

## **WEIGHING THE RISKS AND REWARDS OF INCREASING YOUR ASC'S SERVICES**

To evaluate whether to add new procedures, first determine whether the procedures in that specialty fall into the same class as the ASC license. As a general rule, it is the type of Anesthesia used and/or the procedure type and risk of infection that governs the type of procedures approved for that type of facility. In an unlicensed facility, many times, a single specialty ASC, but one that is Medicare Certified, adding new procedures simply becomes a function of the bylaws. Tread carefully....if the ASC is approved by the State as a single specialty, adding new procedures performed by another specialty may require a change in Licensure.

Bylaws may restrict the addition of new services based on ownership and/or type of ASC. Step one is to ascertain whether these bylaws can be changed and whether this becomes a legal issue, a governing board issue or a state jurisdiction issue. For instance, the bylaws may indicate that in order to add services to an existing delineation of privileges, the provider must be re-credentialed, adequately trained, proof of a certification course or perhaps even mentored. The same would apply to approve a new provider with a requested delineation of privileges that would be a new service for the ASC.

Although some State Departments of Health use their own building code and do not refer to the following "Classes", these distinctions as set forth by the AIA Design and Construction of Health Care Facilities can be used as a reference.

Class A-local sedation  
Class B-moderate sedation  
Class C-general anesthesia

Look closely at the advantages and disadvantages of adding procedures of the same specialty or a new specialty that would require a higher level of Anesthesia. For instance, some new technology procedures may require changes to your existing physical environment. If the facility is only approved for local and/or Moderate Conscious sedation, adding procedures that require general anesthesia will mean additional increase in air quality, medical gases, power backup and certainly in building cost and construction will mean down time. Evaluate the cost of greater square footage, higher increases in the quality of finishes, fire protection, air quality standards and other requirements before you add to your scope of services.

To begin the calculation of potential revenue generation, let's start with Medicare reimbursement. Start by looking up the ASC payment for the procedures performed by that specialty for precise Medicare revenue analysis since all payors base their reimbursement on some form of Medicare payment. Then calculate the amount with the Geographical Adjustment Factor for that location.

The next step in ascertaining the potential revenue is to run a payor mix report. Adding new services will require going back to all the Managed Care Contracts. You may find that these fee schedules are tied to the Medicare payment groups at a percentage of the National Average Allowance. Generally the contract fees are subject to change based on the contract with the payer. It is critical to identify the current fee schedule and list of covered services. Most Managed Care contracts typically do not send their entire fee schedule that represents all of their approved fees. For procedures that are not listed on their fee schedule, it is important to ascertain how non-covered services will be paid, such as fee for service and at what percentage of billed charges. Negotiations on the facility contract should include exclusions. Determine their policies on what is included in the facility fee rate. Many MCO's will reimburse for the technical component of fluoroscopy or other X-rays and drugs/supplies in addition to the flat rate. Bear in mind that some Managed Care facility contracts include Anesthesia. If the contract proposal for the facility is inclusive of Anesthesia, make this an opportunity for re-negotiation.

Commercial and Workers Compensation plans can be up to 300% Medicare. Some States have set facility fee schedule for Workers Compensation facility reimbursement and many publish their fee schedule-<http://www.comp.state.nc.us/ncic/pages/all50.htm>.

Don't assume that all Workers Compensation and private payors follow the same reimbursement rules. Get written confirmation by providing a detailed description of the device, drug or procedure which may require that you send supporting documentation and information from medical and industry associations or the CPT Advisory Panel.

The next step is to calculate the costs associated with adding these 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. Extra staffing additions i.e. more RN coverage and/or X-ray technologist required. Then look at procedure time allotment for OR and Recovery Room. This is especially important when combining new specialties. For instance a GI ASC that is accustomed to doing only 2 cases per hour may have trouble keeping up with a new specialty such as Pain Management which typically turns over 4 cases per hour. Prepare for change by recognizing that different specialties vary significantly in time and resources. Some procedures in group 1 can be performed at 3-4 procedures per hour making the benefit ratio greater than the reimbursement for one higher group procedure per hour. One advantage to adding fast moving cases such as pain management is that many procedures involve bilateral injections and/or multiple levels so each procedure can yield two to three facility fees (multiple procedure 50% rule). Adding procedures with short procedure and recovery time; such as pain, cataracts, some arthroscopic procedures or podiatry can maximize the productivity of both the facility and staff.

Now, create a checklist to include the following:

1. Valid CPT code for each procedure? Do not rely on manufacturer, vendor, supplier or company representative to provide you with this information.

2. One or more valid ICD-9 codes to support medical necessity?
3. Will all payors accept the code?
4. Do all payors have a straightforward process for reimbursement?
5. Is the reimbursement at an acceptable level?
6. Will payors reimburse for additional equipment or drugs that the product or procedure must be used with?
7. Attach written verification from the manufacturer, your Medicare carrier, private payors, Regional CMS office, and/or CPT Advisory Panel.

Adding new services can increase revenue and provide ASC enhancement. Research is the key to success before you purchase new equipment or start offering new procedures.

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