Pain Management in ASC’s

Current Methods to Increase Profits

This Business of Pain

- Patient’s need to resolve their pain disorder… think about the patient’s experience in your ASC from scheduling to discharge.

  You must offer prompt, courteous, compassionate and professional services.

  AND..,

  You should be offering the most advanced, market driven, proven techniques at a fair fee.

Successful Scheduling

- Blocks and Injections first
  - 3-4 patient encounters per hour

- Then more involved OR cases, i.e. neurolytics, discography, for last of the day or intermingle any long case to be done right before lunch so that discharge by the afternoon is probable
  - 2 patient encounters per hour

- But, cases that require longer recovery time should be the first slots.
**Efficiency**

An ASC that is accustomed to doing only 2 cases per hour may have trouble keeping up with a specialty such as Pain Management.
- Don’t give up, make adjustments.

Above all else, STAY ON TIME. If you are running behind, keep your patients and their responsible party (driver) apprised.

**Cross Train Staff**

- Train Radiology and/or surgical technicians to:
  - Process sterile supplies
  - Take vital signs
  - Place patients in pre op rooms for RN
  - Assist in PACU to discharge patients.

**Retain Your Physicians**

- Understand the SOS Differential
- Be well versed on overhead and State Regulations affecting Office Surgery
- Offer ownership shares at fair market value without creating an unrealistic sense of empowerment
**State Regulations**

- 28 State Health Departments have jurisdiction on office based surgery
- Typically involves:
  - Levels of anesthesia used and/or
  - Complexity of procedure performed
  - Licensed
  - Registered
  - Accredited

**Anesthesia Provider (s)**

- Credentialing vs. Privileging.
  - Pain procedures training and insurance vs. a separate Anesthesia provider for another pain physician. Billing opportunity?
- LCD’s - Check Part B Medical Necessity Guidelines
- Who can supervise as well?

**Manipulation Under Anesthesia**

- Who is credentialed to provide this?
  - Who should be privileged to provide this?
- What are your revenue expectations?
- Will your payers recognize this?
Payer Mix and Negotiations

- Take avenues to change the percentages.
  - Know what you can offer to the plans enrollees, other participating providers and their patients.
- What Sets You Apart from the Competition?
- Utilize demand for these types of services, your physicians' and ASC's expertise, familiarity in your area, community, language… in your favor.

Review Payer Policies

- Is the fee based on Medicare's former ASC payment groupers? Same mapping?
  - Which is better for your ASC? New or old??
- How are off list (non-grouped) procedures paid?
- How are implantable devices such as spinal cord electrodes and stimulators and/or drug infusion pumps paid?
- Other carve outs? Percutaneous Disc Probe-C2614?
  - Is the procedure covered anyway? 62287 coverage…

Commercial Payer Policies

- How are multiple procedures paid?
  - Case Rate? Make sure it high enough to cover 3-4 billable procedures.
- How will they pay the technical component of C-arm and/or US use?
New Facet Joint Codes

<table>
<thead>
<tr>
<th>Previously</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>64470 – 1st</td>
<td>64490 – 1st</td>
</tr>
<tr>
<td>64472 each add'l</td>
<td>64491 – 2nd</td>
</tr>
<tr>
<td></td>
<td>64492 – 3rd +</td>
</tr>
<tr>
<td>64475 – 1st</td>
<td>64493 – 1st</td>
</tr>
<tr>
<td>64476 each add'l</td>
<td>64494 – 2nd</td>
</tr>
<tr>
<td></td>
<td>64495 – 3rd +</td>
</tr>
</tbody>
</table>

Advise payers that 64492 & 64495 should be reimbursed at a higher fee.

Important Policies For Pain

- CLEAR financial policies on your charges for cancellations or no-shows (PREVENTION is #1)
- Collect all co-pays and co-insurance at time of service, offer payment plans and “Care Credit”.
- Verify Eligibility
- Pre Certification/Pre Authorization
- Valid Referral?
- Pre Procedure tests obtained?
- Medicare “non grouped” (off-list) procedures?

Billing

- Know the nuances of pain billing
  - Bundling issues?
  - Covered diagnosis? Medical Necessity?
  - Know what modifiers apply to the ASC
  - Be aware how each payer wants bilateral and multiple procedures reported.
  - Are there procedure limits?
PLEASE negotiate on your epidural and nerve block trays – GPO’s or purchasing organizations can help save significant $. Or,
Consider picking items off the shelf vs. using packs, the amount of time it takes to pull the 10 things you need for a pain case takes seconds.

<table>
<thead>
<tr>
<th>Top 6 Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
</tr>
<tr>
<td>27096</td>
</tr>
<tr>
<td>62311</td>
</tr>
<tr>
<td>64483</td>
</tr>
<tr>
<td>64490</td>
</tr>
<tr>
<td>64522</td>
</tr>
<tr>
<td>64523</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item Description</td>
</tr>
<tr>
<td>Epidural Tray</td>
</tr>
<tr>
<td>Contrast Dye</td>
</tr>
<tr>
<td>Equipment</td>
</tr>
<tr>
<td>Staffing</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>
Adding More Invasive Procedures

The good and not so good...

Spinal Cord Stimulator

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT/HCPCS Codes</th>
<th>Medicare Bundled Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implantable Neurostimulator Electrode Array</td>
<td>63650 + L8680</td>
<td>$3,495.46</td>
</tr>
<tr>
<td>Implantable Neurostimulator Pulse Generator</td>
<td>63685 + L8687</td>
<td>$12,877.21</td>
</tr>
</tbody>
</table>

Spinal Cord Stimulator Trial and Permanent CY 2007 Group 2 = $446
Plus L8680 (Electrode Array) lead $375.52-$502.12 – (Cost: $800-$1500 per lead)
Plus L8687 (Generator) $13,052.03-$18,602.70 (Cost – up to $20K)

Other Payers Equipment Payment

- CMS’ revised ASC payment methodology has not been implemented by all non-Medicare payers
  ASCs should continue to charge non-Medicare payers for procedure and equipment unless contractual agreements have been revised
  Unlike CMS, non-Medicare payer payment methodology is not transparent
  Should be tracking payer allowances for expensive equipment
Thermal Intradiscal Procedures (TIPS)

- CMS has a National Coverage determination (NCD) that TIPS are not reasonable and necessary for the treatment of low back pain.

- TIPS include procedures that employ the use of a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc.

Disc Procedures Using Thermal Or Radiofrequency

- Intradiscal electrothermal therapy (IDET)
- Intradiscal thermal annuloplasty (IDTA)
- Percutaneous intradiscal radiofrequency thermoablation therapy (PIRFT)
- Radiofrequency annuloplasty (RA)
- Intradiscal Biacuplasty (IDB)
- Percutaneous (or plasma) disc decompression (PDD) or coblation
- Targeted disc decompression (TDD)
- SpineCath
discTRODE
- SpineWand
- Accutherm
- TransDiscal electrodes
- DISC-FX
- SED (By Yeung)

Conundrum

The MCR NCD does not include procedures that do not utilize radiofrequency energy source or electrothermal energy

The code description for CPT 62287 Decompression procedure of nucleus pulposus of intervertebral disc... describes "any method". When mechanical or laser methods are used, Medicare carriers / contractors may deny the service based on the NCD in error.
Discography

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>ASC MCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>62290</td>
<td>Discography, lumbar</td>
<td>0.00</td>
</tr>
<tr>
<td>62291</td>
<td>Discography, cervical</td>
<td>0.00</td>
</tr>
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</table>

Make sure you have identified this on the physician's delineation of privileges for MCR patients. Make sure that other payers reimburse appropriately.

Vertebroplasty

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>22520</td>
<td>Vertebroplasty (Thoracic)</td>
<td>$1,274.83</td>
</tr>
<tr>
<td>22521</td>
<td>Vertebroplasty (Lumbar)</td>
<td>$1,274.83</td>
</tr>
<tr>
<td>22522</td>
<td>Vertebroplasty - Additional</td>
<td>$1,274.83</td>
</tr>
</tbody>
</table>

- Twice the complexity and time of most pain procedures.
- Properly selected patients. Increased risk, infections, complications.
- Cement Kit - $500.00. Additional levels?

Kyphoplasty

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>22523</td>
<td>Percut kyphoplasty, (Thoracic)</td>
<td>$3,551.40</td>
</tr>
<tr>
<td>22524</td>
<td>Percut kyphoplasty, (Lumbar)</td>
<td>$3,551.40</td>
</tr>
<tr>
<td>22525</td>
<td>Percut kyphoplasty, Add on</td>
<td>$3,551.40</td>
</tr>
</tbody>
</table>

- Turf Battle-Neurosurgeons, Interventional Radiologists.
- More often performed in HOPD.
- Costs run about $3,000.
Ancillary Billing Opportunities
(20610-Large Joint Injection)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7321</td>
<td>Hyalgan/supartz inj per dose</td>
<td>K2</td>
</tr>
<tr>
<td>J7323</td>
<td>Euflexxa inj per dose</td>
<td>K2</td>
</tr>
<tr>
<td>J7324</td>
<td>Orthovisc inj per dose</td>
<td>K2</td>
</tr>
<tr>
<td>J7325</td>
<td>Hyaluronan or derivative, Synvisc or Synvisc-One</td>
<td>K2</td>
</tr>
</tbody>
</table>

**K2 - Drugs and biologicals paid separately**

Final Thoughts

- Be aware of what is going on in the pain management industry.
- Know what Medicare is planning next and how it will affect your bottom line.
  - Any ASC with adequate pain management procedure volume to keep staff productive and equipment busy will be profitable

Helpful Links and Resources

- 2010 Pain Management Service Fee Table (Excel) www.mowles.com
- Part B News - registered trademark of UCG/DecisionHealth www.partbnews.com
Pain Management in ASC’s
Improving Profits