GROWING YOUR ASC BUSINE$$

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Where is the business opportunity for ophthalmic ASCs?

Ophthalmic ASCs weathered the storm of a new Medicare ASC reimbursement scheme relatively unscathed. We were neither winners nor losers which, given our substantial dependency on CMS as a payer, is good news. While much has been written about the significant decrease in the yag laser facility rate, for example, ophthalmic ASCs have long viewed that revenue as a "gift" to be appreciated while it lasts. Yag procedures should never be considered "anchor" volume or revenue. Offsetting the yag rate decrease was the addition of several oculoplastic procedure codes to the approved ASC list and increased reimbursement for retina.

Shifting demographics and the emergence of new technology and premium IOLs have had a positive impact on the growth of cataract procedure volume. This is key because ophthalmic surgery is, above all else, a volume-driven business. However, the NTIOL and premium IOL market has not translated into significant revenue opportunities for ophthalmic ASCs. Many third-party payers do not cover the $50 NTIOL reimbursement. Because patients have to pay out of pocket for the premium IOL difference, ASCs face pressure from surgeons to keep the out-of-pocket cost low. In the case of Medicare cataract patients opting for a premium IOL, regulatory constraints preclude ASCs from capitalizing on this out-of-pocket difference as a revenue opportunity.

So where is the business opportunity for ophthalmic ASCs? The "typical" ophthalmic ASC is a cataract center. This well-established healthcare delivery system embodies phenomenal economy, efficiency, and depth of expertise relative to other specialty and multi-specialty ASCs. When evaluating growth opportunities, the ideal would be to build upon the strengths of this model. This begs the question, have we exhausted the opportunities within surgical ophthalmology, before we consider integrating another specialty into the mix?

Subspecialties to Consider

Do you have an oculoplastic surgeon in your community? This subspecialty is an easy assimilation into a typical ophthalmic ASC. Oculoplastic surgeons are often willing to operate on Friday and in the afternoons, which works nicely in cataract centers. There is little or no capital investment required. You probably have enough extra instruments in peel packs to put together an oculoplastic instrument tray, and the growth in lid procedures is being assisted by the boomer bubble entering their senior years.

Reimbursement for glaucoma procedures such as laser trabeculoplasty, trabeculectomy, and glaucoma drainage implants benefited from the recent shift in Medicare reimbursement, and projected payment trends for these procedures look increasingly attractive through 2011 (**Table 1**). However, Medicare facility fees now include the cost of eye implants, so profitability can be challenging. Shrewd contract negotiation, carve-outs for highly priced supplies, implant pre-certification, and accurate procedural coding are essential. Adding glaucoma to an established cataract program requires minimal if any capital outlay, but there are operational considerations. Glaucoma procedures take longer than cataract procedures and the patient profile is different. More often than not, these surgical patients have had a failed trial of drug therapy and suffer significant discomfort associated with increased intraocular pressure.

Retina has been on the table since the proposed CMS reimbursement changes were published in mid-2007. In the past it was difficult to impossible for most ophthalmic ASCs to make a retina service profitable. However, an increase in reimbursement in 2008, followed by expected further increases over the next three years, has prompted many centers to take another look at the viability of a retina program in their center. Making retina profitable is more challenging than cataracts, though, and warrants thorough investigation.

If you go this route, be prepared to spend around $100,000 on capital equipment, depending on your current equipment inventory. Recent advances in small-gauge surgical techniques (23- and 25-gauge) are more expensive but can reduce surgical time. Supply cost per case for retina procedures can range from $500 to $1000. Two supplies that make a huge impact are perfluorooctane and silicone oil. These two items can add

CPT	Procedure	2008	2011
65855	Laser Trabeculoplasty	$148.54	$148.54
66170	Trabeculectomy ab externo	$712.38	$959.50
66180	Glaucoma drainage implant	$948.76	$1644.04
67036	Removal of inner eye fluid	$857.61	$1540.44
67039	Vitrectomy & laser treatment of RD	$1131.36	$1540.44
67040	Vitrectomy & PRP laser treatment	$1131.36	$1540.44
67041	Vit w. mebrane peel, mac pucker	$1540.44	$1540.44
67042	Vit w. mebrane peel, AFX, C3F8 (mac hole)	$1540.44	$1540.44
67043	Vit w.complex membrane peel	$1540.44	$1540.44

Table 1. Reimbursement for ophthalmology subspecialty procedures

CPT	Procedure	2008	2011
45378	Diagnostic colonoscopy	$426.09	$366.34
43239	Upper GI endoscopy w/bx	$422.51	$352.03
28290	Correction of bunion	$638.97	$1217.88
28296	Correction of bunion	$686.97	$1217.88
28308	Incision of metatarsal	$550.08	$862.32
28110	Part removal of metatarsal	$598.08	$862.32
28112	Part removal of foot bone	$598.08	$862.32
28285	Repair of hammertoe	$598.08	$862.32

Table 2. Reimbursement for opportunities outside ophthalmology

an additional $800 to $1000 to the cost of the procedure. Even with increased reimbursement rates, these unreimbursed supply variables can make it impossible to break even on those cases.

Finding a retina surgeon who appreciates the "ASC mentality" is key. Patient selection is also critical. Complex and emergency cases are more appropriately done in a hospital setting. Treatment of macular holes and puckers can be executed efficiently and predictably. Operational implications for retina include longer cases, longer recovery time, less stable patients, and the need for staff training.

Best Bets Outside Ophthalmology

So what makes a good fit after you exhaust the opportunities within ophthalmology? The distinguishing hallmarks of a successful cataract program are high volume and rapid turnover. The procedure is generally predictable, minimally invasive, and requires minimal anesthesia. These distinctions are important contributors to profitability so it would make sense to seek out other business lines that share those characteristics.

Gastroenterology is another high-throughput specialty. Two procedure codes comprise most of the cases. The procedures are short (15–30 minutes), allow for rapid turnover, and require minimal sedation. Few supplies are used so costs are low, particularly when compared to cataract surgery. However, reimbursements are relative (GI was adversely impacted by the recent shift in Medicare rates; see **Table 2**). Like cataracts, GI is largely dependent on the senior population, so it gets a boost from shifting demographics. Capital investment runs between $200K and $250K. The endoscopes require diligent care and handling to avoid expensive repairs.

Pain management is another specialty that lends itself to a high-vol-

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Q&A Questions from the ASC List

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This new discussion group focuses exclusively on issues relating to Ambulatory Surgery Centers. The eGroup List Leader is industry optical expert Regina Boore, RN, BSN, MS. The list is an ASOA member benefit. Sign up today by visiting http://community.asoa.org/ and clicking on "My Subscriptions" to log in with your user name and password. Questions on how to use the service? Email Susan Younker (susan@asoa.org).

Q: We have a very young ASC—two years old—and are trying to make a decision about whether or not we should accredit our facility. How do you feel about accreditation at this time? We currently have no insurance plans that require any accreditation other than the State Health Department/Medicare approval. If you would accredit your facility, who would you use, AAAHC or Joint Commission or someone else?

A: There are two primary reasons to pursue accreditation. The first is payer driven. If you have not had any payers demand it yet, you might consider the option of proactively pursuing it to avoid a potential obstacle to contracting. If you wait until a payer demands it, you may be precluded from accessing those patients for a period of time until you get it.

The second reason is just to force yourself into a cycle of making sure you "keep your house in order." As an accredited facility, you will never go more than three years without a survey, which keeps you from falling into complacency or getting lax about regulatory compliance and quality management and reporting.

There are four accrediting agencies you can consider:

- AAAHC.org (uses volunteer surveyors)
- JointCommission.org (more prescriptive expectations: root cause analysis, risk trackers)
- AAAASF.org (started to serve cosmetic surgery centers; has since expanded to other specialties)
- HFAP.org (an arm of the American Osteopathic Society; expanding presence in ASC arena)

I have had experience with all four agencies and in my opinion there are pros and cons for each one. AE

ASC – *from page 59*

ume, rapid turnover operation. Efficient pain centers can turn 40 or more cases per OR per day. Few CPT codes, predictable, short duration procedures, and minimal sedation make this business line very compatible with cataract surgery. Like GI, however, pain management reimbursement was reduced in 2008. The 2008 reimbursement rate for most pain procedures is $322.77, decreasing to $292.07 in 2011. Unlike GI and ophthalmology, pain procedures frequently involve more than one CPT code. The capital expense for pain procedures includes a C-arm and radiolucent top table.

Podiatry is another specialty that fits well with ophthalmology. The procedures typically involve a block and minimal sedation. Because of the block, recovery is rapid. Supply costs are modest and reimbursement is good and getting better in the next three years. Correction of bunions and repair of hammertoe tend to be the highest-volume procedures. Instrumentation, a tourniquet, and micro drill are required equipment purchases.

Other Opportunities

Gynecology, ENT, general surgery, and orthopedics require general anesthesia. ENT has a pediatric component, which has operational implications for staffing, supplies, and equipment. That doesn't mean they cannot be successfully integrated into your organization. It just means there are operational implications that will require evaluation and adaptation. It's all about finding the right opportunity to grow your business! AE

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