Explosive growth in ASC codes fuels opportunity

April 23, 2019 | BETH FERGUSON, CIRCULAR HEALTH

Since the introduction of the concept of an interventional radiology suites registry project (“INTERACT” in 2016), there’s been an explosion in the number of billing codes that permit an ASC to collect for interventional outpatient procedures.

Simply put, more billing codes means more opportunity for interventional radiologists and their groups to profit from ASC ownership, in a core procedure-wise, it also means higher patient satisfaction, increased professional satisfaction, and building of a new revenue stream that is not dependent on payors and patients when compared with single procedural performance in hospitals or hospital outpatient settings.

To understand what an ASC is, it’s essential for radiologists to understand what an ASC is. An ASC is not an institutional setting where radiologists will perform the majority of their work. Simply put, an ASC is a building.

As radiologists know, imaging services are reimbursed based on two components—the technical component, which reimburses the center for the use of the equipment and the personnel performing the act, and the professional component, which reimburses the radiologist for the interpretation.

Hospitals, by contrast, are reimbursed based on the services rendered. They’re certified, licensed, operated and reimbursed on the same basis as ASCs by the same billing authorities, yet ASCs are reimbursed differently than hospitals and ASCs can be reimbursed more for the same procedure.

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However, with an eye to 2025 as the baseline, consider the following:

In its 2019 Advocacy Survey (Cyste Health), Medispecx addressed approximately 117 IT procedures code.

As in 2017, Medispecx added close to 50 new codes to the list, creating a total of over 250 CPT codes making ASCs financially viable.

And as we, for 2018, Medispecx has added an additional 176 ASC codes.

This is why the beginning. It forecasts even greater expansions of medical ASC codes over the coming years. The number is only going to increase as more and more procedures are performed in ASCs today and moving procedures currently performed in hospitals to the ASCs as their target goal. To this end, we can expect more and more codes, including more codes for services.

This cost savings push to the ASCs is having another, positive impact. It appears that the advancement of the centers on the rise of both interventional and diagnostic radiologists and their practices that develop an ASC will make these centers more competitive with hospitals.

However, the inescapable fact is that payers will bill procedures directly to the hospital as the procedure is being performed.

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But simply looking at what Medicare pays, consider the following examples of scheduled ASC fees:

- **CPT code 32315**, “insertion of pacemaker pulse generator only, with existing dual leads,” generates Medicare to ASC reimbursement of more than $1,400 and, over a little over $150 in ASC fee as well.

- **Anc CPT code 34756**, “milky subarachnoid,” yields Medicare ASC reimbursement of more than $600.

- If such same procedure performed in a physician’s office would yield a Medicare Office-Based Surgery payment of approximately $350.

Getting Started

Correctly, since the interventional procedure, the training program starts with an analysis of projected cases, value columns, and courses, costs of treatment and preparation. Although it is an ASC as an out-patient service, the interventional procedures can be performed inASC setting for an all-inclusive facility plus all physicians’ fee. However, the amount of $10,000 to $15,000 and still be quite profitable to the ASC due to the much lower surgery center cost.

A Budding Business Opportunity

The facility side reimbursement for interASC cases runs well into the four figures per procedure.

Due to inter-strict restrictions, we can’t reveal actual figures in connection with contracted (as opposed to Medicare fee schedule) rates. However, some interventional radiology procedures that would result in a hospital charge in the range of $35,000 (exclusive of any physician fees) can be performed in an ASC setting for an all-inclusive facility plus all physicians’ fee. However, the amount of $10,000 to $15,000 and still be quite profitable to the ASC due to the much lower surgery center cost.

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