The In-Office Endoscopic Carpal Tunnel Release Reimbursement Guidebook

WALANT, OBS, ECTR

by

Jeffrey P. Restuccio, CPC, COC, MBA

The In-Office Endoscopic Carpal Tunnel Release Reimbursement Guidebook

WALANT, OBS, ECTR

For Doctors and Administrators

First Publishing, March 24, 2021

Updated January 31, 2022

All Rights Reserved

No part of this book may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information-storage and retrieval system, without permission in writing from the publisher.

Copyright© by Jeffrey P. Restuccio 2021

by Jeffrey P. Restuccio, CPC, COC, MBA

Other books by Jeffrey Restuccio (paperback manuals)

*The Ultimate Compendium of Coding, Billing, and Documentation Advice For Primary Care (2020 Edition)* [Amazon Link](https://www.amazon.com/dp/1658507487)

The Ultimate Compendium of Coding, Billing, and Documentation Advice: for Ophthalmologists and Optometrists (2020 Edition) [Amazon Link](https://www.amazon.com/dp/197789982X)

**Hold Harmless Statement**

This coding and reimbursement guideline is provided for educational purposes only. It is not intended to represent the only, or necessarily the best, coding advice for the situations discussed, but rather represents an approach, view, statement, or opinion that may be helpful to persons responsible for coding and billing in a medical clinic.

The statements made in this publication should not be construed as policy or procedure, nor as standards of care. State laws, codes and policies change all the time; while every effort was made to ensure accuracy, the author makes no representations and/or warranties, express or implied, regarding the accuracy of the information contained in this book and disclaims any liability or responsibility for any consequences resulting from or otherwise related to any use of, or reliance on, this book.

**Preface**

My goal with this guidebook is to provide information on how to set up *and* be fairly reimbursed for In-Office Endoscopic Carpal Tunnel Release (IOECTR). There are numerous surgical procedures in orthopedics, and other specialties, that are considered “facility-only” by Medicare and other insurance carriers. When performed in an Office-Based Surgical Suite (OBSS) these procedures require negotiating a *carve-out* with each insurance carrier. This guidebook will help.

It will also help you with advice on *setting up* an OBSS. The main issue is that that *every state* has different rules and regulations concerning OBS. I have posted state-by-state links on my website (under the state-by-state TAB).

The information will help surgeons who are interested in performing ECTR in the office using a technique known as WALANT (Wide-Awake Local Anesthesia, No Tourniquet) rather than at a facility (ASC, HOPD, or hospital). Those facility locations would continue to be options, but if the patient is healthy enough many hand-and-wrist procedures can be performed safely, under local anesthesia, in the office suite.

My goal is to help Providers, insurance carriers, researchers, and professional associations. I recommend first downloading our latest [OBS Reimbursement Checklist](https://12uh.com/ioectr/one-page-reimbursement-checklist-for-obbs-walant-ioectr/) available under Posts on the website: [www.ioectr.com](http://www.ioectr.com).

Don’t feel you have to read *every chapter* in this guidebook. I recommend that you scan through the different topic headings for about twenty-minutes *before* you read each chapter in detail. After extensive research (JAN 2022) into Office-Based ECTR reimbursement, I found a lot of information in regard to office-based surgery is generic and vague. Very few address the issue of [Site-of-Service Differential](#_What_is_the). I’ve read through dozens of articles and hundreds of pages of research and distilled it as best I could. There are numerous terms, acronyms, and definitions. A lot of the concepts (NON-FAC PE versus FAC PE) may be unfamiliar to you—and even experienced coders, billers, and managers.

The book is set up in two sections: **Section One** for reimbursement negotiation and **Section Two** for those new to OBS with information on how to set up your OBS. There is also an **Appendix** with additional information for the truly curious.

All of my information, including this document, is available on the website: [www.ioectr.com](http://www.ioectr.com) and in MS-Word (.doc) and MS Excel (.xls) format so you can cut-and-paste and customize it to your unique situation.

It is all free to share. It is royalty-free.

The Kindle version of this publication is meant more as a marketing channel and introduction; it is all the same information as the version on the website; it’s convenient to read on any device, anywhere.

If you have any comments, observations, or feedback please contact using the website [Contact Us Form](https://12uh.com/ioectr/contact-us/).

## Table of Contents

[**Preface** 3](#_Toc94534156)

[Table of Contents 4](#_Toc94534157)

[Introduction 7](#_Toc94534158)

[Available Information (JAN 2022) 7](#_Toc94534159)

[The Checklist 7](#_Toc94534160)

[Step-by-Step and a Contract Negotiation Decision-Tree 7](#_Toc94534161)

[Section One 8](#_Toc94534162)

[Terms You Need to Know 8](#_Toc94534163)

[What is the Primary Issue? 10](#_Toc94534164)

[Non-Facility NA Indicator 11](#_Toc94534165)

[NON-FAC PE Expense Calculations 11](#_Toc94534166)

[Practice Expense RVUS 11](#_Toc94534167)

[ECTR versus OCTR Reimbursement 12](#_Toc94534168)

[29848: Endoscopy, wrist, surgical, with release of transverse carpal ligament (ECTR) 14](#_Toc94534169)

[64721: Neuroplasty and/or transposition; median nerve at carpal tunnel 15](#_Toc94534170)

[Facility Charges for ASC, HOPD, and Hospital 16](#_Toc94534171)

[Hospital Charges 16](#_Toc94534172)

[Research 18](#_Toc94534173)

[Research Cost Paper - 2018 20](#_Toc94534174)

[Patient Case Studies 21](#_Toc94534175)

[Patient Satisfaction Research 23](#_Toc94534176)

[Patient Safety / Location 24](#_Toc94534177)

[Benefits of IOECTR / WALANT / Office-Based CTR 24](#_Toc94534178)

[Levels - Anesthesia, Surgery and Facility 25](#_Toc94534179)

[Anesthesia Levels 25](#_Toc94534180)

[Office Surgery Levels 25](#_Toc94534181)

[Surgical Facility Classes 26](#_Toc94534182)

[Additional Reimbursement Factoids 26](#_Toc94534183)

[Graphics, Summaries and Facility Practice Expense: 27](#_Toc94534184)

[IOECTR Contract for Reimbursement 27](#_Toc94534185)

[Negotiating a Contract for IOECTR 28](#_Toc94534186)

[Example Negotiating Strategies 29](#_Toc94534187)

[Negotiation Breakout Summary 30](#_Toc94534188)

[Decision-Tree Point System 31](#_Toc94534189)

[Contracts 32](#_Toc94534190)

[How Does One Negotiate the Rates of Payment and Terms of The Contract? 33](#_Toc94534191)

[Section Two 34](#_Toc94534192)

[Registration, Licensing and Accreditation Issues 34](#_Toc94534193)

[State Laws and IOECTR (OBS) 36](#_Toc94534194)

[Candidates for Level II procedures 36](#_Toc94534195)

[State Guidelines 36](#_Toc94534196)

[Regulation 35 Office-Based Surgery 36](#_Toc94534197)

[Medical Board of Georgia Office-Based Surgery and Anesthesia Guidelines 37](#_Toc94534198)

[New York State laws 37](#_Toc94534199)

[What are the Office-Based Surgery (OBS) NY laws? 37](#_Toc94534200)

[When did the laws regarding Office-Based Surgery become effective in NY? 37](#_Toc94534201)

[What is Office-Based Surgery? 38](#_Toc94534202)

[California State Laws 39](#_Toc94534203)

[Do California outpatient surgery settings or ambulatory surgery centers have to be accredited, licensed or certified? 39](#_Toc94534204)

[Summary 40](#_Toc94534205)

[Author Biography 41](#_Toc94534206)

[Glossary 42](#_Toc94534207)

[Appendix 44](#_Toc94534208)

[When Endoscopic CTR Turns Into Open CTR Coding 44](#_Toc94534209)

[Reporting and Coding for Code the Manos Procedure for Carpal Tunnel 44](#_Toc94534210)

[What is WALANT? 44](#_Toc94534211)

[RVU Basics 44](#_Toc94534212)

[Insurance Policies Regarding Office-Based Surgery 46](#_Toc94534213)

[Carpal Tunnel Release Surgery Description 47](#_Toc94534214)

[Open Carpal Tunnel Release 47](#_Toc94534215)

[Endoscopic Carpal Tunnel Release 47](#_Toc94534216)

[Benefits of ECTR 47](#_Toc94534217)

[ICD-10-CM Codes for Carpal Tunnel 48](#_Toc94534218)

[Place of Service (POS) Codes 48](#_Toc94534219)

[Global Days 48](#_Toc94534220)

[Office Surgical Suite Protocols 49](#_Toc94534221)

[IOECTR Office-Based Equipment Needs 49](#_Toc94534222)

[Office Flow 50](#_Toc94534223)

[Statement on Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia 51](#_Toc94534224)

[What Is MAC Anesthesia? 53](#_Toc94534225)

[Monitored Anesthesia Care MAC is DIFFERENT THAN moderate Sedation Analgesia Conscious Sedation 54](#_Toc94534226)

[Guidelines for Office-Based Anesthesia 55](#_Toc94534227)

[Patient Safety Principles for Office-Based Surgery 55](#_Toc94534228)

[Core Principle #1 55](#_Toc94534229)

[Core Principle #2 55](#_Toc94534230)

[Core Principle #3 56](#_Toc94534231)

[Core Principle #4 56](#_Toc94534232)

[Core Principle #5 56](#_Toc94534233)

[Core Principle #6 56](#_Toc94534234)

[Core Principle #7 56](#_Toc94534235)

[Core Principle #8 56](#_Toc94534236)

[Core Principle #9 56](#_Toc94534237)

[Core Principle #10 57](#_Toc94534238)

[Background 57](#_Toc94534239)

[Practice Expense Origins and the AMA Socioeconomic Monitoring System (SMS) 58](#_Toc94534240)

[SOSD Statistics 59](#_Toc94534241)

[GPCI Localities 60](#_Toc94534242)

## Introduction

There are a number of reimbursement terms and concepts in this guidebook so bear with me. In layman’s terms, there are procedures that are often performed at a facility: ambulatory surgery center, hospital outpatient department, or hospital, and procedures that are typically performed in the office. Some can be performed in *either location* and the amount of reimbursement is generally **higher** for the surgeon when performed in the office. That compensation is for the “overhead” of the **Office-Based Surgical Suite (OBSS).** The more common acronym is simply OBS for Office-Based Surgery and I added the extra “S” for “Suite”. We will be calling that difference the **Site-Of-Service Differential (SOSD)** and you will see OBSS and SOSD often in this document.

Numerous surgical procedures that historically were only performed at a facility are now routine-enough, and safe-enough to perform in the office under local anesthesia. This includes cataract surgery, numerous podiatry surgeries, and many hand-and-wrist procedures (e.g., **IOECTR)**. With **WALANT** and local anesthesia, there are [additional benefits](#_Benefits_of_IOECTR) to performing the surgeries in the office. The SOSD for ECTR, in particular, is **zero**; there is no additional reimbursement for the OBSS overhead.

This Reimbursement Guidebook is for anyone interested in OBS, WALANT, IOECTR and negotiating a fair reimbursement for office overhead when performing ECTR in an OBSS. It can also be used for any of 97 hand-and-wrist procedures that could be performed using WALANT in an OBSS and do not have an SOSD.

## Available Information (JAN 2022)

There is very little information on the Internet that addresses the Site of Service Differential issue in general and specifically relating to IOECTR. Many articles and research papers discuss how the healthcare system saves money with in-office procedures but most savings go to the *insurance carrier*. A patient’s out-of-pocket charges (co-pay) may be less due to the lack of a facility fee from the ASC, HOPD or hospital. In addition, the patient requires fewer labs and tests when only local anesthesia is used. There is a convenience factor for both the patient and the surgeon (who saves on travel time). [Click here](#_Benefits_of_IOECTR) for more benefits of OBS.

## The Checklist

Before you read this document, I recommend spending some time with our [one-page Checklist](https://12uh.com/ioectr/one-page-reimbursement-checklist-for-obbs-walant-ioectr/). It is a concise outline, in spreadsheet form, of the steps and issues related to IOECTR reimbursement. This Guidebook can be intimidating to some so start with the Checklist.

## Step-by-Step and a Contract Negotiation Decision-Tree

In addition to the information here, I have a [Step-by-Step Guide in Spreadsheet](https://12uh.com/ioectr/step-by-step-contract-negotiation-template-for-walant-obbs-procedures/) format to help you with the numerous issues and requirements for establishing the OBS suite. I added a Contract Negotiation [Decision-Tree graphic and spreadsheet](https://12uh.com/ioectr/ioectr-carrier-negotiation-decision-tree/). I highly recommend these two documents. The decision-tree graphic is concise; the SS offers a detailed plan that will assist you with negotiation, leverage, and pricing

Perhaps the most important decision is, “Why do you want to perform surgical procedures in the office?” What are the benefits? To whom? What are the costs? Are there licensing or accreditation issues? How much will you be reimbursed?

As with everything in this Guidebook, this information is for educational purposes only. Rules and Guidelines change often. So be sure to check with the state medical board, a healthcare attorney, state and local guidelines, as well as zoning and construction laws. Your professional association may be able to assist with the most up-to-date information.

.

# Section One

## Terms You Need to Know

There are numerous terms used throughout this document. The most important are the concepts of overhead, facility, NON-FAC PE, FAC PE, SOSD, POS, and RVU’s in general.

**Facility:** This means “not office” and includes an Ambulatory Surgery Center (ASC), Hospital Outpatient Department (HOPD), or a Hospital Inpatient. The office is *not* a facility; the office is *never* a facility. While the SOSD is the “facility fee” for the office-based surgical suite, it should never be referred to as a “facility fee.” The hospital, ASC, and HOPD are facilities. Only facilities have facility fees which *are billed separately by the facility*.

**Place of Service (POS):** The location where the surgery was performed. Office=11. This is reported on the claim form.

**PE / Practice Expense** (Overhead) includes: staffing; clinical services, supplies, and equipment; office space; office supplies and services, and professional services.

**Overhead** (PE): this includes both direct and indirect costs for the facility or office-based surgical suite.

**NON-FAC PE**: Non-Facility Practice Expense; this simply means the Place of Service is office (11) or not a recognized facility.

**FAC PE**: Facility Practice Expense. This is the RVU reimbursement to the surgeon when the procedure is performed at a facility. This applies to a hospital, HOPD, or ASC. Facility fees, billed on the UB-04 claim form are contrasted with Professional fees (aka fee-for-service using CPT codes), which are billed on the CMS-1500 form claim form.

**Facility Fees** go to the ASC, HOPD, or Hospital. For OBS the facility reimbursement is included in the professional fees (surgeon payment). These are submitted on the UB-04 form. The reimbursement methodology is different for each location.

**Site of Service Differential (SOSD):** Subtract the NON-FAC PE from the FAC PE to get your SOSD value. If they are the same the SOSD is zero. The “Non-Facility NA INDICATOR” field in the Medicare PFSRVU 2022 database will be "NA". This is considered a “facility-only” procedure. It is payment for the “overhead” or “facility fee” for the office.

**Total RVU's**=W+PE+M: Relative Value Units include: Work=physicians’ skill and expertise; PE=Practice Expense; M=Malpractice insurance. There is also a fourth component: A Geographic Price Cost Index (GPCI). More information on [RVU’s is available here](#_RVU_Basics).

**Professional Fees** this is the payment that goes to the surgeon. Pro fees are based on RVU’s. When people talk about high hospital costs most of the charges are for the facility, the hospital, not the Pro fees going to the surgeon.

**OBS:** Office-Based Surgery is any surgery performed in the office and reported as POS=11. Even if you have a separate Tax ID for the OBSS never bill it as a facility or anything other than POS=11.

**OBSS**: Office-Based Surgical Suite. This is my acronym; you won’t find it anywhere else. OBS is a common term; OBSS is an acronym I created to describe a surgical operating room that is not in an ASC, HOPD, or hospital. Some use the term “in-office surgery”.

**WALANT:** Wide-Awake Local Anesthesia, No Tourniquet is a technique where minimal anesthesia is used and the patient is awake and able to communicate during the procedure. [More information on WALANT](#_What_is_WALANT?) is provided in the Appendix.

## What is the Primary Issue?

Succinctly it is: negotiating a contract with each carrier for fair NON-FAC PE expense reimbursement for ECTR when performed in an OBSS (as opposed to a facility: ASC, HOPD or hospital). For ECTR the SOSD is currently zero. The short-term solution is to negotiate an IOECTR reimbursement contract with each carrier. The long-term solution is to request an AMA / Medicare status change of the Non-Facility NA INDICATOR and calculate a fair reimbursement for the office surgical suite for IOECTR. However, that is simply not going to happen any time soon (or ever). There is little interest in re-evaluating these codes from any medical professional association.

A carrier may deny ECTR when performed in the office (with a Wrong Place of Service as your denial code) or simply pay you the *facility rate* (FAC PE [essentially not reimbursing you any amount for the office-based surgical suite.]) The issue applies to *any* surgical procedure where SOSD = zero.

**NOTE:** You can use the WALANT technique in a facility or perform a procedure with a zero SOSD in the OBSS—without it being a WALANT procedure. In 2022 the majority of WALANT procedures are still performed in the ASC.

From a negotiation standpoint it’s always best to start with the most expensive alternative–performing the procedures at the hospital–and show the insurance company how much *they* will save if you perform ECTR in the office and they reimburse you for your Office-Based Surgical Suite overhead. Your historical facility usage will impact your ultimate strategy; the majority of ECTR surgeries are performed in the ASC. We will discuss [negotiating strategies](#_Example_Negotiating_Strategies) in more detail later.

The secondary issue is assisting hand-and-wrist surgeons with *setting up* an office-based surgery suite.

**NOTE:** If you feel you have a good grasp on the concepts, you can skip most of the detail below regarding the SOSD calculations, and NON-FAC versus FAC PE.

## Non-Facility NA Indicator

Procedures with a status indicator of "NA" in the “Non-Facility NA INDICATOR” field in the Medicare **P**hysician **F**ee **S**ervice **R**elative **V**alue **U**nit database (PFSRVU) are typically not recognized or reimbursed by payers if performed in a physician's office. Getting this flag changed requires working with the professional societies, the AMA and the Medicare RUC committee to change the code (29848) status and allocate NON-FAC PE RVU's for the procedure when performed in the office (POS=11). This process could take 2-3 years or longer (JAN 2022). Few codes are reviewed each year—probably less than 25.

This indicator in the Medicare PFSRVU database determines whether there is an SOSD. The number of orthopedic codes *without* a Site of Service Differential (SOSD) = 1,174 or 71% of all orthopedic procedures. Some might call these “facility only” procedures. The other 29% can be performed in either Place of Service and the surgeon is paid extra (for the office overhead) when performed in their office base on the NON-FAC PE.

In summary:

Non-Facility NA INDICATOR=NA No SOSD No reimbursement for OBS / overhead

Non-Facility NA INDICATOR=blank SOSD Reimbursement for OBS / overhead (The physician is paid more when performed in the office.)

## NON-FAC PE Expense Calculations

This information is only for the extremely curious. The RAND Corporation’s *Practice Expense Methodology and Data Collection Research and Analysis* document is a 148-page document outlining in detail specifically PE history, methodology, and issues. It can be downloaded [from this link](https://www.rand.org/pubs/research_reports/RR2166.html). While very detailed, it does **not** discuss SOSD in any depth and *why* some procedures are considered “facility-only” and others not.

From other discussions I assume that the main issues are complexity, historical anesthesia requirements, and risk. The main takeaway from the document is how difficult it is to create accurate cost-accounting totals of NON-FAC and FAC Practice Expenses. The PE calculations are fraught with data and collection errors. For that reason, it may be best to work the cost savings over facility charges angle and have a best-case estimate of direct and indirect expenses as a backup during negotiations.

## Practice Expense RVUS

Total RVU’s have three components:

1. Work Expense (W)
2. Practice Expenses (PE)
3. Malpractice Expense (M)

Remember that there are *facility* PE expenses (FAC PE) for procedures performed in an ASC, HOPD, or hospital and *non-facility* (office) PE (NON-FAC PE) for procedures performed in the office. Medicare does not recognize the office Place of Service (POS; code=11) as an official “facility.”

**NOTE:** Most private carriers follow Medicare guidelines (but not all).

**Practice Expenses** for services provided in a physician’s office include the following:

1. Clinical Staff Time
2. The Equipment
3. Supplies Typically Used During A Procedure
4. Administrative Staff
5. Building Space
6. Office Supplies

**NOTE:** Determining direct and indirect costs is very time-consuming, fraught with error and requires knowledge of cost-accounting. Your professional association should have the allocated indirect cost information. Hopefully, reviewing the PE will not be necessary for contract negotiation. If you can avoid it altogether, I would.

Components 1-3 are *direct costs* and 4-6 are *indirec*t. In addition, the first three are calculated based on actual cost data whereas 4-6 are *allocated per specialty*.

In general for any given PE:

32% are direct costs

41% are indirect costs

Billing services are considered an \*allocated\* direct cost, not indirect.

The estimate that 32 percent of physician practice expenses are for direct costs is based on Medical Economics survey data [Physician Payment Review Commission, 1992a). The remaining 68 percent of MFS indirect practice expense payments-are allocated to services in proportion to the sum of physician work and direct costs. And yes, many argue that PE data is out-of-date and does not reflect a modern office cost structure.

The rationale for the site of-service differential is that physicians incur direct costs only when a service is performed in their office. The indirect costs of maintaining an office, on the other hand, are incurred by the physician regardless of where services are performed and are therefore *assigned proportionately to all services (allocated)*.

Each practitioner can use the six components above to determine their actual overhead or non-facility (office) Practice Expense. Globally this has proven to be very difficult due to data collection errors (low participation rates). In addition, large clinics, those owned by large corporations, and single physician practices have very different expense structures and accounting systems.

## ECTR versus OCTR Reimbursement

While this guidebook focuses specifically on ECTR the concepts and contract negotiation will apply to any procedure that does not have an SOSD. The CPT™ code for endoscopic carpal tunnel release is 29848.

There is also the **open technique** for carpal tunnel release. A group of surgeons could decide to perform both open and endoscopic carpal tunnel release in the same office surgical suite. In addition to the procedures being significantly different, CPT code 64721: Neuroplasty and/or transposition; median nerve at carpal tunnel *does* have an SOSD and the surgeon is paid about $6.90 (2022) *more* when performed in the office versus a facility. Therefore, additional fees *do not* need to be negotiated for open CTR. However, I would think that most surgeons are not happy with such a low SOSD reimbursement amount but the direct expenses for OCTR are much lower than ECTR—that is a global issue impacting ECTR use worldwide.

**NOTE:** Always use my cost numbers as *estimates*. In regard to your actual reimbursement, it will most likely be higher or lower depending on your geographic location. In addition, most private insurance carriers pay higher than Medicare and the amounts vary. Medicaid typically pays less. Use the Medicare RVU’s and fee schedule as a template and estimate.

## 29848: Endoscopy, wrist, surgical, with release of transverse carpal ligament (ECTR)

Procedure 29848 priced for 1/18/2022 **(No Site of Service Differential**)

|  |  |  |  |
| --- | --- | --- | --- |
| Procedure 29848 priced for 01/29/2021 |   |   |  |
|   |   | Medicare Facility | Medicare Non Facility |
| Global | Allowed | $521.50  | $521.50  |
|   | Reimbursement | $417.20  | $417.20  |
|   | After Sequest | $408.86  | $408.86  |
|   | RVUw | 6.39 | 6.39 |
|  These are the same | **RVUpe** | 7.61 | 7.61 |
|   | RVUm | 1.2 | 1.2 |
|   | RVU total | 15.2 | 15.2 |
| Global period: 90 days |   |   |   |

In the Table above we see the Work RVU’s (RVUw), the Practice Expense RVU’s (RVUpe), and the Malpractice RVU’s (RVUm). Together these are total RVU’s for the procedure.

The Facility reimbursement and Non-Facility reimbursement **PE RVUs, above** **are the same** (7.61). This amount is what the clinic needs to negotiate, individually, with all of your main carriers. The ASC facility reimbursement, for CPT code 29848 is roughly $742 and paid separately to the ASC.

There are approximately 1,174 orthopedic procedures that fall into this “facility-only” category. [A complete list is available on the website](https://12uh.com/ioectr/orthopedic-procedures-with-a-site-of-service-differential-of-zero-2021/). There is also a shorter list of nearly 100 hand-and-wrist procedures that might lend themselves to WALANT. The Medicare database lags a few years plus both 2020 and 2021 will not be representative years.

## 64721: Neuroplasty and/or transposition; median nerve at carpal tunnel

Procedure 64721 priced for 1/18/2022

|  |  |  |  |
| --- | --- | --- | --- |
| Procedure 64721 priced for 01/18/2022 |   |   |  |
|   |   | Medicare Facility | Medicare Non Facility |
| Global | Allowed | $445.07  | $453.70  |
|   | Reimbursement | $356.06  | $362.96  |
|   | After Sequest | $348.93  | $355.70  |
|   | RVUw | 4.97 | 4.97 |
|  **Different Values** | RVUpe | 7.01 | 7.26 |
|   | RVUm | 0.99 | 0.99 |
|   | RVU total | 12.97 | 13.22 |
| Global period: 90 days |   |   |   |

There is a Site of Service differential for OCTR but it is only $6.90 (.25 RVU’s)! The ASC facility reimbursement, for CPT code 64721 is $825.71 or over 10X the amount. One could question why is the OCTR facility reimbursement higher than ECTR facility reimbursement? I don’t know the answer. In this case, there *is* compensation for performing the procedure in the office (Non-FAC PE) but it is very low. There are 471 orthopedic codes **with** a positive **SOSD**.

## Facility Charges for ASC, HOPD, and Hospital

Below are 2022 Medicare charges for Code 29848 and 64721.

|  |  |  |
| --- | --- | --- |
| Reimbursement Information | Wrist Endoscopy / Surgery | Carpal Tunnel Surgery (Open) |
| CPT™ Code: | 29848 | 64721 |
| APC Code: | 5112 | 5431 |
| PFS Relative Value Units: | 15.2 | 12.97 |
| Medicare Allowable (Physician Services Fee): | $526.01 | $448.84 |
| Facility Fee Payment Weight: ASC: | 14.8649 | 16.5419 |
| Facility Fee Reimbursement: ASC: | $742 | $825.71 |
| Facility Fee Payment Weight: HOPD: | 16.899 | 21.304 |
| Facility Fee Reimbursement: HOPD: | $1,422.51 | $1,793.31 |
| Facility Fee Reimbursement Hospital (MS-DRG=502)\* | $7,840.34 |  |
| Total Reimbursement ASC (Pro Fee + Facility): | $1,268.01 | $ 1,274.55 |
| Total Reimbursement HOPD (Pro Fee + Facility): | $1,948.52 | $ 2,242.15 |
| Total Reimbursement Hospital (Pro Fee + Hospital)\*: | $8,483.85 |  |

**Note:** that there are [GPCI](#_RVU_Basics) variances to the professional fees and other factors that impact the hospital fees so use the values above as *estimates*. Each locality will have slightly different numbers. Each carrier may pay more or less. The main takeaway is that facility charges increase from ASC to HOPD to hospital.

## Hospital Charges

While it’s not common to perform ECTR in an inpatient hospital (POS=21), if your clinic has any history, I would present the data when negotiating with the insurance company. However, it might also be argued that if the patient was sick enough to warrant the hospital setting then they might not be a good candidate for office-based surgery. If it was the *only* available option in your area then that is a different story.

ECTR surgery typically takes 13 minutes or less. I’ve heard reports that it can be done in less than half that.

One report listed in 2006 that 160,000 CTR surgeries were performed. The mean charge across facilities was $2,572. [I am assuming that this is a mean of all facilities (ASC, HOPD, hospital) of the total Professional fees and facility fees.] That number seems low to me.

I don’t have a firm number of the total number of ECTR and OCTR procedures performed in the United States per year. I have found three different values:

1. 250,000 Carpal Tunnel surgeries performed per year (includes both ECTR and OCTR).
2. Over 230,000 carpal tunnel surgeries are performed per year, the second most common type of surgery.
3. More than 350 000 carpal tunnel release procedures are performed annually per a 2006 paper. One estimate had ECTR at about 20% of the total; the rest are open.

HOPD reimbursement was about $500 higher than ASC for CTR. A paper on total CTR costs is listed below:

*Nguyen C, Milstein A, Hernandez-Boussard T, Curtin CM. The Effect of Moving Carpal Tunnel Releases Out of Hospitals on Reducing United States Health Care Charges. J Hand Surg Am. 2015 Aug;40(8):1657-62. doi: 10.1016/j.jhsa.2015.04.023. Epub 2015 Jun 9. PMID: 26070229; PMCID: PMC4516645.*

“Examination of charges for CTR suggests that surgical setting is a large cost driver with the potential opportunity to lower charges for CTRs by approximately 30% if performed in ASCs.”

Note that the study above is comparing ASC facility fees to the HOPD only. There were no hospitals in this study. The overhead for the OBSS is less than the ASC so the cost-savings would be greater.

The 2015 paper above uses *2006 data* and does not reference office-based CTR or ECTR. Carpal tunnel release performed in office-based minor procedure rooms was not captured in the NSAS dataset. It does reference local anesthesia.

## Research

As of January 31, 2022, we have 72 complete OBS, WALANT. and ECTR research papers supporting the efficacy, benefits, and safety of the procedure when performed in the office. If you are interested in the papers I can provide access to Google Drive. If you wish access to the database, E-mail us at obsreimbursement@gmail.com and copy to ritecode@gmail.com.

Below is our first draft list of top research regarding ECTR, OBS, WALANT, safety and other factors relevant to your negotiations. I’ve sorted them by their value in negotiating a carve-out. If you have your favorites, suggestions, or know of additional research papers I should include please e-mail me. I am not a clinician so the ranking is a best guess.

**Citations:**

1. Lalonde, D, Bell, M, Benoit, P. A multicenter prospective study of 3,110 consecutive cases of elective epinephrine use in the fingers and hand: the dalhousie project clinical phase. J Hand Surg 2005; 30(5): 1061–1067.
2. Van Demark RE, Becker HA, Anderson MC, Smith VJS. Wide-Awake Anesthesia in the In-Office Procedure Room: Lessons Learned. HAND. 2018;13(4):481-485. doi:10.1177/1558944717715120
3. C.J. Thomson, D.H. Lalonde, K.A. Denkler, A.J. Feicht, A critical look at the evidence for and against elective epinephrine use in the finger, Plast Reconstr Surg, 119 (1) (2007), pp. 260-266
4. Sang Ki Lee, Sung Gul Kim, Won Sik Choy, A randomized controlled trial of minor hand surgeries comparing wide awake local anesthesia no tourniquet and local anesthesia with tourniquet, Orthopaedics & Traumatology: Surgery & Research, Volume 106, Issue 8, 2020,
5. Bhattacharya R, Birdsall PD, Finn P, Stothard J. A randomized controlled trial of knifelight and open carpal tunnel release. J Hand Surg. 2004;29(2):113–5. doi:10.1016/j.jhsb.2003.09.001.
6. Sardenberg T, Ribak S, Colenci R, Campos RB, Varanda D, Cortopassi AC. 488 hand surgeries with local anesthesia with epinephrine, without a tourniquet, without sedation, and without an anesthesiologist. Rev Bras Ortop. 2018 Apr 5;53(3):281-286. doi: 10.1016/j.rboe.2018.03.011. PMID: 29892577; PMCID: PMC5993883.
7. Zuo, D., Zhou, Z., Wang, H. et al. Endoscopic versus open carpal tunnel release for idiopathic carpal tunnel syndrome: a meta-analysis of randomized controlled trials. J Orthop Surg Res 10, 12 (2015). https://doi.org/10.1186/s13018-014-0148-6
8. Tulipan, Jacob E. MD; Ilyas, Asif M. MD Carpal Tunnel Syndrome Surgery: What You Should Know, Plastic and Reconstructive Surgery - Global Open: March 2020 - Volume 8 - Issue 3 - p e2692 doi: 10.1097/GOX.0000000000002692
9. Denkler K. A comprehensive review of epinephrine in the finger: to do or not to do. Plast Reconstr Surg. 2001 Jul;108(1):114-24. doi: 10.1097/00006534-200107000-00017. PMID: 11420511.
10. Ejiri S, Kikuchi S, Maruya M, Sekiguchi Y, Kawakami R, Konno S. Short-term results of endoscopic (Okutsu method) versus palmar incision open carpal tunnel release: a prospective randomized controlled trial. Fukushima J Med Sci. 2012;58(1):49–59.
11. Halley MC, Rendle KA, Gugerty B, Lau DT, Luft HS, Gillespie KA. Collecting Practice-level Data in a Changing Physician Office-based Ambulatory Care Environment: A Pilot Study Examining the Physician induction interview Component of the National Ambulatory Medical Care Survey. Vital Health Stat 2. 2017 Nov;(176):1-18. PMID: 29148968.
12. Thoma A, Veltri K, Haines T, Duku E. A meta-analysis of randomized controlled trials comparing endoscopic and open carpal tunnel decompression. Plast Reconstr Surg. 2004;114(5):1137–46.
13. Results of Endoscopic Carpal Tunnel Release Relative to Surgeon Experience With the Agee Technique” Beck JD, Deegan JH, Rhoades D, Klena JC. Journal of Hand Surgery, 2011; 36A:61–64
14. Macdermid JC, Richards RS, Roth JH, Ross DC, King GJ. Endoscopic versus open carpal tunnel release: a randomized trial. J Hand Surg. 2003;28(3):475–80. doi:10.1053/jhsu.2003.50080.
15. PHALEN, GEORGE S. The Carpal-Tunnel Syndrome, The Journal of Bone & Joint Surgery: March 1966 - Volume 48 - Issue 2 - p 211-228
16. Wong KC, Hung LK, Ho PC, Wong JM. Carpal tunnel release. A prospective, randomised study of endoscopic versus limited-open methods. J Bone Joint Surg. 2003;85(6):863–8.
17. Trumble TE, Diao E, Abrams RA, Gilbert-Anderson MM. Single-portal endoscopic carpal tunnel release compared with open release: a prospective, randomized trial. J Bone Joint Surg Am. 2002;84-A(7):1107–15.
18. Atroshi I, Larsson GU, Ornstein E, Hofer M, Johnsson R, Ranstam J. Outcomes of endoscopic surgery compared with open surgery for carpal tunnel syndrome among employed patients: randomized controlled trial. BMJ. 2006;332(7556):1473. doi:10.1136/bmj.38863.632789.1F.
19. Larsen MB, Sorensen AI, Crone KL, Weis T, Boeckstyns ME. Carpal tunnel release: a randomized comparison of three surgical methods. J Hand Surg Eur Vol. 2013;38(6):646–50. doi:10.1177/1753193412475247.
20. Sennwald GR, Benedetti R. The value of one-portal endoscopic carpal tunnel release: a prospective randomized study. Knee Surg, Sports Traumatol, Arthroscopy: Off J ESSKA. 1995;3(2):113–6.
21. Aslani HR, Alizadeh K, Eajazi A, Karimi A, Karimi MH, Zaferani Z, et al. Comparison of carpal tunnel release with three different techniques. Clin Neurol Neurosurg. 2012;114(7):965–8. doi:10.1016/j.clineuro.2012.02.017.
22. Boeckstyns ME, Sørensen AI. Does endoscopic carpal tunnel release have a higher rate of complications than open carpal tunnel release? An analysis of published series. J Hand Surg Br. 1999 Feb;24(1):9-15. doi: 10.1016/s0266-7681(99)90009-8. PMID: 10190596.
23. Brown RA, Gelberman RH, Seiler 3rd JG, Abrahamsson SO, Weiland AJ, Urbaniak JR, et al. Carpal tunnel release. A prospective, randomized assessment of open and endoscopic methods. J Bone Joint Surg Am. 1993;75(9):1265–75.
24. Ferdinand RD, MacLean JG. Endoscopic versus open carpal tunnel release in bilateral carpal tunnel syndrome. A prospective, randomised, blinded assessment. J Bone Joint Surg. 2002;84(3):375–9.
25. Ayeni O, Thoma A, Haines T, Sprague S. Analysis of reporting return to work in studies comparing open with endoscopic carpal tunnel release: A review of randomized controlled trials. Can J Plast Surg. 2005;13(4):181-187. doi:10.1177/229255030501300403
26. Endoscopic Carpal Tunnel Release: A Comparison of Two Techniques with Open Release.” Palmer DH, Paulson JC, Lane-Larsen CL, Peulen VK, Olson JD. Arthroscopy: The Journal of Arthroscopic and Related Surgery. 1993; 9(5):498-508

## Research Cost Paper - 2018

The 2018 research paper, *Cost Implications of Varying the Surgical Technique, Surgical Setting, and Anesthesia Type for Carpal Tunnel Release Surgery*, published in *the Journal of Hand Surgery* offers some insight. [[Download link](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6218304/)]

The project aims to determine price differentials between:

1. Surgical Technique (Open versus Endoscopic)
2. Surgical setting (POS)
3. Anesthesia Type (local, Bier Block, MAC, and general)

The null hypothesis is that there is no difference. As expected the results are that there are.

In general Endoscopic CTR is more costly than Open CTR.

Facility costs are hospital, HOPD, and then ASC, in descending cost.

Anesthesia costs for General, Bier Block, and MAC are higher than local (WALANT).

The research confirms what we already knew.

Since the study is on an actual group of surgeons working for a particular institution, it appears that none performed ECTR in an OBSS. In the study they used the term “procedure room (RM)” which, as a reimbursement consultant, I found vague but I assume it means it is not an operating room in a facility. A procedure room is not a valid Place of Service for billing. An office is (POS=11).

The conclusion of the study is that OCTR, using WALANT (local anesthesia), in a procedure room, is the lowest cost surgery. It is important to know this in case your insurance carrier brings up this issue. They may simply say, “why don’t you just do open carpal tunnel release?” and your problem is solved? OCTR does have a very minor SOSD ($6.90.

In the paper, of 479 included patients, the mean age was 55.3 ± 16.1 years, and 68% were female. Payer mix included

1. Commercial (45%)
2. Medicare (37%)
3. Medicaid (13%)
4. Workers compensation (2%)
5. Self-pay (1%)
6. Other (3%) insurance types.

This is useful information. I don’t know of anyone who has successfully negotiated with Medicare for an IOECTR carve-out. I am not sure if it is possible. Remember that there are multiple jurisdictions of Medicare so Noridian might pay and Cahaba not. Never accept someone stating, “Medicare does not pay.”

The carrier in their jurisdiction does not pay, but another might. Assuming Medicare does not pay, if your mix is 37% then you must subtract that from your reimbursed procedures. If the surgeon performs a procedure for a Medicare patient that is *not* a covered service, you must have them fill on an Advanced Beneficiary Notice (ABN) and clearly explain that there will be out-of-pocket costs for the ECTR procedure in the office. Or just do all of them in the ASC. But that does not help with your fixed overhead costs of the OBSS.

Also, of interest in this paper, are the different papers referenced. I would rate these high on your list of supporting research. You need to be familiar with them:

**Four pertaining to the safety and effectiveness of ECTR versus OCTR.**

4. Sayegh ET, Strauch RJ. Open versus endoscopic carpal tunnel release: A meta-analysis of randomized controlled trials. Clin Orthop Relat Res. 2015; 473:1120–1132. [PubMed: 25135849]

5. Trumble TE, Diao E, Abrams RA, Gilbert-Anderson MM. Single-portal endoscopic carpal tunnel release compared with open release : A prospective, randomized trial. J Bone Joint Surg Am. 2002; 84-A:1107–1115. [PubMed: 12107308]

6. Kang HJ, Koh IH, Lee TJ, Choi YR. Endoscopic carpal tunnel release is preferred over mini-open despite similar outcome: A randomized trial. Clin Orthop Relat Res. 2013; 471:1548–1554. [PubMed: 23100191]

7. Thoma A, Veltri K, Haines T, Duku E. A meta-analysis of randomized controlled trials comparing endoscopic and open carpal tunnel decompression. Plast Reconstr Surg. 2004; 114:1137–1146. [PubMed: 15457025]

**Two pertaining to the cost of ECTR.**

8. Zhang S, Vora M, Harris AH, Baker L, Curtin C, Kamal RN. Cost-minimization analysis of open and endoscopic carpal tunnel release. J Bone Joint Surg Am. 2016; 98:1970–1977. [PubMed: 27926678]

9. Foster BD, Sivasundaram L, Heckmann N, et al. Surgical approach and anesthetic modality for carpal tunnel release: A nationwide database study with health care cost implications. Hand (N Y). 2017; 12:162–167. [PubMed: 28344528]

**One discussing preoperative medical testing**. This is a cost to the carrier. Be sure they include this when they add up all their reimbursement costs.

15. Davison PG, Cobb T, Lalonde DH. The patient’s perspective on carpal tunnel surgery related to the type of anesthesia: A prospective cohort study. Hand (N Y). 2013; 8:47–53. [PubMed: 24426892] Kazmers et al.

**Three discussing success and costs of WALANT.**

16. Rhee PC, Fischer MM, Rhee LS, McMillan H, Johnson AE. Cost savings and patient experiences of a clinic-based, wide-awake hand surgery program at a military medical center: A critical analysis of the first 100 procedures. J Hand Surg Am. 2017; 42:e139–e147. [PubMed: 28011033]

17. Leblanc MR, Lalonde DH, Thoma A, et al. Is main operating room sterility really necessary in carpal tunnel surgery? A multicenter prospective study of minor procedure room field sterility surgery. Hand (N Y). 2011; 6:60–63. [PubMed: 22379440]

18. Leblanc MR, Lalonde J, Lalonde DH. A detailed cost and efficiency analysis of performing carpal tunnel surgery in the main operating room versus the ambulatory setting in canada. Hand (N Y). 2007; 2:173–178. [PubMed: 18780048]You need to be aware that this research exists.

## Patient Case Studies

"After incorporating wide-awake hand surgery in my practice, I've had patients specifically request this technique. It's a game-changer in terms of quality of care and improved patient satisfaction."

–Julie E. Adams, M.D., orthopedic surgeon at Mayo Clinic's campus in Rochester, Minnesota.

"Postoperative pain and swelling are less, "I've also noticed that using this technique (WALANT) plus multimodal non-narcotic pain management protocols results in a decreased need for any postoperative narcotic analgesics. Many patients have thanked me after an operation. But it was only after I started doing wide-awake surgery that patients began telling me they enjoyed the operation and learned something from it."

—Peter C. Amadio, M.D., orthopedic surgeon at Mayo Clinic's campus in Minnesota.

Dr. Adams performs wide-awake hand surgery in the operating room in Rochester and also in her clinical office at Mayo Clinic Health System in Austin, Minnesota.

"Patients sit in a reclining chair for their procedures," she says. "I typically mark and then inject them, and let them relax while the lidocaine with epinephrine takes effect. While the block sets up and the arm is prepped and draped, I see a few other patients in the clinic.”

"I then do the WALANT procedure. Some patients listen to music or watch television, but other patients enjoy watching the procedure. It's a great way to get patients engaged in their own care," Dr. Adams says. "Afterward, most patients say they wish they hadn't waited so long to have surgery, and ask, 'Why would anyone go under sedation for this procedure?' "

## Patient Satisfaction Research

In a recent study, it was found that:

Between September 2015 and December 31, 2017, **370 cases were done in the procedure room**. The superficial infection rate was 3.5% with no deep infections. All the infections cleared with oral antibiotics and local wound care. There were no secondary procedures done for this patient group.

Of the treated patients, 99% rated their operative experience better or equal to a dental visit and **98% would recommend the experience to a friend or family member**.

Our clinical results mirror the experience of several authors who have published on WALANT. Previous authors have reported a low infection rate and high patient satisfaction (Leblanc et al., 2011; Leblanc et al., 2007; Rhee et al., 2017; Tang et al., 2017). Another advantage of the in-office procedure room is cost savings. The savings seen with no preoperative labs or medical evaluation are hard to calculate but are significant (Leblanc et al., 2007; Rhee et al., 2017; Tang et al., 2017).

In a recent study, Rhee et al. reported their experience using an in-office procedure room at a military institution.

**The costs savings ranged from 70% for trigger finger releases and 85% for carpal tunnel releases.**

In a 9-month period, there was a total cost savings of $393,099.53 for 71 cases done in an in-office procedure room instead of the hospital. [It is not clear how these savings were calculated and who saved – Jeff].

Patient satisfaction was high; 71% of patients felt less pain than a dental visit and 94% would do WALANT again for a procedure (Rhee et al., 2017).

With WALANT anesthesia, a majority of hand surgery cases can be moved from a hospital operating room to an outpatient setting. The in-office procedure room allows cases to be done in a cost-efficient manner while providing safe care with high patient satisfaction. As we continue to see increasing pressure for cost savings and quality in health care, access to an in-office procedure room will play an important role in the future of hand surgery.

**Seven papers with references to patient satisfaction:**

Lalonde, D, Bell, M, Benoit, P. A multicenter prospective study of 3,110 consecutive cases of elective epinephrine use in the fingers and hand: the dalhousie project clinical phase. J Hand Surg 2005; 30(5): 1061–1067.

Tulipan JE, Kim N, Abboudi J, Jones C, Liss F, Kirkpatrick W, Rivlin M, Wang ML, Matzon J, Ilyas AM. Open Carpal Tunnel Release Outcomes: Performed Wide Awake versus with Sedation. J Hand Microsurg. 2017 Aug;9(2):74-79. doi: 10.1055/s-0037-1603200. Epub 2017 May 22. PMID: 28867906; PMCID: PMC5579466.

Macdermid JC, Richards RS, Roth JH, Ross DC, King GJ. Endoscopic versus open carpal tunnel release: a randomized trial. J Hand Surg. 2003;28(3):475–80. doi:10.1053/jhsu.2003.50080.

Tumescent local anesthesia for hand surgery: improved results, cost effectiveness, and wide-awake patient satisfaction. Arch Plast Surg. 2014;41(4):312-316. doi:10.5999/aps.2014.41.4.312

Brown RA, Gelberman RH, Seiler 3rd JG, Abrahamsson SO, Weiland AJ, Urbaniak JR, et al. Carpal tunnel release. A prospective, randomized assessment of open and endoscopic methods. J Bone Joint Surg Am. 1993;75(9):1265–75.

Ferdinand RD, MacLean JG. Endoscopic versus open carpal tunnel release in bilateral carpal tunnel syndrome. A prospective, randomised, blinded assessment. J Bone Joint Surg. 2002;84(3):375–9.

Jacobsen MB, Rahme H. A prospective, randomized study with an independent observer comparing open carpal tunnel release with endoscopic carpal tunnel release. J Hand Surg. 1996;21(2):202–4.

## Patient Safety / Location

During contract negotiations the issue of *patient safety* may come up. The main factors that determine where a procedure is performed (and allowed) are the complexity, level of the anesthesia used, and the overall risk to the patient. Comorbidities are also a factor here. The **American College of Surgeons** (ACS) drafted **Patient Safety Guidelines** concerning office-based surgery. It was updated September 1, 2019. If only local anesthesia is used these rules may not officially apply but are still recommended. ([Read the Statement Here](#_Statement_on_Patient))

These [Core Principles](#_Patient_Safety_Principles) relate to moderate sedation/analgesia. The majority of guidelines, regulations, and accreditation agencies relate to anesthesia levels *above local*. If only local anesthesia is used, most regulations and accreditation services do not apply. Please confirm this with your state agencies and a healthcare attorney.

## Benefits of IOECTR / WALANT / Office-Based CTR

There are numerous benefits of WALANT and OBS procedures in general for the patients, the surgeons, and the medical insurance company. Combine this with our research list if necessary for negotiations.

1. Avoids sedation or general anesthesia during hand surgery.
2. Helps patient recover and return to normal activities more quickly.
3. Fasting is not usually required. Patients can eat or drink something light the morning of surgery.
4. Unlike sedation or general anesthesia, WALANT eliminates uncomfortable side effects such as nausea. There is no prolonged sedation. Patients feel normal immediately after surgery.
5. Eliminates intravenous injections.
6. Eliminates the need for the patient to stop or "bridge" anticoagulant medications such as warfarin. Lidocaine and epinephrine do not interfere with anticoagulants and blood thinners.
7. WALANT, as an alternative to general anesthesia, has been proven a safe and effective means for performing hand surgery.
8. Patients who were previously not candidates for surgery due to other medical problems can now have ECTR surgery. By eliminating the need for general anesthesia the risks have been significantly decreased—opening the door for those previously deemed “too sick” for surgery.
9. The surgical process is shortened. Preoperative anesthesia planning and postoperative recovery are eliminated from the surgical process.
10. Postoperative pain and swelling are less.
11. WALANT reduces costs for patients and the medical system, and the amount of medical waste.
12. Patients save time and money. Preoperative blood work and medical tests are rarely needed. In addition, the fees for anesthesia are eliminated.
13. The wide-awake (WALANT) procedure allows surgeons to assess and adjust tension for tendon transfers, check the integrity of tendon repairs, and look for “gapping” with active motion following flexor tendon repair.
14. Patients can communicate with their surgeon during and after surgery. Patients know what is going on during surgery and they receive post-operative instructions immediately after their surgery is over. Patients are also able to demonstrate limb function during the procedure per the surgeon’s request, allowing for immediate evaluation of the treatment.

##

## Levels - Anesthesia, Surgery and Facility

These levels/Classes are important to know as they are one of the main criteria for determining whether accreditation or registration is necessary for your OBSS. These are critical to establishing your OBSS. Questions related to them will very likely be part of your negotiation and contract. The levels/classes are correlated but also separate.

There are **three levels** of **Anesthesia** as outlined by AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities) and anesthesia level.

There are **three levels** of **Surgery**. Note that these are separate from the anesthesia levels above but there will be a positive correlation (the more complex the surgery the higher likelihood of a higher level of anesthesia).

There are **three classes** of **Facility** (A, B and C).

## Anesthesia Levels

While the AAASF information below refers to ASC’s it also applies to office-based surgical suites subject to state guidelines. In general, a level 1 anesthesia level does not require accreditation; as of September 2021 the following states require either registration or accreditation for **all levels of anesthesia**:

1. Texas
2. Delaware
3. New York
4. Arizona
5. South Carolina
6. Alabama
7. Kansas

***Always*** confirm with your state guidelines and a healthcare attorney for the any updates or changes.

**AAAASF (**[**American Association for Accreditation of Ambulatory Surgery Facilities**](https://www.aaaasf.org/)**) and anesthesia level.**

**Note:** The operative word is “ASC” here. Most OBSS utilize Level 1(local anesthesia) only.

AAAASF realizes that centers may provide different levels of services and therefore their requirements are targeted to three separate classes of service. The classes are based on the tiered classifications of anesthesia used and are defined as:

**Level 1:** All procedures performed in the facility are under local or topical anesthesia.

**Level 2:** Surgical procedures performed in the facility encompass Class A type and are performed under intravenous or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia (including nitrous oxide).

**Level 3:** Surgical procedures performed in the facility include Class A and B types with the use of endotracheal or laryngeal mask intubation and/or inhalation anesthesia, which is administered by an anesthesiologist or a Certified Registered Nurse Anesthetist.

## Office Surgery Levels

**Level I Office Surgery** includes, but is not limited to minor procedures such as excision of skin lesions, moles, warts, cysts, lipomas and repair of lacerations or surgery limited to the skin and subcutaneous tissue performed under topical or local anesthesia not involving drug-induced alteration of consciousness other than minimal pre-operative tranquilization of the patient. Most of these are considered “minor surgery” and have a 10-day global period.

**Level II Office Surgery** includes peri-operative medication and sedation used intravenously, intramuscularly, or rectally, thus making intra- and post-operative monitoring necessary. This includes any surgery where the patient is placed in a state that allows the patient to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and/or tactile stimulation (i.e., WALANT). Patients whose only response is reflex withdrawal from a painful stimulus are sedated to a greater degree than encompassed by this definition.

**Level III Office Surgery** involves, or reasonably should require, the use of general anesthesia or major conduction anesthesia and pre-operative sedation. This includes, but is not limited to, the use of intravenous sedation beyond that defined for Level II office surgery and general anesthesia.

## Surgical Facility Classes

These are based on the level of care rendered. Each facility class has minimal equipment required on site.

**Class A facility**: Provides for minor surgical procedures performed under topical, local, or regional anesthesia without preoperative sedation. Excluded are intravenous, spinal, and epidural routes; these methods are appropriate for Class B and C facilities.

**Class B facility**: Provides for minor or major surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs.

**Class C facility**: Provides for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.

## Additional Reimbursement Factoids

Note that the facility practice expense (FAC-PE) is allocated to the total RVU's paid to the surgeon; it is not the reimbursement the facility receives. That is s a separate payment, and a different payment methodology (e.g., fee-for-service or Prospective Payment System [PPS]) under either APC's (ASC) or DRG's (hospital).

Everyone involved needs to understand basic reimbursement and coding terms, concepts and issues. Additional information is provided in this document and the Appendix on each issue.

Current PE data used by Medicare to determine the NON-FAC PE is from a 2005 survey! (per RAND study).

Medicare RVU's are **budget-neutral** meaning if you request a change or adding RVU’s to any code you must subtract from another. Therefore whenever a specialty requests an increase in RVU’s they must subtract RVU's from another code to compensate.

## Graphics, Summaries and Facility Practice Expense:

There are [two Visio graphics posted to the website](https://12uh.com/ioectr/visio-graphics-summaries-and-outlines/). These are very useful, one-page snapshots of issues related to IOECTR and OBS in general. Each graphic has a different slant. I will be adding more as the year progresses. These are particularly useful for interdisciplinary meetings with accountants, healthcare lawyers, reimbursement experts, top management, and the surgeons. You might want to look up all the terms in this document first because it is highly likely you will be explaining them to everyone.

## IOECTR Contract for Reimbursement

Most middle and large-size clinics are already familiar with the contract negotiation (carve-out) process. For experienced negotiators, my main goal is to help you specifically with ECTR and the esoteric issue of the SOSD for office-based surgical procedures–when the SOSD=zero. The carrier may be completely unfamiliar with the concept.

A sample contract and different strategies is provided separately. First, the carrier must accept the idea that you should be compensated for the office-based surgical suite and all overhead; that is currently not reflected in the NON-FAC PE RVU’s for CPT code 29848: endoscopic carpal tunnel release.

**Only Heard Here:** I heard one report that the insurance carriers’ position was that if the clinic did not like the FAC PE reimbursement rate (no overhead) then don’t perform the procedure in an OBSS. This simply means that 1) You are speaking to the wrong person; 2) You have not clearly explained that you are *saving the insurance company money.* 3) There are benefits to the patient from WALANT and the OBSS.

Your goal is to negotiate a *fair SOSD* reimbursement amount. They might agree to pay you and then you will discover the amount is $36.09 or less (one RVU). We can provide assistance in the negotiation process. Not everyone will agree on what is fair.

In general, the contract will have the following format:

1. Definitions
2. The Health Plan’s Obligations
3. The Physician’s Obligations
4. Term and Termination (legal / contractual)
5. General Provisions.

More detailed information is provided in the Sample Contract document, available separately on our website.

## Negotiating a Contract for IOECTR

We have added a separate [Step-by-Step Document](https://12uh.com/ioectr/step-by-step-contract-negotiation-template-for-walant-obbs-procedures/) Excel Spreadsheet so please download it from the [www.ioectr.com](http://www.ioectr.com) website. In addition, I recently created a [Decision Tree Matrix](https://12uh.com/ioectr/ioectr-carrier-negotiation-decision-tree/) that uses a sample point system to help with understanding how leverage works. Also on the website is an Excel SS with numerous tabs that will help you with your negotiation. Below is a general outline.

1. **Leverage**: Identify your clinic's leverage before entering negotiations with a health plan. How many surgeons perform ECTR in your city? I have this data if you need it.
2. **Unique Services**: Does your practice offer any unique services (procedures) that will benefit the health plan and its members?
3. **Number of Total Surgeries**: Calculate how many ECTR surgeries you performed last year and the Place of Service.
4. **Patient Mix**: An OBS / WALANT clinic can accept patients not appropriate for full anesthesia.
5. **ECTR by City**: I have 2017 Medicare ECTR numbers by city. Remember that these are estimates based on Medicare data so there are all kinds of caveats but a start from which you can extrapolate.
6. **Calculate Total Costs**: Estimate how much the surgeries cost the insurance company adding both professional fees and facility fees. Use [this chart](#_Facility_Charges_for) as a start.
7. **IOECTR Projections:** Calculate how many ECTR surgeries you plant to perform in your OBS suite and calculate the savings to the insurance company.
8. **Aim High**: The higher the estimate the better. Remember that whatever you ask for they will likely counter with a lower figure. Facility costs are highest at the hospital, then HOPD then ASC. Work in that order.
9. **Balance Billing**: Address whether "balance billing" is allowed in the contract. You will most likely have to agree to not balance bill the patient for the difference in costs. If they agree to allow balance billing I would take it. You must inform the patient that they would be paying a premium for the convenience of the office-based and wide-awake surgery. In general “balance billing” is not allowed by Medicare and most carriers.
10. "**Facility Fee":** The focus is on negotiating a fair "facility fee" for the office-based surgery suite. See Guidebook for details.
11. **Efficacy and Safety**: Address efficacy, safety, reduced pre-op tests, post-op care and patient satisfaction research.
12. **Other Issues**: Determine if other procedures or other issues need to be in this contract.

## Example Negotiating Strategies

**Negotiating Tactic:** Our initial feedback (DEC 2021) is that surgeons ideally would like a total reimbursement amount between $1,000 and $1,500 for ECTR. That includes the Pro Fees (professional fees) per the Medicare fee schedule and the negotiated overhead reimbursement. That is a lot—our goal is to aim high with the expectation that the insurance carrier will counter with a lower amount.

Your best resource is the newly added [Contract Negotiation Decision Tree graphic and spreadsheet](https://12uh.com/ioectr/ioectr-carrier-negotiation-decision-tree/) available for free download on the website.

**Only Heard Here:** We have one report of total reimbursement of $1,500 for IOECTR. The surgeon performs a lot of them with four operating rooms. My guess is that all of the leverage factors lined up perfectly and the insurance carrier saved money at that price point. For most, I think $1,000 is a more reasonable expectation.

## Negotiation Breakout Summary

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **0.1** | **Category** | **Description** | **Decision** | **Amount** |
| 0.5 | Calculate Estimate\* | Using your methodology of choice estimate your starting request for IOECTR reimbursement. | Starting Amt. |   |
| 0.75 |   | Remember, there are at least 97 hand-and-wrist procedures with zero SOSD. You should negotiate for all of them. |   |   |
| 1 | Cash price 1 | Endoscopic Carpal Tunnel Release (includes surgery, facility & anesthesia) | **Estimate 1** |  **$ 3,100**  |
| 2 | Cash price 2 | Endoscopic Carpal Tunnel Release (St George Utah)  | **Estimate 2** |  **$ 2,600** |
| 3 | Breakout: PROFEE | Doctor's Fees: (seems high per RVU) (From Medicare Price Lookup site) | Pro Fees |  $ 756  |
| 4 | Breakout: FACILITY | HOPD (see below for ASC and hospital): | Facility Fee |  $ 1,297  |
| 5 | Breakout: ANESTHESIA | Facility Anesthesia Expense (billed separately from anesthesiologist): | Anesthesia Fee |  $ 408  |
| 6 | Breakout: PRE-OP EXP. | Pre-op office visits and labs for general anesthesia. (this is a guess; need more data) | Pre-Op Costs |  $ 250  |
| 7 | Total Breakout: | Estimated amount includes (surgery, facility, anesthesia, and pre-op expenses). | **Estimate 3** |  **$ 2,711**  |
| 8 | Research Paper | Reusable System Cost estimate (does not include OBSS-specific costs) (Add Anesthesia & OBSS items and amount is roughly $1500\*\*  | **Estimate 4** |  **$ 1,019**  |
| 9 | Preferred total payment | Feedback is that surgeons would like between $1000 and $1500 total reimbursement for IOECTR. | **Estimate 5** |  **$ 1,500**  |
| 10 | **Negotiate** | Ask for 80-85% of the ASC/HOPD/Hospital cost: That is high and expect them to negotiate down.  |   |   |
|  |  | **\*All amounts above are estimates only. Use your own data.** |  |  |

See the [Decision Tree Spreadsheet](https://12uh.com/ioectr/ioectr-carrier-negotiation-decision-tree/) on the website for more information.

## Decision-Tree Point System

See graphic and Excel SS for details.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 |   | Asking Price | Feedback is that surgeons would like between $1000 and $1500 total reimbursement for IOECTR. So start negotiation at $1500 noting that the ins. Co. will negotiate down from your starting point. | POINTS |
| 2 |   | Negotiate | Ask for 80-85% of the ASC/HOPD/Hospital cost: That is high and they may likely balk but we expect them to negotiate down. You need to know about what their total costs are but get them to tell you rather than you tell them how much you want. If their costs are $2500, you could start at $2000 instead of $1500. |   |
| 3 |   | COLA | Check your Cost of Living percentage using the Cost Index TAB in this Workbook and adjust accordingly. A high COL does not increase your chances, but it does raise your asking price. |   |
| 4 |   | The Right Person | The most important factor to insurance carrier negotiation success is talking to the right person.  | 100 |
| 5 |   | OBSS friendly | OBSS friendly negotiator | 100 |
| 6 |   | ECTR friendly | ECTR-friendly negotiator | 100 |
| 7 |   | Surgery POS | Hospital: 15 points (if this is the only other local option you should be able to name your price): | 15 |
| 8 |   | Surgery POS | HOPD: 5 points | 5 |
| 9 |   | Surgery POS | ASC: No points. This is the default facility option. | 0 |
| 10 |   | Add Points If | You perform procedures that no other orthopedic surgeon performs in your area. | 15 |
| 11 |   | Add Points If | You are part of a large multi-specialty clinic. | 7.5 |
| 12 |   | Add Points If | The insurance carrier MUST have you in-network. | 25 |
| 13 |   | Add Points If | Your only facility option in your area is the hospital or HOPD, which have higher facility fees than the ASC. | 10 |
| 14 |   | Add Points If | Determine if "walking away" is an option. Could you drop an insurance carrier as in-network? Is it a bluff or actual negotiating option? | priceless! |
| 15 |   | Add Points If | You have a skilled contract negotiator or your clinic currently has carve-outs for other procedures. | 7.5 |
| 16 |   | Add Points If | Largest orthopedic clinic in the area. | 4 |
| 17 |   | Add Points If | If the number ECTR procedures are increasing every year. | 4 |
|   |   | **Subtract Points** | If you perform WALANT, using only Local Anesthesia, at a facility, subtract 10 points. The default assumption is that the insurance company is paying for general anesthesia. | **-10** |
|   |   |   | The higher your point total, the better your chance of negotiating a fair reimbursement amount. |   |
|   |   |   | Be honest with yourself regarding your success. |   |

In terms of negotiating, be aware that median NON-FAC PE numbers are in the $118.74 and $138.59 range. That is low. For ECTR an approximate calculation would be $526 for the Professional Fees) plus $371 (1/2 of the ASC facility rate of $742.00) for a total of $897.

Add the general anesthesia and the pre-op expenses. Note that the HOPD rate is $1,422 so calculate how many procedures were performed in the HOPD (and hospital) the previous year and use that information to negotiate for the higher rate. How much you can negotiate is based on your clinic’s leverage and your facility mix discussed earlier.

**NOTE:** Any **pre-op visit** or lab that would be required for general anesthesia for example is not part of the ECTR CPT™ code NON-FAC PE amount but should be included in your negotiation. Be sure to think of all the costs involved when using a facility. Also note that the PE costs change if you would perform WALANT (and anesthesia Level I) in the ASC versus Level II or III anesthesia.

Another option, for a negotiated contract, a clinic could use **actual expense data** if they felt they required higher reimbursement than an estimated amount for all IOECTR patients. Private carriers can pay either according to their fee schedule, a percentage of Medicare or a percentage of billed charges.

Negotiating 101 implies that you should *always* ask for more than you want with the expectation that the insurance carrier will surely counter with a lower amount.

Spending days formulating actual office PE expenses for ECTR is a tedious task; there is a wide variance in inputs, data accuracy, terminology, and costs in relation to the size of the clinic. While it is valuable to have this information available in some form (macro or micro) it may not be your best or first weapon of choice. I would have an estimate of your actual expense if the carrier asks for it or want to get into expense detail. Every negotiation will be different.

## Contracts

Large, multi-specialty clinics often will negotiate special agreements with insurers if they have leverage in a given market. I refer you to the Decision-Tree spread on the website for more information.

Whenever you sign with an insurance company, if you have unique services, or special requirements you will need to negotiate with each insurance company–individually. It is a time-consuming process. In regard to office-based surgeries, some carriers will agree to your request and some will refuse to pay for IOECTR and require that it only be performed in a facility.

Note: Once the carrier is sold on paying you an SOSD, the next issue will be *how much they pay.*

If your clinic has 85 % of the orthopedic surgeons in a small market, or your surgeons are the only ones performing ECTR, for example, you can request payment for procedures that may not be in their fee schedule. For example, CPT™ category III codes, (aka “T” codes for investigational, experimental or new technology) are typically *not paid* by any insurance carrier; they have zero RVU’s in the Medicare fee schedule.

However, if your clinic has a surgeon who performs a procedure that is deemed to be medically necessary and valuable to their patient base, you may have enough leverage to negotiate a fair payment. A few “T” codes *are* paid–but that is often the result of extensive lobbying and assistance from the vendor–and a team of coding and reimbursement experts. In contract negotiations the focus is always the benefit to the patients and the insurance carrier–not the surgeons or the practice. If your service is valuable the carrier needs to have your surgeon “in-network.”

As discussed earlier, when you submit CPT™ code 29848 for ECTR with a POS=11 (office) that may flag the claim. There are four options:

1. It may be denied as a “wrong place of service.”
2. It may be paid at the “facility” rate meaning there is no compensation for the overhead of the OBS suite. The insurance company saves on paying facility fees; you get the facility rate and nothing additional.
3. It may be paid at a higher rate (rare) without negotiation if the carrier has a policy to encourage OBS since they will save money (versus paying the ASC facility rate). While possible I assume this is a very rare event.
4. You negotiate a favorable reimbursement amount, roughly between $1,000 and $1,500.

If a patient prefers the WALANT, local anesthesia form of ECTR, then it is also possible that the particular surgeon is not **in-network**; in any given city there may be few surgeons (if any) who perform the procedure in the office, under local anesthesia. You will need to request that they pay you an **in-network rate**. The issue of in-network versus out-of-network is a separate issue that also should be addressed by the negotiation period. Just be sure to ask that they include patients that are not in-network in your carve-out. They may balk but so few provide this service they may allow it.

You may hear the term **Single Case Agreement (SCA**), which is a contract between an insurance company and an out-of-network provider for a specific procedure or patient. The fee and terms for the service paid by the insurance company is negotiated by the insurance company and the provider as part of the SCA. Typically, this is for an individual patient–not a blanket contract for a service—so this is not an SCA contract but a carve-out for at least one year.

A contract is not *always* required for the insurance carrier to pay the clinic an SOSD; your carrier may decide to pay the clinic for the office overhead without one. That is very rare but the larger the carrier, and the more knowledgeable they are about OBS, WALANT, NON-FAC RVU’s and the benefits of OBS to the patient and the carrier the greater the chance that they see the benefits of supporting your OBSS efforts.

## How Does One Negotiate the Rates of Payment and Terms of The Contract?

In addition to simple cost savings, insurance companies are *legally obligated* to provide patients with adequate treatment by properly trained professionals. Negotiations can be very straightforward or complex. The carrier may be already familiar with and completely open to the Office-Based Surgical Suite and welcome it with open arms. Or they may simply say, “perform all your procedures in a facility.” Currently, there are hundreds of clinics performing cataract surgery in the office; which also does not have an SOSD; the same is true with numerous podiatry surgical procedures. The successful clinics were able to negotiate a favorable payment that is beneficial to everyone.

NOTE: If the carrier fee schedule already has different payments for non-facility (office) and facility then there is no need for a negotiated contract. You will be paid extra for the office surgical suite. If you disagree with the additional amount (for open CTR for example) and are large enough and/or have leverage, then you could request a more appropriate reimbursement amount as part of your negotiation. Essentially that is what a carve-out is–the procedure is special; I’m special and here is why we want special treatment and compensation.

If you’re in a solo practice, it may be more difficult to successfully negotiate a contract. Also, your staff may not have much experience with negotiating a carve-out. In that case, read carefully all of the contract negotiation material and perhaps seek out a professional healthcare contract negotiator.

# Section Two

Steps for setting up an office-based surgical suite:

1. Decision Process
2. Benefits
3. Logistics
4. Registration, Licensing, and Accreditation Issues
5. Safety
6. Marketing

I will be adding to this section as I work with more surgeons implementing OBSS. Be sure to read [Anesthesia Levels](#_Anesthesia_Levels) and [Office Surgery Levels](#_Office_Surgery_Levels). Typically, the complexity and risk of a surgical procedure will be correlated with the level of anesthesia. However, they are separate issues.

## Registration, Licensing and Accreditation Issues

Many states require a registration, license, accreditation, or state certification for office-based surgery.

Each state is different and if you only use local anesthesia (WALANT) this may not be an issue.

Hospital privileges *may* be required and an emergency plan in place in the event of a severe adverse effect. Note that accreditation and safety issues, preparing for and creating the office-based surgical suite has nothing to do with the specific issue of reimbursement, which is the focus of **Section One**. They are separate issues. **Section Two** is for those who are deciding whether to perform IOECTR and establish an office surgical suite.

The requirement is typically based on the levels of anesthesia used and/or the complexity of procedure performed. For instance, New York and Pennsylvania refer to pain management as "invasive and complex" regardless of whether anesthesia or moderate sedation is used with the procedure.

At least twenty-six health departments have regulations including Alabama, Arizona, California, Colorado, Delaware, Connecticut, DC, Florida, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Mississippi, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia and Washington.

**Accreditation** focuses on Accepted Standards of Care–what is "safe and appropriate" for the procedure performed. Accreditation bodies vary in their physical environment regulations; regulations are specific to the types of procedures and level of anesthesia. Accreditation by a third party is the most typical way of satisfying the office-based surgery state regulation. A few states require their own survey. In either case, both the state regulations and the accreditation standards will have governance.

**NOTE:** Accreditation does not mean you can bill for facility fees. The office (POS=11) is never a facility.

Some clinics create a separate corporation and tax ID for the office surgical suite. That still does not allow you to bill it as a “facility”. That would be illegal. The POS is office (11) and that is not considered a facility–even if you have a dedicated surgical office suite. CMS is the authority having jurisdiction for ambulatory surgery centers only; CMS does not govern office-based surgery suites.

**Design requirements** for office-based surgery suite. Issues to address include:

1. Local building codes – the number of exits, widths of exits
2. Zoning ordinances – parking, setbacks, height & area limitations, landscaping
3. Plumbing codes -- required toilets, etc.
4. HIPPA requirements-- privacy by design.
5. Checkout separation
6. Personal space in waiting rooms
7. Door swings
8. Sight-lines & patient orientation
9. Soundproofing
10. Accessibility Codes
11. Americans with Disabilities Act
12. State & city-specific requirements

**NOTE:** The information provided here is for information only and changes continually. It is recommended you work with an in-state healthcare attorney or consulting firm familiar with in-office surgical suites before making crucial decisions.

**Additional Things to Ask**

Ask what is *deemed status* and whether that would be necessary for your office-based surgical suite in your state? This is related to accreditation and if that is not necessary for IOECTR in your state it may be a moot point.

## State Laws and IOECTR (OBS)

Practitioners performing office-based surgery (OBS) should be familiar with the laws and leading issues associated with OBS procedures. If only minimal sedation or local anesthesia is used then the IOECTR procedure requirements may be minimal.

In the past decade, there has been a steady increase in WALANT and office-based ECTR

While advances in medical technology have enabled more procedures to be performed in an office setting, patient safety concerns remain crucial and warrant a re-examination of legal and regulatory oversight.

The precise definition ***varies from state to state;*** an OBS procedure is generally any surgical or diagnostic procedure performed in a physician’s medical office that is invasive or involves subcutaneous penetration, excluding minor surgical procedures. Most jurisdictions classify procedures as “surgical” or “invasive” based on the ***type and level*** *of sedation or anesthesia used*.

In this document we are using the Medicare definition; any 90-day global procedure is considered “major surgery”. Note that this covers a wide range of procedures in terms of complexity, the time required, and risk to the patient. By definition, a 10-day global procedure is considered “minor surgery.” While most 10-day global procedures are routinely performed in the office, exceptions abound. Some 10-day procedures have higher RVU’s than 90-day.

### Candidates for Level II procedures

In the state of NC, patients with an **ASA Physical Status Classification** I, II, or III may be acceptable candidates for **office-based surgical** or special procedures requiring **conscious sedation/ analgesia.**

ASA physical status classification III patients should be specifically addressed in the operating manual for the office. They may be acceptable candidates if deemed so by a physician qualified to assess the specific disability and its impact on anesthesia and surgical or procedural risks.

In the state of NC, only patients with an ASA physical status classification I or II, who have no airway abnormality, and possess an unremarkable anesthetic history are acceptable candidates for Level III procedures.

**NOTE:** As I repeat often, most guidelines *do not* apply to local anesthesia only (WALANT). These are FYI if anyone asks about them.

## State Guidelines

Based on feedback from third-party payers, health maintenance organizations and the federal government many states have adopted guidelines for the management of an in-office surgical suite (some may call it an in-office surgical *facility* but I would prefer not use the term *facility* to avoid confusion.

Managed care organizations, through the **National Committee for Quality Assurance** (a primarily private-sector organization for evaluation and accreditation of managed care organizations), have pressed for **National Standards for An Office-Based Surgical Facility (OSF).**

**The American College of Surgeons** has recognized a need for this process. In addition, the College has recognized that compliance with standards of national accreditation organizations may be unduly burdensome or impossible for a small practice. Indeed, it is possible that those responsible for making national directives for a surgical practice have little appreciation for the reality of that practice. For these reasons, the College, in maintaining its mission of ensuring quality surgical care to all patients, has fostered the development of guidelines for surgeons, by surgeons, who provide ambulatory surgical care.

## Regulation 35 Office-Based Surgery

Posted on the Arkansas Medical Board website, the complete three-page document is [available on the Arkansas Medical Board website](https://www.armedicalboard.org/Professionals/pdf/REGULATION%2035%20Office-based%20Surgery.pdf). These are guidelines for OBS specifically in the state of Arkansas.

## Medical Board of Georgia Office-Based Surgery and Anesthesia Guidelines

[**Guidelines for Optimal Ambulatory Surgical Care**](https://web4.facs.org/ebusiness/ProductCatalog/product.aspx?ID=126#:~:text=Guidelines%20for%20Optimal%20Ambulatory%20Surgical%20Care%20and%20Office-Based,an%20appropriate%20manner%20and%20in%20a%20safe%20environment.)

**Guidelines for Optimal Ambulatory Surgical Care and Office-Based Surgery**

Developed by the Board of Governors Committee on **Ambulatory Surgical Care**. A set of optimal educational guidelines to help the surgeon in the office practice of surgery provide this service to patients in an appropriate manner and in a safe environment. (May 2000).

NOTE: This applies to Ambulatory Surgical Care and is FYI only. The concepts may be valuable but this is for a facility, not an OBSS.

Price: Single copies: Free; Additional: $5 each; 10 or more copies: $4.50 each

Developed by the Board of Governor's Committee on Ambulatory Surgical Care is a comprehensive, commonsense application of good surgical principles to an outpatient setting. Included in these guidelines are sections on:

1. Administration
2. Facility Design
3. Ancillary Services
4. Surgical Care
5. Quality Assurance

### New York State laws

### What are the Office-Based Surgery (OBS) NY laws?

The laws that refer to OBS in the State of New York are Public Health Law (PHL) § 230-d and 2998-e, State Education Law § 6530(48)

To view copies of those laws, return to the Office-Based Surgery home page on this website and go to the section: "Laws of New York". That section contains the laws noted above.

Minor integumentary procedures are performed with minimal or no sedation, and therefore can be performed in offices **not requiring OBS accreditation**. Generally, magnetic resonance imaging (MRI) procedures are not subject to this law.

However, MRIs and other imaging studies that involve administration of **intravenous contrast** must be performed in an accredited OBS office if the patient involved receives moderate or deep sedation, major upper or lower extremity nerve blocks, neuraxial or general anesthesia.

If only minimal sedation and/or local or topical anesthesia is required to complete or attain sufficient patient comfort for the procedure, then it is exempt from the OBS statute and the office-based surgical suite does not need to be an Article 28 licensed facility or an accredited OBS practice.

### When did the laws regarding Office-Based Surgery become effective in NY?

 **NOTE:** The information below relates to New York state only.

Effective January 14, 2008, the OBS adverse event reporting requirements began for any licensed physician, physician assistant or specialist assistant (licensees) under PHL§ 2998-e. See OBS Adverse Events below.

Effective July 14, 2009, physician practices performing Office-Based Surgery (OBS) were required to be accredited by an agency designated by the Commissioner of Health.

Effective February 17, 2014, podiatrists privileged to perform ankle surgery by the State Education Department seeking to perform such surgeries in office(s) of a private podiatry practice utilizing more than minimal sedation or local anesthesia must be OBS accredited and file adverse event reports with the Department of Health.

Effective April 13, 2016, the deadline for submission of an OBS adverse event was extended from 24 hours to 72 hours and OBS practitioners were required to report two additional adverse events; unplanned emergency department visits within seventy–two hours of office-based surgery and unscheduled assignment to observation services within a hospital occurring within seventy–two hours of office-based surgery.

### What is Office-Based Surgery?

Public Health Law (PHL) § 230-d defines Office-based Surgery as "any surgical or other invasive procedure\*, requiring general anesthesia, moderate sedation, or deep sedation, and any liposuction procedure, where such surgical or other invasive procedure or liposuction is performed by a licensee\*\* in a location other than a hospital, as such term is defined in article twenty-eight\*\*\* of this chapter, excluding minor procedures\*\*\*\* and procedures requiring minimal sedation." (See definitions of sedation at question 8 below.)

**Invasive Procedures:** are procedures performed for diagnostic or treatment purposes that involve puncture, penetration or incision of the skin, insertion of an instrument through the skin or a natural orifice, or insertion of foreign material other than medication into the body.

Invasive procedures include, but are not limited to, the injection of contrast materials such as used for an MRI or CT scans when these imaging procedures are accompanied by moderate or deep sedation, major upper or lower extremity nerve blocks, neuraxial or general anesthesia.

\*\*\*\*The OBS law defines minor procedures as "(i) procedures that can be performed safely with a minimum of discomfort where the likelihood of complications requiring hospitalization is minimal; (ii) procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less than 500 ml of fat under unsupplemented local anesthesia."

\*\*The OBS law initially defined licensee as an "individual licensed or otherwise authorized under articles one hundred thirty-one or one hundred thirty-one-B of the education law." Individuals licensed under these laws include physicians, physician assistants and specialist assistants. In 2012 the definition of "licensees" in the OBS law was expanded to include podiatrists licensed under article one hundred forty-one of education law and privileged by the State Education Department to perform ankle surgery.

### California State Laws

Each state has a .gov Medical Board. These provide accreditation, license or certification. Note "outpatient surgery settings" could mean anything so pay careful attention to definitions.

<https://www.mbc.ca.gov/Consumers/Outpatient_Surgery/>

### Do California outpatient surgery settings or ambulatory surgery centers have to be accredited, licensed or certified?

In order to protect consumers, the Legislature passed various laws to prevent surgeries from being conducted in **unregulated out-of-hospital settings**. California law prohibits physicians from performing **some outpatient surgeries**, unless they are performed in an accredited, licensed, or certified setting.

Specifically, if the surgical procedure requires **anesthesia** to be administered in doses that have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, **then the surgery must be performed in an accredited, licensed, or certified setting.**

If the surgery only requires **local anesthesia or a peripheral nerve block** (complying with the community standard of practice), or if the setting administers anxiolytics (anti- anxiety medications) or analgesics (“pain killers”) in doses that do not place the patient at risk for loss of life-preserving protective reflexes, then the surgery **does not have to be performed in an accredited, licensed, or certified setting.**

**Where can outpatient surgery take place?**

Outpatient surgery, as described above, may take place at any of the settings listed below. Questions or complaints about an individual facility should be directed to the appropriate regulating agency.

An outpatient setting that is accredited by an accreditation agency approved by the Medical Board of California. This includes:

1. A **Surgical Clinic** licensed by the California Department of Public Health.
2. An **Ambulatory Surgical Center** certified by the Center for Medicare and Medicaid Services to participate in the Medicare program.
3. Other approved settings (see Health & Safety Code Section 1248.1).

The **Medical Board of California** only has jurisdiction over the accredited outpatient surgery settings in that the Board approves the accreditation agencies that inspect and accredit these settings.

The list of state agencies and guidelines above is representative only. It is not meant to be all-inclusive. Regulations and guidelines change often. Be sure to contact all your local agencies before proceeding with an office-based surgical suite.

## Summary

The information in this guidebook can help all who:

1. Are interested in OBS and WALANT.
2. Desire to establish an OBSS and negotiate with their carriers for reimbursement “carve-outs” for those procedures that do not have an SOSD.
3. Help promote the benefits to the patients, the insurance carriers, and the surgeons of OBS.
4. Specifically, assist those performing hand-and-wrist procedures with IOECTR as an example.

In **Section One** we discussed the lack of an SOSD for IOECTR and provided background and information on how best to negotiate a carve-out contract with your insurance carriers.

In **Section Two** we reviewed Information on how to establish an office-based surgical suite for IOECTR and other procedures.

The **Appendix** includes additional background information for the truly curious. It might be overkill for most administrators and physicians but I decided to include it as optional information.

Please [contact me](https://12uh.com/ioectr/contact-us/) if you have feedback or questions. We are updating this document continually and there should be updates at least every month. It’s best to send me your e-mail address so I can notify you of updates.

## Author Biography

Jeffrey Restuccio, CPC, COC, MBA is a resident of Memphis, TN since 1980. He has two coding certifications: The Academy of Professional Coders (AAPC) certified professional coder for physician (outpatient) reimbursement and the AAPC certified professional coder for hospital (inpatient) reimbursement. Jeff has been a certified coder since 1999.

Jeff has the unique combination of over twenty years of experience, medical coding certification (CPC & COC), training experience (medical coding and billing), a strong background in databases and Information Systems, and an MBA in Finance.

Jeff is an experienced healthcare educator and auditor, having conducted over 365 live training courses, worldwide on CPT and ICD-10 coding and billing since 2007. He has personally audited over 10,000 medical records. Over his career he has instructed thousands of doctors, coders and billers through his online training courses and reimbursement manuals.

Jeff has assisted several companies with unique requests including new HCPCS code submission, preparing white papers outlining the reimbursement landscape and the submission process as well as the many reimbursement hurdles with new codes and technology.

He consulted with a national children’s hospital in Memphis TN, full-time for over 18 months. I trained their coding staff, assisted in converting from an outside to an inside billing system. He created and implemented a *carrier-specific* rules database for over 350 insurance carriers by carrier and CPT™ code.

Jeff has taught coding and revenue cycle *internationally* (United Arab Emirates) working with Providers and staff to learn CPT™ concepts and documentation standards.

Jeff has also worked with reimbursement database startup companies teaching reimbursement concepts to management and the programming staff. This included all revenue cycle sites of services: office (professional fees), outpatient, ASC, HOPD, and inpatient hospital.

He has worked with numerous vendors (Alcon, Abbot, Pfizer), software companies (Eli Global) and state medical (optometry) associations (CA and NE). Jeff has taught coding, billing, and compliance seminars at several universities (Ketchum [CA], New England School of Optometry, and Nova College of Optometry).

Jeff has a BA from West Virginia University and an MBA from the University of Memphis.

## Glossary

OBS: Office-Based Surgery is any surgery performed at POS=11. Even if you have a separate Tax ID never bill it as a facility or anything other than 11.

OBSS: Office-Based Surgical Suite. The O/R is setup at the medical practice and billed as POS=11. It is not a facility and cannot be billed as one.

Site of Service Differential (SOSD): is the difference between the non-facility (office) practice expense (NON-FAC PE) and the FAC PE. If the SOSD is zero then the “Non-Facility NA INDICATOR” field in the Medicare PFSRVU 2021 database will be "NA". This is considered a “facility-only” procedure. It is payment for the “overhead” or “facility fee” for the office.

Facility: This means “not office” and includes an Ambulatory Surgery Center (ASC), Hospital Outpatient Department (HOPD), or a Hospital Inpatient. The office is not a facility. Therefore while the SOSD is the “facility fee” for the office-based surgical suite, it technically should never be referred to as a “facility fee” because that has a very specific meaning. The hospital, ASC, and HOPD are facilities.

PE / Practice Expense (Overhead) includes: staffing; clinical services, supplies, and equipment; office space; office supplies and services, and professional services.

Overhead (PE): this includes both direct and indirect costs for the facility or office-based surgical suite.

NON-FAC PE: Non-Facility Practice Expense; this simply means the Place of Service is office (11) or not a recognized facility.

FAC PE: Facility Practice Expense. When the facility is paid separately use this amount. This applies to a hospital, HOPD, or ASC.

Total RVU's=W+PE+M: Work=physicians’ skill and expertise; Practice Expense = overhead; M=Malpractice insurance. There is also a fourth element: A Geographic Price Cost Index (GPCI). More information on [RVU’s is available here](#_RVU_Basics).

Professional Fees this is the payment that goes to the surgeon. When people talk about high hospital costs most of the charges are for the facility, the hospital, not the surgeon.

Facility Fees go to the ASC, HOPD or Hospital. For OBS the facility reimbursement is included in the professional fees (surgeon payment). These are submitted on the UB-04 form. The reimbursement methodology is different for each location.

WALANT: Wide-Awake Local Anesthesia, No Tourniquet is a technique where minimal anesthesia is used and the patient is awake and able to communicate during the procedure. More information on WALANT is provided in the Appendix.

Place of Service (POS): The location where the surgery was performed. Office=11.

**Place of Service Codes**

Reimbursement varies based on the location of the surgery. DRG pricing applies to a patient admitted to a hospital for inpatient services. The Place of Service (POS) codes are:

POS 11: Office

POS 21: Inpatient Hospital (admitted)

POS 22: Hospital Outpatient Department (HOPD)

POS 23: Emergency Room (not a POS for ECTR)

POS 24: Ambulatory Service Center (ASC)

Conversion Factor (CF): Reimbursement amount per unit for professional and facility fees (different values)

HCPCS: Healthcare Common Procedure Coding System

OPPS: Outpatient Prospective Payment System

APC: Ambulatory Payment Classification

APC Status Indicators: J1 – Hospital Part-B services paid through a comprehensive APC

CC: Complication and/or Comorbidity

MCC: Major Complication and/or Comorbidity

MS-DRG: Medicare Severity Diagnosis Related Group. Other MS-DRGs may apply

Separate procedure: are considered to be incidental and bundled with any related comprehensive/major procedure when performed during the same session, through the same incision, and/or at same anatomic site.

NCCI edits: These are lists of codes that cannot be reported on the same Day of Service (DOS). There are “breakable” edits (those that can be appealed with use of a modifier).

# Appendix

## When Endoscopic CTR Turns Into Open CTR Coding

The National Correct Coding Initiative Policy Manual for Medicare Services updated Jan. 1, 2017 states: CPT™ code 29848 describes endoscopic release of the transverse carpal ligament of the wrist. CPT™ code 64721 describes a neuroplasty and/or transposition of the median nerve at the carpal tunnel and includes open release of the transverse carpal ligament. The procedure coded as CPT™ code 64721 includes the procedure coded as CPT™ code 29848 when performed on the same wrist at the same patient encounter. If an endoscopic procedure is converted to an open procedure, **only the open procedure may be reported.**

## Reporting and Coding for Code the Manos Procedure for Carpal Tunnel

**Question:** Which of these codes would you report?

64721 (neuroplasty and/or transposition; median nerve at carpal tunnel)

29848 (endoscopy, wrist, surgical, with release of transverse carpal ligament)

64999 (unlisted procedure, nervous system)

**Answer:** Understanding how a procedure is performed is key to the correct code choice. The procedure is performed through two small punctures, therefore it would **not** be correct to report 64721. Because the procedure is **not** performed with the use of an endoscope, it would also not be correct to report using code 29848. The correct code choice in this scenario is 64999 (unlisted procedure, nervous system).

## What is WALANT?

Many hand surgery procedures such as **carpal tunnel release, tendon repair and removal of masses** can now be performed under local anesthesia alone, avoiding the use of sedation or general anesthesia. The technique—known as Wide-Awake Local Anesthesia, No Tourniquet **(WALANT**)—can be performed in the surgeon's office. The ability to safely control bleeding and extend the duration of local anesthesia allows hand surgeons to perform many procedures with minimal bleeding and without the use of sedation, general anesthesia or a painful tourniquet to control bleeding. WALANT also can be used safely in patients who have medical complications or take blood thinner medications—factors that might otherwise preclude surgery. While WALANT can be performed in an Ambulatory Surgery Center, it is often performed in the office and therefore considered an Office-Based-Surgery (OBS).

Hand surgery has traditionally been performed under anesthesia due to the common use of a tourniquet. While the tourniquet prevents blood flow to the limb in order to achieve a bloodless operative procedure, it is particularly painful for an awake patient.

In this revolutionary procedure, the tourniquet has been replaced by two medications in order to avoid anesthesia. These medications are lidocaine (to block pain), epinephrine (to stop bleeding – a task formerly achieved with the tourniquet) and sodium bicarbonate (to buffer the solution to make it nearly painless). In WALANT typically lidocaine and epinephrine 10:1 are buffered with 8.4% bicarbonate.

## RVU Basics

**What are RVUs?**

Relative Value Units (RVUs) are used by Medicare (and private insurance companies) to determine how much physicians are paid for providing healthcare services. Total RVUs have three components: Physician Work Expense, Practice Expense, and Malpractice Expense. Add to these the Geographic Practice Cost Indices (GPCI) multiply by the current Medicare Conversion Rate and these are five RVU components necessary for accurate reimbursement calculation. These are all explained below. The PFSRVU file for 2022 is available from the Medicare Website.

**Practice Expense (RVUp):** This is composed of the direct costs (supplies, non-physician labor, equipment cost, etc.), and a factor accounting for the indirect costs, of providing the medical service (overhead for the office). In the Medicare PFSRVU database there are *Facility* Practice Expenses and *Non-Facility* Practice Expenses. When these two PE values are the same that means there is *no* Site of Service Differential, the procedure is considered “facility-only” and the Office-Based surgical suite *overhead* is not reimbursed. NON-FAC PE and FAC PE are discussed in more detail later.

**Malpractice Expense (RVUm)**: This includes malpractice (professional liability) and other insurance expenses. These costs are separated from general overhead expenses so they can be tracked separately, and because they vary quite widely based on geography.

**Physician Work (RVUw)**: This includes items such as the physician’s time (salary), training, skill, judgment, etc. necessary to provide the service. If a procedure is more complex, it is assigned a higher “work” value. This value is the same whether the procedure is performed in the office or a facility.

The three values above equal the total RVU’s for a given procedure or service. Once that is calculated it is multiplied by the GPCI, below and the current Medicare Conversion Factor (2022=$34.6062) to determine the Medicare Allowable Reimbursement. Medicare pays 80% of the Medicare Allowable and the patient is responsible for the remaining 20%.

Due to *budget neutrality changes* required by law, The 2022 Medicare conversion factor will be reduced by about 3.85% from $34.8931 (2021) to $34.6062 for 2022.

**Geographic Practice Cost Indices (GPCI):** Any given procedure would be more expensive if it was provided in San Francisco CA than in rural Tennessee. These are national GPCI tables and these apply the same to all procedures.

There’s a geographic adjustment for practice expense, another for malpractice expense, and a third GPCI for physician work).

**The RVU Formula is:**

Relative Value = (Practice Expense RV \* Practice Expense GPCI) + (Malpractice RV \* Malpractice GPCI) + (Physician Work RV \* Physician Work GPCI)

There are other factors that impact reimbursement such as modifiers and the 150% Rule (where the second procedure is paid at 50% and not 100%) or when surgical assistants are used.

The total RVUs determine reimbursement rates for each procedure provided by a physician. Procedures are coded using CPT™ Codes–a standard developed and provided by the American Medical Association (AMA). Multiply the RVU for a procedure by the Medicare Conversion Factor to arrive at a Medicare reimbursement rate for any given CPT™ code.

## Insurance Policies Regarding Office-Based Surgery

**Unicare,** an Anthem Company has a policy C-13002, 4/6/2018 on the subject of overhead expense for office-based surgery. It is one of the very few that addresses the Site of Service Differential. It is summarized below:

Policy UniCare reimbursement to a surgeon for Office-Based Surgery includes compensation for all expenses involved in the performance of the surgery.

UniCare does not separately or directly reimburse any other provider or vendor [this refers to the ASC or HOPD] that furnishes any of these expense items for or during performance of the office-based surgery unless such other provider or vendor has a contract with UniCare.

The office-based fee allowance that is paid to the surgeon who performs the office-based surgery is inclusive of all necessary overhead expenses.

UniCare incorporates office-based *site of service differentials* in its fee schedule methodologies for most routinely and commonly performed office-based surgeries. [It is not clear here if Unicare adds an SOSD where none currently exists or simply follows current PFSRVU FAC and NON-FAC PE reimbursement.- Jeff]

Consequently, only the surgeon who performs the surgery may submit claims to UniCare for office-based surgery and associated expenses.

**Site of Service Differential**

1. Difference in reimbursement, based on where the professional service is performed.
2. Some professional services may be provided either in a facility or a non-facility.
3. When a professional service is provided in a facility, the costs of the clinical personnel, equipment, and supplies are incurred by the facility, not the physician practice.
4. For this reason, reimbursement for professional services provided in a facility may be lower than if the services were performed in a non-facility setting.

## Carpal Tunnel Release Surgery Description

## Open Carpal Tunnel Release

Open release via this incision remains the predominant procedure, as this technique affords full inspection of the transverse carpal ligament, the contents of the carpal canal, and the ability to observe for possible anatomic variations of the median nerve.

## Endoscopic Carpal Tunnel Release

Using endoscopic techniques for transecting the transverse carpal ligament utilizing less invasive techniques has been developed **to lessen the possible complications** of the open procedure. The performance of endoscopic surgery is completed by transecting the transverse carpal ligament through small incisions, often placed outside the palm, away from the high-contact surface of the hand. Endoscopic release techniques of the transverse carpal ligament involve an incision approximately 1cm proximal to the distal wrist crease. The **one-portal** releases utilize this incision only. There is also a technique that utilizes **two portals**, the incision at the wrist, and a small palmer incision. The one and two portal releases use a variety of specially designed endoscopic devices to release the transverse carpal ligament.

## Benefits of ECTR

The scar issmaller and there are fewer complications, less incisional tenderness and earlier return of grip and pinch strengths permit the patient to return to work and Activities of Daily Living (ADL's) earlier than with OECTR.

Studies have also demonstrated that:

"despite a relatively high incidence of incomplete release of the transverse carpal ligament, endoscopic techniques consistently increase the carpal canal volume in a manner similar to that reported for open carpal tunnel releases".

As this quote notes, there is some question concerning this technique.

"Cadaveric endoscopic release studies and clinical case reports of endoscopic releases cite significant risks to and documented injuries of the median nerve, the deep motor branch of the ulnar nerve, the digital nerves, the superficial palmer arterial arch, the ulnar artery, and flexor tendons".

Endoscopic techniques have also had incidences of incomplete releases, as the surgeon is unable to visualize the ligament during this technique.

**Miniopen techniques** using small incisions placed away from the mid-palm have been developed for carpal tunnel release. Miniopen carpal tunnel release can be performed with a smaller palmer incision and a specially designed cutting guide. The proponents of these techniques claim that the small incisions lessen postoperative palmer pain but still afford the necessary visualization to minimize neurovascular injury and incomplete ligament release.

## ICD-10-CM Codes for Carpal Tunnel

ICD-10-CM breaks down carpal tunnel syndrome based on laterality. The codes are in Chapter 6, Diseases of the Nervous System:

G56.00 Carpal tunnel syndrome, unspecified upper limb

G56.01 Carpal tunnel syndrome, right upper limb

G56.02 Carpal tunnel syndrome, left upper limb

G56.03 Carpal tunnel syndrome, bilateral upper limb

## Place of Service (POS) Codes

Office= 11

Ambulatory Surgery Center (ASC) =23

Hospital OutPatient Department (HOPD) =22

Hospital (admitted) = 21 (an Emergency Room is a separate POS and a patient place on observation is not admitted).

## Global Days

A 90-day global period procedure is considered major surgery. This is a Medicare definition and does not necessarily reflect the time or complexity of the procedure as technology improves. Some 90-day procedures have an SOSD and some do not. This is determined by the AMA RUC committee, input by professional associations, physicians, and Medicare.

In general, 10-day global procedures are considered minor surgery and these are routinely performed in the office. They would only be performed in the facility if there was significant risk to the patient due to comorbidities.

##

## Office Surgical Suite Protocols

**Endoscopic Surgery** is highly effective and has been used for more than 20 years. It results in less post-operative pain, a minimal scar, and generally allows patients to resume some normal activities in a short period of time. Most protocols revolve around the following issues:

The laws that refer to OBS are:

Public Health Law (PHL) § 230-d and 2998-e

State Education Law § 6530(48)

**State Medical Board:** This is where you will most often find your state’s regulations for OBS.

**General Building Code Requirements**: These are local guidelines. Most are common sense. Ensure there is a recovery room, set up a waiting room and scheduling process.

**Level of anesthesia:** (Accreditation is based on this; it is generally not required for local anesthesia only). However always check with local state guidelines as they do vary.

**Contingency Plan for emergencies**. Since this is not technically a facility, ASC or HOPD rules do not apply. However there should be protocols for an adverse effect of the local anesthesia or other problem.

**Create a supply list:** Anything that the ASC provided you will need to have. Make a list. Below is an example.

A good FAQ on OBS from the New York state department of health can be found at [this LINK](https://www.health.ny.gov/professionals/office-based_surgery/obs_faq.htm).

## IOECTR Office-Based Equipment Needs

The information below is a rough draft of equipment needs. I need this reviewed and updated by ECTR surgeons. In addition, from a strategic negotiation perspective, getting into the weeds with the actual cost of supplies may not be the best way to justify a total cost of $1,000 to $1,500. It may never add up. The better strategy is the savings over the total cost to the insurance company when performed in the ASC, HOPD, or hospital. Transferring from the inpatient hospital saves the carrier the most, with HOPD next and last ASC. With that being said I would have some rough numbers if the issue is addressed during negotiations.

* Endoscopic equipment, supplies, anesthesia (WALANT).
* Microaire SmartRelease™ endoscopic soft tissue release system (minimally invasive, single-port technique)
* Dilator - small
* Dilator - medium
* Sterilization tray for SmartRelease 83040
* Elevator
* Video Monitor: Connects to standard camera couple [this is traditional supplied by the ASC therefore part of the “overhead” of the OBSS. BR Surgical Monitor 19 Inch, Wide-View for Endoscopic Video System ($2,507).

<https://www.devineexpress.com/products/br900-4419-br-surgical-monitor-19-inch-wide-view-for-endoscopic-video-system?variant=15393443708971&cmp_id=403238383&adg_id=1345802770256574&kwd=&device=c&msclkid=1060443ee1d31f04b4272439f76fc0c8>

Costs and lifespan of the ECTR equipment. The approximate life of the hand piece / endoscope is 5 years and about $6,000. Use your actual costs and depreciation schedule (ask your accountant).

**NOTE:** Since the endoscopic device is necessary regardless of the location, then I question whether that is a cost that should be included in the NON-FAC PE. Only supplies, personnel and costs that would be charged by the facility should be included in your NON-FAC PE calculation.

* Endoscopic hook
* Endoscopic knife
* Supplies (disposables) and support people needed for the procedure in the office. Calculate an FTE per hour and apply accordingly.
* Standard disposable blade assembly supply: a $200 blade is only good for one use
* Capes and drapes
* Local anesthesia inventory of drugs and cost.

If you are an ECTR surgeon please provide feedback on the information above. This is just what I was able to find. I am not an ECTR surgeon.

## Office Flow

While setting up your OBSS spend some time diagraming the flow of patients from scheduling, checking in, the waiting room, surgery, the recovery room and then post-op care. Remember that even though it is a separate office and may have its own billing ID, it is still Place of Service = 11 or Office. It is *never* a facility. It is not an ASC.

1. Hand and wrist surgery in the office setting
2. Scheduling
3. Ancillary staff
4. Patient Preparation
5. Surgery
6. Post-Op suite
7. Additional follow-up

## Statement on Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia

Updated on September 1, 2019

[**https://www.facs.org/about-acs/statements/118-office-based-surgery**](https://www.facs.org/about-acs/statements/118-office-based-surgery)

The **American College of Surgeons (ACS)** Board of Governors Surgical Care Delivery Workgroup recently revised and updated the 2004 ACS Statement on Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia, Deep Sedation/Analgesia, or General Anesthesia.

**NOTE:** Once again, safety protocols are based on the level of anesthesia. Therefore, these do not apply to WALANT or IOECTR performed under local anesthesia only! This is provided as information-only.

The original statement was the result of an ACS-sponsored resolution at a 2002 American Medical Association meeting urging collaboration to develop requirements and guidelines to ensure quality and safety for patients undergoing office-based procedures. Eventual discussions among more than 40 stakeholder organizations led to consensus on 10 Core Principles. In the intervening years, many of the Core Principles have become standards of care, while ever-increasing numbers of surgical procedures are performed outside of the hospital operating room setting.

The following revision reflects the ACS mission to improve the care of the surgical patient and to safeguard standards of care in an optimal and ethical practice environment. The ACS Board of Regents approved the revised statement at its June 7−8, 2019, meeting in Chicago, IL.

To ensure patient safety, the ACS believes that surgical procedures using deep sedation/analgesia or general anesthesia should only be performed in accredited surgical centers.

1. Physicians who perform office-based surgery utilizing moderate sedation/analgesia should have their facilities accredited by a national or state accrediting organization and be state-licensed.
2. Physicians should select patients for office-based procedures using the American Society of Anesthesiologists (ASA) Physical Status Classification System.\* Preprocedure patient evaluation, including history, focused examination, and any consultations with medical specialists, should be documented. ASA III and above patients should undergo surgical procedures in accredited surgical centers.
3. Informed consent for the nature and objectives of the anesthesia planned and operation to be performed should be in writing and obtained from patients before the procedure is performed. Informed consent should only be obtained after a discussion of the risks, benefits, and alternatives and should be documented in the medical record.†
4. Surgeons should perform procedures commensurate with their board certification, documented training and experience, and within their state-recognized scope of practice.
5. Anesthesia should be administered by experienced and licensed health care providers in accordance with national guidelines.‡ Individuals trained in Advanced Cardiovascular Life Support, intravenous access, management of airway complications, and the use of pharmacologic antagonists must be present when a surgical procedure using sedation is being performed. The patient must be monitored during recovery from sedation and discharge criteria met before leaving the facility.
6. Written protocols must be in place to transfer a patient who develops complications or requires a higher acuity of care to a qualified acute care facility. The governing body of the office-based surgery practice should conduct a regular review of patient transfers and adverse events and implement focused professional reviews of involved health care professionals as indicated.
7. The governing body of the office-based surgery practice is required to maintain records of physician credentialing and licensure and participate in a program of ongoing professional practice evaluation.

\*American Society of Anesthesiologists. ASA Physical Status Classification System (updated October 15, 2014). Available at: www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system. Accessed July 23, 2019.

†Federation of State Medical Boards. Report of the Special Committee on Outpatient (Office-Based) Surgery. 2002. Available at: www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf. Accessed July 23, 2019.

‡American Society of Anesthesiologists. Practice guidelines for moderate procedural sedation and analgesia 2018. Anesthesiology. 2018;128(3):437-479.

## What Is MAC Anesthesia?

Monitored Anesthesia Care (MAC) is a type of anesthesia service that renders a patient still aware, but very relaxed. It is also known as **Conscious Sedation** or twilight sleep, a type of sedation that is administered through an IV to make a patient sleepy and calm during a procedure. The patient is typically awake, but groggy, and able to follow instructions as needed.

**NOTE:** This would be an upgrade from Level I anesthesia to Level II. [The question is what percentage of IOECTR cases ever need to be upgraded? Any? A few? Is the surgeon able to do perform MAC or is an anesthesiologist required?]

**NOTE:** I found an article on ASAHQ.org that explains that MAC is **not** the same as Moderate Sedation. While the topic may be more than you ever wanted to know, I have included [the article here](#_Monitored_Anesthesia_Care).

This type of sedation is used for outpatient procedures, such as a colonoscopy, where the patient is expected to go home after the anesthesia has completely worn off. The amount of sedation provided during MAC is determined by the anesthesia professional (physician anesthesiologist or nurse anesthetist) providing the care.

A patient may be only lightly sedated, moderately sedated, or deeply sedated to the point that they’re completely unaware of the procedure. The patient may not even remember any events during the procedure.

The level of sedation administered depends on the health of the patient and the type of surgical or diagnostic procedure being done. This type of anesthesia is typically used for outpatient procedures where the patient will be going home once the anesthesia wears off.

Medications used during MAC include:

1. Midazolam (Versed)
2. Fentanyl
3. Propofol (Diprivan)

## Monitored Anesthesia Care MAC is DIFFERENT THAN moderate Sedation Analgesia Conscious Sedation

Distinguishing Monitored Anesthesia Care (ʺMACʺ) from Moderate Sedation/Analgesia (Conscious Sedation)

<https://www.asahq.org/standards-and-guidelines/distinguishing-monitored-anesthesia-care-mac-from-moderate-sedationanalgesia-conscious-sedation>

Developed By: Committee on Economics

Last Amended: October 17, 2018 (original approval: October 27, 2004)

**Moderate Sedation**/Analgesia (**Conscious Sedation**; hereinafter known as **Moderate Sedation**) is a physician service recognized in the CPT procedural coding system.

During Moderate Sedation, **a physician supervises or personally administers** sedative and/or analgesic medications that can allay patient anxiety and limit pain during a diagnostic or therapeutic procedure.

During Moderate Sedation the responsible physician typically assumes the dual role of performing the procedure and supervising the sedation. Such drug- induced depression of a patient’s level of consciousness to a “moderate” level of sedation, as defined in the Joint Commission (TJC) standards, is intended to facilitate the successful performance of the diagnostic or therapeutic procedure while providing patient comfort and cooperation.

Physicians providing moderate sedation must be qualified to recognize “deep” sedation, manage its consequences and adjust the level of sedation to a “moderate” or lesser level. The continual appraisal of the effects of sedative or analgesic medications on the level of consciousness and on cardiac and respiratory function is an integral element of this service.

The American Society of Anesthesiologists has defined **Monitored Anesthesia Care** (MAC) (see Position on Monitored Anesthesia Care, updated on October 17, 2018). This physician service can be distinguished from Moderate Sedation in several ways.

An essential component of MAC is the periprocedural anesthesia assessment and understanding of the patient’s coexisting medical conditions and management of the patient’s actual or anticipated physiological derangements during a diagnostic or therapeutic procedure.

While Monitored Anesthesia Care may include the administration of sedatives and/or analgesics often used for Moderate Sedation, the qualified anesthesia provider of MAC is focused exclusively and continuously on the patient for any attendant airway, hemodynamic and physiologic derangements.

Further, **the provider of MAC must be prepared and qualified to convert to general anesthesia**. The proceduralist providing moderate sedation may have their attention diverted to their primary focus, the procedure. Additionally, a provider’s ability to intervene to rescue a patient’s airway from any sedation-induced compromise is a prerequisite to the qualifications to provide Monitored Anesthesia Care.

By contrast, **Moderate Sedation** is not expected to induce depths of sedation that would impair the patient’s respiratory function or ability to maintain the integrity of his or her airway. These components of Monitored Anesthesia Care are unique aspects of an anesthesia service that are not part of Moderate Sedation.

The administration of sedatives, hypnotics, analgesics, as well as anesthetic drugs commonly used for the induction and maintenance of general anesthesia is often, but not always, a part of Monitored Anesthesia Care. In some patients who may require only minimal sedation, MAC is often indicated because even small doses of these medications could precipitate adverse physiologic responses that would necessitate acute clinical interventions and resuscitation. The attention of the proceduralist is focused on the completion of the procedure, not physiologic alterations. If a patient’s condition and/or a procedural requirement is likely to require sedation to a “deep” level or even to a transient period of general anesthesia, only a practitioner privileged to provide anesthesia services should be allowed to manage the sedation. Due to the strong likelihood that “deep” sedation may, with or without intention, transition to general anesthesia, the skills of an anesthesia provider are necessary to manage the effects of general anesthesia on the patient as well as to return the patient quickly to a state of “deep” or lesser sedation.

Like all anesthesia services, Monitored Anesthesia Care includes an array of post-procedure responsibilities beyond the expectations of practitioners providing Moderate Sedation, including assuring a return to baseline consciousness, relief of pain, management of adverse physiological responses or side effects from medications administered during the procedure, as well as the diagnosis and treatment of co-existing medical problems.

Monitored Anesthesia Care allows for the safe administration of a maximal depth of sedation in excess of that provided during Moderate Sedation. The ability to adjust the sedation level from full consciousness to general anesthesia during the course of a procedure provides maximal flexibility in matching sedation level to patient needs and procedural requirements. In situations where the procedure is more invasive or when the patient is especially fragile, optimizing sedation level is necessary to achieve ideal procedural conditions.

In summary, MAC is a physician service that is clearly distinct from Moderate Sedation due to the expectations and qualifications of the provider who must be able to utilize all anesthesia resources to support life and to provide patient comfort and safety during a diagnostic or therapeutic procedure.

## Guidelines for Office-Based Anesthesia

**Developed By: Committee on Ambulatory Surgical Care**

Last Amended: October 23, 2019 (original approval: October 13, 1999)

<https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia>

Once again, most of this very likely does not apply to WALANT ECTR procedures. Most OBS suites won’t employ an anesthesiologist.

These guidelines are intended to assist ASA members who are considering the practice of ambulatory anesthesia in the office setting: office-based anesthesia (OBA). These recommendations focus on quality anesthesia care and patient safety in the office. These are minimum guidelines and may be exceeded at any time based on the judgment of the involved anesthesia personnel. Compliance with these guidelines cannot guarantee any specific outcome. These guidelines are subject to periodic revision as warranted by the evolution of federal, state and local laws as well as technology and practice.

This is only the first paragraph. Please visit the website for the remainder of the anesthesia guideline.

## Patient Safety Principles for Office-Based Surgery

### Core Principle #1

Guidelines or regulations should be developed by states for office-based surgery according to levels of anesthesia defined by the American Society of Anesthesiologists' (ASA's) "Continuum of Depth of Sedation" statement dated October 13, 1999, **excluding local anesthesia or minimal sedation**.

### Core Principle #2

Physicians should select patients by criteria, including the ASA Patient Selection Physical Status Classification System II, and so document.

### Core Principle #3

Physicians who perform office-based surgery should have their facilities accredited by the:

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

2. Accreditation Association for Ambulatory Health Care (AAAHC)

3. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)

4. American Osteopathic Association (AOA)

5. A state-recognized entity such as the Institute for Medical Quality (IMQ)

6. State licensed. Medicare does not license office-based surgical suites.

**NOTE:** These recommendations are generic and relate mostly to the level of anesthesia level and safety issues. Most may not apply if only local anesthesia is used. However everyone interested in OBS needs to check with their accountant, their healthcare attorney, and their state medical society.

### Core Principle #4

Physicians performing office-based surgery must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

### Core Principle #5

States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding **informed consent.**

### Core Principle #6

States should consider legally privileged **adverse incident reporting requirements** as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement.

### Core Principle #7

Physicians performing office-based surgery must obtain and maintain **board certification by one of the boards recognized by the American Board of Medical Specialties**, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

### Core Principle #8

Physicians performing office-based surgery may show competency by **maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center for the procedures they perform in the office setting.** Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

### Core Principle #9

At least one physician, who is credentialed or currently recognized as having successfully completed a course in **Advanced Resuscitative Techniques** (ATLS®, ACLS, or PALS), must be present or immediately available with age and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).

### Core Principle #10

Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.

The preceding principles were based on a document that was unanimously approved by the following groups during a March 17, 2003, **American College of Surgeons** (ACS)/American Medical Association (AMA) coordinated consensus meeting on office-based surgery:

### Background

Over the past few years, there has been a noticeable increase in the number of invasive procedures being performed in the office setting. Recognizing that many states still haven't issued patient safety guidelines in this area, the **American College of Surgeons** sponsored a resolution, which was passed at the American Medical Association's December 2002 Interim Meeting of its House of Delegates. In brief, the resolution called on the AMA to work with the ACS in "convening a work group of interested specialty societies and state medical associations to identify specific requirements for optimal office-based procedures and utilize those requirements to develop guidelines and model state legislation for use by state regulatory authorities to assure quality of office-based procedures."

## Practice Expense Origins and the AMA Socioeconomic Monitoring System (SMS)

The original practice expense RVUs were based on specialty-specific information on hours worked and total practice expense spending from the American Medical Association’s **Socioeconomic Monitoring System (SMS)** and estimates of non-physician resources required for individual services made by Clinical Practice Expert Panels.

The professional liability insurance RVUs were based on reported premiums by specialty. The Centers for Medicare & Medicaid Services (CMS), which is responsible for maintaining the fee schedule, has continued to modify and refine the original methodology for estimating RVUs and developed new sources of information. CMS’s methodology relies on ensuring that each component of providing a service (such as taking a patient history, administering an injection) is valued the same across services.

Some of the SMS data have been updated by physician specialty societies through member surveys that met certain specifications, as allowed by law. CMS also relies on advice and recommendations from the **American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC).** The 31 RUC members, most of whom are appointed by a major physician specialty society, and others who provide input to CMS understand that increasing the RVUs for any service will result in a commensurate decrease in fees for other physician services, which is widely believed to help ensure that a specialty does not try to inappropriately boost the resources associated with the services it tends to provide.

Congress requires CMS to review the RVUs no less than every five years and it must develop RVUs for new services. Outside of the five-year reviews, CMS may examine the RVUs for services that it or physician specialty societies identify as being “mis-valued” and possibly needing modification.

For services selected for review, relevant specialty societies field surveys of their members to gather data on physician time and effort and the practice expenses required to provide the service. The RUC reviews these data and makes comparisons with similar services to develop its recommendations. CMS reviews the RUC recommendations and the underlying data. The proposed RVUs are then published in the Federal Register for public comment before a final change is made to the physician fee schedule. In the past, CMS accepted over 90 percent of the RUC recommendations on revisions to the RVUs. In recent years, CMS has accepted fewer of the RUC recommendations.

## SOSD Statistics

These statistics are somewhat academic but interesting if you find the insurance company wanting to get into the details of your overhead for the office-based surgical suite.

The total number of HCPC (CPT) codes in the 2022 Medicare database (including Category III codes) is 12,517.

The total number of 90-day global procedures is 3,770 (2022 Medicare PFSRVU). The median of 3,770 is approximately 1892; where we find a FAC PE RVU of 9.27 for all 90-day global including those with and without NON-FAC PE RVUs. That is a Medicare reimbursement of $311.46 based on a 2022 Medicare Conversion Factor of $34.6062. Remember that if the procedure is performed in a hospital, a Hospital Outpatient department (HOPD) or an Ambulatory Surgery Center (ASC) the facility is paid separately.

The median SOSD percent is 63.8%, 3.29 RVU’s or $118.74 at the 258 mark. The median SOSD value (RVUs) is 3.84 RVU's or $138.59 at the 258 mark. What this means is that if we asked for the median amount for the office-based endoscopic carpal tunnel release, it would be around $125 for each operation. If we believe it should be more than that we must justify the request.

The SOSD for 87 codes is *one RVU or less* ($36.09), 11 are less than $10. Some SOSD percentages are negative (which looks like a data error).

The SOSD for 18 codes is $500 or more with the highest at $5,538.73.

The total number (2022) of orthopedic procedures = 1,645.

**Orthopedic codes without a Site of Service Differential (SOSD)** = roughly 71% of all orthopedic procedures. NON-FAC NA INDICATOR = NA.

These procedures are considered "facility only" and there is no additional reimbursement when performed in an OBSS (POS=11). When performed in a facility (ASC, HOPD, or hospital) there is a separate facility fee billed and paid to the facility. For this reason, transferring to an OBSS is seen by some insurance companies as preferable as *they* save money (and the patient saves as well).

**Orthopedic codes with an SOSD** is about 29%.

**Note:** In general, codes with an SOSD are considered less risky and considered safe enough to be performed in the office or a facility. They typically can be performed under lower levels of anesthesia.

These procedures can be performed in the facility or the office and the reimbursement to the surgeon is higher for the office to pay for the OBS "overhead" or NON-FAC PE.

Some procedures (29999: unlisted procedure) do not have any RVU's.

There are 299 Orthopedic 90-day global procedures, 17.4% **with** a Site of Service Differential (either office-based or Facility).

There are 1,416 orthopedic 90-day global procedures, 82.6% **without** a Site of Service Differential (Facility-Only). The CPT Code has a status indicator of "NA" in the “Non-Facility NA INDICATOR” field.

In general, these “facility-only” procedures are more complex, require a higher level of anesthesia or pose more risk to the patient. With improvements in surgical techniques, patient safety, anesthesia and the benefits of WALANT (Wide Awake Local Anesthetic No Tourniquet) many of these procedures should be allowed and compensated as office-based surgeries (OBS).

**TAKEAWAY:** Lots of procedures, that do have an SOSD, do not pay very much. For that reason many societies are reluctant to revisit codes—without an SOSD—with the AMA RUC committee for fear that they will reduce the total RVU’s—or allow a minimal SOSD.

## GPCI Localities

In addition to the three components of RVUS (Work, Practice Expense, and Malpractice Insurance) there is also the GPCI. In 2021 there were 112 total Geographic Practice Cost Indices (GPCI) Physician Fee Services (PFS) Localities. Think of this as a cost-of-living index. Physicians are paid less in rural areas than large, expensive cities. When negotiating fees in San Francisco you ask for more than a surgeon in Jackson TN.

[2021 Update file](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PFSLOCCO.zip) (zipped).

The current Physician Fee Schedule (PFS) locality structure was developed and implemented in 1997.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Locality.html>

The current Physician Fee Schedule (PFS) locality structure was implemented in 2017 in accordance with the Protecting Access to Medicare Act of 2014 (PAMA 2014). Section 220(b) of that legislation added section 1848(e)(6) of the Act, which requires that, for services furnished on or after January 1, 2017, the locality definitions for California be based on the Metropolitan Statistical Area (MSA) delineations as defined by the Office of Management and Budget (OMB).

The resulting modifications to California’s locality structure increased its number of localities from 9 under the previous structure to 27 under the MSA-based locality structure (operational note: for the purposes of payment the actual number of localities under the MSA-based locality structure is 32).

Additionally, for some of these new localities, PAMA required that the GPCI values realized under the new MSA-based locality structure be gradually phased in (in one-sixth increments) over a period of six years. As a result of these changes to the locality structure, there are currently 112 total PFS localities; 34 localities are statewide areas (that is, only one locality for the entire state).

There are 75 localities in the other 16 states, with 10 states having 2 localities, 2 states having 3 localities, 1 state having 4 localities, and 3 states having 5 or more localities. The District of Columbia, Maryland, and Virginia suburbs, Puerto Rico, and the Virgin Islands are additional localities that make up the remainder of the total of 112 localities.