerous ASCs have performed these procedures safely on non-Medicare patients." Noting that "the primary factor in whether it is appropriate to perform the procedure in an outpatient setting is the medical condition of the particular patient," we argued that "CMS should include it on the ASC list and let physicians and patients decide what is best for each individual beneficiary."

Explaining its reason for not adding these procedures, CMS indicated that while these procedures may be appropriately performed in an ASC for non-Medicare patients, an overnight stay often would be required for Medicare patients. This analysis is troubling for several reasons. It seems entirely inappropriate to deny one Medicare beneficiary for whom the ASC is an appropriate setting access to an ASC because another patient might need an overnight stay. As technology improves more and more patients will be appropriate candidates for ASCs. Infrequent updates in the ASC list mean that if CMS isn't using state of the art information when it is published it will be very out of date before the next update is made. Finally, if the procedures were only being performed on inpatients the argument would have validity but Medicare volume data shows that these procedures were being performed on an outpatient basis 50%, 46% and 25% of the time, respectively. Given this data, we believe it is an error to argue that these are inpatient procedures. Moreover, as noted above, the issue should be whether these meet the criteria and we believe they do.

### **New FASA Recommendations**

Although CMS only specifically sought comments on the procedures added that were not proposed in the 1998 proposed rule, it is FASA's understanding that CMS will need to begin a new list of procedures to add within a couple of months if CMS is to meet the statutory

requirement of another list update in two years. To facilitate this, FASA is suggesting a few codes to begin the list. The list provided here is only a beginning. FASA is evaluating almost 300 codes that our members have indicated should be on the ASC list. We will be providing CMS a more thorough list in the near future.

Incision and drainage of pilonidal cyst: complicated (CPT 10081): This procedure is currently performed on privately insured patients in ASCs safely. This procedure does not exceed 90 minutes nor does recovery time exceed four hours. Anesthesia can be local, regional or general. This procedure involves minimal blood loss and does not involve major or prolonged invasion of body cavities, or major blood vessels. The procedure is not generally emergent or life-threatening in nature. The appropriate site for this surgery may vary depending on the patient so the physician should have flexibility in choosing the most appropriate site for his or her patient's needs.

Excision, benign lesion including margins, scalp, neck, hands, feet, genitalia and face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm (CPT 11423 & 11443): These procedures are safely and efficiently performed with high quality in an ASC on privately insured patients. These procedures do not exceed 90 minutes nor does recovery time exceed four hours. Anesthesia may be local, regional or general case. This procedure involves minimal blood loss and does not involve major or prolonged invasion of body cavities, or major blood vessels. The procedure is not generally emergent or life-threatening in nature. Addition of this code would give the physician flexibility to choose the correct environment for the situation. This is likely to be the case when the patient is having multiple lesions repaired.

Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 2.1 to 3.0 cm (CPT 11603): This procedure does not exceed 90 minutes nor does recovery time exceed four hours. Local, regional or general anesthesia is used depending on the patient and what other procedures are being performed. This code is similar to CPT 11604, which is on the ASC list. This procedure involves minimal blood loss and does not involve major or prolonged invasion of body cavities, or major blood vessels. The procedure is not generally emergent or life-threatening in nature. This is performed in ASCs on privately insured patients.

Image guided placement, metallic localization clip, percutaneous, during breast biopsy (CPT 19295): This procedure should be added as it is always used when performing CPT 19102 and 19103 which are all ASC list. FASA urges CMS to add this procedure to the ASC list to allow physician's the full spectrum of options when performing a breast biopsy in an ASC. It meets all the criteria for being on the ASC list. When CPT 19102 and 19103 were added in 2001, FASA recommended that this be added and CMS responded that it cost less than lowest payment group to perform. In response FASA provided data showing that event though this part might be paid a little higher than its costs, when considering it is always done as part of a multiple procedure the total payment for the combined procedures would not be excessive. Moreover, we showed the total payment would be less than the HOPD would receive.

Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic or lumbar (CPT 22520 & 22521): These procedures are performed to relieve pain in the vertebrae where a fracture exists. The procedures take 20 to 30 minutes and recovery time required is

between 30 and 90 minutes. They can be safely performed in an ASC with local anesthesia. These procedure should be added to the ASC list.

Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair (CPT 40812): This procedure is currently performed on privately insured patients in ASCs safely and efficiently allowing more flexibility depending upon lesion status. This procedure does not exceed 90 minutes nor does recovery time exceed four hours. Anesthesia will be local, regional or general depending on patient specific criteria. This procedure involves minimal blood loss and does not involve major or prolonged invasion of body cavities, or major blood vessels. The procedure is not generally emergent or life-threatening in nature.

Colonoscopy through stoma; with transendoscopic stent placement (CPT 44397), Proctosigmoidoscopy, rigid; with transendoscopic stent placement (45327), Sigmoidoscopy, flexible; with transendoscopic stent placement (45345) & Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (45387): FASA believes these codes should be added to the ASC list because they require a dedicated operating room or suite with post-operative recovery space, they are performed on an inpatient basis in a hospital, but can be safely performed in an ASC, and they are not commonly or safely performed in a physician's office. In addition, procedure time is less than 90 minutes and recovery time is less than four hours. These procedures involve minimal blood loss and do not involve major or prolonged invasion of body cavities, or major blood vessels. These procedures are not generally emergent or life-threatening in nature.

Injection procedure for diskography, each level, lumbar and cervical or thoracic (CPT 62290 & 62291): These procedures require a dedicated procedure room and radiology support and conscious sedation making it difficult to perform in a physician's office. Both were performed more than 95percent of the time on an outpatient basis in 2001. These procedures involve minimal blood loss and do not involve major or prolonged invasion of body cavities, or major blood vessels. These procedure is not generally emergent or life-threatening in nature.

Release eye tissue (CPT 67343): This procedure requires a dedicated operating room to control infection and patient monitoring to assure patient safety. The average OR and anesthesia time is approximately 45 – 60 minutes with an average recovery time of less than 60 minutes. This procedure does not involve extensive blood loss, major or prolonged invasion of body cavities, or major blood vessels. It is not generally emergent or life-threatening in nature. This procedure is usually performed in conjunction with other procedures that are on the ASC list, including 67311 or 67318.

Repair detached retina (CPT 67110): This procedure requires a dedicated operating room to control infection and patient monitoring to assure patient safety. The average OR and anesthesia time is approximately 45 minutes with an average recovery time of less than 60 minutes. This procedure does not involve extensive blood loss, major or prolonged invasion of body cavities, or major blood vessels. It is not generally emergent or life-threatening in nature. CPT 67101 and 67105 are similar in approach and technique and are on the Medicare ASC list. In addition, 67110 is routinely performed on non-Medicare patients in ASCs.

## REIMBURSEMENT

Several of the new codes added to the ASC list raise concerns regarding the group to which they have been assigned.<sup>1</sup> In several cases the final rule payment is substantially different from that proposed in 1998. FASA would have expected that absent significant evidence that the rate proposed in 1998 was incorrect, the final rate would have been the 1998 proposed rate adjusted by the same inflation update that the procedures on the list received. This does not appear to be the methodology followed so we are uncertain how the rates were established. FASA would be interested in reviewing the methodology used to develop these rates. In the meantime, we are recommending grouping changes for several procedures. As noted above inadequate reimbursement not only limits access for Medicare beneficiaries, but also may deny access to beneficiaries of other government programs and private pay patients whose insurers rates are directly tied to Medicare rates.

The following procedures appear to be assigned to the wrong group. We urge CMS to reconsider these placements.

Ureteroscopic Lithotripsy (CPT 52353): FASA believes that this code is assigned to the wrong payment group and would recommend that it be reassigned to payment group 9. In the proposed rule a payment rate of \$1,131 was proposed. CMS offered no explanation for the 44.3 percent reduction to the final rate \$630. Medicare beneficiaries are not likely to gain access to this procedure in an ASC if the rate is not increased. By moving this procedure to group 9, the reimbursement would be \$1,339, and ASCs would likely offer this procedure to Medicare beneficiaries. If this resulted in 25% of these procedures moving to the ASC from the HOPD, the Medicare program would save more than a half a million dollars. Patient savings would be more than \$100,000. We urge CMS to reevaluate this payment rate.

Endoscopic retrograde cholangiopancreatography (43269): FASA believes this code is inappropriately placed in group 2 resulting in an unreasonably low payment. Because of the expensive equipment and supplies involved in providing this procedure. It should be placed in a higher group, such as group 5. At this rate, the ASC would still offer the Medicare program and its beneficiaries cost savings from the HOPD setting.

Cystourthroscopy with ureteroscopy (CPT 52344, 52345 & 52346): FASA recommends that these codes be reassigned to group 4. Based on similar codes (CPT 52352 and 52354) these procedures are inappropriately assigned to group 3. These procedures require the same resources as CPT 52352 and 52354 and if paid a similar rate would offer Medicare a savings of approximately \$400 from the HOPD payment.

Another problem with ASC reimbursement is that confusion exists about what is included in the ASC facility fee and what is not. This problem did not originate with these additions but is one that ASCs constantly struggle with. Since the inception of the ASC benefit, payments bundled

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<sup>1</sup> Although there are many procedures that FASA believes Medicare reimbursement is inadequate, our comments in this document are limited to procedures that were added in the rule that is the subject of these comments.

and paid on a prospective basis and a bundled payment. We have no objection to this approach. However, Medicare needs to define the bundle clearly and assure that its carriers implement the policy consistently. It is our understanding that the facility fee is not designed to include payment for implants and prostheses and thus ASCs should be paid separately when using in a reimbursed service. Despite this policy appearing clear, ASCs across the country are not being paid when such devices are used. CMS's volume data supports this. Variations occur not just among carriers, but even among claims processed by the same carrier. In one situation, an ASC sometimes received payment for a particular implant and sometimes did not. The ASC was the same, the implant was the same, and the procedure was the same. Communication with the carrier was not enlightening as to why the ASC was sometimes paid for the implant and sometimes not. As the technology of medicine expands, so does the costs of devices used. As these costs rise, so does the significance of this problem.

The real frustration is that this should not be a judgment call. When CMS sets the payment rates for performing a procedure it includes certain costs. Whether or not its cost calculation included a device or implant is a factual question.

In the 1998 proposed rule, a list of all HCPCS codes was included with a status indicator that denoted whether or not the device was included in the facility fee. This was helpful in attempting to resolve issues with carriers. However, since it was only an addendum to a proposed rule and is now many years out of date a new document would be useful. We would be eager to work with CMS to develop such a list.

In addition to being a problem for many procedures already on the ASC list, such as implantation of neurostimulator (CPT 63650) and implantation of spinal neurostimulator electrodes (CPT 63685), it is a major issue for the following two procedures added to the ASC list.

Implantation of inflatable penile prosthesis (CPT 54405) was added to the ASC list. The prosthesis used in this procedure costs several thousand dollars. The payment rate for the procedure is set at \$510. Thus it seems clear that ASCs should be paid separately for the device. However, prior to performing the procedure, ASCs need to know whether or not the prosthesis will be paid separately.

Brachytherapy (CPT 55859): Brachytherapy was placed in payment group 9. FASA urges CMS to issue guidance on Medicare reimbursement for the radioactive seeds used in this procedure. Clearly, CMS does not intend the \$1,339 facility fee to cover these costs which can cost thousands of dollars per procedure depending on type and number used. In response to an inquiry, CMS's staff said that the physician could bill Medicare for these devices. This would appear to be a reasonable solution to the problem, however, we urge CMS to take action to assure that all carriers will follow this policy. It should be noted that the ASC will still incur the costs of complying with government requirements for the handling of radioactive devices and storage of devices until use even if the physician orders and pays for these devices.

## **DELETIONS**

We are pleased that in response to comments on the proposed rule CMS did not delete several important pain management and urodynamic codes as planned. In general, CMS is deleting procedures from the ASC list that have not been frequently performed in an ASC. In part this shows that physicians are selecting the most appropriate environment for procedures and when the procedure can safely be performed in a physician's office that site is being used. For a few codes we recommend that CMS reconsider its decision to delete these codes from the ASC list as we believe it is in the best interests of Medicare beneficiaries to have these procedures available in ASCs.

Electronic analysis of programmable spine pump (CPT 62367 & 62368): FASA believes that good patient care dictates that these two codes remain on the ASC list at least when performed at the same time the pump is implanted. According to the manufacturers of the device, it is necessary to analyze and program the pump to assure that the pump is functioning and the drug is being delivered appropriately. If these procedures are not on the ASC list, the patient will need to visit a physician office following the procedure to have this programming performed. Several problems result from separating the programming from the implantation. For example, the patient has a non-functioning pump and therefore is not getting the desired pain relief until the follow-up physician appointment can be scheduled. With CMS's emphasis on appropriate pain management for the elderly, we would think that CMS see this as a significant problem for its beneficiaries. A similar issue is present when the pump is used for treating severe spasticity. The second visit, and we would argue unnecessary one, would require the patient additional expense and inconvenience to get to the appointment. This might not be a major issue for all patients, but for those in rural areas or with mobility problems this additional, unnecessary visit might be a significant imposition. Finally, the follow-up appointment might be with a physician who is not nearly as experienced in the use of infusion pumps. Often physicians most experienced with these devices only practice in the ASC setting. These two codes were billed 6,800 times in 2001 in an ASC so their elimination from this list affects a significant number of beneficiaries.

Flap for face nerve palsy (CPT 15842), Decompress fingers/hand (CPT 26035 & 26037), insert description (CPT 27440), Reconstruct cleft palate (CPT 42225) & Partial removal of thyroid (CPT 60220 & 60225): According to the commentary accompanying the final rule, CMS's staff reviewed these procedures in response to a comment received on the proposed rule indicating that these were hospital procedures and should not be on the ASC list. As the result of its review, CMS deleted these from the ASC list. FASA objects to the process and the decision. The regulations spell out the criteria for a procedure being on the ASC list. Nowhere in the criteria does it say that "hospital procedures" cannot be on the ASC list. To the contrary, one of the criteria for being on the ASC list is that the procedure is "commonly performed on an inpatient basis in hospitals." The procedures in question meet this requirement.

These procedures are also routinely performed on an outpatient basis. The procedures in question were performed on an outpatient basis 38%, 54%, 27%, 23%, 45%, 41% and 39% of the time, respectively. Procedures that can be safely performed on an outpatient basis in the hospital can also be safely performed in an ASC meeting the Medicare conditions of coverage.

We recognize that in some situations procedures that can safely be performed on an outpatient basis (in an ASC or HOPD) may not meet the specific criteria for being on the ASC list. For example, procedures that may safely be performed in the outpatient setting may require anesthesia for more than 90 minutes and thus not meet the ASC criteria. However, CMS did not indicate how these procedures failed to meet its criteria for being on the ASC list.

FASA believes when removing a procedure from the ASC list, one which Medicare beneficiaries have had access to in an ASC, CMS should specifically indicate how it fails to meet the criteria. Both the Medicare program and its beneficiaries will incur greater expense by moving these procedures to the HOPD setting. The increased Medicare payments in the HOPD setting are \$163.87, \$109.29, \$109.29, \$758.05, \$1,057.71, \$1,437.36 and \$1,373.36 respectively. In these cases, the suggestion to delete was made in response to a proposed rule. Nothing in the proposed rule suggested that CMS was considering deleting these procedures so the affected parties had no opportunity to demonstrate how these procedures meet the criteria. If this is the process to be used, it would appear that industry representatives should include in every set of comments submitted how all procedures on the ASC list continue to meet the criteria. Prior to deleting procedures, the industry should have an opportunity to comment.

Although these low volume procedures are not often performed in an ASC, the process for removing procedures from the list should follow the regulation and CMS should clearly indicate its reasons. Absent this delineation it is difficult for those affected to challenge the decision. Removal of a procedure that has been performed in an ASC and for which problems have not occurred should require more documentation than simply not adding a procedure.

Injection for ureter x-ray (CPT 50684 & 50690), Injection for bladder x-ray (CPT 51600 & 51610) & Preparation for bladder x-ray (CPT 51605): CMS indicated that it was deleting these five procedures as each of these codes is packaged into an imaging procedure that is not payable in the ASC. This argument makes sense on the surface, but in reality it will exacerbate a problem that ASCs have in providing certain services to Medicare beneficiaries. CMS's failure to reimburse ASCs for imaging procedures provided in conjunction with surgery is a problem for many ASCs. Not covering imaging procedures results from the outdated approach to the ASC list. When developed in 1982, surgery and imaging technology were separate and distinct procedures. In 2003, however, increasingly the two are used together. For Medicare to fail to recognize this demonstrates an antiquated view of current practice. Since imaging is required when performing certain procedures the ASC provides the imaging service but is not reimbursed for doing so. It is patently unfair to expect a provider deliver services and not be reimbursed. Nonetheless, many ASCs are doing so. The best solution would be to add imaging procedures used in surgery to the ASC list or to increase the facility fees for procedures which have a radiologic component to cover the costs of providing imaging service. However, in the absence of such a change these procedures should not be deleted. With these procedures on the ASC list, the ASC can at least get paid for providing the injection that was needed for the imaging. Deleting this partial payment from the ASC list will further impede ASCs in providing appropriate care to Medicare beneficiaries. One of these, CPT 51600, ASCs provided 1,200 times in 2001, the second highest volume item of the procedure being deleted, so denying coverage will affect many beneficiaries.

## CONCLUSION

In closing, although this final rule expands Medicare beneficiaries' access to the ASCs, this rule does not do as much as it could for improving access to ASCs. By applying the criteria for being on the ASC list in narrow way, CMS limits ASC services. Moreover, by paying grossly inadequate rates in some cases CMS offers ASCs little incentive to offer Medicare beneficiaries services, often increasing costs for the program and its beneficiaries. As noted, sometimes these actions are not only hurting Medicare beneficiaries but private pay patients as well.

FASA is eager to work with CMS to address these issues and others so that Medicare beneficiaries will have access to the many benefits ASCs offer.

Sincerely,

A handwritten signature in black ink, appearing to read "Kathy Bryant". The signature is written in a cursive, flowing style.

Kathy J Bryant  
Executive Director