Over the past several years ASCs have seen an increase in the performance of musculoskeletal procedures. Outpatient type procedures account for approximately 63% of all surgeries performed in community hospitals nationwide. Advances in surgical technology and anesthesia allows more complicated procedure to be safely performed in the ASC setting, in addition, healthcare policies have created economic incentives that encourage this type of setting. It’s a win-win for both the surgeon and the patient.

Musculoskeletal procedures are three of the 10 most common ambulatory surgery procedures. In 2003, procedures related to the musculoskeletal system were performed in nearly 26% of all ambulatory surgeries. One third of ASC claims submitted to Medicare are musculoskeletal procedures.

CMS will reimburse ASCs on the basis of a uniform percentage of the rates paid to Hospital Outpatient Department’s (HOPDs) for the same service, some services will be reimbursed higher than HOPDs and some services will be paid less in the ASC rather than the HOPD. HOPDs historically acquire more costs due to budget neutrality, hospital costs (e.g. 24 hour staffing), treating the uninsured and higher safety standards. ASC will be reimbursed at the rate of 65% which will be transitioned over a four-year period. They will allow special payment rules to avoid disruptive cuts in payments.

As the graphs 1- and 2 show on next page, even most procedures will increase during the first year of transition with substantial increases by the time fully implementation is done. In addition ASCs will now receive the same annual updates and other relevant adjustments as HOPDs.

Key items to watch for are utilization of unlisted procedures. CPT does not always keep current with newer technology and many times, by the time CPT codes are implemented the procedure has been performed for a number of years. Medicare will not allow payment for unlisted procedures in the ASC facility, but the physician will still be reimbursed.

New CPT codes will be updated on an annual basis and will be reimbursed at the full national rate without subject to the transition period. An example is CPT code 29828 for Arthroscopic biceps tenodesis will be reimbursed at the 2008 rate of $1892.32.

There were major changes and new codes added to CPT for 2008. These are also af-
Some of the different aspects that will affect Orthopedics are:

<table>
<thead>
<tr>
<th>Item</th>
<th>ASC-Current</th>
<th>ASC-Final Rule 2008</th>
<th>HOPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs</td>
<td>No Payment</td>
<td>Separate payment allowed for drugs separately paid in HOPD when covered.</td>
<td>Separate payments for certain pass-through and nonpass-through drugs when covered.</td>
</tr>
<tr>
<td>DME – Implantable</td>
<td>ASCs can receive payment for DME.</td>
<td>Included in facility fee as HOPD.</td>
<td>Included in facility fee for inserting device.</td>
</tr>
<tr>
<td>DME – Nonimplantable</td>
<td>Only reimbursed if a DME Medicare supplier.</td>
<td>No Change.</td>
<td>Separate reimbursement available for DME.</td>
</tr>
<tr>
<td>Prosthetic Implant</td>
<td>ASC can receive additional payment for implants meeting the Medicare definition of prosthetics.</td>
<td>Included in facility fee as HOPDs.</td>
<td>Included in facility fee.</td>
</tr>
<tr>
<td>Other Implantable Devices</td>
<td>No additional payment for devices such as stents, mesh, etc.</td>
<td>No changes.</td>
<td>No additional payment.</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>ASC not reimbursed. If the ASC is enrolled as an IDTF, the IDTF can be paid.</td>
<td>Separate payment for some ancillary radiology services that are integral to the performance of covered service.</td>
<td>Separate payment for some radiology services.</td>
</tr>
</tbody>
</table>

Let now take a look at some of the major differences in payment by Orthopaedic Specialty.

Knee Surgery

<table>
<thead>
<tr>
<th>Code</th>
<th>2007 ASC Rate</th>
<th>2008 National Payment Rate</th>
<th>2008 National Payment Rate at 65 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>29888</td>
<td>$ 510.00 (group 3)</td>
<td>$ 1892.32</td>
<td>$ 1230.01</td>
</tr>
<tr>
<td>29881</td>
<td>$ 630.00 (group 4)</td>
<td>$ 1191.53</td>
<td>$ 774.49</td>
</tr>
<tr>
<td>29877</td>
<td>$ 630.00 (group 4)</td>
<td>$ 1191.53</td>
<td>$ 774.49</td>
</tr>
<tr>
<td>29873</td>
<td>$ 510.00 (group 3)</td>
<td>$ 1191.53</td>
<td>$ 774.49</td>
</tr>
</tbody>
</table>

Hand Surgery

<table>
<thead>
<tr>
<th>Code</th>
<th>2007 ASC Rate</th>
<th>2008 Fully Implemented National Rate</th>
<th>2008 National Rate at 65 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>64721</td>
<td>$ 446.00 (group 2)</td>
<td>$ 747.36</td>
<td>$ 485.78</td>
</tr>
<tr>
<td>26055</td>
<td>$ 446.00 (group 2)</td>
<td>$ 681.61</td>
<td>$ 443.05</td>
</tr>
<tr>
<td>25447</td>
<td>$ 717.00 (group 5)</td>
<td>$ 1486.46</td>
<td>$ 966.20</td>
</tr>
<tr>
<td>25111</td>
<td>$ 510.00 (group 3)</td>
<td>$ 681.61</td>
<td>$ 443.05</td>
</tr>
</tbody>
</table>

Shoulder Surgery

<table>
<thead>
<tr>
<th>Code</th>
<th>2007 ASC Rate</th>
<th>2008 Fully Implemented National Rate</th>
<th>2008 National Rate at 65 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>29827</td>
<td>$ 717.00 (group 5)</td>
<td>$ 1892.32</td>
<td>$ 1230.01</td>
</tr>
<tr>
<td>29826</td>
<td>$ 510.00 (group 3)</td>
<td>$ 1892.32</td>
<td>$ 1230.01</td>
</tr>
<tr>
<td>23412</td>
<td>$ 995.00 (group 7)</td>
<td>$ 1779.62</td>
<td>$ 1156.75</td>
</tr>
<tr>
<td>25609</td>
<td>$ 717.00 (group 5)</td>
<td>$ 2451.90</td>
<td>$ 1593.74</td>
</tr>
<tr>
<td>29807</td>
<td>$ 510.00 (group 3)</td>
<td>$ 1892.32</td>
<td>$ 1230.01</td>
</tr>
</tbody>
</table>

The ASC reimbursement from CMS will be as follows:

Code 20690 Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
ASC 2008 Fully Implemented National Fee - $ 1208.50
Code 20692 Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (e.g., Ilizarov, Monticelli type)
ASC 2008 Fully Implemented National Fee - $1208.50
Code 20693 Adjustment or revision of external fixation sys-
tem requiring anesthesia (e.g., new pin(s) or wire(s) and/or new ring(s) or bar(s))

**ASC 2008 Fully Implemented National Fee - $880.55**

**Code 20694** Removal, under anesthesia, of external fixation system

**ASC 2008 Fully Implemented National Fee - $880.55**

Medicare will not reimburse the ASC for G0289 Arthroscopy, knee, surgical, for removal of loose body, foreign body, debride-
ment/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee. This code is valued for intraoperative services only for the physician and provides no facility payment. If only chondroplasty is performed on a Medicare patient, then CMS will reimburse the 29877, if that is the only service performed. If performed with any other arthroscopic procedure there is no separate payment.

Code 20555 was added for placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioele-
ment application (at the time of or subsequent to the procedure) it excludes the following codes:

- Breast – 19296-19298
- Soft tissue head/neck – 41019
- Prostate – 55875
- Pelvis/genitalia - 55920

Previously there was not a code for the placement of needles or catheters for musculoskeletal areas. The ASC 2008 Fully Imple-
mented National payment will be $ 1208.50

Codes 24350, 24351, 24352, 24354, 24356 were deleted, new

tenotomy codes were added:

- 24357 – Tenotomy, elbow, lateral or medial; percutaneous
- 24358 – debridement, soft tissue and/or bone, open
- 24359 – debridement, soft tissue and/or bone open with tendon repair or reattachment.

These new codes will allow greater flexibility in reporting medial and lateral debridement procedures for treatment of epicondylitis. The new series of codes provide simpler descriptions of tenotomy, tenotomy with debridement and tenotomy with debridement and tendon repair or reattachment.

**Code 24357** Tenotomy, elbow, lateral or medial; percutaneous

**2008 ASC Payment $1208.50**

**Code 24358** debridement, soft tissue and/or bone, open

**2008 ASC Payment $1208.50**

**Code 24359** debridement, soft tissue and/or bone open with tendon repair or reattachment.

**2008 ASC Payment $1208.50**

New code, 27416 – Osteochondral autograft(s), knee, open (mosaicplasty) (includes harvesting of autograft[s]) was added to the current family of codes 27412, 27415, 29866-29868. 27416 was developed to report open approach osteochondral autograft knee procedures for smaller articular injuries inside the frame-
work of the current code family for articular cartilage procedures. This code is reported for the treatment of small to moderate sized articular cartilage injuries.

**Code 2008 27416**

**ASC Payment $ 1779.62**

Three new codes were added to report treatment of posterior malleolus type fractures.

- **27767** Closed treatment of posterior malleolus fracture; without manipulation
- **27768** with manipulation
- **27769** Open treatment of posterior malleolus fracture, includes internal fixation, when performed

These codes were established to report open and/or closed ap-
proach for posterior malleolar fracture treatment that involve posterior malleolar fragments.

**Code 27767** Closed treatment of posterior malleolus fracture; without manipulation

**2008 ASC Payment $73.21**

**Code 27768** with manipulation

**2008 ASC Payment $73.21**

**Code 27769** Open treatment of posterior malleolus fracture, includes internal fixation, when performed

**2008 ASC Payment $1701.96**

New code 28446 was established to report open osteochondral talus grafting through restoration of ankle joint by repair of large
osteochondral defect(s) of the talar dome. Instructions do indicate that code 28446 is reported only one time regardless of the number of harvest required to complete the repair. In addition, if this procedure is performed arthroscopically then you are to report 29892.

**Code 28446**

*2008 ASC Payment $1832.77*

In addition to the shoulder biceps tenodesis arthroscopy code, four other new arthroscopic codes were added for subtalar arthroscopic surgery. Advancements in scope technology, these new codes will help address smaller joints in the body. These new codes are for joint procedures performed between the talus and calcaneus in the hindfoot, such as synovectomy, intra-articular fractures.

**Code 29904** Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body  
*2008 ASC Payment $1191.53*

**Code 29905** with synovectomy  
*2008 ASC Payment $1191.53*

**Code 29906** with debridement  
*2008 ASC Payment $1191.53*

**Code 29907** with subtalar arthrodesis  
*2008 ASC Payment $1892.32*

Many minor office procedures were added to the ASC reimbursement list, historically if these procedures were performed in the ASC, there would be no facility payment made, but the physician would receive additional payment to account for costs of procedure to be performed in the office. The ASCs were to have billed the physician, or the OIG could have viewed nonbilling as a Stark Violation for enticement. Now ASCs will receive minimal reimbursement with the new payment system. For example:

- There are also some drugs that are reimbursable with a K2 payment indicator, meaning drugs and biologicals are paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
  - J7321 Hyalgan/supartz inj per dose K2 $101.81
  - J7322 Synvisc inj per dose K2 $178.11
  - J7323 Euflexxa inj per dose K2 $110.95
  - J7324 Orthovisc inj per dose K2 $174.50

The new Medicare payment system will take time to conquer and understand and changes may be made on a quarterly basis. It will be imperative that staff monitor Medicare bulletins on a regularly. As always, correct coding is the key to successful reimbursement regardless of type of facility or physician. Understanding today’s burdensome regulations and different payment mechanisms will ensure financial success to the ASC facility. Remember, one miscoded procedure can lose the facility thousands of dollars, either in lost revenue or compliance issues.

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