

## How to Profit From Pain Management Services

Are you ready to enhance your Ambulatory Surgery Center and help a growing number of patients needing and requesting pain management procedures? ASC's can count on basing a very satisfactory level of profit from pain cases by successfully handling these six elements of operations:

1. Volume of procedures performed
2. Case cost versus reimbursement
3. Staffing levels
4. Case selection
5. Managing contracts
6. Scheduling

**Volume** considerations include types as well as the complexity and time involved in procedures performed. Usually anywhere from 2,400 to 3,000 separately billable procedures (not patient encounters) per year will support the expenses of one Class B operating room. As many pain procedures involve bilateral injections and/or multiple levels, each encounter can yield several full facility fees. The volume count starts with billable equivalents rather than patient encounters. Profitability increases dramatically as the procedure volume goes beyond the break-even point.

Financial benefits and advantages of **Case Cost versus Reimbursement** for ASCs offering pain management can be significant. Most Pain Management procedures in an ASC are typically well paid - quick turnaround and relatively low cost per case with only a short recovery time needed. A pain management physician is generally able to perform as many as four procedures per hour with nursing and ancillary staff time being brief as well, thus maximizing the productivity of both the facility and staff. A busy pain management physician typically tops 3,000 billable procedures in a year.

Many of the more commonly performed pain management procedures fall into the Medicare APC which currently yields (2008) an unadjusted national allowance of \$322.77. Additionally, Medicare, and the vast majority of other payors as well, pays 100 percent of the highest payment for multiple procedures or additional levels/bilateral in a single session and 50 percent for each additional procedure.

For other payors as well, ASCs that offer pain management often have an advantage. At the current time, Commercial payors typically reimburse some percentage of Medicare's prior fee schedule. Many of the considered office based procedures were non-grouped (off list) on Medicare's prior grouper system and are often paid at a percentage of billed charges or a flat rate.

In ascertaining the potential revenue the next move is running a payor mix report. Adding new services will require going back to review all the Managed Care Contracts. It is critical to identify the current fee schedule and list of covered services. Negotiations on the facility contract should incorporate exclusions as applicable. Determine their policies on what is included in the facility fee rate. Some payors may reimburse additionally for the technical component of fluoroscopy and drugs/supplies in addition to the flat rate for the facility fee. Commercial and Workers Compensation plans can allow up to 300% of Medicare. However, some states do have a facility fee schedule for Workers Compensation. Texas and California are examples of set facility fee schedules that came into play just this year. Texas

is now at 213% of the Medicare facility fee schedule while California Workers Compensation has based their ASC facility fee schedule at 125% of the HOPD, OPSS payment system

**Managing contracts** calls for extensive dealing with insurers who expect to pay for only one procedure per patient encounter regardless of the type of procedure. During the same encounter physicians treat pain both bilaterally and at additional levels in order to get better results than when they must bring back the patient a month or even a day later to fit insurer requirements. Not only is it often better for the patient but also this approach is cost effective for the carrier, who then does not have to pay at 100% when the patient returns.

Some pain procedures are not on Medicare's payment list for ASC facility reimbursement. These procedures then fall under Medicare's site of service differential rule, meaning that professional fees are paid at the higher "office" site of service differential. As to facility fees, a Medicare patient cannot be billed or asked to sign an Advanced Beneficiary Notice (ABN) or Notice of Exclusion of Medicare benefits (NEMB) for facility fees when the procedures are not on the approved list for a Medicare-covered procedure. Payment to the surgeon is inclusive of the entire procedure

Physicians who do not have ownership interest in the ASC may wish to enter into a contractual agreement with the ASC whereby they compensate the ASC a market value fee will allow them to perform services on Medicare beneficiaries that are not on the ASC covered list. All contractual agreements should be carefully reviewed by Healthcare counsel to ensure that they are in compliance with all Federal and State Laws.

There is language in all Commercial Managed Care contracts as to how non covered services may be billed to the patient. The contractual agreement usually requires the provider to notify the patient in writing prior to the procedure that his/her insurance plan will not cover a service after which payment can be collected from the patient.

Proper **Staffing** is primarily responsible for operational productivity and efficiency and is it is the major ASC expense. The break-even point is significantly affected by the choice of staffing levels -- typically 45-50% of overall operational costs. Even a 10% change in staff can yield 4-5% change in profit.

For example, some state regulations allow the surgeon to operate the C'arm. This may save communications time and personnel costs. Those few minutes added to physician time could cost far less than having a Certified X-ray Technician remain in the OR throughout the procedure. Alternatively, many ASC's find that a well trained Technician saves procedure time and enhances overall efficiency both pre, intra and post procedure by positioning the patient and C'arm, setting the parameters of the machine, taking the films as well as turning over the room.

During the procedure the Registered Nurse who is monitoring the Conscious Sedation cannot have any other duties. A trained Medical Assistant to help with supplies, etc. is then the most cost effective way to have as an aide to the surgeon during the procedure. A Medical Assistant or Technician can also prepare the room for the next patient, assist patients and take relevant telephone calls

While Monitored Anesthesia Care by a separate provider may be desirable in some procedures, Local Coverage Determinations from Medicare Carriers may preclude payment for such care for the majority

of patients. Some Managed Care facility contracts include Anesthesia. If the contract proposal for the facility is inclusive of Anesthesia, and most of your cases require the use of a separate Anesthesia provider, make this an opportunity for negotiation.

In adding pain services to an existing ASC, the only significant capital cost is for the C-arm and fluoroscopy table, if they are not already on site for other specialties and procedures. Many companies now re-manufacture demo or used models and provide them with a good warranty for 50% less than new ones.

Direct costs per pain management case might only relate to the epidural tray, injected drugs and contrast material. Approximately \$125,000.00 would cover:

- Refurbished C-Arm
- Fixed height Basic Imaging Table
- RF unit
- Patient Monitoring Equipment
- Transportable stretcher
- Recovery recliners
- Crash cart package
- IV Poles and
- Physician/Nurses stools.

The next step is to calculate the costs associated with adding these pain mitigation procedures. Start with the cost of major medical equipment. Then include all drugs and supplies needed per case. Include costs of Anesthesia type and coverage. Determine extra staffing additions such as more RN coverage and/or X-ray technologist required. Then consider procedure time allotment for both the pre-op area, OR and Recovery Room. This is especially important when combining new specialties. For instance an ASC devoted to GI procedures that are accustomed to doing only two cases per hour will have to adjust to setting up for and scheduling a new specialty like Pain Management which typically turns over four cases per hour.

In considering Pain Management **Case Selection** actual procedure selection gets a little more complicated with certain invasive procedures when reimbursement may not be much above actual cost. One such example may be Percutaneous Disc Decompression (CPT 62287) which Medicare pays a national total reimbursement average of \$1348.61. The problem is that this procedure calls for a consumable Percutaneous lumbar discectomy probe that will be used once and can cost up to \$1,100. The ASC must negotiate a carve out for this consumable probe (Pass Through Code for the decompressor device (C-2614) with other payors if the payment is less than the cost of performing the procedure. It is also imperative to review your Medicare Carriers local coverage determinations and other payors for their non-coverage policies. Insurers such as Aetna, Cigna and the majority of the Blues consider Nucleoplasty investigational and have published non-coverage decisions. Trailblazers and Noridian Medicare Carriers for several states, determined not to cover this, believing it inappropriate to bill the Nucleoplasty also have policy statements whereby they require Nucleoplasty to be reported using the unlisted procedure code 64999. The result is a long delay to receive payment, if ever paid.

Another arena that may be fraught with coverage difficulty is Implantables. Medicare's payment is inclusive of the device(s). Total case cost management including the actual device is mandatory. The ASC may likely spend more than it gets back for physician time and ancillary staff resources.

Decide the acceptable kinds of cases you want to take on. What are your revenue expectations per work hour or per work year? Imagine doing four cases in an hour that can generate multiple facility fees versus one case that generates a single facility fee with longer OR and recovery time. Some of those longer cases, while possibly satisfying to complete, will bring in far less per hour than several short ones.

Adding new technologies to your site can increase revenue and provide practice enhancement in variability and volume. First -- before you purchase new equipment or start offering new procedures -- do your cost effectiveness homework. Be sure that your staffing and space can support new procedures. Figure out how many new cases you must take to offset basic costs before profit kicks in. Research the likelihood of procedure usage.

**Scheduling** is most effective when you block the same and similar procedures back to back.

- Set your goals for sets of 4 injections or blocks per hour, for example.
- Schedule a longer or more complicated case as the last case of the day with enough staff time allotted for recovery monitoring.

If efficiently scheduled, adding pain management services can increase revenue and provide ASC enhancement. For existing ASCs concerned with the costs of adding pain management services, a change to the physical environment would most likely not be necessary if the facility is already certified to perform anesthesia services at a higher level than required for procedures performed with moderate sedation. With the right guidance and an ongoing commitment to compliance with your State's License provisions and Medicare's Conditions for Coverage, even developing and operating a start-up pain management ASC need not be an intimidating endeavor.

When you are ready to offer such services, arranging marketing targeted to bone fide referral sources will produce all the patients you can handle!