ASC Partnership as a Hospital without Walls; Easing Back into the New “Normal”

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Everyone is anxious for life to return to normal, but none more than those patients who had planned to have surgery in March or April, but had their surgery canceled due to the COVID-19 pandemic. These patients have conditions that warrant surgery but were deemed not to be urgent or emergent, and therefore could safely be delayed.

Consider one of the most common surgeries performed, the total joint replacement. These are classified as elective surgeries. But for the person with severe arthritis who can no longer walk down to the mailbox, and has exhausted all conservative measures, that surgery is not one they want to put off any longer than necessary. The same issues apply to a person with vision-limiting cataracts. Though he or she will never die from their cataracts, being unable to drive or read the morning newspaper has a major effect on their activities of daily living.

On the other hand, no one wants patients or medical personnel to be harmed by rushing to resume surgeries while COVID-19 remains prevalent. As more is learned about this virus, there is increasing apprehension among providers. The pre-symptomatic phase of infection can last several days, making screening prior to surgery vitally important. Data from China found that when patients were screened simply with questions about fever, cough, and other symptoms prior to surgery, infected SARS-CoV-2 patients can still be missed. In one small published report, over 20 percent of the 38 pre-symptomatic patients who underwent surgery died. Many hospitals are already planning for resumption of surgery by dedicating preoperative, operating room, and recovery room staff and rooms to these patients. Yet that still exposes the patient to the hospital
environment and its inherent risks. Patients who require an overnight stay, or longer, must be isolated from other patients to avoid infection, yet this is not optimal, since COVID-19 patients may still be in the same facility. Ambulatory surgery centers (ASCs) provide a more controlled environment, but are limited by state and federal laws to performing only ambulatory surgeries.

But there may be another option. Under the 1135 waiver allowing hospitals to operate without walls, any hospital may contract with an ASC to provide services “under arrangement.” Under such an arrangement, the care is provided at the ASC, but billed by the hospital as if the service was provided in the hospital, by hospital staff. With this arrangement, all types of surgery could be performed at the ASC, including surgery designated by Medicare as “inpatient only.” The only limitation would be the availability of nursing staff 24 hours a day, and the availability of proper equipment and access to consulting physicians, if needed. Since the ASC will be operating under the hospital’s license, nurses from the hospital can be reassigned to the ASC to supplement the ASC staff, and the medical staff at the hospital can provide services to the patients at the ASC using their hospital privileges. These visits can also be provided remotely by telehealth.

The billing for the surgery would be based on the designated status, inpatient or outpatient, and paid at the Inpatient Prospective Payment System (IPPS) or Outpatient Prospective Payment System (OPPS) rate to the hospital, including any amounts for IME, DSH, and other add-ons. The hospital would then pay the ASC at an agreed-upon rate. As the OPPS rate for any surgery is significantly higher than the ASC rate, both parties could be made whole from such an arrangement - and, of course, the setting has no effect on the physician’s professional fee.

Since the ASC would be operating under the hospital’s license under arrangement, the patient’s medical record and all billing information must be available at the hospital. This should be relatively easy to accomplish by “printing” the record to an electronic document and uploading that to the patient’s chart at the hospital.

While your legal, compliance, and finance staff would need to provide significant input into such an arrangement, the ability to start performing most surgeries in a COVID-19-free environment, with the ability to keep patients “hospitalized” as long as medically necessary, will let almost all patients get the care they need. This seems like a win-win-win-win for patients, doctors, ASCs, and hospitals.